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CHILD ABUSE

STATISTICS, RESEARCH, AND RESOURCES

By Jim Hopper, Ph.D.

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I am a researcher and therapist with a doctorate (Ph.D.) in clinical psychology. I have conducted survey research on rates of child abuse. I have also studied the lasting effects of child abuse - initially the psychological and behavioral effects in men, more recently effects on biology and the regulation of emotion. I am a licensed clinical psychologist, and for 15 years I have been a therapist to men and women abused in childhood, providing individual and group treatment.

My main collaborators include Dr. Bessel van der Kolk, a leader in the psychological trauma field at The Trauma Center and Boston University. I am currently a researcher and Instructor in Psychology at McLean Hospital and Harvard Medical School. In this position I am focusing on studies of substance abuse in people with histories of child abuse and PTSD.

If you are interested in my professional services, which include psychotherapy, talks, workshops, and consultations, please visit that page.

The contents of this page reflect my level of experience and expertise, as well as opinions I have formed over the years.

Please note: I work with adults who were abused in childhood, not abused children or their caregivers (but for helpful resources on this page, see Resources for Parents & Caregivers).

Finally, I would like to highlight a new page of mine, Mindfulness: An Inner Resource for Healing from Child Abuse. It explains the many benefits of cultivating mindfulness and provides resources for learning to be more mindful. For some, simply reading the page will introduce them to new and healing ways of thinking about and experiencing their own mental and emotional processes.

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Introduction - Unavoidable Controversies & Biases, in Historical Contexts

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- When thinking about statistics on child abuse, it is helpful to know that the very idea of "child abuse" is controversial.

    - Only recently, and only in particular countries and cultures, has the abuse of children come to be seen as a major social problem and a main cause of many people's suffering and personal problems.

    - Of course children have been abused throughout human history. But for people to think about child abuse as we do now, to create legal definitions and government agencies that can remove children from their homes, and to conduct thousands of research studies on the effects of abuse - these are historically and culturally embedded developments.

    - Some believe that, for the first time in history, we are beginning to face the true prevalence and significance of child abuse. Others worry that many people have become obsessed with child abuse and deny any personal responsibility for their problems while "blaming" them on abuse and bad parenting. (I believe that each view has some validity.)

    - Clearly, then, some very large contexts and controversies shape debates about particular issues concerning child abuse.

- Statistics on rates of child abuse and neglect are controversial.

- All statistics on the incidence and prevalence of child abuse and neglect are disputed by some experts. (Incidence refers to the number of new cases each year, and prevalence to the percentage of people in a population who have had such experiences.)

- Why?

    - Complex and subtle scientific issues are involved in studies that generate these statistics.

    - Even the most objective scientific research is imperfect. At least one or two methods used in any study must be chosen by researchers based on opinions and judgements, not just facts and logic. The objectively best methods available may still have limitations.

    - For example, there are important controversies about how to define abuse and neglect. This is true for official government studies and any other research study.

        - The definitions of abuse used in official government studies are based on laws, because government definitions are needed for more than research purposes. They are also needed for purposes like determining whether or not suspected abuse should be reported, investigated, "substantiated" (as actually having occurred), and lead to action by a social service agency or court.

        - In contrast, independent researchers can use different definitions because they have different purposes than government agencies, like understanding the different effects of mild and extreme emotional, physical, and/or sexual abuse.

    - No matter what kind of study it is, small changes in definitions can result in big differences in statistics on abuse and neglect.

- Some bottom lines:

    - Emotions and moral commitments influence everyone's reasoning and judgement to some extent.

    - Any experts who claim to be without bias are fooling themselves or trying

to fool you.

- The contents of this page are influenced by my values, my informed opinions, and my experiences as a researcher and therapist over many years.

- This page includes links to Web sites that address these issues and provide statistics, including sites with different statistics and points of view on these issues.

Sources of Statistics - Official Numbers, Actual Numbers, & Estimates

Contents

- Most abused and neglected children never come to the attention of government authorities.

- This is particularly true for neglected and sexually abused children, who may have no physical signs of harm. In the case of sexual abuse, secrecy and intense feelings of shame may prevent children, and adults aware of the abuse, from seeking help.

- Therefore, official government statistics do not indicate actual rates of child abuse.

- Government statistics are based on cases that were (a) reported to social service agencies, (b) investigated by child protection workers, and (c) had sufficient evidence to determine that a legal definition of "abuse" or "neglect" was met. In the official government studies linked to below, terms like "substantiated cases" (United States) and "registered children" (England) refer to such cases.

- In short, official government statistics are only "the tip of the iceberg."

- In general, four major types of studies are the sources for large-scale child abuse statistics:

    1. Studies that collect official government statistics.

    2. Studies that include official government statistics plus additional sources of data intended to "provide a more comprehensive measure of the scope of child abuse and neglect known to community professionals, including both abused and neglected children who are in the official statistics and those who are not" (quote from U.S. National Incidence Study).

    3. Studies that survey a "representative" sample of people (e.g., from a country) about their first-hand knowledge of child abuse. Typically questions refer to incidents in respondents' own households over the past year, and usually only adults are surveyed, but sometimes adolescents as well.

4. Studies that survey adults and ask them to recall and report abuse that they may have experienced in childhood.

- All four types of studies are linked to, discussed and/or critiqued on this web page. The critical discussions of methogological issues - that is, tools to help you to avoid being confused and misled - are in "Statistics Are Human Creations" and "Retrospective Survey Research Methods."

- To begin thinking critically about the issues involved, consider these questions: Which of the following are easier for people to do? In which resulting statistics would you have more confidence?

    1. To choose to tell someone in authority, particularly if you are a child, family member, victim or perpetrator, that you know or suspect abuse is currently occurring, especially if you know that your report could result in an investigation by a social service agency, removal of the child or perpetrator from the home, etc. (Source of official statistics.)

    2. To acknowledge, anonymously, as an adult or adolescent, that incidents researchers could define as "abuse" - but probably do not in the survey - have occurred in your own household within the past year. (Source of incidence statistics from surveys on directly witnessed abuse.)

    3. To report, as a professional trained to recognize child abuse, an estimate of how many cases came to your attention over the past year. (Source of supplemental data in studies like the U.S. National Incidence Study.)

    4. To acknowledge, anonymously, as an adult, in an interview or on a questionnaire, that when you were a child someone behaved toward you in a way that fits a definition of "abuse" - again, without ever having to label the experience as abusive. (Source of prevalance statistics from retrospective surveys.)

Statistics Are Human Creations - Tools to Avoid Being Confused & Misled

Contents

I've already mentioned (Introduction) that historical and cultural factors have created and shaped the concept of "child abuse" as most of us understand it today. The same is true of our relationship to statistics: it is embedded in historical and cultural patterns, particularly how science and statistics are used to define important social problems, shape debates about them, and decide public policies.

Unfortunately, our healthy respect for scientific research, empirical data and quantifiable knowledge is often untempered by critical thinking:

- We often don't believe a problem is significant, or even real, unless those who say so can provide impressive-sounding statistics.

- The media often insist on such statitics for their stories, even if no good ones

exist.

- The media often report on statistics, good and bad, without providing the information we need to evaluate their quality and meaning.

- The media seldom tell us:

    - How was the problem defined?

    - What questions were asked?

    - What methods were used to seek answers?

    - Who was studied or asked the questions?

    - If one statistic is compared to another statistic from an earlier study, were different methods of measurement used, or was the object of measurement changed or redefined?

- Finally, even when the necessary information is provided, most people simply don't have the tools to think critically about statistics.

Again, widespread uncritical faith in statistics is historically fairly recent. And it causes significant confusion - among members of the media, politicians, judges, and advocates for various causes, not to mention average citizens. Therefore, having tools for thinking critically about statistical findings reported in the media (and on the web) will help you better understand a variety of important issues, not just child abuse.

Two good, recently published books can help you cut through the confusion and hype that surround most presentations of statistical and scientific findings in the popular media. In this section, I introduce those books, provide a few short excerpts from each, and link to a radio show in which the authors discuss these issues.

Keep in mind that the authors of these books, like everyone else, have their biases. The trick is to take what they can teach you (quite a lot), and use it to detect and critically evaluate those biases, even when they are presented as obvious truths.

The 3 parts of this section:

- *It Ain't Necessarily So: How Media Make and Unmake the Scientific Picture of Reality*

- *Damned Lies and Statistics: Untangling Numbers from the Media, Politicians, and Activists*

- Interview with the authors

Murray, D., Schwartz, J., & Lichter, S. R. (2001). It Ain't Necessarily So: How Media Make and Unmake the Scientific Picture of Reality

This book is the longer of the two, and more focused on how the media can generate confusion and mislead people. However, it covers much of the same territory as Best's book (below), in terms of how to think critically about the statistics we encounter every day, and has more discussion of child abuse statistics (excerpts below).

Praise from the book jacket:

> "Fake statistics flood the news media these days. This book is the essential antidote." - John Leo, *U.S. News & World Report*
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> "Risk and uncertainty plague our daily lives, especially when they drive media headlines. But savvy consumers of news have a new ally with the appearance of this timely and entertaining read that manages to take the process apart and show us the guts of how news is really made." - John D. Graham, Harvard Center for Risk Analysis

First excerpts on child abuse statistics from It Ain't Necessarily So - Is the trend really down?

> "A group of researchers conducted two surveys of child abuse, in 1975 and 1985. Their second survey found that reports of child abuse had dropped by almost 50 percent. In 1975, respondents were interviewed in their homes whereas in 1985 respondents were interviewed on the phone. Could this change in interviewing technique have contributed to the decrease? Or would the change have made an increase in reports more likely?
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> "[T]he answers that [researchers] receive (and newspapers report) greatly depend on precisely what the [researchers] ask and how they ask it. For this reason, the most important problem with survey data was outlined in a conversation having nothing to do with [survey research] that took place at the deathbed of the modernist writer Gertrude Stein. Alice B. Toklas, Stein's companion, hoping for a final illumination from her brilliant friend, is reported to have asked the question, 'Gertrude, Gertrude, what is the answer?' But Stein offered no blinding insight, instead parrying Toklas's question with one of her own: 'Alice, Alice, what is the question?'" (page 98).
>
> **"Asking in Person and on the Phone**
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> "In 1975 sociologists Murray A. Straus of the University of New Hampshire, [Suzanne Steinmetz of Indiana University-Purdue University at Indianapolis] and Richard J. Gelles of the University of Pennsylvania conducted the National Family Violence Survey to determine the incidence of child abuse and spousal abuse in the United States. In 1985 they conducted a second survey (the National Family Violence Re-Survey) to update their findings. Their most striking discovery was that child abuse (which they defined as kicking, biting, punching, beating, threatening with a gun or knife, or using a gun or knife) had declined by 47 percent among two-parent families with at least one child aged three to seventeen. There were thirty-six incidents of child abuse per thousand children in 1975, but only nineteen such incidents of child abuse per thousand children in 1985.
>
> "Straus and Gelles stressed that this encouraging finding could be interpreted in different ways: child abuse could actually have decreased over the ten years, or respondents could have been more reluctant to admit to child abuse in 1985 than 1975. They argued that the decrease probably

reflected real behavioral changes (resulting from factors such as the rise in average age for first-time parents, the decline in the number of unwanted children, an improved economy, expanded treatment programs for offenders, and a greater sense that child abuse is wrong and that abusers risk punishment). They did not, however, rule out the possibility that abusers were becoming less willing to own up to their own deeds in interviews with strangers. Because child abuse is stigmatized, one must always be cautious about equating what people report with what they actually did.

"For our purposes, though, the possible impact of methodological changes between the surveys is of great interest. The 1975 findings on child abuse derived from hour-long in-person interviews with parents in 1,146 households; the 1985 emerged from thirty-five-minute telephone interviews with parents in 1,428 households. What was the likely impact of the methodological changes between the two surveys?

"Interestingly, Straus and Gelles contended that 'the differences in methodology should have led to higher, not lower, rates of reported violence.' First, 'the anonymity offered by the telephone [used in 1985 but not 1975] leads to more truthfulness and, therefore, increased reports of violence.' In addition, 85 percent of the 1985 telephone interviews were completed, compared with only 65 percent of the 1975 in-person interviews; and it is 'more likely that the violence rate is higher among those who refuse to participate.' Thus 'a reduction in refusals would tend to produce a higher rate of violence, whereas we found a lower rate of violence in 1985 despite the much lower number of refusals.' Finally, in 1975 'never' was an option offered respondents as an answer to questions about violent acts; in 1985, by contrast, the response categories began with 'once' and continued to more than 20 times,' so that respondents had to volunteer an answer of 'never' themselves. Again, this shift in interviewing technique would tend to have decreased the number of denials that child abuse ever occurred.

"In short, the reported decline in child abuse was all the more significant because it seems to have occurred in spite of the methodological changes between the surveys. We see yet again that survey answers are much more meaningful when they are understood in the contexts of the way in which the questions are asked. It is interesting to look at newspaper reports of Straus and Gelles's 1985 survey to see how the methodological issues were covered or ignored. Bear in mind that it required no effort to address the survey's methodology (Straus and Gelles did not conceal the methodological issues, as tendentious researchers will sometimes do) but instead called attention to them.

"The *New York Times* reporting was exemplary. To begin with, the *Times* story was careful to note (both in the headline and in the body of the story) that the survey examined admissions of child abuse (as opposed to incidents of it): Straus and Gelles necessarily looked at what parents said they did, not what they actually did. The story also took note of the competing interpretations of the decline in reports and explored the possible impact of the switch from in-person to telephone interviewing. The *San Diego Tribune* also noted the possible impact of interviewing by telephone; but the *Chicago Tribune* and *Christian Science Monitor* ignored the methodological context for Straus and Gelles's substantive finding. Too often, even when researchers themselves stress the importance of methodology, reporters limit themselves to recounting substantive findings in a procedural vacuum" (pages 110-113).

Second excerpts on child abuse statistics from It Ain't Necessarily So - Is the trend really up?

"Secretary of Health and Human Services Donna Shalala recently declared that 'between 1986 and 1993, the number of children who were physically abused nearly doubled.' She based this claim on an increased number of reports of child abuse. But do more reports clearly show that conditions are worsening? Could they also indicate that even though behavior has not worsened, the standards by which it is judged have become more strict?" (page 133).

"Stricter Standards for Child Abuse

"The National Incidence Study of Child Abuse and Neglect was released in September 1996, following up on previous studies conducted in 1980 and 1986. The study found that child abuse and neglect were seriously worsening. Between 1986 and 1993 the number of cases doubled, going from 1.4 million to 2.8 million; and the number of cases involving serious injuries nearly quadrupled, rising from 143,000 to almost 570,000.

"Commendably, newspaper accounts (presumably following a lead raised by the study itself) alerted readers to the possible divergence between reports of child abuse and the reality of child abuse. The *Chicago Tribune,* for example, described the increase as 'a "true rise" in the severity of the problem rather than one based solely on heightened awareness.' There is certainly reason to suppose the number of cases of actual abuse might be rising, since child abuse could be expected to rise when drug and alcohol abuse were increasing and when broken homes were becoming more common.

"Nevertheless, despite the study's assurance to the contrary, there is also good reason to suppose that much of the increase reflects heightened awareness rather than worse behavior. American Enterprise Institute researcher Douglas J. Besharov (writing with research assistant Jacob W. Dembosky) advanced this argument in an article in the on-line Journal *Slate* [Child Abuse: Threat or Menace. How common is it really?]. Besharov and Dembosky noted that child abuse fatalities (for which there is, of course, objective evidence that cannot easily be hidden) have risen only modestly, going from 1,104 in 1986 to 1,216 in 1993. If serious abuse had in fact quadrupled, one would expect to see a comparably enormous increase for the most deadly abuse of all.

"Why might the study's alarming findings indicate heightened awareness rather than a true rise in awful behavior? Besharov and Dembosky observed that the study's conclusions emerge from a survey of a representative sample of 5,600 child-welfare professionals. Of the 1.4 million additional cases counted in 1993, almost 80 percent consisted of cases that do not involve physical or sexual abuse. (Note that the survey examined child neglect as well, although Shalala's written comments in releasing its findings referred only to abuse.) Fully 55 percent of the additional cases involved endangered children: those who are not actually harmed by parental abuse or neglect, but are simply 'in danger of being harmed according to the views of community professionals or child-protection service agencies.' Cases of emotional abuse and neglect made up an additional 15 percent of cases; and educational neglect, the frequent failure to send a child to school, accounted for another 8 percent.

"A similar pattern emerges regarding the serious cases that were said to have quadrupled. Of the 427,000 additional cases of serious abuse found in 1993, emotional maltreatment was at issue in half. Furthermore, cases were characterized as serious physical abuse even if they were restricted to mental or emotional injury. Finally, in three categories (sexual abuse, physical

neglect, and emotional neglect), the increase in serious cases was accompanied by a decline in moderate ones - which might suggest that the increases resulted in some measure from upgraded standards, whereby behavior once thought to be only moderately bad has now come to be considered seriously harmful.

"In short, the child abuse study appears to be a perfect example of what we have elsewhere described as the tactic of 'bait and switch': the increase does not appear to stem from many more cases of real physical abuse (as Shalala's remarks and the *Tribune* article, which nowhere discussed the study's definition of 'abuse and neglect,' implied). Instead, what is mostly at issue is a heightened awareness and sensitivity among child-welfare professionals, who now report more behavior as abusive and neglectful than they would have earlier. It seems likely that more stringent standards, rather than a greater amount of adult depravity, is what chiefly explains the rise reported in the child abuse study" (pages 138-139).

".... In principle, of course, there is nothing wrong with making standards stricter, for judging child abuse or anything else; it's certainly possible that prior standards were too lax (and not that the new, toughened standards are unreasonably exacting). But... the problem is that we won't properly understand the trendline unless we realize that our measuring instrument has been altered so that it catches examples of abuse that would have gone unrecognized in the past.

"Ironically, then, the increased conscientiousness of public servants can be mistaken for increased social depravity. If the people who keep count of various pathologies get better at their jobs, it is easy to reach the possibly false conclusion that pathology is on the upswing. In other words, an actual decline in pathology is altogether consistent with an increased number of reports of pathology (and increased societal focus on it). As new and higher standards arise, behavior that had once seemed acceptable comes to be thought heinous, so it is reported where once it had been ignored; what that can mean, though, is not that behavior has gotten worse, but that the standards of judging it have risen.

"That point has been nicely argued (with specific respect to child abuse) by sociologists Murray A. Straus and Richard J. Gelles.

> Those concerned with America's children might be pleased that each year's 'official statistics' on child abuse tops the previous year's figures. This is because the figures might indicate something quite different from a real increase in the rate of child abuse. The true incidence of child abuse may actually be *declining,* even though the number of cases is increasing.... New standards are evolving in respect to how much violence parents can use in childrearing.... This can create the misleading impression of an epidemic of child abuse [emphasis in original article; M. A. Straus & R. J. Gelles (1986), "Societal change and change in family violence from 1975 to 1985 as revealed by two national surveys," *Journal of Marriage and the Family, 48,* 466-467].

"In sum, being aware of the occasional disparity between reports and reality can be helpful, in that it can remind us of likely disparities between subjective self-reports and objective reality. But it may be still more helpful if we learn not to confuse objective observers' improvements in tabulating pathologies with actual increases in the pathologies themselves" (pages 142-

143).

See also *Explanations for the Decline in Child Sexual Abuse Cases*, an excellent 2004 paper on this issue written for the US Department of Justice by David Finkelhor and Lisa Jones. Dr. Finkelhor is an internationally renowned researcher and Director of the Crimes Against Children Research Center.

Best, J. (2001). Damned Lies and Statistics: Untangling Numbers from the Media, Politicians, and Activists.

This book has extremely clear and concise explanations of how activists, the media, experts and other key players like politicians and the staff of government agencies create good and bad statistics. The author gives you lots of tools for critical thinking about how statistics are created by people and organizations.

In fact, Best gives you some good critical tools for seeing his own biases, which come across when he addresses issues like child abuse and sexual assault. Still, we would cheat ourselves of much knowledge if we failed to learn from people we don't agree with - and Best has a lot of valuable things to teach about the social and political creation and uses of statistics. Just reading the excerpts will be very informative.

Praise from the book jacket:

> "A real page turner. Best is the John Grisham of sociology." - James Holstein, coauthor of *The New Language of Qualitative Method*

> "In our era, numbers are as much a staple of political debates as stories. And just as stories so often turn into fables, so Best shows that we often believe the most implausible of numbers–to the detriment of us all." - Peter Reuter, coauthor of *Drug War Heresies*

Excerpt 1: "The Rise of Social Statistics"

"[T]he first 'statistics' were meant to influence debates over social issues. The term acquired its modern meaning – numeric evidence – in the 1830s. . . The forerunner of statistics was 'political arithmetic'; these studies – mostly attempts to calculate population size and life expectancy – emerged in seventeenth-century Europe, particularly in England and France. Analysts tried to count births, deaths, and marriages because they believed that a growing population was evidence of a healthy *state*; those who conducted such numeric studies – as well as other, nonquantitative analyses of social and political prosperity – came to be called *statists.* Over time, the statists' social research led to the new term for quantitative evidence: *statistics*.

". . . . From year to year, they discovered, the number of births, deaths, and even marriages remained relatively stable; this stability suggested that social arrangements had an underlying order, that what happened in a society depended on more than simply its government's recent actions, and analysts began paying more attention to underlying social conditions.

"By the beginning of the nineteenth century, the social order seemed especially threatened: cities were larger than ever before; economies were beginning to industrialize; and revolutions in America and France had made it clear that political stability could not be taken for granted. The need for information, for facts that could guide social policy, was greater than ever before. A variety of government agencies began collecting and publishing statistics.... Scholars organized statistical societies to

share the results of their studies and to discuss the best methods for gathering and interpreting statistics. And reformers, who sought to confront the nineteenth-century's many social problems. . . found statistics useful in demonstrating the extent and severity of suffering. Statistics gave both government officials and reformers hard evidence – proof that what they said was true. . . .

"During the nineteenth century, then, statistics – numeric statements about social life – became an authoritative way to describe social problems. There was growing respect for science, and statistics offered a way to bring the authority of science to debates about social policy. In fact, this had been the main goal of the first statisticians – they wanted to study society through counting and use the resulting numbers to influence social policy. They succeeded. . . But, beginning in the nineteenth century and continuing through today, social statistics have had two purposes, one public, the other often hidden. Their public purpose is to give an accurate, true description of society. But people also use statistics to support particular views about social problems. Numbers are created and repeated because they supply ammunition for political struggles, and this political purpose is often hidden behind assertions that numbers, simply because they are numbers, must be correct. People use statistics to support particular points of view, and it is naive to simply accept numbers as accurate, without examining who is using them and why" (pages 11-13).

Excerpt 2: "Creating Social Problems"

"*[S]ocial* problems are products of what people do.

"This is true for two reasons. First,. . . . social problems have their causes in society's arrangements. . . . Most people understand that social problems are social in this sense.

"But there is a second reason social problems are social. Someone has to bring these problems to our attention, to give them names, describe their causes and characteristics, and so on. Sociologists speak of social problems as 'constructed' – that is, created or assembled through the actions of activists, officials, the news media, and other people who draw attention to particular problems. 'Social problem' is a label we give to some social conditions, and it is that label that turns a condition we take for granted into something we consider troubling. . . .

"The creation of a new social problem can be seen as a sort of public drama, a play featuring a fairly standard cast of characters. Often, the leading roles are played by *social activists* – individuals dedicated to promoting a cause, to making others aware of the problem. . . .

"Successful activists attract support from others. The *mass media* – including both the press (reporters for newspapers or television news programs) and entertainment media (such as television talk shows) – relay activists' claims to the general public. Reporters often find it easy to turn those claims into interesting stories. . . . Activists need the media to provide that coverage, just as the media need activists and other sources for news to report.

"Often activists depend on the support of *experts* – doctors, scientists, economists, and so on – who presumably have special qualifications to talk about the causes and consequences of some social problem. . . Activists use experts to make claims about social problems seem authoritative, and the mass media often rely on experts' testimonies to make news stories about a new problem seem more convincing. In turn, experts enjoy the respectful attention they receive from activists and the media.

"Not all social problems are promoted by struggling, independent activists; creating new social problems is sometimes the work of powerful organizations and institutions. *Government officials* who promote problems range from prominent politicians trying to arouse concern in order to create election campaign issues, to anonymous bureaucrats proposing that their agencies' programs be expanded to solve some social problem. And

businesses, foundations, and other private organizations sometimes have their own reasons to promote particular social issues. . . .

"Statistics play an important role in campaigns to create – or defuse claims about – new social problems. Most often, such statistics describe the problem's size. . . When social problems first come to our attention, we're usually given an example or two (perhaps video footage of homeless people living on city streets) and then a statistical estimate (of the number of homeless people). Typically this is a big number. The media like to report statistics because numbers seem to be 'hard facts' – little nuggets of indisputable truth. Activists trying to draw media attention to a new social problem often find that the press demands statistics. . . Experts, officials, and private organizations commonly report having studied the problem, and they present statistics based on their research. Thus, the key players in creating new social problems all have reasons to present statistics" (pages 14-18).

Excerpt 3: "The Public as an Innumerate Audience"

"Most claims drawing attention to social problems aim to persuade all of us – that is, the members of the general public. We are the audience, or at least one important audience, for statistics and other claims about social problems. If the public becomes convinced that prostitution or homelessness is a serious social problem, then something is likely to be done: officials will take action, new policies will begin, and so on. Therefore, campaigns to create social problems use statistics to help arouse the public's concern.

"This is not difficult. The general public tends to be receptive to claims about new social problems, and we rarely think critically about social problems statistics. Recall that the media like to report statistics because numbers seem to be factual, little nuggets of truth. The public tends to agree; we usually treat statistics as facts.

"In part, this is because we are innumerate. Innumeracy is the mathematical equivalent of illiteracy; it is 'an inability to deal comfortably with the fundamental notions of number and chance.' Just as some people cannot read or read poorly, many people have trouble thinking clearly about numbers.

"One common innumerate error involves not distinguishing among large numbers. . . . Because many people have trouble appreciating the differences among big numbers, they tend to uncritically accept social statistics (which often, of course, feature big numbers).

"Innumeracy – widespread confusion about basic mathematical ideas – means that many statistical claims about social problems don't get the critical attention they deserve. This is not simply because an innumerate public is being manipulated by advocates who cynically promote inaccurate statistics. Often, statistics about social problems originate with sincere, well-meaning people who are themselves innumerate; they may not grasp the full implications of what they are saying; reporters commonly repeat the figures their sources give them without bothering to think critically about them.

"The result can be social comedy. Activists want to draw attention to a problem. . . The press asks for statistics. . . Knowing that big numbers indicate a big problems and knowing that it will be hard to get action unless people can be convinced a big problem exists (and sincerely believing that there is a big problem), the activists produce a big estimate, and the press, having no good way to check the number, simply publicizes it. The general public – most of us suffering from at least a mild case of innumeracy – tends to accept the figure without question" (pages 19-21).

Excerpt 4: "Organizational Practices and Official Statistics"

"One reason we tend to accept statistics uncritically is that we assume that numbers come from experts who know what they're doing. Often these experts work for government agencies.... Data that come from the government – crime rates, unemployment rates, poverty rates – are *official statistics.* There is a natural tendency to treat these figures as straightforward facts that cannot be questioned.

"This ignores the way statistics are produced. All statistics, even the most authoritative, are created by people. This does not mean that they are inevitably flawed or wrong, but it does mean that we ought to ask ourselves just how the statistics we encounter were created....

"[C]onsider a... complicated example: statistics on suicide. Typically, a coroner decides which deaths are suicides. This can be relatively straightforward: perhaps the dead individual left behind a note clearly stating an intent to commit suicide. But often there is no note, and the coroner must gather evidence that points to suicide – perhaps the deceased is known to have been depressed, the death occurred in a locked house, the cause of death was an apparently self-inflicted gunshot to the head, and so on. There are two potential mistakes here. The first is that the coroner may label the death 'suicide' when, in fact, there was another cause (in mystery novels, at least, murder is often disguised as suicide). The second possibility for error is that the coroner may assign another cause of death to what was, in fact, a suicide. This is probably a greater risk, because some people who kill themselves want to conceal that fact (for example, some single-car automobile fatalities are suicides designed to look like accidents so that the individual's family can avoid embarrassment or collect life insurance benefits). In addition, surviving family members may be ashamed by a relative's suicide, and they may press the coroner to assign another cause of death, such as accident.

"In other words, official records of suicide reflect coroners' judgments about the causes of death in what can be ambiguous circumstances. The act of suicide tends to be secretive – it usually occurs in private – and motives of the dead cannot always be known. Labeling some deaths as 'suicide' and others as 'homicides,' accidents,' or whatever will sometimes be wrong, although we cannot know exactly how often. Note, too, that individual coroners may assess cases differently; we might imagine one coroner who is relatively willing to label deaths suicide, and another who is very reluctant to do so. Presented with the same set of cases, the first coroner might find many more suicides than the second.

"It is important to appreciate that coroners view their task as classifying individual deaths, as giving each one an appropriate label, rather than as compiling statistics for suicide rates. Whenever statistical reports come out of coroners' offices (say, total number of suicides in the jurisdiction during the past year), are by-products of their real work (classifying individual deaths). That is, coroners are probably more concerned with being able to justify their decisions in individual cases than they are with whatever overall statistics emerge from these decisions.

"The example of suicide records reveals that all official statistics are products – and often by-products – of decisions by various officials: not just coroners, but also the humble clerks who fill out and file forms, the exalted supervisors who prepare summary reports, and so on. These people make choices (and sometimes errors) that shape whatever statistics finally emerge from their organization or agency, and the organization provides a context for those choices.... In other words, official statistics reflect what sociologists call *organizational practices* – the organization's culture and structure shape officials' actions, and those actions determine whatever statistics finally emerge" (pages 21-25).

Excerpt 5: "Thinking About Statistics as Social Products"

"The lesson should be clear: statistics – even official statistics such as crime rates, unemployment rates, and census counts – are products of social activity. We sometimes

talk about statistics as though they are facts that simply exist, like rocks, completely independent of people, and that people gather statistics much as rock collectors pick up stones. This is wrong. All statistics are created through people's actions: people have to decide what to count and how to count it, people have to do the counting and the other calculations, and people have to interpret the resulting statistics, to decide what the numbers mean. All statistics are social products, the result of people's efforts.

"Once we understand this, it becomes clear that we should not simply accept statistics by uncritically treating numbers as true or factual. If people create statistics, then those numbers need to be assessed, evaluated. Some statistics are pretty good; they reflect people's best efforts to measure social problems carefully. But other numbers are bad statistics – figures that may be wrong, even wildly wrong. We need to be able to sort out the good statistics from the bad. There are three basic questions that deserve to be asked whenever we encounter a new statistics.

"*1. Who created the statistic?* Every statistic has its authors, its creators.... In asking who the creators are, we ought to be less concerned with the names of the particular individuals who produced a number than their part in the public drama about statistics. Does a particular statistic come from activists, who are striving to draw attention to and arouse concern about a social problem? Is the number being reported by the media in an effort to prove that this problem is newsworthy? Or does the figure come from officials, bureaucrats who routinely keep track of some social phenomenon, and who may not have much stake in what the numbers show?

"2. *Why was this statistic created?* The identities of the people who create statistics are often clues to their motives....

"3. *How was this statistic created?* We should not discount a statistic simply because its creators have a point of view, because they view a social problem as more or less serious. Rather, we need to ask how they arrived at the statistic. All statistics are imperfect, but some are far less perfect than others.... Once we understand that all statistics are created by someone, and that everyone who creates statistics wants to prove something (even if that is only that they are careful, reliable, and unbiased), it becomes clear that the methods of creating statistics are key. The remainder of this book focuses on this third question" (pages 26-28).

The June 8, 2001, "Science Friday" show of National Public Radio's "Talk of the Nation" included an interview with David Murray and Joel Best, authors of the books above. The piece was called "Arguing With Statistics," and all 47 minutes are available as RealAudio files for 14.4 or 28.8 (or higher) connection speeds.

Official Statistics: United States

Contents

By far the best site for official United States statistics on child abuse is the Child Welfare Information Gateway, a service of the Children's Bureau in the Administration for Children and Families, which is part of the US Department of Health and Human Services. (See the Gateway's About Us page for more information about its mission, resources, etc.)

Before following the links below, read the official definitions of maltreatment. If possible, look at the law which codified those definitions, the 1996 Federal Child Abuse Prevention and Treatment Act (CAPTA) (223 KB PDF).

CWIG collects and reports the statistics from two studies conducted using different methods.

1. Child Maltreatment: Reports from the States to the National Child Abuse and Neglect Data System
   - 2006 report/2004 data: Summary of Key Findings - HTML - 1.77MB PDF Version (get PDF Reader)
   - 2005 report/2003 data: Summary - HTML
   - 2004 report/2002 data: Summary - HTML - PDF
   - 2003 report/2001 data: Summary - HTML - PDF
   - 2002 report/2000 data: HTML - PDF

   This annual study and report is based on data reported by state agencies responsible for investigating suspected cases of child abuse. As I mentioned above, and as NCCAN recognizes, these statistics are underestimates, since most cases of abuse and neglect never come to the attention of these state agencies.

   On the other hand, there is strong evidence that incidents sexual and physical abuse of children declined in the 1990s. See *Explanations for the Decline in Child Sexual Abuse Cases*, an excellent 2004 paper written for the US Department of Justice by David Finkelhor and Lisa Jones. Dr. Finkelhor is an internationally renowned researcher and Director of the Crimes Against Children Research Center.

2. National Incidence Study - Executive Summary

   The National Incidence Study (NIS) is designed to estimate the actual number of abused and neglected children, including cases both reported and not reported to state Child Protective Services (CPS) agencies. NIS bases estimates on information from more than 5,600 community professionals who come into contact with maltreated children in a variety of settings. The most recent NIS survey (NIS-3) examines data from 1993.

   Though the statistics from this study are closer to the true rates of abuse and neglect in the US than those cited in the official Child Maltreatment reports, they may still be underestimates. On the other hand, the increase in estimated cases of abuse and neglect from the 1986 to 1993 NIS studies may reflect heightened awareness and stricter standards among professionals responsible for recognizing and investigating the abuse of children - not an actual increase in rates of child abuse and neglect. For discussions of this issue, see the excerpt above, from the book It Ain't Necessarily So, and *Explanations for the Decline in Child Sexual Abuse Cases*, an excellent 2004 paper written for the US Department of Justice by David Finkelhor and Lisa Jones. Dr. Finkelhor is an internationally renowned researcher and Director of the Crimes Against Children Research Center.

See also the Statistics section of the Gateway website, which will give you a sense of the information available.

The Gateway site has an excellent searchable catalog of publications (try searching with terms like "bibliography," "fact sheet," "prevention," and "webliography"). Many publications are available in Spanish.

Official Statistics: Canada

Contents

The best site for official Canadian statistics on child abuse is the National Clearinghouse on Family Violence, a web site of Health Canada, "the federal department responsible for helping the people of Canada maintain and improve their health."

There are now national statistics on child abuse and neglect in Canada. (Until recently these had not been compiled, largely due to the challenge posed by varying definitions of child abuse across the country's provinces and territories.)

> **Canadian Incidence Study of Reported Child Abuse and Neglect (CIS)**
> From the Foreword: "The [CIS] provides, for the first time, national estimates of child abuse and neglect reported to, and investigated by, child welfare services in Canada. These data will strengthen our understanding of the extent of child maltreatment in Canada while also guiding our policy, program, and research responses to the problem. In addition to examining the incidence rates of child maltreatment, the study explored the characteristics of the children, youth and families who were the subject of child welfare investigations for alleged child abuse and neglect. The CIS also examined selected key determinants of health to better understand their relationship to the incidence of child maltreatment."

The NCFV site also has an extensive Publications section, including many on issues related to Child Abuse and Neglect, Child Sexual Abuse, and Family Violence. The Frequently Asked Questions page has information about how to order publications. Finally, here are a few of their informative fact sheets:

- Child Abuse and Neglect
- Child Sexual Abuse
- What is Emotional Abuse
- Family Violence and Substance Abuse

NCFV also offers many videos on child abuse and family violence, for the general public and for professionals working in the field. These may be borrowed from partner public libraries across Canada (listed available on the web page), and some are available for purchase.

Official Statistics: Australia

Contents

The best site for official statistics on child abuse is the National Child Protection Clearinghouse. The Clearinghouse is a great site with many full-text articles on child abuse and its effects. It is funded by the Commonwealth Department of Family and Community Services, under the auspices of the National Child Protection Council, as part of the National Strategy for the Prevention of Child Abuse and Neglect. (See About the Clearinghouse for more information about its mission, functions, resources, etc.)

It's not easy to find the Child Protection Statistics page, but it provides excellent information - on where the official statistics come from, how to make sense of them, and links to the two most recent national studies. After reading the introductory paragraphs on that page, you can access the following:

- Comparability of Child Protection Data
  "Comparability of national data... is crucial in national reporting on child protection services.... The project used a combination of document analysis and interviews with key personnel to examine the comparability of child protection data Australia-wide.... [It found] that there were significant differences across Australia in how child protection matters are defined and that these differences impact on comparability."

- Child Protection Australia 2003-04
  ""This report is based on information from three national child protection data collections - child protection notifications, investigations and substantiations; children on care and protection orders; and children in out-of-home care. These data are collected each year by the Australian Institute of Health and Welfare from the community services departments in each state and territory. Most of the data in this report cover the 2003-04 financial year, although data on trends in child protection are also included."

- Child Protection Australia 2002-03

- Child Protection Australia 2001-02

- Child Protection Australia 2000-01

- Child Protection Australia 1999-00

- Child Protection Australia 1998-99

The Clearinghouse site has an exceptional Publications section. It includes some in-depth, sophisticated and scholarly papers on child abuse, its effects, and how to prevent it. Some good articles are somewhat hidden, inside particular issues of the Clearinghouse Newsletter.

Official Statistics: England

Contents

The best place for official statistics is not a web site dedicated to these issues, but a few pages with reports of studies conducted in a collaboration between the Office for National Statistics and the Department of Health. Links to these pages can be found under the "Children" heading of Section C - Personal and Social Services of the Health and Personal Social Services Statistics page of the Statistical Publications web site.

Every year since 1989, the Department of Health has collected and reported statistics on child abuse and neglect in the publication, "Children and Young

People on Child Protection Registers." The statistics are "derived from the statistical returns submitted to the Department of Health by local authorities and include data for individual local authorities and England estimates."

Summary information and tables from the last four annual surveys are available for free on the web. (Only the full publication "contains detailed commentary and comprehensive explanation of the figures at both England and local authority level." It is available for a charge of £8 from the Department of Health, PO Box 777, London, SE1 6XH. Fax: 01623 724 524.)

Before looking at any findings from these studies, it is important to understand some limitations of the data. The following statement is from the Statistics Division of the Department of Health:

> **Child Protection Registers**
>
> Each Social Services Department holds a central register which lists the names of all those children in the area whose names have been placed on the Child Protection Register. The decision to register the child's name takes place at a child protection conference. This decision is made if the child is at continuing risk of significant harm and hence in need of a child protection plan and registration.
>
> It should be emphasised that the primary purpose of having child protection registers is to assist in the protection of children. Their value for statistical purposes is, therefore, a secondary benefit. The registers are not intended to be a list of all children in the area who have suffered or are likely to suffer significant harm but are those for whom there is a need for a child protection plan. **These figures should therefore not be interpreted as a record of all child abuse**.

Here are links to the last 2 of these studies:

- Children and Young People on Child Protection Registers - Year Ending 31 March 2002
- Children and Young People on Child Protection Registers 2000-01

Finally, in 2000 the Department of Health, for the first time, conducted a survey of "Children in Need," that is, children in need of services from Social Services' Children and Families teams across England. The resulting report "summarizes the results of [the survey] and the activity and expenditure reported by Social Services in respect of provision for Children in Need in a 'typical' week in February 2000." The Executive Summary notes, "The main need for social service intervention on children is cases of 'abuse and neglect' which account for just over half (56%) of all Children Looked After and 28% of other Children in Need." Several related documents are available on the Department of Health web site:

- Children in Need 2004
- Children in Need 2001

Official Statistics: International

Contents

On October 11, 2006 the United Nations (UN) released the first *UN Secretary-General's Study on Violence Against Children,* which addresses violence against children within the family, schools, alternative care institutions and detention facilities, places where children work, and communities. The study took years to complete, and was supported by the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), and the Office of the High Commissioner on Human Rights (OHCHR).

As noted in the report's introduction, the study is a "first" in two important ways:

- "First comprehensive, global study conducted by the United Nations on all forms of violence against children."
- "First global study to engage directly and consistently with children. Children have participated in all regional consultations held in connection with the Study, eloquently describing both the violence they experience and their proposals for ending it."

The study and its results are being published in three formats and many languages:

- Report available online – English, French, Spanish, Arabic, Chinese, and Russian
- "Child-friendly" version, United Nations Secretary-General's Study on Violence against Children - Adapted for Children and Young People
- Book, *World Report on Violence against Children* – Information on obtaining copies will be available December 1, 2006

The report includes the following overview statistics (section II. B., pp. 9-10, with references to specific studies provided for each):

- Almost 53,000 children died worldwide in 2002 as a result of homicide.
- Up to 80 to 98% of children suffer physical punishment in their homes, with a third or more experiencing severe physical punishment resulting from the use of implements.
- 150 million girls and 73 million boys under 18 experienced forced sexual intercourse or other forms of sexual violence during 2002.
- Between 100 and 140 million girls and women in the world have undergone some form of female genital mutilation/cutting. In sub-Saharan Africa, Egypt and the Sudan, 3 million girls and women are subjected to genital mutilation/cutting every year.
- In 2004, 218 million children were involved in child labour, of whom 126 million

were in hazardous work.

- Estimates from 2000 suggest that 1.8 million children were forced into prostitution and pornography, and 1.2 million were victims of trafficking.

Our Right to be Protected from Violence: Activities for Learning and Taking Action for Children and Young People, is an educational booklet for children and young people over the age of 12, which provides information about violence and ideas for actions they can take to prevent violence and respond to it.

Here are links to the web sites devoted to the study:

- The United Nations Secretary General's Study on Violence Against Children – Official site, comprehensive, including many technical resources and background information

- Violence Against Children: United Nations Secretary General's Study – More user-friendly site, especially for kids, also available in Spanish, French and Arabic

Also see the World Health Organization's 2002 study, World Report on Violence and Health. The entire report, a 372-page and 2.4-megabyte PDF, is available in English, French, Russion or Spanish. A 54-page (600 KB) summary is available in Arabic, English, French, German, and Spanish. **Chapter 3, Child Abuse and Neglect by Parents and Other Caregivers**, is 30 pages (177 KB) and can be dowloaded in English, French, or Russian. Chapter 3 reviews and provides references for many academic studies on rates of abuse in a variety of countries (though it is not comprehensive).

There is also a 1994 paper by sociologist David Finkelhor, an internationally recognized expert on research on the incidence and prevalence of child sexual abuse, and Director of the Crimes Against Children Research Center. The countries covered in the paper: Australia, Austria, Belgium, Canada, Costa Rica, Denmark, Dominican Republic, Finland, France, Germany, Greece, Great Britain, Ireland, Netherlands, New Zealand, Norway, South Africa, Spain, Sweden, Switzerland, and the United States. Please note: Because this is a 1994 publication, and this is a growing field of research, additional studies for some of these countries and other countries have been published by now. Here's the citation and abstract:

> Finkelhor, D. (1994). The international epidemiology of child sexual abuse. *Child Abuse & Neglect, 18,* 409-417.
>
> Abstract: "Surveys of child sexual abuse in large nonclinical populations of adults have been conducted in at least 19 countries in addition to the United States and Canada, including 10 national probability samples. All studies have found rates in line with comparable North American research, ranging from 7% to 36% for women and 3% to 29% for men. Most studies found females to be abused at 1.5 to 3 times the rate for males. Few comparisons among countries are possible because of methodological and definitional differences. However, they clearly confirm sexual abuse to be an international problem."

Retrospective Survey Research Methods - Tools for Critical Understanding

Contents

This section is focused on sexual abuse and the sexual abuse of boys largely because I have conducted research in these areas. Another reason is that research on the abuse of male children was once my main area of expertise, and the sexual abuse of males remains virtually unacknowledged throughout the world.

This is a long section (4 printed pages). But please consider reading it before reading (or reading about) studies of child abuse prevalence. It will take some time, but reading this will help you to understand this kind of research, and to think more critically about opinions you encounter in the popular media.

When it comes to measuring prevalence - that is, how many children are sexually abused in childhood? - the *methods* used by researchers are absolutely crucial.

Five important methodological issues are covered below:

1. Population from which the research sample is drawn.
2. Whether or not "gate questions" are used.
3. Wording of questions or items, especially whether or not the word "abuse" is used.
4. Definitions of abuse used to categorize research data.
5. Number of questions or items.

Please note:

> I do not attempt or claim to address the definitional issue completely or authoritatively. Indeed, this is a most complex and controversial (methodological) issue, not only among researchers but in society as a whole, and not only in terms of sexual abuse but physical and emotional abuse as well. Thus I will only touch on a few important points, though certainly the definitions of "sexual abuse" applied by researchers to study data have decisive effects on estimates of the prevalence of sexual abuse.

1. An important methodological issue has to do with the population (group of people) from which a sample, or selected group of a population actually researched, is drawn. Different prevalence rates have been found in samples of: college students; clinical populations or people receiving psychological treatment; and community populations or whoever lives in some area (e.g., a city, state, or country). Other methods being equivalent, compared to samples of people receiving mental health treatment, broad community samples will yield lower prevalence rates and provide more accurate data about the rate of child sexual abuse in a society.

2. Whatever the population and sample, researchers have to ask questions. They can ask questions by interviewing research subjects, over the phone or face-to-face. They can also ask questions by giving people questionnaires, typically anonymous ones. Some have argued that anonymous questionnaires are better for research on men, who may be less willing to acknowledge unwanted sexual experiences in the presence of another person. Some who conduct interview studies disagree, and there is not yet sufficient evidence to make this judgement. Whichever of these methods is employed, there are

other methodological issues related to the nature of the questioning; for example, whether or not a subject must answer "yes" to an initial "gate question" in order to be asked more questions, the wording of the questions, and the number of questions asked. These are important methodological parameters that have had significant effects on the prevalence rates researchers have found.

For some studies researchers have used gate questions, in which a subject is only asked a series of questions about possible abuse experiences if he or she answers "yes" to an initial question. Not surprisingly, these studies have tended to find lower rates of sexual abuse in their samples. For example, someone may answer "no" to this question: "Before the age of 16, did you ever experience unwanted sexual contact with someone more than 10 years older than you?" But one minute later this same person may reply "yes" to this question: "Before age 16, did anyone more than 10 years older than you use threats or force to get you to fondle his or her genitals?" If subjects in a research study are not asked further questions after answering "no" to a general question about unwanted sexual experiences in childhood, many of those who were in fact sexually abused will be categorized as never sexually abused.

3. The wording of research questions is extremely important, and can dramatically skew prevalence rates. Imagine that an interviewer or even an anonymous questionnaire begins by asking, "Were you ever sexually abused before age 16?" This question requires subjects to scan their memories, and to decide whether or not to label any memories that come up as "abuse," which would be to accept the identity of "sexual abuse victim." Obviously most people, especially men, will automatically resist doing these things, even if they have experienced unwanted and emotionally harmful sexual experiences in childhood. So any study that uses the words "sexual abuse" will wrongly categorize some people who have been sexually abused--but don't label their experience that way--as not having been sexually abused.

This methodological issue, the wording of questions, touches on the issue of definition, and all the attendant controversy. Some people given attention by the popular media have focused on the wording of questions in ways that misrepresent research on sexual abuse and rape. Major publications like *The New York Times Magazine* have given cover-story treatment to people who have minimal understanding of social science methodology, and apparently even less interest in the truth about rates of abuse and assault in our country. These people have claimed that researchers "make up" abuse that never happened by labeling subjects' experiences as abusive even though the subjects might not.

This charge has been made against Mary Koss, an accomplished researcher who has conducted studies on prevalence rates of rape among college women (and has found that one in four have experienced rape or attempted rape since age 14). In constructing her questionnaire items, Koss made a good faith effort to use language that fit the *legal definition* of rape in the state where she lived when she conducted the research. Yet she has been accused of irresponsibly mislabeling her subjects' experiences and exaggerating rates of rape. (Decide for yourself: read Koss, M., Gidicz, C., & Wisniewski, N. [1987]. The scope of rape: Incidence and prevalence of sexual aggression and victimization in a national sample of higher education students. *Journal of Consulting and Clinical Psychology, 55,* 162-170.) One way that Koss has answered this critique is by referring to an analogous situation. I will paraphrase her argument. Imagine yourself questioning an alcoholic: Do you have more than six alcoholic drinks in one sitting several times a week? Yes. Do you often wake up with such a hangover that you can't go to work? Yes. Have friends and family members repeatedly tried to help you stop drinking? Yes. Do you

suffer from withdrawal symptoms when you stop drinking? Yes. Are you an alcoholic? No.

The point here is that good prevalence research must use *behavioral descriptions* to which definitions like "alcoholic" or "sexual abuse" may be applied. Researchers should not rely on people defining themselves as alcoholics or defining their sexual experiences as abusive. Such definitions can only be uninterpretable and unreliable. Again, for many people who have been sexually exploited and hurt by others in childhood--especially men, who aren't supposed to be victims--it's very painful to acknowledge what has happened. Researchers must not ignore the effects this can have on subjects' responses to questions about childhood experiences that may have been abusive.

For these reasons, researchers seeking to determine prevalence rates should not use the word "abuse" in their interviews or questionnaire items. Instead, they should provide *clear behavioral descriptions* of experiences to which subjects can answer "yes" or "no". When an answer is yes, further information should be elicited, including: the age of the subject and the other person involved; the nature of the relationship (parent, sibling, friend, priest, etc.); the level of coercion or violence; the number of times and period of time over which the experience happened; and the person's emotional appraisal of the event when it occurred and at the time of the research.

Here are two examples of questionnaire items employing behavioral descriptions and follow-up questions. Both are from research on the sexual abuse of males conducted by David Lisak and his colleagues (Lisak & Luster, 1994; Lisak, Hopper, & Song, 1996; see Recommended Books and Articles section of Sexual Abuse of Males for complete citations):

1. Someone fondled you (i.e., touched your genitals or other parts of your body) in a sexual way. YES_____ NO_____

   If yes...
   Who was the person?_____
   Was the person male or female?_____
   How old were you at the time?_____
   About how old was the other person?_____
   How many times did it happen?_____
   For how long did it happen (i.e., days, weeks, months, years)?_____
   How do you now feel about the experience (i.e., negative, neutral or positive)_____
   How distressing did you find this at the time:
   Not at all distressing - A . . . . . B . . . . . C . . . . . D . . . . . E - Very distressing

   How much force or persuasion did the person use?
   (Please check off the appropriate categories below.)
   Activity was voluntary_____
   They took advantage of your trust_____
   They used bribes or enticements_____
   They used sexual seduction_____
   They used intimidation or adult authority_____
   They used threats against you or someone else_____
   They used physical force_____
   Other (please explain)_____

2. A woman had you perform vaginal intercourse on her. YES____ NO____

   If yes...
   Who was the person?_____
   . . . . [see above]

4. With this kind of information researchers are in a better position to evaluate whether or not an experience fits a reasonable and understandable definition of sexual abuse.

As noted already, the definition of child sexual abuse employed in a prevalence study may be the most important methodological parameter. I will only make a few points here, to suggest some of the definitional issues in prevalence research. For example, it's easy to imagine the differences in prevalence rates the very same data will yield when categorized with each of these definitional criteria:

- A child is a person under age 16, and a sexual experience is abusive if verbal threats were used and the person feels negatively about the experience.
- A child is a person under 14 years old, and sexual abuse must involve physical force.

Besides the age of the subject at the time and the level of coercion involved, any age difference between the subject and the other person is an important factor. If a twenty year old woman has sexual intercourse with a ten year old boy, this is clearly abusive even if no physical force is used or no threats are made. Because large age differences may constitute vast discrepancies of power, especially with younger children, reasonable definitions of child sexual abuse must address the issue of age difference.

Of course, there are no clear-cut answers when it comes to definitions of child sexual abuse employed in research studies--or, for that matter, definitions used by all of us in conversation and debate. There will always be disagreements about what constitutes "sexual abuse," even among experts in this area. Some will ground their definitions in the exploitive intention of the person having the sexual experience with the child, no matter how the child or remembering adult feels about the experience. Others will believe this dilutes the meaning of the words and trivializes the suffering of people who, for example, have been raped by align="center" a parent repeatedly for years. These people will advocate for very conservative definitions.

Though they will never all agree, researchers have become increasingly sensitive to the need for carefully considered, and clearly articulated, definitions of child sexual abuse. Unfortunately, this has not been the case for most commentators and critics given attention by the popular media.

5. Finally, the number of questions asked of subjects in a research study can have a large effect on prevalence rate findings. Sadly, there are many ways to sexually abuse a child. Thus only a number of specifically worded behavioral descriptions of possible experiences (probably at least 10 to 15), will suffice for researchers trying to determine whether a person was sexually abused in childhood. Having subjects answer a number of questions also increases the likelihood that some memory of an abusive experience will be accessed. For example, a subject may read several questions before remembering and reporting an experience of sexual abuse, even though earlier questions described aspects of the same experience. Thus only by using multiple questions consisting of clear behavioral descriptions can researchers generate sufficient data to which definitions of abuse may be applied. Obviously, studies that ask fewer questions will yield lower

prevalence rates for childhood sexual abuse.

These are some of the most important methodological issues in research conducted on adults to estimate prevalence rates of child sexual abuse. Keeping these issues in mind, and the built-in biases of certain methods, will help you to understand the research below or any other studies you read about, and to think more critically about what you encounter in the popular media--especially from people who claim abuse rates are exaggerated and base their claims on uninformed or misleading critiques of research conducted by social scientists.

And there is one more very important point to keep in mind:

> Any research study, even one with the most effective methodology, is likely to *underestimate* the actual prevalence of sexual abuse in the population being investigated.

Why?

> There is evidence emerging that as many as *one in three* incidents of child sexual abuse are not remembered by adults who experienced them, and that the younger the child was at the time of the abuse, and the closer the relationship to the abuser, the more likely one is not to remember. Please see the section on Linda Williams' research on my Web page, Recovered Memories of Sexual Abuse: Scientific Research & Scholarly Resources.

Prevalence of the Sexual Abuse of Boys

Contents

Approximately one in six boys is sexually abused before age 16.

Why only the early research, up to 1996? That's when I conducted a comprehensive review for my masters thesis, and since then I've been much less focused on rates of sexual abuse among males than on how all kinds of abuse can affect men and women. This section will still be useful to people who want to understand how different research methods yield different prevalence statistics.

Please note: This section and the one above are nearly identical to sections of my page, Sexual Abuse of Males: Prevalence, Lasting Effects,and Resources. That page also contains a list of references to all the articles and books cited in this section, as well as others addressing lasting effects and links to Web pages for men who were sexually abused in childhood.

The following review is grouped into three sections, according to the sample studied:

1. Male college students.
2. Men from an identified community.
3. Men receiving mental health services.

As noted above, please keep in mind: All of the rates below are likely to be *underestimates* of the actual prevalence of the sexual abuse of boys in our society. This is so because:

> There is evidence emerging that as many as *one in three* incidents of child sexual abuse are not remembered by adults who experienced them, and that the younger the child was at the time of the abuse, and the closer the relationship to the abuser, the more likely one is not to remember. Please see the section on Linda Williams' research on my Web page, Recovered Memories of Sexual Abuse: Scientific Research & Scholarly Resources.

1. Studies of male college students have found prevalence rates from 4.8% to 28%. At the lower extreme of 4.8% is a study by Fritz, Stoll and Wagner (1981) in which 412 students responded to a self-report questionnaire that required them to label their experiences as "abusive"--a method guaranteed to cause under-reporting (see discussion in section above). Risin and Koss (1987) obtained a rate of 7.3% in a national sample of 2,972 male college students. They used eight self-report behavioral descriptions about sexual behaviors before age 14. As pure behavioral descriptions, none of the items included the word "abuse." Finkelhor (1979) used a similar list of behavioral self-report items in a study of 266 college students and found an 8.3% prevalence rate; he included non-contact experiences and used specific age criteria (if under 14 there had to be a 5 year age difference with the perpetrator, if 14-15, a 10 year difference).

Higher prevalence rates of 20% and 24% came from Fromuth and Burkhart's (1987) study of students in two separate schools. They compared the effect of different definitions of sexual abuse on prevalence rates. However, their questionnaire utilized a gate question. The highest rates of 20% and 24% came from the most inclusive definition: the same as Finkelhor's 1979 study (including non-contact and age differential criteria), but with the addition that sexual contact between peers involving force or threat was categorized as abuse.

Research on college students also has been conducted by David Lisak and his colleagues, including myself (Lisak & Luster, 1994; Lisak, Hopper, & Song, 1996). The college samples in these studies were not typical, but consisted of men who commuted to an urban university, were an average of 25 years old, and from socioeconomic background more typical of the surrounding community than many college student populations used in this research. This work yielded prevalence rates of:

- Approximately 17% for child sexual abuse of males involving physical contact.
- Over 25% when non-contact forms of abuse were included.

Non-contact experiences (e.g., a relative exposing her or his genitals to a child) were investigated because such acts are sexually exploitive and can have negative long-term psychological and interpersonal effects. However, this definition also includes experiences, like a single "flashing" episode involving a stranger, that many would argue are not abusive because the subject suffered no significant or lasting harm, if any at all. As clarified below, Lisak and his colleagues (1994, 1996) deliberately chose to weight their definition of sexual abuse in terms of the power differential accompanying significant age differences and the older person's presumed deliberate sexual use and exploitation of the younger subject. So long as significant differences in age and power existed, Lisak and his colleagues defined incidents as abusive, regardless of subjects' emotional appraisal or lasting effects (the latter were not measured).

Lisak and his colleagues (1994, 1996) used an anonymous questionnaire which has 17 behavioral descriptions of possible experiences and an 18th item for "other" experiences subjects describe. If subjects endorsed an item, they were then directed to provide further information about the experience, which was used to categorize the experience as abusive or not. If the subject was age 13 or younger when the incident occurred and the other person was at least 5 years older, the incident was classified as sexually abusive. If the subject was age 13 or younger when the incident occurred and the other person was less than 5 years older, two criteria had to be met for the incident to be classified as abusive: the subject reported feeling "negative" about it and reported that some degree of coercion was used by the other person. Similar principles apply to incidents occurring when the subject was age 14-15: the incident was classified as abusive if the other person was at least 10 years older; if the other person was less than 10 years older, the abuse classification was assigned only if the subject reported feeling negative about it and reported some level of coercion by the other person.

Though the definitional criteria in Lisak and his colleagues' studies are complex, they address two important issues.

- The reality of the power differential which characterizes relationships between adults and children, and between young children and adolescents, because whether or not a sexual experience is abusive can depend on this dynamic.
- The fact that whether or not a sexual experience is abusive can also depend on one's subjective appraisal and emotional response to the incident.

Lisak and his colleagues argue that the criteria they employed to assess sexual abuse are clear and relatively conservative in their treatment of the issues of power and subjects' responses.

A prevalence rate similar to the Lisak et al. studies was found in another study of college males. Collings (1995) used an anonymous questionnaire and defined sexual abuse as "unwanted" sexual experiences taking place before the age of 18. The term "unwanted" is likely to bias rates downward, as noted above, but the inclusion of subjects aged 16 and 17 is likely to increase the found prevalence rate. Not surprisingly, Collings found that 29% of the 284 male respondents had been sexually abused, with 20% reporting non-contact abuse and 6% reporting abuse experiences involving physical contact.

2. Studies with community samples have ranged in their prevalence rates from 2.8% to 16%. Again, methodology has been crucial. Kercher and McShane (1984) mailed a single self-report question including the word "abuse" to a random sample of Texas drivers. They found a prevalence rate of 3%. Given the wording of their single question, this rate is not surprising.

Two random-sample telephone interview studies by Murphy (1987, 1989, cited in Urquiza & Keating, 1990) also demonstrate the profound effects of single questions including the word "abuse" rather than instruments with multiple behavioral descriptions. In one of the studies (1987) the former method was employed, and it produced a rate of 2.8% with a sample of 357; in the other study (1989) the latter method yielded a prevalence rate of 11% with a sample of 777.

Bagley, Wood and Young (1994) conducted a community study of men aged 18 to 27 in the Canadian city of Calgary. They first contacted subjects by phone, then administered anonymous questionnaires in their homes via programs on portable computers. Their

questionnaire asked about "unwanted" experiences before the age of 17. This wording is likely to result in under-reporting because people who have been sexually abused, but especially males, are sometimes convinced that they wanted and were responsible for the sexual contact. Bagley and his colleagues found a prevalence rate of 15.5%, and that 6.9% of their subjects had experienced *multiple* episodes of sexual abuse. Interestingly, this rate for multiple episodes was *identical* to that found for women in a previous study that employed the same methodology, despite the fact that the prevalence rate for any unwanted sexual experiences in that study was 32%, or double that found for males (Bagley, 1991).

The highest community-sample prevalence rate of 16% was found in a random telephone survey of 2,626 men, known as the "L.A. Times survey" (Finkelhor, 1990). However, these findings are very difficult to interpret, since the wording of the questions would be expected to produce contradictory effects: each question used the word "abuse," but ended with the phrase, "or anything like that?"

In contrast to studies with women, published studies using face-to-face interviews with men have yielded very low prevalence rates, perhaps due to subjects' adherence to stereotypes about males not being victims (Urquiza & Keating, 1990). Finkelhor's (1984) face-to-face interview with Boston-area fathers yielded a rate of 6%. Siegel and colleagues (1987), using gate-question interviews with 1,480 Los Angeles-area men, found a prevalence rate of 3.8%. Baker and Duncan (1985) used a single question that described various sexual acts and found the highest face-to-face prevalence rate of 8% in their random sample of 970 men in Great Britain.

3. Studies with clinical samples have obtained prevalence rates from 3% to 23%. The lowest rate was reported from a study that used psychological records of 954 male and female patients of a large regional medical center (Belkin, Greene, Rodrique, & Boggs, 1994). In a chart review of emergency room records of a Buffalo, New York hospital, Ellerstein and Canavan (1980) found an 11% prevalence rate. DeJong and colleagues (DeJong, Emmett, & Hervada, 1982) reviewed several clinical studies and found rates from 11% to 17%, and in their own hospital population found a rate of just under 14% (1982). Metcalfe and his associates (1990) found a prevalence of 23% in their survey of 100 male psychiatric inpatients.

However, it is important to note here that assessment for sexual abuse histories in hospitals has traditionally been *extremely poor,* and remains so in many settings. Thus these rates, based on reviews of records, are likely to be vast underestimates. For example, Briere and Zaidi (1989) reviewed intake reports on women presenting to an urban psychiatric emergency room. They randomly reviewed 50 charts before and 50 after the intake staff were instructed to question clients about previous sexual victimization. The first 50 charts had recorded rates of 6%, and the second set, 70%.

Frequently Asked Questions

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No one can be an expert in everything related to child abuse and neglect, and I do not have enough time to share everything I do know via this web page. But I would like to make this page as useful as possible, particularly to the thousands of students who visit every day, looking for more information than I can provide directly.

One question that I'm often asked is this: "How do I get my husband/wife/partner/boyfriend/girlfriend/friend to get some therapy?" This is one that I attempt to answer on this page, though not in the way you may expect. See below, Resources for Spouses, Partners, Friends, etc.

I often receive emails from parents of children who are or may be being abused, for example by the other parent, and who are looking for good local help for themselves and their child (that is, therapy, and sometimes legal help). See the National Child Traumatic Stress Network's How to Find Help) page, and especially their Network Members page, which lists centers and clinics all around the US, each of which will know of excellent resources in their area. (See also the Resources for Parents & Caregivers section of this page for recommended books, etc.)

The rest of the questions below I am most frequently asked in emails from students. For each one, I have a couple of links to excellent resources on that issue, almost exclusively from the web site of the United States' Child Welfare Information Gateway.

I have one request of you: Please email me suggested additions to this section. When you find something really helpful, send me the address of the page. Your fellow students and other visitors to this page from around the world will appreciate it.

What are the (main) causes of child abuse?
Risk and protective factors for child abuse and neglect

What are the signs and symptoms of child abuse?
Recognizing Child Abuse and Neglect: Signs and Symptoms - PDF Version

What are the effects of child abuse and neglect on children?
Impact of Abuse and Neglect
Treatment for Abused and Neglected Children: Infancy to Age 18 - PDF Version
Long-term Effects of Child Sexual Abuse
Acts of Omission: An Overview of Child Neglect
See also the next section of this page, Effects of Child Abuse

How are alcohol and substance abuse related to child abuse?
No Safe Haven: Children of Substance-Abusing Parents (PDF)

What treatment is there for children who have been abused?
Treatment for Abused and Neglected Children: Infancy to Age 18 - PDF Version

How can we prevent child abuse?
Preventing Child Abuse and Neglect

Effects of Child Abuse

Contents

There are many web sites with information about possible effects of child

abuse, including findings from solid research. Unfortunately, too often these are "laundry lists" of problems and symptoms, which can lead people to believe that almost every case of child abuse inevitably leads to permanent damage and great long-term suffering. Of course child abuse can lead to problems and suffering, but it's not that simple. My aim here is to provide some basic information that helps people appreciate the complexity of this issue and avoid unnecessarily pessimistic beliefs as they seek for knowledge and understanding.

You may be wondering: "Why do I have problems dealing with emotions, relating to friends, getting close to people? Could it be related to abuse I experienced as a child? Will I (my child, husband, friend, etc.) be forever damaged by the abuse?"

I have three basic answers, or at least beginnings of answers to these questions:

1. Being abused and/or neglected as a child are not the only painful and potentially damaging experiences that human beings may suffer in childhood.

2. Whether or not, and to what extent child abuse and neglect (or other painful experiences) have negative effects depends on a variety of factors - related to the abuse itself, but also to relationships, in which the abuse and the child's responses occur.

3. Child abuse, in itself, does not "doom" people to lives of horrible suffering.

Child Abuse and the Human Condition

It is important to consider these issues in relation to what some people refer to as "the human condition." By this I mean:

- All human beings suffer painful experiences, and some of these occur in childhood.

- All caregivers of children are sometimes unable to protect them from painful experiences.

- We all need love and support to deal with the effects of painful experiences.

- Everyone must find ways to cope with the emotions generated by painful experiences - whether or not we get love and support from others.

- Many coping or self-regulation strategies work in some ways, but also limit people in other ways. For example:

    - Ignoring painful feelings may reduce one's conscious experience of them. But it also prevents one from learning how to manage them in smaller doses, let alone larger ones - which makes one vulnerable to alternating between feeling little or no emotions and being overwhelmed and unable to cope with them.

- Avoiding getting close to people and trying to hide all of one's pain and vulnerabilities may create a sense of safety. But this approach to relationships leads to a great deal of loneliness, prevents experiences and learning about developing true intimacy and trust, and makes one vulnerable to desperately and naively putting trust in the wrong people and being betrayed again.

- At the extreme, getting really drunk can block out painful memories and feelings, including the feeling of being disconnected from others - but cause lots of other problems and disconnections from people.

- Some people suffer more painful experiences than others, and abuse is one of many possible causes of extreme emotional pain (others include life-threatening illness, death of a loved one, physical disfigurement, etc.).

- Some people get more love and support from their families and friends than others, and families in which abuse occurs tend to provide less of the love and support needed to recover from abuse. But families in which abuse does not happen can also experience significant problems, and can make it hard for family members to deal with the inevitable painful experiences in life.

- Finally, because everyone needs caring relationships and love, emotional *neglect* can be more devastating than abuse, particularly in the earliest years of life.

The Effects of Child Abuse Depend on a Variety of Factors

We have learned from many people's experiences and a great deal of research that the effects of abuse and neglect depend on a variety of factors. Below I group these effects into those which research has shown to influence negative outcomes, and a variety of other factors that are harder to measure for research purposes and/or may be very important for some people but not others.

Factors research has shown to influence the effects of abuse:

- Age of the child when the abuse happened. Younger is usually more harmful, but different effects are associated with different developmental periods.

- Who committed the abuse. Effects are generally worse when it was a parent, step-parent or trusted adult than a stranger.

- Whether the child told anyone, and if so, the person's response. Doubting, ignoring, blaming and shaming responses can be extremely harmful - in some cases even more than the abuse itself.

- Whether or not violence was involved, and if so, how severe.

- How long the abuse went on.

Additional factors that are difficult to research or may differ in significance for different people:

- Whether the abuse involved deliberately humiliating the child.
- How "normal" such abuse was in the extended family and local culture.
- Whether the child had loving family members, and/or knew that someone loved her or him.
- Whether the child had some good relationships - with siblings, friends, teachers, coaches, etc.
- Whether the child had relationships in which "negative" feelings were acceptable, and could be expressed and managed safely and constructively.

Some of these factors are about how severe the abuse was, and some are about the relational context of the abuse and the child's reactions. Both types of factors are extremely important.

A great deal of research has been conducted, and continues to be conducted, on how such factors determine outcomes for those abused in childhood. Factors that increase the likelihood of negative outcomes have been referred to as "risk factors," and ones that decrease the likelihood of negative outcomes as "protective factors." Every person who has experienced abuse is unique. And every person who has experienced abuse has a unique combination of risk and protective factors that have influenced, and continue to influence, the effects in his or her life.

In summary, it is important to appreciate that these issues are very complex, and to be familiar with how abuse and neglect can - *depending on a variety of other factors* - affect various aspects of a person's life. Keep this in mind as you search the web for information and understanding about the effects of child abuse.

Finally, you may find it helpful to keep in mind what I have presented above while comparing the following articles:

- The Consequences of Child Maltreatment - example of the "laundry list" approach
- Long-term Effects of Child Sexual Abuse - example of more complex and sophisticated discussion.
- The psychological impact of sexual abuse - example of scholarly research that is not abstract or disconnected, and shows that males who are sexually abused can experience many of of the same effects as females [warning, 2 megabyte PDF, may be best to save by Right-Mouse-Click then "Save Target As..."].

About Therapy & Recovery - Resources to Inform Your Search

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For many people, recovery from significant effects of child abuse requires consultation or

therapy with a trained professional; this can also be true for those who want to effectively support someone else in his or her healing. But it is not always clear how to go about finding good professional help. You can greatly increase the odds of finding and benefiting from qualified help if you learn about the stages of recovery from the effects of abuse, about how people successfully change problem behaviors in general, and about how and where to find qualified help. Providing some of this knowledge is my goal for this section.

This section is primarily addressed to adults who experienced abuse as children, though it also has useful information for teenagers, those subjected to violence in adulthood, and people seeking help for loved ones who have been abused or assaulted.

(For more information about seeking help for a spouse, partner, friend, boyfriend, etc., see Resources for Spouses, Partners, Friends, etc. For information about finding help for children and adolescents, see the National Child Traumatic Stress Network's How to Find Help) page, and especially their Network Members page, which lists centers and clinics all around the US, each of which will know of excellent resources in their area.)

This section can be downloaded and printed as a PDF file (its hyperlinks won't work), and has four subsections:

1. Stages of treatment for child abuse trauma
2. Stages of voluntary behavioral change
3. Principles of treatment important for child abuse trauma
4. Specific resources for finding, choosing and evaluating therapists

1. Stages of treatment for child abuse trauma

Among experts in the treatment of people who have suffered from extreme child abuse and other traumas, since the early 1990s there has been a consensus on two points: treatment and healing from the effects of abuse takes place in stages, and there are fundamental principles of good treatment which apply at every stage. In this section, I address the stages of treatment and recovery. My discussion borrows heavily from Judith Herman's classic book, *Trauma and Recovery*, which goes into great depth on these stages and principles.

In this section, I mention particular types of treatment. The "Specific resources" section below (#4 within this overall subsection) has additional information about these treatments and how to find therapists experienced with them.

The first stage of healing and of any helpful therapy or counseling is about:

- Getting a "road map" of the healing process.
- Setting treatment goals and learning about helpful approaches to reaching those goals.

- Establishing safety and stability in one's body, one's relationships, and the rest of one's life.

- Tapping into and developing one's own inner strengths, and any other potentially available resources for healing.

- Learning how to regulate one's emotions and manage symptoms that cause suffering or make one feel unsafe.

- Developing and strengthening skills for managing painful and unwanted experiences, and minimizing unhelpful responses to them.

Please note that the first stage of recovery and treatment is not about discussing or "processing" memories of abuse, let alone "recovering" them. (For more on how the stages of recovery are related to memories of abuse, particularly recovered memories, see "Words of Caution II: Personal Concerns & Questions" on my page, Recovered Memories of Sexual Abuse.)

Of course, everything is not always so perfectly ordered and sequential. For example, during the first stage it may be necessary to discuss the contents of abuse memories that are disrupting one's life. This may be required to help manage the memories, or to understand why it is hard to care for oneself (the abuser suggested unworthiness of care or love, etc.). However, in this case addressing memories is not the focus of therapy, but a means to achieving safety, stability, and greater ability to take care of oneself.

Most important, the key to healing from child abuse is achieving these "stage-one" goals of personal and interpersonal safety, genuine self-care, and healthy emotion-regulation capacities. Once these have become standard operating procedures, great progress and many new choices become possible.

Depending on the person, the first stage of treatment may also involve:

- Addressing problems with alcohol or drugs, depression, eating behaviors, physical health, panic attacks, and/or dissociation (e.g., spacing out, losing time).

- Taking medication to reduce anxiety and/or depressive symptoms, for example serotonergic reuptake inhibitors (SSRIs) like sertraline (Zoloft) or paroxetine (Paxil).

- Participating in Dialectical Behavior Therapy (DBT), a treatment designed to help people who are having serious problems tolerating and regulating emotions, interpersonal effectiveness, and/or self-harming behaviors. (For more information about DBT, see Dr. Cindy Sanderson's excellent Dialectical Behavior Therapy - Frequently Asked Questions.)

Throughout all stages of treatment, it is often necessary to address psychological "themes" and "dynamics" related to one's history of abuse. As discussed below, under "Principles of treatment," some of these are core issues in child abuse trauma that should determine the very nature and structure of treatment. These include:

- Powerlessness
- Shame and guilt

- Distrust
- Reenacting abusive patterns in current relationships

In the first stage of treatment, these themes and dynamics must be addressed when they are obstacles to safety, self-care, and regulating one's emotions and behavior. Therapy can help with recognizing habitual behavior patterns, beliefs, and motivations that maintain self-defeating and self-destructive behaviors outside of conscious awareness or reflection. Increased awareness of these themes and dynamics brings increased understanding, increased ability to take responsibility for them, and increased capacities to choose new, healthier responses and actions. (Mindfulness meditation practices can also help cultivate such awareness and freedom; see my page, Mindfulness: An Inner Resource for Recovery from Child Abuse)

The second stage of recovery and treatment is often referred to as "remembrance and mourning." Even before saying what this stage is about, it is important to note that some people may decide to postpone working on "stage-two issues," and some may decide never to address them (at least in therapy).

The main work of stage two involves:

- Reviewing and/or discussing memories to lessen their emotional intensity, to revise their meanings for one's life and identity, etc.

- Working through grief about remembered abuse and its negative effects on one's life.

- Mourning or working through grief about good experiences that one did not have, but that all children deserve.

After establishing a solid foundation of understanding, safety, stability and self-regulation skills one can decide - mindful of the potential pain and risks involved - whether or not to engage in the work of stage two. In fact, once the first stage of recovery has provided such a foundation, some people realize that thinking and talking about their abuse memories is not necessary to achieve their goals, at least in the short term, and/or that those memories are no longer disrupting their life and no longer of much interest to them. (And sometimes people need to educate their therapists about this!)

For those who do choose to focus on abuse memories, or need to because the memories are still disrupting their lives, there are several therapeutic methods available for "processing memories" in the second stage of treatment. In general, these methods involve "exposure" to the traumatic memories within a safe and healing therapy setting. These treatment approaches can be very effective at ending the influence that abuse memories have over one's daily life, emotions, sense of identity, and self-understanding.

There are different psychological theories about what is involved in processing traumatic memories, and discussing these in detail is beyond the scope of this section. (One theory is that successful treatment involves "extinguishing" habitual and maladaptive fear responses to trauma reminders, and replacing them with adaptive responses. Another is that treatment "transforms" traumatic memories consisting of intense fragmentary sensations and emotions into more normal and integrated memories, ones characterized by verbal narratives rather than vivid sensations and intense emotions. Also, these theories are not incompatible.)

Theories are much less important than this fact: there are very effective therapy methods that have been proven, through years of clinical experience and extensive research, to bring great relief and healing by tranforming how people experience memories and reminders of child abuse. (Please note: such treatments do not "erase" memories, and are not designed or used to "recover" memories; if you have personal questions about this issue, see the "Words of Caution II" section on my page, Recovered Memories of Sexual Abuse).

The two most studied and research-supported treatment approaches for processing traumatic memories are:

- Eye Movement Desensitization and Reprocessing (EMDR)
- Prolonged Exposure (PE)

EMDR is a treatment that facilitates the rapid transformation of traumatic memories – without having to talk about them in detail, which makes it very appealing and accessible to many people. It is not yet known exactly which components or combination of components of this treatment are responsible for its effectiveness. But a large body of research has proven the effectiveness of EMDR as a treatment for posttraumatic stress disorder (PTSD). (Disclosure: I have conducted treatment outcome research on EMDR, funded by the National Institute of Mental Health.)

What happens in EMDR sessions, and how it is different from what happens in Prolonged Exposure sessions:

- First of all, each treatment involves at least one "preparatory" session before those involving exposure to trauma-related memories. I will not describe those here.
- EDMR has the client begin the exposure phase of sessions by focusing on the most distressing image associated with the traumatic experience, plus the emotion accompanying the image, how the emotion feels in the body, and an associated negative belief about oneself (e.g., "I deserved it," or "I'm unlovable."). Traditional exposure treatments have clients begin the exposure phase by describing, in detail, the very beginning of the traumatic event.
- Then, while holding in mind the most distressing image/emotion/body sensation/cognition, and not speaking, in EMDR the client tracks the therapist's moving finger or a moving light, as they move back and forth across the visual field, for 10 to 40 seconds. In traditional prolonged exposure, in contast, the client continues to narrate the traumatic experience from the beginning, out loud, in detail, in the sequence it unfolded during the original event. Thus not just the eye movements, but the lack of talking as well, are different at this point.
- In EMDR, the client is told, in advance, that during any set of eye movements his or her experience may or may not change, and is not "supposed" to do anything. In typical exposure therapies, the client is told in advance that they must narrate the memory in detail, in the sequence it happened, from start to finish, if necessary starting over at the beginning, until the end of the session.
- In EMDR, after each set of eye movements, the client is asked, "what are you

noticing?" (which is briefly reported), then directed to "go with that" for another set of eye movements (while not talking), after which they are again asked, "what are you noticing?" This basic, repeated sequence is the core and the majority of an EMDR session. In traditional exposure therapies, as noted above, the client continues to narrate the trauma out loud, in sequence, from beginning to end; when the end of the narration is reached, the client is directed to start over again at the beginning.

- In EMDR, if the client associates forward or backward in time, to earlier or later parts of the traumatic event, or even to completely different past events, thoughts about the future, or entirely new ideas, this is all normal and acceptable. The therapist simply checks in after each set of eye movements with "what are you noticing," does not engage in discussion of what the client reports, and directs the client to "go with that" into the next eye movement set. (Of course, if the client gets overwhelmed, the therapist will intervene to prevent the experience from being retraumatizing.) In traditional exposure therapy, if the client deviates from narrating the event in the exact sequence, in detail, the therapist (gently) directs the client to return to where they left off and continue the narration.

- Two other differences, clear from the above, are that EMDR involves many brief exposures, as opposed to prolonged exposures, and allows for incomplete exposure to details of the memory (as opposed to attempting to expose the client to all details; the aim of traditional prolonged exposure here, as described below, is to ensure that no important details are missed).

The above describes very clear differences between EMDR and traditional exposure therapy. Importantly, all of them allow the client to associate, within the session and within exposures, to different memories, themes, and ideas - including positive ones. In fact, anyone who has any experience at all with EMDR, as a client or therapist, is quickly impressed by just how many such associations and connections occur during EMDR sessions. (Therapists and clients report that such associations occur with traditional exposure therapy too, though, not surprisingly, after and between sessions as opposed to within them.)

In short, simple observation shows that EMDR is quite different from traditional exposure treatment in a variety of ways, most relating to allowing and even fostering associative processes within sessions.

Additional Information about EMDR

Because EMDR is still a "controversial" treatment in some ways, it is helpful to provide some information relevant to the controversy. Though I would rather not get into this issue, it is necessary because of the risk that some may decide not to try this very effective treatment due to misleading or inaccurate information in the popular media, on the web, even in scholarly publications. The points below are intended to explain how the controversy arose and to demonstrate that the main criticism of EMDR is not based on facts.

- EMDR was aggressively marketed before much research had been conducted on it, with some fairly extreme statements about its ability to "cure" PTSD in a few sessions, and without significant effort to explain how it works in terms of widely accepted academic theories. Thus it was inevitable that EMDR would be criticized (and at times viciously attacked) by some academic researchers – an outcome easily understood by anyone familiar with academic politics and the tendencies for

conflict between therapists and researchers in the field of clinical psychology.

- The primary and most repeated critique of EMDR, as opposed to its promotion and promoters, is this: "What works isn't new and what's new doesn't work." By this is meant that the only substantial difference between EMDR and traditional exposure treatments like Prolonged Exposure is the eye movements, and that the eye movements add nothing to the treatment. This critique can be addressed as follows:

    - It is true that some studies have found that the eye movements do not make the treatment more effective, though this issue is not settled.

    - However, it is not true that EMDR minus the eye movements is basically the same as exposure treatment.

    - In fact, there are several major differences between EMDR and traditional exposure treatments; this is very clearly demonstrated in the comparative description above.

    - Therefore, the claim "what's new doesn't work and what works isn't new" obscures just how different EMDR is from traditional exposure treatments, despite the fact that it overlaps with them too. In fact, as any informed academic theorist or researcher knows, and as explained below, using brief exposures and allowing clients to follow associations and deviate from sequential narration, according to the dominant model of how exposure treatment works, should prevent the therapy from being effective. But EMDR research, and clinical experience every day in thousands of therapy offices around the world, proves this is not so.

- Finally, for those interested in pursuing the scholarly work on the EMDR debate, a good place to start is a journal article by Susan Rogers and Steven Silver, Is EMDR an exposure therapy? A review of trauma protocols. My discussion above overlaps with theirs in many ways, but they provide much more theory and references to relevant scholarly work. They also provide case examples, which give a feel for the treatment and how it can help unique individuals. The article is one of several articles in a special January 2002 issue of the *Journal of Clinical Psychology* on EMDR. Another excellent (and brief) article on EMDR describes why, to quote the title, "EMDR minus eye movements equals good psychotherapy."

Additional Information about Prolonged Exposure

Prolonged Exposure therapy is the other most-researched treatment for postraumatic stress disorder, and very established in the academic mainstream. (Of course, this does not guarantee it is the best approach for a particular person; this is also true for EMDR, in fact any treatment when it comes to unique individuals rather than groups of research participants.)

The theory behind how PE works is the Emotional Processing Model of Edna Foa and Michael Kozak. These authors have presented this model in several influential papers, particularly these:

Foa, E.B., & Kozak, M.J. (1986). Emotional processing of fear: Exposure to

corrective information. Psychological Bulletin, 99, 20–35.

Foa, E.B., & Kozak, M.J. (1998). Clinical applications of bioinformational theory: Understanding anxiety and its treatment. Behavior Therapy, 29, 675–690.

While these are long and fairly technical papers, some people may find reading them to be useful. Their theory can be summarized briefly as follows:

- People with anxiety disorders, including postraumatic stress disorder (PTSD), suffer from pathological "fear structures" in their "memory networks."

- Fear structures are networks of information that provide a program to detect and escape threats. These structures contain information about the stimuli associated with the feared situation (e.g., threatening faces, sexual images) and responses to it (i.e., bodily responses of fearfulness, escape behaviors), as well as information about the relationship between these responses.

- Pathological fear structures include extreme response elements (e.g., pounding heart, shaking body), unrealistic expectations about the likelihood of harm (i.e, convinced one will be harmed in very safe situations with one or two aspects reminiscent of the original abuse), and resistance to change even in the face of contradictory information (e.g., repeated experiences of people getting angry without becoming violent).

- The fear structure in PTSD is large and can "pull in" all kinds of stimuli that remind the person of the original trauma. It is continually but incompletely activated, such that people with PTSD from child abuse repeatedly get "triggered" by reminders of their trauma but, because they immediately engage in escape and avoidance behaviors, don't get the experience that the reminders themselves are not actually dangerous.

- The goal of treatment is to modify the pathological fear structure. This is accomplished by helping clients experience the stimulus aspects of the original trauma(s) in a safe setting, and experience them fully, so that they can truly learn that reminders of the trauma (aside from actually dangerous situations) are not dangerous and need not result in massive fear, avoidance and escape responses. In this way, it is possible to incorporate "corrective information" into the fear structure (e.g., I am safe even when remembering. Just because something reminds me doesn't mean it's happening again).

- For treatment to be effective, it must fully activate the fear structure, and it must provide corrective information that truly does not fit with the pathological structure and thus can effectively modify it.

Based on this description of the model and how it views effective treatment, it makes sense why traditional exposure therapies like Prolonged Exposure insist that clients narrate their traumatic memories in detail, in sequence. This is seen as the only way to ensure that the fear structure is fully activated: if clients are allowed to "jump around" or to associate to other memories (as in EMDR), the thinking goes, then they might avoid key aspects of the memory and fear structure. And if they do not activate it fully, they will not be able to truly incorporate corrective information and transform the fear structure so it is no longer pathological.

In short, traditional exposure therapies like PE insist that clients narrate the trauma out loud, in detail, from start to finish, so the therapist can be sure that the client is fully activating the fear structure, fully engaging with the emotions, and really getting the full benefit of the treatment. Similarly, clients are required to listen to an audiotape of their narration of the trauma in between sessions – again, to ensure full activation and incorporation of corrective information as hearing the tape over and over again generates less and less fear and avoidance responses. However, it should be noted that many therapists modify traditional exposure therapy by beginning with less traumatic memories, by not requiring the "homework" of listening to oneself narrate the trauma on audio tape, and in other ways that reduce its stressfulness.

Importantly, I have focused on these two highly-researched treatments for changing one's relationshp to traumatic memories, but there are certainly others that people with child abuse histories have found helpful. One common component is exposure to distressing aspects of the memory in a safe and structured setting. Again, the main point here is that there are effective and relatively rapid methods for dealing with intensely distressing memories. People do not have to be tortured by them for years.

The third stage of recovery and treatment focuses on reconnecting with people, meaningful activities, and other aspects of life.

I am not going to describe this stage further. Instead, I recommend Judith Lewis Herman's classic book, Trauma and Recovery, which describes the three stages of recovery in depth and detail.

2. Stages of voluntary behavioral change

Over the past two decades very important work has been conducted on the stages of change that people go through in order to voluntarily change their own behavior. This work emerged from those studying how people quit addictive behaviors, but is applicable to other habitual behaviors that people have a hard time quitting. Two of the best known people who have conducted and presented this work are Carlo DiClemente and James Prochaska.

Generally speaking, experienced and skilled therapists understand the stages of change, even if they do not think about them in terms of this model. They are also skilled at matching what they say, and the treatment methods they provide, to where their clients are (in relation to particular "problem behaviors") in the stages described below.

Before describing the stage model, it's important to note that this work is particularly relevant to people in the first stage of recovery.

- During this stage of recovery and treatment, people are often struggling with deeply habitual strategies for managing painful, trauma-related emotions – strategies that have become ineffective, destructive, or even retraumatizing.

- Such behaviors include dependence on alcohol or drugs to block out painful experiences or promote positive ones, deliberately harming their bodies to become numb or feel alive, compulsive use of pornography or food, impulsive and

aggressive venting of anger on others, provoking others to reject, abandon or abuse them, etc.

- For those who grew up in situations where more healthy ways of handling intense negative experiences were not learned, such behaviors can become very ingrained habits and be difficult to change. They may be experienced as the "only" way to cope with certain painful experiences – or the only sure-fire way that doesn't require trusting or depending on others. People may know they are self-destructive and/or harmful to others, but feel like giving them up would make things even worse. When I refer to "problem behaviors" below, this is what I am referring to, and this may include behaviors that you, understandably, at least for now, see not as "problems" but as survival skills.

- In short, whether these ways of coping were learned during times of abuse and neglect or some time later, they are not working very well any more (if they ever did). Further, they have become ingrained habits and automatic reactions that are difficult to quit and replace with more helpful ways of coping. However, people can change such behaviors, and understanding some general principles about how voluntary behavior change occurs can help a lot.

The five stages of change below have been found to describe all voluntary behavior change, whether one is getting professional help or making changes on one's own:

- **Precontemplation stage**

    - At this stage, people lack an awareness that they have a problem. If they go to treatment, they feel pushed to do so by others, but they are not (yet) committed to getting help, and may be "resistant" or passive in therapy. They are avoiding steps to change their behavior (consciously and/or unconsciously). Others may see them as "in denial."

    - At this stage, trying to get people to focus on behavior change is completely ineffective, because it simply doesn't match or meet them where they are. (We can all remember, and not fondly, times when others pushed us to make changes before we had even come to terms with the fact that we had a problem.) Instead, it is most helpful to give people a chance to discuss their mixed feelings and thoughts about the problem behaviors, and how they see the costs and benefits of changing and not changing. In having such discussions, it is essential, but can be very difficult, not to take sides in their internal debate and argue for change. This is essential because doing so puts you in the position of advocating for change and leads them to "argue the other side" (of their mixed feelings) and justify their behaviors rather than thinking about change.

    - It would be hard to overemphasize how important it is to understand this stage, in general and in relation to therapy. For more on how to relate effectively to people in the precontemplation stage, including people you care about but are having trouble helping, see the next section of this page, Resources for Spouses, Partners, Friends, etc., especially the information and resources on "motivational interviewing."

- **Contemplation stage**

- At this stage, people are distressed about their own problem behaviors, wanting to get some control over them, seeking to evaluate and understand their behavior, and thinking about making change. They haven't yet acted to make a change, and have not even committed to doing so. But they are definitely evaluating the pros and cons of sticking to their behavior versus making changes.

- Important change processes or interventions include "consciousness raising," that is, learning new facts and information that support making the change, and "self-reevaluation," or beginning to see oneself as someone who could be free of the problem behavior and embody alternative constructive behaviors. Again, the focus is not yet on behavioral change – which would still be a mismatch – but on strengthening people's motivation and commitment to make a change.

- **Preparation stage**

    - At this stage, people are intending to change their behavior, ready to change in terms of both attitude and behavior, and on the verge of taking action. They are engaged in the change process, and prepared to make firm commitments to follow through on the action option(s) that they choose.

    - Similar processes and intervention are helpful here as in the Contemplation stage, with an increasing emphasis on strengthening the commitment to change and to follow through with change behaviors. Still, it's not about giving people methods for change, let alone pushing them to take action, but about strengthening their motivation for the specific actions that they are on the verge of choosing and taking.

- **Action stage**

    - At this stage people have definitely decided to make change, are very motivated to change, and have verbalized or otherwise demonstrated firm commitment to doing so. They are making active efforts to modify their behavior and/or their environment, and are willing to seek out and try suggested strategies and activities for bringing about change.

    - Here a wide variety of behavioral change methods, from self-help methods to specific therapy interventions and a variety of other resources, including exercise and other training programs, are finally appropriate for others to suggest and to help them use. It is still essential that people's freedom to choose, and to use behavior change methods in their own unique ways, are respected.

- **Maintenance stage**

    - This stage refers to a time when the behavior change has been made and maintained for at least several months (six months is commonly used as an indicator of entering this stage). At this time, people are working to sustain changes achieved thus far, and considerable attention is focused on avoiding slips or a relapse. People may still experience fear or anxiety about possible relapse, and worry about how they would deal with a

situation that presented a high risk for relapse. They may face less frequent but quite intense temptations revert back to problem behaviors or bad habits. These are very normal and natural experiences, and are totally consistent with continued strong motivation and commitment. Indeed, when people no longer fear relapse, they may be at higher risk for "letting down their guard" and making a slip. However, as time goes on and the behavior change becomes more ingrained in their lives, such fears and temptations tend naturally to decrease.

- A wide variety of behavioral change and maintainence methods are useful during this time. The mix of methods may evolve, with some becoming no longer necessary and others becoming more appropriate. But people are still making use of various methods to "stay on track" and to continue the new behaviors and positive habits they have developed.

All of us can remember behavior changes that we've made by going through these stages. You're probably in the midst of (at least) one now. If you've been focused on someone else who "needs to make a change," particularly someone you've been trying to persuade to make a change, it would probably be helpful to reflect on your own experiences of going through these stage in relation to something particularly difficult, then to think about where in the stages of change the other person is now, and how effectively you've been relating to him or her.

Importantly, where people are in the stages of change determines:

- What they are open to hearing from a therapist, partner, friend, or anyone else.

- Which treatments or interventions they are ready to benefit from.

A couple of other key points:

- The stages almost always play out in cycles, in which people gradually advance, and occasionally "relapse" back to earlier stages in the process before eventually moving forward again. All of us have bad habits with which we have struggled in these stages. Every one of us has sometimes, typically during times of stress and/or lack of support, reverted back to old problem behaviors and to pre-contemplative or contemplative stages in relation them.

- For those traumatized by child abuse, there are likely to be many behaviors that are problematic and suffering-increasing. At any particular time, only some of these will be addressed by moving forward through the stages of change in relation to them. The first stage of treatment and recovery involves coming to terms with the need to change deeply ingrained habits that developed as "survival skills" during the abuse, and developing the motivation and commitment to change, then working hard to make use of change methods that are available. Achieving safety and stability, and increasing acceptance of and mastery over one's emotions and conditioned responses to abuse reminders, is very much about progressing through the stages of behavior change. This is true whether one is dealing with dependence on drugs and alcohol, repeating abuse dynamics in current relationships, or a variety of other problems common during the first stage of recovery.

- Understanding these stages of change, how they play out in cycles, and how child abuse can result in many problem behaviors that cannot all be changed at once or without occasional "backsliding," can be very helpful and bring more patience and acceptance of ourselves and others.

- If you seek out treatment, keep these stages in mind. When you are focused on a particular goal, or on a particular type of behavior change that you want or that other people are pushing you to make, you can make use of this model. You can discuss with your therapist, or another trusted and supportive person, what kinds of conversations and interventions will truly meet you where you are, and will truly empower you to sort through your own mixed feelings – about your behavior and its consequences, and about your own values, motivations, and options for change.

For more information about the stages of change:

- The Addictions Alternatives web site has a nice, brief overview of the stages of the model.

- ETR Associates has a good page on the processes of behavior change as described by the model.

- The University of Rhode Island's Cancer Prevention Research Center has a more detailed overview.

- The National Health Care for the Homeless Council has a 5-page PDF document that nicely lays out the stages of change, as well as appropriate interventions at each stage.

3. Principles of treatment for child abuse trauma

There are several important principles of treatment that anyone seeking good professional help in dealing with the effects of child abuse should know about. I cannot list them all or spell them out in great detail. However, in this section some crucial ones are introduced and described, to aid with interviewing potential therapists or consultants and reflecting on one's experiences in treatment. Reflecting on these principles can be particularly helpful at the beginning of therapy, while establishing trust, as well as during other difficult phases.

Competence. Not all professional therapists are competent to provide treatment to people with histories of severe child abuse, or with particular sorts of problems that can result from extreme forms of abuse. Competence requires but is not guaranteed by extensive experience and training in work with survivors of child abuse, or ongoing supervision with a more senior and qualified therapist. (Section 4 below has resources for interviewing therapists to gather information about their likely level of competence.)

Empowerment. The core experience of child abuse, like all severe traumas, is disempowerment: one's needs, wishes and choices (including not to be abused) are ignored and trampled upon. Because child abuse involves violation and betrayal of trust by a more powerful person, it is essential that the therapist and therapy not repeat these patterns.

- Thus good treatment is not something that a more powerful professional requires the client to accept and "comply" with, as the medical model of therapy tends to assume. Therapists with this approach and/or attitude are much less likely to be helpful.

- Rather, the client must be educated about the treatment process, informed of options, and involved as a partner in the formulation of treatment goals and decisions about how to go about achieving them. (There are exeptions, of course, in cases where clients are at immediate risk to harm themselves or others and not able to make safe choices on their own; however, even then, the client should be given as many options and choices as possible.)

- Two other principles related to the therapist working to empower the client are worth noting here: neutrality and disinterestedness.

  By "neutrality" is meant that the therapist does not take sides in clients' inner conflicts (e.g., Should I leave or should stay? Do I trust her or not?), but helps clients identify and work through their mixed feelings and come to their own decisions and solutions. Often people expect therapists to give them advice or tell them what to do – but this can take power away from clients, prevent new learning and growth, and even increase their attachment to maladaptive patterns as they react negatively to being "told what to do".

  By "disinterestedness" is meant that the therapist does not use the client to meet his or her needs. This principle not only covers more extreme examples, like sexual exploitation of the client, but more subtle things like the therapist using the client to gratify needs to be admired, respected, etc. This also refers to the therapist not using the client to promote a personal agenda, for example, about how abuse survivors should relate to family members or the perpetrator. Of course, as Judith Herman points out, this is "an ideal to be striven for, never perfectly attained" – since therapists are, after all, human beings with their own needs and motives for doing therapy, personal biases and limitations, etc.

Connection. Disconnection is another core experience of child abuse. Thus a therapist must be capable of connecting with her or his client, of being present as another human being with genuine relatedness and empathy.

- However, some people with severe abuse histories may be unable to accurately perceive the therapist at times, and may "project" their own difficulties connecting (or those of the perpetrator or an unprotecting parent) onto the therapist.

- Also, connection does not mean "closeness" or "intimacy" in the traditional sense of non-therapy relationships. Boundaries between the therapist and client are absolutely essential. Therapists who share too much of their own experience, become over-involved or engaged in "rescue missions" are not helping their clients, but violating the principles of neutrality and disinterestedness. This can do tremendous damage to the therapy relationship, disempower the client, prevent healing, and even retraumatize the client.

Therapeutic frame. Because the therapy relationship can be an intense

experience, and involves addressing vulnerable areas of one's life, it is absolutely necessary that the relationship is bounded by a "frame." This can be understood as the collection of "ground rules" that create consistency and stability in several dimensions of the relationship, thereby ensuring that it can be safe and healing.

- Elements of the therapeutic frame include the length of sessions, starting and ending on time, cancellation and payment procedures, confidentiality and its limits, etc.

- The frame helps ensure that the relationship will be a healing one, in which expectations can be established and clarified, boundaries can be maintained, and intense emotions, memories and other experiences can be contained and managed.

Much more could be said about principles of treatment. The point here has been to spell out a few that are particularly relevant to people with abuse histories. Please know it is your right to ask potential therapists to describe the principles of treatment that guide them in their work with people who have experienced child abuse.

4. Specific resources for finding, interviewing, choosing, and evaluating therapists

The Sidran Foundation has an extensive list of therapists and clinics around the country that specialize in treating people with histories of severe child abuse. See their page on Information and Referrals from Sidran's Resource Specialist. Neither I nor the Sidran Foundation can vouch for every therapist on the list; but they can usually, at a minimum, provide some good leads.

As described above, EMDR is a therapy proven to help people decrease the distress associated with memories of traumatic experiences. It is also practiced by thousands of therapists around the world, many if not most of whom are very experienced with stage-oriented treatment of people who were abused as children. You can find EMDR therapists through the Find a Therapist service of the EMDR International Association. EMDRIA's primary objective is to "establish, maintain and promote the highest standards of excellence and integrity in Eye Movement Desensitization and Reprocessing (EMDR) practice, research and education."

There are some more general resources on the web about how to choose a therapist. Here are three that complement each other well:

- Click on "How to Choose a Therapist" at the web site of Dr. Patti Levin

- Dr. John Grohol's How to Choose a Therapist (a bit biased when it comes to degrees and training, but has a lot of helpful information)

- So You Wanna Choose a Therapist (flippant and superficial in some ways, but covers issues not mentioned by others)

The Consumer's Guide to Psychotherapy, by Drs. Jack Engler and Dan Goleman (author of the best-selling Emotional Intelligence), is an excellent book available in paperback from Amazon, both new and used (some really cheap), and may be in your local library.

Though it was published in 1992, and is not up to date on the latest treatment innovations, this book has a great deal of timeless wisdom about choosing a therapist, the nature of therapy, different schools of therapy, etc.

Resources for Spouses, Partners, Friends, etc.

Contents

You may have come to this page seeking understanding of someone you love, including how his or her past abuse history is affecting your relationship. You may be wondering how you can be more supportive and helpful when your loved one's abuse memories or relational dynamics get "triggered." Maybe you're wondering how you can help someone find professional help, or make the commitment to seek help and follow through. Or maybe you're looking for books that could help you better understand what your partner or friend is going through, and how to best manage your own responses and relate most effectively.

In this section I have some comments and suggestions relating to challenges often facing partners and friends of those with child abuse histories. (For more resources for adults with histories of child abuse, see the Additional Resources section.)

First, I recommend these two books:

> Allies in Healing: When the Person You Love Was Sexually Abused as a Child, by Laura Davis. Perrenial Books, 1991.
>
> Outgrowing the Pain Together: A Book for Spouses and Partners of Adults Abuse As Children, by Eliana Gil. DTP, 1992.

Trying to be supportive and helpful to someone you love who is suffering from the effects of child abuse can be very difficult and challenging. Just knowing what they went through can bring up feelings of sadness, helplessness, frustration, and anger. If they clearly could benefit from some professional help but reject that as an option, or say they'll get help but never follow through, it can become very frustrating. And it can be scary, if the well-being of your relationship or family seem to depend on what they choose.

How to help someone you love who has mixed feelings about seeking help? How to discuss the issue without taking sides in your loved one's inner conflict over whether or not to seek help – especially when you have so much at stake on their decisions and actions?

Much of it comes down to managing your own feelings, and managing your impulses to push them to make decisions or take action. But it also requires sorting through your own thoughts, feelings and needs, and figuring out how you can most effectively discuss these issues with your partner or friend. There may be options for communicating that you don't yet realize exist.

The vast majority of people who could benefit from seeking professional help have very

mixed feelings about doing so. On the one hand, they may hope that someone could really understand and help them make changes they would like to make in their lives. On the other hand, they may fear that a therapist won't understand, won't be able to help, or will see them as "crazy." They may fear that a therapist won't really care and will just use them to make money from their suffering. They may not feel worthy of being helped, or fear that it would be just too painful or humiliating to confront their suffering and problems in therapy. These mixed feelings and fears are quite normal for people who were abused and betrayed in childhood.

In trying to help a partner or loved one struggling with such mixed feelings, one of the most common traps to fall into, though totally understandable and often done without realizing that it's happening, is this: trying to "show" or "convince" or otherwise push them into "admitting" they need help, that they "must" go into therapy, etc. Unfortunately, this doesn't work. In general, when people have mixed feelings about something and someone else does all the talking (and pushing) for one side, it puts the other person in the unbalanced position of "holding the other side" and thinking and talking about the reasons they don't want or need to change.

Also, when the person who fears that change might have some serious drawbacks is someone who was abused as a child, being pushed to change can repeat dynamics of coercion and experiences of disempowerment that characterized their child abuse experiences. Of course, you may be genuinely trying your best, and pushing out of love and concern (not just growing fear and desperation). But the fact is – as you've probably already begun to realize, even if you still don't quite know what else to do – this approach is not likely to work. The fact is, it tends to polarize things further, and to increase resistance to change, including seeking professional help.

The reasons that such communication styles do not work are very well explained by the therapists and researchers who developed "motivational interviewing." This style of therapy, or way of being with clients, was developed to help people with substance use problems, who often have very mixed feelings about stopping or dramatically reducing substance use and are seen by others as being "in denial." But the principles of motivational interviewing apply to any situation where one person is trying to help another person resolve their mixed feelings about making a positive behavior change or committing to taking positive action. As the developers of motivational interviewing, William Miller and Stephen Rollnick, have written:

> "Constructive behavior change seems to arise when the person connects it with something of intrinsic value, something important, something cherished. Intrinsic motivation for change arises in an accepting, empowering atmosphere that makes it safe for the person to explore the possibly painful present in relation to what is wanted and valued. People often get stuck, not because they fail to appreciate the down side of their situation, but because they feel at least two ways about it. The way out of that forest has to do with exploring and following what the person is experiencing and what, from his or her perspective, truly matters."

To learn some very effective ways of communicating with people who have mixed feelings and fears about seeking help and making positive changes in their behavior, visit the Clinical Issues section of the Motivational Interviewing web site and read the following pages:

- What is MI? (8 pages)
- Philosophy (5)

- “Traps” (6)
- Interaction Techniques (11)

Another extremely helpful resource is the "stages of change" model, which describes the stages that everyone goes through when it comes to changing problem behaviors. For example, this model explains why it's not helpful to push therapy on someone who hasn't concluded that they have problems therapy could help, or thinks they have problems but hasn't yet committed to changing and seeking help. It also provides guidance on how to match one's comments and suggestions to where a person is in the stages of change process. For more on this very helpful model, see Stages of voluntary behavioral change above, in About Therapy & Recovery. Really, I strongly suggest checking out that section, and could easily repeat it here if space weren't an issue.

When people email me with questions about how they can "convince" their partner or friend to get into therapy, I often recommend that, before suggesting therapy to their partners, they try consulting – maybe just one or two sessions – with a therapist who is very experienced at helping people with their partner's history and difficulties. Talking in person to a qualified professional can help you sort through your feelings, fears, frustrations, and strong impulses to take action (in what may feel like an increasingly unbearable situation). After all, it's your ability to manage such feelings and impulses that will determine how effective you are at discussing these issues with your loved one in a way that is not polarizing, in a way that increases the likelihood that they will come to their own (freely chosen and internally motivated) decision to seek help.

Basically, it often makes sense for you to get some consultation, support and help in dealing with the difficult situation you are in, so you can maximize your chances of helping your partner or friend make her or his own decisions and commitments about seeking help and making changes for the better. Ultimately, it's up to them. But how other people discuss these issues with them, particularly you, can make a big difference.

Resources for Parents & Caregivers

Contents

As discussed in the section Effects of Child Abuse, the effects of child abuse can be increased or decreased by key relationships in the child's life. More than anyone else (including therapists), parents and caregivers can help children recover from abuse and its effects. In this section I provide some basic resources for parents and caregivers of abused children.

The sections before this one, About Therapy & Recovery and Resources for Spouses, Partners, Friends, etc., have information that is helpful for understanding and relating to older children and teenagers. The Additional Resources section below has some useful information and links to resources as well.

If you want immediate information, including on how to find professional help for a child or adolescent, see the National Child Traumatic Stress Network's How to Find Help page, and especially their Network Members page, which lists centers and clinics all around the US, each of which will know of excellent resources in their area.

Because working with children and parents is not my specialty, I have consulted with trusted colleagues who have specialized training and years of experience working with abused children and their caregivers. Below are their book and video recommendations for parents and caregivers of children who have been abused.

Your Body Belongs to You, by Teri Weidner (Illustrator), Cornelia Maude Spleman, and Cornelia Maude Spelman. Albert Whitman & Co, 2000. (This book is for parents and teachers of young children, and more focused on prevention.)

Children and Trauma: A Guide for Parents and Professionals, by Cynthia Monahan. Jossey-Bass, 1993.

How long does it hurt? A guide to recovering from incest and sexual abuse for teenagers, their friends, and their families, by Cynthia Mather, Kristina Debye, Judy Wood, and Eliana Gill. Jossey-Bass, 1994.

Handbook for Treatment of Attachment-Trauma Problems in Children, by Beverly James. The Free Press, 1994.

Trauma in the Lives of Children: Crisis and Stress Management Techniques for Teachers, Counselors, and Student Service Professionals, by Kendall Johnson. Hunter House, 1998.

RealLife Heroes: A Life Storybook for Children, by Richard Kagan. Haworth, 2004.
Available from Amazon or the Sidran Foundation (which provides much more information about the book).

The Traumatized Child
This video series, created by Cavalcade Productions, features Dr. Margaret Blaustein, with whom I have worked and respect very highly, and three of her colleagues. All have years of experience as therapists with abused children and their caregivers, and as trainers of therapists doing this work. There are three videos in the series, which can be purchased or rented individually or as a set: Understanding the Traumatized Child, Parenting the Traumatized Child, and Teaching the Traumatized Child.

On the prevention of sexual abuse, here are four books that parents can read to and discuss with their 4 to 8 year old children: My Body Is Private, Your Body Belongs to You, Those are MY Private Parts, and The Right Touch.

If you are the parent or caregiver of a child or teen with sexual behavior problems, Stop It Now publishes an excellent newsletter, PARENT*talk*. It is written by and for parents of children and teens with sexual behavior problems, and offers "an opportunity to break the isolation surrounding this issue and offer support to each other through personal stories." All issues are free online.

See also Helping Traumatized Children: A Brief Overview for Caregivers, by Dr. Bruce Perry, Director of the ChildTrauma Academy.

Additional Resources

Contents

This section consists primarily of links to Web sites, but I also suggest three hotlines, a referral service that can help you find a therapist in your area, three books, and an article on the international prevalence of child sexual abuse. (For resources specifically for parents and caregivers of abused children, scroll up to the section just above this one.)

If you are looking for a therapist or counselor in the United States, even if only for a couple of consultations, the Sidran Foundation has an extensive list of therapists and clinics around the country that specialize in treating people with histories of severe child abuse. See their page on Information and Referrals from Sidran's Resource Specialist.

If you need immediate information about and/or connection to resources in your own community, here are four 24-hour toll-free hotlines that you can call, three in the US and one in the UK:

Childhelp USA's National Child Abuse Hotline

1-800-422-4453
(1-800-4ACHILD)

Childhelp USA is a non-profit organization "dedicated to meeting the physical, emotional, educational, and spiritual needs of abused and neglected children." Its programs and services include this hotline, which **children can call with complete anonymity and confidentiality**. For more information, see What to Expect When Calling and other helpful information at their web site. From the site: "The Childhelp USA® National Child Abuse Hotline is open 7 days a week, 24 hours a day. Don't be afraid to call. No one is silly or unimportant to us. If something is bothering you or you want information, CALL!" To learn more about reporting child abuse or neglect in your state, see Local Phone Numbers.

Rape Abuse & Incest National Network

1-800-656-4673 (HOPE)

RAINN is a national network of rape crisis centers. This is an automated service that links callers to the nearest rape crisis center automatically. Rape crisis centers are staffed with trained volunteers and paid staff members who also have knowledge of sexual abuse issues and services (though sometimes they are not adequately prepared to refer male survivors). *All calls are confidential, and callers may remain anonymous if they wish.*

National Domestic Violence/Abuse Hotline

1-800-799-SAFE
1-800-799-7233
1-800-787-3224 TDD

This is a 24-hour-a-day hotline, staffed by trained volunteers who are ready to connect people with emergency help in their own communities, including emergency services and shelters. The staff can also provide information and referrals for a variety of non-emergency services, including counseling for adults and children, and assistance in

reporting abuse. They have an extensive database of domestic violence treatment providers in all US states and territories. Many staff members speak languages besides English, and they have 24-hour access to translators for approximately 150 languages. For the hearing impaired, there is a TDD number. This is a good resource for people who are experiencing or have experienced domestic violence or abuse, or who suspect that someone they know is being abused (though it is not perfect, and may not have the best number in your area). *All calls to the hotline are confidential, and callers may remain anonymous if they wish.*

ChildLine (UK)

0800 1111

"ChildLine is the free helpline for children and young people in the UK. Children and young people can call us on 0800 1111 to talk about any problem – our counsellors are always here to help you sort it out."

In terms of books, these are my top recommendations:

How Long Does It Hurt? A Guide to Recovering from Incest and Sexual Abuse for Teenagers, Their friends, and Their Families, by Cynthia Mather, Kristina Debye, Judy Wood, and Eliana Gill.

This book was written by an incest survivor, and provides step-by-step guidance for sexually abused teenagers. It has a great deal of knowledge and resources to help teenagers understand what they are going through and overcome feelings of isolation, confusion, and self-doubt to truly heal.

It Happened to Me: A Teen's Guide to Overcoming Sexual Abuse, by William Lee Carter.

This workbook is written for teenagers, and has effective exercises help them learn about the different aspects of trauma, clarify their own ideas and beliefs, and explore new ways of feeling and relating. The author is a psychologist who works with sexually abused teens on a daily basis. His approach is very positive. The exercises focus on gaining the strength and confidence needed to reshape one's self-image, connect with others in healthy ways, and develop the skills needed to realize one's full potential.

Growing Beyond Survival: A Self-Help Toolkit for Managing Traumatic Stress, by Elizabeth Vermilyea.

If you want to start learning and practicing the self-regulation skills essential to recovering from the effects of child abuse, or to build on progress you are already making, particularly if you struggle with dissociation, I recommend this book. To learn more about the book and/or order it directly from the publisher (for a higher price than Amazon), go to the Growing Beyond Survival page of the Sidran Press catalog.

Trauma and Recovery, by Judith L. Herman.

I still believe this is the best book on psychological trauma and recovery, particularly extreme child abuse. Herman integrates a great deal of research with decades of clinical wisdom and some thought-provoking historical and political perspectives. *Trauma and Recovery* is appropriate for survivors of child abuse and other interpersonal traumas, as well as clinicians and the general reader.

I especially recommend this book to students and others just beginning to learn about child abuse and how people recover from these experiences. Though a lot has been learned since Herman wrote this book (e.g., the widely available treatment EMDR has been proven to be an effective and efficient treatment for posttraumatic stress disorder), this book has easily stood the test of time.

You can learn more about the book (critical acclaim, contents, brief excerpts) from my Web page: *Trauma and Recovery* - Judith Herman's Landmark Book on Child Abuse & Other Traumas.

The following two books offer a wealth of helpful information, including explanations of post-traumatic stress disorder and related problems, and many great techniques for managing trauma-related emotions, memories and various other symptoms and problems commonly struggled with by people who were abused as children.

The PTSD Workbook: Simple, Effective Techniques for Overcoming Traumatic Stress Symptoms, by Mary Beth Williams and Soili Poijula

Post-Traumatic Stress Disorder Sourcebook, by Glenn Schiraldi

If you are looking for books and/or articles on the sexual abuse of males, please see the Recommended Books and Articles section of my page, Sexual Abuse of Males: Prevalence, Lasting Effects, and Resources. There's a lengthy listing of books and articles. Some are reviewed, and some can be ordered.

If you are looking for books on recovered memories of sexual abuse, please see the Books on Recovered & Traumatic Memories section of my page, Recovered Memories of Sexual Abuse: Scientific Research & Scholarly Resources.

If you are looking for statistics on child abuse in other countries, see Official Statistics: International.

There are numerous Web sites with content addressing child abuse and recovery issues in addition to those already mentioned on this page. Below is a sampling. (All links open in new windows.)

Please note:

If reading material on these issues may upset you, remember to take care of yourself, and that you can always create a favorite/bookmark and come back to this page or any of the links below when you feel prepared.

Center for Sex Offender Management

This is a Project of the U.S. Department of Justice's Office of Justice Programs. "Established in June 1997, the Center for Sex Offender Management's (CSOM) goal is to enhance public safety by preventing further victimization through improving the management of adult and juvenile sex offenders who are in the community." CSOM's goals are carried out through three activity areas, including information exchange. In

addition to an "Ask COSM" feature, their Documents section has a wealth of informative html and pdf materials, including "Myths and Facts About Sex Offenders" in html and pdf formats, and "Recidivism of Sex Offenders," also in html and pdf. Finally, their Reference Library has a searchable documents database and a topically organized list of National Resource Group Recommended Readings. Finally,

Childhelp USA

Childhelp USA is a non-profit organization "dedicated to meeting the physical, emotional, educational, and spiritual needs of abused and neglected children." Its programs and services include a hotline (800-422-4453) that **children can call with complete anonymity and confidentiality**. To know what to expect when you call, see see What to Expect When Calling. From the site: "The Childhelp USA® National Child Abuse Hotline is open 7 days a week, 24 hours a day. Don't be afraid to call. No one is silly or unimportant to us. If something is bothering you or you want information, CALL!" To learn more about reporting child abuse or neglect in your state, see Local Phone Numbers.

ChildTrauma Academy

This organization, Directed by Dr. Bruce Perry, "focuses on service, training and research in the area of child maltreatment." The site has a number of articles by Dr. Perry, including explanations of child abuse effects and Helping Traumatized Children: A Brief Overview for Caregivers.

Child Abuse - Article in online Microsoft® Encarta® Online Encyclopedia

An informative article by researcher pioneering researcher and author, Richard Gelles, Ph.D. Broadly and topically covers the following issues: Types, Prevalence, Causes, Effects on Children, Protecting Children.

Child Abuse Legislation Study Project

"A non-profit organization dedicated to tracking bills, laws, and legislative action on child abuse, incest, and domestic violence."

Child Welfare Information Gateway

Official U.S. site with a wealth of great resources, including an excellent searchable catalog of publications (try searching with terms like "bibliography," "fact sheet," "prevention," and "webliography"). Many publications are available in Spanish. For help with accessing their statistical information, see above, Official Statistics: United States.

Child Welfare

This site has a wealth of scholarly resources, including an online journal, *Child Welfare Review,* and information about the Oxford University Press Series in Child Welfare Practice, Policy and Research.

Common Responses to Trauma - And Coping Responses

This two-page handout, by Dr. Patti Levin, provides excellent and helpful information and suggestions. Dr. Levin's site has other helpful handouts and excellent information on how to choose a therapist. (The above link is to a PDF file, and it's also available as a web page.)

Court Appointed Special Advocates (CASA)

"Volunteer Court Appointed Special Advocates (CASA) are everyday people who are appointed by judges to advocate for the best interests of abused and neglected children. A CASA volunteer stays with each child until he or she is placed into a safe, permanent and nurturing home." More than 900 CASA programs are in operation across

the United States, with 52,000 women and men serving as CASA volunteers. This website of National CASA explains what CASA's do, how to become one, etc.

Crimes Against Children Research Center

"The mission of the Crimes against Children Research Center (CCRC) is to combat crimes against children by providing high quality research and statistics to the public, policy makers, law enforcement personnel, and other child welfare practitioners." The center is directed by Dr. David Finkelhor, a sociologist and internationally recognized expert on child victimization, including child sexual abuse. The site has many good resources, including a Publications section with the paper, *The Decline in Child Sexual Abuse Cases*, a classic 1993 scholarly review paper, The impact of sexual abuse on children: A review and synthesis of recent empirical studies, and an excellent Fact Sheet with facts and statistics compiled from a variety of sources.

David Baldwin's Trauma Info Pages

These pages are loaded with scholarly resources and references to work on Posttraumatic Stress Disorder, especially from neuropsychological and cognitive-behavioral perspectives.

EMDR Institute

Eye Movement Desensitization and Reprocessing (EMDR) has been proven to be an effective and efficient treatment for posttraumatic stress disorder (PTSD), which can be an effect of childhood abuse. It can be particularly helpful at transforming intrusive and upsetting memories of abuse, and does not require one to talk about what happened in detail (fors those avoiding therapy for this reason). In recent years, therapists have learned how to use EMDR with children. The EMDR Institute provides referrals to EDMR-trained therapists around the country (by zipcode) and around the world; follow the link from the home page.

You can also find EMDR therapists through the Find a Therapist service of the EMDR International Association, whose primary objective is to "establish, maintain and promote the highest standards of excellence and integrity in Eye Movement Desensitization and Reprocessing (EMDR) practice, research and education."

FaithTrust Institute

"FaithTrust Institute is an international, multifaith organization working to end sexual and domestic violence. We provide communities and advocates with the tools and knowledge they need to address the religious and cultural issues related to abuse. FaithTrust Institute works with many communities, including Asian and Pacific Islander, Buddhist, Jewish, Latino/a, Muslim, Black, Anglo, Indigenous, Protestant and Roman Catholic." Their site has a number of resources on the issue of Sexual Abuse by Clergy.

Jennifer J. Freyd's Trauma, Memory, and Betrayal Trauma Research

This page has links to reviews of Dr. Freyd's books and web pages on which she discusses several clarifying perspectives on these issues, including her theory of why it is *adaptive* for some children not to remember childhood abuse experiences.

Healing from Childhood Sexual Abuse: Book Reviews

Scott Abraham reviews eight books for men who were sexually abused in childhood. Good review, very helpful. If you're considering buying a book, read this first.

isurvive.org - Abuse Surivors Learning to Thrive

This volunteer-run web site and non-profit organization has many great resources – the most valuable being the people who help each other by sharing their experiences, struggles and hard-earned wisdom. There are online chats and forums for survivors of

child abuse, including those struggling with addiction and abusing others, as well as friends and family members. It also has a great resources page with many not listed here.

Legal Resources for Victims of Sexual Abuse

This section of Attorny Susan Smith's web site has extensive resources on remedies for victims, statutues of limitations, and mandatory child abuse reporting laws in most states of the U.S.

Lost in the Void

This book is self-published by Lana Walker, an American citizen who has been through a nightmare in the British courts – not only losing custody of her children, but any and all contact with them. She has written this book to alert parents, both mothers and fathers, who marry citizens of other countries and live in those countries with their children, about how vulnerable they and their children are to terrible injustices committed by another country's laws and courts.

Making Daughters Safe Again

This organization and its web site, founded and directed by a graduate student in clinical psychology, provide "support for survivors of mother-daughter sexual abuse."

MaleSurvivor: National Organization against Male Sexual Victimization

Their mission: "We are committed to preventing, healing, and eliminating all forms of sexual victimization of boys and men through treatment, research, education, advocacy, and activism." Their site has many helpful resources.

Pat McClendon's Clinical Social Work Home Page

These are general mental health pages with a focus on abuse and trauma resources, especially those related to dissociation.

National Child Protection Clearinghouse (NCPC)

Great official Australian site with an exceptional Publications section, including full-text articles on child abuse, its effects, and how to prevent it - some quite in-depth, sophisticated, and scholarly. For help with accessing NCPC statistical information, see above, Official Statistics: Australia.

National Child Traumatic Stress Network (NCTS)

This network of treatment centers was created by an initiative of the US Congress just a few years ago. Their mission is "To raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States." The site has many great resources, including for parents, caregivers, and school personnel. For example, to find professional help for a child or adolescent, see the How to Find Help page, and the Network Members page, which lists centers and clinics all around the US, each of which will know of excellent resources in their area.

National Clearinghouse on Family Violence (NCFV)

Official Canadian site with several "fact sheets," an extensive Publications section addressing Child Abuse and Neglect, Child Sexual Abuse, and Family Violence, Intimate Partner Abuse Against Men, Intimate Partner Abuse Against Women, and Preventing Family Violence , a collection of videos for the general public and professionals. For help with accessing NCFV statistical information, see above, Official Statistics: Canada.

National Crime Victim Bar Association

An organization of attorneys who work for victims of crime, including child abuse, to pursue civil cases against perpetrators and other parties who may be found liable for physical and mental injuries suffered. See "Info for Victims," which includes information about how to find a qualified local attorney through their service.

Partners and Allies of Sexual Assault Survivors Resource List

This page by Kerry Cater, M.S.W., at The Wounded Healer Journal provides a comprehensive list of resources, from Internet mailing lists and newsgroups to newsletters and books, some of which can be ordered online.

Psychological Trauma and Substance Abuse in Women

This site, by Barbara Hilliard, M.Ed., has some excellent resources on psychological trauma, posttraumatic stress disoreder and substance abuse for women struggling with these issues and those who treat them. In addition to links to various organizations and informative articles, including Barbara's Getting Sober While Staying Sane.

Publicizing Child Molester's Prison Release

This site belongs to Mark Welch, a California lawyer who has publicized the release from prison of his brother, who has admitted to sexually abusing him in childhood. This is clearly a very controversial issue. Mr. Welch provides a thoughtful essay on publicizing the release of one's perpetrator, including various ethical considerations.

Safer Society Foundation

The Safer Society Foundation, Inc. (SSF) is a nonprofit agency and national research, advocacy, and referral center for the prevention and treatment of sexual abuse. The SSF provides training and consultation to individuals, agencies, states and organizations. Their Web site has a list of Safer Society Press books and videos. For information about their "Treatment Referrals Program" for sexual abuse perpetrators, see their Contact Us page.

Self-Compassion

Dr. Kristin Neff's site includes scholarly research and exercises for how to increase self-compassion. People who have experienced abuse in childhood often have a difficult time being compassionate toward themselves, and instead get caught in being judgmental toward themselves, self-pitying, and/or self-indulgent. This site provides a healthier, healing alternative, and is written for "students, researchers, and the general public."

The Sexual Assault Information Page

This site is now only available in archive format (last version of October 2001, but is still very useful with its over 400 links to information and resources on child abuse and neglect, as well as the sexual assault of adults.

Sidran Foundation Online Resources

This is a national non-profit organization that offers services to people who have experienced trauma and/or suffer from dissociative disorders, and those who provide services to them. There are many excellent resources here, including a Traumatic Memories Brochure and pages with Resources for Survivors and Information for Students.

Silent Edge

This page has links to several resources addressing sexual abuse and exploitation by coaches, particularly of figure skaters.

STOP IT NOW!

"STOP IT NOW!'s mission is to call on all abusers and potential abusers to stop and seek help, to educate adults about the ways to stop sexual abuse, and to increase public awareness of the trauma of child sexual abuse."

SNAP - Survivors Network of those Abused by Priests

"SNAP is a national self-help organization of men and women who were sexually abused by Catholic priests (brothers, nuns, deacons, teachers, etc). Members find healing and empowerment by joining with other survivors."

The Trauma Center

The Trauma Center, founded by Bessel van der Kolk, an leading expert in the field of traumatic stress studies, is a clinic affiliated with the Boston University School of Medicine. The site includes pages on the work of Dr. van der Kolk, including links to his articles on the web and psychological trauma assessment instruments.

Tips for Abuse Survivors and Their Dentists

As indicated by its name, this page at Dental Fear Central was written for abuse survivors and their dentists, and has some helpful advice on dealing with many of the issues and difficulties that can arise.

VOICES In Action, Inc.

Victims of Incest Can Emerge Survivors - "VOICES in Action, Inc. is an international organization to provide assistance to victims of incest and child sexual abuse in becoming survivors and to generate public awareness of the prevalence of incest.

The Wounded Healer Journal

"Points of Departure for Psychotherapists and Other Survivors of Abuse." This site, maintained by Linda Chapman, L.C.S.W., has a great wealth of pages and links, including Partners and Allies of Sexual Assault Survivors Resource List.

Contents

This page is maintained by Jim Hopper, Ph.D., as are these related pages:

Mindfulness: An Inner Resource for Healing from Child Abuse

Sexual Abuse of Males: Prevalence, Lasting Effects, and Resources

Recovered Memories of Sexual Abuse: Scientific Research & Scholarly Resources

Jim Hopper's Professional Services - Therapy, Talks, Workshops & Consultation

Factors in the Cycle of Violence - Abused Boys, Gender Socialization, and Violent Men

Trauma and Recovery - Judith Herman's Landmark Book on Child Abuse & Other Traumas

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http://www.jimhopper.com
*jhopper * jimhopper99.com [modified to thwart spammers - replace * with @ and remove numbers]*
Please note: Sadly, I cannot always respond to every message.