Sexual Abuse of Children

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Abstract

Knowledge about many aspects of the sexual abuse of children has exploded over the last four decades. This chapter reviews definitions of child sexual abuse, how common is the abuse, factors increasing the risk for some children to be abused, what is known about people who sexually abuse youth, and the effects on children of early sexual abuse.

Keywords

Child sexual abuse · Risk factors · Historical development · Effects · Sexual offenders · Prevalence · Incidence

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Introduction

The sexual use of children and vulnerable humans by more powerful humans appears as old as human history. It is only in the last four decades or so that child sexual abuse (CSA) has received attention from the public and researchers. Indeed, until very recently a four-volume Encyclopedia on Interpersonal Violence would not have been possible. Today as this is written, a comprehensive treatment of the topic of childhood sexual abuse (CSA) itself would require multiple chapters, if not volumes. This entry is intended to provide an overview of the subject, especially for new professionals and investigators. A comprehensive review of research addressing each topic in this entry is not possible, although key references will be cited for the reader. Important research topics for future investigation will also be identified. A number of advanced topics in CSA will not be addressed here. These include psychotherapy with victims of CSA (see, e.g., Fitzgerald and Berliner 2018, and Briere and Scott 2014), pornography (see, e.g., Anderson 2017), sexual trafficking (see, e.g., Greenbaum et al. 2018), and others.

History

Those reading this chapter to the Encyclopedia will no doubt wonder why it is important to give even a momentary thought to the history of the awareness and response to CSA. What seems more important is what is known now as this is being written and read. This is a reasonable question to ask.

We will not labor long here on history, but we would submit to the reader that history tells us not only what is the foundation of what we know and believe today but may also illustrate how we have approached knowledge and practice in the past; perhaps at times for well-meaning purposes but with insufficient knowledge. Perhaps there are lessons to be learned going forward.

First phase. There are no comprehensive histories of modern awareness of CSA. Legal scholar John E. B. Myers, in his important *A History of Child Protection in America* (Myers 2004), provides a good summary chapter on early developments. More recently, former FBI agent and long-time child abuse expert Ken Lanning, in his memoir *Love, Bombs, and Molesters: An FBI Agent's Journey* (Lanning 2018), provides an excellent overview of some of the missteps and knowledge errors early in the field. (See also Herman 1992; Olafson et al. 1993; Costin 1992; and Gordon 1988.)

As Myers (2004) and earlier Conte (1982 and 1991a) point out, Freud was among the first professionals to speculate about the adverse effects of adult sexual use of children. Conte notes that the first phase of professional development went from the late 1890s to the mid-1970s and was largely characterized by lack of awareness or focus on the wrong aspects of CSA. Freud's speculations about the effects of CSA, his theory of fantasized sexual contact with adults, and his interest in repression, even though written about 100 years ago, provided an ancient straw man for authors to make interesting historical and other points. (See, e.g., Masson 1984.)

While Freud never abandoned his interest in childhood sexual abuse and speculations about why he developed the theory that children's fantasized sexual contact with adults was more important than the reality of abuse (e.g., fear of the reactions of others in Victorian Vienna or that because he harbored incestuous feelings for his daughter Anna whom he analyzed), a more balanced and perhaps more objective view of Freud is that his real error was basing statements on limited observation of 18 patients and on theory rather than research. Revisionist psychoanalyst Alice Miller pointed to the idea that humans bring their own personal histories and biases to a subject as emotional as CSA when she noted that Freud, being the father of psychoanalysis, never had the benefit of it (Miller 1984). CSA is inherently a subject which triggers strong emotions, has the potential of significant impacts on all involved, and is easy to allow personal biases to outweigh evidence. It is fortunate for the professional today that evidence is accumulating faster than in the past.

As both Conte and Myers point out, CSA received only scattered attention from Freud's time until the mid-1970s. Early research was concerned with whether there were genetic deformities resulting from children born from incest (see, e.g., Adams and Neel 1967), and also there were only scattered references to the effects of CSA (for review see Conte 1985a).

For whatever reasons, professionals and the public largely ignored CSA, even though there were scattered references in the professional literature and newspaper accounts of sexual offenders being arrested and convicted. Arguably, modern rediscovery of childhood sexual abuse was not something professionals came to but rather the sensitivities of the rape crisis movement and attention to adult rape moved the public and then professionals toward the subject of child rape. Survivors of CSA appeared on national talk shows such as those of Phil Donahue or/and Oprah Winfrey, and by sharing their experiences, professionals began addressing CSA. Pioneer child abuse researchers Ann Burgess and David Finkelhor and advocate Sandy Butler responded to and expanded the emerging awareness (Burgess et al. 1978; Finkelhor 1979a; Butler 1978).

Second phase. In the second period of CSA history from the 1970s to the 1990s or so, efforts might be characterized as discovery and missteps. As this chapter will illustrate, much was learned in this period. We will not dwell on the many missteps, but it is now clear that there were many beliefs that research subsequently proved to be false. These debunked beliefs include but are not limited to: Children never lie about being abused; incest is a family problem instigated as much by mother and daughter as father; sexual abuse is not really about sex, it is about power; incest in families is a love relationship gone wrong; anatomical dolls are sexually suggestive and lead to false reports of abuse; children who use dark colors in artwork or include phallic images in artwork have been sexually abused; a child's behavior (e.g., acting out) proves sexual abuse; repression is the mechanism that leads to amnesia; young children cannot provide reliable reports of their experiences; long-term memories of abuse are inherently unreliable; the diagnosis of Parent Alienation Syndrome is supported by definite criteria which distinguish between children who reliably report abuse versus those who are led by their mother to falsely accuse a male; there are a large number of satanic cults worldwide sexually abusing and

sacrificing babies; children in therapy playing Candy Land or Checkers who do not bring up abuse are not ready to talk about it; indeed, talking about trauma is not a good idea and the goal of therapy is to forget it; and so many more that it becomes overwhelming to think about the errors in practice made based on such beliefs. (For discussion see Conte 1982, 1991a, b.) This is not the place to argue why these errors were made. Certainly the desire to help on the part of many professionals and limited knowledge supported a reliance on what were not really tested ideas. A lag between knowledge development and putting knowledge in practice is common in many fields. There were personal motives (e.g., testifying in defense of adults accused of CSA or applying one's favorite theory from previous work to CSA where the theory was untested in the new context) based on doing what was believed versus what was known to be correct. As a reader if you believe any of the above are accurate statements of knowledge, we urge you to do some independent research.

It may be difficult for readers today to appreciate that, in the early period of rediscovery of CSA, there were serious discussions about whether CSA was a mental health problem or should be prosecuted (see Conte 1982 for discussion), whether criteria other than what a child said happened should be used to substantiate allegations of CSA (see, e.g., Conte et al. 1991), or whether CSA was associated with ill effects (see, e.g., Constantine and Martinson 1981). Many of the thinking and practice errors of the first several decades of awareness of CSA led to a backlash with well-meaning and some not-so-well-meaning critics of CSA responding (see Myers 1994). Some of the issues raised were driven by efforts to defend adults accused of sexual abuse whether they had research support or not (e.g., anatomically correct dolls stimulate children into making false reports) and others by research which demonstrated the errors in previous ideas. (For discussion see, e.g., Conte 1990, 1991b.)

The good news for professionals entering and working in the field today is that research has exploded in the last two decades on many of the topics which make up modern understanding of CSA. The current historical period is characterized by the explosion of research on CSA and on its dissemination to the public and professionals.

Notwithstanding this explosion, we may believe things today which tomorrow will be proven wrong. Indeed, professional practice with vulnerable children and adults abused in childhood demands that all ideas and practices are approached with the same caution and search for data that any potentially powerful belief or practice deserves.

Foundations

Definitions. Defining child sexual abuse would seem at first thought to be easy.

It involves some kind of abusive sexual contact with a child. Early definitions described tricked, coerced, or manipulated sexual contact with a child and a person 5 or so years older. Over time the inadequacy of this definition became clear as it was understood that many children are abused by a peer who is not 5 years older. Also,

what is sexual can be difficult to determine in some situations. Direct contact between the parts of the body associated with sex and the body of an older person is relatively easy to identify. Wrestling which allows for disguised contact, entering the bathroom while the child is bathing, and other situations can be more difficult to identify as sexual abuse, at least without knowing how often the behavior takes place.

Some definitions of what constitutes sexual abuse refer to the "context" or intent of the adult. For example, in a thoughtful discussion Haugaard (2000) points out that abuse definitions are on a continuum from where there is agreement that the act is abusive (intercourse with a child) to less clear (e.g., a parent bathing with a child). Wikipedia (Child sexual abuse, n.d.) currently defines CSA as follows:

> "Child sexual abuse, also called child molestation, is a form of child abuse in which an adult or older adolescent uses a child for sexual stimulation. Forms of child sexual abuse include engaging in sexual activities with a child (whether by asking or pressuring, or by other means), indecent exposure (of the genitals, female nipples, etc.), child grooming, child sexual exploitation or using a child to produce child pornography." (https://en.wikipedia.org/wiki/Child_sexual_abuse).

Intent can be difficult to determine and may only be apparent over time, such as with the stepfather who routinely "accidentally" enters the bathroom while his stepdaughter is showering. Young children may engage in what on the surface appears to be "sexual abuse" such as inserting a stick into the vagina or anus of another child or repeatedly pulling down the pants of other children, but the underlying motivation for the behavior may not be clear. It is also important to understand how the child victim perceives the act. The child who was hurt by the stick may understand this act more as a physical assault that hurt than a sexual one and labeling the act as sexual abuse may either have no meaning to the young child or add uncertainty to the child's understanding of the aggression.

In a recent review of definitions in professional, legal, and policy literatures, Mathews and Collin-Vézina (2019) suggest that future definitions should be based on four criteria: the person must be a child, true consent must be absent, acts must be sexual, and acts must constitute abuse. As the authors note, each criterion is in itself complex. Following the criteria suggested by the authors allows each reader to consider and professionals to seek consensus on how to define each. Consent, especially "true" consent, can be difficult to determine since the point of grooming or conditioning of the child by the more powerful person is inherently about getting the child to go along with the abuse or to believe the sexual contact was the child's idea. Finkelhor (1979b) long ago argued that a child cannot give informed consent to sexual abuse because the child often does not understand what is being consented to and does not have the true power to say no. Indeed, some victims locked in ongoing abuse situations may initiate sexual contact as a way of managing the anxiety associated with not knowing when the abuse is going to happen. Victims frequently believe they have given consent by not disclosing after the first incident of abuse or after the grooming has progressed, and the contact has become more sexual.

Terms such as "abuse," "exploitation," "harm," and even "sexual" are inherently difficult to define. They carry assumptions about the potential impact of behaviors, about inherent values associated with various behaviors (e.g., school-age children should not masturbate in public), and what behaviors deserve adult attention and potential intervention.

In the early stages of professional awareness of CSA, the internet was nonexistent. Today it has mixed implications for professional and public awareness. A recent webpage (Tracy 2019, https://www.healthyplace.com/abuse/child-sexual-abuse/what-is-child-sexual-abuse) states:

Definition of Sexual Abuse

In its simplest form, child sexual abuse is any sexual encounter that occurs between a child and an older person (as children cannot legally consent to sexual acts). This abuse may involve contact, like touching or penetration. It also includes non-contact cases, like "flashing" or child pornography.

However, in practice, there are actually two working definitions of child sexual abuse. One definition of childhood sexual abuse is used by legal professionals while the other is used by clinical professionals, like therapists.

In the realm of legal definitions, both civil (child protection) and criminal definitions exist for child sexual abuse. Federally, the definition of child sexual abuse is contained within the Child Abuse Prevention and Treatment Act. Sexual abuse is defined to include:1.

• "(A) the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or.

• (B) the rape, molestation, prostitution, or other forms of sexual exploitation of children, or incest with children;. . .".

The age under which one is considered a child varies by state and sometimes an age differential between the perpetrator and the victim is required.

Clinical Definition of Child Sexual Abuse.

Clinicians, like psychiatrists and psychologists, though judge childhood sexual abuse more on the effect it has on the child and less on a cut-and-dried definition. The traumatic impact is generally what clinicians look for in cases of sexual abuse. (Read about: Effects of Child Sexual Abuse on Children).

A clinician often considers the following factors when differentiating abusive from non-abusive acts:

- *Power differential – wherein the abuser has power over the abused. This power may be physical or psychological in nature.*
- *Knowledge differential – wherein the abuser has a more sophisticated understanding of the situation than the abused. This may be due to an age difference or cognitive/emotional differences.*

- *Gratification differential – wherein the abuser seeks gratification for themselves and not the abused.*

This extended discussion of what CSA is certainly reflects ideas developed and confirmed by the experience of victims and survivors. The notion of the differentials between victim and offender is one of these. Legal definitions and clinical definitions may be different and serve different purposes. This webpage is correct that therapists often look at the effects of CSA but including this in a section on definitions confuses the acts which make up CSA and the effects which may or may not be present in any given case. Effects, harms, damages, and symptoms resulting from CSA are not helpful in defining what CSA is. Not all victims will experience the same effects, not all effects are present in a victim's life at any one time, and many of the "effects" of CSA are also the effects of any number of other negative experiences.

In a seminal research effort, Giovannoni and Becerra (1979) surveyed a large sample of professionals and members of the public concerning how they defined child abuse. The resulting categories of abuse and differences between various groups may or may not be directly relevant to today's world but the method deserves careful consideration. Future research and practice would be aided by following the line of thought outlined by Haugaard (2000) and Mathews and Collin-Vézina (2019), and developing a taxonomy of behaviors perhaps simply defined as sexual behaviors/situations which children may be exposed to or engaged in. Behavior-specific descriptions of experiences or acts would eliminate confusion over terms such as abuse, exploitation, and harm. Moral/ethical judgments and research-based consequences of the behaviors (e.g., is young children's viewing of pornography harmful or not) could be separate issues. Agreement on a taxonomy of types of CSA would be a great aid to future research and practice in the area.

Prevalence. Among the oldest issues beginning in the rediscovery and missteps phase in CSA professional history and in many ways continuing to this day is that of how large a problem CSA is. Prevalence describes the rate of occurrence of some characteristic in the general population. Arguments for responding to a problem, funding of responses, and justifying attention to a problem are often made based on how many people experience the problem. From the very beginning, studies disagreed over the lifetime exposure rate of people to CSA. In a 2013 review, Barth and colleagues report that results from 55 studies in 24 countries report prevalence estimates for CSA from 8% to 31% of girls and 3% to 17% of boys (Barth et al 2013). Earlier, in a review of 65 studies, Pereda, Guilera, Forns, and Gómez-Benito (Pereda et al. 2009) report overall rates of 19.7% for females and 7.9% for males.

Finkelhor et al. (2009a) report results on a nationally representative sample of youth aged 0 to 17 who were interviewed by telephone and found lifetime prevalence of any sexual victimization to be 12.2% in girls and 7.5% in boys. In the same year, Hébert et al. (2009) report on a telephone survey of a representative sample of adults in Quebec and report prevalence rates of 22% for women and 9.7% for men. Of interest, 57% delayed disclosure for 5 years or more. In 2007 Basile, Chen, Black, and Saltzman report results from a national telephone survey conducted between

2001 and 2003 which found lifetime forced sex prevalence rates at 10.6% for women and 2.1% for men (60.4% of females and 69.2% of males report being forced to have sex before turning 18) (Basile et al. 2007).

Widely different estimates tend to create a sense of disbelief in the public and policymakers. The reasons for different rates have been suggested for some time. Bolen and Scannapieco (1999), in a review of prevalence studies, suggest the number of questions asked to identify CSA, the year the study was completed and the number of female respondents (more respondents lower prevalence rates) are all associated with the resulting prevalence rate reported in the study. Peters et al. (1986) argue that the definition of abuse, the number of questions asked, the method of data collection (paper and pencil surveys, telephone, or face-to-face interviews) impact prevalence rates. (See also Gorey and Leslie 1997.) In an interesting study, Bagley and Genuis (1991) compared computerized versus paper surveys. Although the data were collected 6 years apart, the computerized questionnaire yielded a prevalence rate of 14% compared to the printed questionnaire rate of 8.2%. Roosa et al. (1998) compared different measures of incidence (dichotomous measures, measures that took into account severity, and measures that included or excluded similar-aged peers as offenders) and found that the choice of measure resulted in up to a 300% difference in incidence rates. More recently, Goldman and Padayachi (2000) have argued that a host of methodological factors may impact prevalence rates, including the time period and awareness in that time, age limits defining childhood, definitional inconsistencies, and the number and types of questions. In an important empirical effort to understand variation in prevalence rates, Prevoo et al. (2017) identified moderator effects found in previous meta-analyses on the self-reported lifetime prevalence of child sexual abuse (and other forms of abuse) in international studies. Results indicate that boys in low-resource countries report higher prevalence rates. For females, smaller sample sizes report higher prevalence and also for females broader definitions result in higher prevalence rates. Paper and pencil surveys are associated with higher prevalence rates, lower rates for computer administered, and intermediate rates for face-to-face interviews.

Although Finkelhor et al. (2005) report that very few respondents in their telephone survey refused to answer a question, it is also known that some respondents may report that they were not abused even though they were because they do not recall the abuse (Williams 1994). Some individuals with documented medical findings of abuse in childhood later deny that they were abused when asked (see Williams 1994; Lawson and Chaffin 1992).

There is a disconnect between research on prevalence and research indicating that some childhood victims of sexual assault either as children or later as adult survivors do not report the abuse. Potential reasons vary from not recalling it, fear of stigma associated with sex and abuse, not wanting to hurt loved ones, or other unknown reasons. While the exact number of victims who cannot or do not report CSA is not known, it is clear that the numbers are sufficient to require consideration in trying to understand prevalence rates. As noted above, there is reason to believe that the year of publication of incidence studies is associated with the prevalence rate, which may be a proxy measure of the change in cultural or social norms and views of CSA and

reporting. Certainly the #MeToo movement and widespread media coverage of Catholic, Boy Scout, and sporting organizations with large numbers of victims may be having an impact on willingness to report CSA. We are aware of no research on public attitudes and understanding of CSA that may impact disclosure and support for victims who do disclose. Nor are we aware of any analysis of how these attitudes and knowledge may have changed over the decades of modern awareness. Such research could be invaluable in improving the science of our field and in understanding attitudes that may impact funding of programs, juries who hear cases involving CSA, and indeed child and adult victims themselves.

We are not the first to call for methodological research (see, e.g., Pereda et al. 2009) on how best (e.g., paper and pencil, computer, telephone, in-person interviews with matched or unmatched interviewer-interviewee pairs) to ask respondents about abuse histories, how stable are positive or negative responses (e.g., over a 12-month period), and what factors impact reporting of CSA, including socioeconomic status, ethnicity, perceived stigma associated with CSA, and mental health symptoms. The methodological issues faced in determining prevalence rates for sexual abuse are similar to those faced in other fields conducting surveys and evaluating lifetime experiences. Greater collaboration across fields facing similar methodological issues should be encouraged. Research would be useful with survey respondents to learn how they react to personal questions and if their responses would have changed if contacted again after a time to think about their experiences. The hallmark of a mature science is research on how to conduct research in that area. We have a long way to go in the CSA field in this regard.

Decline in reports. A related issue to understanding the prevalence of CSA is the observation that rates are declining. Finkelhor and Jones et al. (2012) have argued that both official child abuse reports, but more interestingly a number of self-report surveys of adolescents, have all demonstrated a decline in reports. As reported by Finkelhor and Jones, these declines are substantial. For example, the National Incidence Studies of official reports show a 47% decline. The National Crime Victimization Surveys show declines from 1993 to 2008 of 69%. The National Survey of Family Growth from 1995 to 2008 reports a 39% decline. From 2017 to 2018 however, recent evidence of official reports from the National Child Abuse and Neglect Data System (NCANDS) shows a marked increase (6%) for the first time in more than 15 years (Finkelhor et al. 2020). While Finkelhor et al. (2020) do not speculate as to the reasons behind this increase, they report that longer-term trends are more telling than year-to-year changes, which "may or may not represent something enduring." Overall, NCANDS data shows a 62% decline between 1992 and 2018 (Finkelhor et al. 2020).

These are widely different rates of decline which cause some questioning as to what extent methodological or other issues may account for the variations. That all but one of the surveys noted by Finkelhor and Jones et al. (2012) show declines does point to an interesting question (the National Survey of Adolescents found a non-significant decline for girls and a non-significant increase for boys between 1995 and 2005). At the very time that CSA is receiving increasing attention, and a large number of adults are coming forward to describe abuse in childhood, why are the data showing a decline? (See Finkelhor and Jones 2004.)

Finkelhor and Jones (2006) have a well-argued discussion of the decline and note a general decline over the same period in other crime statistics. Discussing possible explanations for this decrease, the authors suggest that it may be the increasing availability of psychotropic medications over the same time period as the decline that account for at least some of the decline. This is not a particularly convincing explanation since it is unclear that any mental condition linked to offending is successfully treated by medication (e.g., depression appears unrelated to sexual offending). Of some concern is that the most reliable data relied upon in thinking about the decline are adolescent self-report surveys. The factors impacting adolescents might be different from those impacting children. To be sure, if there has been a decline it would be helpful to more clearly identify the factors accounting for the declines and do more of whatever it was that was associated with the decline. Thoughts about whether there is a real or only an apparent decline also tends to detract from the more basic fact which is a very large number of children and youth continue to be sexually abused.

Risk factors. It has long been recognized that offenders do not abuse every child with whom they have contact. In addition, whatever the actual prevalence rate is, not all children are sexually abused in childhood. Hence there is considerable value in identifying factors specific to the child or environment which places that child at increased risk for experiencing CSA.

Typical of research on most topics, CSA research has not always identified the same risk factors. Research by Finkelhor and Asdigian (1996) based on the National Youth Prevention Study identified risk factors pertaining to the environment (risky behavior such as running away from home, getting drunk, and carrying a weapon to school) and those targeting congruence (vulnerability) (being a female, being older, experiencing psychological distress). More recently, Butler (2013), using data from the Panel Study of Income Dynamics, identified risk factors for sexual assault including relatively lower income; lower maternal education; lower achievement scores in children; being in special education; and family factors, including absent biological father or mother or lack of caregiver warmth.

Pérez-Fuentes et al. (2013), in a large national study of more than 34,000 adults surveyed in 2004–2005, identified risk factors for CSA, including parent with substance abuse disorder; child physical abuse, maltreatment, or neglect; lower levels of perceived family support; a previous history of CSA; being Black or Native American versus being White; being widowed, separated, or divorced versus married; having public insurance versus private insurance; less likely to be males, Asian, foreign-born, or have completed high school. One of the problems with surveying adults to identify risk factors is that some of the factors which distinguish adults who have CSA histories from those who do not may actually be the results of, or caused by, CSA.

In a 2001 review of 11 research reports and 1 book, Black et al. (2001) identified risk factors pertaining to perpetrators (less educated, poorer, extrafamilial victims, emotionally needy) and victim characteristics (lower family income, lower parental occupation status, single- or stepparent families, poor parent-child relationships

[especially mother-daughter], parents less satisfied with parenting, parents more likely to leave child at home without adequate supervision).

Most recently, in an impressive intellectual achievement, Assink et al. (2019) completed a meta-analysis of Western research completed between 1980 and 2017. They report that 765 risk factors were identified and classified into 35 risk domains, 23 of which showed significant effects through a series of three-level meta-analyses. These 23 risk factors were organized into the following 7 "risk themes": (1) prior victimization of the child and/or their family members, for which the strongest effects were found (i.e., prior CSA victimization of the child and/or siblings, prior victimization of the child other than child abuse, prior or concurrent forms of child abuse in the child's home environment, a parental history of child abuse victimization), (2) parental problems and difficulties (e.g., intimate partner violence between the child's parents; other parental relationship problems; parental substance abuse; psychiatric/mental or physical problems of parents; a low level of parental education), (3) parenting problems and difficulties (i.e., low quality of parent-child relation including low parental attachment, parental overprotection, low levels of parental care/affection, and low parenting competence), (4) a nonnuclear family structure (i.e., growing up in a nonnuclear family, a child having a stepfather); (5) family (system) problems (i.e., problems in functioning of the family system, social isolation of the family or the child, a low family socioeconomic status, six or more moves/resettlements of the child and family), (6) child problems (i.e., physical and/or mental chronic condition, using drugs or engaging in delinquent behavior), and (7) child characteristics (i.e., a low level of social skills, frequent use of the Internet).

The strongest effects were found for prior victimization of the child and/or the child's family members. Strong effects were also found for prior victimization (other than child abuse) or concurrent forms of child abuse in the child's home environment and parental history of child abuse victimization. The most frequently cited risk factors in included studies were prior or concurrent forms of nonsexual child abuse in home, nonnuclear home excluding having a stepfather, being female, parental mental/psychiatric or physical problems, and low family SES.

Some research has suggested that children with disabilities are at an increased risk (Little 2004; Jones et al. 2012; Hershkowitz et al. 2007). Sullivan and Knutson (2000) report on a large population-based study of children in a single school district over a single year. Results indicate children with disabilities were 3.4 times more likely to have been abused than peers without disabilities. In a review, Westcott and Jones (1999) reviewed research dating as far back as the 1960s and report that prevalence of CSA in children with disabilities varied from 4% to 83%. Factors contributing to abuse included dependency, institutional care, and child communication difficulties. In a more recent review, Govindshenoy and Spencer (2007) could find only four studies which met their criteria for inclusion and indicate the evidence for a connection between disability and increased CSA is weak.

Two recent meta-analyses examined the prevalence and risk of violent victimization among people with disabilities (Hughes et al. 2012; Jones et al. 2012). The study by Hughes et al. (2012) reviewed evidence from 21 studies with adult samples. It found that the overall odds ratio (OR) for violent victimization among adults with

disabilities (any type of disability) as compared with adults without disabilities was OR = 1.5. Thus, an adult with a disability is 1.5 times more likely to be victimized than an adult without a disability.

Research in this area is particularly difficult. Some disabilities make directly questioning the potential victim impossible or impractical. There may be differences in persons with disabilities besides their disability which may be linked to increased risk for CSA (e.g., institutional care, personal care of an intimate nature by non-related adults, poverty, and isolation). It also appears, with notable exceptions, that persons with disabilities have not been a major focus of CSA research. For example, it does not appear that surveys of prevalence in the general population screen for disabilities. The lack of large representative samples of individuals with and without disabilities limits a clear appreciation of the risk for CSA in this population. Nonetheless it should be understood that any vulnerability, whether physical, emotional, social, or otherwise, does place the child at risk if that child comes in contact with a predator.

Another potential risk factor receiving some attention is LGBTQ status. Roberts et al. (2012) report on a large longitudinal cohort of youth. Gender nonconformity was associated with an increased risk for abuse (all forms). Andersen and Blosnich (2013), in a multistate probability-based sample, note that compared to heterosexual peers, gay/lesbian respondents had twice the odds of CSA and bisexual peers had nearly three times the odds. Balsam et al. (2010) examined a group of LGB adults they characterize as diverse (78% of the sample was White). Higher rates of CSA were reported among Latino/a and African American respondents as compared to Asian and White respondents.

In a meta-analysis, Friedman et al. (2011) looked at adolescent school-based studies comparing the likelihood of childhood abuse (including CSA) among sexual minorities versus heterosexuals. The meta-analysis yielded 17 studies that satisfied inclusion criteria, plus an additional 37 studies that were added from data sourced from the Youth Risk Behavioral Surveillance Survey (or a similar survey with respect to the sample and questions asked). Analyses of childhood sexual abuse were based on 26 school-based studies in 11 geographic areas. Overall, sexual minority participants were 3.8 times more likely to experience CSA compared to heterosexuals. Compared to heterosexual adolescents, sexual minority adolescents were on average 2.9 times more likely to report CSA. Mean prevalence among females was 40.4% for bisexuals, 32.1% for lesbians, and 16.9% for heterosexuals. Mean prevalence among males was 24.5% for bisexuals, 21.2% for gays, and 4.64% for heterosexuals. Potential moderators of childhood sexual abuse were also examined. Gender was found to moderate the association between sexual orientation and childhood sexual abuse: compared to heterosexual males, sexual minority males were 4.9 times more likely to experience CSA, and compared to heterosexual females, sexual minority females were 1.5 times more likely to experience CSA.

Rothman et al. (2011) report on a review of 75 studies on the prevalences of CSA and lifetime sexual assault among gay or bisexual men and lesbian or bisexual women. This review encompassed a total of 139,635 respondents over the various studies. Mean estimates of CSA among LGB individuals was found to be 22.7% for

men (versus 30.4% lifetime sexual assault in LGB men and 2–3% lifetime sexual assault in general population men) and 34.5% in women (versus 43.4% lifetime sexual assault in LGB women and 11–17% lifetime sexual assault in general population women).

Race and ethnicity in CSA have been understudied although attention was called to these factors by the pioneering work of Wyatt (1985) and Wyatt (1990), who suggested that disclosure rates are influenced by a number of factors and that race/ethnicity may contribute only a small degree to these differences. Fear of disclosure does not appear limited by racial/ethnic group. In a review, Kenny and McEachern (2000) point to a number of methodological problems in research on race and ethnicity. The use of terminology to classify different racial/ethnic groups poses a serious methodological issue, as group classifications ("ethnic lumping") vary across literature and may obscure factors critical to understanding CSA in particular populations. Additional issues in the literature examining racial/ethnic differences in CSA include the use of small sample sizes and retrospective self-reports of abuse. The authors make some observations from the existing literature (described below) but caution against any definitive conclusions as more cross-cultural research is needed.

In terms of prevalence and incidence, findings were inconsistent regarding whether rates differ or are the same by race/ethnicity. Possible methodological differences contributing to differing estimates include (a) small sample sizes, (b) whether a sample is representative or not (cited representative studies found people who are Black to be overrepresented in estimates, while cited unrepresentative studies found people who are Black underrepresented), and (c) underreporting by race/ethnicity (which is suggested to occur in Asian American populations). There is a lack of evidence distinguishing whether race/ethnicity is a risk factor for abuse or if it is better explained by socioeconomic status. With regard to mothers' responses to CSA disclosures, Black mothers seem to be more supportive to child disclosure than White or Hispanic mothers, while Asian and Asian American parents are found to be unsupportive of child disclosures and unlikely to believe or report abuse. In terms of severity of abuse, there is some evidence that Black youth experience higher rates of penetration compared to White and Hispanic youth, but studies are inconsistent with how they measure severity.

A recent methodologically superior study (Newcomb et al. 2009) examined a community sample of youth ages 16 to 19 in Los Angeles. This study explores prevalence and psychosocial consequences of CSA in a community sample of 223 (Latino $n = 132$; White $n = 54$; other $n = 27$). Overall prevalence of CSA was found to be 38.1%, with significantly higher rates among females than males (45.5% versus 24.4%; $p < 0.01$); Latinos than Whites (44.4% vs. 27.8%; $p < 0.05$); and Latinas versus Latinos, White females, and White males (54.2% vs. 23.9%, 28.1%, 27.3%; $p < 0.001$). Perpetrators of males were 52.9% female, and perpetrators of females were 91.9% male. The majority of participants were abused by one perpetrator (62.1% of females and 52.6% of males); however, several participants reported being abused by four or more perpetrators (7.6% of females and 15.8% of males).

The search for factors in the child or environment (especially the child caring environment), which increases risk for CSA, is an important goal. While prevention efforts toward improving conditions which negatively impact child and family development are not necessarily major priorities of our society, one can hope that advocacy and political change will make them more so. From a social justice if not a moral/ethical perspective, providing resources to children who are at increased risk seems to be a call to professionals and the public. This is especially true because there seems to be an emerging consensus in the risk factor research that conditions impacting parenting are critical risk factors.

Nonetheless, it is also important to appreciate that all children are inherently vulnerable, and children from privileged homes are also abused. Efforts to "harden the target" and make for child safe environments (see discussion below) should not be ignored or weakened in meeting the real needs of vulnerable children and families. The argument that we cannot do it all results in some set of children being left at greater risk.

Adult sex offenders and youth with illegal sexual behavior problems. Perhaps no other aspect of CSA has inspired more controversy and confusion than that of sex offenders. While news accounts of "perverts" and "predators" can be found in newspapers from the 1900s, stereotypes of men in trench coats persist. Sex offenders tend to be monolithically hated and vilified. But one's perception of an individual who offends may be complicated when that person is found to be a known member of our families, churches, youth groups, or other places that are familiar.

It is now understood that the vast majority of people who sexually abuse children are someone the child knows. Official reports known to police have shown that nine in ten children who were sexually abused were victimized by an acquaintance or family member (Finkelhor and Shattuck 2012; Bureau of Justice Statistics 2000). Acquaintances might include peers or persons ostensibly in a position of care for the child, such as doctors, sports coaches, or religious leaders, as high-profile cases reported by the media have shown in the last two decades. Data from official reports have demonstrated that acquaintances constituted the largest group of sex offenders against youth (58%), followed by family members (33–34%), while strangers made up only 4–7% of offenders (Finkelhor and Shattuck 2012; Bureau of Justice Statistics 2000). Juveniles themselves have been found in official reports to be responsible for more than one third (35.6%) of sexual offenses committed against youth (Finkelhor et al. 2009b).

Knowledge has progressed over the period of modern awareness of CSA from early focus on incest offenders to a broader view (see Conte 1982). Knowledge was significantly advanced by pioneering efforts of Gene Abel, Judith Becker, and their colleagues. Rigorous research on a sample of identified sexual offenders operating under a Certificate of Confidentiality (which was thought to increase the reliability of self-report data) conducted by these researchers over the 1980s challenged long-held beliefs about sexual offenders. Abel et al. (1988) reported that 49% of incestuous fathers and stepfathers abused children outside of the home, significantly challenging the idea that incest was a family problem. Eighteen (18) percent had raped adult women at the same time as they were abusing children. Another significant finding

was that incestuous offenders demonstrated sexual arousal to children in laboratory assessments (Abel et al. 1981). Other research in this same area furthered the understanding that at least in part sexual abuse of children was a sexual problem and not a more significant emotional problem disguised as sexual. (For discussion of these early ideas see Conte 1991b.)

Early research led Conte (1985b) to suggest a functional view of sexual offending against children which summarized the components of adult sexual use of children as denial; sexual arousal/interest; sexual fantasies; cognitive distortions, which minimize or rationalize sexual use of children; social skills deficits; and other problems. Since that time, there has been an increasing awareness that offenders are a heterogeneous group, and it is not known to what extent these components are present in all sex offenders or, more importantly, if there are other components more relevant to understanding offenders. Is an adult engaged in routine sexual abuse of a minor presenting with the same important components that make up the motivation for such behavior as a young child who inserts a stick into the vagina or anus of a same-age peer? Research that leads to understanding the various aspects of functioning which lead a human to sexually abuse another human would be of considerable value. This is in no way to suggest that research on factors associated with the development of people who sexually offend against youth is not important. Clearly it is. But the factors which maintain a problem may be different than those that lead to the onset of the same problem.

Much of the research on sexual offending has focused on etiology and adolescents. Although illegal sexual behavior problems in youth have long been recognized as an aspect of CSA, it has become increasingly clear that many children are abused by peers, so it is worthwhile to understand the youth who abuse. Researchers have also referred to this group as "adolescent sex offenders," a term which has been critiqued as developmentally inappropriate and for leading to responses that favor arrest over intervention, increased stigma, and a belief that the youth is "beyond" treatment (Silovsky, J., personal communication, April 30, 2020). The search needs to focus on what are the same and different between youth with illegal sexual behavior problems and other typologies of people who sexually abuse children. Today after decades of research and practice, it is safe to say that the sexual use of children is a behavior that peers, older adolescents, and adults engage in with some frequency. Like all behaviors it is not determined by one or even one set of factors. It is also clear that interest in whether incest offenders are somehow different persists.

A recent review by Seto et al. (2015) of 78 samples of offenders in the USA and Canada indicate in their analysis that intrafamilial offenders were significantly lower on variables such as antisocial tendencies (e.g., criminal history, juvenile delinquency, impulsivity, substance abuse, and psychopathology) and atypical sexual interests (e.g., pedophilia, other paraphilias, and excessive sexual preoccupation). They also showed lower offense-supportive attitudes and beliefs, emotional congruence with children, and interpersonal deficits. They also were more likely than nonfamily offenders to have experienced sexual abuse, family abuse or neglect, and poor parent-child attachments.

A number of studies have compared sex offenders with non-offenders. For example, Whitaker et al. (2008) summarize results from 89 studies published between 1990 and April of 2003. Risk factors were classified into one of the following six broad categories: family factors, externalizing behaviors, internalizing behaviors, social deficits, sexual problems, and attitudes/beliefs. Sex offenders against children (SOC) were compared to three comparison groups identified within the 89 studies: sex offenders who perpetrated against adults (SOA), non-sex offenders, and non-offenders with no history of criminal or sexual behavior problems. Results for the six major categories showed that SOC were not different from SOA other than showing lower externalizing behaviors. Sex offenders against children were somewhat different from non-sex offenders, especially with regard to sexual problems and attitudes. Sex offenders against children showed substantial differences from non-offenders with medium-sized effects in all six major categories. In short, sex offenders against children are different from non-sex offenders and non-offenders but not from sex offenders against adults.

Other investigators have reviewed research examining emotional congruence between offenders and children (see McPhail et al. 2013). Thirty studies on emotional congruence with children in sex offenders against children were included in a random effects meta-analysis. Extrafamilial SOC – especially those with male victims – evidenced higher emotional congruence with children than most non-SOC comparison groups and intrafamilial SOC. In contrast, intrafamilial SOC evidenced less emotional congruence with children than many of the non-SOC comparison groups. It has long been thought that one approach to prevention would be to increase empathy, especially in males, for children and vulnerable adults. You cannot hurt a person with whom you have an empathetic connection, so the argument goes.

Increased interest in adolescents with illegal sexual behavior problems has resulted in a number of reviews. Some adult offenders exhibit illegal sexual behavior problems when they are adolescents. The factors associated with the onset of a behavior like CSA may be different from the factors that maintain it after years of engaging in the behaviors. In describing the following studies, we have used their own terms to describe youth with illegal sexual behavior problems. This includes the use of "adolescent sex offenders" which is a contested term in the field as previously stated. An appropriate discussion of alternative and person-centered terms to describe adolescents deserves attention but is beyond the scope of this chapter. Certainly, definitions of sexual behavior that harms others are extremely important in communicating to all parties involved and professionals the value, meaning, and impact of the behavior. Seto and Lalumière (2010), in a particularly thorough review of studies with adolescent sexual and nonsexual offenders, note that many of the assumed differences (exposure to nonsexual violence, family relationship problems, social incompetence, conventional sexual experiences, and antisocial attitudes and beliefs) were not factors distinguishing between sexual and nonsexual adolescent offenders. Atypical sexual interests did distinguish between sexual and nonsexual offenders. Atypical interests included pornography, sex with animals, or sex with very young children. In an earlier review, Veneziano and Veneziano (2002)

described adolescent sex offenders as a heterogeneous population with respect to onset of perpetration, age of victims, involvement of psychological coercion, and involvement of physical violence. Frequently described characteristics of adolescent sexual offenders include a history of severe family problems; separation from parents and placement away from home; experiences of sexual abuse, neglect, or physical abuse; social awkwardness or isolation; academic and behavioral problems at school; and psychopathology. Some evidence suggests that developmental trauma may be more common in juvenile than adult offenders (e.g., experiences of physical abuse in 25–50% of juvenile sex offenders). Generally, victims are known to the adolescent offender, and particularly high rates of incest abuse have been recorded (e.g., 30–46% in cited studies).

The authors note that three groups of adolescent sex offenders are presented: sexually assaultive juveniles, pedophilic juveniles with victims three or more years younger than them, and a mixed group who has committed more than one class of offense. Across the literature, there is a consistent finding that juveniles with illegal sexual behavior problems are likely to have experienced prior sexual victimization, with estimates ranging from 40% in a national sample of adolescents, to 49% in a study with a very young sample, to 50–80% in other studies. However, the developmental pathways connecting prior sexual victimization and illegal sexual behavior problems in adolescence are unclear (e.g., whether it is reactive, conditioned, or learned behavior).

Trauma and sexual abuse histories in offenders has long been of interest. Dillard and Beaujolais (2019) report on a review of 13 studies and note that only 4 reported higher rates of CSA and 3 reported multiple forms of trauma or abuse. Grabell and Knight (2009), in an interesting study, examined the age at which adolescent offenders were abused themselves and the development of sexual fantasies. Results indicate that abuse during the period 3–7 years of age was the only age that predicted sexual fantasy. The authors do not speculate why this would be so but it alerts us to the clear finding of much of the research, which is that there is more we do not know.

Knight and Sims-Knight (2004) evaluated an etiological model in 218 juvenile offenders in inpatient sexual offender treatment programs and found support for their three-part model of etiology in which sexual drive/preoccupation, antisocial behavior, and callousness/unemotionality are critical factors. Simons et al. (2008) compared developmental experiences of child sexual abusers ($n = 132$) and rapists ($n = 137$) (total $N = 269$) in a convenience sample of 280 incarcerated adult male sexual offenders in Colorado prisons identified through official records and obtained between 2003 and 2004. Differences were found in the etiology of sexual offending against children versus adults, with more sexuality in development found among child sexual abusers and more violence found in development among rapists. Compared to rapists, child sexual abusers were more likely to report incestuous sexual abuse, abuse by a male, multiple abuse episodes, and more severe abuse (involving force or oral or anal penetration). Developmental experience characteristics of child sexual abusers include significantly higher rates of child sexual abuse compared to rapists (73% vs. 43%) of which 55% was fondling and 15% was severe CSA (e.g., anal penetration). One third of abusers were sexually abused by more

than one perpetrator, 54% were abused by a male, and 22% were abused by a family member. Compared to rapists, child sexual abusers were significantly less likely to have experienced childhood physical abuse (56% vs. 68%), emotional abuse, or witnessed parental violence. Compared to rapists, child sexual abusers were significantly more likely to have been exposed to pornography before the age of 10, reported masturbating before the age of 11 (8% vs. 60%,), reported more bestiality in childhood (11% vs. 38%,), and have anxious attachment style (rapists were more likely to have an avoidant attachment).

Much of the research in this area has employed samples of incarcerated or adjudicated juveniles and adults. It is completely understandable that potential subjects who engage in behaviors which place them at considerable risk would be difficult to recruit for research, especially in light of mandated reporting of child abuse. Subjects identified by courts and found to suffer from the problem of interest to investigators (sexual offending) are readily identifiable. Considerable quality research has been conducted with these samples. Nonetheless there may be currently unknown differences between known offender samples and those who remain unknown. One could argue that offenders identified by law enforcement and handled by courts are the unsuccessful ones, and there may be many differences between that group and the group of unknown offenders.

In this regard the work of Ybarra and Thompson (2018) is quite interesting. Using a national online survey in 2006 and 2012, 1,586 youth responded. More than one in six females and one in five males report engaging in some form of sexual violence before age 21. Sexual harassment was the most common form (23% of males and 17% of females), but actual sexual assault was reported by 10% of males and 12% of females. Older age was associated with higher levels of sexual assault. Five percent of non-perpetrators of rape reported to have been previously a victim of rape versus 37% of rape perpetrators. While volunteers to an online survey may be different from those who do not volunteer, nonetheless efforts to obtain samples of interest that are not yet identified in the community would be of incredible value in expanding knowledge about CSA.

There has also been interest in whether online offenders are different from other sexual offenders. Babchishin et al. (2011) reviewed 27 studies. Online offenders were defined as those arrested or convicted, although one study employed self-report to define an online offender. Acknowledging the small sample sizes and preliminary nature of the data, the authors report that online offenders tended to be Caucasian and younger. They were twice as likely to be unemployed as the general population. Samples were mixed and included different types of sexual offenders. (See also Seto et al. 2011 and Babchishin et al. 2015.)

Recidivism has received considerable attention. In a society that favors legal handling of behavior, it is not surprising that the impact of incarceration would be an interest. For example, Hanson and Morton-Bourgon (2005) summarized 82 studies of recidivism indicating that defiant sexual preferences and antisocial orientation were the major predictors of recidivism. (See also Hanson and Bussiere 1998.)

Notwithstanding what has been an impressive body of research on various aspects of sexual offending, there is much yet to learn. Although there have been

impressive efforts to conceptualize etiology (see, e.g., Marshall and Barbaree 1990; Ward and Siegert 2002), little research has elaborated on these conceptual models. A more complete understanding of the role of early life experiences, the family and larger social context, exposure to pornography, personality characteristics and co-occurring psychopathology, and other factors is important in understanding how sex offenders come to be. Research is needed which identifies components of illegal sexual behavior problems in youth, sexual offending in adults, and the identification of different types of sexual offenders defined at least in part by those components (e.g., sexual arousal, anger/hostility, reenactment of prior trauma) that are associated with CSA and can be targets of prevention and treatment efforts. The identification, recruitment, and study of people of all ages in the general population who engaged in CSA and who have not been identified by law enforcement or social services seems to be a critical need. Putting aside briefly the issue that children are abused in the making of child pornography, are there users of child porn who never abuse an actual child? Are the adverse effects of child pornography viewing more negative for some viewers than others (e.g., viewers with prior histories of abuse or violence)? True prevention is going to require substantial additional research on the nature and origins of CSA offending.

Effects of Sexual Abuse

There is simply no question that knowledge about the harmful impact of sexual assault has expanded greatly since the late 1890s when Freud first suggested that sexual use of children was associated with mental health problems in adults. Early investigations including those of Freud are essentially observations, typically of patients. Beginning in the more modern period effects were described based on more rigorous clinical assessments of symptoms and standardized measures (see, e.g., Gomes-Schwartz et al. 1990). Over time different measures of harm or damage have been used in different studies. Many studies are based on clinical samples such as victims who are seen at emergency rooms or in mental health service organizations. Such studies raise questions about how similar these victims are to those who have not disclosed or who are in the community. Studies often group victims abused by a wide range of offenders including strangers, relatives, romantic partners, and the like. Many studies are cross-sectional, examining victims at one point in time, and do not follow the victim over extended periods of time after the assault to see how the harms and damages may change over time. Few studies have examined individuals before they were victimized and then after. Collaborations between CSA researchers and researchers in other areas may identify longitudinal samples which could address this issue. Most studies examine victims at one point in time and not over extended periods of time. Harms seen or not seen at one point in a lifetime may differ, disappear, or appear for the first time at some later point over a lifetime. Some types of damage may well not appear until years after the assault. For example, assaulted young children may not present with sexual performance problems until later in their development as older teenagers or as adults when sexual behavior is a

normal part of life. There have been a precious few but important studies which have drawn random samples from the general community and compared victims and non-victims.

There is a large body of individual research reports over many decades which have been periodically reviewed. Most of this research consists of clinical studies in which a specific population (e.g., victims in treatment, sex workers, or people with substance abuse issues) is studied. There is always a question about how this special clinical sample may reflect the general community. Nonetheless, over a large body of research, a range of harms and damages has been identified with sexual assault.

Research has examined the effects of abuse on children while still children. In a 1993 review, Kendall-Tackett et al. (1993) reviewed studies on the effects of childhood sexual abuse (abuse before age 18). Results of their review suggest that sexually abused children have more significant problems than children who are not sexually abused in nonclinical studies and in most studies comparing clinical samples of abused and non-abused children (but in a clinical sample for some reason other than abuse). A number of studies have found that, among clinical samples, abused and non-abused children do not show different symptoms, pointing to what is generally known which is that CSA is not the only factor causing children to have problems. As noted by the authors, CSA was associated strongly with sexualized behavior and more general problematic behavior (e.g., depression, aggression) but in the case of the latter symptoms not more than other children in clinical samples. Across studies generally 20% to 30% of victims exhibited a particular symptom except for PTSD, which most victims exhibited. Also noted by the authors, certain symptoms appear to be more consistent within age groups than across ages. The most common symptoms for preschoolers, for example, were anxiety, nightmares, general PTSD, internalizing, externalizing, and inappropriate sexual behavior. For school-age children, the most common symptoms were fear, neurotic and general mental health behaviors, aggression, nightmares, school problems, hyperactivity, and regressive behavior. For adolescents the most common symptoms were depression, withdrawal, suicidal or self-injurious behavior, somatic complaints, illegal acts, running away, and substance abuse. Nightmares, depression, withdrawn behavior, neurotic mental illness, aggression, and regressive behavior were most common across age groups. The authors note that previous studies have reported that between 21% and 49% of children thought to have been abused are asymptomatic at the time they were examined for the research.

An early work by Conte and Schuerman (1987) reports on a study of 369 sexually abused children 4 to 17 years of age and a community comparison sample. Parent- and social worker-completed behavior checklists of frequently reported symptoms of CSA were employed. The social worker-completed checklist of symptoms (e.g., low self-esteem, fearful abuse stimuli, generalized fear, academic problems) indicated that the average number of symptoms was 3.5. Twenty-seven percent of abused children had four or more symptoms. Differences between abused and non-abused children on a measure created out of parent data all indicated significant differences on all the dimensions of behavior.

However, the effects of CSA are primarily an adult problem. A 1992 review by Beitchman et al. (1992) summarized a large body of research available by the early 1990s. Their review noted CSA to be associated with adult symptomatology, including sexual disturbances, anxiety, fear and depression, suicide, and re-victimization. Polusny and Follette (1995) reported on a review of published research available to them. Studies reviewed employed a wide range of methodologies including differing samples and measures. As reported by the authors, studies of nonclinical student samples point to CSA being associated with general psychological distress including various symptoms and psychiatric diagnoses. Studies report CSA associated with depression although rates range from 4% to 66% for non-abused and 13% to 88% for abused subjects. Differing methodologies may account for the large range. Studies also report CSA to be associated with self-harm behaviors including suicidal behaviors and self-mutilation. Anxiety, substance abuse, eating disorders, dissociation and memory impairment, somatization, and personality disorders are also reportedly associated with CSA. The authors also reviewed research pertaining to social and interpersonal functioning. As noted by the authors, studies point to increased hostility, fear, and distrust of others in CSA survivors.

Research has pointed to problems in sexual satisfaction and sexual functioning in CSA survivors. High-risk sexual behaviors (e.g., a high number of sexual partners or unprotected sex) and re-victimization are also noted. Neumann et al. (1996) completed a meta-analysis of research published between 1974 and July 1992. Thirty-eight studies met stringent requirements for inclusion in the review including a clinically equivalent comparison group to the CSA group. Outcomes included those of affect (anger, anxiety, depression), behavior (re-victimization, self-mutilation, sexual problems, substance use, and suicidality), identity/relational (self-concept impairment and interpersonal problems), and psychiatric (dissociation, obsessions, compulsions, somatization, and traumatic stress responses). Results indicate CSA had a significant impact of psychological distress and dysfunction in adult women.

Paolucci et al. (2001), in a more recent review, reviewed studies from 1981 to 1995. Thirty-seven studies met their stringent criteria for inclusion in the meta-analysis. Six major abuse effects were examined: PTSD, depression, suicide, sexual promiscuity, victim-perpetrator cycle, and poor academic achievement. These 37 studies included 88 samples comprising 25,367 subjects, of which 36% reported childhood sexual abuse. This major review employed an effect size analysis in which a positive effect indicates that CSA had a negative impact on functioning and a negative effect size indicated that CSA had a positive consequence to the examined outcomes. The results of this recent meta-analysis indicate that a substantial effect of childhood sexual abuse was found for PTSD, depression, suicide, sexual promiscuity, and academic achievement. The largest effect sizes were for suicide (0.44), depression (0.44), and PTSD (0.40).

Studies of the general population, especially those based on random samples of subjects, are extremely important. Factors that may account for variation in functioning and are not measured or are unknown are assumed to be in similar proportions in the victim and non-victim samples due to random selection. Subjects are

also not selected for some specific factors such as abuse status or mental health condition and thus findings may be more relevant to understanding impact of assault in the general population.

Burnam et al. (1988) report on a large cross-sectional probability study of 3,132 households in two Los Angeles communities and compared lifetime diagnoses of nine major mental disorders in those who reported and did not report sexual assault. Just over 13% (13.2%) of the households reported lifetime sexual assault (i.e., a sexual assault at some point over a lifetime). One third of sexual assault victims reported one lifetime assault; two thirds reported two or more. Lifetime assaults were more common in women (16.7%) than in men (9.4%) and in non-Hispanic White women (19.9%) than Hispanics (8.1%). Eighty percent of assaulted individuals were assaulted between ages 16 and 20. Assaulted individuals were more likely to exhibit major depressive disorder, drug abuse or dependence, panic disorder, and obsessive compulsive disorder. Of note, the rate of onset for non-assaulted individuals is relatively constant, while for assaulted individuals, the onset is higher within the year after the assault.

A 1992 study (Saunders et al. 1992) reported on a representative probability sample of adult women in Charleston County, South Carolina. Of 391 respondents, 33.5% had been the victim of at least one assault before age 18. Over 24% (24.6%) of victims experienced a physical contact assault (rape or molestation), of which 15.6% reported molestation, 10% suffered a child rape, and 12% a non-contact assault. Typically, victims reported significantly more mental health problems than non-victims, including depression, agoraphobia, obsessive compulsive disorder, social phobia, simple phobia, sexual disorders, post-traumatic stress, and suicide attempts.

Golding (1996) examined the functional impact of a sexual assault history in two general population surveys ($N = 6{,}024$) in Los Angeles and North Carolina as part of the Epidemiological Catchment Area study. Results indicate that bed days and restricted activity days were significantly more common for persons with a history of sexual assault than those without. The odds of restrictions in normal activities were one and one-half times greater for those with a history of sexual assault. Repeated assaults, assaults by a spouse, and assaults associated with sexual disturbances were more strongly associated with functional impairment.

A 1999 study (Fleming et al. 1999) of 3,958 female Australians selected from the compulsory voting roles found that 41% reported at least one sexual experience before age 16 and 20% reported CSA. Long-term effects were attributed to CSA by women (46%) which included low self-esteem (28%), distrust (25%), sexual problems (27%), fear of men (9%), depression (9%), eating problems (7%), drug problems and alcohol problems (1% each), and other problems (4%). Women reporting more severe forms of sexual abuse were more likely to experience long-term negative effects. Multivariate analysis indicated that other than women with a history of penetration, the association between sexual abuse and mental health problems did not remain significant when controlling for social and family background variables. The authors note, “The results of this study along with other research indicate that the associations between CSA and adult difficulties persist

even after the potentially confounding childhood family and social factors are controlled for. . .CSA coupled with growing up in a family characterized by domestic violence, alcohol abuse, and emotional deprivation increases the likelihood of long-term negative outcomes" (p. 156).

A US study (Saunders et al. 1999) was designed to learn the prevalence of a history of completed rape in childhood among American women to collect incident-characteristic data and to examine the increased risk, if any, of childhood victimization for certain mental health problems. Telephone interviews were conducted with a national probability sample of women using a multistate, stratified, random-digit dialing method. One sample oversampled for younger women (18–34) based on the idea that younger women may be at higher risk for sexual assault. The average age for first child rape was 10.8 years and the mode was 16. The majority of first rapes (59.8%) occurred prior to age 13. The most common offender was a nonrelative known to the victim (38.9%). Strangers were the offender in 11.2% of cases. Child victims were more likely than non-victims to report both lifetime and current PTSD (victims three times as likely as non-victims) and depression (victims nearly two times as likely as non-victims). At the time of the interview, child rape victims were three times more likely than non-victims to suffer from depression. Victims were also more likely to have taken prescriptions in a non-prescribed manner, to have used illicit drugs, and to report current and lifetime alcohol abuse.

Thompson et al. (2002) report on data from the National Violence Against Women Survey, a national telephone survey about women's experience with violence. Over 8,000 women provided responses. Seven measures of health problems in adulthood, including perception of general health, serious physical injury, miscarriage or stillbirth, chronic physical health condition, chronic mental health condition, drug use, and alcohol use were studied. Both physical and sexual abuse were associated with five of seven health outcomes. Women who were sexually abused in their youth (age 18 or under) reported poor perceptions of general health, sustained a serious injury in adulthood, have had a miscarriage or stillbirth, acquired a chronic mental health condition in adulthood, and have used drugs in the month before the interview.

A more recent British study reports on a representative sample of men and women in the UK (Plant et al. 2005). Subjects were asked to indicate during the previous 12 months if any of eight possible behaviors had "interfered with daily life." Of the sample, 12.5% of females and 11.7% of males reported having been sexually abused. As can be seen, the differences between abused and non-abused individuals' experiences with problems in the previous 12 months are small but several are significant. For example, for women, eating problems were associated with sexual abuse at any age. When the authors combined all problems, sexual abuse before the age of 16 was associated with having at least one problem behavior. Thirty six percent of abused versus 20.7% of non-abused adults had at least one problem behavior. For both genders, being abused after age 16 was associated with self-report of poorer physical health than non-abused adults. Adults who were abused reported poorer mental health than those who were not.

Finally Elliott et al. (2004) report on a general population study of 941 individuals. Results indicate that adults assaulted in adulthood were more symptomatic on all ten scales of the Trauma Symptom Inventory (TSI) than non-assaulted peers. Assaulted men were more symptomatic than women on Dysfunctional Sexual Behavior and Sexual Concerns. Women were more symptomatic on Tension Reduction Behavior than men. Younger subjects were more symptomatic than older subjects. Men were angrier than women assaulted in adulthood. CSA was higher in ASA (Adult Sexual Assault) than non-assaulted subjects (59% vs. 18%).

A significant body of research points to fact that CSA is associated with significant long-term negative effects. No single negative effect is seen in all victims nor is it clear when in adulthood negative effects (a.k.a. symptoms, problems, harms, and psychological damages) will appear. Many victims suffer some effects not understanding that their symptoms are associated with CSA. Other victims hide symptoms from others as long as possible or deny that the behavior is a problem (e.g., substance abuse or compulsive sexuality).

CSA is a negative experience. How victims react may depend on a range of risk and resiliency factors. It is unlikely that a single theory will explain the wide range of behaviors that may result from CSA. Freeman and Morris (2001) provide a nice review of conceptual models explaining CSA effects. Although not all the frameworks are really complete explanations of the adverse effects of CSA (e.g., child abuse accommodation syndrome), the authors do point out that different effects may result from different mechanisms. Some behaviors (effects) may be the result of learning (e.g., cognitions that the world is unsafe or that the victim's only use is as a sexual object). Other effects such as anxiety, hyperarousal, fears, and others are related to responses to overwhelming trauma. Emotional problems including depression or anger may be reactions to CSA. Difficulties in relationships, including distrust, negative attachment, or attraction to harmful partners, are more a function of disrupted or warped development which takes place when a child is sexually abused. The point is to avoid a simplistic formulation which tries to account for all the effects and harms resulting from CSA by a single theoretical or conceptual framework. As noted, how people react to the experience of CSA can be quite varied.

Key Points

- Reports suggest that child sexual abuse in the United States has declined over the past 30 years, but it remains common. Different definitions and methodological issues persist that contribute to varying estimates of incidence and prevalence.
- The vast majority of sexual abuse against youth is perpetrated by someone the child knows, such as an acquaintance or family member. More than one-third of all sexual offenses against youth are committed by other youth.
- Various factors at the family and child levels may increase children's risk of abuse, including a child's disability or LGBTQ status. Research on possible differential risk associated with a child's race and ethnicity is lacking and needed.

- The long-term effects and harms of child sexual abuse vary from person to person but may include behavioral responses to trauma, emotional problems, and difficulties in relationships. A simplistic explanation that seeks to account for all of its effects should be avoided.

Summary and Conclusion

As noted above this chapter could not deal with all aspects of CSA. The material above does reflect current basic knowledge about many aspects of CSA, and we encourage the reader to appreciate that learning about CSA is likely to be a lifelong process as research explores new facets of the problem and broadens understanding. Important in the near future will be increased efforts to develop definitions and categories of abuse which help distinguish between more subtle forms of sexual interactions (e.g., entering the bathroom while a child is bathing), examine acts and motivations for the acts, and identify other dimensions which lead more directly to interventions. Some attention should be given to developing taxonomies of acts in offenders (i.e., abusive behaviors), motivations for those acts, and victim responses.

Cross-References

► Child Sexual Abuse Disclosure and Forensic Practice

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