

PRACTICE BRIEFS



Youth Sexual Abuse: Prevalence, Assessment, and Trauma-Informed Treatment

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ABSTRACT: Youth sexual abuse is a pervasive public health concern with lasting effects on development, mental health, and interpersonal functioning. Counselors are uniquely positioned to intervene through early identification, trauma-informed assessment, and evidence-based, developmentally appropriate care. By integrating clinical expertise with ethical responsibility and systemic advocacy, counselors can support healing, promote resilience, and contribute to broader efforts to prevent abuse and protect youth.

Introduction

Youth sexual abuse (YSA) refers to any sexual activity involving a minor who lacks the developmental capacity to fully understand the act, provide legal consent, or refuse participation (World Health Organization [WHO], 2022). YSA includes contact and non-contact sexual acts imposed on a youth by an adult, exploiting limited capacity to consent and often occurring in relationships marked by power, trust, or authority (Centers for Disease Control and Prevention, 2024). Both contact behaviors, such as fondling and penetration, and non-contact acts, such as indecent exposure, voyeurism, and sexually explicit communication, are often perpetrated in contexts marked by secrecy, coercion, or manipulation. These acts exploit the youth's limited capacity to consent and often occur within relationships marked by power imbalance, trust, or authority (WHO, 2022). These behaviors violate legal and social norms and can lead to serious and long-lasting harm to a young person's physical, emotional, and psychological development (Child Welfare Information Gateway [CWIG], 2019b). The potential for ongoing trauma is further heightened when the abuse is committed by a trusted caregiver or authority figure (Dailey, in press).

Beyond its defining characteristics, YSA is also a significant public health concern, with a substantial prevalence across various populations and geographic regions. In the United States, approximately one in four girls and one in thirteen boys experience YSA during childhood (Finkelhor et al., 2024). Globally, an estimated 370 million girls and women have experienced rape or sexual assault before the age of 18, while between 240 million and 310 million boys and men have experienced sexual violence during childhood (United Nations Children's Fund, 2024a). Beyond prevalence, YSA is most often perpetrated by known individuals, frequently occurs during adolescence, remains substantially underreported, particularly among boys, and is associated with significant long-term consequences (United Nations Children's Fund, 2024b). Risk of victimization increases with age and is highest between 14 and 17 years of age (Finkelhor et al., 2024).

Understanding prevalence is insufficient without examining the developmental and contextual factors that increase young people's vulnerability to abuse. Youth are especially vulnerable due to their limited ability to assess risk, assert boundaries, or recognize exploitative behavior, compounded by their reliance on adults for guidance, protection, and care. This vulnerability is often exploited through grooming, a deliberate process in which perpetrators manipulate youth into exploitable situations while minimizing the likelihood of disclosure (Rabe, Abuse & Incest National Network [RAINN], 2025).

Grooming behaviors may include attention-seeking, gift-giving, boundary testing, and isolating the youth from protective relationships. This manipulation often leads to confusion, compliance, or loyalty, making youth disclosure more difficult. Offenders may exploit familial, institutional, or digital environments, and grooming can occur both in-person and online. YSA often co-occurs with other forms of maltreatment including neglect, physical abuse, or domestic violence (CWIG, 2019a). These adversities contribute to complex trauma, disrupt attachment, and impair emotional and behavioral regulation. Although not all youth who experience YSA develop posttraumatic stress disorder (PTSD), 30% to 50% meet diagnostic criteria, and many others show subthreshold symptoms such as hypervigilance, dissociation, avoidance, aggression, or sexualized behavior (Maikovitch et al., 2009).

Given the wide range of trauma exposure, the clinical presentation of YSA is highly variable and requires careful assessment. YSA symptoms vary by age, context, and trauma history. Accurate assessment requires developmentally grounded, trauma-informed clinical judgment and careful differential evaluation. Symptom expression following YSA is shaped by multiple factors, including developmental stage, the nature and duration of the abuse, and the relationship to the perpetrator (Lanktree & Briere, 2015; Underwood & Dailey, 2017). Survivors may exhibit emotional dysregulation, behavioral changes, dissociation, somatic complaints, or disruptions in identity development (Fenster et al., 2018). Internalized shame, mistrust, and attachment difficulties are also common, particularly when the abuse involves grooming, manipulation, or betrayal by a trusted adult (Cross et al., 2017). These responses may be shaped by cultural beliefs, family dynamics, and systemic factors influencing how youth interpret abuse.

In addition to psychological and behavioral effects, YSA is associated with measurable neurobiological changes that further shape symptom development and recovery. YSA can disrupt neurological development, particularly during periods when brain systems involved in emotion regulation, memory, and executive functioning are maturing (Cruz et al., 2022). Alterations in the amygdala, hippocampus, and prefrontal cortex help explain symptoms such as emotional reactivity, dissociation, somatic complaints, and attention difficulties (Briere & Scott, 2025; Fenster et al., 2018). Amygdala overactivity may heighten threat detection, and disruptions in the prefrontal cortex and hippocampus can impair regulation, orientation, and memory processing (Dailey et al., 2026). These disruptions often manifest in emotional and behavioral symptoms such as irritability, sleep disturbances, somatic complaints, dissociation, and risk-taking behaviors. Dysregulation in neurochemical systems, including cortisol, serotonin, and dopamine, can further affect mood, attention, and self-regulation (Briere & Scott, 2025). As a result, symptoms of YSA may mimic or overlap with other diagnoses, such as attention-deficit/hyperactivity disorder (ADHD) or anxiety, reinforcing the importance of trauma-informed, developmentally attuned assessment practices. Fortunately, neuroplasticity allows for early interventions to support recovery and adaptive brain development (Cross et al., 2017).

Description

YSA is a trauma exposure that can disrupt emotional, relational, and neurobiological development. Presentations of YSA may reflect PTSD, complex trauma, or dissociation, often emerging through somatic symptoms, behavioral shifts, or regulatory difficulties.

Assessment Strategies

Effective assessment of YSA requires a developmentally attuned, trauma-informed approach that accounts for varied symptom presentation, co-occurring adversity, and cultural context. Many young people do not disclose abuse directly, instead showing nonspecific signs such as mood instability, somatic complaints, sleep disruptions, dissociation, or sexualized behaviors (AACAP, 2024). School counselors should engage in ongoing observation across academic, behavioral, and social domains, noting patterns such as sudden declines in academic performance, increased absenteeism, frequent visits to the nurse, or avoidance of specific peers or adults. Counselors can also use developmentally

appropriate check-ins and open-ended, nonleading questions to create opportunities for disclosure without pressure. Counselors should watch for behavioral changes like secrecy, withdrawal, age-inappropriate sexual knowledge, or unusual attachment to unfamiliar adults (CWIG, 2019b). In younger children, symptoms often present as dysregulation or physical complaints rather than verbal reports of distress (Fenster et al., 2018). Because these signs often emerge across settings, collaboration with teachers, school nurses, and other school staff is critical for identifying concerning patterns. Caregiver dynamics, including emotional enmeshment, excessive control, or isolating behaviors, also warrant attention. Although symptom expression varies, certain contextual factors can intensify impacts and increase risk for long-term harm. Risk is elevated when YSA co-occurs with intimidation, emotional abuse, or physical violence (CWIG, 2019a). Because symptoms may mimic or overlap with conditions such as ADHD or anxiety, accurate diagnosis requires careful differential assessment and sound clinical judgment (Briere & Scott, 2025).

Counselors can incorporate relevant screening questions into existing intake and assessment processes and, when indicated, supplement these with standardized trauma measures. A multi-method, multi-informant approach is recommended, integrating caregiver reports, standardized trauma assessments, and developmentally appropriate clinical interviews. Assessment should consider developmental level, co-occurring adversities, and contextual risk factors, as many youth affected by sexual abuse also experience emotional neglect, physical abuse, or household instability, which compound trauma responses and increase complexity (Dailey et al., 2026).

Above all, assessment begins with establishing psychological safety, pacing evaluations according to the youth's regulatory capacity, and coordinating with caregivers and multidisciplinary partners. Mandated reporting laws must be followed, and concerns must be documented objectively. Ongoing reassessment is essential to track symptom progression and guide effective treatment planning.

Validated assessment tools commonly used with YSA-affected children and youth include:

- **Clinician-Administered PTSD Scale for DSM-5 – Child/Adolescent Version (CAPS-CA-5):** A structured clinical interview for youth ages 7–18 that assesses PTSD symptom frequency and intensity (Pynoos et al., 2015). Considered a gold standard, the CAPS-CA-5 is available free of charge with approved request.
- **Child and Adolescent Trauma Screen (CATS):** A free screener for trauma exposure and *DSM-5* PTSD symptoms in children ages 7–17, available in both caregiver and youth report formats (Sachser et al., 2017).
- **Child PTSD Symptom Scale for DSM-5 (CPSS-5):** A 27-item self-report measure for youth ages 8–18 that maps directly onto *DSM-5* PTSD criteria and assesses functional impairment (Foa et al., 2017). Available at no cost in self-report format; to access the interview version, contact the authors directly at foa@mail.med.upenn.edu.
- **Trauma Symptom Checklist for Children (TSCC):** A 54-item self-report measure for youth ages 8–16 assessing trauma-related symptoms, including PTSD, dissociation, sexual concerns, and anger; includes validity scales (Briere, 1996). The introductory kit is priced from \$172.
- **Trauma Symptom Checklist for Young Children (TSCYC):** A 90-item caregiver-report measure for children ages 3–12 that assesses PTSD, sexual concerns, anxiety, and related symptoms (Briere et al., 2001). One of the few norm-referenced tools available for children under age 7. The introductory kit starts at \$230.

Scope of Practice

Counselors must recognize YSA indicators, comply with mandated reporting laws, and practice within their legal/ethical scope. In complex cases, supervision, consultation, and specialized training ensure clinical competence and mitigate vicarious trauma.

Treatment Approaches

Effective treatment for YSA requires a trauma-informed, developmentally attuned approach that considers the youth's unique symptoms, history, and context. Interventions should promote safety, regulation, and recovery within a consistent therapeutic relationship. The treatment models and counseling strategies described below reflect widely used approaches that may be adapted based on developmental stage, clinical setting, and caregiver involvement.

Trauma-Focused Cognitive Behavioral Therapy

Trauma-focused cognitive behavioral therapy (TF-CBT) is a structured, evidence-based model for children and adolescents (ages 3–18) exposed to sexual abuse and other traumas (Cohen et al., 2017). It combines psychoeducation, affect regulation, trauma narration, and caregiver involvement over approximately 12–25 sessions. TF-CBT is particularly well suited for outpatient clinics, community mental health clinics, and school-based counseling settings where time-limited, skills-focused interventions are prioritized. This model is especially effective when non-offending caregivers are involved.

Eye-Movement Desensitization and Reprocessing

Eye-movement desensitization and reprocessing (EMDR) employs bilateral stimulation (e.g., eye movements, tapping) to help clients reprocess traumatic memories without requiring detailed verbal recounting (Shapiro, 2018). It works by pairing bilateral stimulation with trauma imagery and cognitive processing. This approach is particularly advantageous in outpatient and specialty trauma settings for clients who experience avoidance, dissociation, shame, or have difficulty verbalizing traumatic memories (Moreno-Alcázar et al., 2017). Because EMDR requires advanced training and a controlled therapeutic environment, it may be less feasible in school-based or high-turnover community settings. EMDR is recognized by the WHO as an effective trauma treatment (WHO, 2022).

Play-Based and Expressive Therapies

For younger children and those with limited verbal capacity, play therapy, art, and sand tray approaches provide developmentally appropriate pathways for trauma expression and integration. These approaches are particularly well suited for early childhood settings, foster care systems, child advocacy centers, and outpatient clinics serving developmentally young or delayed children. These modalities help children process abuse symbolically, reduce internalized shame, and develop emotion regulation skills in a safe, therapeutic relationship (Gil, 2017). Although outcome research specific to YSA continues to develop, play-based interventions have demonstrated effectiveness in supporting foundational treatment targets such as establishing safety, reducing trauma-related internalizing symptoms, and enhancing emotional expression and agency (Baggerly et al., 2010). More comprehensive YSA treatment outcomes are addressed through trauma-focused models such as TF-CBT and EMDR. Although outcome research is still emerging, play-based interventions are widely recognized as effective for building safety, reducing internalizing symptoms, and restoring a sense of agency (Baggerly et al., 2010).

Child-Centered Play Therapy

Counselors can use child-centered play therapy (CCPT) as an effective, developmentally responsive treatment approach for children who have experienced YSA by creating a therapeutic environment grounded in safety, acceptance, and empathetic understanding. CCPT recognizes play as the child's natural language, allowing children to express traumatic experiences, emotions, and relational disruptions symbolically, which they may not yet have the verbal capacity to articulate (Ibharim et al., 2023). Within a nondirective environment, the counselor follows the child's lead, trusting their innate tendency toward growth and healing while carefully observing recurring play themes such as mistrust, danger, shame, and aggression that often reflect the impact of sexual abuse. As therapy progresses, shifts in the theme of play may reflect safety, protection, nurturing, autonomy, and creativity, serving as indicators

of emotional regulation, restored trust, and developmental movement. By identifying and tracking these play themes across sessions, counselors can assess therapeutic change, understand the child's emotional struggles, and tailor their therapeutic presence to support relational repair without retraumatization (Ibharim et al., 2023).

Parent-Child Relational Interventions

Relational models such as child-parent psychotherapy (CPP) and combined parent-child cognitive behavioral therapy (CPC-CBT) are particularly effective when trauma occurs within the caregiving system. These models are well suited for family-based outpatient clinics, early childhood mental health programs, and child welfare settings where caregiver involvement is central to treatment success. These interventions promote attachment repair, emotional safety, and caregiver-child co-regulation (Landolt & Kenardy, 2022). CPP is an attachment-based, trauma-informed treatment for children ages 0–5 and their caregivers, emphasizing co-regulation, narrative integration, and strengthening the caregiver-child relationship (Lieberman et al., 2005). CPC-CBT is designed for children ages 3–17 who have experienced physical abuse or exposure to domestic violence. The model integrates individual CBT with joint parent-child sessions to improve safety, communication, and regulation.

Cognitive Behavioral Intervention for Trauma in Schools

Cognitive behavioral intervention for trauma in schools (CBITS) is a school-based group model designed for children ages 10–15 exposed to trauma, including YSA (Jaycox et al., 2012). It incorporates cognitive restructuring, psychoeducation, and skill-building in a structured group format, with optional caregiver and teacher involvement. CBITS expands access to school-based trauma care, especially for underserved populations.

Trauma-Focused Integrated Play Therapy

Trauma-focused integrated play therapy (TFIPT) combines play-based methods with trauma-informed and cognitive strategies to address complex trauma in children (Gil, 2017). This integrative model is especially effective in outpatient and specialized trauma clinics serving children with developmental delays, preverbal trauma, or disrupted attachment. It is particularly effective for those with developmental delays, preverbal trauma, or disrupted attachment. The model integrates traditional play therapy with narrative processing, emotional regulation, and cognitive restructuring techniques (Dailey et al., 2026). While empirical research is still emerging, TFIPT has shown promise in fostering resilience among children who have experienced sexual assault (Polk, 2021).

Counseling Interventions

In addition to formal treatment models, counselors should employ practical, developmentally appropriate strategies tailored to each youth's cultural context and trauma history. When delivered within a safe, consistent therapeutic relationship (Gill et al., 2024), core interventions such as emotion regulation, narrative processing, psychoeducation, and co-regulation help youth understand and manage their experiences. Affect regulation is essential in YSA recovery, particularly for youth with dissociation, emotional outbursts, or internalized distress. Grounding techniques, including paced breathing, sensory tools, and mindfulness, can stabilize arousal and increase present-moment awareness (Briere & Scott, 2025). Narrative methods (e.g., trauma storytelling, bibliotherapy, and art-based journaling) allow youth to symbolically process experiences in a developmentally appropriate way (Dailey et al., 2026). Body-oriented techniques are well-suited for youth with heightened physiological reactivity or limited verbal expression. Strategies such as rhythmic movement, body scans, and breathwork promote regulation and safety, especially when integrated into play or relational therapies (Dailey et al., 2026).

Although these interventions form the foundation of trauma-informed counseling with youth, their effectiveness is strengthened when counselors also attend to caregiver involvement, psychoeducation,

and specialized training that support regulation and safety beyond the individual session. Counselors are encouraged to seek training in youth-focused somatic approaches such as Sensorimotor Psychotherapy (Sensorimotor Psychotherapy Institute, n.d.) or Somatic Experiencing (Somatic Experiencing International, n.d.). Psychoeducation also plays a vital role in helping youth and caregivers understand trauma reactions, body boundaries, and emotional safety. For younger clients, this may include books, games, or role-play to reinforce autonomy and self-protection. Assessing the caregiver-child dynamic and introducing co-regulation tools, joint activities, or parent coaching can support emotional repair when appropriate (Landolt & Kenardy, 2022). Used consistently and with clinical attunement, these interventions foster safety, resilience, and readiness for long-term healing.

Cultural and Ethical Considerations

Cultural norms, spiritual beliefs, and systemic mistrust can shape how families interpret, disclose, or seek help for YSA (Gill et al., 2024). Some caregivers may discourage outside involvement due to stigma, prior institutional harm, or differing views on parenting. Language barriers and limited access to culturally responsive services may further hinder disclosure. Counselors must clearly explain confidentiality and mandated reporting, obtain informed consent, and avoid over-pathologizing behaviors rooted in cultural adaptation or trauma survival (Dailey et al., 2026). Ethical care requires balancing legal duties with emotional safety, practicing cultural humility, and affirming diverse identities, especially for LGBTQ+ youth, youth with disabilities, and marginalized populations (ACA, 2014).

Advocacy

YSA advocacy begins with examining one's own practice to ensure it promotes safety, equity, and access to healing for diverse survivors. It includes a broader responsibility to support legislation that protects survivors, expand trauma-informed services, and increase access to culturally responsive care. In schools, this may include advocating for age-appropriate body safety education, educator professional development, and clear protocols for responding to disclosures. In the community, counselors can partner with child protection agencies, health-care providers, and legal systems to ensure coordinated, trauma-sensitive responses and reduce re-traumatization. Additional efforts include caregiver education, public awareness, and challenging cultural or institutional norms that silence survivors.

Counselor Self-Care

Counselors who work with YSA survivors are at an increased risk for vicarious trauma and emotional strain due to repeated exposure to clients' traumatic experiences. Research indicates that intentional self-care practices play a critical role in mitigating the negative psychological effects of trauma exposure among helping professionals. Scott et al. (2023) found that self-care and supportive professional practices are associated with reduced distress and increased resilience in professionals. Engaging in regular self-care, clinical supervision, and peer support is essential to maintaining counselor well-being, ethical competence, and effective trauma-informed care.

Conclusion

YSA is a pervasive public health concern with lasting effects on development, mental health, and interpersonal functioning. Counselors are uniquely positioned to intervene through early identification, trauma-informed assessment, and evidence-based, developmentally appropriate care. By integrating clinical expertise with ethical responsibility and systemic advocacy, counselors can support healing, promote resilience, and contribute to broader efforts to prevent abuse and protect youth.

Resources

- **Child Welfare Information Gateway (CWIG):** A federally funded resource from the U.S. Children's Bureau offering definitions, signs, and symptoms of child abuse and neglect. Designed for professionals working in child protection, education, and mental health, CWIG provides guidance and practitioner-oriented resources on child sexual abuse, including reporting requirements, multi-disciplinary collaboration guidance, and fact sheets (<https://www.childwelfare.gov>).
- **National Center for Missing & Exploited Children:** Provides education and recovery resources for professionals working with children impacted by sexual exploitation or abuse as well as reporting and prevention tools (<https://www.missingkids.org>).
- **National Child Traumatic Stress Network:** Offers evidence-based resources on child sexual abuse, including treatment guidelines, fact sheets, and training materials such as the Core Curriculum on Childhood Trauma and TF-CBT implementation tools (<https://www.nctsn.org>).
- **National Sexual Violence Resource Center:** Provides research-informed publications, prevention toolkits, and clinical support materials related to sexual abuse and trauma in children and adolescents (<https://www.nsvrc.org>).
- **Rape, Abuse & Incest National Network:** Provides resources for counselors, caregivers, and survivors, including recovery tools, communication strategies, and links to local services (<https://www.rainn.org>).
- **Substance Abuse and Mental Health Services Administration:** Offers trauma-informed care guidelines, data reports, and evidence-based practices related to YSA, child maltreatment, and behavioral health (<https://www.samhsa.gov/child-trauma>).
- **World Health Organization:** Provides internationally recognized definitions and statistics on child maltreatment, including sexual abuse, emotional abuse, neglect, and exploitation (<https://www.who.int/news-room/fact-sheets/detail/child-maltreatment>).
- **Trauma-focused cognitive behavioral therapy:** Free training and resources are available through the TF-CBT National Therapist Certification Program (<https://tfcbt.org/>).
- **Eye-movement desensitization and reprocessing:** EMDRIA offers details on training requirements, certification processes, approved trainings, and a searchable directory of certified therapists (<https://www.emdria.org/>).
- **Play-based and expressive therapies:** The Association for Play Therapy offers a Registered Play Therapist credential requiring 150 hours of play-specific instruction and supervised experience, and a national RPT directory (<https://www.a4pt.org/>).
- **Child-parent psychotherapy:** Training is coordinated by the UCSF Child Trauma Research Program (<https://childtrauma.ucsf.edu/training-program/>).
- **Combined parent-child cognitive behavioral therapy:** Counselors seeking guidance on CPC-CBT are encouraged to consult the treatment manual (Runyon & Deblinger, 2014) and the CPC-CBT fact sheet available through the National Child Traumatic Stress Network (<https://www.nctsn.org/interventions/combined-parent-child-cognitive-behavioral>).
- **Cognitive behavioral intervention for trauma in schools:** Materials and training are available through the National Child Traumatic Stress Network (<https://nctsn.org/interventions/cognitive-behavioral-intervention-trauma-schools>).
- **Trauma-focused integrated play therapy:** Training and certification are available through the TraumaPlay Institute (<https://www.traumaplayinstitute.com/pages/traumaplay-certification>) and the Gil Institute's Starbright program (<https://www.gilinstitute.com/training-center-services>).

References

American Academy of Child & Adolescent Psychiatry. (2024). *Trauma and child abuse*. https://www.aacap.org/aacap/Families_and_Youth/Resource_Centers/Child_Abuse_Resource_Center/Home.aspx

- American Counseling Association. (2014). *ACA code of ethics*. <https://www.counseling.org/docs/default-source/default-document-library/ethics/2014-aca-code-of-ethics.pdf>
- Baggerly, J. N., Ray, D. C., & Bratton, S. C. (Eds.). (2010). *Child-centered play therapy research: The evidence base for effective practice*. John Wiley & Sons. <https://doi.org/10.1002/9781118269626>
- Briere, J. (1996). *Trauma Symptom Checklist for Children (TSCC) professional manual*. Psychological Assessment Resources.
- Briere, J., Johnson, K., Bissada, A., Damon, L., Crouch, J., Gil, E., Hanson, R., & Ernst, V. (2001). The Trauma Symptom Checklist for Young Children (TSCYC): Reliability and association with abuse exposure in a multi-site study. *Child Abuse & Neglect*, 25(8), 1001–1014. [https://doi.org/10.1016/S0145-2134\(01\)00253-8](https://doi.org/10.1016/S0145-2134(01)00253-8)
- Briere, J. N., & Scott, C. (2025). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment* (3rd ed.). Sage.
- Centers for Disease Control and Prevention. (2024, May16). *About child sexual abuse*. U.S. Department of Health and Human Services. <https://www.cdc.gov/child-abuse-neglect/about/about-child-sexual-abuse.html>
- Child Welfare Information Gateway. (2019a). *Long-term consequences of child abuse and neglect*. U.S. Department of Health and Human Services, Administration for Children and Families, Children’s Bureau. https://cwlibrary.childwelfare.gov/discovery/delivery/01CWIG_INST:01CWIG/1218590080007651
- Child Welfare Information Gateway. (2019b). *What is child abuse and neglect? Recognizing the signs and symptoms*. U.S. Department of Health and Human Services, Administration for Children and Families, Children’s Bureau. <https://www.childwelfare.gov/resources/what-child-abuse-and-neglect-recognizing-signs-and-symptoms/>
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2017). *Treating trauma and traumatic grief in children and adolescents* (2nd ed.). The Guilford Press.
- Cross, D., Fani, N., Powers, A., & Bradley, B. (2017). Neurobiological development in the context of childhood trauma. *Clinical Psychology: Science and Practice*, 24(2), 111–124. <https://doi.org/10.1111/cpsp.12198>
- Cruz, D., Lichten, M., Berg, K., & George, P. S. (2022). Developmental trauma: Conceptual framework, associated risks and comorbidities, and evaluation and treatment. *Frontiers in Psychiatry*, 13, Article 800687. <https://doi.org/10.3389/fpsy.2022.800687>
- Dailey, S. F. (in press). Abuse and trauma. In V. E. Kress, M. J. Paylo, & N. A. Stargell (Eds.), *Counseling children and adolescents* (2nd ed.). Pearson.
- Dailey, S. F., Zoldan-Calhoun, C. A., & McAllister, C. A. (2026). Trauma- and stressor-related disorders. In V. E. Kress & M. J. Paylo (Eds.), *Treating those with mental disorders: A comprehensive approach to diagnosis, case conceptualization, and treatment* (3rd ed., pp. 225-266). Pearson.
- Fenster, R. J., Lebois, L. A. M., Ressler, K. J., & Suh, J. (2018). Brain circuit dysfunction in post-traumatic stress disorder: From mouse to man. *Nature Reviews Neuroscience*, 19(9), 535–551. <https://doi.org/10.1038/s41583-018-0039-7>
- Finkelhor, D., Turner, H., & Colburn, D. (2024). The prevalence of child sexual abuse with online sexual abuse added. *Child Abuse & Neglect*, 149, Article 106634. <https://doi.org/10.1016/j.chiabu.2024.106634>

- Foa, E. B., Asnaani, A., Zang, Y., Capaldi, S., & Yeh, R. (2017). Psychometrics of the Child PTSD Symptom Scale for DSM-5 for trauma-exposed children and adolescents. *Journal of Clinical Child & Adolescent Psychology*, 47(1), 38–46. <https://doi.org/10.1080/15374416.2017.1350962>
- Gil, E. (2017). *Posttraumatic play in children: What clinicians need to know*. Guilford Press.
- Gill, C. S., Dailey, S. F., Karl, S. L., & Barrio-Minton, C. A. (2024). *Learning companion for counselors about DSM-5-TR®*. American Counseling Association.
- Ibharim, N. S., Wan Ismail, W. M. R., Abdul Jalil, N. I., & Musa, A. Z. (2023). The use of child-centered play therapy for children who have experienced sexual abuse. *International Journal of Academic Research in Business and Social Sciences*, 13(8), 956–973. <https://doi.org/10.6007/IJARBSS/v13-i8/18159>
- Jaycox, L. H., Kataoka, S. H., Stein, B. D., Langley, A. K., & Wong, M. (2012). Cognitive behavioral intervention for trauma in schools. *Journal of Applied School Psychology*, 28(3), 239–255. <https://doi.org/10.1080/15377903.2012.695766>
- Landolt, M. A., & Kenardy, J. A. (2022). Evidence-based treatments for children and adolescents. In U. Schnyder & M. Cloitre (Eds.), *Evidence based treatments for trauma-related psychological disorders: A practical guide for clinicians* (2nd ed., pp. 421–441). Springer Nature Switzerland AG. https://doi.org/10.1007/978-3-030-97802-0_20.
- Lanktree, C. B., & Briere, J. (2015). Integrative treatment of complex trauma. In J. D. Ford & C. A. Courtois (Eds.), *Treating complex traumatic stress disorders in children and adolescents: Scientific foundations and therapeutic models* (pp. 59–83). The Guilford Press.
- Lieberman, A. F., Van Horn, P., & Ippen, C. G. (2005). Toward evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child & Adolescent Psychiatry*, 44(12), 1241–1248. <https://doi.org/10.1097/01.chi.0000181047.59702.58>
- Moreno-Alcazar, A., Treen, D., Valiente-Gomez, A., Sio-Eroles, A., Perez, V., Amann, B. L., & Radua, J. (2017). Efficacy of eye movement desensitization and reprocessing in children and adolescent with post-traumatic stress disorder: A meta-analysis of randomized controlled trials. *Frontiers in Psychology*, 8, 1750. <https://doi.org/10.3389/fpsyg.2017.01750>
- Polk, S. (2021). *Integrating TF-CBT and play therapy: Promoting resilience in child sexual assault survivors* (Doctoral dissertation, Walden University). Walden Dissertations and Doctoral Studies. <https://scholarworks.waldenu.edu/dissertations/10362>
- Pynoos, R. S., Weathers, F. W., Steinberg, A. M., Layne, C. M., Kaloupek, D. G., Schnurr, P. P., Keane, T. M., Blake, D. D., Newman, E., Nader, K. O., & Krieglner, J. A. (2015). *Clinician-Administered PTSD Scale for DSM-5 – Child/Adolescent Version* [Assessment]. National Center for PTSD. <https://www.ptsd.va.gov/professional/assessment/child/caps-ca.asp#obtain>
- Rape, Abuse & Incest National Network. (2025). *Get the facts about grooming*. <https://rainn.org/get-the-facts-about-sexual-violence/get-the-facts-about-grooming/>
- Runyon, M. K., & Deblinger, E. (2014). *Combined parent-child cognitive behavioral therapy: An approach to empower families at-risk for child physical abuse*. Oxford University Press.
- Sachser, C., Berliner, L., Holt, T., Jensen, T. K., Jungbluth, N., Risch, E., Rosner, R., & Goldbeck, L. (2017). International development and psychometric properties of the Child and Adolescent Trauma Screen (CATS). *Journal of Affective Disorders*, 210, 189–195. <https://doi.org/10.1016/j.jad.2016.12.040>
- Scott, H., Killian, K., Roebuck, B. S., McGlinchey, D., Ferns, A., Sakauye, P., Ahmad, A., McCoy, A., & Prashad, N. A. (2023). Self-care and vicarious resilience in victim advocates: A national study. *Traumatology*, 29(3), 368–374. <https://doi.org/10.1037/trm0000481>

- Sensorimotor Psychotherapy Institute. (n.d.). *Sensorimotor psychotherapy*. <https://sensorimotorpsychotherapy.org/>
- Shapiro, F. (2018). *Eye movement desensitization and reprocessing (EMDR) therapy: Basic principles, protocols, and procedures* (3rd ed.). The Guilford Press.
- Somatic Experiencing International. (n.d.). *Somatic Experiencing*®. <https://traumahealing.org/>
- Underwood, L. A., & Dailey, F. L. (2017). *Counseling adolescents completely*. Sage Publications.
- United Nations Children’s Fund. (2024a, October 9). Over 370 million girls and women globally subjected to rape or sexual assault as children [Press release]. <https://www.unicef.org/press-releases/over-370-million-girls-and-women-globally-subjected-rape-or-sexual-assault-children>
- United Nations Children’s Fund. (2024b). *When numbers demand action: New estimates on child sexual violence*. UNICEF Data. https://data.unicef.org/wp-content/uploads/2024/10/UNICEF_When-Numbers-Demand-Action_Oct_10_2024.pdf
- World Health Organization. (2022, June 8). *Child maltreatment*. <https://www.who.int/news-room/fact-sheets/detail/child-maltreatment>

To Cite This Practice Brief:

- Dailey, S. F., Kress, V. E., Burk, T., & Chumita, C. C. (2026). *Youth sexual abuse: Prevalence, assessment, and trauma-informed treatment* [Practice Brief]. Counseling Nexus. <https://doi.org/10.63134/ANAO5637>