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Sexual Abuse Issues

Introduction

This chapter will address child sexual abuse allegations, investigations, and interventions, focusing on how they are handled in the child welfare system. Since child sexual abuse is also a crime and requires multi-agency collaboration, attention will be given to how the criminal justice system and other systems interface with the child welfare system on sexual abuse cases.

Estimates are that about half of sexual abuse cases are intrafamilial; they involve a child’s caregiver as the abuser (e.g., father or stepfather) or as being neglectful and not preventing sexual abuse (e.g., when a babysitter is the abuser and the caregiver has knowledge of the abuse) (e.g., Faller 2003). The remainder of sexual abuse cases are extrafamilial. In most communities, the child welfare system is only responsible for intrafamilial cases. Extrafamilial cases are handled solely by law enforcement, but since law enforcement also has responsibility for intrafamilial sexual abuse, child protective services and law enforcement are intended to work together on intrafamilial cases of sexual abuse (Pence & Wilson 1994).

Definition of child sexual abuse

The definition of sexual abuse found in the CAPTA, the Federal Child Abuse Prevention and Treatment Act, is as follows:

“the term “sexual abuse” includes — “ 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 “the rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or
incest with children” (CAPTA 2010). For states to be eligible for federal discretionary funds, their state statute definition must be consistent with the federal one.

Child welfare professionals, however, further define sexual abuse in terms of: 1) the types of the sexual acts and 2) criteria for differentiating an abusive versus a non-abusive sexual encounter.

(B) Types of sexual acts
Although definitions vary somewhat, generally sexual acts include: 1) non-contact behavior (voyeurism, making sexually explicit remarks, exposure of private parts, and internet sexually explicit content); 2) sexual contact (touching of the breasts, vagina, penis, and anus); 3) oral sexual acts (tongue kissing, cunnilingus, fellatio, analingus); 4) sexual penetration (digital, penile, and object penetration of the vagina and anus); and 5) sexual exploitation (child prostitution, child pornography). Sexual contact, oral sex, and sexual penetration may involve the offender committing the act against the child or requiring the child to engage in the act on the body of the offender. When children view sexual content on the Internet, caregivers may be defined as neglectful and as inadequately supervising their children. There is also an increased incidence and awareness of Internet crime involving sexual exploitation of children (Finkelhor, Mitchell, & Wollack 2000), but, in these instances, the offenders are usually not the child’s caregivers. Nonetheless, caregivers may be viewed as neglectful because they did not protect their children from exploitation.

(B) Defining an encounter as abusive
Sexual acts 1-4 are neither abusive nor illegal when they involve consenting adults. For the act to be considered abusive, the sexual act is usually characterized by an age differential between offender and the child victim, a knowledge differential between offender and victim, a power
differential, and lack of victim informed consent. States vary in the maximum age for child protective services (usually 17) (Federal, State, and Tribal Laws 2011). As a rule, child sexual abuse is defined as sexual acts involving a child (a person under the age of 18) and a person five or more years older than the child. The child is often naïve about the meaning of the act (its sexual nature and/or that it is a crime), but the offender is not. Although the offender may use a variety of inducements to engage the child, such as saying the act is a game or is educational, ultimately the offender has greater physical and psychological power than the child. Some acts are physically pleasant for the child, but abusive acts are primarily for the sexual gratification of the offender. Finally, even though the child may agree to the act, because of lack of knowledge and power, the child cannot provide informed consent to the sexual act (Finkelhor 1979).

Demographic Patterns for Children, Youth, and Families Affected

Sexual abuse cases currently represent about 10% of annual reports of child maltreatment as found in the National Child Abuse and Neglect Data System (NCANDS) (Child maltreatment 2011). Sexual abuse reports increased from 1976, when national data were first collected (3% of reports; 6000 cases) until 1986 (15% of reports; 132,000 cases) (American Association for the Protection of Children 1988). There were then three years with no national federal government reports of child maltreatment while the Children’s Bureau developed the NCANDS (Faller 2003). In 1990, when NCANDS data first became available, sexual abuse still represented 15% of reports. However, since the early 1990s, the number of reports of child sexual abuse has declined (Finkelhor & Jones 2006). There have been comparable declines in reports of physical abuse, but not of neglect (Sedlak, Mettenburg, Basena, Petta, McPherson, Greene, & Li 2010).

Other than providing incidence rates for sexual abuse, the NCANDS (2011) provides little information about the demographic patterns of child sexual abuse. The National Incidence
Studies (NIS-1, 2, 3, 4) do, however. NIS studies gather data from a nationally representative sample of “sentinals,” professionals who are mandated reporters. Data collection involves queries of sentinals about how many child maltreatment cases they encountered in a three month period and how many were reported. The research compares sentinel identification and child welfare system responses, uses sentinel reports to make national projections, and provides findings on characteristics of different types of child maltreatment, including child sexual abuse (Sedlak et al. 2010). In addition, knowledge of sexual abuse comes from studies of representative samples and special populations of adults, who are asked about their sexual abuse during childhood (e.g., Kilpatrick & Saunders 1999; Russell & Bolen 2000) and a few telephone surveys of youth, which ask them about their experiences of victimization, including sexual abuse (Finkelhor 2008). These studies can inform us about the prevalence, risk factors, and characteristics of child sexual abuse. Finally, there are studies of sexual offenders, who may be incarcerated or in treatment, that shed some light on the problem of sexual abuse (e.g., Abel, Mittelman, & Becker 1985; Prentky, Knight, & Lee 2006).

Unlike physical abuse and neglect, there is scant evidence that sexual abuse is related to the stress and circumstances of poverty and disadvantage (Finkelhor & Baron 1986; Russell & Bolen 2000). Research and practice suggest that the primary causes are: 1) sexual arousal on the part of the offender to children, which may be circumstantial and/or fixed, and 2) the offender’s willingness to act on the arousal (Faller 1988, 2003; Lanning 2001; Prentky, Knight, & Lee 2006). This is not to say that family and environmental factors do not contribute to the risk of sexual abuse, but they are not prerequisites (Faller 1988). Despite the lack of association between sexual abuse and poverty/disadvantage, cases of sexual abuse that come to the attention of the child welfare system are more likely to involve poor and disadvantaged families because these
cases are more likely to come to the attention of professionals who comply with reporting statutes (Sedlak et al. 2010).

Similarly, child sexual abuse does not appear to be related to race (Finkelhor 1994; Russell, Schurman, & Trocki 1988). There are, however, cultural differences in how sexual abuse is perceived, experienced, and responded to (Fontes 1995; Fontes & Faller 2007; Fontes & Plummer 2010). Thus, there are no risk differentials based upon racial identity.

Virtually every study finds that girls are a greater risk for sexual abuse than boys. In terms of prevalence, Bolen and Scannapieco’s (1999) meta analysis found that between 30-40% of females experience sexual abuse during childhood. There are fewer studies of male sexual abuse victimization, but estimates are that between 8 and 20% of males are sexually victimized during childhood (Bolen & Scannapieco 1999; Finkelhor 1979; Gorey & Leslie 1997). Regarding incidence rates, approximately 80% of reports involve female victims and 20% males (Finkelhor & Baron 1986; Sedlak et al. 2010). However, boy victims may be less willing to self-identify as victims than girls, and, because of gender differences in sexual socialization, boys may be less likely to perceive a sexual encounter with an adult as an assault than girls, and may experience it as an “opportunity for sex” (Faller 2003; Finkelhor & Baron).

Perpetrators of sexual abuse are predominantly males, an estimated 90-95% being males (Russell & Bolen 2000). In the NIS-4 study, 87% of offenders were males (Sedlak, et al. 2010). However, there are concerns that both professionals and the public fail to recognize female sex offenses and that many acts by female perpetrators go undetected because they occur in the privacy of the home (Faller 1995).

There is some evidence that children living with only one of their parents are at greater risk for sexual abuse (Finkelhor & Baron 1986; Moore, Gallup, & Schussel 1995; Sedlak, et al.
2010). This increased risk may derive from having a stepfather, the fact a mother has a non-related partner (either live-in or not), or the fact that children in single parent families live in changing and unpredictable circumstances.

**Societal Context of Child Sexual Abuse**

Although child sexual abuse is against the law and clearly considered abusive behavior, experts in sexual abuse note cycles of disbelief and belief of sexual abuse reports. These cycles characterize both professional and the public responses (Mildred 2003; Olafson, Corwin, & Summit 1993). The influence of Sigmund Freud and psychiatry contextualizes these cycles. Freud is considered to be the father of psychoanalysis, and arguably of psychotherapy (Brill 1938; Brown 1972). In 1896, Freud gave a paper entitled The Aetiology of Hysteria, in which he proposed that the origin of hysterical illness, a mental illness currently labeled a somatoform disorder (DSM-IVCTR 2000: 485), was traumatic sexual abuse during childhood. His paper received a chilly reception from his Viennese colleagues (Masson 1984). In 1905, he formally retracted the theory that his patients had experienced actual sexual abuse and proposed instead that their reported experiences were Oedipal fantasies—that is, wishes to have sex with the named adult (Masson 1984). This recasting of the alleged victim into a perpetrator and alleged perpetrator into a victim had a profound effect on views about sexual abuse allegations. For over 50 years, based upon Freud's later work and writings, mental health professionals believed that the overwhelming majority of children's accusations of sexual abuse had their basis in fantasy (Faller & Corwin 1995; Lipian, Mills, & Brantman 2004; Masson 1984; Olafson, Corwin, & Summit 1993). Child sexual abuse, especially intrafamilial sexual abuse, was considered a very rare phenomenon (Riemer 1940).
After the passage of the Child Abuse Prevention and Treatment Act in 1974, sexual abuse cases began to be reported in increasing numbers. Ironically, child protection investigators, most of whom were not trained in Freudian psychology, did not initially approach such allegations with skepticism. They “believed the child” (Faller 1988). The “believe the child” response to sexual abuse reports, however, was short-lived. In the late 1980s and early 1990s, Child Protective Services (CPS) experienced a general backlash (Hechler 1988; Myers 1994b). The system was criticized for both overreaching and incompetence. Most of the criticism was directed toward handling of child sexual abuse allegations (Finkelhor 1994; Myers 1994b). Myers identified three reasons for the particular focus on child sexual abuse: 1) the degree of emotion generated by sexual abuse of children; 2) society’s blind spot (about child sexual abuse); and 3) the failings of the child protection system (Myers 1994b:19). Faller (1993) identified competing affective responses to child sexual abuse as “rage” (How could someone commit the heinous act of sexual abuse on a child?) and “denial” (No one would sexually abuse a child.) as playing an important role in the pendulum swing between believing and disbelieving. However, very important in the backlash is the fact that middle class and prominent people were being accused of sexually abusing children, persons with power and resources (e.g., Michael Jackson and Woody Allen). In addition, the backlash was fueled by a number of multi-victim cases with a great deal of media coverage (Scott County, McMartin, Wee Care, Little Rascals). These cases challenged belief in a way that the more typical case (a one-time instance of sexual abuse of a single child) does not (Berliner & Loftus 1992).

Subsequent to the backlash of the late 1980s and early 1990s, cases involving sexual abuse by clergy, focusing primarily on Roman Catholic clergy, have decreased skepticism about child sexual abuse. In large part because of the role of investigative journalists, beginning in
2002 clergy sexual abuse began to be taken seriously (e.g., Bruni & Burkett 2002; Goodstein & Zirilli 2003). In that year, the U.S. Conference of Catholic Bishops commissioned a study of church records conducted by the John Jay College of Criminal Justice (Terry 2010). This study spanned records from the years 1950-2002 and documented sexual abuse cases involving more than 4,000 Catholic clergy and over 10,000 children.

Clergy abuse cases are not usually handled by Child Protective Services, but their documentation moderated the backlash and skeptical response to allegations of child sexual abuse. Nevertheless, certain types of cases, for example those involving parents who are not together and may be adversarial, are especially likely to encounter a skeptical response by child protection workers when they are reported (McGraw & Smith 1992).

**Current Policies at Federal and State Levels**

CAPTA has a “sunset clause,” that is it is time limited. Thus, it requires periodic reauthorization (Child Welfare Information Gateway 2011). Altogether there have been 11 reauthorizations and amendments, the most recent being in December, 2010. These changes frequently involve the inclusion of new policy or the refinement of existing policy. Policy updates may also be made via other federal child welfare statutes, for example the VOCA statutes.

**The “Criminalization” of Child Sexual Abuse**

Policy changes related to sexual abuse have shifted the child welfare response from treating this type of maltreatment as a parental problem to responding to it as a crime. Changes include fostering joint investigations of sexual abuse allegations by child protection and law enforcement, the development of sex offender registries, and not requiring reasonable efforts toward family reunification when sexual abuse has been proven in the child protection court (CAPTA 2010).
An unanticipated outcome of these changes has been some goal displacement in the child welfare system. The priority goal of the sexual abuse investigation and intervention has shifted from child safety, permanence, and wellbeing to gathering information for successful criminal prosecution. Although statutory changes have played a role in this shift, so has the relative status of child welfare professionals (lower) and legal professionals (higher) and differences in their cultures (problem-solving versus confrontation) (Faller & Vandervort 2007).

Because in most criminal cases, the child must testify in court, the child’s role may be transformed from a victim in need of protection and treatment to a vehicle for proving the criminal case. Law enforcement and the prosecutor may dictate interventions. Emphasis during the investigative interview of the child may shift from what is most helpful for the child to what is “forensically defensible” in a criminal court. Criminal litigation is often protracted. Research indicates the delays in the court process exacerbate child trauma (Runyan, Hunter, Everson, & Whitcomb 1994). Sometimes prosecutor delays the child’s individual or group treatment to avoid the defense’s challenge that the child’s account has been contaminated and to try to ensure the child will be emotional on the witness stand. Since one goal of treatment is to address the child’s emotional dysregulation, treatment may result in the child being a less distraught witness (TF-CBT WEB 2005).

**Children’s Advocacy Centers**

Another important policy and programmatic innovation has been the development of Children’s Advocacy Centers (CACs) (National Children’s Advocacy Center 2011). Although the primary goal of CACs is to gather information for criminal prosecution, CACs also focus on the child. The core concept is that the child should come to one child-friendly place (the CAC) for all of the investigative procedures: a forensic interview conducted by a skilled interviewer and a
medical exam conducted by a medical professional experienced in conducting child abuse medical exams. CACs usually have multidisciplinary teams, led by the prosecutor, but involving child protective services, law enforcement, a victim advocate, and sometimes mental health professionals who can provide treatment. These professionals may be behind a one-way mirror observing the child’s forensic interview or the interview may be videotaped for later viewing by key professionals. Goals of CACs also include minimizing the number of times the child is interviewed and coordinating case intervention (NCAC 2011).

The first CAC was developed by the District Attorney in Huntsville, AL, Bud Cramer, in 1984 (NCAC 2011). The concept caught on, and soon there was a loose network of 23 CACs (National Children’s Alliance 2006). Children’s Advocacy Centers received national recognition and federal financial support when District Attorney Cramer became U.S. Congressman Cramer. In 1992, Cramer persuaded his colleagues in Congress to add a provision to the Victims of Child Abuse legislation funding Children’s Advocacy Centers (CACs) (Bud Cramer n.d; Faller & Palusci 2007). Today there are over 700 CACs accredited by the National Children’s Alliance (NCA), which is a membership organization of CACs. The NCA sets standards for membership and administers the federal funds to support CACs. Standards that must be satisfied include 1) a multidisciplinary team, 2) cultural competency and diversity, 3) forensic interviews, 4) victim support and advocacy, 5) medical evaluations, 6) some mental health services, 7) case review, 8) case tracking, 9) organizational capacity), and 10) a child-focused setting. These standards are intended to engender uniformity in CACs, but in fact there is considerable variability because of the venues where centers are located and the differences in the professions instrumental in each center’s development. CACs may be free-standing entities, located in hospitals, found in treatment agencies, under the umbrella of the prosecutor’s office, or a part of child protective
services. Professionals instrumental in their development include child protection staff, prosecutors, mental health professionals, medical professionals, and police. A challenge faced by communities as they develop CACs is how the CAC interfaces with the mandated institutions (child protective services and law enforcement) on child sexual abuse cases.

Despite the popularity of and federal funding for CACs, there was no evaluation of the CACs until 2002 (Jones, Cross, Walsh, & Simone 2007), when the Department of Justice funded a national evaluation of CACs. By that time, there were over 600 CACs and clearly collecting data on outcomes for all of them was not feasible. The researchers used a design in which they selected four well-established CACs and matched them with contiguous jurisdictions without CACs (e.g., Cross, Jones, Walsh, Simone, & Kolko 2007). The evaluation involved case record reviews of over 1,000 cases (Cross, Jones, Walsh, Simone, & Kolko 2007) and qualitative interviews with 203 parents and 65 youth (Jones, Atoro, Walsh, Cross, & Shadoin 2007). Thus, despite the limited number of jurisdictions involved, this evaluation was a very complex undertaking.

Selected findings follow. With regard for whether the investigation took place in a child-friendly environment, 85% of CAC investigations did, whereas in non-CAC communities investigative interviews occurred in the family home, in the CPS office, or at the police station. CAC investigations were more likely to involve both CPS and law enforcement (Cross et al. 2007). In the CAC and comparison counties, children typically experienced two or fewer interviews. However, the mean number of interviews at CACs was significantly higher (1.42) than non-CAC communities (1.29, p<.05) (Faller & Palusci 2007). That said, more than a single interview by the same professional is not problematic (Faller 2007; Faller & Palusci 2007). There were too many missing data to examine whether CAC investigations were more likely to
result in criminal prosecution. When CAC and non-CAC data are combined, 329 cases had sufficient information to determine whether criminal charges were filed. The researchers determined that cases with evidence in addition to the child’s disclosure (e.g., confession, an eye witness, physical evidence) were more likely to result in criminal charges (Walsh, Jones, Cross, & Lippert 2010). Children interviewed at CACs were twice as likely as non-CAC children to receive a medical exam (Walsh, Cross, Jones, Simone, & Kolko 2007). Finally, in general, parents were more satisfied with CAC investigations than non-CAC investigations, but the only difference found for children was that they were less scared if they were interviewed at a CAC (Jones, Atoro, Walsh, Cross, Shadoin, & Magnusson 2010).

Evidence-based Interventions

The salience of child sexual abuse in child welfare has led to important innovations. Two evidence-based interventions will be discussed in this section, forensic interview protocols and trauma-focused cognitive behavior therapy. These interventions subsequently have been applied to other types of child maltreatment.

Forensic Interviewing

One of the positive outcomes of the backlash of disbelief of sexual abuse reports was the development of better strategies for investigation of sexual abuse cases. When child protection workers began to encounter sexual abuse reports in the late 1970s, they lacked skills for investigation (Faller 1988). These workers and others interviewing possible sexual abuse victims were charged with “confirmatory bias,” that is only gathering data to support sexual abuse. They were also accused of asking leading and suggestive questions (e.g., Ceci & Bruck 1995).

What emerged out of this challenge to child protection was a series of efforts to develop forensic interviewing protocols (e.g., APSAC 1997; Bourg, Broderick, Flagor, Kelly, Ervin, &
A major purpose of these protocols is to avoid an interview that might lead to a false accusation (Faller 2007). Interview protocols specify phases of the interview (3-9) and vary in flexibility, from completely scripted to allowing interviewer discretion. A useful way to conceptualize the interview structure is as having a beginning (introduction of interviewer and purpose of the interview, ground rules, rapport building, and practicing narratives); a middle (inquiry about abuse with follow-up probes); and an end (ascertaining other sexual abuse, providing closure, and giving information about next steps) (Faller 2007).

Forensic interview protocols also define appropriate types of questions and differ somewhat in what are considered appropriate questions. Nevertheless, there is general agreement that open-ended questions and probes (e.g., “Tell me the reason you came to talk to me today.”), which are more likely to elicit a narrative response and accurate information, are preferred. Protocols then advise either narrative cues (e.g., “Say more about that.” “Then what happened?”) (e.g., Faller 2007; Lamb, Orbach, Hershkowitz, Esplin, & Horowitz 2007) or “wh” questions (e.g., “Where were other people?” “What room were you in?”) (Bourg et al. 1999). Most protocols advise using yes/no and multiple choice questions sparingly because they do not elicit a narrative account. Finally, most protocols warn against the use of leading questions (e.g., “Isn’t it true that Mr. Jones touched your peepee?”) because they may elicit false positives (e.g., Faller 2007; Lamb et al 2007).

Despite the proliferation of protocols, by far the most influential and evidence based is the National Child Health and Human Development (NICHD) forensic interview protocol (Lamb et al. 2007). The NICHD protocol was built upon child development research (Lamb &
Moreover, the NICHD researchers have partnered with frontline investigators in order to conduct field studies of their protocol. These partnerships have been developed in the U.S. (Salt Lake City), Quebec, England, and Israel (e.g., Lamb, Orbach, Sternberg, Aldridge, Pearson, Stewart, & Bowler 2009; Lamb et al. 2007). The most impressive partnership has been with Israel, where Israeli Youth Investigators (the equivalent of child protection workers) conduct investigative interviews of children when there are allegations of intrafamilial and extrafamilial physical and sexual abuse, using the NICHD protocol. These interviews are audiotaped and therefore can be transcribed for analysis. In addition, these researchers have a data bank that includes over 25,000 physical and sexual abuse cases interviewed by Israeli Youth investigators over a five year period (Hershkowitz, Horowitz, & Lamb 2005). These U.S. and international research collaborations have resulted in dozens of articles and several books (e.g., Pipe, Lamb, Orbach, & Cederborg 2007; Lamb, Hershkowitz, Orbach, & Esplin 2008), which demonstrate the utility of the NICHD protocol and answer many pressing questions about how best to interview a child when sexual abuse is suspected (e.g., Hershkowitz, Orbach, Lamb, Sternberg, & Horowitz 2006; Lamb, Orbach, Hershkowitz, Horowitz, & Abbott 2007).

Today in most jurisdictions, part of the child protection new worker training involves instruction on how to conduct a forensic interview. Some states have a forensic interview protocol that workers are required to follow when they interview a child about sexual abuse (e.g., Michigan Forensic Interview Protocol 2011).

**Treatment for Sexual Abuse Victims**

Beginning when children were identified as having been sexually abused in the 1980s, the assumption was that they needed treatment (Staller & Faller 2010). However, unlike sex offender treatment (see for example, the Association for the Treatment of Sexual Abusers website,
ATSA), there was little attention to type and effectiveness of treatment. Beginning in the 1990s, initiatives by the National Center on Child Abuse and Neglect (a program of the Children’s Bureau) and the National Institute of Mental Health (one of the National Institutes of Health) funded research to study the treatment of sexually abused children. University-based programs, using cognitive behavioral approaches to sexual abuse treatment, received this support. They shared findings, and out of these collaborations came Trauma-focused Cognitive Behavioral Therapy (TF-CBT) (e.g., Cohen, Berliner, & Mannarino 2000; Deblinger & Hefflin 1996; Deblinger, Mannarino, Cohen, & Steer 2006). These clinicians/researchers have demonstrated the effectiveness of TF-CBT for children with a history of sexual abuse in both a multi-site study (Deblinger, et al. 2006) and longitudinal follow-up (Deblinger, Steer, & Lipmann 1999).

Trauma-focused Cognitive Behavior Therapy (TF-CBT) is a short-term treatment of 12-16 sessions; however, the number of sessions can be varied depending on the child and family’s needs. TF-CBT is manualized and comprised of individual sessions for the child, caretaker(s), and joint caretaker-child sessions. TF-CBT also has a free web-based training (TF-CBT WEB 2005). This training is modulized, takes about 10 hours, and leads to a certificate. The development of the web-based training was supported by the National Child Traumatic Stress Network (NCTSN.org), a network of programs under the umbrella of the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. The majority of the NCTSN programs are child welfare programs.

The ready availability of training in evidence-based treatment for sexual abuse has enhanced the ability of the child welfare system to provide treatment to children it identifies as having been sexually abused. A drawback is that the initial TF-CBT model assumed a single
source of trauma and the availability of a supportive caregiver. The current challenge is to adapt this model so that it is a better fit for sexually abused children in the child welfare system.

**Conclusion**

Child sexual abuse is an enormously challenging type of maltreatment for the child welfare system. Although reports have been declining from a high of 15-17% of maltreatment cases to approximately 10% (Finkelhor & Jones 2006), 10% nevertheless represents a substantial proportion of the caseload. Sexual abuse cases evoke strong emotions that can interfere with case management decisions (Faller 1993). Evidence that is used to substantiate or deny sexual abuse usually comes from the child’s statements and behavior. However, relying on this evidence may raise questions about the child’s perception, memory, and suggestibility (e.g., Ceci & Bruck 1995). Nonetheless, considerable progress has been made in how child protection and other professionals interview children. Child sexual abuse cases also require a great deal of coordination, especially with law enforcement. This coordination has been facilitated by the availability of Children’s Advocacy Centers in many communities. Another challenge is that permanency is often difficult to achieve because family reunification is not necessarily the appropriate goal (CAPTA 2010). Finally, although there is evidence-based treatment for sexual abuse, TF-CBT, this model assumes a single trauma (child sexual abuse) and a supportive caregiver who is also involved in treatment. These conditions may not be present in sexual abuse cases in the child welfare system. Sexual abuse may be but one of several child traumatic experiences. The child’s caregiver may be the perpetrator or neglectful because he/she put the child in harm’s way or did not react protectively when he/she became aware of sexual abuse. Despite these many challenges, the child welfare system has made notable progress in its response to child sexual abuse in the last 40 years.
References


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