



Childhood Sexual Abuse: An Evidence Based Perspective

The Effects of Childhood Sexual Abuse on Children

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The Effects of Childhood Sexual Abuse on Children

A key issue in this field concerns the extent to which CSA leads to subsequent psychological damage and adjustment difficulties during childhood. There is little doubt that children exposed to CSA find this experience bewildering, upsetting, or distressing (Beitchman, Zucker, Hood, da Costa, & Akman, 1991; Kendall-Tackett, Williams, & Finkelhor, 1993). In this chapter, we review the evidence on the impact of CSA on child adjustment. Three central questions underlie this analysis. First, to what extent does exposure to CSA lead to the onset of problem behaviors and difficulties in children? Second, what factors influence the resilience of children exposed to CSA? Third, to what extent does treatment of CSA reduce the adverse effects of CSA on children?

CSA and Childhood Adjustment

Until recently, there has been little attention given to the impact of CSA on children, with most of the research being concerned with the harmful effects of CSA that manifest in later life (Kendall-Tackett et al., 1993). There are, however, a growing number of studies that examine the extent to which children exposed to CSA are at an increased risk of a range of subsequent adjustment difficulties. The majority of studies have used research designs in which a sample of children known to have been sexually abused has been contrasted with a sample of nonabused children.

A study conducted by Mannarino, Cohen, and Gregor (1989) is typical of research in this area. Three groups of girls were selected for study: (a) those known to have been sexually abused and who had been referred to a regional rape crisis center ($n = 94$); (b) those who were attending an outpatient psychiatric clinic but who had not been sexually abused ($n = 84$); and (c) a control group selected from two schools ($n = 75$). Each group was assessed on a series of self- and parent-report measures of behavioral and emotional functioning. Contrasts between the three groups suggested that, when compared with normal controls, sexually abused girls had consistently higher mean levels of all parental reported behavior problems and also had lower mean levels of parent-reported social competence. However, with the exception that sexually abused girls had significantly higher levels of sexual problems than the clinic controls, girls who had been sexually abused showed a similar profile of behavior problems and social competence to the clinic-referred group. Mannarino et al. concluded that “this study and other recent investigations have demonstrated that sexually abused children manifest a wide variety of emotional and behavioral problems” (p. 449).

The majority of studies employing similar methodologies report higher rates of a wide range of adjustment difficulties in children exposed to CSA. Kendall-Tackett et al. (1993) reviewed a series of 26 studies that examined the linkages between CSA and a wide range of adjustment difficulties. [Table 4.1](#) provides a summary of their findings. The table shows (a) the range of childhood outcomes studied, (b) the number of studies that examined this issue, and (c) the number of studies finding elevated rates of adjustment problems among those exposed to CSA. The results in this table make it abundantly clear that the majority of studies that have compared children known to be sexually abused with nonabused control participants have found higher rates of adjustment problems among the abused children, with these problems spanning mental health symptoms, low self-esteem, and problem behaviors including aggression, delinquency, and sexualized behavior.

TABLE 4.1 Summary of Studies Comparing Rates of Problems Among Children

Exposed to CSA and Controls

<i>Outcome</i>	<i>Number of Studies</i>	<i>Number (%) Reporting Significantly Higher Rates of Problems Among Children Exposed to CSA Than Among Controls</i>
Anxiety	8	5 (62.5)
Fear	5	5 (100)
Posttraumatic stress disorder		
Nightmares	1	1 (100)
General	1	1 (100)
Depression		
Depressed	11	10 (90.9)
Withdrawn	11	11 (100)
Suicidal	1	0 (0)
Poor self-esteem	6	3 (50)
Somatic complaints	11	9 (81.8)
Mental illness		
Neurotic	2	2 (100)
Other	7	6 (85.7)
Aggression		
Aggressive antisocial	11	10 (90.9)
Cruel	2	2 (100)
Delinquent	6	6 (100)
Inappropriate sexual behavior	8	8 (100)
School/learning problems	6	5 (83.3)
Behavior problems		
Hyperactivity	7	5 (71.4)
Regression/im maturity	2	2 (100)
Running away	1	1 (100)
General	2	2 (100)
Self-injurious behavior	1	1 (100)
Composite		

symptoms		
Internalizing	8	8 (100)
Externalizing	7	7 (100)

SOURCE: Derived from Kendall-Tackett et al. (1993).

In an extension of their analysis, Kendall-Tackett et al. (1993), using meta-analytic techniques, examined the associations between sexual abuse status (abused versus not abused) and a series of outcomes, including aggression, anxiety, depression, withdrawn behavior, sexualized behaviors, and internalizing and externalizing behavior problems. In their analysis, they estimated the percentage of variance in each outcome that could be explained from a knowledge of sexual abuse status. This analysis suggested the presence of moderate to strong associations between abuse status and outcomes, with variance-explained estimates ranging from 15% for anxiety to 43% for aggression and sexualized behaviors. However, percentage variance estimates are difficult to interpret in clinically meaningful ways, and it would be of interest to know how many more times likely children exposed to CSA are to develop given outcomes when compared with nonabused children. This may be achieved by computing the odds ratio between abuse status (abused versus not abused) and outcome risks. Unfortunately, many studies that were reported in this literature do not present data in a way that permits an estimation of odds ratios. However, we will now review three studies that permit (from a secondary analysis of published data) an estimation of odds ratios between abuse status and outcome risks.

Einbender and Friedrich (1989) compared a series of 46 sexually abused girls identified through agency and private therapist referrals with a group of comparison control girls who had never been known or suspected to have been sexually abused. The two groups were matched for age, ethnicity, family income, and family constellation. The two groups were then compared on a series of measures of intelligence, mental health, and social functioning. The main analyses of this data compared mean scores of the two groups and showed that sexually abused children scored significantly higher on measures of sexual preoccupation as well as cognitive, social, and emotional impairment. As part of the analysis, the authors reported rates of clinical impairment on measures of externalizing and internalizing behaviors. From this analysis, it is possible to deduce that those exposed to CSA had odds of externalizing disorders that were 7.3 times higher than those who were not exposed to CSA and odds of internalizing disorders that were 5.2 times higher than those not exposed to CSA.

Similarly, Deblinger, McLeer, Atkins, Ralphe, and Foa (1989) compared rates of sexualized behaviors in two groups of inpatients in an acute psychiatric unit: 29 children who had been sexually abused and 29 children who had not been. From the data presented in this paper, it was possible to compute the odds ratio between sexual abuse status and two measures of sexual behavior: inappropriate sexual behavior and sexually abusive behavior toward younger children. This analysis showed that in comparison with psychiatric inpatients who were not known to have been sexually abused, inpatients with a history of sexual abuse had rates of sexually abusive behavior to other children that were 12.6 times higher and rates of sexually inappropriate behaviors that were 45.8 times higher.

Finally, Gomes-Schwartz, Horowitz, Cardarelli, and Sauzier (1990) examined a range of measures of mental health and personal adjustment in a sample of 58 children, ages 7–13 years, who were referred for treatment after sexual abuse. Personal adjustment was assessed using the Louisville Behavior Checklist. Although the study design did not include the assessment of a nonabused control group, the authors were able to compare levels of

adjustment in the sexually abused group with population norms for the Louisville Behavior Checklist, and it was possible from secondary analyses of the data to compute odds ratios between abuse status and risks of behavioral disturbance. These calculations produced a total of 10 odds ratios that ranged from 1.9 to 44.1, with a median value of 7.8, and clearly indicated that children who were receiving treatment for sexual abuse had elevated risks of a wide range of personal, social, and behavioral problems.

This evidence clearly suggests that children who are known to have been sexually abused are an “at risk” population for a wide range of disorders and adjustment difficulties, and at first sight the evidence suggests the presence of a causal link (Green, 1993; Kendall-Tackett et al., 1993). In the next section, we review some of the difficulties and uncertainties that arise in interpreting this evidence.

Is There a Causal Relationship between CSA Exposure and Childhood Adjustment?

The evidence previously reviewed in this chapter provides a generally compelling case for children exposed to CSA having an increased risk of adjustment problems, which is consistent with CSA causing those adjustment problems. However, there are a number of alternative explanations of these associations. The major threats to the validity of a causal hypothesis include the following:

1. *The effects of sample selection processes.* In all studies to date, contrasts have been made between children who are known to have been sexually abused and a nonabused control group. In all cases, samples of those children who were abused have not been a random sample of all abused children but, rather, represent selected samples that have been drawn from agency records and other similar sources. The major liability of this design is that the processes by which samples of abused children are selected may produce misleading or spurious associations between CSA and risks of adjustment problems. For example, it may be argued that the heightened rates of adjustment difficulties among these selected samples arises from a bias in which those coming to agency attention are, for other reasons, more likely to have adjustment problems. This is, in fact, likely, given that the presence of behavior problems has often been the grounds for examining whether these adjustment problems were due to CSA (Corwin, 1988). The effects of this sampling bias would be to produce an inflated impression of the linkages between CSA and child adjustment.
2. *Confounding.* Even assuming that comparisons between samples of children known to be sexually abused and control series are not seriously affected by sample selection biases, there are further complications. In particular, as noted in the preceding chapter, children exposed to CSA are frequently exposed to other adverse and disadvantageous circumstances. These factors include greater exposure to family dysfunction and marital difficulties, greater exposure to parental adjustment difficulties, and related factors. It may be argued that the elevated risks of adjustment difficulties among those exposed to CSA reflect the effects of the social and familial context within which CSA is more likely to occur rather than the traumatic effects of CSA itself. To some extent, this threat to validity can be addressed by adjusting differences between abused and nonabused children for other factors that are known to be correlated with abuse status. To date, however, attempts to control for confounding variables have been limited, with the majority of studies in this area making no attempt and others making only limited efforts.

Both sample-selection processes and failure to control for confounding factors pose major

threats to the validity of inferences of causal linkages between CSA and child adjustment. Furthermore, the likely direction of study bias, to date, is to lead to an overestimation of the causal effects of CSA on childhood adjustment. It may nonetheless be argued that despite the possibility of such bias, exposure to CSA does, in fact, lead to increases in rates of a wide range of childhood adjustment difficulties. Several lines of evidence are suggestive of a causal relationship. First, there is evidence to suggest the presence of dose/response relationships in which increasing severity and/or the duration of abuse is associated with increasing risks of later symptoms (Friedrich, Urquiza, & Beilke, 1986; Sirles, Smith, & Kusama, 1989). Second, there is evidence of some degree of specificity of symptoms, to the extent that some children exposed to CSA show evidence of sexualized behaviors that appear to be a specific manifestation of their exposure to abuse (Green, 1993). Third, there is evidence that therapies designed to address CSA in children appear to lead to reductions in psychiatric symptoms and adjustment problems (Finkelhor & Berliner, 1995). In addition, both clinical experience (Briere, 1992; Trepper & Barrett, 1989) and a growing number of biographical accounts of child abuse survivors (Herman, 1981; McGregor, 1994) have highlighted the way in which CSA experiences may have profound impacts on childhood and adult adjustment.

Is There a Behavioral Syndrome That Characterizes the Sexually Abused Child?

Some of the uncertainties about the causal linkages between CSA and child adjustment noted previously would be reduced if it could be shown that exposure to sexual abuse is associated with a characteristic pattern of symptoms that is specific to exposure to CSA. Furthermore, the identification of a child sexual abuse syndrome could prove valuable in diagnosing and detecting cases of CSA. These considerations have led a number of authors to propose a specific CSA syndrome frequently linked to posttraumatic stress disorder (PTSD) (e.g., Goodwin, 1985; Kiser et al., 1988). PTSD is a condition that reflects a response to extreme and traumatic stress that is characterized by intense fear, helplessness, or horror; persistent reexperience of the traumatic event; persistent avoidance of stimuli associated with the trauma and a numbing of general responsiveness; and persistent symptoms of increased arousal (American Psychiatric Association, 1994). As may be seen from [Table 4.1](#), what distinguishes children exposed to CSA is not the presence of a clearly defined set of symptoms but, rather, a diffuse and generalized vulnerability to be at increased risk of a wide range of symptoms. In this respect, the behavioral profiles of children exposed to CSA have considerable similarity to the behavioral profiles associated with a wide range of childhood adversities and difficulties.

The view that CSA has specific consequences that can be used to identify those children who are abused has also occurred in a forensic context, in which those giving expert testimony may argue that the presence of a specific set of symptoms is consistent with the view that the child has been sexually abused. Such expert testimony may mislead lay juries into accepting that since the child shows a particular pattern of symptoms, it is very likely that she or he was abused. This interpretation is not consistent with the available evidence for at least two reasons. First, a substantial minority of children who are sexually abused do not show behavioral symptoms. Studies have suggested that in the region of one fifth to one half of children known to be sexually abused are apparently asymptomatic. Second, with the exception of PTSD symptoms that are clearly consequent on sexual trauma or sexualized behaviors that are likely to be a reflection of adult-child sexual contacts, the pattern of symptoms typically displayed by sexually abused children differs little from the symptom patterns exhibited by children who are exposed to a wide range of social, family, and related adversities (Green, 1993). The theory that sexually abused children typically exhibit a

characteristic syndrome is both empirically unfounded and has the potential to mislead and confuse in debates over the identification of CSA.

Resiliency to CSA

A substantial minority of children known to have been exposed to CSA do not develop significant adjustment difficulties. Estimates of the number of asymptomatic children among those known to have been sexually abused have ranged from as low as 21% (Conte & Schuerman, 1987a; 1987b) to as high as 49% (Caffaro-Rouget, Lang, & van Santen, 1989). There are three possible reasons for the presence of these groups of apparently asymptomatic children exposed to CSA (Kendall-Tackett et al., 1993). First, it may reflect shortcomings in the assessment of adjustment because investigators may not have examined a full range of symptoms or may have failed to measure these adequately. Second, it could be suggested that the presence of asymptomatic children may reflect the presence of so-called sleeper effects, in which some children exposed to CSA will eventually develop symptoms that are not evident at the time of assessment. Third, it may be that there are a number of children who are resilient to CSA exposures and do not develop adjustment difficulties in response to these experiences.

Research into what may make children resilient to CSA is limited, but there have been a number of suggestions about such resilience factors, including the following:

1. Behavior problems are most likely to develop in those for whom the exposure to CSA was severe, of lengthy duration, or involved violence or coercive behaviors. Conversely, the development of adjustment difficulties is least likely in CSA exposures that are less severe, noncoercive, and of limited duration (Friedrich et al., 1986; Sirles et al., 1989).
2. The extent of family support, and particularly maternal support, may be influential in determining responses to CSA exposure. Those most likely to show adjustment problems in response to CSA come from families offering limited support and nurturance, whereas those least likely to exhibit these responses tend to come from supportive and nurturant family backgrounds (Everson, Hunter, Runyan, Edelsohn, & Coulter, 1989; Oates, O'Toole, Lynch, Stern, & Cooney, 1994; Waterman & Kelly, 1993).
3. The child's attitudes and coping skills may play a role in exacerbating or mitigating the effects of abuse exposure (Kendall-Tackett et al., 1993). Children with negative attitudes and limited skills are most likely to develop adjustment difficulties, whereas children with positive attitudes and good coping skills are least likely to develop problems.

From this list, it is apparent that the profile of the child most likely to exhibit adjustment difficulties in response to CSA exposure portrays a child who has been exposed to extreme and traumatic abuse, who is reared in a nonsupportive and non-nurturant family, and who has negative attitudes and limited coping skills. Conversely, the child most likely to survive CSA has been exposed to less traumatic and/or coercive abuse, has been reared in a supportive and nurturant family environment, and has positive attitudes and good coping skills.

An issue related to this is the extent to which responses to CSA are influenced by the child's gender. In particular, there have been ongoing suggestions that there are gender differences in the nature of children's responses following CSA, with males being more prone to exhibit antisocial and aggressive responses and females more likely to develop depression, anxiety, and internalizing responses (Friedrich, Bielke, & Urquiza, 1987; Friedrich et al., 1986; Rogers & Terry, 1984; Summit, 1983). These gender differences may not, however, be specific to CSA

for they appear to mirror gender differences in adjustment problems among children irrespective of whether or not they have been exposed to CSA. In addition it should be noted that Finkelhor (1990), in his review of the literature, emphasized that “perhaps the major [finding] ... is the relative similarity of the response of boys to that of girls” (p. 325).

The Treatment of Children Exposed to CSA

Increasing recognition of the prevalence of CSA and the effects of CSA on childhood adjustment has led to a rapid growth of therapies, treatments, and policies designed to meet the needs of children who have been sexually abused. For example, on the basis of U.S. data, Finkelhor and Berliner (1995) suggest that up to three quarters of children identified as being sexually abused are provided with some form of therapy. The rapid growth of therapies in this area has resulted in a situation in which strong claims are made about the need for, and benefits of, treatment for abused children, yet relatively little research has systematically evaluated the extent to which treatment is effective.

The best method of examining treatment efficacy is through the use of a clinical trial in which a number of children are assigned at random to a specified form of treatment and others are assigned at random to a control condition that does not include the treatment of interest. In the area of CSA, there are clearly ethical problems that arise in the use of randomized trials. They center around the extent to which it is ethically justifiable to expose children to what may be less-than-optimal therapy in the interests of science. For this reason, there have been relatively few attempts to assess the efficacy of CSA treatment by using randomized trials. A number of approaches have used somewhat weaker designs to examine the efficacy of CSA treatment. In an analysis of the effectiveness of treatment for children exposed to CSA, Finkelhor and Berliner (1995) identified 29 studies that used one of three research designs:

1. *The pretest/posttest design.* The majority of studies evaluating CSA treatment have employed a pretest/posttest design in which the symptom levels of children at the point of entry to treatment are compared with symptom levels following treatment. Evidence of a reduction in symptom levels is taken as indicative of possible treatment benefit. In their analysis, Finkelhor and Berliner (1995) identified a series of 17 studies that had evaluated a range of CSA therapies that included music therapy, group therapy, cognitive behavioral therapy, and other therapies. In all but one study, significant improvement in symptoms was reported for at least one outcome, assessed at follow-up periods ranging from 9 weeks to 12 months. A recent meta-analysis conducted by Reeker, Ensing, and Elliott (1997) examined the extent of pretreatment/posttreatment differences in 15 studies of treatment for CSA. These authors found that across all studies, test scores improved by an average of .78 standard deviations, suggesting clear and statistically significant improvements in symptom levels and other outcomes following therapy.

However, the pretest/posttest design provides only very weak evidence of treatment efficacy for at least two reasons. First, apparent improvements in symptoms following treatment may not reflect therapeutic benefits but rather may reflect naturally occurring remission of symptoms with the passage of time. Second, it is possible that apparent changes may reflect design artifacts that arise from retest effects. It has been well documented in many longitudinal studies that on the first administration of symptom or other inventories participants tend to report higher levels of symptoms than at subsequent administrations. The best that may be concluded from pretest/posttest studies is that most CSA therapies appear to meet the bare minimum condition for

therapeutic efficacy, in that participants appear to improve following treatment; however, this does not establish that the treatment was necessarily instrumental in producing this change.

2. *Quasi-experimental designs.* These designs capitalize on the fact that not all children known to have been sexually abused receive therapy, and, therefore, it can be reasoned that those not receiving therapy may be a control group by which the benefits for those receiving therapy can be evaluated. However, the difficulty with this design is that participants may be assigned to treatment and no-treatment conditions by selective processes that may also be related to later outcomes. More generally, there is no guarantee that the treated and untreated groups are equivalent and would be expected to have similar outcomes. To some extent, these issues can be addressed by adjusting differences in group outcome for known factors that influence treatment-group membership using the so-called nonequivalent groups design. Finkelhor and Berliner (1995) identified five studies employing quasi-experimental designs, with two of these studies reporting benefits for treatment.
3. *Experimental studies.* Finally, Finkelhor and Berliner (1995) identified three experimental studies employing randomized or matched-group designs. In general, these studies found that participants exposed to treatment showed benefit. In addition, Finkelhor and Berliner (1995) reported on five studies in which alternative forms of CSA treatment were contrasted. In general, these studies found few differences in treatment outcome for different groups, although Cohen and Mannarino (1996) reported that structured, abuse-specific therapy has advantages over psychotherapy.

Since the publication of Finkelhor and Berliner's (1995) review, there have been a number of other evaluations of CSA treatment that have used pretest/posttest designs or quasi-experimental or experimental designs (Hyde, Bentovim, & Monck, 1995; McGain & McKinzey, 1995). In general, these studies have supported the view that treatment of children exposed to CSA is beneficial. One study that is of particular interest was reported by McGain and McKinzey (1995), who compared the treatment outcomes of 15 girls receiving a program of treatment and support for CSA with a matched series of 15 girls who were on a waiting list for this treatment, with both groups being evaluated six months following trial entry. This analysis showed that, although both groups had similar behavioral profiles at the point of trial entry, those exposed to treatment showed clear reductions in the levels of adjustment problems assessed at six months. In contrast, the untreated group showed less change in behavior outcomes, and there were significant differences between the mean scores of the treated and untreated groups in nearly all comparisons made.

Although accumulating evidence now suggests that the treatment of children exposed to CSA has beneficial effects, this evidence is marked by a number of weaknesses that have included (a) the use of small and often highly selected groups of children, (b) an emphasis on the treatment of sexually abused girls, (c) a lack of studies in which individuals have been assigned randomly to treatment and control groups, and (d) limited information on the extent to which different therapeutic regimes have beneficial effects. It is clear that although the available evidence supports the conclusion that CSA therapy for sexually abused children is beneficial, the evidence for therapeutic benefit still falls far short of the standards demanded for the proof of benefit in many other areas. Many of these uncertainties could be resolved by a number of well-designed randomized trials in which relatively large numbers of children were assigned at random to different treatment options (including no treatment), with the outcomes of treatment being assessed using standardized and validated outcome measures.

Aside from the issue of treatment efficacy, there are further issues in the treatment of CSA that merit comment. It is important to note that CSA is not a disorder but a putative cause of disorder. This issue comes into clear relief when the problems of providing therapy to sexually abused children who are asymptomatic are considered. First, it is clear that with asymptomatic children it becomes difficult, if not impossible, to show therapeutic benefit since these children do not have symptoms that require resolution. Second, it may be asked whether treatment is appropriate for children who are asymptomatic. Nonetheless, Finkelhor and Berliner (1995) argue that, at present, it is prudent to include asymptomatic children in treatment and treatment studies.

Concluding Comment

In this chapter, we have examined a series of issues relating to the impact of CSA on childhood adjustment. The following major conclusions emerge from this analysis:

1. There is little doubt that children who are known to have been sexually abused are a high-risk population who show a generalized vulnerability to a wide range of behavior problems, mental health disorders, and adjustment difficulties.
2. It is probable, but by no means certain, that the elevated risk of adjustment difficulties seen in these children can be attributed, at least in part, to their exposure to CSA. However, it is also likely that existing research may overestimate the impact of CSA on children as a result of research artifacts arising from both sample selection and failure to control for confounding influences.
3. There is little evidence to suggest that children exposed to CSA show a core syndrome that is characteristic of CSA. For these reasons, attempts to diagnose or infer the presence of CSA on the basis of the child's symptom patterns are likely to be ineffective and potentially misleading. Children who are sexually abused typically show symptom patterns that are characteristic of children exposed to a wide range of childhood and family adversities. Possible exceptions to those conclusions exist for the small minority of CSA victims who show highly specific symptoms reflecting either clear and specific responses to sexual trauma or precocious sexual behaviors that are likely to have been learned in the context of the CSA episode.
4. A substantial minority of children appear to be resilient to the effects of CSA exposure and to be asymptomatic. Factors influencing resilience to abuse include the severity of the abuse incident, the extent of family support and nurturance, and the child's attitudes and coping skills. Those most likely to develop adjustment difficulties following CSA exposure are children exposed to severe and coercive episodes of abuse, those reared in nonsupportive or non-nurturant family environments, and those with negative attitudes and poor coping skills.
5. There has been a rapid growth in therapies for sexually abused children, but the evidence for the efficacy of these therapies is far from compelling. Although the weight of the evidence suggests that therapy for CSA may be effective, there is a need for larger and better-designed evaluations of therapy before this conclusion can be supported.
6. Sexual abuse treatment for children is complicated by the fact that what is being treated is not a disorder but, rather, a putative cause of disorder. This poses difficulties defining the objectives of the treatment, assessing treatment outcomes, and making decisions about the appropriate treatment and management of the substantial minority of children who are asymptomatic.

- abused or neglected children
- children
- adjustment
- odds ratio
- abuse
- treatment
- problem behaviors

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