Review Psikiyatride Güncel Yaklaşımlar-Current Approaches in Psychiatry 2023; 15(3):534-547
doi: 10.18863/pgy.1181095

Treatment Issues While Addressing Child Sexual Abuse: A Review

Çocuk Cinsel İstismarını Ele Alırken Karşılaşılan Tedavi Konuları: Bir Derleme

Hatice Odacı[1], Tuğba Türkkan[2]

[1]Karadeniz Technical University, Trabzon
[2]Gümüşhane University, Gümüşhane

ABSTRACT

Child sexual abuse is a traumatic life event that has social, psychological, political and cultural dimensions which is observed in many societies. Sexual abused children are at risk of developing behavioral, emotional, cognitive and physical health problems throughout their lives, and are especially vulnerable when their current condition is combined with other risk factors, such as poverty. In the relevant literature, it is reported that these children have a greater risk of having psychological problems and require treatment. There is evidence that psychotherapeutic treatments have beneficial effects, including ensuring the physical and emotional safety of victims, helping to relieve trauma symptoms, improving quality and functioning of life, and preventing recurrence of abuse. In this review, some of the most common treatment issues for sexual abused children are presented. The appropriateness of the treatment issues and proposed interventions addressed may vary for each victim. These treatment issues and interventions are designed not only to remedy any harm that may have occurred, but also to minimize the negative consequences of experiences of child abuse and prevent future recurrence of maltreatment.
Keywords: Child, sexual abuse, treatment issues

ÖZ

Çocuk cinsel istismarı birçok toplumda görülen sosyal, psikolojik, politik ve kültürel boyutları olan travmatik bir yaşam olayıdır. Cinsel istismara uğrayan çocuklar yaşamları boyunca davranışsal, duygusal, bilişsel ve fiziksel sağlık sorunları geliştirme riski altındadır ve mevcut durumları yoksulluk gibi diğer risk faktörleriyle birleştiğinde özellikle savunmasızdırlar. İlgili literatürde, bu çocukların psikolojik sorun yaşama riskinin daha yüksek olduğu ve mağdurların tedaviye ihtiyaç duyduğu bildirilmektedir. Psikoterapötik tedavilerin, mağdurların fiziksel ve duygusal güvenliğini sağlamak, travma semptomlarını hafifletmeye yardımcı olmak, yaşam kalitesini ve işleyişini iyileştirmek ve istismarın tekrarını önlemek de dahil olmak üzere yararlı etkileri olduğuna dair kanıtlar vardır. Bu derlemede, cinsel istismara uğrayan çocuklar için en yaygın tedavi konularından bazıları sunulmuştur. Ele alınan tedavi konularının uygunluğu her mağdur için farklılık gösterebilir. Bu tedavi konuları ve önerilen müdahaleler sadece meydana gelebilecek zararları gidermek için değil, aynı zamanda çocuk istismarı deneyimlerinin olumsuz sonuçlarını en aza indirmek ve gelecekte kötü muamelenin tekrarlanmasını önlemek için tasarlanmıştır.
Anahtar sözcükler: Çocuk, cinsel istismar, tedavi konuları

Introduction

Child sexual abuse is a complex life experience that is a serious problem for all societies and has become the focus of many legal and professional initiatives (Odhayani et al. 2013, Jackson and Deye 2015). In the last 50 years, researchers have shown an increasing interest in the short and long-term consequences of childhood sexual abuse. However, when the literature on the subject is examined, it is noteworthy that there is no common definition of childhood sexual abuse. The problem of defining "child sexual abuse" and the need to define this concept has been voiced since the 1970s (Giovannoni and Becerra 1979, Finkelhor and Korbin 1988). However, a central problem is that there is no common understanding of what constitutes "child sexual abuse" and therefore no universal definition. This can limit the capacity of researchers, clinicians, policymakers and communities to define, measure, treat, prevent and respond to child sexual abuse (Negriff et al. 2014, Mathews and Collin-Vézina 2019). The World Health Organization (WHO 2006) also draws attention to this need to develop a common understanding as follows: "The various sectors addressing child maltreatment should develop a common conceptual definition and operational case definition of child maltreatment.

Address for Correspondence: Tuğba Türkkan, Gümüşhane University Faculty of Health Sciences, Department of Social Work, Gümüşhane, Türkiye **E-mail:** turkkan83@hotmail.com
Received: 28.09.2022 | **Accepted:** 13.01.2023

It is noteworthy from the literature review that there are three main dimensions of disagreement regarding the definition and conceptualization of child sexual abuse: The age of the child victim of abuse (ranging from 15 to 17 years), the level of contact of the act that qualifies an incident as sexual abuse (whether sexual acts involve penetration), and the relationship and age difference between the child and the perpetrator (e.g., anyone of any age; anyone at least 5 years older; any adult, relative, family friend, or at least stranger). In addition, the age of consent also varies widely across countries (Collin-Vezina et al. 2013). In other words, cases of child sexual abuse, which is a traumatic experience, will be evaluated depending on the legally established age of consent for consensual sexual intercourse in the country where the incident occurred.

Various international organizations have developed different definitions of child sexual abuse. For example, a comprehensive definition was made by the World Health Organization (WHO 1999) as follows: "the involvement of a child in sexual activity that the child does not fully understand, is unable to give informed consent, or for which the child is developmentally unprepared and unable to give consent, or that violates the law or social taboos of society. Sexual abuse of a child is evidenced by such activity between a child and an adult or another child who, by virtue of age or development, is in a relationship of responsibility, trust or power; this activity is intended to satisfy the needs of the other person. Sexual abuse may include, but is not limited to: the persuasion or coercion of a child to engage in any unlawful sexual activity; the exploitative use of a child in prostitution or other unlawful sexual acts; the exploitative use of children in pornographic performances and materials. The United Nations Committee on the Rights of the Child (2011) elaborates child sexual abuse as follows: (a) Persuading or coercing a child to engage in any illegal or psychologically harmful sexual activity; (b) The use of children in commercial sexual exploitation; (c) The use of children in visual or audio images of sexual exploitation; (d) Child prostitution, sexual slavery, sex tourism, trafficking in persons (within and between countries) and the sale and forced marriage of children for sexual purposes. Many children experience sexual victimization that is not accompanied by physical force or restraint, but is nevertheless psychologically exploitative and traumatic. Sexual abuse includes any sexual activity imposed on a child by an adult and for which the child is entitled to protection under criminal law. Sexual activities are considered abuse when they are committed against a child by another child, if the perpetrating child is significantly older than the child victim, or if they use force, threats or other means of coercion. Sexual activities between children are not considered sexual abuse if the children are older than the age limit established by the State party for consensual sexual activities". Although there are differences in all the definitions presented above, the devastating effects of sexual abuse on children have been documented in many studies (Anda et al. 2010, Afifi et al. 2014, Hailes et al. 2019). Therefore, developing a common understanding of child sexual abuse is vital for effective prevention strategies.

Furthermore, it is essential to emphasize that child sexual abuse is a global public health problem (WHO 2016). Child sexual abuse is a common problem seen all over the world and needs to be addressed seriously, and it is estimated that approximately 1 billion children between the ages of 2-17 are physically, sexually or emotionally abused globally (Hillis et al. 2016). World Health Organization (WHO 2016) data reveal that 1 in every 5 adult women and 1 in every 13 adult men are exposed to childhood sexual abuse. When these officially reported data are analyzed, the seriousness of the situation becomes clear. Victims of childhood sexual abuse can be boys and girls of all ages. There is no specific ethnicity, religion or region where child sexual abuse occurs (Kenny and Wurtele 2012). However, previous research suggests that being female, being at a young age, being disabled, low socio-economic status, absence of parents and mental health problems of parents are risk factors for child sexual abuse (Butler 2013, Bulut and Karaman 2018). A good understanding of risk factors will help experts to identify situations involving risk for child sexual abuse and intervene appropriately.

This study examined which points to focus on when providing counseling services to child victims with a history of sexual abuse. Literature on the subject indicates that there are many studies on mental health problems of adults exposed to childhood abuse and related interventions, but there is a limited number of current studies (Nasıroğlu 2014) on treatment issues related to the mental health problems of child victims of sexual abuse. From this point of view, the aim of this review study is to provide information about childhood sexual abuse experiences, to create a framework about common treatment issues in the counseling process carried out with victimized children and to offer recommendations in this direction. Considering the nature of childhood abuse experiences that leave lifelong permanent scars on the child, being equipped to identify the phenomenon of abuse, intervene in it and support the child in the rehabilitation process is very critical for experts working in this field (Bülbül et al. 2019). Within this context, the current study is intended to guide professionals working in the relevant field in the counseling process and contribute to the literature to reduce the negative consequences of sexual abuse in terms of child mental health.

Psychological Effects of Child Sexual Abuse

An overview of the literature on child abuse shows that there is an increasing number of studies examining the links between exposure to childhood sexual abuse and mental health and psychosocial functioning in adulthood. Adults who were sexually abused in childhood were diagnosed with a higher rate of psychiatric illness compared to those who were not abused (Öztürk et al. 2017, Sousa et al. 2018). Childhood sexual abuse is a risk factor for psychological trauma that has a negative impact on brain development and functioning (Heim et al. 2013). Psychological trauma caused by a profound experience of threat, such as sexual abuse, has been reported to lead to a longer-lasting syndrome called post-traumatic stress disorder (PTSD), which has been defined and validated in the clinical literature and is often associated with devastating functional impairment (Chang et al. 2018). Studies concluded that exposure to childhood sexual abuse is associated with psychiatric problems such as depression, anxiety, anti-social behaviors, suicide (Hailes et al. 2013) and substance abuse (Odacı et al. 2021), mental health and adjustment problems. Childhood sexual abuse victims were also associated with higher rates of sexual dysfunctions and related problems (Pulverman et al. 2018). Again, women who were victims of childhood sexual abuse had higher numbers of sexual partners and shorter-term relationships, and had early and risky sexual behaviors (Wilson and Widom 2008, Senn et al. 2017). Furthermore, research findings highlighted that children exposed to sexual abuse are more likely to experience sexual victimization in adulthood, and almost half of the victims are exposed to sexual abuse again (Walker et al. 2019, Scoglio et al. 2021). This situation may be related to the acquisition of inappropriate sexual behaviors, learned helplessness and decreased self-efficacy (Senn et al. 2012). In addition, symptoms in children and adolescents who are victims of sexual abuse may manifest themselves as behavioral and emotional difficulties (Zeanah et al. 2009), dissociative disorders, memory and recall disorders (Wolf and Nochajski 2013), disorganized or insecure attachment (Cry et al. 2010), loneliness tendencies (Türkkan and Odacı 2018), problematic peer relationships (Kim and Cicchetti 2010), high levels of aggression (Thornberry et al. 2010), self-harm and suicide attempts (Trickett et al. 2011), and trauma and trigger-related disorders (Öztürk et al. 2017). As shown in many studies, sexual abuse causes the destruction of children's behaviors and emotions and has devastating consequences for the lives of the victims. Therefore, it is reasonable to assume that effective strategies for the treatment and prevention of child sexual abuse are of vital importance. Given the high rate of mental health problems of child victims of abuse, it is not surprising that these individuals need mental health services and treatment. Indeed, there is evidence that psychotherapeutic treatments have beneficial effects, including helping to alleviate trauma symptoms, increasing functionality and quality of life, improving family functioning, and preventing the recurrence of abuse, with children's physical and emotional safety being a priority (Swenson and Schaffer 2018, Carr 2019).

This review addresses some of the common treatment issues for children with a history of sexual abuse. The term "treatment" is used here in a broad sense to refer to meeting the psychological and emotional needs of the child. The appropriateness of the treatment issues discussed may vary for each victim. There may also be additional treatment issues not discussed here.

Treatment Issues for Sexually Abused Children

Childhood sexual abuse is an important issue that causes negative psychological symptoms in the short and long term. Sexual abuse is recognized as a risk factor for significant psychiatric disorders and social problems (Coles et al. 2015, Easton et al. 2017, Van der Kolk 2017, Altan-Aytun 2019). The most important issues are discussed below.

Trauma

Childhood sexual abuse is a chronic form of trauma in which the abuser overstimulates the child's feelings of physical fear, sexual arousal and helplessness and the child becomes overwhelmed. When this happens, the child's development is likely to be affected, interrupted and delayed (Türkkan and Odacı 2022). Herman (2015) states that repeated trauma in childhood shapes and deforms the personality. A child who faces a situation where he/she is constantly sexually abused, terrorized or humiliated needs to adapt in order to survive. In other words, the child needs to develop strategies to make him/her feel that he/she can survive the experience of abuse. Therefore, the child may create situations that replicate the abuse in order to master overwhelming emotions and gain a sense of having some control over the traumatic experience (Champion 2022).

Young children depend not only on their own ego capacity but also on the helping capacity of their primary caregivers. However, a child who is sexually abused by a close family member also loses the ability to depend on their parents. In essence, the attachment figure becomes a safe base for the child. The loss of this secure base,

usually provided by parents, is considered the earliest and possibly the most damaging psychological trauma (Weihmann 2022). The parent and abuser who failed to protect the child are guilty of primary betrayal; the child experiences the "trauma of betrayal" and adapts or forgets in order to survive.

To make it easier for the child to cope with the trauma, the child can be helped to express the feelings caused by the trauma in different ways. Through interventions including techniques such as relaxation exercises to help the child remember the details of the traumatic event, to help the child identify the feelings, thoughts, emotions and beliefs generated by the experience, to help the child make connections between what happened during the abuse and how they feel now, and to support them to manage overwhelming experiences, the therapist can help the child to recover from the trauma. In particular, children telling trauma stories, expressing their feelings through play, drawing, singing and prospective role play can stimulate the emotional channel. Expressing emotions reduces anxiety and tension. Repeated recounting of what happened gives a sense of order, integrity and control over the traumatic event. In addition, creative activities such as daydreaming, painting, writing, etc. are a way of coping with overwhelming emotions and have a therapeutic effect. Especially play is an effective coping tool for children. Therefore, it may be useful to include activities such as guided imagination, play, fairy tales, drama and animation in psychosocial support activities (Aytan-Erdoğan 2010, Capella et al. 2016).

Fear and Anxiety

The most common psychopathology observed in abused children is posttraumatic stress disorder (Şimşek et al. 2011). Children's reactions to various traumatic events include two basic dimensions of posttraumatic reaction: repetition of trauma and attempts to deny the trauma (McTeague et al. 2010). These symptoms can be considered as attempts to master or cope with the anxiety produced by the traumatic experience. In other words, the anxiety mentioned here is related to the traumatic effect of abuse on the child rather than environmental reactions. The victim may develop phobic reactions to the event, the perpetrator and other aspects of the abuse. Experiences that evoke memories of abuse begin to cause anxiety. In some children, these anxieties and phobias may become permanent due to the avoidance attempts they use to reduce their stress (SAMHSA 2014). Indeed, in various studies, symptoms related to fear and anxiety in children who were sexually abused were frequently defined as immediate or short-term sequelae (Dönmez et al. 2014). In a study, 64% of a cohort of sexually abused children were reported to fulfill the diagnostic criteria for PTSD and most of the children had symptoms of repetition of the traumatic event, avoidance of activities reminiscent of the traumatic event and anxiety (Şimşek 2011). In short, anxiety can be interpreted as a defense against the stressful experience of sexual victimization.

Before treating a child's fears and anxieties, the therapist should ensure that the child is not being sexually abused or at risk of sexual abuse (Green 1993). Indeed, fear and anxiety arise when an external event threatens the child's safety or well-being. A child who is fearful of the perpetrator, fearful of recurrence of abuse and fearful for their safety needs to be protected in the best way possible. Mandatory reporting laws, emergency intervention and out-of-home placement (if the child's safety cannot be ensured at home) can provide some protection for the child. It is essential that the therapist immediately assesses any existing safety or protection issues that may frighten the child. The therapist should then engage the victim in a series of interventions that allow him/her to gradually cope with the abuse, related phobias and anxiety, often in a way that avoids undue stress. These interventions may include play therapy with discussions with the child about various aspects of the abuse experience and accompanying emotions (Fitzgerald and Cohen 2012).

Interventions with young children may include elements of play therapy, desensitization, graded exposure, modeling and assertiveness training. Interventions can be structured in many different ways, such as play interaction, puppets, dolls, artwork or storytelling. The process is structured by gently encouraging and guiding re-enactment and discussion about various aspects of the abuse experience. Desensitization is a common behavioral technique used to treat fears, anxieties and phobias. Using this method, the person learns relaxation techniques and is gradually exposed to a stimulus that causes anxiety, fear or phobia. Exposure to emotional distress can be alleviated by helping the child to talk about the abuse in safe and supportive therapeutic situations. Through the process of talking regularly and authentically about the material related to the abuse, memories eventually lose their capacity to elicit arousal. However, the child should not be forced to remember or talk about the abuse prematurely, as the therapist and the therapeutic environment may become only a negative reminder of the abuse. However, the therapist can model for the child how to manage the difficult experience. The therapist should model appropriate methods of managing anxiety, such as asking for help, talking about feelings and expressing strong emotions, and strengthening the child's effective coping attempts (Barlow et al. 2002, Fitzgerald and Cohen 2012).

Dissociation

Psychological trauma usually refers to a situation in which a person is exposed to an overwhelming emotional experience that exceeds their ability to understand, accept and integrate it into their understanding of the world (Özen 2017). When this situation is sexual abuse, the child often has no understanding of adult sexuality and is therefore exposed to behaviors that have no point of reference in their past experiences. Intense and contradictory feelings of confusion, fear, arousal, shame and anger overload the child's coping capacity. In such situations, dissociative reactions can be used as a primitive defense against complex types of psychological trauma. In other words, the child develops dissociative symptoms to deny the situation or avoid pain (Hebert et al. 2018). The severity of dissociation may differ in each case. A central hypothesis in understanding the link between trauma and dissociative symptoms involves the failure of the central nervous system to effectively integrate traumatic experiences, leading to abnormal memory processing as well as an inability to integrate and synthesize feelings and sensations related to traumatic experiences into a whole (Brand et al. 2012). Key features of dissociation include detachment and disconnection from self and environment, dissociation of psychological structures, and dissociation of normally integrated neurobiological systems such as cognition, memory and affect. Dissociation is considered a psychological defense against trauma-related effects, and when overwhelming physical or psychological pain is inevitable, it leads to a kind of mental escape and separation from the emotional experience caused by the traumatic event (Cardena and Carlson, 2011). In other words, although dissociation can be comforting in the short term, it can be maladaptive and inhibitory in the long term, prolonging the healing process, as it can enable the person to avoid experiencing the pain and loss caused by the trauma (Lahav et al. 2016). In short, although it has an adaptive function in the context of trauma, dissociation interferes with the processing of traumatic experience and may lead to an increased risk of psychopathology (Alley et al. 2015). In more severe cases, dissociative identity disorder develops, resulting in multiple identities that emerge as distinct personalities with different experiences and characteristics, separated by rigid amnesia barriers (Kluft 1984, APA 2013). Children with this disorder are mostly reported to be victims of sexual abuse in the literature (Bernier et al. 2013).

Often in treatment, when asked about the goal of working on the trauma, especially if the client is an adolescent, the client will respond, "I have talked about it", "I don't need to work on it", "It doesn't bother me". Because the trauma is dissociated, the person may not actually be aware of the impact of the events. Resolution occurs when the person is able to tell a story of the traumatic events without emotionally dissociating or reliving the event. In the treatment of trauma, the goal is to reassociate the dissociated, to release trauma bonds, and to revise core beliefs formed in the emotional intensity of traumatic events (Gerber 2008). To achieve these goals, it is necessary to use a therapy model that can access the dissociated experience. Examples of effective treatment models include Eye Movement Desensitization and Reprocessing (EMDR), Internal Family Systems Therapy supported by the use of expressive therapies, and Ego State Therapy. It can also be effective to work on cognitive distortions that result from abuse and can lead to erroneous thinking such as self-blame. For example, an adolescent may have thoughts such as "I should have been able to stop him" or "I shouldn't have let this happen". By working through these and accessing the child's experience, the therapist can help the child to understand the relationship and power imbalance between themselves and the perpetrator. This understanding helps to relieve shame, which in turn can prevent negative self-perceptions such as "I was wrong" or "I was inadequate" (Foster and Hagedorn 2014, Cowan et al. 2020). In addition, expressive therapies used in combination with individual therapy models to access parts of the self can complement this process. These can include art, psychodrama and music therapies. Adolescents in particular can be resistant to direct attention to vulnerable parts of the self, so art and music can be particularly helpful in engaging the individual.

Further to the information presented above, relational cultural therapy (Walker 2011), which uses the therapeutic relationship as a mechanism for connection, growth, and healing, may be particularly useful for survivors of high betrayal trauma (Gómez et al. 2016). An important component of high betrayal trauma is the relational violation of trust and dependence. Therefore, the use of relational cultural therapy can help repair disconnections between therapist and client by developing strong therapeutic relationships based on mutual empathy and empowerment (Gómez et al. 2016).

Feelings of Guilt and Responsibility

Children who are sexually abused often experience feelings of guilt and responsibility (Alix et al. 2020). These feelings may be related to different elements of sexual abuse. However, feelings of guilt and responsibility often prevent children from reporting ongoing abuse to a protective adult. Victims may also feel guilty that they did not stop the sexual abuse or defend themselves better. Children may also blame themselves for the family crisis

caused by the disclosure of abuse. The child may feel guilty about what happened after the abuse was disclosed, especially if the family has financial problems or if the family is experiencing shame, sadness, anger or loss because of the disclosure. In addition, the parents' reaction or their tendency to blame the victim may reinforce feelings of guilt in the child. It is critical for the abused child to identify who is responsible for the abuse and to understand who the victim and the aggressor are. The role of the clinician is to help the child intellectually understand and emotionally accept that they are not responsible (Furniss 2013). The therapist has to know the details of the abuse to address these areas. An active approach is required here, with the therapist allowing the child to experience and express their feelings (Fitzgerald and Cohen 2012).

To help the child work with feelings of guilt and responsibility, the therapist can discuss the child's relationship with the perpetrator. The child can be informed about adult responsibilities (caring for and protecting children, distinguishing right from wrong, etc.) (Porter et al. 1982). The child needs to know that the perpetrator is an adult and knows the difference between right and wrong. It is also vital to help the child explore why he or she kept the abuse secret and why he or she finally decided to disclose the abuse. The child needs to accept that there are reasons why he or she cannot or will not disclose the abuse and that these reasons do not make the child responsible for the abusive behavior. The child may choose to keep the abuse secret for various reasons such as fear of being blamed or not being believed (Türkkan and Odacı 2022). The child needs to understand why this decision seems to be the only alternative but how it puts the child in a vulnerable position. An important point in this experience is for the child to learn that they have choices and feel that they can make decisions to take care of themselves

Self Concept

The invasive and intrusive nature of sexual abuse negatively affects the child's self and self-esteem (Fergusson et al. 2013). For example, the abuse may lead children to develop beliefs that reflect thoughts such as "I am different", "I do not deserve", "I am defective" or "I am inadequate". Many abused children may feel that they are not worthy of care, protection or love. Because of such thoughts and low self-esteem, they may feel inadequate and ineffective in their interactions with people, and their interactions with their peers may be negatively affected. Furthermore, such core beliefs can guide self-perception and other interactions, thus fueling the cycle of shame and anger (Gerber 2008). For these reasons, working with this population is particularly challenging. The most critical aspect of individual therapy is building trust. Learning to trust again is an essential component of recovery, and counselors serve as a model of a safe adult with healthy boundaries. The therapist must build rapport with the child, create a safe environment, and set collaborative and unique goals for therapy. Treatment should be structured to include building self-esteem and developing self-confidence (Foster and Hagedorn 2014). Victims need help to cope with guilt, shame and fear. They should also be allowed to progress at their own pace. Another therapeutic goal should be to help the child identify healthy support networks (Morrill 2014).

The therapist's task is to make the victims feel whole and well again. Work that addresses the issue of self-blame and interventions that help children see themselves as more than victims of abuse can be useful. Supportive activities such as succeeding in school, playing sports, helping another victim can be very beneficial for the victim's recovery (Fitzgerald and Cohen 2012). The therapist can help the child to develop a self-image based on areas of competence. This will enable the child to feel effective and hopeful about engaging in new behaviors.

Depression

Depression is among the most frequently reported symptoms in child victims of sexual abuse. Childhood traumas are emphasized to be an important vulnerability factor for depression (Maniglio 2010, Stead et al. 2010). From a biological perspective, traumatic life experiences such as abuse alter the physiology and even the structure of the brain, causing long-term changes in neural networks involved in the regulation of physiological response to stress (Shonkoff et al. 2011). The response to threat is characterized by varying degrees of sympathetic (fight and flight) and parasympathetic nervous system activation, depending on the event and the individual. These experiences can sensitize other systems involved in the stress response, so that abuse survivors become overreactive to any environmental trigger or stressor (Sachs-Ericsson et al. 2009).

Apart from the biological explanations presented above, the extent, nature and duration of abuse, as well as the age of onset, can also influence depression. The social isolation of the victim, the identity of the abuser and, more importantly, the lack of support also affect the severity of depression (Martin et al. 2014). The identity of the abuser, whether a family member, friend or stranger, has serious negative consequences for victims' emotional well-being and perceptions of those around them. In particular, early life traumatic experiences, such as abuse, have a dramatic impact on the development of schemas related to one's perception of self, others and

the world. In clinical practice, a significant proportion of clients who are victims of abuse report effects that reshape their cognitive schemas, including patterns of thoughts, feelings, and behaviors, compared to those without any history of abuse or trauma (Widom et al. 2018). Moreover, as depression and suicidal behaviors have been documented more frequently in sexually abused adolescents, it is likely that depressive symptoms are associated with greater awareness of the stigmatizing nature of sexual victimization. This may explain increased shame and guilt in older children. The propensity for depression may also be related to the degree of hopelessness of the child victim and the level of support within the family after disclosure of abuse.

To alleviate depression in children and adolescents, the therapist can identify the child's willingness to experience and express their feelings, and to identify their awareness of the abuse and their feelings. Encouraging the expression of feelings is also very important. Various methods such as poetry, song, dramatic play, art and written expression can be used to facilitate the child's expression of emotions (Capella et al. 2016).

Along with the aforementioned, in the treatment of children who are victims of abuse, trauma-focused cognitive behavioral therapy is among the leading interventions and can significantly improve certain symptoms, especially post-traumatic stress symptoms, depression and behavioral problems (Marquez et al. 2020). Trauma-focused cognitive behavioral therapy is based on well-established cognitive-behavioral therapy developed for the treatment of fear, anxiety, and depression and uses stress management procedures. This intervention protocol is tailored 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 trauma. Examples of such procedures include teaching relaxation methods, helping the child and parent manage their emotional reactions to reminders of the abuse, reorganizing misattributions about the cause of the event, developing skills to express emotions, and engaging clients in self-soothing activities. Parents are also included in treatments so that they can be offered guidance in addressing their child's behavioral difficulties. For example, parents may be trained in child behavior management strategies and effective communication, or family workshops may be conducted to improve communication and create opportunities for therapeutic discussion about abuse (Lev-Wiesel 2008).

Attachment

Attachment theory suggests that early infant-caregiver relationships lead to the formation and internalization of mental representations that form templates for subsequent interpersonal relationships (Kesebir et al. 2011, Yıldızhan 2016). Attachment includes representations of the self and is also a concept that has an impact on social relationships. Bowlby (1982) points to attachment problems as the main source of symptom formation and future problems.

Secure attachment requires caregivers to adapt to the child's emotional state and needs. A secure attachment provides safety in which the child can explore the world. Securely attached children are likely to accept their own feelings and attribute value to their emotions. Securely attached children internalize the ability to soothe themselves. Insecurely attached children, on the other hand, do not develop the ability to meet their developmental needs in a healthy way. Among these children, low self-esteem, lack of empathy, poor social skills, lack of self-regulation skills are frequently observed (Bowlby 1982). Lack of self-regulation is associated with poor impulse control and increases the incidence of aggressive behaviors. Furthermore, insecurely attached children may engage in self-stimulating behaviors such as excessive masturbation to avoid emotional overload (Shavega, 2020). Of particular importance for this discussion is the disorganized attachment style, which refers to the absence of a consistent strategy in attachment behaviors. Research has associated disorganized attachment with hostile and aggressive behaviors as well as dissociation in children (Keskin and Çam 2007, Kesebir et al. 2011).

Many of the fundamental aspects of a person's emotional well-being, including trust, respect, value, identity, relationships and intimacy, are based on attachment to a responsive caregiver. The therapist should therefore make sure that the child has a consistent figure in their life with whom they can relate. A sustained and consistent relationship, built over time, is most helpful in developing the trust that facilitates attachment. A child who bonds and relates with a responsive adult can regain some of his or her ability to fulfill developmental tasks. This responsive adult can be a therapist, caregiver, teacher or other appropriate adult with whom the child can interact on a regular basis. In addition, the therapist can model soothing responses to distressing experiences (Gerber 2008). It is important to help the child explore the therapeutic relationship as a model for quality interaction. The therapist can train the child in social behavior, including reciprocal relationships and social responses to others. Such training facilitates the child's acceptance by peers and adults in the community and gradually reduces the child's dependence on the therapist as an attachment figure (Urquiza and Winn 1992).

Further to the information presented above, addressing attachment issues through family therapy and identifying its potential benefit is also essential. Skills training in interpersonal effectiveness is also necessary to help the child/adolescent develop healthy and satisfying relationships. This may include working on communication and assertiveness skills. While the cognitive aspect of this training is necessary, it is also crucial that the treatment includes an experiential component. In other words, practicing these skills allows the child/adolescent to develop a sense of familiarity (Gerber 2008).

Sexualized Behaviors

One of the serious problems seen in children after sexual abuse is sexualized behavior (Paslı 2019). This is among the most striking and dramatic symptoms seen in sexually abused children. Such acts seem to be particularly linked to traumatic sexual experience (Dillard et al. 2019). According to the literature, victims of abuse not only experience sexuality in a developmentally inadequate and interpersonally dysfunctional way, but also adopt misconceptions about their self-worth, sexual morality, and power to control their lives. These distortions can persist into adulthood and negatively impact victims' sexual and relationship functioning (Fortier et al. 2009). Consequently, sexually victimized children may engage in excessive and explicit masturbation or interact sexually with other people (İşeri 2009). Each act of sexualized behavior also has the potential to enhance the likelihood of such future acts occurring. Such acts can lead to stigmatization of the child, which can have a negative impact on the child's sense of self (Mallants and Casteels 2008, Dillard et al. 2019). Given the far-reaching psychological consequences of sexual abuse on victims and the associated disruptions in relationship functioning, psychological treatment for traumatized victims of sexual abuse is urgently needed.

Treatment of sexualized behaviors is also important because sexual abuse creates a "victim-perpetrator cycle". Previous studies have reported that child sexual abuse is a predisposing factor for the transition from victim to offender (Plummer & Cossins, 2018). Just as a physically abused child often exhibits physically aggressive behaviors as a coping and interaction style, a sexually abused child may show sexualized behaviors to express anxiety or socialization problems (Senn and Carey 2010). Rasmussen (2012) points to the belief that since child sexual abusers often report a history of sexual victimization, there is a progression from victim to victimizer. Accordingly, the more deviant the patient population, the higher the rates of past victimization, and offenders often have a tendency to abuse the victim in a way that replicates their own experience of abuse. Untreated sexualized behaviors should therefore be considered a potential danger. With such acts, the child not only harms himself/herself, but can also cause serious harm to many other children over time (Thomas and Fremouw 2009).

Clinicians should work to reduce and/or eliminate sexualized behaviors by teaching behavior controls. Many parents may also be too punitive in their attempts to end such behaviors. Some may reject the child, or in some families where there is a sense of chaos, there may be a lack of capacity to focus on the child's needs. However, these approaches can exacerbate the problem and alienate the child. It is therefore important to help parents/caregivers intervene in inappropriate sexualized behaviours, set limits to such interactions and reinforce the child's new behaviours. However, it is also essential for the therapist to be sensitive when working with parents and to be aware of how they approach the parents, their tone of voice and body language. Parents can be very sensitive to any accusations or tone of voice in this regard. The therapist should be clear about their role and purpose and maintain empathy. A supportive tone of voice often helps parents to relax, lower their defenses and provide more detailed information (Miller 2009). Building a trusting relationship with all family members is vital. First, parents/caregivers can be made to understand that such behavior is not an uncommon response to sexual abuse and that the child is not permanently harmed. Parents can also be taught behavior modification techniques, including rewarding days without sexualized acts and using a "time-out" for sexual behavior. Timeout is an effective behavior reduction technique to reduce inappropriate social behaviors and is defined as the time that passes in a less reinforcing environment that is made dependent on the behavior. In this context, timeout can be seen as any activity that interrupts a destructive behavior pattern so that constructive problem solving can take place (Morawska and Sanders 2011). Moreover, a child's sexualized behaviors can be redirected to more age-appropriate activities by parents monitoring the child, interrupting any sexual acts, and providing opportunities for positive alternative behaviors. These interventions can also be implemented in pairs with the child and caregiver. It may be valuable to provide sex education to the child, discussing age-appropriate terminology for the genitals, the functioning of the genitals and normal sexual behaviors. Sex education can assist in correcting distortions in the child's knowledge or belief system about sexuality. Besides, when children become aware of their sexualized behaviors and develop more appropriate alternative behaviors, they can positively shape their social life and interactions with other people (Silovsky 2007, Allen and Berliner 2015, MNCASA 2017, Lucier-Greer et al. 2018).

A sexually abused child may have been exposed to early sexual behavior and may have been trained, reinforced,

or rewarded to behave in a sexual manner frequently. The child may not be aware of how their behavior appears to other people. Most victims have little awareness that their behavior is seductive. Some children may also assume that any relationship with an adult will involve sexual contact. The therapist should be aware of these possibilities, set boundaries and respond by explaining to the child that sexual contact is not part of the therapeutic relationship. Sexual feelings and urges are addressed in the context of the trusting relationship that develops between the child and the therapist. The distinction between sexual and affectionate touch can also be elicited in individual and family sessions. The therapist should be aware that affectionate touch during sessions may be misinterpreted by the child (Jones 1986).

Risk of Future Victimization

A common symptom of sexually abused children is engaging in sexually inappropriate behavior. These behaviors include increased masturbation, self-exposure, playing sexual games with peers, and engaging in seductive communication with adults. Such behaviors, which stem from the child's distorted perceptions of appropriate interactions with others, can put them at risk of re-victimization (Wilson and Widom 2008). Therefore, treatment of child victims should include strategies to prevent future victimization. As with other forms of harm to children, a specific program should be developed to address sexuality, sexual safety and appropriate sexual boundaries. For example, teaching children to say no and to tell a trusted adult about the abuse they are experiencing can be helpful, especially if such education is offered in a group setting and there are opportunities for role play. In cases of domestic sexual abuse, it is essential to develop specific protective strategies involving family members (Rudolph and Zimmer-Gembeck 2018). Additionally, a child whose perpetrator uses threats, intimidation, force or weapons needs to be assessed for unresolved issues related to physical or sexual abuse. Indeed, these children are also reported to be at risk for problems such as aggressive behavior, antisocial behavior and impulse control (Zeanah et al. 2009, Thornberry et al. 2010). Developing empathy, changing the perspective on one's own victimization in a positive way, behavior management, relapse and prevention techniques make it easier to manage these behaviors. Family therapy can provide a structure in which these skills can be developed and practiced (Urquiza and Winn 1992).

Violent and Aggressive Behaviors

The violent aspects of sexual abuse and the perpetrator's threats against the child can make it difficult for the child to disclose and make sense of their own experiences (Türkkan and Odacı 2022). It may be useful for the therapist to provide direct explanations to help the child make sense of this overwhelming act. Children may also tend to identify with their abusers and at times their anger can be overwhelming. With the therapist's acknowledgment of violent feelings, thoughts and actions, helping the child to understand the origins of these feelings is paramount. However, the therapist should be aware of the need to approach the child as calmly and patiently as possible (Adli Destek ve Magdur Hizmetleri Dairesi Başkanligi 2021). The therapist should develop a relationship of trust with the child, modeling appropriate responses. Allowing the child to express his/her experiences with the abuser and confront the abuser to some extent with metaphorical forms of expression to express aggressive behavior can be more beneficial in terms of promoting the perception of trust (Barut 2021).

A large proportion of severely aggressive children have a history of suspected child maltreatment. These children may identify with the aggressor, have repressed anger, or have problems with impulse control that make it difficult for them to control their behavior. An aggressive child must learn to take responsibility for the consequences of this behavior (Erben Keçici 2018). A child who exhibits aggression has often been raised in families characterized by harsh and inconsistent discipline, little positive parental involvement with the child, and poor supervision of the child's activities (Özbey 2010). Involving parents in interventions is therefore crucial to protect vulnerable children in the home. The aggressive child also needs to be protected. No matter how they behave, children deserve protection from dangerous or inappropriate adult behavior. Structure, planning, continuity, consistency and a nurturing environment are all significant factors when working with aggressive children (Patterson et al. 1998).

While working with children who exhibit aggressive behaviors, it may be of benefit to provide opportunities for the child to reenact past feelings and experiences. This can assist the aggressive child to become aware of the underlying emotions and pain and to develop a plan to manage their reactions. Training the child to delay gratification, manage impulsive behavior, and be aware of how his or her behavior affects others is also worthwhile. These interventions will enable the child to relate to peers and adults in more appropriate and acceptable ways. The therapist should also consider whether the child is a danger to himself/herself or others. Behaviors such as risk taking, creating violent conflicts or attacking others should be restricted. Furthermore,

the clinician should also address sexually aggressive behavior and, if necessary, report this behavior to the relevant authorities (Urquiza and Winn 1992).

Conclusion

Child sexual abuse is a traumatic life experience with devastating consequences. Abused children are at risk of developing behavioral, emotional, cognitive and physical health problems throughout their lives. Therefore, treatment interventions to be applied to victims are very critical. Effective interventions tailored to children's developmental level can help mitigate and prevent some of the serious and lasting effects of abuse. As in all clinical work, the quality of the therapeutic relationship between therapist and child is the foundation of trauma treatment. Interventions should be delivered in the context of a strong and supportive therapeutic relationship and include psychoeducation of the child/young person's coping skills and safety planning. As each child will react differently to the traumatic event, listening to them and trying to understand their perspectives and concerns is essential. However, treatment alone will not eliminate child abuse. Clinicians should organize and use all available resources to help children. Parents, family members, school and law enforcement should work together to protect children from sexual abuse. The need for further research is also felt to ensure the development and dissemination of clinical services that are relevant for traumatic experiences. However, research funding to help better understand sexual abuse and how to address it is limited. In this context, governments should fund research and support child protection programs through inter-agency collaboration to reduce potential risks. A road map for experts working with child victims of abuse on treatment issues was tried to be created in this study. Conducting new studies based on the problems experienced by professionals working in the field in interventions and interviews for this purpose and including examples of practice can contribute to filling the gap in the literature.

References

Adli Destek ve Mağdur Hizmetleri Dairesi Başkanlığı (2021) Mağdura Yaklaşım Kılavuzu. Ankara, Adli Destek ve Mağdur Hizmetleri Dairesi Başkanlığı.

Afifi TO, MacMillan HL, Boyle M, Taillieu T, Cheung K, Sareen J (2014) Child abuse and mental disorders in Canada. Can Med Assoc J, 186:E324–E332.

Alix S, Cossette L, Cyr M, Frappier JY, Caron PO, Hébert M (2020) Self-blame, shame, avoidance, and suicidal ideation in sexually abused adolescent girls: A longitudinal study. J Child Sex Abus, 29:432–447.

Allen B, Berliner L (2015) Evidence-informed, individual treatment of a child with sexual behavior problems: A case study. Arch Sex Behav, 44:2323-2331.

Alley D, Chae Y, Cordon I, Kalomiris A, Goodman GS (2015) Child maltreatment and autobiographical memory development: Emotion regulation and trauma-related psychopathology. In Clinical Perspectives On Autobiographical Memory (Eds LA Watson, D Bernsten):85–106). New York, NY, Cambridge University Press.

Altan-Aytun Ö (2019) Kendine zarar verme davranışı: Özellikleri, işlevleri ve travmatik yaşantılar, çocukluk örselenmeleri, kişilik özellikleri ve baş etme tutumlarının rolü. Doktora tezi. İstanbul Üniversitesi, Cerrahpaşa Adli Tıp Enstitüsü, İstanbul.

Anda R, Tietjen G, Schulman E, Felittei V, Croft J (2010) Adverse childhood experiences and frequent headaches in adults. Headache, 50:1473–1481.

APA (2013) Diagnostic and Statistical Manual of Mental Disorders, 5th edition. Arlington, VA, American Psychiatric Association.

Aytan-Erdoğan Ş (2010) Travma yaşantısı olan üniversite öğrencilerinin baş etme becerilerini geliştirmede psikodramanın etkisi (Yüksek lisans tezi). İstanbul, Marmara Üniversitesi.

Barlow DH, Raffa SD, Cohen EM (2002). Psychosocial treatments for panic disorders, phobias, and generalized anxiety disorder. In A Guide To Treatments That Work (Eds PE Nathan, JM Gorman):301–335. New York, Oxford University Press.

Barut B (2021) Cinsel istismar mağdurlarına yaklaşım ve terapötik süreç. Uluslararası Sosyal Araştırmalar Dergisi, 14:602-615.

Bernier MJ, Hebert M, Collin-Vezina D (2013) Dissociative symptoms over a year in a sample of sexually abused children. J Trauma Dissociation, 14:455–472.

Bowlby J (1982) Attchment and loss: Retrospect and prospect, Am J Orthopsychiatry, 52:578-751.

Brand BL, Lanius R, Vermetten E, Loewenstein RJ, Spiegel D (2012) Where are we going? An update on assessment, treatment, and neurobiological research in dissociative disorders as we move toward the DSM-5. J Trauma Dissociation, 13:9–31.

Brett EA, Ostroff R (1985) Imagery and post-traumatic stress disorder: An overview. Am J Psychiatry, 142:417-424.

Bülbül K, Çakıcı AB, Türkkan T (2019) Sınıf öğretmenlerinin çocuk istismarı ve ihmaline yönelik bilgi ve risk tanıma düzeylerinin incelenmesi . Türkiye Eğitim Dergisi, 4:127-144 .

Bulut S, Karaman HB (2018) Engelli bireylerin cinsel, fiziksel ve duygusal istismarı. Ankara Üniversitesi Eğitim Bilimleri Fakültesi Özel Eğitim Dergisi, 19:277-301.

Butler AC (2013) Child sexual assault: Risk factors for girls. Child Abuse Negl, 37:643– 652.

Capella C, Lama X, Rodríguez L, Águila D, Beiza G, Dussert D et al. (2016) Winning a race: Narratives of healing and psychotherapy in children and adolescents who have been sexually abused. J Child Sex Abus, 25:73–92.

Cardena E, Carlson E (2011) Acute stress disorder revisited. Annu Rev Clin Psychol, 7:245–267.

Carr A (2018) Family therapy and systemic interventions for child-focused problems: The current evidence base. J Fam Ther, 41:153-213.

Champion KM (2022) Coercion in families and child resistance to contact with a parent after family separation. J Fam Trauma Child Custody Child Dev, 19:230-243.

Chang C, Kaczkurkin AN, McLean CP, Foa EB (2018). Emotion regulation is associated with PTSD and depression among female adolescent survivors of childhood sexual abuse. Psychol Trauma, 10:319–326.

Coles J, Lee A, Taft A, Mazza D, Loxton D (2015) Childhood sexual abuse and its association with adult physical and mental health. J Interpers Violence, 30:1929–1944.

Collin-Vézina D, Daigneault I, Hébert M (2013) Lessons learned from child sexual abuse research: prevalence, outcomes, and preventive strategies. Child Adolesc Psychiatry Ment Health, 7:22.

Committee on the Rights of the Child (2011) General comment No. 13 on the right of the child to freedom from all forms of violence. http://www.ohchr.org/EN/ HRBodies/CRC/Pages/CRCIndex.aspx (Accessed 12.01.2023).

Cowan A, Ashai A, Gentile JP (2020) Psychotherapy with survivors of sexual abuse and assault. Innov Clin Neurosci, 17:22-26.

Cry C, Euser EM, Bakermans-Kranenburg MJ, Van Ijzendoorn MH (2010) Attachment security and disorganization in maltreating and high-risk families: A series of metaanalyses. Dev Psychopathol, 22:87-108.

Dillard R, Maguire-Jack K, Showalter K, Wolf KG, Letson MM (2019). Abuse disclosures of youth with problem sexualized behaviors and trauma symptomology. Child Abuse Negl, 88:201–211.

Dönmez YE, Soylu N, Özcan ÖÖ, Yüksel T, Demir AÇ, Bayhan PÇ, Miniksar DY (2014) Cinsel istismar mağduru çocuk ve ergen olgularımızın sosyodemografik ve klinik özellikleri. Turgut Özal Tıp Merkezi Dergisi, 21:44-48.

Easton SD, Kong J, Gregas M, Shen C, Shafer K (2018) Child sexual abuse and depressive symptoms in late life for men: A population-based, longitudinal analysis. J Gerontol B Psychol Sci Soc Sci, 74:842–852.

Erben Keçici S (2018) Okullarda saldırganlık ve yıkıcı davranışları önleme önerisi: Yüzleştirme eğitimi. Milli Eğitim Dergisi, 47:77-90.

Fergusson DM, McLeod GF, Horwood LJ (2013) Childhood sexual abuse and adult developmental outcomes: Findings from a 30-year longitudinal study in New Zealand. Child Abuse Negl, 37:664–674.

Finkelhor D, Korbin J (1988) Child abuse as an international issue. Child Abuse Negl, 12:3-23.

Fitzgerald MM, Cohen A (2012) Trauma-focused cognitive behavior therapy for school psychologists. J Appl Sch Psychol, 28:294-315.

Fortier MA, DiLillo D, Messman-Moore TL, Peugh J, DeNardi KA, Gafey KJ (2009) Severity of child sexual abuse and revictimization: The mediating role of coping and trauma symptoms. Psychol Women Q, 33:308–320.

Foster JM, Hagedorn WB (2014). A qualitative exploration of fear and safety with child victims of sexual abuse. J Ment Health Couns, 36:243–262.

Furniss T (2013) The Multiprofessional Handbook of Child Sexual Abuse: Integrated Management, Therapy, and Legal Intervention. London, Routledge.

Gerber J (2008) Treatment of sexually compulsive adolescents. Psychiatr Clin North Am, 31:657–669.

Giovannoni J, Becerra R (1979) Defining Child Abuse. New York, NY, Free Press

Gómez JM, Lewis JK, Noll LK, Smidt AM, Birrell PJ (2016) Shifting the focus: Nonpathologizing approaches to healing from betrayal trauma through an emphasis on relational care. J Trauma Dissociation, 17:165–185.

Green AH (1993) Child sexual abuse: Immediate and long-term effects and intervention. J Am Acad Child Adolesc Psychiatry, 32:890-902.

Hailes HP, Yu R, Danese A, Fazel S (2019) Long-term outcomes of childhood sexual abuse: An umbrella review. Lancet Psychiatry, 6:830-839.

Haley J (1976) Problem-Solving Therapy. New York, Harper.

Hall M, Hall J (2011) The long-term effects of childhood sexual abuse: Counselling implications. Vistas Online, 19.

Hébert M, Langevin R, Oussaïd E (2018). Cumulative childhood trauma, emotion regulation, dissociation, and behavior problems in school-aged sexual abuse victims. J Affect Disord, 225:306–312.

Heim C, Mayberg HS, Mletzko T, Nemeroff CB, Pruessner GC (2013) Decreased cortical representation of genital somatosensory field after childhood sexual abuse. Am J Psychiatry, 170:616–623.

Herman JL (2015) Trauma and Recovery: The Aftermath of Violence--From Domestic Abuse To Political Terror. New York, NY, Basic Books.

Hillis S, Mercy J, Amobi A, Kress H (2016) Global prevalence of past-year violence against children: A systematic review and minimum estimates. Pediatrics, 137:e20154079.

İşeri E (2009) Çocuk psikiyatrisi uygulamalarında istismar olgularının tanınması. Çocuk İstismarını ve İhmalini Önleme Kongresi, 27-30 Eylül 2009, Ankara.

Jackson AM, Deye K (2015) Aspects of abuse: Consequences of childhood victimization. current problems in pediatric and adolescent. Health Care, 45:86–93.

Jones DPH (1986) Individual psychotherapy for the sexually abused child. Child Abuse Negl, 10:377–385.

Kenny MC, Wurtele SK (2012) Preventing childhood sexual abuse: An ecological approach. J Child Sex Abus, 21:361–367.

Kesebir S, Kavzoğlu SÖ, Üstündağ MF (2011) Bağlanma ve psikopatoloji. Psikiyatride Güncel Yaklaşımlar, 3:321-342.

Keskin G, Çam O (2007) Bağlanma süreci: Ruh sağlığı açısından literatürün gözden geçirilmesi. Ege Üniversitesi Hemşirelik Fakültesi Dergisi, 23:145-158.

Kluft RP (1984) Multiple personality in childhood. Psychiatr Clin North Am, 7:121–134.

Lahav Y, Bellin E, Solomon, Z (2016) Posttraumatic growth and shattered world assumptions among ex-POWs: The role of dissociation. Psychiatry, 79:418–432.

Lev-Wiesel R (2008) Child sexual abuse: A critical review of intervention and treatment modalities. Child Youth Serv Rev, 30:665–673.

Lucier-Greer M, Nichols LR, Peterson C, Burke B, Quichocho D, O'Neal CW (2018) Problematic Sexual Behavior Among Children and Youth: Considerations for Reporting, Assessment, and Treatment. Auburn, AL, Military REACH.

Mallants C, Casteels K (2008) Practical approach to childhood masturbation-A review. Eur J Paediatr, 167:1111–1117.

Maniglio R (2010) Child sexual abuse in the etiology of depression: A systematic review of reviews. J Depress Anxiety, 27:631–642.

Marquez YI, Deblinger E, Dovi AT (2020) The value of trauma-focused cognitive behavioral therapy (TF-CBT) in addressing the therapeutic needs of trafficked youth: A case study. Cogn Behav Pract, 27:253-269.

Martins CM, Von Werne Baes C, Tofoli SM, Juruena MF (2014) Emotional abuse in childhood is a differential factor for the development of depression in adults. J Nerv Ment Dis, 202:774–782.

Mathews B, Collin-Vézina D. (2019) Child sexual abuse: Toward a conceptual model and definition. Trauma Violence Abuse, 20:131–148.

McTeague LM, Lang PJ, Laplante MC, Cuthbert BN, Shumen JR, Bradley MM (2010) Aversive ımagery in posttraumatic stress disorder: Trauma recurrence, comorbidity, and physiological reactivity. Biol Psychiatry, 67:346–356.

MNCASA (2017) Children with sexual behavior problems: Improving Minnesota's ability to provide early identification and intervention services through policy and practice recommendations. Minnesota, Minnesota Coalition Against Sexual Assault (MNCASA).

Morrill M (2014) Sibling sexual abuse: An exploratory study of long-term consequences for self-esteem and counseling considerations. J Fam Violence, 29:205–213.

Nasıroğlu S (2014) Çocuk istismarında rehabilitasyon ve tedavi merkezleri. Psikiyatride Güncel Yaklaşımlar, 6:67-78.

Negriff S, Schneiderman J, Smith C, Schreyer J, Trickett P (2014) Characterizing the sexual abuse experiences of young adolescents. Child Abuse Negl, 38:261–270.

Odacı H, Bülbül K, Türkkan T (2021) The mediating role of cognitive flexibility in the relationship between traumatic experiences in the childhood period and substance abuse proclivity. J Ration Emot Cogn Behav Ther, 39:538–554.

Odhayani AA, Watson WJ, Watson L (2013) Behavioural consequences of child abuse. Can Fam Physician, 59:831-836.

Özbey S (2010) Okul öncesi çocuklarda uyum ve davranış problemleriyle başa çıkmada ailenin rolü. Aile ve Toplum Dergisi, 21:9-18.

Özen Y (2017) Psikolojik travmanın insanlık kadar eski tarihi. The Journal of Social Science, 1:104-117.

Öztürk M, Uzel-Tanrıverdi B, Yalın-Sapmaz Ş (2017) Cinsel istismara uğrayan çocuk ve ergenlerin sosyodemografik ve klinik özelliklerinin değerlendirilmesi, psikopatoloji ve ilişkili risk etkenleri. Çocuk ve Gençlik Ruh Sağlığı Dergisi, 24:155-163.

Paslı F (2019) Çocuğa yönelik cinsel istismar deneyiminin mikro ve mezzo sistemler açısından incelenmesi. Toplum ve Sosyal Hizmet, 30:463-492.

Patterson GR, Reid JB, Dishion TJ (1998) Antisocial boys. In Human Emotions: A Reader (Eds JM Jenkins, K Oatley, NL Stein): 330–336. Malden, MA, Blackwell Publishing..

Plummer M, Cossins A (2018) The cycle of abuse: When victims become offenders. Trauma Violence Abuse, 19:286–304.

Porter FS, Blick LC, Sgroi SM (1982) Treatment of the sexually abused child. In Handbook of Clinical Intervention In Child Sexual Abuse (Ed SM Sgroi): 109-145. Lexington, MA, DC. Heath.

Pulverman CS, Kilimnik CD, Meston CM (2018) The impact of childhood sexual abuse on women's sexual health: a comprehensive review. Sex Med Rev, 6:188-200.

Rasmussen LA (2012) Victim and victimizer: The role of traumatic experiences as risk factors for sexually abusive behavior. Isr J Psychiatry Relat Sci, 49:270–279.

Rudolph J, Zimmer-Gembeck MJ (2018) Parents as protectors: A qualitative study of parents' views on child sexual abuse prevention. Child Abuse Negl, 85:28-38.

Sachs-Ericsson N, Cromer K, Hernandez A, Kendall-Tackett K (2009) A review of childhood abuse, health, and pain-related problems: The role of psychiatric disorders and current life stress. J Trauma Dissociation, 10:170–188.

SAMHSA (2014). Understanding the impact of trauma. In Trauma-Informed Care in Behavioral Health (pp. 59–90). Rockville, MD, Substance Abuse and Mental HealthServices Administration.

Scoglio AA, Kraus SW, Saczynski J, Jooma S, Molnar BE (2021) Systematic review of risk and protective factors for revictimization after child sexual abuse. Trauma Violence Abuse, 22:41-53.

Senn TE, Braksmajer A, Urban MA, Coury-Doniger P, Carey MP (2017) Pilot test of an integrated sexual risk reduction intervention for women with a history of childhood sexual abuse. AIDS Behav, 21:3247–3259.

Senn TE, Carey MP, Coury-Doniger P (2012) Mediators of the relation between childhood sexual abuse and women's sexual risk behavior: A comparison of two theoretical frameworks. Arch Sex Behav, 41:1363–1377.

Senn, TE, Carey MP (2010) Child maltreatment and women's adult sexual risk behavior: Childhood sexual abuse as a unique risk factor. Child Maltreat, 15:324–335.

Shavega T (2020) Intervention strategies of excessive masturbation for a 19-years youth: Experience of counseling ıntervention. Open Journal of Therapy and Rehabilitation, 8:98-109.

Shonkoff JP, Garner AS, Siegel BS, Dobbins MI, Earls MF, Garner AS (2011) The lifelong effects of early childhood adversity and toxic stress. Pediatrics, 129:e232–e246.

Silovsky JF, Niec L, Bard D, Hecht DB (2007) Treatment for preschool children with ınterpersonal sexual behavior problems: A pilot study. J Clin Child Adolesc Psychol, 36:378-391.

Şimşek Ş, Fettahoğlu E, Özatalay E (2011). Cinsel istismara yönelik travmalar ve travma sonrası stres bozukluğu. Dicle Tıp Dergisi, 38:318-324.

Sousa C, Mason WA, Herrenkohl TI, Prince D, Herrenkohl RC, Russo MJ (2018) Direct and indirect effects of child abuse and environmental stress: A lifecourse perspective on adversity and depressive symptoms. Am J Orthopsychiatry, 88:180-188.

Stead R, Shanahan MJ, Neufeld RWJ (2010) I'll go to therapy, eventually: Procrastination, stress and mental health. Pers Individ Dif, 49:175–180.

Swenson CC, Schaeffer CMA (2018) Multisystemic approach to the prevention and treatment of child abuse and neglect. Int J Child Maltreat, 1:97-120.

Thomas TA, Fremouw W (2009) Moderating variables of the sexual "victim to offender cycle" in males. Aggress Violent Behav, 14:382–387.

Thornberry TP, Henry KL, Ireland TO, Smith CA (2010) The causal impact of childhood-limited maltreatment and adolescent maltreatment on early adult adjustment. J Adolesc Health, 46:359-365.

Trickett PK, Noll JG, Putnam FW (2011) The impact of sexual abuse on female development: Lessons from a multigenerational longitudinal research study. Dev Psychopathol, 23:453–476.

Türkkan T, Odacı H (2022) Söylemek mi gizlemek mi? Çocuk mağdurların cinsel istismarı açıklamalarını etkileyen faktörler. Toplum ve Sosyal Hizmet, 33:991-1008.

Urquiza AJ, Winn C (1992) Treatment for Abused and Neglected Children: Infancy to Age 18. Washington DC, United States Department of Health and Human Services Administration for Children and Families.

Van der Kolk BA (2017) Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. Psychiatr Ann, 35:401–408.

Walker HE, Freud JS, Ellis RA, Fraine SM, Wilson LC (2017) The prevalence of sexual revictimization. Trauma Violence Abuse, 20:67-80.

Walker HE, Freud JS, Ellis RA, Fraine SM, Wilson LC (2019) The prevalence of sexual revictimization: A meta-analytic review. Trauma Violence Abuse, 20:67–80.

Walker M (2011) What's a feminist therapist to do? Engaging the relational paradox in a post-feminist culture. Women Ther, 34:38–58.

Weihmann R (2022) Symptomatology of reconstitution of trauma in adults with a history of childhood sexual abuse. An approach from the perspective of S-ONapp application. International Journal of Advanced Studies in Sexology., 4:31-40.

WHO (1999) Report of the Consultation On Child Abuse Prevention. Geneva, World Health Organization.

WHO (2016) Child maltreatment. http://www.who.int/mediacentre /factsheets/fs150/en/ (Accessed 06.11.2022)

Widom CS, Czaja SJ, Kozakowski SS, Chauhan P (2018) Does adult attachment style mediate the relationship between childhood maltreatment and mental and physical health outcomes? Child Abuse Negl, 76:533–545.

Wilson HW, Widom CS (2008) An examination of risky sexual behavior and HIV in victims of child abuse and neglect: A 30-year follow-up. Health Psychol, 27:149–158.

Wolf MR, Nochaiski TH (2013) Child sexual abuse survivors with dissociative amnesia: What's the difference. J Child Sex Abus, 22:462–480.

Yıldızhan E (2016) Bağlanma kuramı ve bağlanma bozukluklarına bir bakış. Anadolu Kliniği Tıp Bilimleri Dergisi, 22:66-72.

Zeanah CH, Egger HL, Smyke AT (2009) Institutional rearing and psychiatric disorders in Romanian preschool children. Am J Psychiatry, 166:777–785.

Authors Contributions: The author(s) have declared that they have made a significant scientific contribution to the study and have assisted in the preparation or revision of the manuscript
Peer-review: Externally peer-reviewed.
Conflict of Interest: No conflict of interest was declared.
Financial Disclosure: No financial support was declared for this study.