

Rethinking the Routine Provision of Psychotherapy to Children/Adolescents Labeled “Sexually Abused”

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Abstract

Whether symptomatic or asymptomatic, children labeled sexually abused are routinely offered treatment at considerable financial cost. One result of this is that mental health professionals are being charged with exploiting the problem of child sexual abuse (CSA). Is the routine provision of psychotherapy for children and adolescents labeled sexually abused warranted? In this paper, it is argued that the evidence indicates it is not warranted. Further, its provision is not in the best interests of either the children or mental health professionals. It is argued it is time to rethink the routine provision of psychotherapy to children and adolescents labeled sexually abuse. A number of recommendations are given which follow from the evidence.

Keywords: sexual abuse, child sexual abuse, therapy, trauma, children.

Introduction

Whether symptomatic or asymptomatic, children and adolescents labeled sexually abused are routinely provided psychotherapy. A 1986 nationwide survey of sexual abuse treatment programs found that in most settings nearly every child/adolescent labeled sexually abused was put in treatment (Beutler, Williams & Zetzer, 1994; Macdonald, Higgins, & Ramchandani, 2006). Finkelhor and Berliner (1995) estimated that among substantiated cases of child sexual abuse (CSA) up to 73 percent receive treatment. A 1996 report of the National Institute of Justice (NIJ) indicated that up to 50 percent of the victims of CSA receive treatment (Miller, Cohen & Wiersema, 1996). This compares with the no more than 4 percent of victims of other crimes.

It is, then, common practice to place children and adolescents labeled sexually abused in therapy regardless of whether or not they evidence symptoms.

A. A Lucrative Form of Practice

Providing psychotherapy is quite lucrative. According to the NIJ, the average cost of mental health services for the typical victim of CSA was nearly sixty times greater than that for the victim of another crime (\$5,800 vs. less than \$100).

In the now infamous Manhattan Beach case, also identified as the McMartin day-care case, the Children’s Institute International interviewed about 400 children from late 1983 through 1984. It received \$455 for each of the interviews (Nathan & Snedeker, 1995, p. 83). Moreover, the California Victims of Crime Fund will have paid at least \$200,000 to a handful of therapists for therapy for the accusers of Dale Akiki (Cantlupe & Hasemeyer, 1994). This occurred despite the fact that experts had testified at trial that the interviews of the children by these very same therapists were experimental, unproven, and had contaminated the children’s statements. Akiki was acquitted. He had spent two and a half years in prison prior to trial.

One can add to this the cost of treating adults who “recalled” abuse during treatment through the “recovered memory therapies.” In Washington State’s Crime Victims Compensation Program, the average cost associated with treating adults whose claims were based on repressed memory (RM) of

childhood sexual abuse was approximately four times the average cost of other mental health claims (Loftus, 1997; Parr, 1996). The average cost of non-RM claims was less than \$3,000. The average cost of RM claims was more than \$12,000. In just more than four years, the citizens of Washington paid out to mental health professionals more than 2.5 million dollars for 325 RM claims.

The recent child abuse scandal in the Catholic Church has proven to be a multimillion dollar bonanza for therapists. Alleged victim treatment costs were at least thirty million dollars (Terry, 2004, Table 6.1.1, p. 105).

Thus, providing psychotherapy to children and adolescents labeled sexually abuse is a lucrative form of practice for mental health professionals.

B. Exploitation by the Mental Health Industry or “The Abuse of Abuse”

As a consequence, critics, both professional and lay, have charged mental health professionals with exploiting the problem of CSA. They are charged with creating an artificial need for their services. This serves their interests but not the interests of service recipients. For example, social workers Costin, Karger, and Stoesz (1996) wrote:

the rediscovery of child abuse by the middle class has also led to the growth of a child abuse industry composed of opportunistic psychotherapists and aggressive attorneys who have prospered from child sexual abuse, exploiting adults who have evidence of having been abused and encouraging memory recall from those who haven't. . . . Unfortunately, one of the causalities of this new industry has been adult victims, who risk being victimized . . . by a child abuse industry seeking out new forms of economic growth (p. 7).

Of E. Sue Blume's assertion that 38 percent of women were molested as children, these authors wrote:

This translates into a potential client pool of close to fifty million women. If even 10 percent of those women were to receive sexual abuse therapy, it would be an economic bonanza for the mental health industry (p. 28).

Clinical psychologist Tana Dineen (2000) referred to sexual abuse as a “growth industry” (p. 160). She asserted that the expansion of what she refers to as the psychology industry had necessitated the creation of new “victims.” Through a process of psychologizing, pathologizing, and generalizing, the psychology industry fabricates victims. This “victim making” is nothing more than “user making” to meet the needs of the growing numbers of service providers (pp. 41-42).

Costin and her colleagues made a similar charge:

In the psychotherapy industry, the technological engine for the development of new products is the disease model, which can transform a range of personal problems into diseases, complete with a proven cure. One production factor common to virtually every commercial enterprise is the stimulation of demand for its product. For this, the psychotherapy industry has only to rely on the media, public agencies, and children's advocacy organizations to aggressively promote awareness of the child abuse problem. The success of these organizations in stimulating demand will ensure the financial success of the psychotherapy industry in providing treatment for sexual abuse (p. 28).

Social psychologist Carol Tavris (1993) also charged the mental health field with creating a demand for its services. In her review of survivor books, she wrote that the problem with these books

was “their effort to *create* victims – to expand the market that can then be treated with therapy and self-help books” (p. 16).

A similar stance is taken by the journalist, essayist, and author Judith Levine (1996; 2002). She posits that mental health professionals are pathologizing *normative* children’s sexuality to promote a new scare, namely, children who molest. They require, they argue, “sex-offense specific” therapy. The mental health professionals have garnered considerable monies from therapy, training tapes and workshops, and research.

The foregoing is an aspect of the trend toward medicalizing and pathologizing the normal. This is a central tenet to what Sommers and Satel (2005) have recently referred to as the doctrine of “therapism.” Among its assumptions is that vulnerability and not strength characterizes the American psyche. As a consequence, the “public requires an array of therapists, self-esteem educators, grief counselors, workshopers, healers, and traumatologists to lead it through the trials of everyday life” (p. 5). Children are especially targeted for therapeutic intervention.

The historian Philip Jenkins (1996) asserted that therapists have a vested interest in the current clergy-abuse problem. The public had developed considerable skepticism about therapists and their role in uncovering child sexual abuse. Indeed, “therapists were being portrayed as a social problem in their own right” (p. 146). But this has been changed by the clergy abuse scandal which has benefited therapists financially and in terms of enhancing their status and reputation. Jenkins wrote that:

for a profession accused of inventing abuse or else exaggerating trivial incidents out of all proportion, it was invaluable to find in clergy abuse a type of offense concerning which the earlier orthodoxies remained unchallenged and expert pronouncements retained public respect (pp. 139-140).

This is an interesting turn of events since it was mental health professionals who had misled the bishops into believing that pedophile priests could be “cured” of their affliction (National Review Board for the Protection of Children and Young People, 2004, pp. 112-119; Sommers & Satel, 2005, pp. 79-88).

A number of professionals of various persuasions, then, have accused members of the mental health industry with exploiting the problem of CSA for their own gain. They asserted as well that this does not serve the interests of those served nor, in reality, does it serve the interest of the professionals themselves.

The latter can be further seen in the fact that mental health professionals have been lampooned by cartoonists. For example, in 1993 at the time of the false accusations against the late Joseph Cardinal Bernardin, a syndicated cartoon from the *Philadelphia Daily News* showed a client at the office of Dr. Vic Timm. The doctor’s price list indicates rates for the remembering of various types of sexual abuse. The “memory of abuse by a priest” is the most expensive, \$30,000 (in Freyd & Goldstein, 1998, p. 95).

In a 1997 cartoon, a mental health professional and woman are talking at a cocktail party. She asks, “How’s the ‘shrink’ business?” He responds that it is great as he is treating a patient with a dual personality. He remarks this is a special case as “they both pay” (in Freyd & Goldstein, 1998, p. 96).

Following the Bernardin case, one series of the syndicated cartoon strip *Doonesbury* had a character undergoing hypnosis. He is being led by the therapist, Dr. Dan Asher, to change innocent statements into terrifying accounts of homicidal and abusive parents (1994).

C. Thesis

In this paper it is argued that the routine provision of treatment to those children and adolescents labeled sexually abused should be discontinued. First, the routine provision of treatment is not in the best interests of either these children or mental health professionals. Second and more importantly, it is not warranted by the evidence. A review of the literature indicates that:

- 1) a case which is identified as substantiated does not mean that sexual abuse has in fact occurred;
- 2) there is a failure to differentiate between coercive and non coercive sexual events;
- 3) psychological harm is the exception rather than the rule and, when present, may be due to factors other than the sexual event(s);
- 4) treatment has not been found to be effective.

I. THE ISSUE OF SUBSTANTIATION

That a case has been identified as “substantiated,” or in the instance of a criminal case, an obtained guilty conviction does not mean that sexual abuse has occurred. For example, there are innumerable instances involving day-care cases where convictions have been overturned. These include Little Rascals, Edenton, SC; Grant Snowden, Miami, FL; Wee Care Nursery School, Maplewood, NJ to mention but a few (Ceci & Bruck, 1995; Nathan & Snedeker, 1995; Victor, 1993).

There are many other instances where the conviction has not been overturned, but where the accused person was innocent. Thus, the San Diego Grand Jury’s (SDGJ) (1992, June 29) investigation of that county’s child protective system found that prosecutors in CSA cases relied on the likelihood that a charge would bring about a plea to a lesser offense. The SDGJ reported that “numerous defense attorneys testified that they allow and even encourage their clients to plea to a minor charge even when they are certain of their client’s innocence in order to facilitate the reunification of the family and to avoid a trial” (p. 12).

Some Child Protective Service (CPS) workers are known to have committed perjury to gain convictions. The SDGJ (1992, Feb.) reported that “attorneys, psychologists, and parents have all testified that some social workers lie routinely, even when under oath in court. There are numerous instances in which social workers ignore or disobey court orders” (p. 21). Additionally, Lorandos (1995) documented social workers withholding or falsifying evidence in court proceedings in order to secure a judgment they deemed “in the best interests of the child.”

There is also the problem of self-proclaimed experts. As an example, Nathan and Snedeker (1995) describe how Dr. Bruce Woodling, a California family physician, promoted the “anal wink test” to determine if a child had been sexually abused. He claimed that if a child’s anus dilated and closed spontaneously, it indicated repeated sodomy. He also pioneered the use of the coloscope which took magnified photos of the genital area. According to Woodling and his followers, the coloscope could show genital, most especially hymenal, aberrations from the norm. In 1988, Dr. John McCann’s studies revealed that non abused children exhibited anal winking and hymenal irregularities, leading to the demise of Woodling’s widely accepted theories. But these theories led to incorrect findings of guilt in an unknown number of cases.

The number of cases erroneously identified as substantiated is not known. But it can be assumed to be substantial. Why might this be so? First, a 1996 NIJ report on the use of DNA evidence to establish innocence after trial suggested that up to 25 percent of those convicted of sex crimes, including sexual

abuse, were innocent (Connors, Lundregan, Miller, & McEwen, 1996). As a result, some have called for reexamining sex crime convictions (Churchill, 2000, Sept. 3). In Wenatchee, WA, where all convictions had been overturned, Innocence Project lawyers called for the appointment of a state commission to reinvestigate all CSA cases in the state to ensure that further injustices were not committed (Maher, 2000, Oct. 29).

Second, there is the question of the competence of CPS workers. The SDGJ (1992, Feb.) reported that “in too many cases, Child Protection Services cannot distinguish real abuse from fabrication, abuse from neglect, and neglect from poverty or cultural differences” (p. 4).

Additionally, many CPS workers are “validators” (Dineen, 2000; Gardner, 1991). Validators are not impartial investigators. Rather, acting as child advocates, they assume that all allegations are true. They use only the evidence that supports the allegation. They ignore or even suppress evidence that does not support their prior beliefs (Bruck & Ceci, 1999). Dineen (2000) concluded that “while validators claim to identify victims, they are, in fact, manufacturing victims: both fabricated abuse victims and victims of false allegations. . . . the psychologists . . . have a vested interest in inflating the numbers” (p. 160). She asserts that they are motivated by both power and profit (p. 17).

A shocking example of validating is provided by the Alicia Wade case (SDGJ, 1992, June 23). This brought about a grand jury investigation of the San Diego child protection system. It involved an eight-year-old who was removed from her home, brutally raped, and sodomized. Two and half years after this event, her family requested assistance from the SDGJ to stop a pending termination of parental rights.

The father had been accused of molesting his daughter, Alicia. The mother had been repeatedly told that the only chance to reunite with Alicia was to say she believed her husband was guilty of raping their daughter. As a result of his wife’s and attorney’s pressure and in response to the promise that his daughter would be returned home almost immediately, the father falsely pled guilty to neglect. The promised return of Alicia did not occur.

Alicia had consistently and insistently denied that her father raped her. She described someone entering her bedroom and taking her to a nearby field, raping her, and then returning her to her bed. Alicia was not believed. She was told she would not be allowed to see her parents until she came up with a more believable story. She was put into court ordered treatment with a therapist who believed the father was guilty. As a result of the therapist's brainwashing during more than thirteen months of twice weekly “therapy” sessions, Alicia finally “disclosed” that her father had raped her.

Following this, the district attorney prepared to bring the case to trial. It was then that semen on Alicia’s underpants was tested. It did not match her father’s DNA. As Alicia and her parents had previously maintained, she had been raped by a stranger. He was a serial rapist who had raped another child using the same method. Appallingly, the therapist, the district attorney, the child abuse detectives, and the CPS workers not only knew about the earlier case but failed to disclose it to the defense. They continued to pursue terminating parental rights even after it had been proven that Mr. Wade could not have been the perpetrator.

More recently, U.S. District Judge Rebecca Pallmeyer found that the investigation process for allegations of child maltreatment against child care workers by the Illinois Department of Children and Family Services was unconstitutional (Dupuy, et al. v. McDonald, 2000). She commented:

something is seriously and obviously flawed in a system where 75% of those child care employees who appeal an indicated finding against them have such a finding overturned or voluntarily expunged by the State months, sometimes even years, later (p. 78)

She concluded that the investigations were one-sided. The investigators gathered only “inculpatory evidence” and disregarded evidence that favored the accused. Their decisions were based on little evidence. As a result many cases were wrongly identified as “indicated.” This unfairly led to the blacklisting of these child care workers who included day-care workers, foster parents, teachers and social workers.

Lastly, allegations of sexual abuse which are false can be the result of adult, including therapist, influence (Campbell, 1998; Ceci & Bruck, 1995; 1999; Loftus, 1994; Nathan & Snedeker, 1995; Poole & Lindsay, 2001). Children are wont to provide their adult interviewers with the type of information that they think the adult wants. When there is a reliance on coercive and manipulative interviewing techniques, play therapy, guided imagery, or the use of anatomically correct dolls – none of which have been proven effective – the result is often to provide the interviewer with what the interviewer expects to be the answer.

For example, Kyle Zirpolo (2005), a former McMartin preschool student, said his earlier accusations of sexual abuse at the school were lies. He describes how he was manipulated by the professional staff at the Children’s Institute International into making accusation of abuse:

I remember them asking extremely uncomfortable questions about whether Ray touched me and about all the teachers and what they did—and I remember telling them nothing happened to me. I remember them almost giggling and laughing, saying, “Oh, we know these things happened to you. Why don’t you just go ahead and tell us? Use these dolls if you’re scared.”

Anytime I would give them an answer that they didn’t like, they would ask me again and encourage me to give them the answer they were looking for. It was really obvious what they wanted. I know the types of language they used on me: things like I was smart, or I could help the other kids who were scared.

In short, a finding of guilt or substantiation does not necessarily mean that sexual abuse has in fact occurred. Professionals involved in protecting children will sometimes say that just because a case has not been substantiated does not mean that abuse has not occurred. But the contrary is at least equally true.

II. THE ISSUE OF PSYCHOLOGICAL HARM

A major assumption underlying the routine provision of treatment to those labeled “sexually abused” is that CSA usually results in conditions that require treatment (Beutler, Williams, & Zetzer, 1994). Seligman (1994) asserted that the mental health industry has described CSA as “a special destroyer of adult mental health” (p. 232). But he noted that the evidence supporting this contention is seriously methodologically flawed, a view shared by Pope (1997). Seligman also asserted that the research is typically ideologically driven and that “once the ideology is stripped away, we still remain ignorant about whether sexual abuse in childhood wreaks damage in adult life and, if so, how much” (p. 234).

Okami (1990) shares Seligman’s view that much of the research in the area of CSA has been ideologically driven. He asserted that adherents to the victimological paradigm have dominated the study of and response to child sexual abuse. This paradigm is based on the conviction that the child or adolescent is incapable of experiencing sexual desire or initiating sexual contact. According to Okami,

this “attributes participation in a peer sexual behavior to ‘curiosity’ and participation in adult/non-adult sexual behavior to ‘coercion’” (p. 93).

Even behavior that is self-reported as positive by the child or adolescent is defined by the victimologists as abusive. Okami described the victimological paradigm as reflecting a Victorian idealization of children as sexless innocents. This is politically correct in the current sociopolitical climate. It is, however, both historically incorrect (Bullough, 1990) and scientifically incorrect (Ceci, & Bruck, 1995; Friedrich, Fisher, Broughton, Houston, & Shafran, 1998).

The assumption that CSA is a “destroyer” of mental health has been based largely on studies involving clinical samples. But even these, when objectively considered, indicated that for the vast majority, CSA is not a “destroyer” of mental health at any age. For example, Constantine (1981) reviewed 30 studies. Twenty-one of the studies involved clinical or legal populations; nine, samples from the general population. Twenty of the studies reported that some subjects did not experience harm. In thirteen of these studies, the majority of the subjects did not experience harm. Six of the studies identified subjects for whom the experience was positive and beneficial.

He concluded that CSA does not lead to an inevitable negative outcome.

Similarly, Browne and Finkelhor (1986) reviewed 28 studies that involved either coerced sexual behavior or sexual behavior between a child and a much older person or a caretaker. Among adults who had experienced CSA less than 20 percent evidenced serious psychopathology. They observed that these findings should provide comfort to victims since severe long-term harm was not inevitable.

Browne and Finkelhor expressed concern over the efforts of child advocates to exaggerate the harmful effects for political purposes because of its potential to harm the victims and their families. They wrote that “advocates [should] not exaggerate . . . the intensity or inevitability of [negative] consequences . . . victims and their families . . . may be further victimized by exaggerated claims about the effects of sexual abuse” (p. 178).

Finkelhor, Hotaling, Lewis, & Smith (1989) later again warned against exaggerating the impact of CSA writing that it is necessary to temper discussions of the long-term effect of CSA with caution because “what has often been neglected . . . is that many victims do not suffer . . . impairments” (p. 395).

Kendall-Tackett, Williams, and Finkelhor (1993) reviewed 45 studies on the effects of CSA. Samples in these studies were drawn primarily from sexual abuse evaluation or treatment programs. Despite this, Kendall-Tackett and her colleagues found that up to 49 percent of the children in their study evidenced no psychological harm. They concluded that the absence of symptoms could not be used to rule out sexual abuse because “there are too many sexually abused children who are apparently asymptomatic” (p. 175). They reported that while some of these children become symptomatic, the vast majority remain symptom free. Among the symptomatic, they found that “the abatement of symptoms has been demonstrated in at least seven longitudinal studies covering children in all age groups” (p. 171). When sexually abused children in treatment were compared with the non abused children in treatment, the sexually abused were less symptomatic than their non abused clinical counterparts.

The use of clinical samples is problematic; namely, bias is inherent in them. Consequently, they do not constitute evidence that abuse gives rise to clinical disorders. Nor are they representative of the general population. Hence, the findings cannot be generalized to the general population.

When non clinical samples are used, the findings indicate that psychological harm is neither an inevitable nor a typical result of CSA. Kilpatrick (1992) conducted a study involving 501 non clinical,

middle class black and white females residing in Florida and Georgia. She asked whether they had sexual experiences as a child (defined as ages zero through 14) or as an adolescent (ages 15 through 17). Fifty-five percent of the women reported having had at least one childhood sexual experience; 83%, at least one adolescent sexual experience. The adult functioning of the women with no sexual experiences was compared with the adult functioning of the women who had sexual experiences. She found that early childhood and adolescent sexual experiences had no influence on later adult functioning. The exception to this was when force or high pressure was present.

Rind and Tromovitch (1997) conducted a meta-analytic review of seven studies on the effects of CSA. Unlike prior reviews, the included studies used national probability samples: four from the United States, and one each from Great Britain, Canada, and Spain. They found that the only a small proportion of those with CSA experiences were permanently harmed. They found that while CSA was related to poorer adjustment in the general population, the magnitude of this relation was small. The produced problems were not intense on average. Further, the data on confounding variables suggested that this relation might not be causally related to CSA. Thus, factors such as temperamental vulnerability, the use of force, or close family ties might produce intense harm. On the other hand, if temperamental factors are favorable, if the child or adolescent participates willingly, or if the sexual experience is trivial or transient, then there may be no harm. The major finding, then, indicated that CSA “is not associated with pervasive harm and that harm, when it occurs, is not typically intense” (p. 237), i.e., severe. A basic conclusion of this study was that previous reviews of the research had overstated CSA’s potential for harm.

These findings were confirmed in a 1998 meta-analytic study, conducted by Rind, Tromovitch, and Bauserman (1998). This review involved 59 studies of CSA using college samples: 36 were peer reviewed research studies; 21, dissertations; and two, master’s theses. Again, Rind and his colleagues found that negative effects of CSA were neither pervasive nor severe. College students who had experienced sexual abuse were, on average, slightly less well adjusted than their counterparts. The magnitude of this association was small with less than 1 percent of the adult adjustment being attributable to a history of CSA. They also found that self-reported reactions to and effects from CSA indicated that negative effects neither pervasive nor intense. Men reacted much less negatively than women, indicating that the sexual experience is not equivalent for both genders.

The 1998 Rind et al. study also provided an answer to the critical question of whether CSA caused later psychological maladjustment. CSA was found to be confounded with family environment. When introduced as a control, the CSA-adjustment relations generally became non significant. This finding challenges the assumption of a direct causality between CSA and later maladjustment. Further, family environment explained considerably more adjustment variance than CSA.

Ulrich, Randolph, and Acheson (2005-2006) undertook a replication of the Rind et al. 1998 meta-analysis. The authors corrected for the methodological and statistical problems identified by certain of the critics of the Rind et al. study. Their findings supported those of the 1998 Rind et al. study. Thus, they found (1) that CSA victims were significantly less well-adjusted than the control participants, but the harm was not intense; (2) females self-reported significantly more negative reactions and feelings to their abuse when compared with males, but the relationship was small; (3) there was no significant difference between male and females in terms psychological adjustment; (4) that CSA accounted for 1% of the variance in later psychological adjustment while family environment accounted for 5.9% of the variance; (6) CSA and family environment are confounded with CSA victims having more problematic family environments.

Additionally, there is no conclusive evidence that CSA causes specific psychological disorders. Laidlaw, Goodyear-Smith, and Gorman (2000) noted that:

As morally reprehensible as child sexual abuse is, studies overall have failed to demonstrate . . . a causal relationship between childhood molestation and any specific psychological disorder [such as eating disorders or depression] (p. 73).

Coid et al. (2003) conducted a study involving 1207 women attending thirteen primary care facilities. Two forms of CSA were identified for the purposes of their study: 1) sexual activity before age 16 and 2) sexual intercourse before age 16. Neither form of CSA was found to be associated with either anxiety or depressive disorders. It was associated, however, with PTSD.

Widom, DuMont, and Czaja (2007) undertook the first prospective assessment of risk for major depressive disorder (MDD) among maltreated children. The subjects were 676 male and female children with documented childhood physical and sexual abuse and neglect which occurred before age 11 years and a matched comparison group of 520 non maltreated children. The subjects were followed up into young adulthood. Like Coid et al., they found CSA was not associated with an elevated risk for MDD. However, they found that both physical abuse and neglect were associated with MDD.

Raphael, Widom and Lange (2001) undertook a study to determine whether childhood victimization increased the risk for adult pain complaints and functional pain syndromes. They used prospective information from documented cases of child maltreatment over the period 1967 to 1971 (N = 676) and a demographically matched control (n = 520). CSA was not found to have a significant relationship to any type of pain symptom assessed in young adults.

Neither does the research support the idea that there is a cycle of sexual abuse. The U. S. General Accounting Office (GAO) (1996) reviewed 25 studies and four review articles relative to this issue. Twenty-three of the studies were retrospective; the other two, prospective: one by Cathy Widom; the other by Linda Williams. Neither study found a relationship between CSA and later sex offending. The GAO report concluded “that the experience of childhood sexual victimization is quite likely neither a necessary nor a sufficient cause of adult sexual offending” (p. 13).

This conclusion is supported by Salter and his colleagues (2003). They undertook a longitudinal study of seven to 19 years’ durations. The study sample involved 224 former male victims of sexual abuse. The vast majority (N=198 or 88.4%) did not subsequently commit a sexual offence, i.e., only 26 (11.6%) boys became sexual abusers. The authors concluded that “most male victims of child sexual abuse do not become paedophiles [sic] . . .” (n. p.)

Nor is CSA associated with juvenile offending according to a large-scale study conducted in Australia by Stewart, Dennison, & Waterson (2002). This study focused on 41,700 children born in Queensland in 1983. By the year 2000, 10 percent of these children had come into contact with a child protection agency and 5 percent had a proven juvenile offense. The authors found that children who were physically abused or neglected were likely to be a juvenile offender. But sexual abuse was found to be unrelated to juvenile offending. These findings are compatible with the work of Cathy Widom (Widom & Ames, 1994; Widom & Maxfield, 2001).

In brief, the evidence indicates that the impact of CSA has been greatly exaggerated as noted by Dr. Sarah Romans, Professor at the Dunedin School of Medicine, N.Z. (cited in Laidlaw et al., 2000, p. 75). It confirms Walters’ (1975) earlier assertion that the widespread belief that CSA necessarily and usually causes psychological damage is a myth.

A negative consequence of this myth is the ignoring by professionals of the fact that many experience what is labeled CSA positively. Rind (2004), in a qualitative review of the research literature reported that among heterosexual adolescents involved with women and among gay/bisexual adolescent

boys with men, the non clinical data do not support the widespread belief of trauma. Rather, the predominant reaction to these experiences was positive. Negative reactions were associated with non consent, feeling coerced, and incestuous contacts.

Many clinicians refuse to accept such findings. Allie Kilpatrick (1992) wrote of the response to her findings:

When I have discussed my study with individuals and groups, my experience thus far has been that many people do not want to hear . . . about positive reactions to early sexual experiences. They do not want their preconceived notions that all early sexual experiences are harmful to be challenged. They especially do not want to hear of incestuous experiences that do not cause irreparable harm. This is particularly true of those who work with the clinical population of survivors of child or adolescent sexual abuse (p. viii).

As a clinician, she too had to come to grips with the fact that her findings did not conform with the myth that CSA necessarily and usually causes harm.

Along the same lines, Pope (1997) identified the assumption that childhood sexual abuse results in the development of psychiatric disorders in adulthood as a leading candidate to join the ranks of other mental health myths. He wrote:

to question the malignant psychiatric effects of childhood sexual abuse is often considered heretical—just as it would have been almost scandalous, a generation ago, to question whether bad mothering could turn children into schizophrenics (p. 86).

The evidence, then, indicates that the assumption that child sexual abuse typically causes psychological harm is false. Not only is it false, Schultz (1980) argued that adherence to the belief that it is typically harmful is unethical. He wrote:

We seem to arbitrarily create “norms” for minors and then justify departures from them as traumatic. Such fabrication is *professionally unethical* and possibly damaging to minors involved in sexual behaviors with others. What inappropriate trauma ideology does is to pit the professional (true believer) against the child or the parents who may feel differently. The risk is that a type of self-fulfilling prophecy emerges that manages to produce the problem it claims to abhor, but which it, in fact, must have in order to sustain the ideology it is based upon. . . . Sexual behavior between adult and child or between two minors is neither harmful or [sic] harmless always (p. 40).

It is most definitely not appropriate for the professional to identify an event as abusive when the participant says otherwise. In this instance the professional pits his/her opinion against that of the participant. Not only is this presumptuous on the part of the professional, it is also a form of malpractice. It contributes to the perception and charge that mental health professionals are exploiters of the problem of CSA. As noted by Rind and his colleagues (2000):

Clearly, children’s resilience is not always welcome. When industries depend economically or ideologically on the harmfulness of early experiences, evidence for resilience may be more of a threat than a relief. Economic and ideological interests have shaped current thinking on CSA over the last 25 years and have become integral to treatment of it as a social problem (p. 220).

III. THE QUESTION OF WHETHER IT WAS ABUSIVE

What might explain the fact that many, if not most, people who have been sexually abused do not suffer psychological harm either in the short-term or the long-term? The simplest explanation is that most people demonstrate resilience (Laidlaw et al., p. 74). There is an unfortunate few who do have inherent vulnerabilities to develop psychological problems regardless of a sexual abuse history. For example, in a review article of posttraumatic distress disorder (PTSD), Bowman (1999) reported that most people experience traumatic or seriously life-threatening events, but few develop PTSD. She concluded that the distress arises from individual differences and not from event characteristics.

Children labeled sexually abused are most likely to be diagnosed as suffering from PTSD (Kendall-Tackett et al., 1993; Saywitz, Mannarino, Berliner, & Cohen, 2000). But this is often based on the assumption that CSA results in PTSD as opposed to their being any evidence for the diagnosis (New, Berliner, & Fitzgerald, 1998). Ratiner (2000) asserted the diagnosis of PTSD is often done in order to gain extra sessions for child abuse victims, even though "it is not clear that the PTSD fully applies to child abuse" (p. 368). Szasz (2001) wrote that "PTSD is now routinely *imputed* to people, especially children helpless to reject the label" (p. 507).

A more controversial explanation is that those events that professionals label abusive either were not abusive or were not experienced as abusive. The term CSA is used in the social science and legal literature to refer to any sexual interaction between a child or an adolescent and significantly older persons as well as between peers when force is involved. Mental health professionals do not distinguish between abuse as harm done to a child or adolescent and abuse as a violation of a social norm (Kilpatrick, 1992). However, it cannot be assumed that a violation of a social norm leads to harm. One need only recall the mental health field's perspective on homosexuality a generation ago to see the validity of this assertion.

Kilpatrick, for example, found that most of the women in her study were active in initiating the sexual experience. They were willing participants. Her findings indicate that the issue of willingness or "consent" is important in differentiating a sexual event as abusive or non abusive. This is compatible, for example, with the work of Rind and his colleagues (1998), of Coxell, King, Mezey and Gordon (1999), and Ulrich et al. (2005-2006). When engaged in willingly, sexual activities are usually not associated with psychological harm.

A study by King, Coxell and Mezey (2002) would seem to contradict this. They found that among men who reported consenting sexual experiences when under age 16 there was an association with acts of self-harm. However, B. Rind (personal communication, May 2002) noted that this study was seriously flawed. When he re analyzed the data, he found that those who had consensual sex prior to age 16 were not psychologically worse off than the controls. This was not the case, however, for those who had non consensual sex.

Thus, not all sexual encounters between a child and an adolescent or an adult or between an adolescent and adult are abusive. Legally in the United States, however, those under ages 16 to 18, depending on the state, cannot give consent and sexual contact with anyone other than a peer is defined as abusive. Mental health professionals also consider such contact abusive (Kilpatrick, 1992).

This view is not supported by either empirical evidence or by common sense. It is generally recognized that prepubescent children cannot give consent. Finkelhor (1979) first proposed the prohibition against child-adult sex contact be based on the fact that prepubescent children are not capable of full and informed consent. He argued for this ethical base since the usual argument opposing such contact, namely that it caused mental harm, was not generally the case.

But this is not necessarily applicable to adolescents. They are not children in a biological sense, and their cognitive functioning is considerably more like an adult (Rind, 2004). This was recognized by the American Psychological Association, the National Association of Social Workers and the American Jewish in their amici brief (1989) to the U. S. Supreme Court. In it they argued that pregnant teenage girls did not need parental consent to obtain abortions because they are capable of making a decision based on informed consent. The associations wrote that psychological theory and research about cognitive, social and moral development strongly supports the conclusion that most adolescents are competent to make informed decisions about important life situations. . . .

In fact, by middle adolescence (age 14_15), teens have developed abilities similar to adults in reasoning about moral dilemmas, understanding social rules and laws, reasoning about interpersonal relationships and interpersonal problems. . . . by age 14 most adolescents have developed adult-like intellectual and social capacities including specific abilities outlined in the law as necessary for understanding treatment alternatives, considering risks and benefits, and giving legally competent consent. . . .

[Further], research has indicated that there is considerable variability in cognitive development and decisionmaking competence among adolescents and there are some 11_to_13_year_olds who possess adult-like capabilities in these areas (pp. 18-20).

The associations went on to note that in many states even young adolescents (11-to-13 years of age) are deemed capable of giving informed consent to medical procedures for themselves, and, if they have a child, for their child. Given this, it seems inconsistent for these associations and mental health professionals in general to reject the assertion that there can be consent or willingness on the part of the adolescent to participate in sexual experiences with an older person.

As to the common sense argument, a child can give what Rind et al. (2000) refer to as “simple consent.” For example, parents may ask children if they would like to go to the movies. If the children say “yes,” they have consented to do so and thus are “consenting” or willing participants. If they say no and are forced to go to the movies, they are being coerced and are unwilling participants.

In other words, while sexual activity between children and/or adolescents and a non peer is for most morally reprehensible and illegal, it is not necessarily abusive. Abuse is something to be established as a conclusion rather than simply accepted as a premise. And it is essential *in the mental health context* to differentiate between abusive and non abusive sexual experiences, based on the facts presented by the participant(s) and not based on *a priori* belief. That is, it is necessary to step back and probe the nuances of these events *from the perspectives of the children/adolescents who participate in them*.

IV. CHILD AND ADOLESCENT PSYCHOTHERAPY: A REVIEW

Once there is a referral for therapy another question is raised: will it be effective--even if it is indicated? Current practice assumes that it is. However, the empirical data do not support this assumption.

Finkelhor and Berliner (1995) reviewed 29 outcome studies on the effectiveness of treatments for the sexually abused. Of the 29 studies, seventeen used a pretest/post test design. While nearly all reported positive improvement, it cannot be said that the improvement was due to the treatment. These authors noted that longitudinal studies had shown that the majority of sexually abused children improved over time without treatment (p. 1409; see also Kendall-Tackett et al., 1993, p. 171). This is an unremarkable and to be expected finding. Kendall-Tackett et al. (1993) report that one of the more common consequences of CSA is posttraumatic stress disorder (PTSD). But the evidence on treating

those with PTSD indicates that the symptoms typically diminish over time without treatment (Bowman, 1999).

Of the seven experimental design studies included in this review, four involved a comparison of treatment alternatives. Three compared treatment and no-treatment groups. These found significant effects of treatment. But the reviewers commented that their “relatively small-scale designs . . . detract from their scientific weight” (p. 1414).

Among the quasi-experimental studies which had equivalent groups (three of the five reviewed), there was no advantage for children receiving therapy compared with children not receiving therapy. While Berliner and Finkelhor took an optimistic posture with respect to the outcome of therapeutic intervention, they concluded that there was no scientific evidence demonstrating the effectiveness of sexual abuse treatment (p. 1415).

Saunders, Berliner, and Hanson (2003) provided guidelines for treating physically and sexually abused children. They developed criteria to classify treatments in one of six categories: (1) Well-supported, efficacious treatment; (2) Supported and probably efficacious treatment; (3) Supported and acceptable treatment; (4) Promising and acceptable treatment; (5) innovative or novel treatment; and (6) concerning treatment. There was heavy reliance on clinical-anecdotal literature in classifying the treatments. Nine of the treatment protocols were child focused interventions; thirteen were family, or parent-child, or parent-focused interventions; and two were offender interventions. Of the child- focused interventions, only one, Trauma-Focused CBT, was classified as a well-supported, efficacious treatment. Seven were classified as supported and acceptable treatments; one as promising and acceptable treatments. Of the family or parent-child or parent-focused interventions, six were classified as supported and acceptable treatments; six, as promising and acceptable. One, Corrective Attachment Therapy was classified as a concerning treatment. Of the offender interventions, one was classified as a supported and acceptable treatment; the other, as a supported and probably efficacious treatment.

All the treatments had the potential for harm with the risk/benefit ratio ranging from little risk for most and some risk for two. One treatment, Cognitive Attachment Therapy, was identified as having a substantial risk. It carried a significant risk of psychological and physical harm. It is the one psychotherapy that has the distinction of resulting in the death of children.

The authors warned that “the level of support enjoyed by all but a few is rather thin” (p. 102). None of the treatment protocols had been tested with child abuse victims and their families. Practitioners were warned that several well-known and commonly used treatments had no empirical support for their efficacy, e.g., Trauma-focused Play Therapy.

Macdonald, Higgins, and Ramchandani (2006) assessed the efficacy of cognitive-behavioral therapy (CBT) with respect to immediate and longer-term sequella of CSA. They located 377 studies that were potentially eligible for inclusion in their review. Only ten met the inclusion criteria of having a randomized or quasi-randomized control trial on children and adolescents up to age 18 who had been sexually abused. The ten studies included 847 participants. Half of the studies included asymptomatic children.

They found that the data suggested that CBT may have a positive impact on the sequella of CSA, but that most of the results were statistically non significant. The results of the review underscored the fact that the quality of the current evidence about the efficacy of CBT in treating sexually abused children is poor.

PTSD is among the more frequent diagnoses for children and adolescents labeled sexually abused. Based on the criteria for identifying treatments as “well-established” and “promising,” the Society of Clinical and Adolescent Psychology (Division 53 of the American Psychology Association) and the Network on Youth Mental Health (2006) reports that there are no well-established or promising treatments for PTSD in children/adolescents.

In brief, the evidence for the efficacy and/or effectiveness of treatments for those children and adolescents labeled sexually abused is more equivocal than some professionals would suggest. Those advocating one particular type of treatment approach do so without empirical evidence (Ratiner, 2000).

But if therapy for children and adolescents is not effective, can it be harmful? Seligman (1994) answered this question affirmatively. He cautioned against therapy for the sexually abused. He noted that it is often asserted that the sexually abused need to relive the event and experience a catharsis in order to improve. Despite the fact that catharsis has a long history as a therapeutic technique, there is no evidence that it works (Bushman, Baumeister, & Stack, 1999; Seligman, 1994; Sommers & Satel, 2005; Wright & Cummings, 2005). On the contrary, as Seligman suggested, reliving the event may be harmful as it heightens the event in the child’s mind and interferes with the natural healing process. Additionally, the treatment guidelines developed by Saunders et al. (2003) recognize the potential for harm and identify the level of risk for harm associated with the various treatments.

In the treatment of adults with repressed memory therapy, a study of the state of Washington’s Crime Victims Compensation Program is suggestive, though not probative, of the harm that occurred in therapy for repressed memories of sexual abuse (Loftus, 1997; Parr, 1996). Between 1991 and 1995, in the state of Washington, 325 repressed memory therapy claims were awarded victim compensation. Loni Parr, a nurse consultant, and staff employees reviewed 183 of these claims. They randomly selected 30 of these to gain a preliminary profile of the cases. Their findings are or should be alarming.

Overall, the status of these claimants deteriorated during treatment. Before recovering memories, three (10%) had attempted or thought of suicide; after recovering memories, 20 (67%) were suicidal. Before memories, only two (7%) had been hospitalized; after, 11 (37%) had been. Before the emergence of memories, only one woman (3%) had engaged in self-mutilation; after, eight (27%) had mutilated themselves (Loftus, 1997).

Before entering therapy, twenty-five (83%) of the patients had a job; after three years of therapy, only three (10%) were still employed. Twenty-eight (93%) were married when they entered therapy; within five years, 18 of the 28 (64%) were divorced or separated. Twenty-one of the patients had minor children and one-third (7) lost custody of their children during therapy. All were estranged from their extended families (Loftus, 1997; Parr, 1996).

These patients were in therapy longer than other mental health patients, and evidenced a high rate of mental and emotional problems, all of which arose and worsened during therapy. In fact, the longer the patients were in therapy the more disabled they became. The primary diagnosis in these cases was Multiple Personality Disorder, and it was usual for claimants to report having dozens or even hundreds of personalities; one person claimed over 3000! The findings of this study buttressed the conclusion of Ofshe and Watters (1994):

examining the fad diagnosis of MPD, the cruelty of recovered memory therapy becomes particularly clear. Thousands of clients have learned to display the often-debilitating symptoms of a disorder that they never had. They become less capable of living normal lives, more dependent on therapy, and inevitably more troubled (p. 223).

As a result of Parr's review, in December of 1996, Washington became the first state to prohibit compensation for any therapy deemed experimental, such as any therapy that focuses on the recovery of repressed memory (Staff, 1997, March; 1997, April).

In short, the evidence does not support the contention that therapy for children and adolescents labeled sexually abused is helpful. It may, in fact, be harmful.

Recommendations

If mental health professionals are to minimize the likelihood of being accused of exploiting the problem of child/adolescent sexual abuse, a number of things need and should be done.

1. Mental health professionals should not routinely provide treatment to children and adolescents labeled "sexually abused." Sexual abuse is not a psychiatric disorder (Finkelhor & Berliner, 1995; Saywitz et al., 2000). Rather, it is an event or a series of events in a person's life.

2. Mental health professionals should consider treatment only if there is demonstrable harm, i.e., the child/adolescent is symptomatic. It should be undertaken with caution because: a) most of those who are symptomatic improve over time without treatment; b) the evidence that the treatment will be effective is at best tentative; and c) it may well be harmful.

It may, in fact, be better if mental health professionals were to follow the Seligman's (1994) recommendation to parents of those labeled sexually abused: "turn down the volume as soon as possible" (p. 235). In other words, a wait and see stance is preferable, given that a significant number of children and adolescents labeled sexually abused become asymptomatic without treatment.

3. Mental health professionals should not treat the asymptomatic child or adolescent labeled sexually abused (MacDonald et al., 2006). To do so is comparable to a physician treating children for bicycle accidents. These children require medical attention if there is a demonstrable clinical condition present. They are not treated if none is present. The event is by itself irrelevant to the receipt of treatment. In other words, the asymptomatic child or adolescent labeled sexually abuse should not be treated.

Saywitz et al. (2000) argued that since CSA is a risk-factor for later psychopathology, treatment should be provided to prevent future pathology. Treatment, however, is not provided for risk-factors. Smokers are not treated for lung cancer until they develop lung cancer. Moreover, there is no evidence that preventive psychotherapy works.

4. Mental health professionals should only treat those who were in fact sexually abused. Those who retract or deny that abuse occurred should be believed. They should not be treated.

5. In treating the symptomatic, mental health professionals should look for factors other than the sexual event(s) as causative. Evidence suggests that sexual abuse is not a direct cause of psychopathology. Sexual abuse provides a simple and likely erroneous explanation to what may well be a complex problem. In reality, it helps neither the therapist nor, most definitely, the client come to grips with their problem.

6. Mental health professionals must assure that prospective clients are appropriately informed of the evidence concerning the need for and effectiveness of interventions so that they may give truly informed consent. This includes advising prospective child and adolescent clients and their parents of the likelihood of a successful versus a non successful outcome as well as the risk of deteriorating as a result

of treatment. It includes informing prospective clients and their parents as to whether or not the treatment they are to be offered has been empirically validated, is still experimental, or has been discredited by sound research.

7. Mental health professionals should educate judges and CPS workers about the evidence concerning a) the impact of CSA and b) the effectiveness of treatment so that they will not make routine referrals for psychotherapy or counseling.

8. Mental health professionals need to avoid the socio-political and legalistic biases contained in the use of such terms as “victims” and “perpetrators. Until it has been established that coercion or harm was involved in the sexual encounter, more neutral terms, such as “participant,” would be more appropriate.

9. Mental health professionals should avoid the use of the terms: “sexual abuse,” “molestation,” and “rape,” until it has been determined that coercion, physical threat, or lack of consent was present.

Further, to define experiences as abusive when they are described by those labeled “sexually abused” as loving, caring, or non coercive is not only a contradiction in terms, it is also an imposition of one’s value system upon the client (Okami, 1994), which is professionally unethical and can have serious negative consequences as pointed out some time ago by Germaine Greer. In 1975, she wrote of the experience of one of her school friends:

From the child’s point of view and from the commonsense point of view, there is an enormous difference between intercourse with a willing little girl and the forcible penetration of the small vagina of a terrified child. One woman I know enjoyed sex with her uncle all through her childhood, and never realized that anything was unusual until she went away to school. What disturbed her then was not what her uncle had done but the attitude of her teachers and the school psychiatrist. They assumed that she must have been traumatized and disgusted and therefore in need of very special help. In order to capitulate to their expectation, she began to fake symptoms she did not feel, until at length she began to feel truly guilty for not having felt guilty. She ended up judging herself quite harshly for this innate lechery (cited in Schultz, 1980, p. 39).

The term “abuse” should be replaced by such terms as “experience” or “event,” until it is determined the event was in fact harmful or coercive. Should this be viewed as politically incorrect or potentially incendiary, then one could use the terms “forced/non forced sexual activity.”

10. Mental health professionals must base more of their practice on empirical evidence. Less and less of what professionals do are based on scientific inquiry. In fact, there is a growing gap between researchers and practitioners (James, S. & Mennen, 2001; Lilienfeld, Fowler, Lohr, & Lynn, 2005; Tavis, 2003; Weisz, 2000). The non reliance on non science has had serious negative consequences. These include sending innocent defendants to prison, the loss of custody of children, and even the death of children. Mental health professionals must use those therapies that the research suggest may be effective. They must also engage in or cooperate with efforts to assess the effectiveness of therapeutic interventions.

11. Mental health professionals have a responsibility to assure that the public is properly informed about child sexual abuse so that it may assist in the shaping of appropriate and relevant mental health policies and programs.

Conclusion

This paper addressed the question: is the routine provision of psychotherapy for children and adolescents labeled sexually abused warranted? It noted that one of the consequences of routinely providing treatment was that mental health professionals have become open to the charge of exploiting the problem of CSA for their own gain—what some professionals are calling “the abuse of abuse” by mental health professionals.

A review of the literature indicates that a significant number of sexual abuse cases are falsely identified as substantiated. It also indicates that many of those sexually abused are not harmed as a result of non adult/adult sexual interaction. Further, the so-called abuse may be experienced positively by the child or adolescent. It is not clear that sexual abuse is a direct cause of psychological maladjustment as there are typically confounding variables in these situations.

Moreover, the routine provision of treatment is not found to be warranted. It may well be iatrogenic. The review indicates that the asymptomatic child or adolescent is typically included in treatment effort, but most definitely should not be. The inclusion of the asymptomatic makes an accurate evaluation of treatment effectiveness impossible since it includes those who do not need treatment. Additionally, the excessive and unnecessary provision of treatment for children and adolescents labeled sexually abused takes resources from other victims and other victim needs (Costin et al., 1996).

It is recognized that professionals who earn their living from diagnosing and treating the sexually abused have not been receptive to evidence questioning the validity of their methods or assumptions. This author would hope that in the interest of those labeled sexually abused and their families, this will no longer be the case.

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