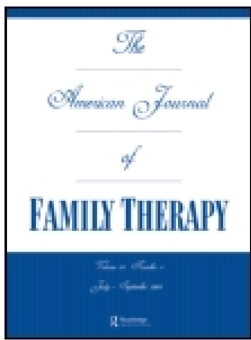

The American Journal of Family Therapy

ISSN: 0192-6187 (Print) 1521-0383 (Online) Journal homepage: http://tandfonline.com/loi/uaft20

Sexual Abuse and Subsequent Risky Sexual Behaviors: A Competency Model for Treatment of Adolescent Females

Anthony A. Hughes, Roy A. Bean & James M. Harper

To cite this article: Anthony A. Hughes, Roy A. Bean & James M. Harper (2015) Sexual Abuse and Subsequent Risky Sexual Behaviors: A Competency Model for Treatment of Adolescent Females, The American Journal of Family Therapy, 43:4, 326-338, DOI: 10.1080/01926187.2015.1051897

To link to this article: http://dx.doi.org/10.1080/01926187.2015.1051897

Published online: 15 Jul 2015.

Submit your article to this journal

Article views: 1649

View related articles

View Crossmark data

Full Terms & Conditions of access and use can be found at
http://tandfonline.com/action/journalInformation?journalCode=uaft20

Download by: [Juliet Grayson] **Date:** 03 February 2017, At: 12:52

The American Journal of Family Therapy, 43:326–338, 2015
Copyright © Taylor & Francis Group, LLC
ISSN: 0192-6187 print / 1521-0383 online
DOI: 10.1080/01926187.2015.1051897

Routledge
Taylor & Francis Group

Sexual Abuse and Subsequent Risky Sexual Behaviors: A Competency Model for Treatment of Adolescent Females

ANTHONY A. HUGHES
Covenant Sex Therapy, Provo, Utah, USA

ROY A. BEAN and JAMES M. HARPER
Marriage and Family Therapy Program, School of Family Life, Brigham Young University, Provo, Utah, USA

Sexual abuse is an antecedent to many psychological and behavioral issues that accompany client families when they present for therapy. This article reviews relevant literature regarding sexual abuse in childhood/adolescence as it relates to resultant risky sexual behaviors and their combined impact on individual and family functioning. Treatment guidelines using Trauma Focused Cognitive Behavior Therapy are presented in the context of three key elements of clinical competence: knowledge, awareness, and skills.

Girls who experience sexual abuse as children are at considerable risk of re-victimization and additional suffering over the course of their lives (Andrews et al., 2004; Polusny & Follette, 1995). This risk is related to the higher probability of hypersexual behaviors and other activities linked with re-victimization (e.g., running away, substance use; Arriola, Louden, Doldren, & Fortenberry, 2005; Senn et al., 2008).

It is unfortunate to find the treatment literature for risky sexual behavior limited by several factors. First, the systemic effects of the abuse and resultant risky sexual behavior on the victim's family and friends are rarely addressed. Most treatment approaches only treat the victimized girl with only ancillary attention paid to other impacted members of the system.

Second, diagnoses often influenced by more dramatic presenting issues instead of the subtle, more common symptoms related to risky sexual behavior and re-victimization. Becoming more knowledgeable about this

Address correspondence to Roy A. Bean, Marriage and Family Therapy Program, School of Family Life, Brigham Young University, 258 TLRB, Provo, UT 84602. E-mail: roy_bean@byu.edu

population's presenting issues will help therapists to more fully provide the necessary clinical services.

Third, little guidance exists to help therapists evaluate their own reactions to this population. Working with a clientele engaging in risky sexual behaviors often triggers reactivity in therapists. This article approaches these conceptual limitations by addressing three dimensions: Knowledge – of the specific presenting issue and the worldviews held by members of the clinical population; Awareness—of therapist's own beliefs and any biases; and Skills—interventions recommended for such individuals and families. Initially used in multicultural competence (Sue et al., 1992; Sue & Sue, 2003), these dimensions have more recently framed clinical competence for a variety of presenting problems (Bean & Titus, 2009; Hall & Bean, 2008).

LITERATURE REVIEW

Clinical Knowledge

Childhood sexual abuse (CSA) is defined as unwanted sexual experiences, including exhibitionism, forcing observation of sexual activity, inappropriate touching, oral–genital contact, attempted/actual rape, and use of children for prostitution or pornography (Putnam, 2003; World Health Organization, 2006). Prevalence of childhood sexual abuse in females ranges from 9 to 28% (Briere and Elliott, 2003; Wonderlich, Wilsnack, Wilsnack, & Harris, 1996) and may be higher since many incidents go unreported. Children who have experienced sexual abuse are three to five times more likely to be re-victimized, even before they become adults (Wekerle and Avgoustis, 2003).

Those who have been sexually abused are either sexually avoidant or hypersexual. The first group exhibits diminished sexual expression, increased sexual anxiety, and fear of sex (Luo, Parish, & Laumann, 2008; Zwickl & Merriman, 2011). They have negative attitudes towards sexuality (Finkelhor & Browne, 1985) and increased sexual dysfunction (Merrill et al., 2003; Simon & Feiring, 2008). Individuals in the second category engaging in risky sexual behaviors, have multiple partners, and oversexualize relationships. Secondary factors accompanying hypersexuality include unwanted pregnancy, lack of contraceptive use, and increased sexually transmitted infections (Herbert, Lavoie, Vitaro, & Tremblay, 2013; Newcomb, Locke, & Goodyear, 2003).

Primary Risk Factor: Hypersexuality

CSA survivors have sex at an earlier age (Luster & Small, 1994), lack boundaries in sexual expression (Mian, Marton, Lebaron, 1996), report

sexual preoccupation (Kendall-Tackett et al., 1993), oversexualize relationships (Simon & Feiring, 2008) and have more sexual partners. Stock, Bell, Boyer, and Connell (1997) found CSA survivors to be 2.3 times more likely to report intercourse, 2.1 times more likely to have intercourse by the age of 15, and 1.4 times more likely to have had more than one partner.

Oversexualization of relationships is likely due to their self-schema (Beitchman et al., 1992). A schema of being overly sexual influences all of an adolescent's interactions. Additionally, inability to see or enforce boundaries is part of this schema. This confusion about boundaries, inability to separate personal worth from sexuality, and the resulting oversexualization are all part of the schema (Beitchman et al., 1992). This negative schema allows for a self-fulfilling prophecy as they engage in sexual acts because they view their worth as primarily sexual and not deserving of self-care.

Cohen et al. (2004) concluded children often have inaccurate attributions about the cause of sexual abuse, their own relative responsibility, and the results of the abuse. These misattributions include blaming self for being seductive so perpetrators couldn't help themselves, leaving the survivor believing that they caused the sexual abuse. The survivor can irrationally confirm these thoughts by selectively searching for evidence that they are more sexual than others their age (e.g., earlier sexual behavior and/or more sexual partners). Young females may even conclude that they deserved what happened, that it was their fate. Distorted perceptions about causality and consequences combine to feed the survivor's self-schema and solidify beliefs that they are highly sexual and incapable of turning down sexual bids.

The teen's hypersexual behavior and distorted schema impacts the larger family and social systems surrounding the adolescent. Their resultant treatment of her reinforces her hypersexualized self-image. For example, knowing that a girl is a CSA survivor, school administrators may give her a break and not take action for sexual comments toward a teacher. The adolescent, in turn, assumes such sexual comments are acceptable. Within the family, parents scrutinize the survivor's actions and are hypervigilant about possible sexual behavior. In turn, the adolescent is more preoccupied with sex because of the parent's hyperfocus. Such feedback loops enable survivors to be hypersexual because they do not provide a healthy feedback about appropriate conduct.

Secondary Risk Factor: Risky Sexual Practices

Abuse is a risk factor for teen pregnancy with CSA survivors, experiencing a 3.1 greater likelihood of becoming pregnant (Boyer & Fine, 1992; Rainey, Stevens-Simon, & Kaplan, 1995; Stock, Bell, Boyer, & Connell, 1997). The higher rate of pregnancy is tied to more frequent intercourse, more

partners, poor boundary setting, insufficient parent-child communication about sexuality, and low contraceptive use.

CSA survivors and their partners are at risk for sexually transmitted infections (STI). Saewyc, Magee, and Pettingell (2004) found that survivors are two times more likely to be treated for a STI than those without sexual abuse. This risk is due, in part, to lack of contraceptive use since 40% of sexually abused youth reported never using condoms (Saewyc, Magee, & Pettingell, 2004), and they are twice as likely to not use birth control (Stock, Bell, Boyer, & Connell, 1997). This may be a product of negative self-schemas, where they judge themselves less valuable and not worth protecting against STIs.

Secondary Risk Factor: Running away

Continued abuse, social shame, and family ridicule may push an adolescent to run away. When the abuser is a family member, running away from home may be a safer option than staying at home, especially if the family is unable to protect the survivor. Running away increases engaging in risky sexual behaviors since runaways often barter sex for food and shelter (Saewyc, Magee, & Pettingell, 2004).

Secondary Risk Factor: Substance use

Abused youth are 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 hard drug use (Kilpatrick et al., 2000; Watts & Ellis, 1993). Alcohol and drugs lead to emotional numbing which facilitates coping (albeit in a maladaptive fashion) with poor circumstance and painful emotions. The addictive and mind altering properties result in poor judgment about sexual partners and safe practices and likely lead to more frequent risky sexual behavior (Inoue et al., 2005). This increases the possibility of getting an STI and experiencing re-victimization. Sexually promiscuous behavior may become a way to get drugs or alcohol.

Clinician Self-Awareness

Therapists should examine their age and gender judgments about those presenting with risky sexual behaviors because such self-evaluation will be an antidote to counter-transference and reactivity (Bean & Titus, 2009; Sue & Sue, 2003). Therapist reactivity with this population is either harsh or enabling and disempowering. Therapists should monitor reduction in compassion and empathy statements and being overly challenging and

confrontational. Signs of enabling reactive behavior include too much normalizing and empathy, failure to give homework assignments, and normalizing risky sexual behavior to the extent that it builds a rationale for further participation.

Sexual attraction may also trigger therapists to be reactive (Harris, 2001), since clients may sexualize relationships and "romanticize" the therapist's role as a protector and advocate. Therapists must consider signs of a client's attraction and misattributions about therapist behaviors (e.g., assessment questions about sexual events can be experienced as "arousing" by some clients). Systemic, family-based work may help avoid misinterpretation of therapist actions because family members can help monitor, correct and interpret meanings of behavior.

Clinical Skills

Trauma Focused Cognitive Behavioral Therapy (TF-CBT) provides an empirically supported treatment approach for working with this population. The general skills of joining, assessment, and intervention will be followed by a case study which presents specific examples of intervention.

General skills: Joining

Therapist empathy, support, non-blaming, and non-shaming are vital when abuse is disclosed. Some survivors have received negative parental and social support to their disclosure of abuse. The therapeutic environment should be empowering, providing clients with opportunities to talk about their experiences as the therapist serves the role of "witnessing": (Meyers, 2012; Schauben & Frazier, 1995). For some, therapy may be the only place where safe and healthy responding occurs. Therapists should be mindful of judgments and stereotypes others place on the client. Normalizing client behavior within context can help reduce shame and negative self-schemas. Therapists can use bibliotherapy, examples of others struggles with similar sexual behavior, and statistics to help clients see that they are not alone. Talking about the function of the sexual behavior can help lessen stigma and help clients see how the abuse and subsequent pain leads to their compensatory risky sexual activity. Helping them to reframe their identity from that of "victim" to "survivor" can be extremely helpful.

General skills: Assessment

Many manualized treatments of sexual abuse neglect systemic effects and implications. Clinicians need to assess for possible systems factors that in-

crease the likelihood of risky sexual behaviors. Such factors include parental dysfunction (e.g., substance abuse), poor family responding (e.g., blaming), familial perpetrator, mother's poor education and history of victimization, domestic violence (Pournaghash-Tehrani & Feizabadi, 2009), father's excessive drinking (Mian, Marton, & Lebaron, 1996), and mother's lack of communication about birth control (Luster & Small, 1994).

It is crucial for therapists to gain a broad picture of their client's sexual involvement, thought processes, and sexual abuse events. As a general guideline, therapists should assess for sexual behaviors, thought processes concerning sex and sexuality, sexual identity, and frequency, duration, and invasiveness of the abuse. Assessment should also include inquires about the age of first consensual sex, duration of sexual relationships including number of current and lifetime sexual partners, frequency of unprotected sex, sexually transmitted infections, and any unwanted pregnancies. Both frequency and invasiveness of child/adolescent sexual abuse have been noted as predictors of increased involvement in risky sexual behaviors.

Some youth and their families do not understand the connection between risky sexual behavior and the original sexual abuse. They may struggle to see that the female adolescent's sexual behavior exceeds the limits of normative adolescent sexual development. Consequently, clients engaging in risky sexual behaviors may present in therapy for other reasons including PTSD (Briere & Elliott, 2003), teen pregnancy (Stock, Bell, Boyer, & Connell, 1997), substance abuse (Watt & Ellis, 1993), police referral due to revictimization (Wekerle & Avgoustis, 2003), depression, familial issues, social service agency referral, or parental concern (Simon & Feiring, 2008). Therapists should be aware that these other presenting issues may accompany risk sexual behavior.

Given the increased likelihood of abusive and coercive sexual relationships (Beitchman et al., 1992), assessment should also include clients' risk of re-victimization. By making clients aware of the risk, clinicians can intervene to reduce behaviors (drug/alcohol use) and thoughts that put CSA survivors in danger of re-victimization. Cognitive distortions such as "I'm already broken or worthless, so who cares if I do it again?" or "This just confirms that my only value to boys is sexual, so why don't I capitalize on that?" are common. Changing cognitive distortions will reduce risky sexual behavior.

General skills: Intervention

Family and positive peer group support helps reduce risky sexual behaviors. Therapists need to engage families to create safety and emotional support. The survivor benefits from family and friends who can be there in times of need, pain, and maladaptive coping. Proper support can help to balance out the negative self-schema and other risk factors. The integration of systemic

support and therapeutic involvement also helps survivors heal and reduce their likelihood for participation in risky sexual behaviors. Including family and other social supports in sessions, therapists can address moments of enabling or harshness that may inadvertently perpetuate risky sexual behaviors.

Case Study: An Application of Trauma Focused Cognitive Behavioral Therapy

While there are a number of treatments for sexual abuse, Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) has significant empirical support (Deblinger, Lippman, & Steer, 1996; Cohen & Mannarino, 1996a, 1996b, 1998a, 1998b; Deblinger, Stauffer, & Steer, 2001; Cohen, Deblinger, Mannarino, & Steer, 2004). The goals of TF-CBT consider both individual and systemic dynamics including reducing adolescent's negative emotional and behavioral responses to the sexual abuse, correcting maladaptive or unhelpful beliefs and attributions, helping non-offending parents cope effectively with their own emotional distress, and equipping parents with skills to respond optimally to their children (Cohen et al., 2007).

Ashley, a 16-year-old sophomore, entered therapy to decide whether to place her unborn child for adoption. Her parents, Sue and David, were surprised to be asked to attend therapy since they assumed that Ashley was the one with the problem. Her parents described Ashley as the center of many boys attention. They said she was rarely without a boyfriend so they worried about her seeming dependency on boys long before finding out about the pregnancy. Ashley said that she was "a pretty sexual person" and usually brought relationships to a more sexual level. The therapist noticed that given her young age, Ashley had a considerable number of boyfriends.

The therapist met separately with Ashley's parents who reported knowing little about Ashley's sexual relationships and dating history. They acknowledged that Ashley was sexually abused when she was 13. They didn't want to go into much detail regarding the abuse other than to say that the perpetrator was an uncle, and many legal issues were involved. David became uncomfortable talking about Ashley's abuse. Sue was more willing to discuss the abuse but generally followed David's lead in limiting discussion. Sue quickly distracted them from Ashley's abuse to her own CSA. They both appeared nervous and uncomfortable at this point in the session.

Assessment and conceptualization

Further conversations with Sue and David revealed details about Sue's own CSA history and David's current alcohol use. Both said they rarely talk about sexuality in their current home or in their families-of-origin. Ashley disclosed

that she was sexually abused by her uncle on several occasions, including fondling and rape when she was 13. Ashley reported sexualizing relationships since the abuse, some STIs, and occasional drug/alcohol use. Ashley described her parents as awkward and uncomfortable when she disclosed the abuse, and the subsequent difficulties in her relationship with them since. She said that her mother didn't know what to say and appeared "frozen," and her father seemed upset, as if it was her fault.

As is often the case, Ashley came to therapy with a problem (i.e., indecision about her pregnancy) related to risky sexual behavior, complicated by unresolved CSA issues. While she saw therapy as a resource to help her resolve decisions about adoption, the therapist saw an opportunity to also help her work through sexual abuse and reduce her risky sexual behavior. This was also an opportunity intervene in the family to help them empower Ashley to reduce Ashley's risky sexual behavior, heal from the abuse, and create a new family culture with more open communication in general and around sexuality.

Intervention: Psycho-education, parenting skills, and family communication

The family received psychoeducation about the risky sexual behaviors that often follow sexual abuse and how relationships can be oversexualized in pursuit of attention and affection. This phase of therapy also helped the family understand Ashley's emotional and behavioral reactions related to the abuse (i.e., anger, hurt, shame). They also received training in effective family communication, especially active listening and validation.

Intervention: Relaxation techniques

Ashley and her parents were taught relaxation techniques and worked collaboratively with the therapist to find adaptive coping strategies to manage anxiety and trauma symptoms of the abuse. Breathing exercises, progressive muscle relaxation, and thought stopping were among the techniques taught to Ashley and to her parents to help them manage their own emotional reactivity.

Intervention: Affective expression and regulation

In family therapy Ashley and her parents slowly learned how to express emotion in a healthy manner. This first began with describing different emotions and then led to specific emotions related to the abuse. These latter emotions were more difficult for Ashley and her parents, but with practice, normalization, and validation, they could openly express feelings, and Ashley could talk about triggers that reminded her of the abuse. She was also

able to express an appropriate amount of emotion or hold back until it was safe for her to express anger and pain when she was triggered. Ashley and her parents were also taught self-soothing activities drawn uniquely from their interests, such as writing.

Intervention: Cognitive coping and processing

Multiple sessions focused on inaccurate attributions about the cause, her responsibility, and the results of the abuse. A large part of these misattributions were due in part to Sue's and David's reactivity when the abuse was disclosed. Ashley always felt that the abuse was partially her fault and that she was a sexual, "easy" girl. Therapy helped Ashley see that the abuse wasn't her fault. She was then able to correct inaccurate beliefs about herself. This included working through misattributions related to her parents' response to the disclosure as well as her sense of lack of control and seeing herself as responsible for the abuse.

Intervention: Trauma narrative

Ashley's narrative of the abuse was addressed through gradual exposure exercises. In TF-CBT, gradual exposure exercises take the form of verbal, written, and symbolic expressions. Since Ashley was an avid journal writer, the therapist encouraged her to write about her perception of the abuse in a gradual way. In the beginning, her writing focused on less threatening aspects of the abuse but gradually progressed to more emotionally-threatening and difficult topics. For example, Ashley was able to write about the complicated and conflictual experiences that she had when her body responded sexually during some abuse experiences. When she first wrote about these events, her writing was fraught with self-contempt. These were processed in therapy, she was asked to write additional entries about this same topic, and, in time, she re-storied her experience. She could see that it is normal for certain sensations to illicit sexual responses, and this helped her change her belief that she "wanted" the sexual abuse.

Intervention: In vivo exposure

Ashley was significantly triggered by environmental stimuli that reminded her of the context of the abuse. In vivo exposure helped to counteract anxiety through gradual exposure first to nonthreatening reminders that engendered adverse emotional responses. Gradual exposure to the dark and being alone in the dark helped reduce Ashley's adverse reactions. Therapy included sessions in a dimly lit room, then being in a dark therapy room with those

people who help her feel safe. In time, Ashley was no longer triggered by being alone in the dark.

Intervention: Conjoint parent/child sessions

Conjoint parent/child sessions helped facilitate communication about the abuse which led to feelings of safety between Ashley as she gained a sense of parents "witnessing". This in session communication generalized to their home environment. The family participated in several sessions to address the abuse, hurt caused by the family's responses, negative attributions Ashley adopted about herself, and her thoughts about the risky sexual behaviors she engaged in. The parents were coached in how to listen and "witness." Sue was also able to talk to Ashley about the negative effects of her own sexual abuse which provided Ashley with understanding, validation, and empathy that she didn't get when she first disclosed the abuse.

Intervention: Enhancing personal safety and future growth

Ashley and her parents were trained in personal safety skills, interpersonal relationships, and healthy sexuality. They were encouraged to use new skills in managing future stressors and trauma triggers. This included discussion of the sexual risks that Ashley takes when she uses drugs/alcohol. The therapist facilitated discussion in family sessions about healthy sexuality and condom use. Ashley was also encouraged to participate in a creative writing class to help manage her future stressors and triggers.

Through a family systems approach to TF-CBT, Ashley's and her parents' negative emotional and behavioral responses to sexual abuse were changed. A supportive environment in therapy and at home helped Ashley and her parents cope with the emotional distress they were experiencing. Ashley developed more adaptive coping techniques (e.g., creative writing) to stress. Sue and David were able to express their pain about the abuse of their daughter and the havoc on their relationship with Ashley and with each other. Additionally, Ashley was able to place her child for adoption because of more open family communication and greater support from her parents.

CONCLUSION

As a maladaptive coping technique, risky sexual behaviors resulting from CSA are common and impact individual, family, and larger systems. This article synthesizes and articulates a competency model of treatment from a family systems approach. It is the authors' hope that clinicians will use

this knowledge to be the first line of defense in identifying, assessing, and treating risky sexual behaviors in female adolescent CSA survivors.

REFERENCES

Andrews, G., Corry, J., Slade, T., Issakids, C., & Swanston, H. (2004). Child sexual abuse. In M. Ezzati, A. D. Lopez, A. Rodgers, & C. J. L. Murray (Eds.), *Comparative quantification of health risks: Global and regional burden of disease attributable to selected major risk factors* (pp. 1851–1940). Geneva, Switzerland: World Health Organization.

Arriola, K. R. J., Louden, T., Doldren, M. A., & Fortenberry, R. M. (2005). A meta-analysis of the relationship of child sexual abuse to HIV risk behavior among women. *Child Abuse & Neglect*, *29*, 725–746.

Bean, R. A., & Titus, G. (2009). Cultural intersection of Asian Indian ethnicity and presenting problem: Adapting multicultural competence for clinical accessibility. *Journal of Multicultural Counseling and Development*, *37*(1), 40–51.

Beitchman, J. H., Zucker, K. J., Hood, J. E., DaCosta, G. A., Akman, D., & Cassavia, E. (1992). A review of the long-term effects of child sexual abuse. *Child Abuse & Neglect*, *16*, 101–118.

Boyer, D., & Fine, D. (1992). Sexual abuse as a factor in adolescent pregnancy and child maltreatment. *Family Planning Perspectives*, *24*, 4–11.

Briere, J., & Elliott, D. M. (2003). Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse & Neglect*, *27*, 1205–1222.

Brook, J., Adams, R., Balka, E., Whiteman, M., Zhang, C., & Sugerman, R. (2004). Illicit drug use and risky sexual behavior among African American and Puerto Rican urban adolescents: The longitudinal links. *Journal of Genetic Psychology*, *165*, 203–220.

Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry*, *43*, 393–402.

Cohen, J. A., Mannarino, A. P., & Knudsen, K. (2004) Treating childhood traumatic grief: A pilot study. *Journal of the American Academy of Child & Adolescent Psychiatry*, *43*, 1225–1233.

Cohen, J. A., & Mannarino, A. P. (1996a). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child and Adolescent Psychiatry*, *35*(1), 42–50.

Cohen, J. A., & Mannarino, A. P. (1996b). Factors that mediate treatment outcome in sexually abused preschool children. *Journal of the American Academy of Child and Adolescent Psychiatry*, *35*(10), 1402–1410.

Cohen, J. A., & Mannarino, A. P. (1998a). Interventions for sexually abused children: Initial treatment findings. *Child Maltreatment*, *3*(1), 17–26.

Cohen, J. A., & Mannarino, A. P. (1998b). Factors that mediate treatment outcome in sexually abused preschool children: Six and 12-month follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry*, *37*(1), 44–51.

Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment*, *1*, 310–321.

Deblinger, E., Stauffer, L., & Steer, R. (2001). Comparative efficacies of supportive and cognitive behavioral group therapies for children who were sexually abused and their nonoffending mothers. *Child Maltreatment 6*(4), 332–343.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry*, *55*, 530–541.

Hall, S. D., & Bean, R. A. (2008). Family therapy and childhood-onset schizophrenia: Pursuing clinical and bio/psycho/social competence. *Contemporary Family Therapy*, *30*, 61–74.

Inoue, M., Nishihira, T., Kakazu, I., Tamashiro, K., Sono, Y., & Kato, N. (2005). A study of high school students' sexual behavior and its influencing factors. *Adolescentology*, *22*, 495–503.

Jessor, R., Costa, F., Jessor, S. L., & Donovan, J. E. (1983). Time of first intercourse: A prospective study. *Journal of Personality and Social Psychology*, *44*, 608–626.

Kendall-Tackett, K., Williams, L., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin*, *113*, 164–180.

Kilpatrick, D. G., Acierno, R., Saunders, B. E., Resnick, H. S., Best, C. L., & Schnurr, P. P. (2000). Risk factors for adolescent substance abuse and dependence: Data from a national sample. *Journal of Consulting and Clinical Psychology*, *68*, 19–30.

Li, X., Stanton, B., Contrell, L., Burns, J., Pack, R., & Kaljee, L. (2000). Pattern of initiation of sex and drug related activities among urban low-income African American adolescents. *Journal of Adolescent Health*, *28*, 46–54.

Luo, Y., Parish, W. L., & Laumann, E. O. (2008). A population-based study of childhood sexual contact in China: Prevalence and long-term consequences. *Child Abuse & Neglect*, *32*, 721–731.

Luster, T., & Small, S. A. (1994). Factors associated with sexual risk-taking behaviors among adolescents. *Journal of Marriage and the Family*, *56*, 622–632.

Merrill, L. L., Guimond, J. M., Thomsen, C. J., & Milner, J. S. (2003). Child sexual abuse and number of sexual partners in young women: The role of abuse severity, coping style, and sexual functioning. *Journal of Consulting and Clinical Psychology*, *71*, 987–996.

Meyers, M. B. (2012). Trauma, therapy, and witnessing. In N. R. Goodman & M. B. Meyers (Eds.), *The power of witnessing: Reflections, reverberations, and traces of the Holocaust* (pp. 289–303). New York, NY: Routledge.

Mian, M., Marton, P., & Lebaron, D., (1996). The effects of sexual abuse on 3- to 5-year-old girls. *Child Abuse & Neglect*, *20*, 731–745.

Millstein, S. G., & Moscicki, A. B. (1995). Sexually transmitted diseases in female adolescents: Effects of psychosocial factors and high risk behaviors. *Journal of Adolescent Health*, *17*, 83–90.

Newcomb, M. D., Locke, T. F., & Goodyear, R. G. (2003). Childhood experiences and psychosocial influences on HIV risk among adolescent Latinas in Southern California. *Cultural Diversity and Ethnic Minority Psychology*, *9*, 219–235. doi:10.1037/1099-9809.9.3.219

Polusny, M. A., & Follette, V. M. (1995). Long-term correlates of child sexual abuse: Theory and review of the literature. *Applied and Preventive Psychology*, *4*, 143–166.

Pournaghash-Tehrani, S., & Feizabadi, S. (2009). Predictability of physical and psychological violence by early adverse childhood experiences. *Journal of Family Violence*, *24*, 417–422.

Putnam, F. W. (2003). Ten-year research update review: Child sexual abuse. *Journal of the American Academy of Child & Adolescent Psychiatry*, *42*(3), 269–278.

Rainey, D. Y., Stevens-Simon, C., & Kaplan, D. W. (1995). Are adolescents who report prior sexual abuse at higher risk for pregnancy? *Child Abuse & Neglect*, *19*, 1283–1288.

Saewyc, E., Magee, L., & Pettingell, S. (2004). Teenage pregnancy and associated risk behaviors among sexually abused adolescents. *Perspectives on Sexual and Reproductive Health*, *36*(3), 98–105.

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors working with sexual violence survivors. *Psychology of Women Quarterly*, *19*, 49–64.

Senn, T. E., Carey, M. P., & Vanable, P. A. (2008). Childhood and adolescent sexual abuse and subsequent sexual risk behavior: Evidence from controlled studies, methodological critique, and suggestions for research. *Clinical Psychology Review*, *28*, 711–735.

Simon, V. A., & Feiring, C. (2008). Sexual anxiety and eroticism predict the development of sexual problems in youth with a history of sexual abuse. *Child Maltreatment*, *13*, 167–181.

Stock, J., Bell, M., Boyer, D., & Connell, F. (1997). Adolescent pregnancy and sexual risk -taking among sexually abused girls. *Family Planning Perspectives*, *29*, 200–203, 227.

Wekerle, C., & Avgoustis, E. (2003). Child maltreatment, adolescent dating, and adolescent dating violence. In P. Florsheim (Ed.), *Adolescent romantic relations and sexual behavior: Theory, research, and practical implications* (pp. 213–241). Salt Lake City: Department of Psychology, University of Utah.

Wonderlich, S. A., Wilsnack, R. W., Wilsnack, S. C., & Harris, T. R. (1996). Childhood sexual abuse and bulimic behavior in a nationally representative sample. *American Journal of Public Health*, *86*, 1082–1086.

World Health Organization. (2006). *Preventing child maltreatment: A guide to taking action and generating evidence*. Geneva, Switzerland: World Health Organization and International Society for Prevention of Child Abuse and Neglect.

Watts, W. D., & Ellis, A. M. (1993). Sexual abuse and drinking and drug abuse: Implications for prevention. *Journal of Drug Education*, *23*, 183–200.

Wyatt, G. E., Newcomb, M., & Riederle, M. (1993). *Sexual abuse and consensual sex: Women's developmental patterns and outcomes*. Newbury Park, CA: Sage.

Zwickl, S., & Merriman, G. (2011). The association between childhood sexual abuse and adult female sexual difficulties. *Sexual and Relationship Therapy*, *26*, 16–32.