

Chapter 11

Policy and Practice Implications

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INTRODUCTION

Child sexual abuse (CSA) occurs at high rates in the United States and worldwide and it is associated with numerous negative consequences (Freyd et al., 2005). Yet, CSA is difficult to contemplate and discuss. Acknowledging the existence and the extent of CSA challenges many of the ways people attempt to understand individual and societal dynamics. CSA threatens people's belief in a just world (Janoff-Bulman, 1992), their trust in the benevolence of caregivers and other authority figures (see Freyd, 1996), and their conceptualizations of primarily genetic or biological models of psychological distress (Ross, 2000). Within some branches of the mental health profession, psychologists have long speculated and observed that both victims of CSA and larger societies may develop cognitive and emotional defenses to protect themselves from awareness of such abuse (Herman, 1992; Miller, 1984). Only recently have researchers begun to report empirical data that illuminate how such defenses operate (DePrince & Freyd, 1999).

Although inhibiting awareness for CSA can protect survivors and others from some degree of pain and discomfort, this response ultimately exacerbates abuse and its effects. Avoiding the topic of CSA may prevent the funding of relevant research and treatment ini-

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tatives, preclude public consciousness regarding the scope and severity of child maltreatment, underscore survivors' experiences of shame and isolation, and ultimately contribute to further instances of abuse. To reduce the occurrence of CSA and mitigate its effects, it is important to understand the phenomena involved in the impaired awareness for this form of trauma that is present on both individual and cultural levels. Other specific goals, including integrating current scientific efforts, increasing funding allocations, and incorporating trauma training into medical and psychological education, are also crucial for lowering the rates and impact of child sexual abuse.

PREVALENCE AND CONSEQUENCES OF CHILD SEXUAL ABUSE

Child sexual abuse is a relatively common phenomenon. Research indicates that in the United States, approximately 30 percent of women and 13 percent of men report having had sexual contact with adults as children (Bolen & Scannapieco, 1999; Finkelhor, 1994). Several factors are likely to contribute to underestimates of CSA prevalence, including victims' underreporting and memory failure (Fergusson, Horwood, & Woodward, 2000; Freyd, 1996). Most perpetrators of CSA are family members or others close to the child (Finkelhor, 1994). A 1996 report from the Department of Justice estimated rape and sexual abuse of children to cost \$1.5 billion in medical expenses and \$23 billion total annually to victims in the United States (Miller, Cohen, & Wiersema, 1996).

CSA is associated with serious emotional and behavioral consequences. Survivors of CSA may exhibit both internalizing symptoms and externalizing symptoms (Berliner & Elliott, 1996). Though some victims of CSA do not demonstrate increased levels of anxiety, depression, and lowered self-esteem as children (Mannarino, Cohen, & Gregor, 1989), difficulties in these areas may appear in adolescence (Gidycz & Koss, 1989). Many sexually abused children do demonstrate post-traumatic symptoms such as anxiety, fear, and trouble concentrating (Conte & Schuerman, 1987), as well as behavior problems (Berliner & Elliot, 1996). Other common psychological sequelae of CSA include post-traumatic stress disorder, depression, self-mutilation, and suicide (Kisiel & Lyons, 2001; Molnar, Berkman, &

Buka, 2001; Molnar, Buka, & Kessler, 2001). Because victims of trauma frequently simultaneously experience many psychological conditions usually conceptualized as discrete (for instance, personality disorders and depressive disorders), Ross (2000) proposes that interpersonal trauma accounts for much of the "comorbidity" evident in psychiatric diagnoses.

Beyond its relations to traditional psychological diagnoses, CSA may disrupt processes of attachment, emotional regulation, and stress response systems (De Bellis et al., 1994). In addition, survivors are at risk for revictimization (Messman-Moore & Long, 2003) and criminal behavior in adulthood (Fergusson, Horwood, & Lynskey, 1996; Putnam, 2003). In a review of sexual revictimization, Classen, Palesh, and Aggarwal (2005) noted that CSA is the most extensively documented predictor of revictimization, and determined that individuals who are repeated victims of sexual violence often demonstrate problems in interpersonal relationships, self-schemas, coping capacities, shame, and self-blame. McClanahan, McClelland, Abram, and Teplin (1999) investigated links between CSA and prostitution in 1,142 women in jail. They found that CSA almost doubled the probability of prostitution experiences.

CSA also produces deleterious health effects. Victims of CSA report a greater incidence of gastrointestinal, headache, gynecologic, and panic-related symptoms (Leserman, 2005), in addition to an increased risk for abusing alcohol and other substances (Kimerling & Goldsmith, 2000). In a study of 296 college women who completed an anonymous survey, De Von Figueroa-Moseley, Landrine, and Klonoff (2004) found that participants who reported CSA were 3.8 times more likely than nonabused participants to be current smokers and were 2.1 times more likely to have commenced smoking before the age of fourteen. CSA can lead directly or indirectly to HIV infection (Johnson, 2004; Kimerling & Goldsmith, 2000; Zurbriggen & Freyd, 2004). Among 409 adolescents, Voisin (2005) found that individuals exposed to CSA were nearly three times more likely to report increased numbers of HIV-risk behaviors than nonabused participants were.

Research reveals gender differences in victims' CSA experiences and reactions. Females report more sexual abuse by family members and close others, and abuse that begins at a younger age, in comparison to males, who report more sexual abuse by individuals outside of

their family and abuse that commences at an older age (DePrince & Freyd, 2002; Goldberg & Freyd, 2006). In an anonymous survey of 733 college students, Ullman and Filipas (2005) found a greater prevalence and severity of CSA among female students, as well as higher levels of distress and self-blame immediately after the abuse. Females also reported an increased reliance on emotional withdrawal and intentional forgetting compared with male students.

Coping processes following CSA represent a confluence of internal and cultural attitudes regarding abuse. Though general conceptualizations of traumatic stress emphasize the fear and arousal conditioning that frequently accompanies trauma, CSA, like other forms of interpersonal trauma, usually involves additional emotional reactions such as shame, guilt, and betrayal (Freyd, 1996; Lee, Scragg, & Turner, 2001). These emotions may be compounded by a society that often ignores or denies abuse (Herman, 1992). deVries (1996) asserts that experiences of traumatic stress should be conceptualized as an interaction between the characteristics of the stressor and those of the victim's post-traumatic environment. Indeed, data indicate that support following disclosure of abuse improves psychosocial outcomes (Berliner & Elliott, 1996; Ullman, 2003). Conversely, negative reactions following disclosure or victim blame can lead to considerable distress (McFarlane & van der Kolk, 1996).

IMPAIRED AWARENESS FOR ABUSE

The motivation for both survivors of CSA and others to keep abuse outside of consciousness is likely to produce a spectrum of impaired awareness (for a review, see Goldsmith, Barlow, & Freyd, 2004). Dissociation refers to the fragmentation of experiences, whereby elements of a trauma are not integrated into a person's consciousness or sense of self (van der Kolk, van der Hart, & Marmar, 1996). Although everyone experiences dissociation to some degree, some individuals display extreme levels of dissociation, and may meet criteria for dissociative disorders. When individuals are the victims of abuse, they often dissociate during the abuse itself as a form of self-protection and exhibit post-traumatic dissociation to avoid the pain that accompanies this betrayal. Extensive research documents the connection between traumatic experiences and dissociation (Kisiel & Lyons, 2001;

Macfie, Cicchetti, & Toth, 2001; Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997). Extreme dissociation is rare in the general population and, as such, may be viewed as pathognomonic for trauma exposure (Briere, 2006). Though it is very uncommon, some individuals develop dissociative identity disorder. Most individuals with this condition experienced severe childhood abuse (Foote, Smolin, Kaplan, Legatt, & Lipschitz, 2006).

Dissociative processes can inhibit the encoding and memory for trauma-related information (DePrince & Freyd, 1999), and memory impairment has been observed in survivors of traumatic events (Herman & Schatzow, 1987; Kardiner, 1941). The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR; APA, 2000) lists "inability to recall an important aspect of the trauma" (p. 468) as one possible symptom of post-traumatic stress disorder. Elliott (1997) mailed a questionnaire to a random sample of 724 individuals from across the United States that included questions regarding demographic information, traumatic experiences, and memory for the traumatic events. Of the 505 individuals who returned the survey, 72 percent reported some form of trauma, and 32 percent reported having experienced delayed recall of the event. Delayed recall occurred most frequently among individuals who witnessed the murder or suicide of a family member, sexual abuse victims, and combat veterans.

In addition to investigations regarding memory impairment for traumatic events in general, there is extensive research documenting impaired memory for CSA. Briere and Conte (1993) investigated memory for sexual abuse in 450 adults in a clinical sample. Two hundred sixty-seven individuals reported that there had been some period in their life before the age of eighteen when they had no memory of their abuse. In a prospective study of memory for CSA in women, Williams (1994) interviewed 136 women seventeen years after their visits to emergency rooms resulting from the abuse. Williams found that 38 percent of participants failed to report the abuse, even though they did reveal other personal information. Fergusson et al. (2000) conducted a longitudinal study of young adults that revealed that about 50 percent of those reporting histories of CSA or regular physical punishment at age eighteen did not report these events at age twenty-one. Couacaud (1999) investigated memory for abuse in

and some report never disclosing the abuse until their participation in research studies. For example, Finkelhor, Hotaling, Lewis, and Smith (1990) found that only about 40 percent of men and women disclosed their abuse experiences immediately; 24 percent of women and 14 percent of men reported disclosing the abuse at a later time; and 33 percent of women and 42 percent of men did not disclose the abuse before their participation in the study. The closeness between the perpetrator and the child increases the likelihood of delayed disclosure (Foyes, Freyd, & DePrince, 2006; Smith et al., 2000). Others have observed the phenomenon that some children recant true claims of having been sexually abused (Elliott & Briere, 1994; Jones & McGraw, 1987). Somer and Szwarcberg (2001) reported that the severity of childhood traumatization contributed to delayed disclosure of the abuse. Other factors affecting delayed disclosure were victims' valuing obedience to grownups and fears of social rejection, people, and the criminal justice system. Because it appears uncommon for victims to disclose abuse spontaneously, it is important that health professionals ask their patients about abuse experiences (Read, McGregor, Coggan, & Thomas, 2005). Among both children and adults, being asked directly about abuse markedly increases the prevalence rates for CSA in clinical samples (Briere & Zaidi, 1989; Lanktree, Briere, & Zaidi, 1991).

It appears that the cultural context of trauma exerts considerable influence on the likelihood that victims will be believed and supported following disclosure. McFarlane and van der Kolk (1996) comment that although the phenomenon of delayed recall among some female survivors of CSA has been contested, it did not provoke controversy when Myers (1940) and Kardiner (1941) observed the same response in male combat veterans. Although some studies suggest that male victims of CSA disclose their abuse less often than females (Finkelhor et al., 1990) or take longer to disclose than females (Alagria, 2004; Kendall-Tackett, Williams, & Finkelhor, 1993), others indicate that gender is not correlated with latency of disclosure (Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003). Furthermore, there may be outside factors influencing these findings, such as the relationship to the perpetrator. For instance, females tend to be at a greater risk of intrafamilial abuse (Goldberg & Freyd, 2006), which, in turn, has been associated with delayed disclosure (Goodman-Brown et al., 2003). Ethnocultural factors also appear to affect responses to abuse

disclosure. For instance, research studies of maternal reactions following CSA include the finding that African-American mothers were more likely to believe their children than European-American or Hispanic mothers were (Kenny & McEachern, 2000).

PROFESSIONAL RESPONSES TO CSA

Mental health professionals vary in the extent to which they are cognizant of the prevalence and effects of childhood abuse. When victims of CSA elicit treatment for symptoms related to their victimization, they are likely to encounter many health professionals with little training for or awareness of the effects of CSA. Courtois (2002) notes that the topic of traumatic stress comprises only a small part of most therapists' training. Other mental health professionals (Ross, 2000) report being actively discouraged from attending to trauma and its effects during their training. A dearth of knowledge regarding CSA among mental health professionals may exacerbate the effects of victims' own impaired awareness for abuse experiences. When individuals understand their symptoms as understandable consequences of the maltreatment they endured, they may experience reductions in self-blame and other internalizing behaviors.

When conducting intakes and assessments, many mental health workers do not ask about childhood abuse (Read & Fraser, 1998; Young, Read, Barker-Collo, & Harrison, 2001), and exposure to childhood abuse is frequently not detected (Bolen & Scannapieco, 1999; Briere & Zaidi, 1989). Because abuse survivors themselves frequently lack insight regarding the etiology of their distress, health professionals' awareness of connections between abuse and mental health is especially important. Survivors of childhood abuse are likely to seek counseling or therapy not because of the abuse itself, but for depression (Berliner & Elliott, 1996), or negative feelings about themselves or their relationships (Briere, 2002). Read and Fraser's (1998) research identifies clinician discomfort, insufficient resources, and a lack of training regarding trauma as some of the reasons health-care professionals do not ask about trauma. McFarlane and van der Kolk (1996) state that distancing and victim blame may constitute coping strategies that professionals may employ to protect themselves from others' suffering.

Many different therapeutic approaches may assist victims of CSA. Abuse survivors may benefit from cognitive-focused therapy (Cohen, Mannarino, Berliner, & Deblinger, 2000) and from interpersonal psychotherapy (Talbot et al., 2005). Behavioral approaches, informed by models of classical and operant conditioning, can also inform treatment with survivors of trauma (van der Kolk, McFarlane, & van der Hart, 1996). Briere (2002) extends these approaches in a model of conditioned emotional responses (CERs) or relational schema that result from interactions with caregivers during childhood. When therapists respond to conditioned stimuli with care and empathy, clients reorganize links between traumatic memories and CERs. Briere (1996) describes the self-trauma model of psychotherapy, which emphasizes the development of self-skills that are compromised by relational experiences, including careful attention to the intensity, pace, and focus of therapy. The emotional regulation component of Linehan's (1993) dialectical behavior therapy (DBT) may be especially helpful for victims of CSA and other trauma. Follette, Ruzek, and Abueg (1998) describe a contextual-ecological perspective that evaluates clients' symptoms and problems in the past and present contexts in which these incidents commenced and the children perpetuated. This approach may be especially useful in terms of viewing deficits in awareness and disruptions in self-schemas as defenses that were once functional adaptations. It is currently not clear which approach is preferable when treating individuals affected by CSA. Martsof and Draucker (2005) evaluated twenty-six outcome studies and two meta-analyses of abuse-focused psychotherapy for adults who experienced CSA. Abuse-focused psychotherapy ameliorated depression and post-traumatic symptoms, although no one therapeutic approach emerged as superior to others.

Although many psychologists have considered how traumatic stress perspectives may inform therapy with abuse victims, many individuals who experience CSA are unlikely to encounter therapists with expertise in this area. Read et al. (2005) found that often mental health professionals do not detect most cases of CSA. In a study by Agar and Read (2002), mental health professionals who were aware of their clients' abuse histories only referred to the abuse in 36 percent of their case summary formulations and 33 percent of their treatment plans. Abuse-focused therapy was provided to clients in only 22 percent of

cases. Champion, Shipman, Bonner, Hensley, and Howe (2003) examined approaches to training in child abuse and neglect in doctoral programs in clinical counseling and school psychology accredited by the American Psychological Association. Based on data collected from programs' training directors, Champion and colleagues (2003) found that most programs addressed child maltreatment, but noted that training in this area did not meet the APA recommendations for competence in child abuse and neglect, and that it had not improved over the course of the previous decade. The data discussed earlier in the section indicate that professional training should increase both therapists' abilities to detect abuse and their understanding of the importance of its effects.

It is also crucial that medical professionals receive thorough training in responses to child maltreatment, including child sexual abuse. Patients' sexual abuse histories are often undetected by medical professionals (Leserman, 2005). Heger, Ticson, Velasquez, and Bernier (2002) examined data from 2,384 children. They found that only 4 percent of children referred for medical evaluations related to sexual abuse had medical examinations with abnormalities. Because abuse detection is greatly improved by questioning, and many victims of CSA do not present to mental health care agencies, medical care should include screening for potential maltreatment. In addition, both medical and mental health professionals should be aware that victims' cultural backgrounds might affect their willingness to seek treatment, their responses to the abuse, and the levels of care to which they have access (Cohen, Deblinger, Mannarino, & De Arellano, 2001).

Research demonstrates inconsistencies in responses to abuse, including reporting procedures and legal action. To illustrate, Delaronde, King, Bendel, and Reece (2000) determined that most mandated reporters were inconsistent in their reporting when they suspected the presence of child maltreatment. Vieth (2005) quoted Anna Salter, who has worked extensively with child molesters for more than twenty years, stating, "In the interviews I have done, they (the perpetrators) have admitted to roughly 10 to 1,250 victims. What was truly frightening was that all the offenders had been reported before by children, and the reports had been ignored" (p. 10). Both health and criminal justice professionals may be reluctant to believe children when they report CSA. Lanning (1996) asserts that children should neither be

immediately believed nor be disbelieved and offers methods for corroborating claims of CSA. Cross, Walsh, Simone, and Jones (2003) conducted a meta-analysis that revealed that child abuse cases were less likely to lead to filing charges and incarceration when compared with most other felonies, but that when cases were filed they were more likely to be carried forward without dismissal. Menard and Ruback (2003) investigated proceedings of CSA cases in Pennsylvania and reported that differing financial allocations for CSA cases across counties resulted in divergent rates of reporting, verification, and sentencing. Additional investigations are necessary to evaluate the efficacy of mandated reporting of CSA and the ensuing legal action.

Professional and public awareness of CSA is likely to be influenced by patterns of media coverage. Media attention to CSA often does not accurately reflect its most common characteristics. In an analysis of media coverage of sexual abuse, Cheit (2003) determined that the media emphasizes "stranger danger" and does not report cases of intrafamilial abuse with a frequency appropriate to their occurrence. When CSA is covered in the media, stories may reflect consumers' predilection for specific narratives as opposed to descriptions of ongoing issues. In recent years, prominent stories have included sexual abuse in the Catholic church and subsequent attempts to hide the story, as well as allegations of sexual assault by Michael Jackson. Though these events have many components that are relevant to the processes described earlier, media emphasis on such salient cases may obscure the full scope of CSA. Attention to these celebrity cases may reinforce assumptions that CSA is rare and far removed from the experience of most individuals.

High levels of skepticism about CSA allegations likely has to do with certain *child abuse myths* that are pervasive in our culture and serve to deny the reality of child abuse. Tamarack (1986) identified fifty myths about CSA that were prevalent in contemporary literature. A theme common to many of these myths is the idea that CSA is rare and that children lie or are mistaken about their abuse history. Cromer and Freyd (2007) reported a gender bias (males believing abuse reports less) and personal history bias (people who have not experienced trauma being less likely to believe trauma reports). Gender and personal history interacted such that trauma history did not affect females' judgment nearly as much as it affected males' judgment.

CSA AND PUBLIC POLICY

The major federal legislation that addresses child abuse and neglect is the 1974 Child Abuse Prevention and Treatment Act (CAPTA). CAPTA serves states by providing funding for research, prevention, assessment, treatment, investigation, and prosecution efforts (National Clearinghouse on Child Abuse and Neglect Information, 2006). CAPTA also oversees the Office on Child Abuse and Neglect and the National Clearinghouse on Child Abuse and Neglect Information. Though CAPTA enables many children and families to receive needed services, it fails to protect a great number of children who are victims of a range of abuse experiences, including CSA (Gelles, 2001). Gelles (2001) notes that although the system has suffered from predictable limitations, including insufficient funding, staffing, training, and legal support, each of these areas has been addressed with little improvement. Solutions must address the limitations of each worker and could include specialized graduate training tracks in child welfare.

Since CAPTA was enacted, national organizations have been established to address trauma and its effects. In 1985, the International Society for Traumatic Stress Studies was founded to promote the research and dissemination regarding trauma phenomena, as well as intervention and treatment strategies. The Leadership Council on Child Abuse and Interpersonal Violence (formerly the Leadership Council on Mental Health, Justice, and the Media) was created in 1998 by psychological, legal, and policy professionals dedicated to serving victims of trauma (Leadership Council on Child Abuse and Interpersonal Violence, 2006). The Leadership Council identifies their mission as the ethical application of psychological science to human welfare. In 2001, the Donald J. Cohen National Child Traumatic Stress Initiative was established to ameliorate services for children and adolescents exposed to trauma and to facilitate multidisciplinary efforts in the field (National Child Traumatic Stress Network, 2006). The initiative provided a series of grants to the Center for Mental Health Services (CMHS), Substance Abuse Mental Health Services Administration (SAMHSA), and U.S. Department of Health and Human Services, to launch the National Child Traumatic Stress Network (NCTSN). The NCTSN comprises fifty-four agencies that

offer community-based treatment to children and their families who have been affected by trauma.

Another recent development is the establishment of Child Advocacy Centers (CACs) to enhance community responses to child sexual abuse, including legal proceedings (National Children's Advocacy Center, 2006). CACs attempt to incorporate a multidisciplinary team, a medical examination of the child, child advocacy, case review, and a thorough interview of the child, mental health services, and tracking of case progress. CACs may increase the likelihood that victims of CSA will receive integrated care and may facilitate prosecutions of perpetrators. Jackson (2004) proposes a systematic evaluation of these centers in order to assess their effectiveness and ameliorate the ways communities address the CSA issue. There is evidence that child abuse assessment services can increase the probability that charges will be filed following CSA (Joa & Edelson, 2004). Schene (1996) recommends early prevention and intervention services to assist people before abuse occurs or post-traumatic issues worsen, and highlights the importance of integrated community systems that involve schools, social services, mental health, law enforcement, courts, and mental health care.

Although these developments represent increased visibility and action for CSA, responses to victims are still beset with challenges. In the United States, each state differs in their definition of child abuse and the legal age at which a person can consent to sexual activity with an adult (Berliner & Elliott, 1996). Child Protective Services (CPS) refers to the public structure of intervention for victims of child abuse and neglect and operates on county levels across the nation (Schene, 1996). Professionals who work with children are accountable for reporting CSA and other forms of abuse and neglect, and CPS employees investigate their reports. However, many CPS agencies cannot respond adequately to suspected cases of child maltreatment (Schene, 1996). Further research is necessary to identify additional reasons for gaps in services and to determine how the system can better prevent CSA and serve victims.

The statute of limitations laws comprise an important issue in legal proceedings for CSA. Because research indicates that victims of CSA may exhibit impaired memory of the abuse, such limitations could prevent the prosecution of their perpetrators. Federal legislation has

abolished statutes of limitations for childhood sexual abuse and decreed that all cases of sexual abuse may be prosecuted during the lifetime of the victim. However, many states retain statutes of limitations concerning CSA that are often limited to a few years. For example, in South Dakota, cases must be prosecuted within three years from the time victims were abused or from the time they recall the abuse. Since most sexually abused children do not disclose until an average of ten years later, such a statute bars most cases from going to trial.

Largely due to the highly publicized cases of sexual abuse by Catholic priests in the past decade, states are increasingly enacting new legislation. Massachusetts, the center of much attention in the Catholic Church scandal, has recently proposed a bill to lift their statute of limitations on criminal child sex abuse cases. However, neither does the bill include cases of incest and sexual crimes against older teens nor does it eliminate the statute of limitations in civil cases.

RECOMMENDATIONS

Freyd et al. (2005) offer several recommendations to improve research and care pertaining to CSA. Both professionals and victims are most likely to benefit from interdisciplinary research efforts. These may be most effectively synthesized through ongoing international consensus panels that address scientific and treatment initiatives related to CSA. These panels should increase the inclusion of traumatic stress perspectives, including CSA education, in mental health and medical curricula. Another area for focus is more accurate and extensive education for health and legal professionals, the public, and the media. Professionals should work toward increased visibility and dissemination of CSA research. Services for potential and current victims of CSA will be enhanced by comprehensive cost-benefit analyses of prevention and intervention initiatives. These recommendations will require additional financial allocations to address CSA and improve treatment. Currently, cancer research receives \$2 in funding for every \$100 allocated for research, whereas child abuse research receives only \$0.05 for every \$100 dollars of research funding (Putnam, 2001). Freyd et al. (2005) also suggest that the National Child Traumatic Stress Network should be extended to address the overwhelming

public health sequelae of child trauma and supported to create new methods of treatment. The substantial psychological and financial costs of CSA constitute sufficient reasons to create an Institute of Child Abuse and Interpersonal Violence within the National Institutes of Health (NIH) (Freyd et al., 2005).

In addition to improving integrated approaches among professionals who encounter CSA, individuals working in these areas must form liaisons with prominent figures who can advocate for victims of violence and agencies that provide research and treatment for trauma. Krugman (1999) notes that policy changes necessitate an "iron triangle" that includes effective lobbying organizations, members of congress who "champion" the issue, and internal assistance from a bureaucracy that supports the initiatives. Because of the current dearth of such connections, the child protection system is ineffective when contrasted with successful political efforts in other areas of health policy. Krugman (1999) adds that there are few prominent congressional advocates who focus on reducing the impact of child maltreatment and characterizes both the lobby and bureaucracy for these issues as weak. Another important issue for advocacy involves insurance costs for victims of CSA. It is disturbing to consider that these individuals may be penalized by insurance companies for preexisting psychological conditions related to the abuse they experienced. Finally, professionals working with CSA should advocate for the abolition of statutes of limitations for prosecuting CSA in all states.

Within mental health disciplines, professionals involved in training must increase attention within mainstream psychology to the role of interpersonal violence. CSA directly affects far more individuals than schizophrenia, obsessive-compulsive disorder, and bipolar disorder combined, yet it may be viewed as outside the canon—an interesting yet nonessential topic suitable for a guest lecture or a tangential consideration. Perhaps because of the lack of attention to trauma within their own training, or because of their own defenses against trauma, psychologists may regard perspectives that accurately address the impact of trauma with suspicion. Mental health training programs that do emphasize environmental components of psychological functioning such as violence and trauma often accomplish this feat by layering these considerations on top of a framework that views

psychological conditions as distinct and offers scant attention to environmental etiologies of dysfunction.

It is important to address the extent to which training in mental health is governed by tradition. For instance, psychopathology courses are often structured to address psychological conditions individually, although psychological conditions usually co-occur (Kessler et al., 1994), especially among individuals who experience post-traumatic symptoms (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). If only approaches to individual disorders are presented, mental health professionals may emerge from graduate programs with attitudes toward treatment that reflect a piecemeal attitude toward functioning, rather than a perspective that accurately accounts for environmental contributions on mental health. Such approaches are unlikely to encourage mental health workers in asking clients about abuse and detecting maltreatment when it occurs. If mental health professionals are to play an active role in reducing the occurrence and impact of CSA, the prevailing framework is not only undesirable, but also dangerous and unethical.

Reducing the prevalence and impact of CSA and its effects is likely to require creative solutions across several professional domains. For instance, Bolen (2003) questions the prevailing emphasis among child abuse prevention programs on providing services to potential victims and states that targeting potential offenders may improve prevention efforts. In particular, school-based interventions that instill healthy relationship patterns may reach and instruct many individuals before they pose risks to others. Such interventions could specifically redress the problem of widely accepted but inaccurate child abuse myths (Cromer & Freyd, 2007).

In order to improve child welfare, we must address the cognitive and emotional defenses against abuse that affect survivors, professionals, and the public. Additional research can clarify some of the ways that such defenses may prevent optimal responses to CSA. Despite the cultural components that may exacerbate victim blame, there are strengths of cultures and communities that can protect individuals from CSA and assuage its effects (deVries, 1996; Goldsmith, Hall, Garcia, George, & Wheeler, 2004). Improving our response to CSA and its consequences necessitates adopting a perspective that views

the issue not as one of individual dysfunction, but one that influences the overall health of communities and cultures.

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