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Gender Differences in Symptom Presentation of Sexually Abused African American Children Ages 8 through 12

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Philadelphia College of Osteopathic Medicine

Department of Psychology

Gender Differences in Symptom Presentation of Sexually Abused

African American Children Ages 8 through 12

By Tania Czarnecki Wismar, M.A., M.S.

Submitted in Partial Fulfillment of the Requirements of the Degree of

Doctor of Psychology

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DEPARTMENT OF PSYCHOLOGY

Dissertation Approval

This is to certify that the thesis presented to us by Tania Czarnecki-Wismar on the 20th day of April, 2010, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

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Acknowledgments

*You may trod me
in the very dirt
But still,
Like dust,
I'll rise
~Maya Angelou*

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Abstract

A well-documented connection exists between child sexual abuse and psychological symptoms that may persist into adulthood. Because of the significant public health implications of child sexual abuse, it is critical to examine the many variables related to such a potentially traumatic event, including its psychological effects and effects on gender, so that treatment providers are able to gain a better understanding of how males and females are affected by their abuse experiences. This study examined the role of gender on psychological symptoms in a largely understudied population of inner city African American children; it also examined gender roles regarding the display of sexual behaviors. Diverse variables, such as number of perpetrators and duration of abuse were also examined. Although gender was not found to be clinically significant in psychological outcome or in the display of sexual behaviors, trends suggested that gender may still play a role in symptomatology and in display of sexually reactive behavior. The number of perpetrators was found to play a role in psychological symptoms when controlling for gender. The results of this study have important implications for the assessment and treatment interventions for children.

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Epigraph

“When I look at the world I'm pessimistic, but when I look at people I am optimistic.”

~ Carl Rogers

CHAPTER ONE: STATEMENT OF THE PROBLEM

Child sexual abuse

Child sexual abuse (CSA) is a significant global health problem affecting an estimated 800 million people worldwide (World Health Organization, 2002). Despite these staggering statistics, child sexual abuse was regarded as a rather uncommon problem as recently as the late 1970's. In more recent times, evidence has steadily accumulated, showing that CSA is more frequent than had previously been assumed and that CSA produces deleterious effects (Romans, Martin, Anderson, O'Shea, & Mullen, 1996). Research has repeatedly demonstrated an association between child sexual abuse and subsequent, negative short and long-term effects on mental health functioning in areas such as increased suicidality, substance abuse, depression and posttraumatic stress symptoms (Tyler, 2002; Fontanella, Harrington & Zuravin, 2000). Research has also shown that gender differences exist among symptom expression, related to being sexually abused (Garnefski & Diekstra, 1997; Evans, Albers, Macari & Mason, 1996). Given the fact that deleterious effects of CSA have been found, it is critical to examine the many variables related to child sexual abuse, including psychological effects and gender, so that clinicians can gain a better understanding about how males and females process their abuse experience; it will also aid in helping to develop individualized treatment for sexually abused males and females rather than treating all children who have been victimized with similar treatment protocols.

Gender Differences and Sexual Abuse

Researchers appear to be in agreement that child sexual abuse survivors are more likely to experience a range of psychiatric and behavioral problems when compared with

a non-sexually abused population (Molnar, Berkman, & Buka, 2001). When researchers examined whether or not gender differences exist in the manifestation of psychological symptoms relative to sexual abuse, mixed results were found. Some studies indicated that females were at a higher risk for mental health problems compared with male subjects, stating that females often suffered from higher rates of internalizing behavior, such as depression and Posttraumatic Stress Disorder, but males engaged in externalizing behavior, such as aggression (Gold, Lucenko, Elhai, Swingle, & Sellers, 1999; Banyard, Williams & Siegel, 2004). Other research results did not find gender differences in psychological symptoms of CSA (Young, Harford, Kinder & Savell, 2007). Some studies examining gender differences and psychological symptoms related to CSA used predominantly female subjects, and other studies were based upon retrospective accounts, making actual gender differences in symptom presentation ambiguous.

African Americans Represented in Sexual Abuse Research

Unfortunately, as in other research areas, African Americans remain largely underrepresented in sexual abuse research, making their psychological functioning following sexual abuse unclear. African American underrepresentation in sexual abuse research is especially alarming considering that African American children and adolescents are at risk for a range of issues, including higher male juvenile arrest rates (Fite, Wynn, & Pardini, 2009) when compared with a Caucasian population; they also have a higher pregnancy rates compared with Caucasian females (Gilliam, Davis, Neustadt & Levey, 2009). Crime statistics have shown that communities inundated with chronic violence are typically those in high-poverty, high-ethnic-minority areas. When chronic violence and eminent danger replace safety in a child's world and are combined

with cultural, social, and economic risk factors, the child becomes at risk for developing emotional and behavioral disorders such as posttraumatic stress disorder (Jones, 2007). Additionally, children exposed to violence tend to exhibit a variety of other emotional and behavioral difficulties (Flannery, Wester, & Singer, 2004). Therefore it is crucial to examine inner city, African American children in order to gain more information regarding how this largely underrepresented population is affected by child sexual abuse.

Purpose of the Study

Although child sexual abuse research currently exists on gender and symptomology, many methodological flaws exist. Child sexual abuse research often times tends to be retrospective; however, there is increasing evidence that procedures for using long-delayed adult retrospective accounts of sexual abuse are fairly unreliable and that they miss substantial information (R. Johnson, 2008). Males are often underrepresented in samples studied, making gender comparison of sexual abuse difficult. Males could be underrepresented because of lower rates of disclosing sexual abuse or simply due to fears of social stigma and shame related to their sexual abuse. Additionally, a paucity of research exists in which prepubescent children in the age category of 8 through 12 are examined. Also, multicultural subjects are often neglected. The current study attempts to counter these limitations by using a similar number of male and female subjects, as well as using prepubescent African American children with recently disclosed abuse that was investigated either by law enforcement and/or by a child welfare agency.

Overview of Literature Review

This study discusses a variety of topics relevant to child sexual abuse, and more specifically, how CSA relates to gender differences symptom presentation. Childhood sexual development will be addressed to elucidate normative sexual development from the ages of 8 to 12, as well as to identify sexually reactive behavior. Sexual abuse will be expounded upon, including its prevalence and disclosure rates, female and male victimization rates and an examination of the issue of perpetrator relationship to the child. The study will then provide an extensive overview of child sexual abuse and its relationship to psychopathology and the role of gender.

Relevance to Cognitive Behavior Therapy

Because both child and adult victims of child sexual abuse often exhibit a range of psychological symptoms related to their sexual abuse, such as anxiety, fear, posttraumatic stress symptoms, depression, and poor self-esteem (Kendall-Tackett, 2002; Briere & Elliot, 2003), therapeutic services are often utilized, making it important to understand how to reduce problematic symptomatology. Although many children who were victims of sexual abuse show improvement over time without mental health treatment, research indicates that interventions for these children are more effective than the mere passage of time (R. Johnson, 2008). The goal of therapy generally focuses on facilitating communication about the abuse experience, enhancing self-esteem, learning about appropriate family roles and boundaries, overcoming isolation, and developing healthy peer relationships (Johnson, 2008). Common treatments include abuse-focused therapy, education, individual and group therapy. Of all the interventions used to treat sexual abuse in children, cognitive behavioral therapy (CBT) has received the most serious

empirical evaluation (Cohen, Mannarino, Berliner & Deblinger, 2000). According to Gil, “Since the early 1990s, the practice of cognitive behavioral therapy (CBT) specifically with sexually abused children has been well studied and the available research strongly suggests that this approach is efficient and valuable for children” (Gil, 2006, p.15). Although CBT appears to be an “efficient” therapeutic tool, an increased CBT focus on how sexual abuse is affected by gender might be an even more effective treatment approach.

Most of the treatment interventions developed for treating trauma-related symptoms in children have been modified from interventions for traumatized adults or from interventions that have been useful in treating non-traumatized children with symptoms similar to those seen in traumatized children; that is, anxiety or depressive symptoms (Cohen et al., 2000). Other literature regarding treatment of sexual abused adolescent and adult victims of sexual abuse focused only on females, although researchers emphasized the importance of viewing sexually abused children and adolescents as a heterogeneous population with correspondingly diverse treatment needs (Johnson, 2008). Because the incidence of sexual abuse in males is lower when compared with sexual abuse in females, and because the community often believes that sexual abuse of boys is less serious and less harmful to boys (Smith, Fromuth, & Morris, 1997), decision-making regarding the care, protection and treatment of boys may be adversely affected (Martin, Bergen, Richardson, Roeger, & Allison, 2004). Therefore, being aware of the gender differences in symptom presentation of sexually abused children is imperative when dealing with an overall conceptualization of treatment needs. Furthermore, when treating inner city, African American children, it is imperative that

clinicians consider not only the child's sexual abuse experience, but also consider the fact that the inner city, African American child may be doubly traumatized, not only because of their sexual abuse experiences, but also because they are potentially at high risk for things such as witnessing community violence.

CHAPTER TWO: LITERATURE REVIEW

Child sexual abuse (CSA) is a significant societal problem in the United States affecting thousands of children of all ages, races, economic status and cultural background each year (World Health Report, 2002). Unfortunately, precise prediction of CSA rates is rather difficult, because many children do not disclose their abuse at the time it occurs, if they ever do, and males appear to underreport their abuse more often than females (Johnson, 2008; Levesque, 1994).

Both longitudinal and short-term studies have consistently shown significant links between child sexual abuse and psychological distress. CSA survivors have been found to have higher rates of suicidality, depression, anxiety, substance abuse and aggression compared with non-sexually abused counterparts. Research examining potential gender differences and CSA is quite varied, and suffers from methodological flaws.

The opening of Chapter Two expounds upon normal and inappropriate sexual development in the prepubescent child in order to prepare the reader to understand some of the crucial, developing areas in the child. Next, the basic concepts of child sexual abuse will be explored, including definitions, prevalence rates, perpetrator characteristics and disclosure issues. A significant part of the literature review explores research on gender and psychological symptoms related to child sexual abuse, which is crucial to understanding the need for the current study. Last, specific psychological symptoms are discussed as they relate to gender differences specific to African American children.

Sexual Development

Sexual development is a multidimensional process, intertwined with the basic human needs of being liked and accepted, with displaying and receiving affection, with

feeling valued and attractive, and with sharing thoughts and feelings (Murphy & Young, 2005). Thanasiu (2004) stated that children's sexual development is marked by curiosity first about their own bodies and then about those of others. Children's attempts at sexual exploration and the repercussions of such attempts assist in shaping the child's sexual development. Children learn about times when they are and are not allowed to satisfy their sexual curiosities. Ponton and Judice (2004) stated that psychological, social-cultural and educational factors all play considerable roles in the development of a child's sexual self. This includes the sexual attitudes of the family, the role of gender, when a child learns about sexual behavior, including masturbation and intercourse and what attitudes are communicated with the dissemination of such information. For example, a rigid parent might enforce a message to the child that masturbation is wrong, hence enforcing inhibition. The child's family creates a psychosexual equilibrium that is a function of the parents' sexual adjustment, the child's developing sexuality, the impact of the child's sexual development on the parental sexual adjustment, and the interaction that is developed as the child's sexual development activates parents to re-experience their own memories and feelings related to sexual development (Friedrich, Grambsch, Broughton, Kuiper, & Beilke, 1991).

In addition to the social aspect of sexual development, genetic and environmental forces begin to shape sexual development before birth. Genetic and biological factors operate, in part, by determining the level of hormones and neurotransmitters that influence sexual response. Hormonal changes, also called adrenarche, begin between the ages of six and eight in both sexes, with males having significantly higher levels of hormones than females (Ponton & Judice, 2004). Girls enter puberty about 2 years

earlier than boys and may complete the process in 3 or 4 years. Puberty typically starts between the ages of 8 and 14 in girls and between the years of 9 and 14 for boys (Ponton & Judice).

Female puberty begins with a growth spurt, the budding of breasts, and pubic hair growth. Menarche typically occurs around 12 and a half years old for North American girls and age 13 for Western European girls, but the range is wide (Berk, 2008, p. 198). The first sign of puberty in boys is the enlargement of the testes, accompanied by changes in the texture and color of the scrotum, then pubic hair growth, the beginning of facial and body hair, a growth spurt and changes in the voice (Berk, 2008, p. 199).

Variations in pubertal growth also exist between and among regions of the world as well as between and among income and ethnic groups. Berk (2008, p. 199) stated that in poverty-stricken regions where malnutrition and infectious disease are common, menarche is greatly delayed. In industrial nations where food is abundant, the joint role of heredity and environment in pubertal growth are apparent and vary according to ethnicity. For an example, breast and pubic hair growth begin, on average, around age 9 in African American girls, a year earlier than in Caucasian-American girls. African American girls also reach menarche, on average about 6 months earlier, around age 12.

With the arrival of puberty, hormonal changes lead to an increase in sex drive (Halpern, Udry, & Suchindran, 1997). In response, adolescents become very much concerned about how to manage sexuality in social relationships. New cognitive capacities involving perspective-taking and self-reflection affect their efforts to do so. Yet adolescent sexuality is heavily influenced by the young person's social context (Berk, 2008, p. 205).

Child Sexual Behavior

Child sexual behavior is quite complex. No general consensus or empirical evidence exists to elucidate those sexual behaviors and feelings which could be considered normal for children of a certain age, gender and cultural background and there is no criteria used to help discern those behaviors and feelings that should be viewed as normal and those which fall within the range of inappropriate or abnormal. With increasing sexual stimuli in western society and increasing information about the prevention of child sexual abuse, parents and educators find it difficult to decide how to react to sexual behaviors or how to answer questions about sexuality from children. Therefore, there are no evidence-based guidelines with respect to intervention or to education of children in this respect (de Graaf & Rademakers, 2006). Parents, teachers and caregivers, however, often teach children good and bad touch to assist them in understanding appropriate and inappropriate sexual behavior. When analyzing child sexual behavior, observers must keep in mind that a child's experience of sexuality differs from an adult's experience, because adults possess a learned component to their sexuality that children have not yet acquired (Thanasiu, 2004). For example, adult sexuality can often be characterized by a passionate and erotic quality that children do not possess (T.C. Johnson, 1999). A preadolescent child's mind is not capable of operating in the same manner as an adult's because preadolescents are still in the preoperational and concrete operational cognitive stages, according to Piaget, and experience sexuality, for the most part, in the here and now and in a more concrete manner (Thanasiu, 2004). Thanasiu further postulates that although some children's sexual comments appear to be motivated by a more adult understanding of sex, the child is often conveying only a

surface meaning in his or her comments. For example, a young boy removed his underwear and commented that he "won't be needing these" any longer as he climbed into bed with his mother. Although the behavior could be construed as the boy planning to seduce his mother, he, in fact, planned nothing further and prepared only to fall asleep (Thanasiu, 2004).

Despite the surrounding confusion about those child sexual behaviors which are normal and those which are outside the normal range, it is important to make some type of distinction between the two because sexual behavior problems can be a common aftereffect of child sexual abuse and can be a useful discriminating variable between sexually abused and non-abused children (Deblinger, McLeer, Atkins, Ralphe & Foa, 1989; Friedrich et al., 1992). Meyer-Bahlburg, Dolezal and Sandburg (2000) stated that sexual abuse of prepubertal children tends to sexualize the behavior of the children. In turn, children may engage in sexualized behavior, such as masturbation, request sexual stimulation or have precocious sexual knowledge.

Many sexual behaviors in children are common and the variability of normative sexual behaviors is extensive (Thanasui, 2004). Although researchers seem to agree that sexual behavior is seen on a continuum as the child ages, (Gil, 1993; Thanasui, 2004), researchers differ on the factors used to differentiate between those that are considered normal sexual behaviors and those that are considered inappropriate, or sexually aggressive. Furthermore, concepts of appropriate and inappropriate sexual behavior vary from culture to culture (Friedrich, Sandfort, Oostveen & Cohen-Kettenis, 2000). The term *normal* frequently describes sexual behaviors that occur as a result of the natural human biological and physiological developmental process (Araji, 1997, p.2), but

behaviors considered inappropriate can be defined as occurring in children 12 years old and younger who demonstrate developmentally inappropriate or aggressive sexual behavior. This definition includes self-focused sexual behavior, such as excessive masturbation, and aggressive sexual behavior towards others that may include coercion or force (National Center on Sexual Behavior of Youth, 2004). Another term, “sexually reactive,” is often used when describing sexual behavior in children. Sexually reactive children are pre-pubescent boys and girls who were exposed to, or had contact with, inappropriate sexual activities. The sexually reactive child may engage in a variety of age-inappropriate sexual behaviors as a result of his or her own exposure to sexual experiences, and may begin to act out, or engage in sexual behaviors or relationships that include excessive sexual play, inappropriate sexual comments or gestures, mutual sexual activity with other children, or sexual molestation and abuse of other children (Rich, 2002). Last, sexually aggressive behaviors represent the extreme end of the sexual behavior continuum. The sexual behaviors are far advanced for children 12 years of age and younger and the behaviors have an aggressive nature, involving use of force, coercion and secrecy. These sexual acts represent patterned rather than isolated events (Aranji, 1997, p. 35).

T.C. Johnson and Feldmeth (1993, pp. 41-42) used seven indicators to gauge whether or not certain sexual behaviors are normal. First, sexual behavior can be viewed as an information-gathering process or an act of curiosity. Second, the children are similar developmentally, as well as in age and in size. Third, both or all children engage in sex play voluntarily. Fourth, the sex play involves children who have an amicable relationship outside the sexual interaction. Fifth, the sexual behaviors are limited in

terms of types and frequency, and children are not preoccupied with sexual behavior. Sixth, if children are caught by others and are told to stop, they do so when they are in front of others, but the behavior may go unseen. Last, the children's sexual activity is usually spontaneous and lighthearted in nature. Johnson and Feldmeth's seven indicators facilitate being able to distinguish whether or not the sexual interplay between children is dictated with an undertone of coercion or curiosity.

Crisci and Brown (as cited in Aaraji, 1995) differentiated between normal sexual behavior and inappropriate sexual behavior by examining the motives behind the behavior. They viewed the motive for normal child behavior as curiosity, but inappropriate and aggressive sexual behavior was viewed as involving coercion, bullying, and a power-control imbalance. The sexual behavior was viewed as a re-enactment of adult sexual acts and the affect expressed is fear, shame and discomfort.

Ryan and Blum (1994) provided three ways of delineating whether or not child sexual behavior is problematic. First, the behavior may be problematic if it puts the child at risk, if it interferes with other developmental tasks or relationships, if it violates rules, if it is self-abusive, or if the child believes the behavior is a problem. Second, the sexual behavior is considered problematic if it causes discomfort in others, occurs at the wrong time or in the wrong place, conflicts with family or community values, is abusive, or all of the above. Last, the sexual behavior is problematic if it involves other children without their consent, if two children are not equal, or if one child is pressured or coerced by another child.

Specific Child Sexual Behaviors

Now that normal versus problematic sexual behaviors have been explored, some of the specific behaviors falling into the normal and inappropriate range will be explored. Gil (1993) found that children from 8 to 12 years of age may engage in a variety of sexual interests. Children during this age range have peer contact in school; they may begin to experiment with sexual behaviors and may have alternating periods of inhibition and disinhibition. T.C. Johnson (1999) identified some distinct characteristics of normal childhood sexual exploration. Children experience normal sexual exploration with positive, healthy feelings. Children's sexual exploration can be observed as lighthearted, silly, spontaneous, and giggly; however, it is uncommon for this to involve anger, shame, fear, or anxiety. Most children experience pleasurable sensations and arousal and some even experience orgasm, although orgasm generally occurs more readily during puberty. Children normally experiment with other children who are within a year of their chronological or developmental age, and participation is on a voluntary basis in normal experimentation. Although some siblings experiment sexually, it is much more common for the other child to be a friend that the child often plays with. Sexual interest and activity, on average, is equal between boys and girls, and children normally range from having no interest in sexual play to being very much interested. The children's interest in sexuality is balanced by their curiosity about the other aspects of their lives. Normal sexual experimentation is spontaneous and sporadic, not something with which the child is persistently preoccupied.

Friedrich, Fisher, Broughton, Houston and Shafran's (1998) seminal study attempted to delineate normal and inappropriate childhood sexual behaviors using 1114

subjects aged 2 through 12. Their study is unique because it is one of very few known to examine non-clinical samples of children. The study excluded children who were sexually abused and examined males and females separately; they also separated the children in two age categories: ages two to six and 7 through 12. The study was broken down further into 77.7% of the subject being White, 7.7% Black, 11.6% Hispanic, 1.7% Asian, 0.5% Native American and 0.7% being in the “other” category.

Results of the study by Friedrich et al. indicated that children in both age categories exhibited a wide range of sexual behaviors at relatively high frequencies. These behaviors included self-stimulatory behavior, kissing and exhibitionism. Their study also determined that certain behaviors were unusual, such as putting one’s mouth on private parts, asking others to engage in a sex act and inserting objects into vaginal and anal area (sexual behavior problems will be further examined below). The study showed some variability according to gender. Behaviors such as imitating sexual behavior with dolls, inserting objects into vagina/anus, flirtatious talk, and pretending to be the opposite sex, were noticeably more common in girls than in boys. Conversely, behaviors observed more frequently in boys when compared with girls included making sexual sounds, looking at nude pictures, touching sex parts in public and trying to look at people undressing. The study also found that ethnicity was not a significant factor in varied child sexual behavior.

A study by Thigpen, Pinkston and Mayefsky (2003), similar to Friedrich and colleagues’ study referenced above, examined normative childhood sexual behavior, but focused specifically on African American children 2 to 12 years of age who did not report sexual abuse. Thigpen and colleagues’ study is of critical importance because

research examining African American children and their sexual behavior is sparse, yet the majority of children labeled as sexually aggressive are African American (Thigpen, et al., 2003, p. 242). Thigpen et al. used the Child Sexual Behavior Inventory (CSBI), which examines normative versus abnormal sexual behavior in children, to study the sexual behavior of African American children. Their results indicated that 20 of the 42 CSBI items were endorsed for the 2 to 6-year-old children compared with 13 items for the 7 to 12 year-old-children. The results showed that more items were endorsed for the younger subjects in comparison with those endorsed by the older subjects, indicating that younger children, at least in this study, showed somewhat more observable sexual behaviors when compared with older children. Gender differences in the total number of endorsed items were also noted. More items were endorsed for boys (20) than for girls (18). Furthermore, the dimensions of sexual behavior that were highly endorsed included self-stimulation, sexuality anxiety, sexual interest, and personal boundaries. Their study suggested that African American children display a range of sexualized behavior that varies with age and gender, which appears similar to the previously referenced study by Friedrich et al. (1998). Both studies showed that children, regardless of ethnicity, display variations in sexual behavior. A limitation in studies by Thigpen et al. and by Friedrich et al. was the exclusion of sexually abused children. Using sexually abused children would have added a richer dimension to the research because sexually-abused children, often prematurely sexualized, may display sexual behaviors different from non-sexually abused children. It could also be possible that a portion of the children in these identified studies were sexually abused, but did not disclose their sexual abuse at the time of the study.

As stated in these studies by Thigpen and colleagues and Friedrich et al., self-stimulatory behavior seems to be rather common. During preadolescence, more children gain experience with solitary sexual behavior, which is defined as all kinds of behavior in which the child touches or stimulates his or her own genitals (whether feelings of pleasure or sexual arousal occur or not) (de Graaf & Rademakers, 2006). An early study by Rutter (1971) found that masturbation increased from 10% at age seven to about 80% at age 13. In another study using college students, about 40% of the female subjects and 38% of the male subjects recalled masturbating before puberty began (Bancroft, Herbenick, & Reynolds, 2003). After reviewing various research articles about parents in different Western countries who were asked whether or not they observed their children (birth to 12-years-old) touching their sex parts at home, rubbing their bodies against people or furniture, masturbating with an object or masturbating with their hands, de Graaf and Rademakers (2006) determined that touching sex parts is the observable, solitary sexual act most frequently reported. Their study determined that parents in the Netherlands observed more solitary sexual behavior than parents in Sweden, Flanders, Spain or the United States. These findings support an early study by Rutter (1971), which stated that masturbation increases from 10% at age seven to about 80% at age 13.

During preadolescence, children begin engaging in interpersonal sexual behavior, which encompasses a heterogeneous group of experiences, depending on the age of the other person and his or her role. The other person can be another child, approximately from the same age or can be an adolescent. The other individual may play a passive or an active role (de Graaf & Rademakers, 2006). During preadolescence, children create a social organization that is homosocial, meaning that males and females separate into

groups by gender. By doing so, sexual exploration and learning at this stage is likely to involve persons of the same gender.

De Graaf and Rademakers (2006) indicated that children touching others' breasts or genitals, looking at people when they are nude and showing genitals to other people are relatively common behaviors in prepubescent children. De Graaf and Rademakers stated that the showing and touching of genitals can also be a part of mutual sexual experiences between children, in which both children are active participants; these experiences are sometimes referred to as sexual play. Children may invent a situation in which they act out adult roles containing some sexual aspects, such as playing doctor or playing mother and father roles; masturbation games are generally played by boys (deGraaf & Rademakers, 2006).

In a retrospective study, Lamb and Coakley (1993) interviewed 300 undergraduate females and found that approximately 60% of the subjects engaged in childhood sexual play and games. Most of the respondents reported that the games involved kissing or exposing themselves to another child. At least one-third reported engaging in genital fondling, with and without clothing, and a few of the respondents indicated engaging in oral-genital contact and attempts to engage in sexual intercourse.

Certain sexualized behaviors, however, appear to occur more frequently among children who have been sexually abused. These sexualized behaviors often occur in the form of resembling adult sexual behavior, including imitating or attempting vaginal or anal intercourse with another child, oral-genital contact, and French kissing (Friedrich, 1993; Larsson & Svedin, 2001). Therefore, although almost no consensus exists for what

is considered normal, healthy and typical, behaviors such as these just mentioned should at least be a potential red flag for caregivers, clinicians and other treatment providers.

Sexual Thoughts and Feelings

Last, outside of specific sexual behaviors, children experience sexual thoughts and feelings, but unfortunately, this realm has not received as much research attention as childhood sexual behavior. Yet a few studies exist on feelings such as being in love, feelings surrounding physical intimacy and sexual arousal.

According to de Graaf and Rademakers (2006), preliminary feelings of sexual arousal, sexual attraction and sexual fantasy are on average reported at the end of childhood. Boys generally experience sexual thoughts and feelings earlier than girls. In a retrospective study of American college students, the average age of first sexual arousal was 9.8 for boys and 10.8 for girls. Boys experienced the first feelings of sexual attraction, on average, when they were 11.4 years old, and girls experienced such feelings around the age of 12.4. Sexual fantasies were reported for the first time when boys and girls were 11.6 and 13.3 years old, respectively (Reynolds, Herbenick & Bancroft, 2003).

Rademakers, Laan, and Straver (2000) examined body awareness and physical intimacy experiences from a child's perspective in 8- and 9-year-olds. The researchers asked the children questions relating to romping, cuddling, and being in love. Physical intimacy was valued by almost all of the children in the study, and the majority of the children reported that romping and cuddling were enjoyable experiences involving their whole bodies. In addition, the study found that children experienced being in love in some ways similar to adolescents and adults. Although children fantasized about the

person they were in love with, these were relatively innocent fantasies (e.g., holding the person or playing with him or her).

Based on the above information, children exhibit an extensive range of sexual behaviors and possess sexual thoughts and feelings. It can be difficult at times to differentiate those sexual behaviors which fall into the “normal” range and those behaviors which are of concern. Various general guidelines of sexual behavior were explored in order to better discern those behaviors which are concerning, especially because research has shown that child sexual abuse can lead to certain sexualized behaviors. By knowing more about the commonality and nature of the sexual behavior being displayed, the better prepared clinicians will be in understanding if a child is in need of intervention. Also, by understanding childhood sexual behavior in the context of child sexual abuse, the clinician, parents and other treatment providers will be armed with knowledge about which behaviors to look out for, in the hope of preventing their child from sexually acting out in a potentially inappropriate manner with another child.

Definition of Child sexual abuse

The following section will examine several issues specific to child sexual abuse. Although child sexual abuse is regarded very seriously as an emotionally and psychologically damaging experience for children (Kendall-Tackett K, 2002; Briere, Woo, Mcrae, Foltz, & Sitzman, 1997), there is a lack of consensus on an agreed upon definition of child sexual abuse. Haugaard (2000) argued that each word in the term “child sexual abuse” has been operationalized differently by researchers, lawmakers and clinicians, and there is no consensus about the definition of any of the words within the context of the term. Haugaard stated that certain acts are not generally agreed upon as

being sexually abusive, such as a parent appearing nude in front of a 10-year-old or allowing a 10-year-old to sleep with a parent. Although some behaviors, such as intercourse, are considered sexual by almost everyone, other behaviors are more ambiguous and are open to interpretation, such as bathing children or sleeping with them. The intent of the adult is an issue that is often considered when deciding whether or not a behavior is sexual, but intent can be difficult to judge in some cases (Haugaard, 2000). Additionally, no common consensus exists regarding the exact age that is considered the cut off age of “childhood.” Finally, controversy exists about the meaning of the word “abuse.” Haugaard stated that abuse can indicate the presence of harm and, consequently, CSA may not be an appropriate term to describe adult-child sexual encounters from which no demonstrable harm can be observed.

Johnson (2004) defined CSA as any activity with a child before the age of legal consent; that is, for the sexual gratification of an adult or a substantially older child. These activities include oral-genital, genital-genital contact, genital-rectal, hand-genital, hand-rectal, or hand-breast contact, exposure of sexual anatomy; forced viewing of pornography to a child or using a child in the production of pornography. Viewing or touching the genitalia, buttocks, or chest by preadolescent children, separated by no more than four years of age, in which there has been no force or coercion is called sexual play.

The World Health Organization (2007) defined CSA as the involvement of a child in sexual activity, either by adults or by other children in a position of responsibility, trust or power over the child; it is activity that the child does not fully comprehend, is unable to give informed consent to or is not developmentally prepared for, or that violates the laws or social taboos of society. Abuse can be non-contact (e.g., unwanted and

inappropriate sexual solicitation or indecent exposure), non-penetrative contact (e.g., sexualized kissing, hugging, touching or fondling) or intercourse (e.g., penetrative acts such as oral, anal or vaginal intercourse or attempted intercourse).

The Crime Codes of Pennsylvania breaks down sexual offenses against children by specific acts (Megan's Law, 2009). Pennsylvania law defined rape of a child as sexual intercourse with a complainant who is less than 13 years of age. Furthermore, the Crimes Code of Pennsylvania defines the sexual abuse of children are the following:

(a) Definition – As used in this section, "prohibited sexual act" means sexual intercourse as defined in 18 Pa. C.S. § 3101, masturbation, sadism, masochism, bestiality, fellatio, cunnilingus, lewd exhibition of the genitals or nudity if such nudity is depicted for the purpose of sexual stimulation or gratification of any person who might view such depiction.

(b) Photographing, videotaping, depicting on computer or filming sexual acts – Any person who causes or knowingly permits a child under the age of 18 years of age to engage in a prohibited sexual act or in the simulation of such act is guilty of a felony of the second degree if such person knows, has reason to know, or intends that such act may be photographed, videotaped, depicted on computer, or filmed. Any person who knowingly photographs, videotapes, depicts on computer or films a child under the age of 18 years engaging in a prohibited sexual act or in the simulation of such an act is guilty of a felony of the second degree.

(c) Dissemination of photographs, videotapes, computer depictions, and films – Any person who knowingly sells, distributes, delivers, disseminates, transfers, displays, or exhibits to others, or who possesses for the purpose of sale,

distribution, delivery, dissemination, transfer, display or exhibition to others, any book, magazine, pamphlet, slide, photograph, film videotape, computer depiction or other material depicting a child under the age of 18 years engaging in a prohibited sexual act or in the simulation of such act commits an offense.

(d) Possession of Child Pornography – Any person who knowingly possesses or controls any book, magazine, pamphlet, slide, photograph, film, videotape, computer depiction or other material depicting a child under the age of 18 years engaging in a prohibited sexual act or in the simulation of such act commits an offense (Megan’s Law, 2009, para. 6).

Prevalence Rates

Through the years, considerable advances have been made in the changing perspective concerning CSA. As recently as 40 years ago, CSA was thought to be extremely uncommon, especially among males. Today’s heightened awareness may stem from growing societal concerns over child abuse in general, an increased comfort level in discussing sexual violence, and/or perhaps due to the publicity surrounding cases in the media involving sexual abuse (Johnson, 2008).

Precise prevalence rates of CSA are notoriously difficult to obtain, making CSA largely a hidden crime. According to the World Health Organization Report of 2002, CSA prevalence rates were higher than many may find comfortable or plausible. The WHO speculates that more than 800 million people worldwide may have experienced CSA, with over 500 million having experienced contact or intercourse types of abuse. Prevalence rates of CSA specific to the United States appear, unfortunately, to be relatively high. Briere and Elliott (2003) examined the prevalence rates of CSA through

a national random sample of 464 male and 471 female subjects and found that approximately 32% of females and 14% of males reported child sexual abuse. It is noteworthy that this data reflects the state of victimization incidence rates from approximately 30 years ago as opposed to possible current rates (Briere & Elliot, 2003). Scher, Forde, McQuaid, and Stein (2004) randomly contacted 967 males and females with a mean age of 40, and found that CSA prevalence rates in their overall sample to be only 5.0%, which is significantly lower than other investigation findings. Scher et al. stated that their low prevalence rate could be due to idiosyncrasies of their population, such as their willingness to disclose.

Many additional investigations on CSA prevalence rates have been conducted. In the United States, any state receiving Federal Government funding is required to report data regarding the maltreatment of children, including alleged sexual abuse (Sapp & Vandeven, 2005). In 2000, 879,000 children from 34 states (representing 78.1% of the child population in the US) were estimated to have been maltreated and of that total, 10.1% or 88,000 children were sexual abuse cases (U.S Department of Health and Human Services, 2002).

Although sexually abused children are a heterogeneous population, much of the research conducted on CSA rates, unfortunately, does not contain a representative sample of African American children. Consequently, there is a dearth of information regarding the prevalence of child sexual victimization in African American communities (Priest, 1992). Priest examined African American college students and found that 168 (25%) of the female respondents and 44 (12%) of the male respondents reported that they were sexually abused before age 17. Priest reported that the rates reflected general findings of

CSA. It is important to note that Priest's use of college subjects could have led to a selection bias. Additionally, Wyatt, Loeb, Solis, Carmona and Romero (1999) reported a 10-year comparison of prevalence rates of CSA in a community sample of African American and European American women and found that 29% of the African American women in the sample reported CSA in the survey compared with 39% of European American females.

Females appear to be at 2.5 to 3 times higher risk than males for sexual abuse, although 22% to 29% of all CSA victims are male (U.S. Department of Health and Human Services, 1998). Males are underrepresented in psychiatric samples, especially older male children who may be reluctant to disclose or who may be shunted into the criminal justice or substance abuse treatment systems (Putnam, 2003). Because males are often underrepresented, it is difficult to obtain more accurate rates of gender differences in sexual abuse rates.

Specific to gender and victimization experience, Levesque (1994) found that females were likely to be subjected to violent threats and physical force compared with male subjects. Fontanella, Harrington and Zuravin (2000) found that boys experienced more fondling and oral intercourse than girls (41% of males versus 9.2% of females). Fontanella et al. also found that in contrast, girls were more likely to experience some form of penetration compared with boys (64% of girls versus 28% of boys). Digital and penile penetration of the vagina was the most prevalent type of penetration for girls, occurring in 24% and 18% of the cases, respectively. The World Health Organization Report (2002) stated that the prevalence of non-contact abuse for females was 6%; contact was 11% and intercourse types of CSA were 4%. In males, it was about 2% for

all categories combined, although data varied considerably among countries. The potential reasons behind the difference in type of sexual abuse as it relates to gender is unknown at this time. It could be hypothesized that girls fall victim of sexual abuse in more serious forms, e.g., penetration, because of perceived social roles and of often being thought of as weaker than males, even among children.

The U.S. Department of Health and Human Services (1998) reported that approximately 10% of sexual abuse victims were between birth and 3 years of age, and children between the ages of 4 and 7 years old are at 28.4%. Children ages 8 to 11 years account for 25.5% of cases, with children 12 years and older accounting for the remaining 35.9% of cases. Some authorities believe that, as a risk factor, age operates differentially for girls and boys, with high risk starting earlier and lasting longer for girls (Putnam, 2003).

Research suggests that children with physical disabilities are at an increased risk for CSA. Physical disabilities, especially those that impair a child's perceived credibility such as blindness, deafness, and mental retardation, are associated with increased risk (Putnam, 2003). Three factors that may particularly contribute to increased vulnerability are dependency, institutional care, and communication difficulties (Putnam, 2003). There appears to be a gender effect because boys are overrepresented among sexually abused children with disabilities compared with their respective proportion of sexually abused children without disabilities (Putnam).

Fortunately, research suggests that child sexual abuse rates are declining. Child sexual abuse appears to have started to decline in the early 1990s after at least 15 years of steady increases. Finkelhor and Jones (2006) indicated that CSA reports were down 49%

from 1990 to 2004, and the number of cases declined 31% in the United States from 1992 to 1998. Some of the statistics showing declines in sexual abuse, however, have provoked skepticism. Because sexual abuse figures are based on reported cases known to and substantiated by state child protection agencies, researchers and policy makers have concluded that the decline might not be an accurate representation and may, in fact, reflect a change in standards of investigation, a decrease in reporting by the agencies, a reduction in funding, or an artifact (R. Johnson, 2008).

There are several factors concerning the reasons why all instances of CSA are not recognized or reported. Sexual abuse is not always reported at the time it occurs, making it difficult to know how many children are being sexually abused each year. CSA also carries a social stigma (Johnson, 2008) and may be held under a veil of secrecy by the family. Both adults and children may be reluctant to report sexual abuse due to the historical norm of keeping such behavior secret because of the sense of shame associated with it. If the abuser is someone close to the victim, such as a caregiver, family friend or relative, the child may be deterred by the likelihood that criminal charges and penalties may be imposed (Johnson).

Victims' young ages and their dependency also tend to be major obstacles to disclosure (Johnson, 2008). Handicapped children might not have adequate communication skills to vocalize their sexual abuse or to provide details. Children might not recognize a sexual action as improper and this lack of recognition is more likely if a female caretaker is the perpetrator. Children and adults may forget or repress unpleasant memories or co-operate with demands for secrecy. Additionally, countries with limited

economic resources may not be able to manage all reports of suspected child sexual abuse or to collect and report data (C.F. Johnson, 2004).

Additional factors affecting the accuracy of CSA incidence data are the lack of consensus about the definition of CSA and the lack of a consistent, state-by-state data collection system. Because of these factors, the data available on incidence should be considered approximations (R. Johnson, 2008). Holmes and Slap (1998) reviewed 166 empirically based studies published between 1985 and 1997 and concluded that 3 of every 4 adolescents (71%) and men (77%), sexually victimized prior to age 12 years, never reported their abuse experience(s) to parents, friends, physicians, or a reporting agencies.

Last, boys who were sexually abused tend to have lower disclosure rates than girls (Levesque, 1994). Levesque hypothesized that boys may be more reluctant to report victimization than girls because of expectations that males should be dominant and self-reliant, should not express helplessness or vulnerability and because of stigma and fears of being perceived as homosexual. Levesque (1994), however, examined disclosure rates of sexual abuse among boys and girls and found that both boys and girls, equally, were likely to disclose their victimization to their mothers and other caretakers, as well as to hospital and school officials.

Victim's Relationship with Offender

Romans, Martin, Anderson, O'Shea and Mullen (1996) examined the characteristics of sexually abusive acts experienced by female children to identify those perpetrators who inflict intrusive and repeated CSA. Findings suggested that the most frequent and invasive CSA comes from someone well-known to the child, particularly a

family member or trusted friend. For example, the study found that 50% of the abusing father figures attempted or completed intercourse; this is in contrast to 17.8% of other relative abusers, 26.7% of acquaintance abusers and 18.4% of strangers. Similarly, the study found a statistically significant relationship between frequency of CSA and the perpetrator. The most frequent CSA (10 or more times) came from 50 % of the father abusers compared with 17.8% of other relatives, 9.6% of acquaintances and 3% of stranger perpetrators. These high frequency rates and invasiveness of the sexual abuse are important because they highlight the “profound betrayal of the child’s trust when an adult caregiver uses his nurturing role for his own sexual gratification and need for dominance” (Romans et al., 1996).

Levesque (1994) explored victims’ relationships with their offenders and found that about one of four male and female subjects reported that the perpetrator was a relative, but not a father figure. In fact, over ninety percent of the subjects were not abused by strangers. This statistics is important in eliminating the popular misconception that sexual abuse perpetrators are most often strangers.

Gender and CSA

Gender differences have long been examined in relation to mental health outcomes. The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association [DSM-IV-TR], 2000), as well as numerous epidemiological studies, illustrate that certain psychological disorders affect males and females at different rates. For example, studies consistently suggested that Posttraumatic Stress Disorder may be more prevalent among females, when compared with males (Tolin & Foa, 2006). Adult females consistently appear to have higher rates of anxiety and

depression, but some studies reported that gender differences do not exist regarding rates of depression in prepubescent children, but by the age of 15, females are shown to be about twice as likely to be depressed as males (Nolen-Hoeksema & Girgus, 1994). Conduct Disorder and Oppositional Defiant Disorder are shown to be less prevalent among females than males (American Psychiatric Association, 1994). There is also a popular belief that males are more likely to exhibit externalizing symptoms, but females are more likely to exhibit internalizing symptoms (Garefski & Diekstra, 1997).

Studies vary widely in their findings regarding gender differences in psychological adjustment following child sexual abuse. Short and long-term studies found mixed results regarding whether or not CSA survivors differ in regard to gender and psychological symptoms (Banyard, Williams & Siegel, 2004; Horowitz, Spatz, Widom, McLaughlin, Raskin, & White, 2001; Young, Harford, Kinder & Savell, 2007). One reason for the debate regarding whether or not gender differences exist in CSA and with the subsequent psychological symptoms has to do with methodology. Methodological flaws can lead to ostensible gender differences when no such differences might be occurring or vice versa. For example, some studies collapsed males and females into study samples, failing to address gender variations specifically (Kendall-Tackett, Williams & Finkelhor, 1993) and other gender studies were not comparable because of overrepresentation of female victims of CSA. Moreover, the few existing studies on gender either have employed adult victims of CSA (e.g., Gold, Elhai, Lucenko, Swingle, & Hughes, 1998; Kendall-Tackett & Simon, 1992) or have combined mixed age groups of children (e.g. Levesque, 1994; Fontanella, Harrington, & Zuravin, 2000).

In spite of methodological flaws, some short and long-term research studies (Levesque, 1994; Tolin & Foa, 2006) report gender differences in psychological symptoms related to CSA. Contrarily, a growing body of literature which includes male CSA survivors provides evidence of gender similarity in outcomes (Banyard, Williams, & Siegel, 2004). For example, research using male-only samples (Miller & Lisak, 1999; Bagley, Wood & Young, 1994) found associations between CSA and a variety of problems similar to those found in studies using female-only subjects. Studies that have conducted gender comparisons also have found more similarities than differences in psychological symptoms of CSA (Young, Harford, Kinder & Savell, 2007; Harrison, Fulkerson, & Beebe, 1997). The following sections will examine research on general psychological symptoms related to CSA in order to elucidate the emotional damage that can occur as a result of CSA; it will also specifically examine both sides of the research on gender differences in psychological symptoms and CSA, examining both long and short-term studies.

Long Term Effects of Sexual Abuse

A considerable number of studies have examined CSA and its long term effects on the psychological well-being of CSA survivors. Much of the information on the psychological sequelae of CSA comes from retrospective research, which often shows that child sexual abuse is linked both with long and short-term consequences for psychological functioning and well-being in both male and female sexual abuse survivors compared with non-victims of CSA. Forty to sixty percent of sexually abused children are estimated to develop significant affective, cognitive and behavioral symptoms following their sexual abuse experience (Kendall-Tackett & Finkelhor, 1993). The

general finding is that almost all psychiatric conditions have increased rates of CSA, including childhood mental disorders, mood disorders, eating disorders, personality disorders, drug and alcohol abuse, dissociative disorders and posttraumatic conditions (Friedman & Tin, 2007). A small number of studies also found an association between CSA and psychotic illnesses, including schizophrenia, but findings are not consistent (Ross, Anderson, & Clark, 1994). In fact, Briere, Woo, Mcrae, Foltz, and Sitzman (1997) found that CSA was the most powerful predictor of later psychiatric symptoms and disorders after controlling for significant demographic variables, such as age, income, race, and marital status.

Numerous studies indicate that the longer and the more serious the abuse, including use of force and paternal incest, the greater the probability that the psychological impact on victims increases (Kendall-Tackett & Finkelhor, 1993; Friedman & Tin, 2007). Essentially, sexual abuse that continues for a longer period of time and involves penetration, as well as intrafamilial abuse, the greater the age gap and aggression, the more likely it is to cause psychopathology and psychiatric illnesses for both males and females.

Briere and Elliot (2003) examined psychological symptoms of self-reported child sexual abuse in a general population sample of 464 adult males and 471 adult females using the Trauma Symptoms Inventory (TSI) as a measure of posttraumatic stress and other psychological symptoms of traumatic events. Results indicated that CSA was associated with elevations on all ten scales of the TSI, including Anxious, Arousal, Depression, Anger-Irritability, Intrusive Experiences, Defense Avoidance, Dissociation, Sexual Concerns, Dysfunctional Sexual Behavior, Impaired Self-Reference and Tension

Reduction Behavior. Another study examined 8580 adults in the United Kingdom and concluded that problems with victimization contribute to vulnerability for psychotic illness (Bebbington et al., 2004)

Molnar, Berkman and Buka (2001) specifically examined suicide rates of adult CSA survivors and found that between 8 to 12% of serious suicide attempts could be attributed to CSA, independent of psychiatric disorders and other adversities. The odds of suicide attempts were 3 to 11 times higher if respondents had experienced child rape or molestation. This high risk of suicide associated with CSA was reduced but did not disappear after psychiatric disorders were included, which is evidence that psychiatric disorders only partially mediate the relationship between CSA and suicidal behavior.

Gender Differences in Long-Term Studies

As stated previously, studies vary in their findings about whether or not gender differences exist between CSA and psychological outcomes. Some studies found that females with CSA histories experience significantly higher rates of mental illness, compared with male CSA survivors. For example, Tolin and Foa (2006) conducted a quantitative review of gender differences in Posttraumatic Stress Disorder (PTSD) from various forms of trauma, including CSA. Their results found that regardless of the type of study, population, type of assessment, or other methodological variables, females had nearly a twofold increase in PTSD frequency when compared with the male participants (PTSD criteria was taken from the DSM-IV-TR diagnosis). Such a finding, according to Tolin and Foa, was consistent with other epidemiological research showing higher prevalence rates of fear- and anxiety-based disorders in general among female respondents. Tolin and Foa (2006) also examined whether or not their finding was

attributable to a higher risk of traumatic experience among female participants, which is a plausible hypothesis. Their results determined that across studies, male rather than female, participants were more likely to report a history of potentially traumatic events. Thus, the higher prevalence of PTSD in female participants could be attributed to their higher risk of experiencing a potentially traumatic event (Tolin & Foa, 2006).

Findings such as Tolin and Foa's, which showed that females appear to have higher PTSD rates when compared with males could be attributed to women's increased vulnerability to sexual abuse. Tolin and Foa (2006) theorized that females, at least those in their study, were more likely than male participants to report experiencing sexual assault and CSA, but male participants were more likely to report accidents, nonsexual assault, or serious illness. This disparity suggests that females might be more vulnerable to CSA than males, as was also shown the previously mentioned prevalence rates. Tolin and Foa also hypothesized that gender differences and PTSD could be attributed to additional factors not captured in most studies. These variables range from external variables such as aspects of the traumatic event, preexisting cognitive and affective reactions to posttraumatic experiences, and a tendency toward different expressions of distress for male versus female participants.

MacMillan et al. (2001) examined 7,016 respondents, 47.6% males and 62.7% females to determine if gender differences exist between psychiatric illness and history of childhood maltreatment, including CSA. The results of their study indicated that a stronger relationship between psychiatric illness and CSA exists for women more so than for men. MacMillan et al. specifically found that female survivors were more likely to report internalizing disorders, such as anxiety and major depressive disorder, compared

with male survivors who were more likely to report externalized disorders such as substance abuse and dependence, and antisocial behaviors.

Banyard, Williams and Siegel (2004) also examined gender differences in mental health outcomes among CSA survivors. Mental health outcomes were assessed using several measures, but the primary outcome measure used was the Trauma Symptom Inventory, which includes 10 subscales: Anxious Arousal, Depression, Anger, Dissociation, Sexual Concerns (dissatisfaction with sexuality, negative thoughts or feelings about sex, shame or problems in sexual relationships), Dysfunctional Sexual Behavior, Intrusions, Defensive Avoidance, Impaired Self-Reference, and Tension-Reduction Behavior. Their study concluded that history of child sexual abuse was associated with higher levels of sexual concerns only among female subjects. Banyard et al. found that exclusive of sexual concerns, males and females did not differ overall in any other mental health outcome. The researchers hypothesized that their results might have been due, in part, to a difference in reporting bias, with women more willing to report a greater degree of symptoms. The study also hypothesized that CSA is an experience that creates powerlessness among its victims and the child survivor has unequal access to resources or control over what happens. This key aspect of abuse experiences of boys and girls may create the conditions for similar patterns of short and long-term mental health consequences among male and female survivors.

Furthermore, Hortwitz et al. (2001) found that childhood abuse and neglect have some impact on mental health over the roughly twenty years that encompass the span of the study. Adult men who were victims of childhood sexual or physical abuse or severe neglect had more symptoms and diagnoses of dysthymia and antisocial personality

disorder than matched controls. Adult women who were abused or neglected as children reported more symptoms of dysthymia and anti-social personality disorder than same-sex controls. Abused and neglected women also reported more lifetime symptoms of alcohol abuse or dependence, although they were not diagnosed with any of the three disorders more than the controls were.

Similar to these cited studies' findings, Rind and Tromovitch's (1997) meta-analysis of psychological correlates and CSA found that CSA experiences for females and males were not equivalent. Rather, about two-thirds of females who were sexually abused reported psychological maladjustment but only a minority of males (about two in five) did so. Afifi et al. (2008) examined CSA, childhood physical abuse and witnessing domestic violence and found that CSA was significantly associated with all groups of psychiatric disorders (anxiety, mood disorders, substance abuse) among women, whereas only childhood physical abuse was significantly associated with all groups of psychiatric disorders among men. In addition, suicidal ideation was attributable to childhood physical abuse and child sexual abuse among women and was attributable, among men, to childhood physical abuse and having witnessed domestic violence. Suicide attempts, however, were attributable, among men, to childhood physical abuse and child sexual abuse.

Conversely, Young, Harford, Kinder and Savell (2007) examined male and female undergraduates with a history of CSA and the results of their study mirrored those of other studies which found that CSA victims reported higher rates of mental health concerns; however, no significant gender differences were found in the specific mental health symptoms reported. The study found that CSA victims reported increased levels

on three scales within the Brief Symptom Inventory: hostility, paranoid ideation, and psychosis, compared with participants without a CSA history. When further exploring these scales, hostility, paranoia and psychosis were not suggestive of severe psychopathology, but rather suggested higher rates of distress, according to Young and colleagues.

Although a profusion of research exists on long-term effects of child sexual abuse on female survivors, few studies have found that male survivors of CSA suffer from higher rates of mental health problems when compared with female survivors. Gold, Lucenko, Elhai, Swingle, and Sellers (1999) directed one such study which found males to have higher rates of depression, phobias, and interpersonal sensitivity compared with females who have been sexually abused in childhood. Dhaliwal, Gauzas, Antonowicz and Ross (1996) reviewed a multitude of studies on male survivors of CSA and reported that males who were sexually abused as children are significantly more depressed and suicidal compared with non-victims of sexual abuse. The study also found that male CSA survivors may suffer from higher rates of rage and low self-esteem, compared with non-victims.

Although retrospective studies give considerable insight into the emotional damage caused by CSA, interpretive limitations exist. Participants' retrospective self-report descriptions of their maltreatment history could have been affected by memory distortions and their symptom endorsements may have been biased by under or over reporting of their actual level of distress (Briere & Elliot, 2003). Participants in retrospective studies also may distort or reconstruct their abusive experiences to make sense of current distress (Spataro, Mullen, Burgess, Wells, & Moss, 2004). Additionally,

some retrospective studies used a cross-sectional design, which precludes definitive causal interpretations regarding the long-term impact of child sexual abuse. The relationship between self-reported childhood maltreatment and adult symptomatology may be due to other intervening variables such as life stressors that might have covaried with child sexual abuse and adult symptom presentation (Briere & Elliot, 2003). Nonetheless, retrospective studies in which adult victims of child sexual abuse suffer from psychological impairment suggest that childhood trauma can potentially be a lifelong battle.

Short Term Studies of CSA

In order to compensate for some of the limitations occurring in retrospective adult CSA survivor studies, such as memory distortions and the inability to correlate sexual abuse with mental health problems, some studies have chosen a short-term approach, using sexually abused children and adolescents in the hope of elucidating a clearer association between child sexual abuse and mental health problems. Unfortunately, similar to many studies that have neglected adequate representation of male and minority subjects, the bulk of the research on short term psychological symptoms related to CSA additionally disregarded prepubescent subjects.

Internalizing Behaviors

A multitude of studies found, that similar to adult CSA survivors suffering from psychological distress related to their earlier abuse, sexually abused boys and girls often suffer from a range of internalizing and externalizing behaviors (Finkelhor, 1990; Tyler, 2002). Internalizing behaviors can be described as fear, social withdrawal, depression, and anxiety, whereas externalized behaviors are defined as acting out aggressively,

impulsivity, substance abuse and limit-testing and antisocial behavior. As with the adult longitudinal research, studies are mixed regarding which internalized and externalized behaviors are experienced by which gender. Furthermore, girls might experience more sexual anxiety, but boys may exhibit higher levels of eroticism after sexual abuse (Feiring, Taska, & Lewis, 1999).

Chandy, Blum and Resnick (1996) examined 370 male and 2681 female adolescents who reported being sexually abused. The study used predominantly Caucasian adolescents whose average age was 15. Similar to many other studies, Chandy et al.'s study was heavily weighted with female participants and excluded a variety of ethnicities. Despite methodological issues, the study's results are important, because they provided further evidence that sexually abused male and female children may respond differently in terms of their psychological experiences. The study by Chandy et al. showed that female adolescents largely engaged in internalizing behavior, but male adolescent subjects engaged in externalizing behavior. Females were at higher risk for suicidal ideation and behavior, as well as for disordered eating. Although females showed more frequent use of alcohol, males reported the greater extreme usage by taking more than five drinks at a time, as well as drinking before school. In addition to alcohol usage, male subjects had more frequent and intense usage of marijuana (substance abuse is examined separately below). Males were also at a higher risk for poor school performance, delinquent activities and sexual risk-taking.

Spataro, Mullen, Burgess, Wells, and Moss (2004) attempted to counter some of the methodological flaws in retrospective studies by examining psychological disturbances in male and female CSA survivors, using a prospective study of 1327

females and 285 males ages 16 and younger. Subjects' sexual abuse was ascertained not only by contemporary accounts but also by medical examination, which in the majority of cases was judged to indicate abuse involving penetration. The study documented the fact that anxiety and acute stress disorders were strongly associated with CSA and among the childhood disorders, conduct disorder was associated with CSA. The rates of schizophrenic disorders, alcohol- and drug-related disorders and other affective and somatoform disorders did not differ significantly from the general population controls. Sexually abused males, compared with male general population controls, had significantly higher rates of anxiety disorders, personality disorders, organic disorders, childhood mental disorders and conduct disorders; sexually abused females were significantly more likely than their population controls to have affective disorders, anxiety, personality disorders, organic disorders, childhood mental disorders and conduct disorders, but this was not the case for other affective and somatoform disorders.

Short term research on gender differences in child sexual abuse and depression produce mixed results. Finkelhor's (1990) review of literature on sexual abuse suggested that there are few differences in responses experienced by sexually abused boys and girls. Specifically, Finkelhor found that girls tended to experience slightly higher rates of internalizing behaviors, such as depression, compared with boys who tend to experience more externalizing behavior, such as aggression. Gover (2004) examined a sample of almost 400 children with sexual abuse history who were institutionalized in a juvenile justice detention center. The population was 65% male and approximately 50% African American. Gover indicated that although sexually abused males and females reported higher rates of depression compared with non-sexually abused males and females, gender

differences were not found. The study's chief limitation was that it did not disentangle the separate relationship between depression and institutionalization, as well as CSA and depression, making the actual context of the depression unclear.

Garnefski and Arends (1998) compared emotional and behavioral problems of 745 sexually abused boys and girls, ages 12–19 years, randomly selected from secondary schools in the Netherlands with a control group of 745 adolescents without a history of sexual abuse, matched for age and sex. Results indicated that sexually abused boys and girls reported significantly more emotional problems including feeling greater loneliness, greater anxiety, greater depression, and the experience of lower self-esteem compared with the control group, but no gender differences were found for emotional problems.

Exclusive of this previously cited study, research specifically examining gender differences in anxiety, not including Posttraumatic Stress Disorder, in sexually abused middle aged children is sparse. Chaffin, Silovsky, and Vaughn (2005) found that among a sample of children who were sexually abused (mean age is 10), sexual abuse was directly linked to the development of childhood anxiety disorders. The researchers determined that outside of the often found link between Posttraumatic Stress Disorder and CSA, separation anxiety and phobias increased four-fold with the onset of CSA. Unfortunately, gender differences were unexamined.

Posttraumatic Stress Disorder. Posttraumatic Stress Disorder (PTSD) is often linked with CSA and other traumatizing events. Prevalence rates of lifetime PTSD have consistently been estimated to be in the range of 10%-12% for women, and 5%-6% for men (Kessler, McGonagle, Zhao, Nelson & Schlerman, 1994). Generally, rates tend to be lower for younger persons, largely reflecting less cumulative risk exposure for traumatic

events. For example, PTSD rates for young persons aged 15 to 24 years from the National Comorbidity Survey were 10.3% for females and 2.8% for males (Kessler, 1994). Using data from a national probability sample, Kilpatrick, et al. (2003) reported rates of 3.7% for boys and 6.3% for girls, aged 12-17 years. In studies that did not draw comparisons between males and females and PTSD, rates of childhood PTSD ranged between 36% and 50% after sexual abuse (Walker, Carey, Mohr, Stein & Seedat, 2004).

Relatively few studies report separate PTSD rates for sexually abused boys and girls. Ackerman, Newton, McPherson, Jones and Dykman (1998) studied the relationship between sexual abuse and posttraumatic stress symptoms in 204 children, ages 7 through 13. Their study found PTSD symptoms in 35% of sexually abused girls compared with 20% of sexually abused boys. Feiring, Taska and Lewis's (1999) research on gender and childhood and adolescent sexual abuse was also consistent with previous research supporting the idea that females report more internalizing and PTSD symptoms than males. Girls showed higher levels of intrusive thoughts and hyperarousal, symptoms associated with vulnerability and thoughts of the world being a dangerous place.

Boney-McCoy and Finkelhor (1995) examined a national sample of 1000 male and 960 female subjects, ages 10 to 16-years-old with a history of prior sexual victimization. Their study found that female gender was a significant, independent predictor of PTSD and accounted for 19% of the variance in PTSD-related symptomatology. Findings suggested that being older than 12, being an African American, female, living in a single parent household, or having a poor relationship with one's parents also contribute to the risk for CSA.

Using a sample of 490 adolescents (164 Caucasian males, 218 Caucasian females; 46 African American males and 62 African American females), Cuffe et al. (1998) examined prevalence rates of PTSD in a community sample of older adolescents. Their study found that Caucasian subjects were most likely to satisfy the re-experiencing and avoidance criteria, and consistent with other findings, the female subjects experienced posttraumatic stress rates of 35% ($n = 25$) in contrast to less than 1% of male subjects. Female subjects reported re-experiencing, avoidance and arousal symptoms and reported a clustering of symptoms. Within racial groups, Caucasian and African American females had higher rates of re-experiencing, avoidance, and arousal symptoms compared with males of their respective race.

Last, in relation to Posttraumatic Stress Disorder, a valuable study by Clear, Vincent and Harris (2006) examined ethnic differences in symptom presentation of sexually abused girls. Unlike many of the studies mentioned throughout this literature review, the researchers investigated the relationship between ethnicity, depression and posttraumatic stress symptoms, such as intrusive and avoidance symptoms. The study by Clear et al. is crucial because cultural factors, as well as gender factors, may influence the way the experience of sexual abuse is processed and the severity and kinds of symptoms that may develop. Clear et al. stated that, for example, a high value is placed on virginity for Hispanic girls, which could have contributed to the higher levels of depression that have been found in some studies. The undersized study by Clear et al. consisted of 19 African American females, with a mean age of 11.4; 19 Hispanic American females with a mean age of 10.6 and 12 Caucasian females, with a mean age of 9.9. Their study found that African American females experienced higher levels of trauma-related avoidance

symptoms than Hispanic girls. The researchers hypothesized that certain factors were involved leading to this disparity, including the fact that African Americans experience negative encounters with social service agencies and other government agencies. Clear et al. stated that recipients of social services frequently reported being treated in a dehumanizing manner by social service worker, which might contribute to distrust towards workers who are associated with the dominant group. Children who are cognizant of this perceived maltreatment may be reluctant to discuss their victimization, preferring to avoid, or not think about it, which could lead to higher levels of avoidant symptomatology (Clear et al., 2006).

Suicide. One particular outcome of CSA that has been examined by various studies is increased suicidality and its relation to gender. Suicide is especially important not only because of its lethality, but also because it is a leading cause of death in young individuals. In 2004, suicide was the third leading cause of death for children ages 10 to 14, adolescents ages 15 to 19 and young adults ages 20 to 24 (National Institute of Mental Health [NIMH], 2008). Martin, Bergen, Richardson, Roeger, and Allison (2004) examined suicidality and gender differences in a community sample of adolescents who were sexually abused, using 1369 boys and 1106 girls with a mean age of 14. Results indicated that the experience of sexual abuse was strongly associated with suicidal ideation and suicidal behavior, comprising situations such as plans, threats, deliberate self-injury and suicidal attempts. Striking gender differences were also found within the study. In girls, although an association between sexual abuse and suicidality was evident initially, hopelessness, depressive symptomatology and family functioning appeared to mediate the relationship. With boys, however, after controlling for hopelessness,

depressive symptomatology and family functioning, boys had a 10-fold increased risk for making suicidal plans and threats and a 15-fold increased risk of attempting suicide when compared with non-sexually abused boys.

Garefski and Diekstra (1997) compared 745 boys and girls who were sexually abused with a comparison group of 745 non-sexually abused children, ages 12 through 19 on mental health problems, including suicide rates. Numbers of male and female subjects were almost equivalent. Two major conclusions can be drawn from their study. First, adolescents with a history of sexual abuse reported significantly more emotional problems, behavioral problems, and suicidality than adolescents without such a history, which is in agreement with a considerable number of studies in the literature (e.g., Kendall-Tackett, Finkelhor & Williams, 1993). Second, although their finding was valid for adolescent boys and girls, it was most conspicuous for boys. Suicidal thoughts and/or behaviors were reported 4.8 times more often by sexually abused girls than by non-abused girls, and 10.8 times more often by sexually abused boys than by their non-abused counterparts.

A sample of 65 sexually abused children (59 females, 7 males) ages 5-17 were examined by Wozencraft, Wagner and Pellegrin (1991). Their results indicated that suicidal ideation was associated with being sexually abused by a family member. As a whole, those children who were sexually abused experienced high levels of depression, whereas 42% of the sample indicated some degree of suicidal ideation. A significant problem with this study, however, was its cross-sectional nature, which makes it unclear about whether or not depression and suicidal ideation are the direct result of being sexually abused.

Luster and Small (1997) also examined suicidality, gender and CSA among adolescents in grades 7 through 12. Their ambitious study examined a population of over 42,000 adolescents, finding that 1% of the population reported being sexually abused at the time of the study. The study was evenly divided by gender and involved predominantly Caucasian youth (95%). The mean age of the sample was 14.9 years and most of the adolescents were living either with biological or with adoptive parents (70%). The results of their study mirrored those of Garefski and Diekstra's (1997), finding a significant interaction between gender and sexual abuse history when suicidal ideation was the dependent variable. Among those who had never been abused, female subjects experienced a higher suicidal ideation score compared with males. Yet among those who reported being sexually abused at the time of the study, as well as those who reported sexual abuse at an earlier time, males had higher suicidal ideation scores than females.

A few studies specifically examined adolescent male subjects with sexual abuse history. Chandy, Blum and Resnick (1997) examined 370 males who reported being sexually abused and compared them with a control group comprising an equal number of male teenagers randomly selected and matched for age and gender, from among those who did not report a history of sexual abuse. The study did not indicate whether or not the control group experienced other types of abuse, such as physical abuse. It is possible that the control group might have consisted of males who were sexually abused, but did not report such abuse. The study examined seventh to twelfth grade males whose mean age was 15.3. The study, as with many other studies, was predominantly Caucasian (over 80%), with African American participants making up only 7% (in the control group only), 2% being Hispanic and the rest of the subjects being Asian or Pacific Islanders.

Chandy et al. found that males, who had been sexually abused, in comparison with the non-sexually abused male control group, had significantly higher involvement in suicidal ideation and behavior than the non-abused control group.

An early study by Harrison, Edwall, Hoffman, & Worthen (1990) focused on males who were receiving treatment for chemical dependency (substance abuse will be further discussed in this dissertation) and who had a history of sexual abuse. Results found that males who were sexually abused were significantly more likely to have suicidal thoughts and to have reported a previous suicide attempt than males who were not sexually abused. The study, however, neglected to indicate whether or not the suicide attempts occurred previous to or following sexual abuse.

Other studies found a link between CSA and suicide attempts, but did not examine gender. These studies are important because they provide further evidence between child sexual abuse and its psychological impact on the victim. One study found child sexual abuse to be a strong predictor of suicide attempts for ninth and eleventh grade populations (Hacker, Suglia, Fried, Rappaport & Cabral, 2006). Hacker et al. hypothesized that the difference for ninth and eleventh graders were consistent with the developmental changes of adolescence.

As indicated in the previous discussion, suicide is a potential psychological outcome following child sexual abuse. It is important to note that many of the studies examined adolescent subjects, but children of younger ages continually have been shown to have attempted suicide. It is important to gather more information about prepubescent children who might be experiencing suicidal ideation and attempts at suicide in order to implement prevention and intervention strategies. Based on the number of adolescents

who have experienced suicidal ideation and who have attempted suicide, it would not be erroneous to consider the possibility that they may have been experiencing such thoughts for a few years.

Externalizing Symptoms

Children with a history of sexual abuse are at risk for increased externalizing behavior (Martin, et al., 2004; Chandy, Blum & Resnick, 1996). Externalizing behavior encompasses conduct problems, aggression and substance abuse. Martin et al. indicated that although many risk factors exist for antisocial behavior, child sexual abuse is a major contributing factor even after controlling for significant parental, family and demographic factors. Further, ages 11 through 14 were identified as turning points at which delinquent attitudes and behavior escalate (Zhang, Loeber, & Stouthamer-Loeber, 1997).

Garnefski and Arends (1998) found that sexually abused adolescents reported significantly more behavioral problems compared with their non-abused counterparts, including aggression. Gender interactions revealed that sexually abused boys had significantly more behavioral problems compared with sexually abused girls. Martin et al.'s (2004) prospective study examined participants yearly, on three occasions. Participants were first examined at age 13, then 14 and finally at the age of 15. The study aimed to examine gender differences in CSA, antisocial behaviors and substance abuse. Their results showed that CSA was significantly and independently associated with substance abuse and antisocial behavior. Martin et al. defined "serious" antisocial activity as self-reports of at least seven antisocial behaviors and "extreme" antisocial activity comprising ten or more antisocial behaviors, which were endorsed in a self-report form. Thirteen-year-old subjects were found to be at greater risk of serious and extreme

antisocial behavior compared with their non-abused counterparts. For older males, the relationship between CSA and delinquent behavior remained strong, with increasing risk as the child aged. The study, however, found that for female subjects, CSA and delinquent behavior supported previous research, which states that females experience more internalizing behaviors, compared with externalizing behavior. Their study reflected Neumark-Sztainer, French, Resnick & Story's research (1997), in which delinquency was found to increase with age for male adolescents, but delinquency decreased for females as they aged.

Substance abuse. Increased rates of substance abuse are another undesirable effect of CSA. Early onset substance abuse before the age of 14 has been associated with continued impairment in behavioral and emotional functioning in later adolescence (Giaconia, Reinherz, Silverman & Pazik, 1994). The implication for early age of usage and later psychological problems are important because of the need for early psychoeducation interventions in young children. Also, because substance abuse may be related to CSA, and because so many children are sexually abused before the age of 14, understanding the potential for continued impairment is especially important for early treatment interventions of prepubescent children who have been sexually abused. Neumark-Sztainer, French, Resnick & Story (1997) found CSA to be strongly related to substance abuse only for sixth graders compared with children in grades nine through twelve. Such a finding is of particular importance because age and gender appear to be important factors that should be examined when exploring substance abuse and its relation to sexual abuse in children.

As has been briefly stated earlier, gender differences in substance abuse were noted in studies by Chandy, Blum and Renick (1996); the studies found that male children experienced increased rates of frequency and duration of alcohol consumption and marijuana usage, compared with similarly aged females. Kilpatrick et al. (2000) also found that young people who reported sexual abuse in the year prior to the study were 2.4 times more likely to report alcohol abuse, 1.6 times more likely to report marijuana use and 2.6 times more likely to report use of hard drugs than other youth, after controlling for age, sex, ethnicity, physical assault and family use of drugs and alcohol.

In addition to gender, CSA and delinquent behavior, Martin et al., (2004) looked at the interplay between these and substance abuse. In contrast to antisocial behavior, the pattern of substance abuse was similar for male and female subjects, usage increased as age increased. Serious substance use was operationally defined as frequent use of two or more drugs or greater variety of illegal drugs. In boys, higher rates of serious drug usage were found in the 14 and 15-year-old population, but not in 13-year-old males. Conversely, 13-year-old sexually abused females were at a significant, increased risk for serious substance abuse, but not among the 14 and 15-year-old females.

Other researchers also found similar associations between sexual abuse and substance use. Luster and Small examined a predominantly Caucasian adolescent population of seventh through twelfth graders in the Midwest and found that sexual abuse was related to alcohol abuse. Males were more likely to engage in binge drinking when compared with females. Garnefski and Arends (1998) found that sexually abused adolescents reported more alcohol usage, compared with non-sexually abused

counterparts. Their study indicated that sexual abuse played a unique role in increasing risk for antisocial behavior and substance abuse.

Sexually Reactive Behavior. As discussed in the beginning of Chapter Two, children often exhibit sexualized behaviors as a normal facet of healthy sexual development. As the full spectrum of sexual abuse sequelae is becoming known, a subset of child sexual abuse victims have been noted to exhibit sexually aggressive behavior. Their sexual behavior far exceeds the mutual exploratory behavior normally seen in young children and more closely resembles the behavior of older sex offenders (Friedrich & Luecke, 1988).

Friedrich and Luecke's seminal study examined school-aged, sexually aggressive children. Their study included sexually abused children, non-sexually abused children and those who were experiencing behavioral problems. Their study determined that the average age of first perpetration for boys was 8.7 (age range of 4 to 12) and 6.7 for girls (age range 4 to 9). T.C. Johnson's (1988, 1989) research indicated that girls began display of sexually aggressive behavior earlier than boys, with an age of 6.7 compared with 8.7 for males. Interestingly, Johnson's and Friedrich and Luecke's research found that children in the sexually abused group appeared to be more psychologically impaired than children in the other two groups, especially in the areas of aggressiveness and conduct or oppositional disorders.

T.C. Johnson (1988, 1989) is yet another researcher whose studies on sexualized behavior are prolific and often cited. Johnson found that boys' sexually aggressive behaviors included vaginal penetration with penis (8%) or finger (3%), anal penetration with penis (12%), oral copulation (10%), fondling (37%), genital contact without

penetration (20%), exposure of genitals (2%) and simulated sexual intercourse (3%). The sexually aggressive behavior of girls were vaginal penetration with finger (6%) or object (6%), anal penetration with finger (8%), oral copulation (12%), fondling (13%), genital contact without penetration (13%), simulated intercourse (11%), intercourse (1%) and French kissing (1%). Forty-nine percent of the male subjects were sexually abused and 100% of the female subjects were sexually abused. Unfortunately, these studies, similar to other studies, studied predominantly Caucasian subjects, making generalizability to other ethnicities difficult. The lack of research on various ethnicities makes it resoundingly clear that more research centered on underrepresented ethnicities is needed. The current study hopes to shed more insight on sexualized behavior and African American children.

Understanding Gender Differences

Theories and empirical studies relevant to understanding gender and CSA illustrate varying reasons for differences and similarities between female and male survivors of CSA. These perspectives often draw from empirical literature of gender differences in characteristics of abuse, theories about gender socialization and issues related to gender and self-disclosure (Banyard, Williams & Siegel, 2004). Banyard et al. indicated that a possible source of gender differences in psychological presentation of abuse is based on gender differences between the characteristics of the abuse itself. For example, females are more often sexually abused by family members but males are most often abused by perpetrators outside the family (e.g., Gold, Elhai, Lucenko, Swingle & Hughes, 1998). Closeness of a victim's relationship to the perpetrator is also associated with more negative consequences as is the experience of multiple types of abuse

(Romans, Martin, Anderson, O'Shea & Mullen, 1996). Therefore, one can hypothesize that female survivors of sexual abuse are generally closer to their perpetrators due to a family link; this could contribute to increased psychological symptoms in females, compared with male CSA victims.

Issues related to the gender of the perpetrator could also potentially contribute to gender differences in psychological symptoms. Research indicates that males are perpetrators significantly more often than females, making boys most likely to have been sexually abused by a member of their own sex. This implies that over and above the feelings of shame, guilt, abomination, and anger that male survivors share with female victims, males may experience confusion about their sexual identity and fears about homosexuality (Browne & Finkelhor, 1986; Beitchman et al., 1992).

Banyard et al. (2004) theorized that male sexual abuse could lead to a more empathic understanding of women's traditional lack of power or that males try to deny serious consequences to conform to societal expectations. Also, it is well established that sexual abuse among boys is underestimated because of the reluctance of male victims to report their experiences (Romano & DeLuca, 2001) It is also possible that the stigma of male-on-male sexual abuse could be associated with males not disclosing their sexual abuse.

Prescribed gender roles and socialization may also play a role in differences in coping with stress that, in turn, affects rates of psychological symptoms from CSA. Research indicates that gender affects those coping strategies that are used most often. According to Byrne (2000), boys and girls from year 7 to 12 begin to employ gender differences in coping strategies, particularly by year twelve. One theory postulates such

differentiation arises because girls learn coping skills more frequently from a mother figure and boys learn these more frequently from father figures. Bird and Harris (1990) found males to be more aggressive and to ventilate feelings of frustration by swearing, complaining or taking their anger out on others. According to Stein and Nyamathi (1999), males tend to use maladaptive coping strategies, such as drugs or alcohol more often than females. The greater tendency for girls to experience internalizing symptoms could be related to their general coping styles. Girls may be more likely to employ a ruminative response style, a pattern of behavior in which individuals focus on their emotional state, inhibiting actions that might distract them from their negative moods. The ruminative response style theory posits the theory that focusing on one's negative mood and the causes and consequences of such moods is the critical mechanism for the development and maintenance of internalizing problems such as depression (Feiring, Taska, & Lewis, 1999).

Feiring et al. (1999) found that sexually abused boys reported a combination of sexual and physical abuse significantly more often than females. Such a finding could not explain more than a very small part of the differences between male and female sexually abused adolescents. After controlling for the effect of concurrent physical abuse, the significant main effect for gender remained.

Finkelhor and Browne's early study (1985) has also made suppositions regarding the relationship between gender and psychological symptoms of CSA. Their often-cited traumagenic dynamics theory, unlike the various hypotheses stated previously that try to explain the gender differences, attempts to conceptualize the reasons why sexual abuse leads to psychological symptoms. Finkelhor and Browne stated that the experience of

sexual abuse can be analyzed in four trauma-causing factors: traumatic sexualization, betrayal, powerlessness, and stigmatization. Traumatic sexualization refers to a process by which a child's sexuality is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse. Betrayal refers to the dynamic by which children discover that someone on whom they were vitally dependent has caused them harm. Powerlessness is a state in which the child's will and sense of efficacy are contravened due to sexual abuse. Last, stigmatization refers to the negative connotations (e.g., shame, guilt) communicated to the child around the experiences and become incorporated into the child's self-image. These dynamics are hypothesized to be the core of the psychological injury inflicted by abuse. Banyard, Williams and Siegel (2004) stated that Finkelhor and Brown's model applied equally well to males and to females, making gender similarities more apparent, rather than more different. In other words, sexual abuse and the four dynamics of powerlessness, stigmatization, traumatic sexualization, and betrayal can be psychologically damaging, in equal degrees, for anyone, lessening potential gender differences. Although these factors are likely contributors to psychological symptoms resultant from CSA, other factors such as intensity, relationship to offender and societal expectations might be greater influence on the psychological experience of the victim. It might not be only the betrayal of being sexually victimized by a trusted family member or friend, but rather the entire experience of the abuse, including breakdown of the relationship, generalizing the betrayal to others, the severity of the abuse and societal expectation that leads to psychological symptoms and gender differences.

When examining psychological functioning of children following sexual abuse, it is important to mention the fact that although gender may play a significant role in symptom presentation, it may not be the primary characteristic behind psychological functioning following sexual abuse. Developmental levels could be playing a role either in place of or in addition to gender. Black, Dubowitz and Harrington (1994) stated that despite the frequency of problems reported by parents of sexually abused children, researchers found no difference between sexually abused and non-sexually abused children specific to psychological functioning. Black et al. hypothesized that younger children may be less traumatized at the time of their abuse than older children who may be aware of social taboos and have clearer boundaries concerning appropriate behavior. It does not appear as though Black et al. examined the possible early sexualization of children that can follow sexual abuse. Although one particular group of researchers found children who were abused during preadolescence and adolescence exhibited more behavior problems than children abused at younger ages (Gomes-Schwartz, Horowitz, & Carderelli, 1990), another group of researchers found that children abused at younger ages were more likely to have disturbances of cognition and self-image (Zivney, Nash & Hulsey, 1998).

Therefore, child sexual abuse has consistently been associated with a number of psychological problems that can continue into adulthood and become lifelong struggles. Although research appears consistent that child sexual abuse survivors are at an increased risk for psychological distress, there is disagreement regarding whether or not gender differences play a role in psychological distress experienced by being sexually victimized. The purpose of the current study is to expand the understanding of the

psychological impact of sexual abuse on children ages 8 through 12. Specifically, the study investigated whether or not gender differences exist in internalized symptoms, such as depression and anxiety, compared with externalizing symptoms, such as aggression, with the theory that females will experience higher rates of internalized symptoms than males and that males will experience higher rates of externalized symptoms compared with female subjects. This study also investigated gender differences in sexualized behavior; it also explored whether or not sexually reactive behavior is correlated to types of symptomatology. Because so much research neglects using the experiences of minorities, who can be at risk for various social and psychological problems, this study chose to include only African American children.

CHAPTER THREE: HYPOTHESES

Over the years, research on child sexual abuse has steadily accumulated evidence showing that child sexual abuse can contribute to both long and short-term psychological symptoms, including externalized and internalized symptoms such as substance abuse, depression, anxiety, and posttraumatic stress for male and female sexual abuse survivors (Garefski & Diekstra, 1997; Friedman & Tin, 2007). Because of the propensity for CSA survivors to develop psychological symptoms resultant from their sexual abuse, CSA has important public and mental health implications. Unfortunately, due in part to secrecy, shame, embarrassment, and social stigma attached to disclosing sexual abuse, sexual abuse victims do not always report their abuse, leading to discrepancies in various realms of CSA research, including exact frequency and prevalence rates. Other significant discrepancies exist as well. As examined in the preceding chapter, research examining gender differences in psychological adjustment following CSA have shown mixed results and have methodological flaws, contributing to the variability. Specifically, short and long-term studies have found mixed results regarding whether or not CSA survivors differ in regard to gender and psychological symptoms (Banyard, Williams & Siegel, 2004; Horowitz, et al., 2001; Young, Harford, Kinder & Savell, 2007).

A significant reason for the debate regarding whether or not gender differences exist in CSA and in psychological symptoms has to do, in part, with methodological flaws. For example, some studies collapse males and females into study samples, failing to address gender variations specifically (Kendall-Tackett et al., 1993) and other studies on gender are often not comparable due to overrepresentation of female victims of CSA. Moreover, the few existing studies on gender have employed either adult victims of CSA

(e.g., Gold, Elhai, Lucenko, Swingle & Hughes, 1998; Kendall-Tackett & Simon, 1992), which could lead to biases in retrospective memory, or have utilized studies which combine mixed age groups of children (e.g., Levesque, 1994; Fontanella, Harrington, & Zuravin, 2000). Furthermore, much of the research on CSA focuses predominantly on Caucasian subjects, making it difficult to understand ethnic and cultural influences related to CSA and gender. The dearth of research specifically examining the African American population and other minority populations is quite startling and does a great disservice to these populations, who are also mental health consumers.

Given the dearth of studies specific to African American prepubescent children, the purpose of this investigation is to expand the knowledge about gender differences in the psychological outcomes of sexually abused African American children, ages 8 through 12. Specifically, this study hypothesizes that male and female subjects will differ in their psychological responses to sexual abuse, with female subjects exhibiting more internalized symptoms and male subjects exhibiting more externalized symptoms.

This study further hypothesizes that gender differences will exist in sexually reactive behaviors displayed by CSA victims. Based on this hypothesis that males will display more externalized symptoms related to their sexual abuse when compared with females, males are hypothesized to display sexually reactive behaviors more frequently when compared to females.

Last, numerous studies have found that the longer and more serious the abuse, including use of force and paternal incest, the greater the increase of psychological impact on victims (Kendall-Tackett et al., 1993; Friedman & Tin, 2007). Essentially, sexual abuse that continues for a longer period of time and involves penetration, as well

as intrafamilial abuse, the greater age gap and aggression is more likely to cause psychopathology and psychiatric illnesses for both males and females. Therefore, it will be important for this study to examine these variables in depth to determine whether or not they play a significant role in symptom presentation. It is hypothesized that intense and frequent sexual abuse will lead to a clinically significant finding on symptomatology as measured by endorsements on the Child Behavior Checklist.

CHAPTER FOUR: METHODS

Subjects

The sample was drawn from a Northeastern urban outpatient center providing specialized psychosexual evaluations and mental health treatment in the area of sexual abuse, sexually inappropriate/reactive behavior, as well as sexual offenses. The center, located in Philadelphia, Pennsylvania, provides services for children and adolescents ranging from ages 3 to 18. The center's referrals come from varying sources, including child welfare agencies (i.e. the Department of Human Services), probation, community institutions (e.g., mental health agencies, residential treatment facilities, family court), as well as referrals from caregivers and other family members.

Subjects were included in this study if they were African-American male and female children who were sexually abused, ages 8 through 12. Their sexual abuse was documented and validated through various types of documentation including child welfare investigation materials, psychological interviews with the child and family and/or legal documentation. The inherent complexity in fully substantiating sexual abuse should be noted and recognized as being difficult. Children were included in this study if they were allegedly sexually abused on one or more occasions. Children were excluded from the study only if they identified as being another race/ethnicity besides African-American, if they were outside the denoted age range and if they were not sexually abused. The children's socioeconomic status could not be determined; however, a significant number of the children who were provided with service at the agency were covered by Community Behavior Health (CBH) insurance, which is available to underinsured and Medicaid-eligible residents.

It was determined that 123 of the center's charts were within this study's age range of 8 to 12. Of those charts, 99 completed Child Behavior Checklist inventories and 62 charts had completed Child Sexual Behavior Inventories (CSBI). The 24 charts missing the CBCL were also reviewed to gather additional data on a mixture of variables in order to garner additional important information about the population pool. Information such as mental health history of parents, incarceration of parents and witnessing domestic violence were reviewed. All of the subjects used in this study were African American male and female children who were sexually abused, ages 8 through 12. The children's average age was 9.7 for males and 9.9 for females. Regarding the CBCL, the study had 47 males and 52 females. Specific to the CSBI, there were 27 males and 35 females. Two tables follow, representing the significant characteristics of the children and their families treated at the center; this should elucidate the variety of the current subject pool.

Table 1

Characteristics of Child and Family: Female Subjects

Variable	Missing	Yes	No
History of physical abuse	0	24	44
Family history of incarceration	1	31	36
Family history of mental illness	2	50	16
Family history of substance abuse	1	47	20
Family history of domestic violence	1	23	44

Table 2

Characteristics of Child and Family: Male Subjects

Variable	Missing	Yes	No
History of physical abuse	0	18	37
Family history of incarceration	3	36	16
Family history of mental illness	5	35	15
Family history of substance abuse	3	38	14
Family history of domestic violence	0	15	40

Sexual abuse was validated through documentation including child welfare investigation, medical reports, psychological interview with the child and family and/or legal documentation. The inherent complexity in fully substantiating sexual abuse should be noted and recognized as being difficult. Children were included in this study if they were allegedly sexually abused on one or more occasions.

Sexual abuse was defined as the central characteristic being the dominant position of an adult that allows him or her to force or coerce a child into sexual activity, but children can also be sexually abused by peers. Child sexual abuse may include fondling a child's genitals, masturbation, oral-genital contact, digital penetration, and vaginal and anal intercourse.

Measures

Inventories

The Child Behavior Checklist (CBCL; Achenbach, 2001) is a 113-item parent-report multi-domain measure designed to assess a child's current overall behavior

problems, internalizing (e.g., depression, anxiety, withdrawal) and externalizing behaviors (e.g., aggression, delinquency, hyperactivity) over a six-month period. Parents and/or caregivers rate each item on the CBCL on a 3-point scale from 0 to 2, 0 being “Not True,” 1 being “Somewhat True” and 2 being “Very True or Often True.” The CBCL has three main scales: Total Behavior Problems, Externalizing and Internalizing, and eight additional DSM-Oriented subscales.

The Child Sexual Behavior Inventory (CSBI) is a 38-item parental report measure designed to assess various domains of sexual behavior in children 2 to 12 years old. The CSBI asks for the frequency of behaviors during the previous 6 months and is scored as 0, 1, 2, or 3 to reflect levels of frequency, i.e., 0 = never; 1 = less than once/month; 2 = 1 to 3/month; and 3 = at least 1/week. Three clinical scales can be derived from the 38 items. The Developmentally Related Sexual Behavior scale reflects the child’s level of age- and gender-appropriate behavior. The Sexual Abuse Specific Items scale contains items that are empirically related to sexual abuse history; these items differ for boys and for girls. The CSBI Total Score assesses all nine domains of sexual behavior, including boundary problems, exhibitionism, gender-role behavior (i.e., interest in acting like or being a member of the opposite sex), self-stimulation, sexual anxiety, sexual interest, sexual intrusiveness, sexual knowledge and voyeuristic behavior (Friedrich, 1997).

Procedure

Subjects attended a psychosexual evaluation appointment with a member of the evaluation department who is either a master or doctoral clinician. During the evaluation, subjects’ caregivers were instructed to complete the Child Behavior Checklist and

Children's Sexual Behavior Inventory. Data for this study were collected via retrospective chart review of intake materials without any identifying information. An Excel sheet was created to include all necessary variables and the data were abstracted from the charts without identifying information. Data were collected in accordance with the guidelines of the Institutional Review Board to protect the confidentiality of all child subjects and their families.

A priori power was assessed for the proposed multiple regression analysis (MRA). Power was evaluated using the GPower 3.0 program, which is a general statistical power analysis program. Following the recommendation of Green (1991), the *a priori* analysis evaluates both: (a) the overall significance of the MRA model and (b) the unique contribution of individual predictors. The significance level for both analyses was set to $p = .05$, as per standard scientific conventions. Medium effect sizes were postulated in keeping with Cohen's (1988) recommendations for MRA (i.e., both f^2 values = .15). In addition, power was set to .80, meaning there would be an 80% probability of reaching statistical significance if the predictors had an effect in the population. Results from the power analysis showed 92 cases would be necessary to evaluate the overall model and 55 cases would be necessary to evaluate individual predictors. The largest N was chosen so that the MRA would be sensitive to the least powerful comparison (i.e., 92 participants).

CHAPTER FIVE: RESULTS

The purpose of the study was to determine whether or not gender differences existed among internalizing and externalizing symptoms on the Children's Behavior Checklist (CBCL), as well as whether or not gender differences were found in sexualized behavior, as seen on the Children's Sexual Behavior Inventory (CSBI). In order to determine if female and male subjects differed in these dependent variables, independent t tests were conducted on both the CBCL and CSBI scores. Regarding the hypothesis that male and female subjects differed in their psychological responses to sexual abuse, female subjects were hypothesized to exhibit more internalized symptoms, compared with male subjects. Male subjects were hypothesized to exhibit higher rates of externalized symptoms, compared with female subjects. Based on the findings from the independent t-tests, no significant differences were found regarding gender differences on the externalizing and internalizing problems scales on the CBCL. Despite clinically insignificant findings, certain trends were found. Compared with males, female subjects had higher rates on the Internalizing Problems scale, and compared with females, males had higher rates on the Externalizing Problems scale. Males had higher rates on the subscales of Aggressive Problems, Attention Problems, Rule-Breaking, and on the Anxious/Depressed and Withdrawn/Depressed subscales, compared with females. Female subjects had higher rates on the Somatic Problems scale, Social Problems, and Thought Problems scales. Table 3 lists the mean and standard deviation scores for all the CBCL scales.

Table 3

Independent T test for the Child Behavior Checklist

Variable	Gender	N	M	SD	Std. Error Mean
Total behavior problems	Boy	47	62.62	13.149	1.918
	Girl	52	60.79	13.171	1.826
Externalizing problems	Boy	47	63.66	12.419	1.811
	Girl	52	61.33	13.018	1.805
Internalizing problems	Boy	47	56.79	12.635	1.843
	Girl	52	57.02	13.836	1.919
Anxious/Depressed	Boy	47	58.04	9.769	1.425
	Girl	52	57.75	9.583	1.329
Withdrawn/Depressed	Boy	47	62.32	11.431	1.667
	Girl	52	60.17	10.571	1.466
Somatic complaints	Boy	47	56.26	8.370	1.221
	Girl	52	59.87	9.474	1.314
Social problems	Boy	47	61.55	9.086	1.325
	Girl	52	62.06	9.809	1.360
Thought problems	Boy	47	62.83	10.897	1.590
	Girl	52	60.13	9.624	1.335
Attention problems	Boy	47	65.30	11.292	1.647
	Girl	52	64.56	13.526	1.876
Rule breaking behavior	Boy	47	65.55	10.257	1.496
	Girl	52	64.37	8.916	1.236

Aggressive behavior	Boy	47	64.09	12.350	1.801
	Girl	52	62.00	11.262	1.577

For the hypothesis that males would display more sexualized behavior compared with female subjects, based on the CSBI Total Score and Sexual Abuse Specific Items scales, an independent t-test was used; the results can be seen in Table 4. No clinically significant findings were determined on any of the scales; therefore, the null hypothesis was accepted. Despite a lack of clinically significant findings, certain trends can be found, based on the results of the CSBI, similar those found on the CBCL. Compared with female subjects, males trended higher on the CSBI Total Score and on the Sexual Abuse Specific Items scales.

Table 4

Independent T test for the Child Sexual Behavior Inventory

Variable	Gender	N	M	SD	Std. Error Mean
Total Score	Boy	27	61.62	21.678	7.665
	Girl	35	53.43	16.491	6.233
Developmentally Related	Boy	27	46.75	11.474	4.057
	Girl	35	50.86	15.700	5.934
Sexual Abuse Specific Items	Boy	27	69.75	22.544	7.970
	Girl	35	58.86	22.901	8.656

Last, a multiple regression analysis was used to investigate the contribution of different sexual abuse variables, such as level of intrusiveness, perpetrator relationship,

duration of abuse and number of perpetrators (independent variables), and the three CBCL scales of internalizing, externalizing and total behavior problems (dependent variables). No clinical significant findings were found for level of intrusiveness ($p = .70$, $p < .05$), perpetrator relationship ($p = .37$, $p < .05$) and duration of abuse ($p = .42$, $p < .05$) on any of the three major CBCL scales. When specifically examining the number of perpetrators and CBCL scores, after controlling for gender a slightly significant finding was found ($p = .014$, $p < .05$) on the externalizing and total behavior problems scale. No clinically significant finding was found on the internalizing scale ($p = .12$, $p < .05$).

When the number of perpetrators was added to the model after a difference in sex was accounted for, the coefficient of determination (R^2) significantly changed. Regarding externalizing problems and number of perpetrator, the R^2 changed from 0.11 to 0.80. In the total behavior problems CBCL scale and number of perpetrators, when controlling for gender, the R^2 went from .017 to .087.

CHAPTER SIX: DISCUSSION

The intent of this study was to expound on possible gender differences in symptom presentation following sexual abuse within a specialized population of African American preadolescent children. This population has often been minimally examined in previous research and deserves close examination. The following discussion highlights the implications of the current study's findings.

First, it was hypothesized that males and females who were sexually abused would present with different symptom presentation. Males were hypothesized to have higher rates of externalizing symptoms (such as aggression) on the Child Behavior Checklist (CBCL) and females would have higher rates of internalizing symptoms (anxiety and depression). Though the history of CSA has been found to be associated with higher levels of mental health symptomatology, this study, using the CBCL, failed to find that gender moderated the effects of CSA on preadolescent sexual abuse. Despite the lack of clinically significance support for gender and symptomatology, the CBCL results showed some promise in identifying symptomatology trends in regards to gender.

Compared with male subjects, females had higher rates on the Internalizing Problems scale, and males had higher rates on the Externalizing Problems scale. Males also had higher rates on the subscales of Aggressive Problems, Attention Problems and Rule-Breaking, compared with females. These results mirror other studies that found that girls exhibit more internalizing behavior and boys exhibit more externalizing behavior (e.g., Feiring, et al., 1999; Friedrich et al., 1986). Furthermore, the American Psychiatric Association (DSM-IV-TR, 2000) also cites the fact that males have higher rates of Attention-Deficit/Hyperactivity Disorder and Conduct Disorder, compared with females.

On the CBCL, females had higher rates on the Somatic Problems scale and Social Problems scales. Interestingly, on the current CBCL results, males also had slightly higher rates on the subscales of Thought Problems, Anxious/Depressed and Withdrawn/Depressed subscales, compared with females, which is somewhat contradictory from other findings that often cite that females are more often diagnosed with anxiety and depression disorders according (DSM-IV-TR, 1994; Kistner, David-Ferdon, Lopez & Dunkel, 2007). Similar to many other areas of research, however, studies focusing on childhood and adolescent depression predominately utilize Caucasian or European-American subjects. Studies examining minorities and depression show a much different picture of depression, compared with studies using Caucasian subjects. Numerous studies have documented higher rates of internalizing disorders among Native American, Latino American, Asian American, and African American adolescents compared with Caucasian subjects (Kennard, Mahtani, Hughes, Patel, & Emslie, 2006). African American boys in grades three through five reported more depressive symptoms on the Children's Depression Inventory (CDI) compared with European American boys, controlling for socioeconomic status (Kistner, David & White, 2003). No differences emerged between African American and European American girls. In a longitudinal follow-up, African American boys reported more depressive symptoms on all five CDI subscales compared with African American girls, and also compared with European American girls and boys (Kistner, et al., 2007). Kistner and colleagues (2007) found that academic and social competence were contributing factors to African American depression rates. Kistner et al. hypothesized that because most teachers and counselors in elementary schools are female or European American, role models of similar

backgrounds may be less available to African American boys relative to other children. Although the current study did not examine academic competence, the children in this study could have been experiencing social difficulties which contributed to depressive/anxious symptomatology, but more information is needed to make such a determination.

The overall lack of significance regarding gender and symptomatology in this study was contrary to other studies (Fontanella, Harrington, & Zuravin, 2000; Feiring, Taska, & Lewis, 1999) that supported the findings that girls exhibit more internalizing behavior and boys exhibit more externalizing behavior. Potentially, the reason why gender differences in symptomatology were not found could be due to caregiver reporting flaws and not using inventories that specifically measure the child's perspective of his or her sexual abuse. Feiring, Taska and Lewis (1999) measured gender's role in psychological distress and their results indicated support for the idea that girls reported more internalizing and posttraumatic stress symptoms than boys. Their study, however, not only obtained information from the child's caregiver, but also self-reports from the child. Research shows that parents and caregivers' judgments about their children's behavior may be moderated by their own personality factors. Everson, Hunter, Runyon, Edelsohn & Coulter (1989) found that the relationship between reports of behavior problems from parents and children were partially determined by the level of parental support. Among supportive parents of sexually abused children, there was a strong relationship between behavioral reports from parents and children; however, when support was low, the association between reports was low (Black, Dubowitz & Harrington, 1994).

The inconsistencies between this study's results and the results of other studies that found gender differences could also be explained by different samples. For example, Feiring et al (1999) used a sample of children who were assessed within eight weeks of the discovery of their abuse and before they received any treatment. The children in this study may have received previous treatment either for sexual abuse or for psychological problems. Therefore it could be hypothesized that if a child received some type of previous mental health intervention, some of their symptomatology might have either decreased or at least it appears that way to their caregiver who filled out the CBCL.

Another possible explanation for a lack of findings in the current study could be due to how the children in this population coped with their sexual abuse. Some individuals may have severe disturbances yet others do not. Clinicians and researchers believe differences in response to abuse could be due to protective factors found in the child, which is often conceptualized as resilience or hardiness. It is possible that some children who have been sexually abused do not believe they are at fault but others do. They believe the blame and shame exist outside of themselves. Further, they adapt to the trauma with less damage to their personalities, resulting in fewer symptoms. These individuals are referred to in various ways such as hardy, resilient, or invulnerable (Feinauer, Hilton, & Callahan, 2003).

It has been suggested that particular coping styles contribute to how susceptible individuals are to externalizing or internalizing problems. Girls may be more likely to employ a ruminative response style, a pattern of behavior in which individuals focus on their emotional states, inhibiting actions that might distract them from their negative mood. It is the focus on negative mood and symptoms, and the inhibition of problem-

focused coping styles that are the defining features of rumination. The ruminative response style theory posits that focusing on one's negative mood and the causes and consequences of such moods is the critical mechanism for the development and maintenance of internalizing problems such as depression (Feiring, et al., 1999).

Regarding the second hypothesis that males would have higher rates of sexually reactive behavior than females, which could be seen as an extension of externalized behavior problems, was not found to be currently clinically significant. It could be that similar to the findings related to the CBCL and psychological symptoms, parent/caregiver report might not have been reliable. It is also quite plausible that with an increased sample size, it might be possible that the above hypotheses would be clinically significant. The power analysis revealed that 92 cases were needed to evaluate the model effectively, but only 62 CSBI were available for review in the current study.

Despite the lack of clinical significance, boys had higher rates of sexual abuse-related behavior than girls, which is a likely indication that gender may play a role in the nature of sexual behavior problems. This trend is consistent with other studies in which sexually abused boys were found to be more sexualized, when compared with girls (Watkins & Bentovim, 1992; Feiring, et al., 1999). Feiring, Taska and Lewis (1999) found that males reported higher levels of eroticism, whereas females experienced more sexual anxiety, indicating less inhibited sexual behavior in males. Also, socialization practices make more negative judgments on girls who engage in sexual behavior.

Last, the current study hypothesized the theory that particular variables would impact symptomatology. Previous studies indicated that the longer and more serious the abuse, including use of force and paternal incest, the greater would be the psychological

impact on victims (Kendall-Tackett et al., 1993; Friedman & Tin, 2007). The current study examined variables such as level of intrusiveness, perpetrator relationship, duration of abuse and number of perpetrators and endorsements on the CBCL internalizing, externalizing and total behavior problems scales. Results were not clinically significant for duration, level of intrusiveness, and perpetrator relationship. Yet when gender was held constant, the number of perpetrators was a stronger predictor of behavior problems than victim sex. In other words, irrespective of gender, childhood sexual revictimization by different perpetrators is correlated with behavior problems. Kellogg and Hoffman (1997) examined subjects who were predominantly Hispanic and who were from low socioeconomic backgrounds and found that sexual revictimization by multiple perpetrators was not uncommon, and that these victims were more likely to experience feelings of self-blame compared with individuals who were victims of a single unwanted sexual experience. Further, feelings of shame were also more common reasons for hesitating to disclose sexual abuse among victims of multiple perpetrators, compared with victims of a single perpetrator. A basic premise of Feiring, Taska and Lewis' (1996) processing model of sexual abuse is that the experience of shame is one primary mechanism by which victims of sexual abuse develop behavior problems and poor adjustment.

Based on this research, a variable such as number of perpetrators may have significant repercussions for psychological functioning following sexual abuse. Therefore it is crucial that those assessing and treating sexual abuse victims conduct a thorough evaluation, making sure that inquiry focuses on possible past sexual abuse, not only presenting abuse. It would also be beneficial for assessment and for treatment to

assess victim's perception of shame and self-blame, because these perceptions appear to be connected to adjustment. Those individuals who are shameful and blame themselves tend to make global attributions (the reason applies to everything about the individual) and tend to view themselves as the causes of their sexual abuse (Feiring, Taska, & Lewis, 1996). It could be that the more shameful an individual is, the less likely he or she is to perceive the fact that each has self-efficacy in preventing future sexual abuse. Because understanding safety and learning assertiveness techniques to prevent revictimization are crucial aspects of treatment of sexual abuse, it is essential to have a baseline understanding of the victim's processing of his or her experience.

Kellogg and Hoffman's study (1997) found violence, substance abuse, and alcohol abuse to be more common in families of victims with multiple perpetrators than in families of those with a single perpetrator. Demographic information from this study also appears to indicate that significant numbers of subjects were exposed to similar family life as those in Kellogg and Hoffman's study. It can be hypothesized that when caregivers are under the influence of illicit substances and of alcohol, ample supervision, education and knowledge regarding sexual abuse prevention are likely inadequate, placing children at increased risk for revictimization. It could also be possible that children might not feel they have safe and reliable persons to share their experiences with.

Limitations of the Study

Despite this study's attempts to address some of the significant methodological flaws that have been common in other sexual abuse research, several limitations still exist. First, the small sample size limits the power to detect group differences. A power

analysis was conducted to determine the sample size necessary to detect a sufficient level of power. The power analysis was calculated for a medium effect with a power of .80. The number of participants needed for this study exceeded the number of completed CSBI. Therefore, significant differences might have been found in this population if a larger sample size existed.

Another limitation to this study was in not utilizing control groups. Although this study used African American subjects from an urban area because of their underrepresentation in other studies, a comparison group of non African American children would have been beneficial to tease out how different ethnicities respond to being sexually abused. Also, a control group of non-sexually abused children would have assisted in making clearer determinations about whether or not these children in this study differed from a non-clinical population in their psychological symptomatology.

Last, pre-abuse baseline data for external and internal symptoms was unknown in the current sample. Because of this, the extent to which psychological functioning reflected the effects of sexual abuse or premorbid psychological symptoms could not be determined. For example, examination of the variable of physical abuse in this population indicated that 42 children within the ages of 8 through 12 were physically abused. It is also possible, and appears likely, that this population might have been victimized in other ways or experienced or witnessed other traumatic situations which may have affected their psychological functioning. Certain information about their families was not taken into consideration in this study and could have contained relevant information. For instance, family functioning has been found to be related to outcome in

CSA, with higher levels of family conflict associated with poorer outcome (Conte & Schuerman, 1987).

Future Directions

The findings of this study offer several suggestions for future research regarding child sexual abuse and psychological symptomatology. Because this study suffered from certain limitations (discussed in the previous section), it would be beneficial for future research to replicate this study using a larger sample size, preferably using clinical and non-clinical control groups. Child sexual abuse research should also concentrate on the contextual variables related to the individual and his or her family/surroundings. It would be helpful to examine the social ecological perspective of children's sexual abuse and its relation to psychological functioning. Personality factors of the child should be examined as well as family functioning. The population used for this study would be good candidates for such research, because appears that a significant number of children's parents from this study have a history of mental illness and incarceration. It might be hypothesized that children from nurturing environments fare better psychologically following abuse, compared with children from dysfunctional homes because of familial buffers. If they live in residences modeling positive coping skills and in safe neighborhoods, perhaps the children might be more psychologically prepared to work through a trauma, knowing that they have the safety and support of their families.

Little is known about those factors which may mitigate or attenuate boys' and girls' adaptations after sexual abuse (Fontanella, Harrington, & Zuravin, 2000). For example, the complex phenomenon of resiliency and its possible role in coping with sexual abuse should be examined using children and adolescents. One study examining

resiliency in adult African American females found that highly resilient women were less likely to have experienced incest or severe physical abuse. By knowing more about resiliency in young populations, school and community-based sexual abuse prevention programs could focus on resilience, which in turn would likely also focus on education and family factors.

Furthermore, future sexual abuse research should focus on the interaction between gender and individual factors, such as coping patterns, levels of self-esteem, intellectual capacities. Familial factors, such as level of parental support and involvement are also important to examine because they could provide important information about how families and children cope with abuse and about possible buffers. It is likely that gender interacts with these moderating variables in intricate ways.

Conclusion

Throughout child sexual abuse literature, there has not been agreement regarding the role of gender on the psychological effects of sexual abuse survivors. Despite a lack of agreement on gender and psychological functioning, research greatly supports a correlation of child sexual abuse and adult psychopathology. Simply because there is not a general consensus regarding gender effects on symptomatology does not mean that gender is not a factor in processing sexual abuse. Therefore it behooves the mental health practitioner who assesses and treats child sexual abuse to be vigilant for gender differences, but also to be aware of individual differences. Mental health treatment interventions should ideally be established as early as possible in the hope of reducing later adult symptoms. A significant starting point would be effective and comprehensive psychological assessments on both the child and family/caregivers.

Despite a lack of consensus regarding gender and psychological symptoms, this study attempted to elucidate a possible connection between the two, by examining whether or not a connection exists between gender presentations of certain behavior problems. The results of this study found that although no clinically significant evidence was determined regarding gender and externalizing and internalizing behavior, trends showed that males had higher rates of overall externalizing behavior and females had higher rates of internalizing behavior problems. This study also examined the role of gender in the display of sexual behaviors, with the hypothesis that males would show higher rates of sexual behavior, compared with females, yet this study was unable to uncover clinically significant findings regarding child sexual behavior. Again, a trend was found to exist in which males had higher overall rates of sexual behavior problems and higher rates of sexual abuse specific behavior problems. Finally, although many different variables were not found to be correlated with symptomatology in this study, the number of perpetrators was found to be slightly significant when controlling for gender. This finding has been previously connected to expression of symptomatology. The results of this study can offer several suggestions for future research regarding child sexual abuse and psychological symptomatology, including the importance of examining contextual variables related to the individual and his or her family/surroundings, the factors that may mitigate boys' and girls' adaptations after sexual abuse, and the interaction between gender and individual factors, such as coping patterns, levels of self-esteem and intellectual capacities.

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