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Child sexual abuse: A critical review of intervention and treatment modalities

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Abstract

Recent years have ushered a growing understanding and a broadening knowledge base of the complexities of child sexual abuse. These complexities are acerbated by the need to account for the specific problem of child sexual abuse (CSA) in the larger context of multi-problem intervention, requiring coordinated multi-disciplinary team efforts as well as sensitive and focused attention to CSA itself. The aim of this paper is to critically examine the literature on several treatment modalities that are utilized by professionals from a range of disciplines treating victims of childhood sexual abuse. Acknowledging recent findings that dissociative disorders among CSA survivors are high compared to survivors of other forms of trauma and that about 80% of adult CSA survivors who were diagnosed with posttraumatic stress disorder actually suffer from dissociative disorders, the author discusses the phenomena of dissociative identity disorder among survivors who were sexually abused. The implications for the development of a therapeutic model are described, including a delineation of the model components.

Keywords: Childhood sexual abuse; Treatment modalities; Dissociation; Trauma

1. Introduction

The World Report on Violence and Health (Krug, 2002) defines sexual abuse as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work" (p. 149). Childhood sexual abuse (CSA) is defined as a sexual act between an adult and a child, in which the child is utilized for the sexual satisfaction of the perpetrator (Briere, 1992). Although the accuracy of statistics citing childhood sexual abuse are questionable due to the inability to assume complete disclosure from children, there is an underlying assumption that quoted prevalence figures of a childhood sexual abuse experience is one out of three or four children (e.g., Briere & Elliot, 2003).

Childhood sexual abuse is considered to be a unique severe traumatic event since it includes violation of the child's body. Unlike other forms of abuse such as physical abuse in which the violation is on the body surface (whether or not internal injuries are caused), sexual abuse denotes oral, anal or genital penetration (e.g., DiLillo et al., 2006). The body, therefore, can no longer be perceived as a "safe home." Escaping the abusive situation can often be possible only virtually in the victim's mind, whereas the body continues to endure suffering (Silberg, 1998).

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Findings such as: (a) Kendall-Tackett, Williams and Finkelhor (1993), and, Rind, Tromovitch and Bauserman (1998) report that up to 49% of the sexually abused children evidenced no posttraumatic stress symptoms, (b) approximately 80% of adult survivors of childhood sexual abuse actually suffer from dissociative disorders (Van Den Bosch, Verheul, Langwland & Van Den Brink, 2003), (c) In most settings children who have been sexually abused are routinely offered treatment (from 44 percent to 73 percent) even if asymptomatic (Finkelhor and Berliner, 1995), and (d) prevalent treatment modalities for survivors of childhood sexual abuse were actually developed for posttraumatic stress symptoms resulting from various traumatic events rather than specifically tailored for survivors of childhood sexual abuse, raise the question whether differential assessment and treatment modalities relating specifically to survivors of childhood sexual abuse should be developed.

Since childhood sexual abuse was found to differ in both context and psychological implications compared to other forms of abuse (Forbey, Ben-Porath, & Davis, 2000) the main issue is whether childhood sexual abuse should be regarded as any other traumatic event or as a unique type of trauma that requires a different therapeutic approach? Is it possible that "sexual abuse effect syndrome" is actually a comorbidity of posttraumatic stress symptomathology and dissociative disorders, requiring the development of unique treatment modalities?

Additional questions to be asked are: should every child who experienced sexual abuse be referred to therapy? Will immediate intervention prevent later symptomathology? If the victim is asymptomatic at assessment, should he or she be diagnosed for possible covert symptomathology? Are there specific unique treatment procedures for children who were sexually abused, yet seem asymptomatic? Should other related individuals besides the victim be targeted for intervention, and if so, who? Will therapy be effective for any case whether or not it is indicated?

The aim of this paper is three-fold: (1) to review the literature on well-known treatment modalities that are used by professionals treating victims of childhood sexual abuse, (2) to discuss the relationship between posttraumatic stress symptoms and dissociation in relation to childhood sexual abuse, and (3) to discuss the phenomena of dissociative disorders - specifically dissociative identity disorder - in relation to survivors who were sexually abused, in terms of treatment modalities.

2. Childhood sexual abuse - impact and assessment

Reviews of a large array of studies examining the long-term sequelae of CSA (Breslau, 2002; Kaysen, Resick & Wise, 2003; Neumann, Houskamp, Pollock, & Briere, 1996; Ruggiero et al., 2004) list numerous psychological, behavioral, and social difficulties in survivors of sexual abuse that include depression, psychological distress, poor self-esteem (Freshwater, Leach & Aldridge, 2001; Johnson, 2004), substance abuse, suicide attempts (Dube et al., 2001; Plant & Miller, 2004), severe posttraumatic stress symptomathology (Petrak & Campbell, 1999), psychopathology disorders (Owens & Chard, 2003), self-destructive behavior (Merrill, Thomsen, Sinclair, Gold, & Milner, 2001), and dissociative disorders (Fleming, Mullen, Sibthorpe, & Bammer, 1999; Simpson & Miller, 2002). Due to the fact that boundaries between the psychological, physical, somatic or social effects are often blurred, it is impossible to identify a "sexual abuse effect syndrome"; rather, what becomes apparent is a multifaceted model of traumatization (Kendall-Tackett, Williams, & Finkelhor, 1993).

Indeed, the literature is abundant with description of the psychological impact of child sexual abuse and possible consequences of misdiagnosing posttraumatic stress disorder with other disorders such as attention-deficit hyperactivity disorder (ADHD) (Weinstein, Staffelbach & Biaggio, 2000) and conduct disorder (Schulenberg & Soundy, 2000). Attention-deficit hyperactivity disorders and posttraumatic stress disorder are the most commonly diagnosed disorders in sexually abused children. Because there is a high degree of symptom overlap and comorbidity between these disorders, differential diagnosis can be confusing. Current diagnostic criteria do not include posttraumatic stress disorder as a differential diagnosis for ADHD, nor do existing assessment guidelines address these diagnostic similarities. This may have serious implications for sexually abused children. Moreover, although research has demonstrated that children who experience familial sexual maltreatment are at risk for developing psychological difficulties characterized by emotional and behavioral dysregulation (Forbey, Ben-Porath, & Davis, 2000), little attention has been directed toward identifying differential processes in emotional development between maltreated youngsters and children who were not molested (Shipman, Zeman, Penza, & Champion, 2000). Based on the myriad of studies such as those mentioned above, recommendations were made for improving clinical decision making and for facilitating differential diagnoses. For instance, routine inquiry about traumatic experiences in children presenting with ADHD symptoms is suggested to increase diagnostic accuracy (Weinstein, Staffelbach & Biaggio, 2000).

3. Treatment modalities for childhood sexual abuse survivors

As mentioned above, in most settings, children who have been sexually abused are routinely offered treatment even if asymptomatic (Finkelhor and Berliner, 1995). Once there is a referral for therapy the question of effectiveness and necessity of therapy comes to the forefront. Current practice assumes both efficacy and necessity, even though there is no empirical evidence to support this claim.

Most treatment modalities adopt one or more of four basic therapeutic goals: (1) *symptom relief,* which may be accomplished by encouraging the child to think differently about the event, teaching the child to manage his or her aberrant behaviors, facilitating the expression of negative affect, affirming the child's experience, and providing emotional support (Rust & Troupe, 1991); (2) *de-stigmatization,* which may be achieved by group affirmation from other child victims and the therapist's supportive stance (Kruczek & Vitanza, 1999); (3) increasing self-esteem through cognitive and interpersonal exercises, role plays, and games (Hill, 2006); and (4) *preventing future abuse* by changing the victim's environment and/or behaviors and awareness.

In addition to a good deal of undocumented and poorly described treatments provided in individual private practices, there are many different theories, strategies of intervention, and treatment techniques within each of the general treatment formats. For example, some theories (among them are psychodynamic and psychoanalytic therapies) emphasize the importance of uncovering repressed and forgotten material (Loftus, 1993). Others (for example, behavioral and cognitive behavioral therapies) focus directly on the events of the sexual abuse and seek to change the victim's social adjustment and adaptive behavior (Calhoun & Atkeson, 1991). Theories of the first type are likely to focus on an array of behaviors beyond the abuse experience itself, while those of the second type are likely to employ more active interventions that are focused on the abuse and its direct sequelae.

Other theories that are evolving to explain the variable effects of child sexual abuse are: (1) *attachment theory* (Alexander, 1992), which contributes to the understanding of the betrayal by a signficanit object in incestuous families and short /long term negative effects such as distorted adult relationships, re-victimization, chronic negative affect, and disturbances in self-concept, (2) *developmental theory* (Celano, 1992; Cole & Putnam, 1992), which broadens the understanding regarding the stage of development in which the child was sexually victimized, the context of the abuse and later behaviors. For example, it delineates the relationship between oral sexual abuse experiences and various personality and addictive disorders in adults and faulty attributions in children; and (3) *cognitive-behavioral and social learning theory,* which illustrates the impact of learning processes in cases of incessant experiences of childhood sexual abuse in the reoccurrence of sexual behavior problems, posttraumatic stress disorder (PTSD), fear, and anxiety (Deblinger, McLeer & Henry, 1990).

The two most popular treatments for this specific population include individual therapy (for the victim) and family therapy, the latter of which may or may not include the offender. Group therapy is also used frequently, either exclusively or in combination with individual therapy (Tourigny et al., 2005; Wanlass, Moreno, & Thomson, 2006). It is important to note though that all treatment interventions for childhood sexual abuse survivors, were developed for general trauma survivors who suffer from posttraumatic stress symptoms.

Despite the multiplicity of programs, widespread use of interventions in this field, and little research on how to effectively assign types of treatments to victims, several empirical studies focusing on the evaluation of specific treatment outcome for sexually abused children are noteworthy (e.g., Saywitz et al., 2000). They indicate that trauma-focused cognitive behavioral therapy (TF-CBT) may significantly improve certain symptoms in sexually abused children, mainly posttraumatic stress symptoms and behavioral problems (e.g., Trowler et al., 2002).

TF-CBT uses well-established cognitive-behavioral therapy and stress management procedures originally developed for the treatment of fear, anxiety, and depression in adults (Wolpe, 1982). These procedures have been used with adult rape victims presenting symptoms of PTSD (Foa, Rothbaum, Riggs, & Murdoch, 1991) and have been applied to children with problems of excessive fear and anxiety. The TF-CBT protocol was adapted to target specific difficulties such as lack of concentration, social withdrawal, and anxiety attacks exhibited by children with PTSD symptoms in response to sexual abuse or other childhood traumas. Examples of such procedures include teaching relaxation methods, helping the child and parent manage their emotional reactions to reminders of the abuse, improving their ability to express emotions, participating in self-soothing activities, and correcting inaccurate attributions about the cause of the event. In addition, well-established parenting approaches (Forehand & Kotchick, 2002) are also incorporated into treatments to guide parents in addressing their children's behavioral difficulties. For example, training may be provided for parents in child behavior management strategies and effective communication, or family work to enhance communication and create opportunities for therapeutic discussion regarding the abuse.

Deblinger, Steer, and Lippmann (1999) studied 100 sexually abused children who were randomly assigned to receive one of four types of intervention: community care, trauma focused cognitive behavior therapy for the child exclusively, for the non-offending parent, or for both child and parent. They found that the symptoms of distress were lower among those who received trauma focused cognitive behavior therapy compared to those who did not. Consistent with the latter, Cohen, Mannarino, and Knudsen (2005) who examined the differential efficacy of trauma focused cognitive behavioral therapy (TF-CBT) and child centered therapy for treating posttraumatic stress disorder in 229 children, found that the children who were assigned to TF-CBT demonstrated significantly more improvement with regard to PTSD, depression and behavior problems compared to other treatment groups.

Another treatment modality that was found by Chard (2005) to be useful in decreasing symptoms of distress among sexual abuse survivors is the cognitive processing therapy (CPT-SA). The CPT-SA is an adaptation of Resick and Schnicke's cognitive processing therapy for rape victims that was designated to focus on the areas of trauma symptom responses that appear to be commonly found in sexual abuse survivors. CPT-SA is based on a broad treatment model combining information processing, developmental (Cole & Putnam, 1992) and self-trauma theories (Briere, 2002), thereby, addressing the roles that fear processing, attachment, cognitions, and development play in the creation and maintenance of symptoms. The modality consists of 17 weeks of manual-guided group and individual therapy. Clients are educated about PTSD, rules and beliefs, discuss their developmental history, identify how the event impacted their lives in terms of thoughts, feelings, and relationships, and following exposure they challenge the disruptive cognitions.

However, whereas data indicate that some cognitive behavioral therapies are effective in reducing posttraumatic stress symptoms, the issue of treatment modalities for individuals who suffer from dissociative disorders resulting from childhood sexual abuse, remains to be discussed.

4. Posttraumatic stress symptoms, dissociation and child sexual abuse

Van Den Bosch, Verheul, Langwland and Van Den Brink (2003) found that the prevalence of dissociative experiences and posttraumatic stress symptoms among those with a history of childhood sexual abuse were high compared to survivors of other forms of trauma. It is well established that the debilitating symptoms of posttraumatic stress (PTS) disorder (PTSD), fall into three clusters: (1) recurring intrusive recollection of the traumatic event such as dreams, 'flashbacks' and intrusive thoughts, (2) persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness and (3) persistent symptoms of increased arousal characterized by hyper-vigilance, increased startle response, sleep difficulties, irritability, anxiety and physiological hyperactivity, reflective of 'hyper- reactive' autonomic nervous system (Dobbs & Wilson, 1960; Horowitz et al., 1980). Recent studies found a relationship between the avoidance and numbing cluster in PTSD symptoms and dissociation.

Dissociation refers to a mental process that produces a lack of connection in the person's thoughts, memories, feelings, actions, or sense of self (APA, 1994). During the dissociation process, certain information is not associated with other information as it would normally be (Somer & Somer, 1997). Dissociative mechanisms are those that allow a person to temporarily escape from pain and suffering (Silberg, 1998). Putnam (1993) lists the defensive functions of the dissociative mechanisms, which include: creating automatic behaviors, responding to overwhelming stimuli, escaping from life stressors and despair, compartmentalizing catastrophic events, cathartic relief from certain feelings, avoiding and relieving pain, and, altering the sense of self so that the traumatic event is experienced as if "it hadn't happened to me."

As a defense mechanism, dissociation seems to protect against immediate experiences; yet, it results in a fragmentation of the self (Shengold, 1989). Through impact-minimizing, silencing and victim blaming, dissociative mechanisms are developed, thereby decreasing the victimized child's ability to verbally describe the experience. The pressure not to see, not to hear and not to speak prevents the processing of the experiences, leading to unhealthy dissociative coping strategies such as identification with the aggressor, identification with the other parent's passivity or silent collaboration, or identification with the victimized self. This might be strengthened by the victim's attempt to avoid thinking about the abuse. The dynamics of helplessness, stigmatization and betrayal by family members serve as reinforcement to avoid thought, feeling or action, thus providing an additional catalyst for the development of dissociative disorders (Silberg, 1998). The dissociative process may therefore take the form of temporary detachment, especially in stressful situations and in response to triggers associated with the abuse (Ellason, Ross & Fuchs, 1996).

In general, dissociation consists of five major symptoms (Steinberg, 1997):

Amnesia – described as memory "holes" or "lost time", lasting from several minutes to several years (Steinberg, 1997);
Depersonalization – a sense of being detached from oneself, a sense that the self is alien or unreal, a sense of being separated from different parts of the body or the body as a whole, or a sense of being detached from feelings altogether (Steinberg, 1997);
Derealization – a sense of detachment or estrangement from the environment, or a sense that the world and the surroundings are unreal (Steinberg, 1997);
Identity confusion – a sense of fragmentation of the self that is unnoticed by the surrounding people (Steinberg, 1997); and,
Identity alteration – noticeable changes in identity or more than one ego state (Talbot et al., 2004). Changes in identity or ego state may be accompanied by amnesia, so that the person is unable to remember events that took place when the new identity emerged.

The severity of the dissociative symptoms may vary depending on factors such as age of abuse onset, severity of abuse, emotional closeness/dependence on the abuser, dysfunction of early social environment and psychological factors (Gold, 1999).

Dissociative Identity Disorder (DID) appears to be the most severe form of disturbance (Draijer & Boon, 1993). According to the DSM-IV, dissociative identity disorder (DID) is characterized by the existence within the person of two or more distinctly different identities or personality states that from time to time take executive control of the person's behavior, with accompanying amnesia (APA, 1994). Despite evidence that DID may be more prevalent than once believed–effecting 1% of the general population and perhaps as many as 5-20% of psychiatric patients who receive other diagnoses (Ellason, Ross & Fuchs, 1996)– many individuals with this disorder often spend years in the mental health system before an accurate diagnosis is made (Duffy, 2002; Weber, 2001).

According to Silberg (1998), sexually abused children tend to dissociate themselves during a traumatic event - a state that allows the child to survive and retain a relatively normal, functioning self (Krystal et al., 2000; Midgley, 2002). The fact that individuals who were sexually abused in early childhood or adolescence showed greater impairment in object relations (Swartz, 2002), were more engaged in self-destructive behaviors such as self-mutilation or risky sex (Rodrigues-Srednicki, 2001) than others, has been explained by the greater use of dissociative experiences (Zelikovsky & Lynn, 2002). Hoyt (2002) suggested that the use of dissociation affects the victims' awareness of danger cues and their willingness to participate in potentially dangerous situations throughout their life.

Despite increased recognition, refinements in techniques of diagnosis and treatment of DID (Ellason & Ross, 1997), it is not yet clear how early full-blown DID can be detected and treated, particularly in early childhood (Draijer & Langeland, 1999). Shirar (1996) pointed out the difficulty in distinguishing dissociative behaviors in childhood (e.g., fluctuating levels of function from highly effective to disabled, severe headaches or other bodily pain, time distortions, time lapse, amnesia, depersonalization, derealization, and destructive behaviors) from other disorders. The result is often misdiagnosis such as attention deficit disorders, oppositional or conduct disorders, anxiety and panic disorders, post traumatic stress disorders, depression and suicidal ideation, or substance abuse. This, in turn, unfortunately leads to ineffective treatment interventions.

Based on the previous findings that dissociation seems to be inter-related to PTS symptoms, the pertinent question whether children who were sexually abused might suffer from a comorbidity of posttraumatic stress symptoms along with dissociative disorders remains to be answered.

5. Treatment modalities for sexual abused survivors diagnosed with DID

In this section three treatment modalities for survivors who suffer from DID due to childhood sexual abuse will be described, although to the best of my knowledge, empirical trials studying their effectiveness are scarce. Chu (1998) and Courtois (1999) developed a **3-phase treatment modality** for sexually abused survivors who are diagnosed with DID. They delineate three basic therapeutic aims: relieving symptoms by enhancing self-control and self-confidence, facing and coping with the traumatic memories, and reintegrating the ego-states thus strengthening the victim's sense of identity.

The treatment modality is based on phases: the first phase aims to reduce the endangering symptoms such as self injury and suicidal acts. This is done through negotiation between the therapist and each of the aggressive ego states, until each agrees to avoid any endangering behaviors throughout the treatment procedure. The second phase is focused on traumatic memories, coping with its meaning, pain, and integration of the memories as part of the personal history. The ability and readiness to remember cuts through the ego states, particular the avoidance ones. The third phase focuses on strengthening the collaboration and integration between the ego-states, as well as between the external and internal worlds. Facing the grief, loss and sorrow, yet investing in the present rather than in the past, defining future goals, all lead according to Courtois (1999) to a better adjustment through a lessening use of dissociative mechanisms.

Another well-known, yet poorly documented treatment modality for DID is the use of **creative arts** in therapeutic settings. Art often enables to express covert material through a form of "play" which might represent a positive returning to childhood. Using means of art encourages a nonjudgmental, creative fun-filled aspect to the process of learning. Creative art (e.g., drawing, clay, or music) may offer something diametrically opposed to the verbal dialogue, which in this context, can be a container or organizer that mirrors internal object relations and their associated defenses. The art form offers a safe psychological space, within which members are encouraged to investigate and experience the object world.

This space has much in common with what Winnicott (1965) called *transitional space*—an intermediate area that is neither inside nor outside but which bridges subjective and objective reality. By using creative art, the various representations of one alter which make contact with the representations of another alter at points of similar experience, perception, and feeling continue to interact on multiple levels of consciousness. They are shaped and reflected through the art form. The representations from the past are expressed through image, symbol, energy, sensation, and color, with its own rhythm, volume, and weight, thus expanding the boundaries of objective reality. Being nonverbal in nature, these symbols and images are often difficult to express clearly in verbal form and therefore, lend themselves well to the art medium.

For example, based on the assumption that music can elicit almost involuntary preconscious responses, Robarts (2006) reported on the use of music in treating a child victim of sexual abuse. Lev-Wiesel (1999) described a thematic drawing technique with a woman who was diagnosed with DID in which the client was invited to work as a co-therapist in the therapeutic process. By strengthening the role of the inner survivor's protective alters, internalizing symbolically the therapist role as an additional protective ego, the survivor stepped out of the role of the victim into the role of the healer. Working as a co-therapist seems to strengthen the victim with a sense of reassurance about his/her ability to confront other alters as well as external difficulties.

6. Individual-group therapy

Based on the concept that dissociative identity disorder can be perceived as a "one person theater", *individual-group therapy* for survivors of childhood sexual abuse who suffer from DID was developed by the author. It is aimed to help the survivor sort out the different ego-states, enhance those who have protective roles, lessen the impact of those ego-states that represent the perpetrators and endanger him or her, yet reframe and harness their power, dominance and authoritative qualities for his or her own benefit. Following screening of the different alters through a deep acquaintance with each one (characteristics and age, history, traits and memories, and life purpose), "group meetings" are called. The final goal is to choose the group leader that will be accepted by all the other alters.

Much like the group therapy process, at the initial stage of the individual-group therapy, alter egos are invited to present themselves, their roles, their alliances within the inner group, and to meet the expectations of each other. Before the inner group can launch into extensive work, typically it must go through a rather difficult transition phase. In this period, alters have the task to recognize and deal with anxiety, resistance, and conflict. The inner group of alters need to decide whether they are willing to invest in this experience which might eventually bring them to better integration, and an awareness of feelings and memories which were previously only dimly experienced. They must test both the therapist and the other alters to determine the level of safety, become more attuned to conflict and learn the importance of saying what they feel and think of others and the external world. In this stage, alters are invited by the therapist to commit to working together towards a mutual goal.

In the next stage – the working stage, the final goal is to elect the leader of the group through pursuing common themes within the inner group of alters. Symbolically, the director for the actors within the inner theatre will be elected. The director's role is to conduct the group, set the boundaries for each actor, set the group's goals and act to achieve it.

This stage is also characterized by a here and now focus. Conflict in the inner group is recognized, and alters have learned that they need not run away from it or "sweep it under the carpet". Working on a conflict and resolving it becomes the focus of work. Being in touch with oneself and trusting oneself more in terms of each alter role and ability, decreases the need for game playing and testing, and contributes to improved integrative thought, emotion, and behavior in everyday life. Inter-alter exchange during this working stage increases the cohesion between alters as a group, thus increasing self-benefit.

The objective of the final stage of treatment is to face the termination of treatment. This includes feelings concerning separation from internal objects that ceased to exist, discussing the therapeutic process and its termination, and most importantly, focusing on present and future plans.

7. Conclusions

Despite the large array of studies indicating the short and long-term negative effects of childhood sexual abuse, follow-up studies focusing on assessment and treatment modalities tailored for sexually abused children are rare. Whereas more progress has been made in the identification and investigation of childhood sexual abuse, there is still a startling paucity of treatment outcome studies. Treatment modalities that are described in the literature, for example TF-CBT or child Centered Therapy (CCT) (Barker-Collo & Read, 2003) that were found to be effective in terms of reduction of symptoms, were actually developed for people at all ages who suffer from posttraumatic stress symptomathology resulting from all kind of traumatic events. Other treatment modalities that were developed and are used by professionals do not have clear protocols, nor have they been scientifically tested for their effectiveness.

Consequently, it seems that case management decisions and decisions about what techniques to be used in treatment are made by clinicians without empirically tested guidelines. The question whether childhood sexual abuse should be regarded as a different trauma requiring a unique approach remains to be discussed. Clearly issues of trust and empowerment of the victim, by means of providing active listening, reflection, accurate empathy, encouragement to share and talk about feelings exist in many other interventions for a variety of difficulties whether the client is a child or an adult, whether the client was sexually abused during childhood or experienced other form of maltreatment.

What then, are the specific issues that need to be addressed in light of the uniqueness of childhood sexual abuse, other than reducing present symptomathology? I suggest two core issues: (a) the body no longer serves as a "safe place", meaning the soul is homeless, and (b) the self and body are perceived to be worthless, weak, and helpless, meaning there is no hope for a better future. These two issues can be presented by symptoms such as self injurious behavior, endanger behaviors, suicidal thoughts and acts, depression, low self esteem, etc.

Further research focusing on the effectiveness of current intervention modalities is also needed. In addition, written protocoals of different intervention techniques used by practitioners are necessary so they can be implemented and tested. It may be surprising that with such a high prevalence of childhood sexual abuse there is such a scarcity of age-related treatment modalities for victims who were sexually abused during childhood and for those who suffer from resulting dissociative disorders. There is a necessity to develop specific age-related treatment modalities for childhood sexual abuse survivors who suffer from posttraumatic stress symptomathology, dissociative disorders or a comorbidity of both phenomena. This should be followed by longitudinal studies focusing on the outcomes of the treatment modalities for further, more effective implementation.

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