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The Results of Child Sexual Abuse and How They Can be Mitigated

Joy Buchman
jbuchman15@winona.edu

Joy L. Buchman

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CERTIFICATE OF APPROVAL

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The Results of Child Sexual Abuse and How They Can be Mitigated

This is to certify that the Capstone Project of

Joy L. Buchman

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Capstone Project Supervisor: _____Mary Fawcett, Ph.D._____
Name

___ _____
Signature

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Abstract

This review of literature sought to compile a list, albeit not exhaustive, of short and long-term effects of childhood sexual abuse (CSA) and several types of play therapy used to effectively mitigate these effects. CSA has a long reaching impact affecting a child's well-being, a nation's societal health in addition to having a massive financial impact worldwide. Some children who are sexually abused do not struggle with negative effects and others are impacted for a lifetime. Some effects of CSA are developmental, cognitive, physical and psychological. These effects can impact the way a child views themselves, adults and the world. This self and world view will have an impact on a child's ability to form healthy relationships in both childhood and later life. Familial and repeated sexual abuse are implicated in longer more impactful negative effects. Age difference between victim and perpetrator, relational health of child and caregiver's attachment style, and level of sexual abuse all impact the child's perceived level of trauma. In an attempt to review therapeutic treatments that were not limited by age or verbal ability two forms of play therapy are considered when evaluating the mitigating effectiveness of therapeutic treatments. Child-Centered Play Therapy and sandtray therapies were found to have a mitigating effect on the short and long-term negative effects of CSA. Results showed effectiveness in very young children, adolescents, older adults, all genders, all sexual orientations and numerous cultures.

Key words: Childhood sexual abuse; short-term effects; long-term effects; attachment; ACE's; Child-Centered Play Therapy; sandtray therapy.

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"Child maltreatment may be the single most preventable and intervenable contributor to child and adult mental illness in the country" (De Bellis, 2001, pg. 539). According to Starr Commonwealth Children of Trauma & Resilience Guidebook (2019), trauma's impact on our society costs 94 billion dollars a year. Childhood sexual abuse (CSA) can result in a host of physical and psychological problems which, when left untreated, continue to affect victims throughout their lives (Felitti et al., 1998; Rellini & Meston, 2011; Somer, 2000). According to CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study respondents who reported having four or more exposures to adverse childhood experiences are 4-12 times more likely to have multiple health risk factors as they age than respondents reporting no ACEs. These health factors include depression, suicidality, alcoholism and drug abuse, smoking, sexually transmitted disease, physical inactivity and obesity, heart and liver disease, chronic lung disease and cancer (Felitti et al., 1998).

Felitti et al. (1998) linked the long-term health problems to the coping strategies employed by those with four or more ACEs. These types of coping strategies utilize the pharmacological and psychological benefits of drugs, alcohol, sex, smoking and overeating as a means of coping with the stress of the adverse experiences. The long-term effects of these chronic coping techniques result in poor health status and disease in adulthood (Felitti et al., 1998). In addition to the physical ramifications of ACEs are the chronic psychological and long-term effects. They noted that depression is a common feature in children exposed to adverse experiences (Felitti et al., 1998). The neurobiological systems involved in the normal progress of emotional/behavioral regulation as well as physical and cognitive development are negatively impacted by the acute and chronic stress of childhood abuse (De Bellis, 2001; Perry, 2005).

Repeated abuse by caretakers can affect normal childhood development (De Bellis, 2001), and create maladaptive schema effecting the child's interpretation of themselves and others even to the extreme of self-loathing (Somer, 2000). This self-loathing can cause the survivors of CSA to neglect their physical and emotional health resulting in long-term health issues (Felitti et al., 1998; Eli, 2000). Children who live in unstable or unsafe homes learn to adapt and form coping strategies to keep themselves safe (The National Child Traumatic Stress Network, 2018a; Somer, 2000). They can become hypervigilant and acutely aware of the emotional state of the adults in their lives. This hypervigilance is in response to physical or emotional threats these children may live with on a daily basis.

Post-Traumatic Stress Disorder can result from a single traumatic episode or long-term chronic abuse (De Bellis, 2001). When this abuse is perpetrated by a trusted caregiver or person in authority it causes dysfunction and traumatization of the interpersonal relationship which, among other things, can affect the child's ability to form trusting relationships in the future (De Bellis, 2001; Kozak et al., 2017). This paper will focus more on the impact of CSA when the perpetrator has a personal relationship with the child and aspects of the initial and long-term impact on survivors. Then it will look at evidence-based treatments used to effectively mitigate many of the effects of CSA. Both fall under the broad heading of play therapy but this paper will look at Child-Centered Play Therapy and sand tray therapies respectively.

Review of Literature

"We are the product of our childhoods" (Perry, 2005, para. 29)

According to Committee on the Rights of the Child (2011, p. 10):

> Sexual abuse and exploitation includes: (a) The inducement or coercion of a child to engage in any unlawful or psychologically harmful sexual activity; (b) The use of

> children in commercial sexual exploitation; (c) The use of children in audio or visual images of child sexual abuse; (d) Child prostitution, sexual slavery, sexual exploitation in travel and tourism, trafficking (within and between countries) and sale of children for sexual purposes and forced marriage. Many children experience sexual victimization which is not accompanied by physical force or restraint, but which is nonetheless psychologically intrusive, exploitative, and traumatic. Sexual abuse comprises any sexual activities imposed by an adult on a child, against which the child is entitled to protection by criminal law. Sexual activities are also considered as abuse when committed against a child by another child, if the child offender is significantly older than the child victim or uses power, threat or other means of pressure. Sexual activities between children are not considered as sexual abuse if the children are older than the age limit defined by the State party for consensual sexual activities.

A review of the literature indicates CSA is a major public health issue in America (Brown & Finkelhor, 1986; Felitti et al., 1998; National Scientific Council on the Developing Child, 2004; Perry, 2005; Kozak et al., 2017), and around the world in all cultures, races, sexual orientations and all types of families presenting an array of initial and long-term effects (Kenny & McEachern, 2000; Dube et al., 2005; Stoltenborgh, et al., 2011; Xu & Zheng, 2015; Roesler, 2019).

Culture, race and ethnicity have an impact on the survivors view of their abuse, as does gender, geographical origin, and sexual orientation which are all influencing factors in the prevalence of CSA reporting (Mennen, 1995; Kenny & McEachern, 2000; Stoltenborgh et al., 2011; Xu & Zheng, 2015). Stoltenborgh et al. (2011) indicated collectivist or individualistic cultural views of sexual norms may influence individual's willingness to report CSA. Along with

culture other factors intertwined with the willingness to report are the child's perception of reporting the abuse, and their fear of the consequences, and their own feelings regarding the abuse (Kenny & McEachern, 2000).

According to several studies girls are at higher risk than boys for sexual abuse (Dube et al., 2005; Stoltenborgh et al., 2011; Karakurt & Silver, 2014; Xu & Zheng, 2015). These findings are supported by a retrospective cohort study of 17,337 adults which found 25% of females and 16% of males reported experiencing sexual abuse in childhood and showed similar long-term effects for both genders (Dube et al., 2005). A meta-analysis collecting data from 1980 through 2008 involving studies published around the world found despite cultural differences girls had a higher prevalence of reporting CSA (Stoltenborgh et al., 2011). In Stoltenborgh et al. (2011) only South America was an exception where boys had a slightly higher incidence of reporting. Asia, Australia, Europe, the United States and Canada have more than a two times higher prevalence of girls reporting than boys (Stoltenborgh, et al., 2011). Stoltenborgh, et al. (2011), and Kenny, McEachern, (2000) agreed although it is widely accepted that CSA occurs globally a consensus has not been reached as to its prevalence within ethnic groups.

Xu & Zheng (2015), conducted a meta-analysis looking at the prevalence of CSA reporting among gay, lesbian and bisexual individuals (GLB). Reports show women's sexuality are shaped by social influences and tends to be malleable thereby being susceptible to the effects of CSA and men's sexuality is more fixed and inflexible and less influenced by sexual abuse in childhood (Xu & Zheng, 2015). The causal relationship between CSA and sexual orientation is still speculative but data show a higher incidence of CSA among those of minority sexual orientation (male-22.2%; female-36.2%) than those reporting to be heterosexual (male-7.9%; female-19.7%) (Xu & Zheng, 2015). Xu & Xheng's (2015) meta-analysis was conducted with 65

studies over 9 countries. They concluded no significant difference of reporting among gay, bisexual or gay-bisexual men and the same with lesbian, bisexual or lesbian-bisexual women (Xu & Zheng, 2015). They did find a significance between male (22.2%) and female (36.2%) sexual minorities reporting CSA (Xu & Zheng, 2015).

The effects of CSA differ widely, and some studies indicate the reason is dependent on the type of abuse suffered and the perpetrator's relationship to the victim (Finkelhor, 1979; Brown & Finkelhor, 1986; Olafson, 2011). Xu & Zheng found sex of the perpetrator influences the severity of outcomes (Xu & Zheng, 2015). In other studies when a father or stepfather perpetrate the sexual abuse, and especially when penetration was completed, survivors report greater perceived trauma than when the perpetrator is another relative or stranger (Brown & Finkelhor, 1986; Russell, 1986, Olafson, 2011).

Types of Abuse

There are two types of sexual abuse; extra-familial and incest. Non-family abuse is sexual abuse which can be perpetrated by any non-family member such as a teacher, coach, priest etc. (Tal et al., 2018). Incest can be perpetrated by a parent to child or sibling to sibling or other family member to a child (Krienert & Walsh, 2011).

Krienert and Walsh (2011) found the most common form of sexual abuse is perpetrated between siblings and the type of sibling sexual abuse most commonly reported was forceable fondling (55%), the next highest was a combination of rape/sodomy (40%). In their study Krienert and Walsh (2011), indicate that sibling incest is estimated to occur three to five times more often than father-daughter incest. Krienert and Walsh (2011) utilized reports from 2000-2007 from official National Incident-Based Reporting System (NIBRS) to compile statistical data on sibling sexual abuse from 13,013 incidents reported to law enforcement. The majority of

victims were younger than thirteen years old with a mean age of eight years old and 83% were biological siblings. The largest percentage of cases (67%), were perpetrated by an older brother on a younger sister and 25% were male to male siblings.

When the perpetrator was a sister the common victims where boys as was the case when multiple offenders were involved (Krienert &Walsh, 2011). They found boys (37%) were more likely than girls (9%) to be victims of sodomy (Krienert &Walsh, 2011). In light of their statistical findings Krienert and Walsh (2011) recommend parents monitor the power differential between their children. Another aspect of incest is the betrayal the victim is left with. Victims of incest feel betrayed by the perpetrator and sometimes other members of the family often causing distrust in adults and lack of trust in future relationships (Karakurt & Silver, 2014).

Level of Violation

The levels of trauma experienced by survivors, when the sexual abuse is perpetrated by a family member or someone in a close relationship to the abused, may be higher dependent on the level of betrayal experienced by the victim (Brown & Finkelhor, 1986; De Bellis, 2001). In reviewing previous research Brown and Finkelhor (1986), cite four studies that indicate the level of trauma is more severe when a father or stepfather are the perpetrators of the abuse. Along with relationship to the perpetrator the type of sexual activity, physical contact or penetration, also dictates the level of trauma and negative outcomes (Brown & Finkelhor, 1986; Mennen, 1995; Draucker & Mazurczyk, 2013). Russell (1986) found 59% of adult women reported extreme trauma in cases where oral, vaginal and/or anal intercourse were attempted or completed.

In their study of the relationship between race/ethnicity and symptom severity Mennen (1995) found when penetration was involved Latina girls had significantly higher outcomes on measures of lack of self-worth, anxiety and depression than Latina girls whose abuse did not

involve penetration. Results from the "other" group which included Asian-American and other races, showed a similar direction to the Latina group when penetration was involved but did not have enough participants in this group to allow comparison (Mennen, 1995). From their study of research Brown and Finkelhor (1986), found that numerous studies agree that the more intimate the contact the greater the trauma. Empirical research has determined there is a higher rate of trauma in cases where force was used during sexual abuse than abuse where force was not used (Brown & Finkelhor, 1986).

Initial Effects

Some initial effects of CSA include a sense of estrangement, feeling numb, trouble sleeping, and nightmares (Finkelhor, 1990; Kendall-Tackett, 2002). Children who live in unstable or unsafe homes learn to adapt and form coping strategies to keep themselves safe (The National Child Traumatic Stress Network, 2018a; Somer, 2000). They can become hypervigilant and remain acutely aware of the emotional state of the adults in their lives (The National Child Traumatic Stress Network, 2018a). This hypervigilance is in response to physical or emotional threats these children may live with on a daily basis. In response to the presence of threatened harm children may hide their own emotions as a coping mechanism intend to keep themselves safe from ongoing abuse (The National Child Traumatic Stress Network, 2018a; Somer, 2000). These attenuated feelings are dissociative defenses victims acquire in an attempt to avoid the overwhelming fear and pain (Finkelhor, 1990; Somer, 2000; Karakurt & Silver, 2014). Some victims of childhood abuse respond with hypervigilant behavior while others respond by repressing awareness of environmental risks which puts them at higher risk of revictimization (Eli, 2000; Perry, 2005). These accommodations can result in long-term sequelae reaching far into later life (Eli, 2000).

Several studies report age of abuse was an indicator of higher levels of perceived trauma (Browne & Finkelhor, 1986; Xu & Zheng, 2015). These studies found the younger a child is at onset of abuse the greater the vulnerability to trauma. Browne and Finkelhor (1986) reported on four other studies showing younger age at onset does not indicated higher levels of trauma. Browne and Finkelhor (1986), in spite of the conflicting research, conclude there is a trend in the data indicating younger age at onset does implicated higher levels of trauma but this single factor is affected by other environmental and individual factor that create a complex set of data that is not fully understood.

Another factor impacting the degree to which survivors experience trauma is how supported they feel by parents or primary caregivers (Godbout et al., 2014). A long-term study on the impact of parental support on future relationships of CSA survivors found when children perceived positive support from parents or primary caregiver these children had healthier interpersonal and intrapersonal adjustment (Kenny & McEachern, 2000; Godbout et al., 2014). They found that participants who perceived parents as unsupportive had more psychological distress and issues with abandonment anxiety (Godbout et al., 2014). From their findings Godbout et al. (2014), found support that survivors with unsupportive parents reinforce their child's view of themselves as being worthless and that attachment figures are not trustworthy resulting in concerns about abandonment in future relationships. Another finding was survivors whose parents intervened when the abuse was disclosed reported having higher levels of intimacy than even non-abused participants indicating parental involvement has a long-term impact on survivor's ability to sustain healthy intimate relationships (Godbout et al., 2014).

Preschool and Young children

Even in utero the environment in which the mother is subjected to can impact the fetus's brain development (Perry, 2005). In utero and in the first four years of life a child's developing brain is organized according to the environment it develops in (National Scientific Council on the Developing Child, 2004; Perry, 2005). Children raised in loving homes with responsive caregivers have normal brain development whereas chaotic and disorganized home life including maltreatment will create neural connections that reflect this disorganization (Perry, 2005; Center on the Developing Child, 2007). At this stage of development neural connections that have been fortified by repetitive use, such as repeated sexual abuse, will remain strong while others that have not been strengthened by repetition will be pruned (Perry, 2005). Early experiences influence how the brain is structured and are the building blocks for the child's abilities to form relationships, learning, and social capabilities throughout life (National Scientific Council on the Developing Child, 2004; Perry, 2005; Center on the Developing Child, 2007).

Child sexual abuse falls under the category of maltreatment and is an environmental risk factor that can affect a child's development (Center on the Developing Child, 2007; Scarborough, 2009). Data collection on developmental delays in preschool survivors is made difficult due to inconsistent definitions of CSA across agencies (Scarborough, 2009). A study conducted by Scarborough (2009) compiled data indicating maltreatment in early childhood creates an extremely high risk of developmental delay in preschool and school age children. The cortex, the area of the brain that has control over the memory, perceptual awareness, and consciousness, is found to be smaller in children who have suffered trauma (The National Child Traumatic Stress Network, 2018a). A smaller cortex could impact the child's IQ, emotion regulation capabilities and there is evidence that these children may lack the perception of safety particularly those without parental support (The National Child Traumatic Stress Network,

2018a). Trauma in early life effects the foundation of the developing brain, at the time these neural systems are being created, causing these systems to be more vulnerable to future mental health problems (National Scientific Council on the Developing Child, 2004; Dunn et al., 2013; Gaskill & Perry, 2014).

Many factors play a role in the development of the brain therefore the effects of trauma are dependent on environmental factors, timing of trauma in the developmental cycle, genetics and epigenetics (Gaskill & Perry, 2014). When a maltreated child is exposed to chaotic, new or threatening experiences there is a shift in the brain activation and the upper regions shut down leaving the lower underdeveloped primal areas to respond to the activating event (Gaskill & Perry, 2014). These areas of the brain are often underdeveloped therefore these children will respond in a disorganized and impulsive manner (Gaskill & Perry, 2014). With the upper regions inaccessible children are unable to access the region of the brain that warns them of consequences or allows them to think and process information, even information previously well known to the child, in an effective way (Gaskill & Perry, 2014). These children have an understandably negative impact in school and social settings (National Scientific Council on the Developing Child, 2004; Gaskill & Perry, 2014).

The National Child Traumatic Stress Network (2018b), indicate that a young child's perception of a traumatic event may cause misconceptions that lead to a greater impact of that trauma for the child. Children under the age of two may "demonstrate poor verbal skills, exhibit memory problems, scream or cry excessively, or have poor appetite, low weight, or digestive problems" (The National Child Traumatic Stress Network, 2018b, p. 2). According to The National Child Traumatic Stress Network (2018b, p. 2) some of the effect of trauma children ages three to six may experience are:

> Difficulties focusing or learning in school, develop learning disabilities, show poor skill development, act out in social situations, imitate the abusive/traumatic event, be verbally abusive, be unable to trust others or make friends, believe they are to blame for the traumatic event, lack self-confidence, experience stomach aches or headaches.

Caring and positive caregivers who provide a stable and safe environment will help build resilience in these children (The National Child Traumatic Stress Network, 2018b).

The development of emotion regulation occurs in early childhood and when these young children are the victims of sexual abuse it often results in behavior problems for preschooler and school age children (Yancey et al., 2011; Langevin et al., 2015). Early sexual abuse can result in deficits or dysfunctions of emotional regulation, anxiety, post traumatic symptoms, mood disorders and other mental health disorders (Gross, 2013). Emotion regulation is defined by Thompson (1994, pp. 27-28) as: “the extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions, especially their intensive and temporal features, to accomplish one’s goals”. Boys who were victims of maltreatment were more likely to have less emotion regulation according to parental report than girls (Langevin et al., 2015).

Adolescents

Survivors of CSA report a higher rate of adolescent pregnancies than non-sexually abused adolescents (Finkelhor, 1986; Homma et al., 2012). In one study reported on by Finkelhor (1986) adolescent pregnancy occurred in 11% of reported cases of father to daughter incest, another study reported 1 in 47 incidents of parental incest resulting in pregnancy. Sexual abuse in either childhood or adolescence increases the likelihood of risky sexual behaviors (Homma et al., 2012). Among these are early pregnancy, multiple sexual partners and

unprotected sex (Mennen, 1995; Homma et al., 2012). A study conducted by Homma et al. (2012) found male survivors of sexual abuse had increased incidents of being involved in early pregnancy, unprotected sex and multiple sexual partners. Mennen (1995) found females engaged in risky sexual behaviors and had a higher incidence of STI's than males and African American females had the highest rate of STI's of all the racial groups studies.

In addition to an increase in risky sexual behaviors researchers of a longitudinal study with 813 maltreated or at-risk youth found participants with a history of CSA reported higher incidents of delinquency and violent behavior (Kozak et al. 2017). Kozak et al. (2017) report both male and female survivors of CSA were more susceptible to these behaviors than non-sexually abused children, females were 52 times less likely to have these behaviors than their male counterparts. Demographics of survivors of CSA who report delinquency and violent behaviors showed black respondents reported the highest rate of CSA at 3.2%, whites reported 2.2%, while mixed-race results were just over 1% and Hispanic results just under 1% (Kozak et al., 2017). These findings indicate almost two times higher incident rate of delinquency and violence for survivors of CSA (Kozak et al., 2017).

Effects

When a child is sexually abused by a trusted family member this early stressor can increase the child's vulnerability to depression in adulthood (Bowlby, 1973; Mennen, 1995; Karakurt & Silver, 2014). A longitudinal study conducted by Dunn et al. (2013) found that age and type of abuse affects a victim's susceptibility to later depression and suicidal ideation (Dunn et al., 2013). This longitudinal study of 15,701 participants found any type of abuse at any age resulted in a greater number of participants experiencing depression and/or suicidal ideation in young adulthood over non-maltreated participants (Dunn et al., 2013). Those exposed to

maltreatment at the preschool age had the highest rates of depression and those exposed to sexual abuse during early childhood experienced 146% increase in odds of suicidal ideation over those exposed in adolescents (Dunn et al., 2013). Exposure to maltreatment at an early age, during the brains developmental period, may impact the child's ability to self-regulate emotions, stress responses and arousal response (Dunn et al., 2013).

Emotional Reactions and Self-perception

The initial effects of CSA have a broad impact on its victims in areas that include emotional reactions; interpersonal relationships; social functioning; sexuality; self-perception; and physical or somatic symptoms (Brown & Finkelhor, 1986; Briere, 1992; Putnam, 2003; Krienert & Walsh, 2011; Dunn et al., 2013; Karakurt & Silver, 2014). In an attempt to compile a list of symptoms differentiating abuse and neglect Augusti et al. (2017), found that abused children exhibited more externalizing symptoms than neglected children and had more enhanced psychological problems. Olafson (2011) found symptoms of shame, stigmatization and sexualized behaviors were only found in CSA survivors. Studies have found abuse-specific shame, blame, guilt and a sense of responsibility for the abuse may create a sense of stigmatization in some survivors (Brown & Finkelhor, 1986; Homma et al., 2012; Karakurt & Silver, 2014).

Studies reported shame, guilt, boundary violation and feelings of powerlessness, feelings of inferiority, lack of worth, betrayal, anxiety, depression, fear, anger, sleep problems, distractibility and hostility were among the initial reactions of children who have been sexually abused (Finkelhor, 1979; Brown & Finkelhor, 1986; Karakurt & Silver, 2014; Kozak et al., 2017). The data examined by Finkelhor (1986) showed 13% of four to six-year olds manifested severe fears and had scores higher than the norms on both aggression and antisocial behavior.

The seven to thirteen-year age group reported severe fears in 45% and 45%-50% showed elevated levels of aggression and antisocial behaviors with 35% of those displaying outward aggression (Finkelhor, 1986). Betrayal was also associated with both internalized and externalized problems with depression being the most common internalized result of CSA (Karakurt & Silver, 2014).

A sense of powerlessness can ensue when a child lives in the same home and is unable to escape continued contact with the perpetrator or when a child who is smaller than the perpetrator, attempts to stop the assault but fails (Finkelhor 1990; Karakurt & Silver, 2014). This sense of powerlessness can result in acute or chronic dissociation, memory loss due to dissociative amnesia, negative beliefs about self, fear, horror, guilt, or PTSD (International Society for the Prevention of Child Abuse and Neglect, 1988; APA, 2013). The American Psychiatric Associations (APA) Diagnostic and Statistical Manual 5 (2013), indicate symptoms of PTSD can include intrusive recurrences of distressing memories, distressing dreams, flashbacks, intense or prolonged psychological distress or marked psychological reactions from internal or external cues.

Interpersonal Relationships/Sexuality

According to Bowlby (1973) and Karakurt & Silver, (2014) a healthy bond between caregiver and infant are imperative for the healthy development of the child. This bond is the foundation which future relationships are built upon and prescribe how the child sees themselves as worthy of love (Bowlby, 1973; Karakurt & Silver, 2014). When survivors of sexual abuse experience an unhealthy attachment to their primary caregiver, as the result of the sexual abuse or otherwise, they have a greater likelihood of entering into a marriage filled with conflict (Godbout et al., 2009; Karakurt & Silver, 2014). This is due to the child having been exposed to

a defective relationship model in childhood (Karakurt & Silver, 2014). The insecure attachment in relationships of childhood can manifest later in life as maladaptive emotions such as jealousy and anxiety in adult relationships (Godbout et al., 2009; Karakurt & Silver, 2014).

In a healthy relationship with a caring adult and developmentally appropriate experiences the infant/young child's brain develops normally and the child is able to form friendships, later intimate relationships and grow to be a well-functioning contributor to society (Perry, 2005; Center on the Developing Child, 2007). Without these healthy aspects of childhood where severe and prolonged adversity exist the brain will not develop normally and will impact the child's ability in future relationships and social engagement (National Scientific Council on the Developing Child, 2004; Perry, 2005; Center on the Developing Child, 2007; Godbout et al., 2009).

Humans are social creatures and need connectedness to sustain well-being (Kendall-Tackett, 2002). Lack of social connectedness has been linked to poor participation in health promoting activities resulting in poorer health, homelessness, and revictimization for both men and women (Kendall-Tackett, 2002). Abuse impairs the survivor's ability to establish and maintain relationships and effects the survivor's relational style (Kendall-Tackett, 2002).

A host of symptoms are associated with survivors of CSA in interpersonal and sexual relationships (Rellini & Meston, 2011). Among the many long-term symptoms of CSA are risky sexual behaviors (Kendall-Tackett, 2002). Female survivors have a greater instance of STDs, younger age at first consensual sexual experience, teen pregnancy and multiple sexual partners than non-abused women (Kendall-Tackett, 2002; Fix et al. 2019). A study looking at the intersectionality of CSA, sexually transmitted infections (STI) and race/ethnicity also found

females were at higher risk and in particular black female survivors of CSA were at higher risk than black males and whites for STI's (Fix et al., 2019).

Both men and women have reported feeling like damaged goods after surviving CSA and this sense of being damaged creates emotional anxiety and shame around the idea of being sexually normal (Hall, 2008). A study conducted by Rellini (2011) found women who had a negative sexual self-schema reported negative affect prior to sexual stimuli and lower satisfaction in their sexual experiences. Rellini (2011), also found negative affect prior to sexual encounters resulted in lower sexual arousal.

Sexual dysfunction is a common complaint of CSA survivors with orgasm dysfunction the most common (Brown & Finkelhor, 1986; Staples et al., 2012). A predictor for low orgasm functioning in female survivors of CSA are avoidance of interpersonal closeness and emotional involvement (Staples et al., 2012). A study conducted by Staples et al., (2012) found female survivor of sexual abuse with avoidance tendencies had lower orgasm functioning. These women use distraction, dissociation, substance abuse and abstinence as coping strategies to avoid sexual experiences in adulthood (Staples et al., 2012). Staples et al. (2012) also noted other studies found hypersexuality in survivors of CSA which often lead to risky sexual behaviors.

Social Functioning

A twin study conducted in 2000 found women likely to report social phobia as a long-term symptom of CSA, however, male survivors did not report the same symptom (Dinwiddie et al., 2000). Healthy social functioning involves reciprocal social connections, unfortunately for survivors of childhood maltreatment the ability to build and maintain relationships is negatively impacted by past abuse (Kendall-Tackett, 2002). Studies have found abuse survivors adopt one of two modes of interpersonal interaction styles (Kendall-Tackett, 2002). An avoidant relational

style involves lack of warm interaction with others, avoidance of close relationships, and having few friends whereas the intrusive style has a high need for closeness to others, is marked by a lack of discernment in limiting self-disclosure and a high degree of clinginess (Kendall-Tackett, 2002). Both styles lead to socially unacceptable behavior resulting in negative consequences (Kendall-Tackett, 2002).

Other socially unacceptable behaviors are reported in a study researching the connection between CSA, delinquency and violent behavior (Kozak et al., 2017). Kozak et al. (2017) report both male and female survivors of CSA were more susceptible to violent or delinquent behaviors than non-sexually abused children. Based on racial grouping those reporting delinquent and violent behaviors found black respondents reported the highest rate of CSA at 3.2%, whites reported 2.2%, while mixed-race results just over 1% and Hispanic results just under 1% (Kozak et al., 2017).

Physical or Somatic Symptoms

When the sequelae of CSA go untreated in children the effects continue into adulthood (Eli, 2000) and children who survive maltreatment are more likely than non-maltreated children to engage in harmful behaviors and report a lack of good health in adulthood (Felitti et al., 1998; Kendall-Tackett, 2002). In an article in the 1992 Mayo Clinic Proceedings, Briere states 113 out of 500 women surveyed report being victims of CSA. The author referenced several earlier studies making connections between CSA and multiple physical complaints (Briere, 1992). The women surveyed reported higher incidents of medical conditions that include “pelvic pain, pelvic inflammatory disease, yeast infections, complications of pregnancy, breast disease, bladder infections and obesity” than the women who did not report CSA (Briere, 1992). The same women report utilizing higher health risk coping strategies consisting of early cigarette use,

alcohol use/abuse, earlier sexual activity, a greater number of sexual partners, adolescent pregnancies and avoidance of regular pap smears than women who did not report CSA in their history (Briere, 1992).

Long-Term Effects

There is a large body of empirical and clinical literature concluding there are long lasting psychological and physical effects of CSA (Finkelhor, 1990; Briere, 1992; Eli, 2000; Stoltenborgh, 2011). In a community sampling of 930 women Russell (1986), found the negative impact of CSA to be indicated in seventy-eight percent of women reporting they had been victims in their childhood. Hypervigilance can be found in the aged survivor of protracted childhood abuse (Eli, 2000). Eli (2000) reports survivors of abuse may intentionally deny engaging in self caring practices such as following recommended medical advice, seeking medical attention when needed, or self-harming practices due to the self-hatred many survivors exhibit (Kendall-Tackett, 2002). In the Dunn et al. (2013) study participants who were sexually abuse in early childhood had 146% higher likelihood than non-abused participants to experience suicidal ideations in young adulthood.

Men and women show very similar long-term problems without a significant difference between genders (Finkelhor, 1990; Karakurt & Silver, 2014). The slight differences indicated men experience a higher rate of externalizing symptoms such as the desire to hurt others, while women have a slightly higher rate of internalizing symptoms showing more depression than men (Finkelhor, 1990). Survivors of CSA have a higher likelihood of reporting depression and suicidal ideations in young adulthood than non-abused respondents (Dunn et al., 2013). In a twin study those who experienced CSA also reported major depression, suicidal ideations and suicidal

attempts (Dinwiddie et al., 2000). Other long-term diagnoses reported in this study were panic disorder, conduct disorder and alcoholism (Dinwiddie et al., 2000).

In their study of previous literature Draucker and Mazurczyk (2013) reviewed studies linking CSA to substance use/abuse and risky sexual behaviors in adolescents. In these studies, they found an association between CSA and adolescent alcohol: use/abuse; frequency, regular and/or current use and dependency (Draucker & Mazurczyk, 2013). They also found survivors of CSA had higher incidence of smoking beginning in adolescents with higher prevalence of nicotine dependence. Numerous studies indicate CSA and adolescent drug use were positively related (Draucker & Mazurczyk, 2013). From these studies Draucker and Mazurczyk (2013) concluded when penetration was involved the abuse was more frequent, correlated with revictimization and occurred in conjunction with other childhood maltreatment.

Interventions

The ability to self-regulate is developed through safe and nurturing attachments to caregivers during early childhood (Gaskill & Perry, 2014). When these attachments are broken due to maltreatment this acute and chronic stress has a negative impact on the neurobiological systems involved in the normal development of emotional/behavioral regulation (De Bellis, 2001; Perry & Dobson, 2013; Gaskill & Perry, 2014). The neural networks in the lower part of the brain region affect all areas of the brain and body (Gaskill & Perry, 2014). When there is maltreatment early in life the development of these systems is impacted, the dysregulation causes compromise throughout the system which can be evident cognitively, socially, emotionally, in motor functioning and in the stress response systems of these children (Bratton, et al., 2013; Gaskill & Perry, 2014). Play therapy addresses the needed avenues to reorganize and modulate these systems, then once moderately regulated, integration of traumatic experiencing and other

developmental growth can take place in this regulated state (Barfield, 2012; Gaskill & Perry, 2014). Because maltreatment in early childhood disrupts the brain's developmental processes repetitive somatosensory activities that are soothing, patterned, and administered in a relational atmosphere of acceptance and safety are required to rebuild these regulatory networks (Barfield et al., 2012; Gaskill & Perry, 2014).

Severely maltreated children can exhibit competencies at multiple age appropriate levels, for instance, a biological age of ten years, cognitive organization of a three-year old, self-regulation abilities of a two-year old and social skills of a five-year old (Perry & Dobson, 2013). Therefore, it will be necessary for the therapist to complete a thorough developmental history (Perry & Dobson, 2013). The best practice for this level of dysfunction is to create a neural brain map (the current functional organization of the brain), to provide sequential developmentally appropriate therapeutic interventions that will address the individual developmental needs of each child (Barfield et al., 2012; Perry & Dobson, 2013). According to Gaskill and Perry (2014) a severely dysregulated child will require a well-managed environment to provide control over developmentally inappropriate stimuli and to prevent over stimulation that could act as a trigger for aggression, tantrums and other frustrations for the child. There is no one size fits all for the proper therapeutic interventions of severely maltreated children but, many are appropriate when viewed through the lens of the child's neurobiology (Perry & Dobson, 2013; Gaskill & Perry, 2014).

This paper will now look at the effectiveness of several types of play therapy in treating survivors of CSA. Child-Centered Play Therapy is a non-directive child lead approach which emphasizes a firm belief in the innate nature of the child toward growth and self-directed healing based on Carl Rogers person centered therapy (Landreth, 2012; Bratton et al., 2013). "Child-

Centered Play Therapy is a complete therapeutic system, not just the application of a few rapport-building techniques" (Landreth, 1993, p. 19). Child-Centered Play Therapy utilizes toys and play as a means for children to express their internal, often nonverbal, emotional processing in a safe, non-judgmental and accepting therapeutic relationship (Bratton et al., 2013).

Children do not possess the verbal or cognitive abilities found in adults therefore developmental theorists view play as the means for children to gain experience across many developmental arenas (Gaskill & Perry, 2014). Children's verbal skills develop slowly over time therefore play therapy is an appropriate means of communication for verbal or non-verbal individuals (Landreth, 2012; Roesler, C. 2019), in addition studies show play therapy is efficacious regardless of the presenting problem and is a culturally-responsive intervention (Bratton et al., 2013; Gaskill & Perry, 2014; Roesler, 2019; Haas & Ray, 2020). Child-Centered Play Therapy is particularly culturally responsive because it is child led, utilizing their own cultural and ethnic perspective, therefore the clinician follows the child's lead and does not rely on their own cultural or ethnic background (Bratton et al., 2013; Lin & Bratton, 2015). Play therapy has been used for emotional maladjustment, anxiety, developmental disabilities, schizophrenia, alcohol and drug abuse, withdrawal, maladaptive school behaviors, multicultural issues and many other mental health issues (Bratton et al., 2013).

As addressed earlier many of the outcomes of maltreatment lead to displays of disruptive behavior (Perry, 2005; Barfield, 2012). In an effort to find an effective therapy to mitigate the potential negative trajectory of children with early childhood disruptive behaviors Bratton et al. (2013) conducted a randomized controlled study looking at the effectiveness of Child-Centered Play Therapy in preschool children. In this study Bratton et al., (2013) utilized the Head Start program with 54 at-risk preschool children from lower socioeconomic households including

several minority populations; 55% Hispanic, 19% African American, and 15% Caucasian. Common symptoms displayed by participants of this study were hyperactivity, conduct problems, impulsivity, aggression, attention problems and oppositional behaviors (Bratton et al., 2013). Results from the Bratton et al., (2013) study showed a significant reduction in disruptive behavior problems within 30-40 sessions in this study.

Barfield et al. (2012) conducted a study in a Head Start program using two to seven-year old children who had previously failed in the Head Start program. This was a similar study to Bratton et al., (2013) but it used Filial Therapy, which is Child-Centered Play Therapy taught to and executed by parents with their own children, the results showed a significant reduction in aggression, anxiety and depression (Barfield et al., 2012). Other studies utilizing Child-Centered Play Therapy showing significant improvement in children's behavior include a case study conducted by Haas and Ray (2020) involving two children with eight Adverse Childhood Experiences (ACE) each. They found that although each child progressed at their own rate both showed significant reduction in problematic and prosocial behaviors (Haas & Ray, 2020).

Another study conducted by Kot et al. (1998), found children who had witnessed domestic violence found a significant reduction in behavior problems and significant increase in the participants self-concept through the use of Child-Centered Play Therapy. Studies found Child-Centered Play Therapy has the potential to interrupt the long-term negative effects of trauma thereby mitigating the more severe impairment seen later in the lives of abuse survivors (Bratton et al., 2013; Haas & Ray, 2020).

A meta-analysis of 53 studies was conducted by Lin & Bratton (2015) to determine the overall effectiveness of Child-Centered Play Therapy. The findings of this meta-analysis clearly showed Child-Centered Play Therapy to a be a beneficial treatment especially for children

younger than eight years old (Lin & Bratton, 2015). Lin & Bratton's (2015) study also found clear evidence not only the age of the child but presenting issue, caregiver involvement, and ethnicity were important moderators of play therapy. They found Non-Caucasian participants showed a substantially greater improvement than Caucasians in this meta-analysis, however this study was not designed to determine the causality behind this finding (Lin & Bratton, 2015). They went on to show Child-Centered Play Therapy to be effective over all the presenting issues, but it showed greatest improvement in the child's self-esteem, stress within the child-caregiver relationship, and over a broad spectrum of behavioral issues (Lin & Bratton, 2015). Lin & Bratton (2015) concluded Child-Centered Play Therapy to be an effective and culturally responsive therapy for abused children.

It is important for counselors to be informed about the different cultural or ethnic populations in their area in order to be prepared to offer support when needed (Taylor & Thompson, 2018). This is true of the non-heterosexual and non-gender conforming cultures due to the lack of support for these children from their family, peers and the community at large, especially at school where they spend most of their time (Taylor & Thompson, 2018). CSA can have a lasting bearing on the individual's mental health (Byrd et al., 2021). Child-Centered Play Therapy, when correctly applied, has the power of being child affirming and has been found to be effective in the school setting (Bratton et al., 2013; Byrd et al., 2021). Because of its child led and child affirming methodology Child-Centered Play Therapy is a good choice when working with clients who are non-heterosexual and non-gender conforming (Bratton et al., 2013; Taylor & Thompson, 2018; Byrd et al., 2021). Another expressive therapy showing a significant decline in problematic behaviors and cultural diversity is sand tray therapy.

Sandtray therapy is an unstructured sensory experience where a client creates a world in a tray of sand by arranging and manipulating miniature toys to represent and resolve their internal struggles (Doyle & Magor-Blatch, 2017; Morin, 2021). The sand itself is therapeutic and facilitates the reflective expression of the client's inner world even when the client is unable to express it verbally (Ferreira et al., 2014; Doyle & Magor-Blatch, 2017; Roesler, 2019). Because sandtray therapy does not require verbalization for the client to process their inner world numerous studies have found it effective for children, adolescents, adults, immigrants, refugees, people with disabilities, and those on the autism spectrum (Doyle & Magor-Blatch, 2017; Roesler, 2019). Sand Tray Therapy is effective without involving language, it has the ability to cross cultures and is effective in a large age range because of this more countries are incorporating it into their practice (Roesler, 2019).

An overview of 17 effectiveness studies and 16 randomized control tests, from numerous countries concluded there was significant reduction in trauma symptoms with non-verbal participants and participant from other cultures (Roesler, 2019). Several aspects of Sand Tray Therapy make it a desirable therapeutic treatment with diverse cultures. Roesler (2019) credited the non-verbal cross-cultural aspect of Sand Tray Therapy to its growing popularity in countries like "Latin America (Brazil, Uruguay, Mexico) and Asia (Japan, China, Taiwan, Korea, Indonesia)" (p. 84). Another study contributing to the field of research was a qualitative study conducted by Doyle & Magor-Blatch (2017) involving an adult survivor of childhood sexual abuse. The participant reported a noticeable positive effect at the end of the study and there was a measurable improvement of her overall mental well-being (Doyle & Magor-Blatch, 2017). The participant credited self-expression without words to be a major contributor to her overall improvement (Doyle & Magor-Blatch, 2017). These studies showed Sand Tray Therapy is

effective with diverse cultures, non-verbal participants and many different age groups (Doyle & Magor-Blatch, 2017; Roesler, 2019).

Sand tray therapy can be used with children and adults and can be conducted in individual session or through a group experience with more than one client at a time (Flahive & Ray, 2007; Roesler, 2019; Jang & Kim, 2012; Tornero & Capella, 2017). Flahive & Ray (2007) conducted of group Sand Tray Therapy study with 56 preadolescent participants displaying behavior problems. Based on teacher ratings students in the experimental group (N=28) showed a significant improvement over the control group (N=28) on internal and external behaviors post Sand Tray Therapy (Flahive & Ray, 2007). Parents in this study reported significant decreases in external behaviors problems and the student's self-report showed no statistical significance (Flahive & Ray, 2007). Han et al. (2017) use a combination of individual and small group Sand Tray Therapy sessions with twenty 4-5-year-old children in Seoul, South Korea with severe external behavior problems. After sixteen sessions the experimental group (N=10) showed significant reduction in aggression and negative peer interaction in post-test scores as compared to the control group (N=10) who had no intervention (Han et al., 2017). These studies show Sand Tray therapy is effective throughout a diverse age range and over a vast array of diagnoses (Flahive & Ray, 2007; Roesler, 2019). Another similarity in these CSA survivors is found in the thinking patterns evident in themes played out in the sand tray (Flahive & Ray, 2007; Perry & Dobson, 2013; Gaskill & Perry, 2014; Tornero & Capella, 2017).

Studies conducted using sand tray therapy found the presence of similar disorganized and chaotic thinking in participants that was evident in the Child-Centered Play Therapy studies mentioned earlier in this paper (Flahive & Ray, 2007; Perry & Dobson, 2013; Gaskill & Perry, 2014; Tornero & Capella, 2017). Sand tray allows the participant to create a world in the sand

where they can act and reenact a mixture of reality and fantasy (Flahive & Ray, 2007; Tornero & Capella, 2017; Roesler, 2019). These worlds progress from scenes with suffering, fear and defenselessness to more positive scenes of collaboration, caring, and love (Flahive & Ray, 2007; Jang & Kim, 2012; Tornero & Capella, 2017). Several studies found themes relating to violence and disorganization at the onset of the study and as sand tray therapy progresses much more structured problem solving, self-actualization behaviors and safer environments emerge (Flahive & Ray, 2007; Jang & Kim, 2012; Tornero & Capella, 2017). The changes Flahive & Ray (2007) and Tornero & Capella (2017) found showed evidence of the integration of the thoughts and emotions from the abuse and the reassignment of new meaning to the trauma for these CSA survivors. Each of these studies show a reduction in internal problems and external behavior problems after sand tray therapy was conducted showing effectiveness of this therapy in preschool, adolescent and adult survivors of CSA (Flahive & Ray, 2007; Tornero & Capella, 2017; Roesler, 2019).

Conclusion and Discussion

Childhood sexual abuse creates many short and long-term difficulties for survivors (Kenny & McEachern, 2000; Dube et al., 2005; Stoltenborgh, et al., 2011; Xu & Zheng, 2015). These symptoms can be found in physical, cognitive, emotional, relational, sexual, and developmental areas in the life of the survivor (Brown & Finkelhor, 1986; Briere, 1992; National Scientific Council on the Developing Child, 2004; Perry, 2005; Center on the Developing Child, 2007; Krienert & Walsh, 2011; Dunn et al., 2013; Karakurt & Silver, 2014). Factors involving genetic, epigenetic, timing in the developmental cycle, and the child's environment come into play when looking at the effects of CSA and therefore no single set of criteria can be labeled as the exclusive symptoms of CSA (Finkelhor, 1979; Perry, 2005; Gaskill & Perry, 2014).

The data collected in this paper imply play therapy, in general terms, is very effective in relieving internal and external symptoms in CSA survivors (Flahive & Ray, 2007; Bratton et al., 2013; Gaskill & Perry, 2014; Roesler, 2019; Haas & Ray, 2020). Maltreatment effects the neural structuring of the brain which in turn effects the entire body and the brain's ability to organize itself (De Bellis, 2001; Perry, 2005). This data implies therapies applied through the lens of neurobiological development appear to be the most effective (Perry & Dobson, 2013; Gaskill & Perry, 2014). Evidence shows play therapies can be used from the youngest to the oldest survivors through the means of nondirective play and sandtray therapies (Ray et al., 2001; Flahive & Ray, 2007; Jang & Kim, 2012; Garrett, 2013; Han et al., 2017; Tornero & Capella, 2017; Roesler, 2019) .

Numerous theoretical perspectives using play therapy have been studied but this paper focused on Child-Centered Play Therapy and Sand Tray therapy. These studies found varying degrees of improvement and most show promise in alleviating the short and long-term health and emotional effects of childhood sexual abuse ((Flahive & Ray, 2007; Bratton et al., 2013; Gaskill & Perry, 2014; Roesler, 2019; Haas & Ray, 2020). Studies with participants as young as preschool age showed significant improvement in externalizing behaviors using play therapy methods (Flahive & Ray, 2007; Han et al, 2107; Haas & Ray, 2020). Perry found mapping the neural development of abused children aided in targeting specific individual areas of difficulty giving clinicians a road map to creating an effective treatment plan (Barfield et al., 2012). This brain mapping can be utilized with many therapeutic treatments which when coupled with repetitive appropriate developmental experiences can result in a more successful treatment modality (Barfield et al., 2012; Gaskill & Perry, 2014).

This paper has compiled a list, though not exhaustive, of many short and long-term effects of sexual abuse in childhood in an effort to aide and guide clinicians in diagnosing and treating survivors of CSA. Treatment planning for survivors of CSA can be made more effective when addressed through the lens of the neurobiological developmental states (Gaskill & Perry, 2014). Measuring the strengths and deficiencies of the child or adolescent survivor should guide the clinician's treatment planning and modality to be most effective for the child and family on an individual basis (Gaskill & Perry, 2014). Despite the final diagnosis clinicians make for the survivor of CSA, this paper has demonstrated the effectiveness of Child-Centered Play Therapy and Sand Tray Therapy in mitigating the host of symptoms found in sexual abuse survivors (Kot et al., 1998; Barfield et al., 2012; Bratton et al., 2013; Lin & Bratton, 2015; Haas & Ray, 2020).

Limitations and implications

A limitation of this data is in the use of qualitative research which is always subject to the researcher's biases either putting in or leaving out information of their choosing. This can result in biased data. Because some of the data used in this paper was collected via case studies of one, two and ten participants this data is not generalizable to the general public, other cultures, ethnicities etc. However, the information obtained from this research adds to the knowledge base and offers points of interest to spark further research through quantitative studies. Some of the other studies used to contribute to this paper utilized small sample sizes. Even though the sample sizes were small many of the studies were similar in size and results. Another limitation of these findings is the limited duration of some of the studies which only provides a snapshot in time of the data being collected therefore longitudinal studies would impact the knowledge base even more.

Because this paper used a narrow lens of theoretical data other researchers may find more robust results using other theoretical perspectives. In spite of these limitations this paper has compiled data from a diverse collection of research using a combination of qualitative and quantitative studies and meta-analyses to validate the findings of the benefits of Child-Centered Play Therapy and Sand Tray Therapy. A limitation specific to sand tray therapies is the required supplies of miniatures and sand trays the therapist must acquire in order to practice Sand Tray Therapy. The cost involved in collecting enough objects to allow the self-expression of the client could be a drawback for some clinicians.

Further Study

Further study should be conducted using other major theoretical perspectives with play therapy to gain a broader perspective of the versatility and effectiveness that can reached using expressive art therapies. Continuing studies in other theoretical perspectives using a quantitative method to ascertain the effectiveness of play therapy and sandtray therapy in older and elderly survivors of CSA would broaden understanding in this area. Additional studies of the effectiveness of these play therapies in other cultures would be a worthwhile venture for future researchers to conduct with these and other theoretical perspectives utilizing play therapy and sand tray therapy. Future quantitative studies would benefit our understanding of the effectiveness of play therapy and sandtray therapy in children and adult survivors of childhood sexual abuse.

Several studies researching the impact of race/ethnicity and correlations to CSA have addressed the inconsistencies in previous data and have called for more accuracy in describing ethnic groups (Mennen, 1995; Draucker & Mazurczyk, 2013). Culture determines a large portion of how survivors of CSA view their experience therefore race/ethnicity, which contribute much

to defining a culture's values, needs to be addressed to a greater degree in future studies to help inform clinicians on the kinds of symptoms likely to develop in their clients from diverse races and ethnic backgrounds (Mennen, 1995; Draucker & Mazurczyk, 2013).

Applications to Clinical Mental Health Counseling

Understanding of the basics of neurological effects of maltreatment on young children's developing brains gives cause for therapists to consider the therapeutic modality that will best help reorganize the stress systems of their clients. Using this lens to guide treatment planning that incorporates rhythmic, patterned somatosensory, activities in an accepting, empathetic therapeutic relationship with a safe and compassionate clinician will offer significant intervention to the long lasting impact of trauma for sexual abuse survivors.

The ACE study indicates that the coping strategies enlisted by survivors of adverse childhood experiences (i.e. smoking, sexual relations, overeating, drugs or alcohol use/abuse), are used to give immediate relief of the negative effects of these experiences. As clinicians we are able to use this information to provide psychoeducation and other interventions to help our clients prevent long-term negative health consequences (Felitti et al., 1998). Helping clients understand the neurobiology behind many of their presenting problems may help alleviate some of their negative self-concept and offer hope to adult survivors who have not experienced successful intervention previously.

For those working with young children Langevin et al., (2015), showed helping children attain or maintain emotion regulation will mitigate the behavior problems and foster resilience in preschool survivors of sexual abuse. These children will benefit greatly from counselors who use psychoeducation to teach emotion regulation skills in an effort to prevent long-term negative effects (Langevin et al., 2015). They will be further helped when the counselor models these

skills by showing the client how to use them and then applying them via practice in session (Langevin et al., 2015).

When working with children it is important for the counselor to understand the impact abuse has on the entire family. When children are blamed for the abuse or suffer from a lack of parental/caregiver support studies have found these children are at greater risk of being re-victimized than children who are believed and have supportive caregivers (Karakurt & Silver, 2014). In order to build resilience in children counselors may need to provide skills to parents teaching them how to connect and co-regulate with their children. This would involve teaching parents to use their regulated emotions to help the child learn to stabilize and regulate their own. Parents who are emotionally distraught are not able to help their child regulate their own emotions therefore helping the parents learn emotion regulation will benefit the parent child relationship which in turn helps to build resilience in the child (Tal et al., 2018). Tal et al. (2018) conducted a study on the effectiveness of Child-Parent Relationship therapy with survivors of extra-familial sexual abuse. This therapeutic model teaches parents non-directive play therapy techniques that build and strengthen the parent child relationship (Tal et al., 2018). This model also addresses the parental trauma which provides the parents the ability to be more emotionally available for their child which strengthens the child's ability to cope (Tal et al., 2018).

Therefore, working to help parents stabilize their emotional states will empower the parent to be more available emotionally for their child which in turn will help build resilience (Tal et al., 2018). The therapist will need to support the caregivers through psychoeducation, modeling and practicing skills to create a caring and positive atmosphere for the child. These positive and reinforcing attitudes from the parent/caregiver and other family members will aid in the mediation of long-term negative effects of the sexual abuse (Karakurt & Silver, 2014).

High risk sexual behaviors, delinquency and violence are some of the results of maladaptive coping strategies used by CSA survivors in adolescents (Homma et al., 2012; Kozak et al., 2017). Armed with this information clinicians can advocate for the education of judicial and law enforcement agents to increase their awareness of the root causes of these behaviors and help create alternative venues to incarceration (Kozak et al., 2017). Utilizing a trauma-informed-lens, clinicians can initiate programs to provide social support and mental health interventions in an effort to mitigate life-long negative effects (Kozak et al., 2017). Black male survivors of CSA have a higher rate of reporting delinquency and violence and as a marginalized group would benefit greatly from these types of interventions with the aim of preempting further victimization (Kozak et al., 2017).

In an effort to give back to their communities, clinicians can take this information to create community programs providing psychoeducation and prevention information to small community groups, new parent trainings, public community meetings or anywhere the clinician is able to make an impact. Psychoeducation, prevention and intervention are all areas clinicians are able to have an impact and improve their own communities while fulfilling their ethical obligations.

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