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THE EFFECTS OF CHILD SEXUAL ABUSE

A substantial body of empirical evidence now shows that child sexual abuse has profound effects on the psychological adjustment of children (Kendall-Tackett, Williams & Finkelhor, 1993) and these effects in some instances continue on into adulthood (Beitchman, Zucker, Hood, Da Costa & Akman, 1991). A wide range of factors mediate the impact of abuse on adjustment (Spacarelli, 1994). In this chapter the impact of sexual abuse on children and adults will be addressed with reference to the empirical literature in the field and the implications of this for prevention considered.

DOMAINS AFFECTED BY SEXUAL ABUSE

Sexual abuse can affect children's functioning in the following domains: behavioural adjustment; attachment; intrapsychic integration and dissociation; and physiological functioning.
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Behavioural adjustment

Sexually abused children exhibit more behavioural problems compared with their non-abused counterparts (e.g. Cohen & Mannarino, 1988; Gomes-Schwartz et al, 1990; Tong, Oates & McDowell, 1987; Kendall-Tackett, Williams & Finkelhor, 1993). Sexually abused children typically become either more withdrawn, depressed, disinterested in school and other activities or they become angry, aggressive and disruptive. That is, they may display both internalising and externalising behaviour problems (Achenbach, 1984). In addition a proportion show inappropriate sexual behaviour. (e.g. Gale, Thompson, Moran & Sack; 1988, Friedrich & Leucke, 1988). This is uniquely related to the process of premature sexualisation inherent in the abuse. Explicit sexual behaviours among non-abused children are rare but are exhibited by a significant proportion of child sexual abuse victims. Sexually abused children tend to display compulsive sexual behaviours and may also engage in sexual behaviour imitative of adult sexual activity (Friedrich, Grambsch, Damon et al, 1992). In adulthood, psychosexual difficulties are common among survivors of child sexual abuse (e.g. Browne & Finkelhor, 1986; Courtois, 1988).

Attachment disruption

Children victimised at an early age by their primary caregivers develop insecure attachments (Carlson, Cicchetti, Barnett & Braunwald, 1989). These early attachment difficulties lay the foundation for relationship difficulties at later stages of development (Cicchetti & Lynch, 1993). There is substantial evidence that difficulties in interpersonal relationships are reported by both children (Friedrich, Beilka & Urquiza, 1987) and adults who have been sexually abused (Courtois, 1988; Elliot, 1994). Insecure attachments may also predate and increase vulnerability to abuse or previously secure relationships may be disrupted by the trauma of abuse. For instance, the reaction of parents to a
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disclosure may destroy trust and compound the child's sense of betrayal and the effects of the abuse (e.g. Conte & Schuerman, 1987b; Elliot & Briere, 1994; Gomes-Schwartz et al, 1990).

Alexander (1992) has identified rejection; premature parentification; and the integenerational transmission of trauma as three attachment-related processes common in abusive families. The process of rejection results in avoidant attachment and is often determined by parents' own impoverished experiences of attachment and care. One critical consequence of rejection is that parents do not respond appropriately to children's distress. Children then learn that these feelings fall outside the realm of shareable experiences and so are apt to deny their own feelings of distress and related needs for safety and security. This dynamic explains the increased vulnerability of such children to revictimisation (e.g. Gomes-Schwartz et al, 1990). The second attachment-related process described by Alexander (1992) is premature parentification. This role reversal process is commonly observed in sexually abusive families (e.g. Levang, 1989). Again, this premature parentification deprives the child of the support and nurturance they need before and after the trauma of sexual abuse and leads them to construct maladaptive internal working models for relationships which persist into other developmental stages. The multigenerational transmission of fear and unresolved trauma evident in abusive families is the third attachment-related process identified by Alexander (1992). Here the attachment history of the parent is recapitulated in their relationship with the child. This dynamic is consistent with empirical evidence on risk factors which contribute to sexual abusive behaviour (Friedrich, 1990).

Intrapsychic integration and dissociation

Summit (1983) described how sexually abused children trapped in secrecy and helplessness adapt to abuse by engaging in denial and dissociation. Dissociation
is typically used by children as a defense mechanism to protect themselves from overwhelming anxiety. Dissociation reduces anxiety by psychologically negating the pain of the immediate impact of the abuse. In order to cope with sexual abuse, children may split themselves off from an awareness of what is happening by dissociating from abuse-related physical sensations or they may cope by pretending the lower part of their body does not exist. Prolonged abuse forces the child to routinely rely upon dissociation and so a dissociative response pattern becomes entrenched (Putnam, 1990). Children victimised during the preschool period are particularly likely to use dissociation as a defence mechanism and to develop a chronic pattern of dissociation (Kirby, Chu & Dill, 1993). These same defence mechanisms which facilitate psychic survival in childhood are serious obstacles to effective psychological integration in later life. Dissociation may present in adulthood as psychic numbing, depersonalisation, disengagement, amnesia for the abuse, borderline personality disorder, and multiple personality disorder (Briere & Conte, 1993; Elliot & Briere, 1995; Williams, 1994; Herman & Schatzow, 1987; Barnard & Hirsh, 1985; Bryer et al, 1987; Bliss, 1984; Coons & Milstein, 1986; Anderson, Yadenik & Ross, 1993). Multiple personality disorder, the most dysfunctional outcome of a chronic pattern of dissociation, is associated with severe forms of victimisation such as co-occurring sexual and physical abuse prior to age eight (Kluft, 1990).

**Physiological functioning**

Severe chronic sexual abuse may have long-term effects on neuroendocrine functioning (Herman & Van Der Kolk, 1989; Pitman, Orr, Forgue, De Jong & Claiborn, 1987). Putnam and Trickett (1993) found that abnormal levels of cortisol occur in preadolescent sexually abused girls. Neuroendocrine
abnormalities have also been detected in pre-pubescent boys who were victims of physical and sexual abuse (Jensen, Pease, Ten Bensel & Garfinkel, 1991). Sexual abuse may also lead to earlier onset of puberty (Herman-Giddens, Sandler & Friedman, 1988; Trickett & Putnam, 1993).

THE DEVELOPMENTAL COURSE OF SYMPTOMS

In the immediate aftermath of victimisation between one fifth and two fifths of abused children seen by clinicians show significant psychological adjustment problems (e.g. Gomes-Schwartz et al, 1990; Mian, Marton & Le Baron, 1996; Tufts, 1984). As adults, between one fifth a quarter of victims of sexual abuse experience considerably more impairment than non-victims (e.g. Kendall-Tackett et al, 1993; Finkelhor et al, 1990; Browne & Finkelhor, 1986). Extreme long-term effects are not inevitable and a majority of victims appear to recover and function adequately (Bentovim, Von Elberg & Boston, 1988; Gomes-Schwartz et al, 1990; Lanktree & Briere, 1995).

Fluctuating patterns of symptoms following sexual abuse have also been observed. Mannarino et al's (1989) found a significant reduction in the internalising but not externalising behaviour problems over time and Friedrich and Reams (1987) reported a rise in sexual preoccupation among preadolescents. Some long-term effects may be delayed and only appear when the individual matures or life events precipitate the emergence of abuse-related symptomatology. This *sleeper effect* occurred in a study by Kinzl and Biebl (1992) who found that the onset of severe psychological problems in female survivors of child sexual abuse was precipitated when their own children reached the age at which they were first victimised.

Sexual abuse may have different effects on children at different developmental stages (Kendall-Tackett et al, 1993). Abuse related depression for instance, may be expressed as clingy behaviour in a pre-schooler, as disruptive behaviour during pre-adolescence, and as a major mood disorder with suicidal
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ideation and self-injurious behaviour in adolescence. Abuse related symptom patterns common among pre-schoolers, pre-adolescents and adolescents deserve particular mention and will be outlined below.

**Pre-schoolers**

While some early studies of sexually abused pre-schoolers appeared to indicate they were less behaviourally disturbed than older children (Adams-Tucker, 1982; Gomes-Schwartz, Horowitz & Sauzier, 1985), subsequent findings have not borne this out (Friedrich et al, 1986; Mian et al, 1986). The short-term effects documented as most characteristic of sexually abused pre-school children include inappropriate sexual behaviour (Friedrich, Beilke & Urquiza, 1988; Friedrich & Luecke, 1988; Gale, Thompson, Moran & Sack, 1988; Jampole & Weber, 1987) and excessive internalizing behaviour problems such as tearfulness, nightmares, clinginess and anxiety (Fagot, Hagan, Youngblade & Potter, 1989; Friedrich, Urquiza & Beilke, 1986).

**Pre-adolescent children**

Behavioural and academic problems at school are commonly reported symptoms among preadolescent children with a history of sexual abuse (Adams-Tucker, 1982; Black, Dubowitz & Harrington, 1994; Elwell & Ephross, 1987; Johnston, 1979; Tong, Oates, & McDowell, 1987). For instance, Tong et al (1987) found that teachers rated sexually abused children as performing significantly less well in school work than other non-abused children. However, it is possible that cognitive deficits may pre-date the trauma of the abuse since the presence of
learning difficulties and developmental delays are risk factors for sexual victimisation (Gomes-Schwartz et al, 1985; Senn, 1988).

Increased internalizing behaviour problems including depression, anxiety, poor self-esteem, and post-traumatic stress disorder have also been noted in this age group (Mannarino, Cohen, Smith & Moore-Motily, 1991; McLeer, Deblinger, Atkins, Foa & Ralphe, 1988). Sexually inappropriate aggressive behaviour while less manifest in this age group than in sexually abused preschoolers or adolescents is still significantly more frequent among preadolescent victims than among any non-abused controls (Hewitt & Friedrich, 1990; Friedrich, 1993; Friedrich, Grambasch, Broughton, Kuiper & Beilke, 1991).

**Adolescents**

Sexually abused adolescents show a wide range of internalizing behaviour problems including depression, anxiety, low self-esteem, suicidal ideation, self-injurious behaviour, post-traumatic stress disorder and eating disorders such as bulimia (Gomes-Schwartz et al, 1985; Sansonnet-Hayden, Haley, Marriage & Fine, 1987; Lindberg & Distad, 1985; Hibbard et al, 1990; Kendall-Tackett et al, 1993). Higher levels of all these symptoms are reported even in non-clinical samples of sexually abused adolescents (Gidycz & Koss, 1989). Externalizing behaviour problems such as running away, truanting and substance abuse are frequently reported sequelae of sexual abuse among adolescents (Briere & Runtz, 1987; Burgess, Hartman & McCormack, 1987; Gomes-Schwartz et al, 1990; Lindberg & Distad, 1985).

Increased sexual behaviour among adolescents is manifested as promiscuity (Gomes-Schwartz et al, 1985; Chandy, Blum & Resnick, 1996), involvement in prostitution or gender identity disturbance (Bagley & Young, 1987) and sexual confusion (Friedrich, Beilke & Urquiza, 1987; Sansonnet-Hayden et al, 1987). Particularly among adolescent males, abuse-related sexualized behaviour may be
expressed as sexually abusive behaviour towards younger children (Gil & Johnson, 1993; Green, 1993)

**EFFECTS OF CHILD SEXUAL ABUSE ON ADULTS**

At least a fifth of sexually abused children suffer serious long-term psychological harm (Browne & Finkelhor, 1986). However, the effects of childhood sexual abuse on adult adjustment are far from uniform. In adults, childhood sexual abuse has been found to lead to a wide variety of adjustment problems including anxiety, post-traumatic stress disorder (PTSD) and dissociative states; depression and self-injurious behaviour; relationship and sexuality difficulties; antisocial behaviour and sexual offending; and parenting problems (Beitchman et al, 1992; Polusny & Follette, 1995).

**Anxiety**

Anxiety is one of the most common responses to the trauma of child sexual abuse (Donaldson & Gardner, 1985; Peters, 1988). Sexual abuse survivors in the general population are more likely than non-victims to suffer from agoraphobia, panic disorder, obsessive compulsive disorder and social phobia (Ernst, Angst & Foldenyi, 1993). The extent to which the experience of child sexual abuse predisposes adult survivors to chronic anxiety is shown by the finding that they are five times more likely to be diagnosed with an anxiety disorder than their non-abused peers (Saunders, Velleponteaux, Lipovsky & Kilpatrick, 1992a; Stein et al, 1988). Furthermore, in clinical samples, chronic or severe anxiety is
correlated with repeated violent sexually abusive experiences (Briere & Runtz, 1987; Herman & Schatzow, 1987).

**Post-Traumatic Stress Disorder (PTSD)**

Anxiety and fear stemming from the trauma of early sexually abuse may also manifest itself in the development of post-traumatic stress disorder (e.g. Briere, 1992; Briere & Runtz, 1991; Rowan, Foy, Rodriguez & Ryan, 1994). Child sexual abuse has been shown to result in PTSD in as many as 36% of adult survivors and is particularly prevalent in victims reporting contact sexual abuse and child rape ((Donaldson & Gardner, 1985; Saunders et al, 1992a, 1992b). While not all victims of child sexual abuse go on to develop full blown PTSD, the experience of both intrusive traumatic memories and attempts at avoidance of these memories are common (Elliot & Briere, 1995). A history of concurrent physical and sexual abuse during childhood may increase the risk of PTSD (e.g. Rodriguez, Ryan & Foy, 1992).

**Dissociation**

Dissociation occurs commonly among adult survivors of sexual abuse (Briere & Runtz, 1987; Chu & Dill, 1990; Kluft, 1990; Putnam, 1990). As has already been noted, dissociation presents as psychic numbing, depersonalisation, disengagement, amnesia for the abuse, borderline personality disorder, or multiple personality disorder. A significant proportion of child sexual abuse victims report partial or complete amnesia for their abuse experiences (Briere & Conte, 1993; Elliot & Briere, 1995; Williams, 1994). This phenomenon was also noted by Groth and Burgess (1979) among sex offenders asked about childhood abuse. Many did not deny the experience but were not sure if something had happened. Dissociation of abuse related memories appears to be correlated with chronic and violent maltreatment with an early age of onset (Briere & Conte,
An association between borderline personality disorder and child sexual abuse has been reported by several authors (Barnard & Hirsh, 1985; Bryer et al, 1987). Multiple personality disorder, the most extreme manifestation of dissociation, is associated with extremely severe and concurrent physical and sexual abuse (Bliss, 1984; Coons & Milstein, 1986; Anderson, Yasenik & Ross, 1993).

**Depression and self-injurious behaviour**

Depression is consistently reported as the most common long-term effect of child sexual abuse and has been documented in a variety of clinical and non-clinical studies (Briere & Runtz, 1988; Browne & Finkelhor, 1986; Mullen et al, 1996; Russell, 1986; Silverman, Reinherz & Giacona, 1996; Wyatt & Powell, 1988; Beitchman et al, 1992). Stein et al (1988) in a large scale community survey found that sexual abuse victims have as much as a fourfold greater lifetime risk for major depression than non-victims. Victims of sexual abuse are more likely to be identified as requiring treatment, usually for depression (Mullen, Romans-Clarkson, Walton and Herbison, 1988) and the degree of depression is directly related to the severity of the abuse (Peters, 1988). In studies of clinical populations higher rates of depression have been found in female patients with histories of sexual abuse compared to psychiatric control groups (Margo & McLees, 1991; Pribor & Dinwiddie, 1992). Recovery from a major depressive episode is also negatively affected by a history of child sexual abuse. For instance, Zlotnik, Ryan, Miller and Keitner (1995) reported that women without a history of child sexual abuse were three times more likely to have recovered from depressive episodes by 12 months. Given the strength of the association between a history of child sexual abuse and depression, it is not surprising that increased suicidal ideation and self-injurious behaviours have also been linked to sexual abuse in studies of both community and clinical populations (Bagley & Ramsay,

**Interpersonal relationships and sexuality**

Women who have been sexually abused in childhood report a greater fear of both men and women (Briere & Runtz, 1988). They report difficulty trusting others and are more likely to have a history of failed relationships or marriages than non-abused women (deYoung, 1982; Russell, 1986). They are more likely to have fewer friends (Gold, 1986), experience less satisfaction in their relationships and have more maladaptive interpersonal patterns (Elliot, 1994). Sexual maladjustment has been found to be associated with a childhood history of sexual abuse in both clinical (e.g. Briere & Runtz, 1988) and non-clinical samples (e.g. Saunders et al, 1992b). Saunders et al (1992b) found that 32% of sexually abused subjects, compared to 16% of non-abused subjects, met diagnostic criteria for a psychosexual disorder at the time of interview. Briere and Runtz (1988) reported that 45% of sexual abuse survivors, compared to 15% of non-abused clients at a walk-in counselling centre reported sexual problems.

In adulthood, victims of child sexual abuse have been found to engage in more promiscuous or indiscriminate sexual behaviour (Briere & Runtz, 1991; Herman, 1981; Courtois, 1988). Such promiscuous behaviour is associated with higher rates of HIV infection among adult survivors of child sexual abuse (Zierler, Feingold et al, 1991). Wyatt et al (1993) concluded that the severity of sexual abuse experiences contributes to the higher frequency of sexual activity observed during adulthood thus increasing the chance of exposure to HIV infection and other sexually transmitted diseases.

Another form of high risk behaviour associated with a history of sexual victimisation in childhood is prostitution which is even more common among male victims than females (Silbert & Pines, 1981; Zierler, Feingold et al, 1991).
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Just as sexual abuse increases the risk of subsequent sexual victimisation for children (Gomes-Schwartz et al, 1990) adult victims of child sexual abuse also show a greater vulnerability to revictimisation, both physical and sexual later in life (Wind & Silvern, 1992). In summary, child sexual abuse appears to have a devastating effect on adult sexuality for a significant proportion of victims, these effects include impaired sexual satisfaction and functioning, promiscuous behaviour, higher rates of HIV infection, prostitution and a greater vulnerability for revictimisation which may involve sexual assaults or physical violence.

Anger, antisocial behaviour and sexual offending

Chronic irritability, uncontrollable rage and fear of their own anger are common complaints among adult survivors of child sexual abuse (Briere & Runtz, 1987; Donaldson & Gardner, 1985). Survivors are nearly twice as likely to have problems with anger than non-victims (Briere & Runtz, 1988). The rage experienced by former victims of sexual abuse can intensify when it is restimulated by interpersonal events which parallel the original experience of child abuse (e.g. Kinzl & Biebl, 1992). This anger may be internalised as self-injurious behaviour (e.g. Courtois, 1988) or externalised as antisocial behaviours including the perpetration of abuse (e.g. Briere & Runtz, 1988; Herman, 1988). A small proportion of victims externalise their rage by sexually abusing others. Approximately 30% of offenders report having been sexually abused as children (Murphy & Smith, 1996) and there is some evidence to suggest that this group of offenders have higher overall levels of sexual deviancy and increase levels of psychological disturbances (Langevin, Wortzman, Wright & Handy, 1989). One hypothesis is that the victim who becomes a victimiser is identifying with the aggressor and by taking on the abusive role. This identification with the aggressor may have a number of pay-offs including reducing the sense of powerlessness associated with the original trauma.
**Parenting**

Women who were sexually abused as children, particularly victims of incest, may have difficulty parenting their own children and creating a safe and secure home environment for their offspring. Cole and Woolger (1989) found that female incest survivors, compared to survivors of extrafamilial abuse, had excessive expectations of autonomy for their children; were less accepting or supportive of their children; and also reported greater conflict with their children. Children of mothers who experienced incest have been found to be at risk for maltreatment (Cole, Woolger, Power & Smith, 1992). Also, the children of adult victims of child sexual abuse have a higher risk for intrafamilial sexual victimisation (Cohen, 1995; Gelinas, 1983).

**MEDIATING VARIABLES**

A variety of variables mediate the effects of sexual abuse and these include age of onset of the abuse; the frequency and duration of the abuse; the degree of violence involved in the abuse; the nature of the abusive acts; the relationship to the abuser; the gender of the victim; the child's cognitive appraisal and coping style; family support; and the context of the disclosure.

**Age of onset.**

Results of empirical studies on the impact of age of onset of abuse on later psychological adjustment are far from clear-cut (Beitchman et al, 1992; Kendall-Tackett et al, 1993). For example, in studies of children Zivney, Nash and Hulsey (1988) found that those victims with early age of onset were most likely to show psychological adjustment problem. However, findings from other studies show
that children abused during pre-teenage and teenage years show the greatest levels of disturbance (Adams-Tucker, 1982; Sirles, Smith & Kusama, 1989). The picture emerging from studies of adult survivors is also equivocal. While some studies have reported a clear association between younger age and greater adjustment problems (e.g. Courtois, 1979; Meiselman, 1978; Ussher & Dewberry, 1995; Sedney & Brooks, 1984; Murphy, Kilpatrick et al, 1988), other studies have found no significant association (Finkelhor, 1979; Langmade, 1983; Russell, 1986). Bagley and Ramsay (1986) reported that when the traumatic effect of penetrative abuse was controlled for, the effect of age of onset of abuse was no longer significantly associated with the degree of later maladjustment.

The major difficulty in assessing the independent contribution of age of onset to outcome is that this variable is connected with several other abuse specific variables. Older children and adolescents are more likely to be subjected to penetrative abuse (e.g. Murphy, Kilpatrick et al, 1988) while younger children are more likely to be abused by a father or stepfather (e.g. Russell, 1986). Both these variables are associated with high levels of trauma and harm. Age of onset may also be correlated with duration of abuse which again is associated with severity of impact. Furthermore, because the full extent of the aftermath of the abuse may not be evident when children are first assessed the effects of the abuse may be underestimated (Gomes - Schwartz et al, 1990).

It is also probable that severe and repeated sexual, has a more detrimental effect on psychological adjustment if it begins when the child is very young because it disrupts the child's sense of safety and security and may lead the child to adopt dissociation as a defence mechanism (Cole & Putnam, 1992). In contrast it is also probable that less severe forms of abuse, particularly abuse that does not involve physical contact such as exhibitionism or voyeurism has a less marked effect on younger children since they are less likely to appraise such abuse as particularly threatening, whereas older children may perceive it as a major threat to their well being. Clearly, questions remain to be answered about the relationship of age of onset of abuse to later psychological adjustment.
**Frequency and duration**

The frequency and duration of child sexual abuse is associated with both short-term and long-term psychological adjustment problems (Beitchman et al, 1992; Kendall-Tackett et al, 1993). Briere and Runtz (1985) and Conte and Schuerman (1987a) in studies of clinical populations of adults and children respectively, found that the duration of abuse was the factor most strongly associated with degree of maladjustment. The findings of several non-clinical studies all support the increased traumatising effect of abuse of extended duration (Bagley & Ramsay 1986; Peters, 1988; Russell, 1986; Tsai, Feldman-Summers & Edgar, 1979). These results are particularly persuasive because they are based on community samples of adults and so represent a wide spectrum of frequency and severity of abuse. Sexual abuse by multiple perpetrators has also been associated with more severe outcome in both children and adults (e.g. Friedrich et al, 1986; Wind & Silvern, 1992).

**Violence**

In studies of sexually abused children, sexual abuse involving violence has consistently been found to lead to more profound psychological problems (e.g. Conte & Schuerman, 1987a; Cohen and Mannarino, 1988; Elwell & Ephross, 1987). This finding parallels the trends reported in studies of adult survivors of sexual abuse (e.g. Gold, 1986; Mullen et al, 1988; Peters, 1988; Russell, 1986).

In Elwell and Ephross’ (1987) sample of school-age sexual abuse victims, the most severe symptoms were associated with physical injury to the child, the use of force by the perpetrator and sexual abuse involving penetration. Cohen and Mannarino (1988) found that children who experienced abuse involving physical force or vaginal penetration subsequently engaged in a high level of aggression and externalising behaviour problems. This suggests that more
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violent assaults may result in more subsequent aggressive behaviour by the victim.

Beitchman (1992) in his review of long-term effects of child sexual abuse, asserts that the interaction of violence and aggression with sexual abuse may produce effects specific to this combination which do not occur or are rarely associated with the presence of either aggression or sexual abuse alone. These effects include Multiple Personality Disorder and suicidality. Studies such as those by Mullen et al (1996) and Gold (1986) indicate that the concurrent experience of multiple forms of abuse produce higher levels of psychopathology and poorer outcome patterns among survivors.

Type of sexually abusive act

While the literature is clear on the impact of violent sexual assault during childhood, whether the type of abusive act consistently influences trauma is less certain (e.g. Finkelhor, 1979). The results of some studies which focused on short-term effects of abuse, such as those by Elwell and Ephross (1987) and Mian, Marton and Le Baron (1996), suggest that experiences which involve penetration do result in more severe symptomatology in childhood. Most of the available research on adult survivors of sexual abuse also implicate more serious sexual abuse, including anal or vaginal penetration as a major factor in producing serious long-term psychological problems (e.g. Bagley & Ramsay, 1986; Russell, 1986; Wind & Silvern, 1992). Studies which failed to find an association between the severity of the abusive acts and degree of adjustment problems (e.g. Finkelhor, 1979; Fromuth, 1986) had very low rates of actual or attempted intercourse among sample participants, limiting the scope of these studies in terms of assessing this particular variable. The available evidence from studies where abuse involving penetration was frequent enough to permit valid conclusions to be drawn, suggests that more invasive abuse is associated with
more traumatic impact in the short-term (e.g. Black, Dubowitz & Harrington, 1994) and in adulthood (e.g. Mullen et al, 1988).

**Relationship to Offender**

The most devastating violation of trust occurs when the perpetrator is closely related to the victim (e.g. Kendall-Tackett et al, 1993; Beitchman et al, 1992). Studies investigating the relationship between the identity of the perpetrator and victim distress have consistently found that abuse by a father or stepfather is associated with the most serious sequelae in both children and adults (e.g. Adams-Tucker, 1982; Friedrich et al, 1986; Mian et al, 1996; Peters, 1988; Russell, 1986; Sirles et al, 1989; Ussher & Dewberry, 1995). Few studies have examined the differential impact of abuse by fathers compared with stepfathers, but Gomes-Schwartz et al (1990) found that children abused by a parent substitute (e.g. step-father or mother’s live-in partner) were the most severely distressed. These children also had the least supportive mothers. These findings highlight the significance of family intactness and the interaction of maternal support with the identity of the offender in some cases of sexual abuse.

The consequences for the child and family are likely to be particularly traumatic when intrafamilial rather than extrafamilial abuse is disclosed. Unlike extrafamilial abuse, intrafamilial abuse may lead to family break-up and imprisonment of the abuser or disbelief and scapegoating of the abused child. The frequency and duration of the abuse is also likely to be of greater significance when the perpetrator is a family member compared with cases of extrafamilial abuse (e.g. Bagley & Ramsay, 1986). Thus, the association of abuse by a close family member, particularly a father or father figure, with the most severe outcomes is complex since other variables are involved including frequency and duration of abuse; anticipated consequences of disclosure; and actual consequences of disclosure.
**Gender of the victim**

The gender of the victim is associated with both the nature of the sexual abuse experienced and subsequent psychological adjustment problems. Pierce and Pierce (1985) in a chart review of 15 male and 180 female victims of child sexual abuse found that boys were more likely to be abused by a stepfather and girls were more likely to be abused by their natural fathers. According to these authors force and violence were more likely to be used against male victims. Other studies have found that the co-occurrence of physical abuse is more common in male victims (e.g. Sansonnet-Hayden et al, 1987; Sirles et al, 1989). While Adams-Tucker (1982) reported that girls were more likely to suffer multiple sexual victimisations and abuse of longer duration. These studies show that the experience of abuse may differ for males and females.

Briere et al (1988) and Seidner, Calhoun and Kilpatrick (1985) found higher levels of maladjustment in male victims as compared with female victims. Chandy, Blum and Resnick (1996) examined gender differences in outcomes of sexually abused youngsters and found that female adolescents with a history of child sexual abuse engaged in more internalising behaviour problems while males displayed a tendency to show more externalising behaviour problems. Males were at higher risk than females of poor school performance, delinquent activities and sexual risk taking. Conversely female adolescents were more likely to develop suicidal ideation, self-injurious behaviour and eating disorders. Among the sequelae specifically associated with males are sexual preoccupations and compulsiveness (Singer et al, 1989), gender identity confusion and sexual orientation confusion (Finkelhor, 1979). Finkelhor (1979) found that males who had been sexually abused prior to age 13 by an older male were four times more likely to be homosexually active. The high rate of child sexual abuse histories among sex offenders (approximately 30%) demonstrates the long-term impact of child sexual abuse on adult male sexual adjustment (e.g. Becker, 1988).
Cognitive appraisal and coping

Victims' appraisals of abusive experiences, their attribution of blame and their understanding of the social and interpersonal meaning of abuse, as well as the coping strategies they use to deal with trauma account for some of the individual differences in the impact of similar traumatic experiences on different victims (Spaccarelli, 1994). Younger children’s lack of understanding may buffer them from the immediate impact of trauma, although realisation in retrospect can have very negative consequences (Gelinas, 1983). Higher levels of cognitive functioning are correlated with greater reported distress (Shapiro, Leifer, Marton & Kassem, 1990). This may be because older children or those with more sophisticated cognitive functioning are more aware of the implications of the abuse. Changing cognitive appraisals may also effect willingness to disclose abuse (Finkelhor, 1995). For instance, boys become more reluctant to disclose abuse as they approach puberty due to an increased awareness of the stigma related to homosexuality (Urquiza & Keating 1990; Watkins & Bentovim, 1992).

Among the abuse related cognitions reported by children are self-blame, perceptions of the self as different to peers, and reduced interpersonal trust (Mannarino, Cohen & Berman, 1994). It is not surprising that many adult survivors of abuse continue to experience abuse-related cognitions in the form of self-blame, low self-esteem, lack of a sense of self-efficacy, feelings of helplessness and perceptions of life as threatening or hopeless (Gold, 1986; Jehu, 1988). These negative appraisals are associated with impaired psychological functioning in adults and adolescents (Drauker, 1989; Morrow, 1991). Greater distrust in children is associated with a global, stable and internal attributions for abusive experiences reflecting a sense of self-blame as constant across time and situations (Wolfe, Gentile & Wolfe, 1989).

The coping strategy which appears to be associated with the most severe symptomatology is avoidant coping, represented by denial, dissociation and suppression (e.g. Johnson & Kenkel, 1991; Leitenberg, Greenwald & Cado,
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1992). Active coping strategies such as disclosure and support seeking are associated with better long-term adjustment, although purposeful disclosure may be associated with increased distress initially (Gomes-Schwartz et al, 1990; Wyatt & Newcomb, 1990). However the positive impact of active coping strategies is likely to be mediated by the response to disclosure of significant members of the child's network and the amount of support available, particularly from non-abusing parents and family members.

Family factors

A number of specific features of the family environment are risk factors for sexual abuse (Beitchman et al, 1991). These include family breakdown and dysfunction (Mian et al, 1986); parental psychopathology and violence (Friedrich & Leucke, 1988); and parental substance abuse (Burgess et al, 1987). Significantly, a history of sexual abuse in the mothers of sexually abused children has been reported in a number of studies (Friedrich & Reams, 1987; Sansonnet-Hayden et al, 1987; Smith & Israel, 1987). This implies the possibility of an inter-generational transmission of sexual abuse.

In addition to increasing the likelihood of intrafamilial sexual abuse, family dysfunction may also exacerbate the effects of the abuse (Alexander, 1992; Courtois, 1988). Higher levels of distress are found in children whose families are characterised by communication problems, organizational difficulties, high levels of conflict and low levels of cohesion (Friedrich & Reams, 1987; Mian et al, 1996).

Maternal support and belief in the child’s disclosure of sexual abuse and warmth toward the child promotes recovery and helps to mitigate the impact of trauma (Conte & Schuerman, 1987b; Everson, Hunter, Runyan, Edelson & Coulter, 1989; Peters, 1988). Maternal support is compromised most often when the perpetrator is a step-father or boyfriend (Elliot & Briere, 1994; Gomes-Schwartz et al, 1990). Children who lack maternal support are more likely to
recant an abuse accusation (Elliot & Briere, 1994) and to experience an out-of-home placement (Hunter, Coulter, Runyan & Everson, 1990).

The context of disclosure

The way disclosure occurs and the context of the revelation are important predictors of both short and long-term consequences for the victims of child sexual abuse (Everson et al, 1989; Gomes-Schwartz et al, 1990; Sauzier, 1989; Wyatt & Mickey, 1988; Russell, 1986). Most sexual abuse is never disclosed (Finkelhor, 1990; Russell, 1986) and only a minority of abuse is ever reported to authorities subsequent to disclosure (e.g. Saunders et al, 1992a; Wyatt & Mickey, 1988). Among adult survivors of child sexual abuse, nondisclosure of abuse has consistently been found to be associated with more profound psychological adjustment problems in adulthood (e.g. Wyatt & Mickey, 1988; Wyatt & Newcomb, 1990). For children the lowest levels of distress are found among those who did not disclose abuse but whose abuse was discovered accidentally (e.g. Sauzier, 1989). Taken together, these findings suggest that disclosure is inherently stressful and results in increased levels of symptomatology in the short-term but may lead to enhanced recovery in the longer-term.

The levels of stress and trauma associated with disclosure are strongly associated with family dynamics and the anticipated and actual reactions of caretakers and others to the revelation of the abuse. (Sauzier, 1989; Lawson & Chaffin, 1992; Sorenson & Snow, 1991). As mentioned previously, support from non-abusing parents and their belief in the child’s disclosure is a critical factor in the child’s adaptation to sexual abuse (Everson et al, 1989; Gomes-Schwartz et al, 1990; Wyatt & Mickey, 1988). Children who are well supported show fewer adjustment problems.

Believing a child’s disclosure, offering protection and support and refraining from blame or pressure are considered crucial to the child’s recovery. However, as Lawson and Chaffin (1992) point out, parental attitude to disclosure
is not a discrete post-disclosure event but may be explicitly or covertly manifest prior to the disclosure itself. It may therefore influence not only post-disclosure adjustment but also the child’s decision to reveal the abuse. Lawson and Chaffin (1992) studied 18 children who were not previously suspected of being sexually abused, and for whom there were only physical indicators of possible abuse (i.e. sexually transmitted disease). They found that children whose caretakers accepted the possibility of sexual abuse disclosed at a rate 3.5 times that of those whose caretakers denied any possibility of abuse.

Professional interventions following disclosure and the nature of the legal process in which the child participates may influence the impact of abuse on the child's psychological adjustment. For example, multiple interviews by different personnel are associated with greater psychological adjustment problems (Tedesco & Schnell, 1987), although repeated interviews by the same person may not increase distress. The specific effects of court involvement and testimony have been investigated in a small number of longitudinal studies. For example, Runyan et al (1988) reported that poorer recovery was associated with participation in protracted legal proceedings. Williams (1991) demonstrated that some of the adverse effects of court testimony could be mitigated by giving videotaped evidence or using closed-circuit televisions systems. Overall, while certain types of court proceedings appear to delay recovery, these aspects are open to modification and consequently, much of the negative impact associated with legal proceedings is preventable.

**CHILD SEXUAL ABUSE ACCOMODATION SYNDROME**

Summit (1983) argues that child sexual abuse, its effects and the dynamics of unsuccessful disclosure may be conceptualized as an accommodation syndrome with five distinctive features: secrecy; helplessness; entrapment and accommodation; delayed and unconvincing disclosure; and retraction.
Secrecy

CSA is predicated upon secrecy. The secrecy surrounding the sexually abusive incident serves both as a source of fear and a promise of safety. The child is terrified of the implied or explicit consequences of the secret being discovered and so is intimidated into silence. The child also experiences a sense of safety from reassurances given by a perpetrator that, as long as the secrecy is maintained, the child will be all right. So the abused child rarely discloses. The power of secrecy is demonstrated by retrospective surveys which indicate the majority of victims never told anyone during their childhood. Summit concludes that children must be helped to expect a supportive, nonpunitive response to the disclosure before they will be able to share the secret.

Helplessness

Summit points out that a child is three times more likely to be molested by a recognized trusted adult than by a stranger. Given the authority of the adult and the dependence of the child, the victim is easily rendered helpless. It is this terrified helplessness which is often misconstrued as consent, or compliance. The child is unable to protest, unable to resist and frequently unable to escape. Adults may despise helplessness because it runs counter to the cherished adult sense of free will and are quick to attribute blame to children who submit to abuse. Summit contends that children need to have their helplessness and noncomplicity acknowledged and their innocence affirmed if they are not to become filled with guilt and self-hate for somehow inviting the sexual victimization.

Entrapment and accommodation
Constrained by the demands of secrecy and rendered helpless by the power imbalance in their relationship, the sexually abused child has little choice but to accept the situation in an attempt to survive. The child must find a way to accommodate to the experience which often entails not only intrusive sexual demands, but also a need to view the perpetrator as an idealized authority. That accommodation may entail the child assuming a sense of power and control over the situation, such that the child accepts responsibility and blame for the sexually abusive relationship. The normal moral order is reversed. Disclosure becomes a sin greater than the abuse. Accommodation mechanisms used by children to cope with this way of viewing their abusive situation include splitting of reality, altered consciousness, hysterical phenomena, delinquency and self-mutilation.

**Delayed, conflicted and unconvincing disclosure**

The form which disclosure takes and the factors which trigger it can mitigate against the youngster being believed. Confronted with an angry and rebellious adolescent, many adults assume that a disclosure is a revolutionary response against a parent’s attempt to achieve reasonable control and discipline. Denial also operates strongly when a child or adolescent who has demonstrated no outward conflict or behaviour problems discloses sexual abuse. The fact that the child did not talk before now and showed no signs of abuse can be used to invalidate the disclosure, or to attribute responsibility for its occurrence to the victim. Summit concludes that specialists must help skeptics overcome their disbelief.

**Retraction**
Retraction is described by Summit as an escape route often taken by children and adolescents in the chaotic aftermath of disclosure. Children can feel revictimised by the process surrounding validation. Their families may be fragmented and the perpetrator’s threats may appear to be fulfilled. Retraction restores the family's equilibrium. The child bears the burden of either preserving or destroying the family. In the absence of immediate support and strategic interventions to force the offender to take responsibility for the abuse and its aftermath, the child will usually retract, thereby undermining the credibility of the original disclosure.

Summit's model highlights that the very dynamics of the Sexual Abuse Accommodation Syndrome reinforce the victimization of children and society's complacency and denial of its destructiveness. Only by challenging and interrupting the accommodation process can the chain of abuse be broken.

Summit's model is an important framework for understanding some of the effects of child sexual abuse and the dynamics surrounding chronic abuse and unsuccessful disclosure. The model highlights the adaptive role of some of the effects of abuse (e.g., splitting, self-mutilation) and disclosure related difficulties (e.g. retraction) as being important for the victim’s survival from the victim's perspective.

**TRAUMAGENIC DYNAMICS MODEL**

Like Summit, Finkelhor and Browne (1985) have developed a conceptual framework within which to conceptualize the many effects of CSA. They argue that sexual abuse traumatises children through four distinctive mechanisms, which in turn, account for the variety of outcomes experienced by victims. The four traumagenic dynamics are (a) traumatic sexualisation, or experience of developmentally inappropriate sexual behaviours; (b) powerlessness, or feelings resulting from the contravention of the child’s will and domination by the abuser; (c) stigmatisation, or the shame, self-blame and negative connotations of the abuse which the victim internalises; and (d) betrayal, or the shattering of the child’s belief that trusted adults will protect and not harm them. These key dynamics, alter a child’s cognitive or emotional orientation to the world and
distort the child’s self-concept, world view or affective capacities, leading to the psychological and behavioural problems characteristic of child victims and adult survivors of sexual abuse.

**Traumatic Sexualisation**

Traumatic sexualisation is the process involved in the inappropriate conditioning of the child’s sexual responsiveness and the socialisation of the victim into distorted beliefs and assumptions about sexual behaviour. Several distinct processes mediate the dynamic of traumatic sexualisation. These include the manner in which sexual behaviour, inappropriate to the child’s level of maturity, is rewarded and the fact that parts of the child’s body become fetishised by the abuser and thus acquires distorted importance and meaning for the victim. The distorted views of sexual behaviour and morality transmitted by the offender also contribute to traumatic sexualisation as do other frightening aspects of the abusive experience which may become strongly associated with sexual activity.

Traumatic sexualisation increases the salience of sexual issues (e.g. Gale et al, 1988) results in confusion about sexual norms or identity (e.g. Sansonnet-Hayden et al, 1987) and accounts for abuse outcomes such as sexual precocity, compulsive sexuality and sexual aversion or dysfunction (e.g. Burgess, Hartman & McCormack, 1987; Courtois, 1988), as well as aggressive sexual behaviours (Friedrich & Leucke, 1988). The impact of traumatic sexualisation is manifest in the symptomatic behaviour of pre-schoolers in their sexualised play, compulsive masturbation and age-inappropriate sexual knowledge (e.g. Gale, Thompson, Moran & Sack, 1988; Friedrich, Grambsch, Broughton, Kuiper & Beilke, 1991). In older pre-adolescent children, sexual preoccupation, sexual aggression and other inappropriate behaviours are again more common in sexually abused children than their non abused counterparts (e.g. Deblinger, McLeer, Atkins, Ralphe & Foa, 1989; Friedrich & Leucke, 1988). Adolescents may manifest the impact of this dynamic through promiscuity, prostitution or sexual aggression
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(e.g. Burgess, Hartman & McCormack, 1987; Sansonnet-Hayden et al, 1987). Gender identity problems are also found in adolescent victims (e.g. Johnson & Shrier, 1985; Sansonnet-Hayden et al, 1987). In adulthood, traumatic sexualization is manifested as sexual dysfunction or sexual offending (e.g. Courtois, 1979; Gelinas, 1983).

Betrayal

The traumagenic dynamic of betrayal arises from the child’s realisation that a trusted person has used, manipulated and failed to protect them. It may involve the shattering of the child’s confidence in the most fundamental of relationships, with their parents and thus may destroy or impair their subsequent ability to trust others (e.g. Mannarino et al, 1994). This betrayal may occur in a variety of ways: directly, at the hands of the abuser, when the child realises the callous disregard inherent in the sexual abuse; or betrayal may involve the realisation that others have colluded with or failed to protect them from the abuser. It may also stem from the reactions of others to the disclosure of abuse. Children who are disbelieved, blamed, or ostracised, experience a double betrayal, in the sense that the impact of the abuse is compounded by the negative reaction to disclosure (Finkelhor & Browne, 1985).

The dynamic of betrayal is linked to feelings such as grief, depression, heightened dependency, mistrust and anger. It is associated with clinging behaviour, vulnerability to further abuse, intimacy problems and conduct problems, all well documented sequelae among child victims and adult survivors of child sexual abuse (Kendall-Tackett et al, 1993; Beitchman et al, 1992). The prevalence of depression in survivors of child sexual abuse (e.g. Peters, 1985) may reasonably be seen as an attenuated grief reaction in the wake of betrayal. The heightened dependency seen in some young victims (e.g. Mian et al, 1996) may emerge as a constant search for a redeeming relationship in adulthood which increases their vulnerability to physical, sexual and psychological revictimisation.
(e.g. Wind & Silvern, 1992; Wyatt & Newcomb, 1990). Difficulty in intimacy also operates as a form of protection (e.g. Elliot, 1994). At the opposite end of the spectrum of reactions to betrayal, are hostility and anger rather than dependence. The anger and hostility shown by a significant proportion of victims may be a primitive attempt to protect the self from further betrayal and distress (e.g. Briere & Runtz, 1988; Donaldson & Gardner, 1985). Antisocial behaviour and offending behaviour are forms of retaliation for the original betrayal (e.g. Herman, 1988; Gil & Johnson, 1993).

**Stigmatisation**

The dynamic of stigmatisation relates to the isolation and sense of differentness experienced by many victims. Keeping the secret of the abuse increases the victims sense of isolation (e.g. Wyatt & Newcomb, 1990) and diminishes their self-esteem (e.g. Mannarino et al, 1991; Zivney et al, 1988) leading to negative self-evaluations. Stigmatisation covers all of the mechanisms which operate to undermine the child’s positive self image; the sense of shame that is instilled; the accompanying self-blame; the ostracism suffered; and the negative stereotypes acquired from society (Kendall-Tackett et al, 1993). These are linked to sequelae such as social marginalism, for example involvement in drug addiction or criminal activities or prostitution (Bagley & King, 1990; Silbert & Pines, 1981). At its most extreme, the dynamic of stigmatisation leads to self-injurious behaviour and suicide (Briere & Runtz, 1987; Saunders et al, 1992b).

**Powerlessness**

The traumagenic dynamic of powerlessness is related to a constellation of effects, including fear, anxiety and aggression (Finkelhor & Browne, 1985). Symptoms
of fear and anxiety, such as nightmares, phobias and somatic complaints which reflect powerlessness are among the most common reactions noted in sexually abused children (Adams-Tucker 1981; Tufts, 1984; Kolko, Moser & Weldy, 1988). Anxiety is also common in adults along with eating disorders (e.g. Palmer, Chaloner & Oppenheimer, 1992) and dissociation (Briere & Runtz, 1987). The experience of powerlessness impairs the child’s sense of mastery, competence and their coping skills (Black et al, 1994; Silverman et al, 1996). For example, Silverman et al (1996) found that sexually abused adolescents showed an impaired sense of self-efficacy, learning problems, school difficulties, depression and anxiety. Studies of adult survivors of child sexual abuse also support this association. For instance, the high rates of revictimisation reported in several studies (e.g. Russell, 1986; Sorenson, Siegel, Golding & Stein, 1991) suggest that for some victims the feelings of powerlessness associated with the original abuse persist across time, situations, and relationships and render them vulnerable to further abuse. Aggression may occur as a compensatory reaction to the experience of powerlessness. A need to control and dominate typical of male victims (Silverman et al, 1996) which results in antisocial behaviour (e.g. Bagley & King, 1990) or at its most extreme, sexual offending (e.g. Gil & Johnson, 1993) arises from the dynamic of powerlessness.

From the preceding account of Finkelhor and Browne’s (1985) traumagenic dynamics model of child sexual abuse it can be seen that this conceptualisation provides a comprehensive and multifaceted description of the multiple processes involved in traumatisation.

CONCLUSIONS

From this discussion it may be concluded that child sexual abuse has a devastating effect on behaviour, attachment, intrapsychic integration and physiological functioning which persists throughout childhood and into adulthood for a significant proportion of victims. Broadly speaking, this review
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shows that with respect to behaviour, child sexual abuse may lead to an increase in internalizing and externalizing behaviour problems and an increase in inappropriate sexualized behaviour. At an interpersonal level, sexual abuse may disrupt parent-child attachment and this in turn may compromise children's capacity to make and maintain supportive relationships with peers and other adults. At an intrapsychic level, children may cope with sexual abuse through dissociation and subsequently develop a dissociative response set which compromises psychological integration. In the most severe cases this may lead to the development of multiple personality disorder. At a physiological level, sexual abuse may lead to abnormal neuroendocrine functioning.

The impact of child sexual abuse shows a developmental trajectory in that both the nature and severity of symptoms vary with age. Developmentally specific problems following sexual abuse occur in pre-school children, preadolescent children, and adolescents. For example, pre-schoolers may show clingyness, tantrums and frequent masturbation; preadolescents may show underachievement at school, nightmares and peer relationship problems; while adolescents may engage in truanting, drug abuse, sexual abuse of others and prostitution. In adults sexual abuse has been found to lead to anxiety disorders including PTSD, dissociative states, depression, self-injurious behaviour, psychosexual adjustment difficulties, antisocial behaviour, sexual offending and parenting skills deficits.

The impact of sexual victimisation during childhood is mediated by the age of onset of the abuse; the frequency and duration of the abuse; the co-occurrence of violence; the nature of the abusive act; the relationship of the victim to the perpetrator and the gender of the victim. Broadly speaking, poorer psychological adjustment occurs in boys and is associated with intrafamilial, frequent, chronic abuse which began at an early age and involved penetration and violence.

The impact of child sexual abuse is also mediated by the types of coping strategies used, the availability of social support, and the way in which the family and professionals respond to disclosure. Better psychological adjustment occurs
in cases where children do not attribute the cause of the abuse to themselves; cope with the abuse by disclosing it to a trusted peer or adult; receive support and warmth from the non-abusing parent and other members of their social network; and engage in a brief minimally intrusive legal process. Poorer psychological adjustment occurs where children blame themselves for the abuse; use denial, dissociation and avoidant strategies to cope with the abuse and other life difficulties; and do not disclose the abuse to adults. In cases where children make disclosures about the abuse, poorer adjustment occurs where children find that the non-abusing parent or others disbelieve them and are forced to engage in multiple forensic interviews with different interviewers and participate in protracted legal proceedings.

Finkelhor and Browne's (1985) traumagenic dynamics model offers a parsimonious yet comprehensive framework for conceptualising the complex and multi-dimensional nature of the effects of child sexual abuse. Within this model the traumatization process in cases of sexual abuse may be conceptualized as being underpinned by four distinct mechanisms: traumatic sexualization, powerlessness, stigmatization and betrayal. Traumatic sexualization accounts for the inappropriate sexual behaviour shown by victims of sexual abuse. The dynamic of betrayal accounts for subsequent attachment and relationship difficulties. Negative self-evaluation, depression and self-injurious behaviour are accounted for by the dynamic of stigmatization. Excessive anxiety on the one hand and excessive anger on the other are accounted for the dynamic of powerlessness within Finkelhor and Browne's model.

The devastating effects of child sexual abuse provide grounds for the development of and evaluation child abuse prevention programmes. The multifaceted nature of abuse and factors which mediate its impact suggest that prevention programmes should be multisystemic and target not only children but also significant members of their social networks including parents and teachers. That is, prevention programmes should aim to help children develop safety skills. However such programmes should also aim to help parents and teachers create a
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supportive context within which children's use of safety skills is encouraged and children's disclosures of abuse are believed.

REFERENCES


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