<table>
<thead>
<tr>
<th><strong>Title</strong></th>
<th>The epidemiology of child sexual abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Authors(s)</strong></td>
<td>MacIntyre, Deirdre, Carr, Alan</td>
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THE EPIDEMIOLOGY OF CHILD SEXUAL ABUSE

The scale of child sexual abuse is the central concern in this chapter. There are two main types of studies which attempt to describe the scope of child sexual abuse. Firstly, there are incidence studies which seek to estimate the number of cases identified in a specific population during a given time period and in a given locality. Secondly, there are prevalence studies which attempt to estimate the proportion of a population that has been sexually abused in the course of their childhood. Incidence figures are usually expressed as a number of cases per 1000 children per annum in a designated geographical area. Prevalence figures, on the other hand, are expressed as a percentage of cases within a defined population reporting abuse.

In the United States, there have been two major attempts to gather nationwide incidence figures. The American Humane Association (AHA) under the auspices of the US government, served as the clearing house until 1985, for statistics on child abuse and neglect gathered by child protective agencies in individual states. From these reports the AHA then extrapolated national estimates of the actual incidence of child sexual abuse. However, the reliability of these data is questionable. Firstly, many cases of child sexual abuse never come to the attention of child protection agencies and many agencies do not systematically collect the required information and the estimates are therefore, unlikely to yield an accurate picture of the extent of the problem. The National Incidence Study (NCCAN, 1981) in an effort to obtain a more reliable measure of incidence examined a random sample of 26 US counties and attempted to include all cases that came to the attention of other professionals, in addition to child protection agencies. This study estimated that 44,700 children were sexually victimised in the year starting May 1, 1979, yielding an incidence rate of 0.7 per 1,000 children.
In Britain and Ireland, a small number of incidence studies have been conducted. In Northern Ireland, Kennedy, Manwell, Vincent, McKenzie and Blaney (1990) and in Britain Mrazek, Lynch and Bentovim (1983) attempted to estimate the extent of the problem by identifying cases which had come to the attention of professionals. Mrazek et al.’s (1983) study yielded an estimate of 0.17 per 1,000 children based on questionnaires sent to GPs, police surgeons, paediatricians and child psychiatrists. Kennedy et al. (1990) using a narrower definition of child sexual abuse, estimated an incidence of 0.9 per 1,000 children for Northern Ireland. In the Republic, a similar study by McKeown and Gilligan (1990) found the number of confirmed cases to be 1.2 per 1,000 children. In both the Republic of Ireland and Northern Ireland studies 80% of identified cases were female.

Incidence figures probably operate as an index of a community's awareness of the problem of child sexual abuse and may indicate whether the cultural climate is conducive or not to disclosure and detection. While incidence studies have some value in recording the number of cases coming to professional attention, they have major shortcomings in terms of estimating the true scope of the problem (Finkelhor & Hotaling, 1984). Most cases of the child sexual abuse are never reported to child protection agencies, professionals or the police (Finkelhor, 1986), and professional efforts at case detection can dramatically increase the number of cases reported (e.g. Lanktree, Briere & Zaidi, 1991). It comes as no surprise therefore, to discover that a comparison of incidence and prevalence studies reveals that the former consistently underestimate the scale of the problem (Peters, Wyatt & Finkelhor, 1986).

FACTORS WHICH INFLUENCE
THE RESULTS OF PREVALENCE STUDIES

Prevalence studies begin with the premise that most sexual abuse is not reported and therefore the most accurate measures of the extent of the problem must be
derived directly from victim or offender self-reports. Establishing the extent of child sexual abuse by this method has proved problematic and the findings of prevalence studies have been characterised by huge variations in estimated prevalence rates. Variation in prevalence rates across studies may be accounted for by differences in:
- samples studied
- definitions of abuse
- age limits of childhood
- age limits of offenders
- data collection methods
- actual differences in prevalence.

Three different types of samples have typically been studied in investigations of the prevalence of child sexual abuse: (1) probability and non-probability samples of the general population; (2) college student samples; and (3) clinical inpatient and outpatient samples. Tables 2.1, 2.2 and 2.3 summarise findings from prevalence studies of child sexual abuse in each of these categories. Few studies have examined representative samples of the population as a whole. This is unfortunate since it is prevalence rates based on these sorts of samples which would yield the most accurate measure of the extent of the problem at a national level.

Some of the variation in prevalence rates arises from differences in operational definitions of what constitutes child sexual abuse. Examples of broad and narrow definitions have already been given in Table 1.1. Much debate has surrounded the issue of whether or not non-contact abuse should be included in reports of the prevalence of sexual abuse. Some researchers have restricted their attention to contact abuse (e.g. Russell, 1983) while others have extended their definition to include exhibitionism (e.g. Baker & Duncan, 1985; Wyatt, 1985) and exposure to obscene phone calls and harassment (Di Vasto, Kaufman, Rosner, Jackson & Christy, 1984). Two studies, Russell (1983) and Wyatt (1985) have resolved this issue by reporting prevalence rates with non-contact
abuse included and excluded. This solution probably represents the most useful way of reporting prevalence rates and points the way forward for future studies.

A further source of variance emerges from the use of different age limits to define the boundaries of childhood. These in turn reflect legal differences between states. To illustrate, Baker and Duncan (1985) defined childhood as including individuals of 16 years or less, while other researchers use 17 years (e.g. Lewis, 1985), or even 18 years as the upper limit of childhood (e.g. ISPCC-IMS, 1993; Russell, 1983; Wyatt, 1985). Some authors do not specify any upper age limit (e.g. Kercher & McShane, 1984).

A related issue concerns the inclusion or exclusion of incidents involving peers as perpetrators (Peters, Wyatt & Finkelhor, 1986). A number of studies have included peer abuse if these experiences are unwanted (Russell, 1983), forced (Stein, Golding, Siegal, Burnam & Sorenson, 1988) or coercive (Wyatt, 1985) in order to distinguish these experiences from sexual exploration or sexual play with peers.

Differences in data collection procedures also account for some of the variance in prevalence rates. A variety of methods for eliciting a history of child sexual abuse have been used. These include retrospective reviews of clinical charts (Carmen, Reiker & Mills, 1984); telephone interviews (Lewis, 1985; Murphy, 1985); mailed questionnaires (Kercher & McShane, 1984); and semistructured interviews conducted by trained interviewers (Baker & Duncan, 1985; Russell, 1983; Saunders, Villeponteaux, Lipovsky & Kilpatrick, 1992a; Wyatt, 1985). The response set induced by the pattern of questioning also influences obtained prevalence rates. For example, the contrasting rates reported by Baker and Duncan (1985) and Russell (1983) or Briere and Zaidi (1989) reflect differences on this dimension. Baker and Duncan (1985) used a single screening question to elicit information on sexual victimisation during childhood, while Russell (1983) and Briere and Zaidi (1989) both relied on multiple screening questions. The emerging evidence suggests that the latter is the superior method (Pilkington & Kremer, 1995b). It is not surprising that such widely varying methodologies yield differing prevalence rates.
It should, however, be borne in mind that discrepancies between prevalence rates of different studies may genuinely reflect actual differences in the prevalence rates of child sexual abuse among various segments of the population or between regions or ethnic groups. It is also likely that differences in prevalence rates reflect the willingness or reticence of the respondents to disclose abuse. For example, Baker and Duncan (1985) found that 10% of those interviewed reported that they had been sexually assaulted before the age of 16. Another 13%, perhaps symptomatic of this problem, refused to answer.

**PREVALENCE STUDIES OF COMMUNITY SAMPLES**

A summary of the main findings of 25 prevalence studies of community samples is presented in Table 2.1. The overall trends in the studies reviewed in Table 2.1, indicate that child sexual abuse is a serious problem not only in Ireland but world-wide.
Table 2.1. Prevalence of child sexual abuse among international community samples

<table>
<thead>
<tr>
<th>Author</th>
<th>Sample Description</th>
<th>N</th>
<th>Location</th>
<th>Age*</th>
<th>Method</th>
<th>Abuse type</th>
<th>% Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Badgley et al (1984)</td>
<td>Random</td>
<td>1006 (f) 1002 (m)</td>
<td>Canada</td>
<td>&lt;18</td>
<td>Q RR=94%</td>
<td>contact &amp; non-contact</td>
<td>34 (f) 13 (m)</td>
</tr>
<tr>
<td>Bagley &amp; Ramsay (1986)</td>
<td>Random</td>
<td>377</td>
<td>Canada</td>
<td>&lt;16</td>
<td>I</td>
<td>contact (Abuser &gt;3y older) contact &amp; non-contact</td>
<td>22 (f)</td>
</tr>
<tr>
<td>Baker &amp; Duncan (1985)</td>
<td>Random</td>
<td>1049</td>
<td>UK</td>
<td>-</td>
<td>I</td>
<td>contact &amp; non-contact</td>
<td>12 (f)</td>
</tr>
<tr>
<td>Di Vasto et al (1984)</td>
<td>Parent group</td>
<td>500</td>
<td>New Mexico, USA</td>
<td>-</td>
<td>Q RR=97%</td>
<td>contact &amp; non-contact</td>
<td>60 (f)</td>
</tr>
<tr>
<td>Ernst et al (1993)</td>
<td>Random SS in longitudinal study</td>
<td>224 (f) 197 (m)</td>
<td>Switzerland</td>
<td>&lt;16</td>
<td>I RR=72%</td>
<td>contact</td>
<td>11 (f) 3 (m)</td>
</tr>
<tr>
<td>Finkelhor (1984)</td>
<td>Random parent sample</td>
<td>344 (f) 187 (m)</td>
<td>Boston, USA</td>
<td>&lt;17</td>
<td>Q RR=74%</td>
<td>contact &amp; non-contact</td>
<td>15 (f) 6 (m)</td>
</tr>
<tr>
<td>Finkelhor et al (1986)</td>
<td>Random national</td>
<td>1141 (f) 1145 (m)</td>
<td>Los Angeles, USA</td>
<td>&lt;18</td>
<td>TI RR=76%</td>
<td>contact &amp; non-contact</td>
<td>27 (f) 16 (m)</td>
</tr>
<tr>
<td>Gagnon (1965)</td>
<td>White middle class</td>
<td>1200</td>
<td>USA</td>
<td>&lt;12</td>
<td>I</td>
<td>contact</td>
<td>28 (f)</td>
</tr>
<tr>
<td>ISPCC-IMS (1993)</td>
<td>Random 18-54</td>
<td>1001</td>
<td>Ireland</td>
<td>&lt;18</td>
<td>I</td>
<td>contact</td>
<td>14 (f) 10 (m)</td>
</tr>
<tr>
<td>Keckley-Market Research (1983)</td>
<td>Random digit dial</td>
<td>603</td>
<td>Nashville, USA</td>
<td>-</td>
<td>TI RR=70%</td>
<td>not specified</td>
<td>11 (f) 7 (m)</td>
</tr>
<tr>
<td>Kerscher &amp; McShane (1984)</td>
<td>Random adult</td>
<td>593 (f) 461 (m)</td>
<td>Texas, USA</td>
<td>-</td>
<td>Q RR=53%</td>
<td>contact abuse</td>
<td>11 (f) 3 (m)</td>
</tr>
<tr>
<td>Kinsey et al (1953)</td>
<td>White middle class urban</td>
<td>4444</td>
<td>NY, USA</td>
<td>&lt;12</td>
<td>I</td>
<td>contact &amp; non-contact (Abuser &gt;5y older) contact &amp; non-contact</td>
<td>24 (f)</td>
</tr>
<tr>
<td>Lewis (1985)</td>
<td>Random</td>
<td>1374</td>
<td>USA</td>
<td>-</td>
<td>TI RR~</td>
<td>not specified</td>
<td>27 (f)</td>
</tr>
<tr>
<td>MRBI (1987)</td>
<td>Random adults 18-44</td>
<td>500</td>
<td>Ireland</td>
<td>-</td>
<td>Q</td>
<td>contact &amp; non-contact</td>
<td>7 (f) 5 (m)</td>
</tr>
<tr>
<td>Miller (1976)</td>
<td>Random</td>
<td>3185</td>
<td>IL, USA</td>
<td>-</td>
<td>I</td>
<td>not specified</td>
<td>14 (f) 8 (m)</td>
</tr>
<tr>
<td>Mullen et al (1988)</td>
<td>Random electoral rolls</td>
<td>1330 (f)</td>
<td>New Zealand</td>
<td>&lt;16</td>
<td>I RR=66%</td>
<td>contact</td>
<td>10 (f)</td>
</tr>
<tr>
<td>Murphy (1985)</td>
<td>Random digit dial</td>
<td>415 (f) 413 (m)</td>
<td>Minnesota, USA</td>
<td>&lt;18</td>
<td>I</td>
<td>not specified</td>
<td>13 (f) 3 (m)</td>
</tr>
<tr>
<td>Newman (1983)</td>
<td>Readers of 19 magazine</td>
<td>3000</td>
<td>UK</td>
<td>-</td>
<td>Q</td>
<td>Intrafamilial and extraromfamilial contact non-contact contact infraromfamilial contact extraromfamilial</td>
<td>36 (f)</td>
</tr>
<tr>
<td>Russell (1983)</td>
<td>Random</td>
<td>930</td>
<td>San Francisco, USA</td>
<td>&lt;18</td>
<td>I RR=50%</td>
<td>contact &amp; non-contact</td>
<td>54 (f) 28 (f) 16 (f) 31 (f)</td>
</tr>
<tr>
<td>Saunders et al (1992a, 1992b)</td>
<td>Random</td>
<td>391 (f)</td>
<td>South Carolina, USA</td>
<td>&lt;18</td>
<td>I RR=43%</td>
<td>contact &amp; non-contact</td>
<td>33.5 (f)</td>
</tr>
</tbody>
</table>
### Prevention of CSA

<table>
<thead>
<tr>
<th>Study</th>
<th>Methodology</th>
<th>Sample Size</th>
<th>Location</th>
<th>Age</th>
<th>Interview Type</th>
<th>Contact &amp; Non-contact</th>
<th>RR%</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shei (1990)</td>
<td>Random council registry</td>
<td>118</td>
<td>Norway</td>
<td>-</td>
<td>I</td>
<td>contact &amp; non-contact</td>
<td>78%</td>
<td></td>
</tr>
<tr>
<td>Siegal et al (1987)</td>
<td>Random household</td>
<td>1645 (f) 1480 (m)</td>
<td>Los Angeles, USA</td>
<td>&lt;16</td>
<td>I</td>
<td>contact</td>
<td>7 (f)</td>
<td></td>
</tr>
<tr>
<td>Stein et al (1988)</td>
<td>Multi-stage</td>
<td>1632 (f) 1460 (m)</td>
<td>Los Angeles, USA</td>
<td>&lt;16</td>
<td>I</td>
<td>contact</td>
<td>59%</td>
<td></td>
</tr>
<tr>
<td>Wyatt (1985)</td>
<td>Random</td>
<td>248 (f)</td>
<td>Los Angeles, USA</td>
<td>&lt;18</td>
<td>I</td>
<td>contact</td>
<td>55%</td>
<td></td>
</tr>
</tbody>
</table>

*Note:* *Refers to age at which abuse occurs. I= interview, TI= telephone interview, Q= questionnaire; (f)=female; (m)=male; RR%= response rate. Adapted and expanded from 'A review of epidemiological research on child sexual abuse: Community and college student samples' by B. Pilkington and J. Kremer, 1995, Child Abuse Review, 4, 84-98.

From these studies it may be concluded that the prevalence of child sexual abuse for females ranges from 6% for repeated penetrative sexual abuse to 62% when low frequency non-contact sexual abuse is included. For males, the range is 3% for repeated penetrative abuse to 16% for low frequency non-contact sexual victimisation.

The profile of the problem of child sexual abuse is generally consistent across community sample studies. In terms of the ratio of female to male victims they show rates of victimisation for females to be 1.5 times to 3 times that of males. They also show intrafamilial abuse to be more common for girls than boys, constituting one third to one half of girls' abusive experiences. All of the studies showed the perpetrators to be predominantly male. Across the studies only about half the victims disclosed the experiences to anyone.

Among the most robust of these studies was that carried out by Diane Russell in 1983. Using narrow definitions of intra- and extrafamilial abuse, Russell found that 16% of her sample of 930 women had experience of intrafamilial sexual abuse before age 18. Twelve percent of the women had been abused by a relative before the age of 14 and the prevalence rate increased to 38% when experiences of non-contact abuse were also included. Saunders et al (1992a) found a similar prevalence rate of 34% using numerous detailed screening questions and sensitive interviewing methods modelled on Russell’s (1983) study. Lower rates such as those reported by Baker and Duncan (1985) in Britain, may be related to a much cruder methodology, using a single, vague
screening question. Wyatt’s (1985) particularly high rate of prevalence (62%) has been attributed to the extensive interview procedure, in which abuse was one of several topics covered, which may have encouraged more disclosures.

The first national survey of adults in the United States concerning child sexual victimisation was carried out by Finkelhor, Hotaling, Lewis and Smith (1990). Although the telephone interview method utilised was not ideal, this study is important because it attempts to address the issue of the prevalence of child sexual abuse in the general population. Twenty seven percent of the females and 16% of the males reported a history of sexual abuse prior to 18. Some studies with particularly low prevalence rates deserve scrutiny. Stein et al. (1988) reported a rate of only 6% for women and 3% for men. This is probably attributable to two factors. The first factor relates to the definition of sexual abuse which was restricted to coercive sexual encounters. Given that empirical and clinical wisdom has taught us that the majority of sexually abusive encounters do not involve force, but rather depend on the insidious manipulation of trust, this definition probably excluded a large proportion of victims. Secondly, Stein et al.’s (1988) study did not use trained interviewers and thus a lack of professional experience may have hampered the eliciting of disclosures.

Another study reporting a similarly low prevalence rate is that of Kercher and McShane (1984). Their sample was drawn from the Texas drivers licence register and questionnaires were mailed to a representative sample. They found a prevalence rate of 11% and 3% for women and men respectively. This study had a high refusal rate of 47%, not surprisingly, given the sensitivity of the topic and the survey methodology and this may account for the low prevalence rates found.

Other factors may also inhibit the willingness of respondents to disclose history of sexual abuse to researchers. Finkelhor (1994) in his review of the international epidemiology of child sexual abuse commented on the low rates reported in an Irish study of prevalence (MRBI, 1987); 7% of females and 5% of males reported sexual abuse prior to the age of 18 and this included non-contact abuse. Finkelhor attributes these low rates to a cultural climate in which disclosures of sexual behaviour are still very problematic. A more recent Irish
study which was more sophisticated, yielded strikingly different results. The 1993, ISPCC - IMS, survey found that 14% of women surveyed and 10% of men reported sexual victimisation during childhood. This elevated rate is even more important when one considers that this survey was restricted to contact abuse only. Methodology alone may not account for the discrepant finding; in the intervening years, Irish society's awareness of the reality of child sexual abuse has escalated, in the wake of several well publicised cases of child sexual abuse and two national enquiries. This altered climate may have been more conducive to disclosure, contributing to the higher prevalence rates reported in the ISPCC - IMS (1993) study.

In summary, while results of studies of community samples show considerable variation, all have found significant rates of child sexual abuse. Despite definitional dilemmas and methodological differences community samples remain the most effective method of establishing the true extent of child sexual abuse.

PREVALENCE STUDIES OF COLLEGE STUDENT SAMPLES

While general population surveys have major advantages over college student samples in terms of representativeness and generalisability, student samples are readily accessed and this may be the main reason accounting for their popularity with researchers. A summary of the results of 13 such studies is presented in Table 2.2.
Table 2.2. Prevalence of child sexual abuse among international student samples

<table>
<thead>
<tr>
<th>Author</th>
<th>Sample</th>
<th>N</th>
<th>Location</th>
<th>Age*</th>
<th>Method</th>
<th>Abuse type</th>
<th>% Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Binder (1981)</td>
<td>Postgraduate students</td>
<td>167</td>
<td>CA, USA</td>
<td>&lt;15</td>
<td>Q RR=33%</td>
<td>Not specified</td>
<td>20 (f)</td>
</tr>
<tr>
<td>Briere &amp; Runtz (1988)</td>
<td>Undergraduate students</td>
<td>278</td>
<td>Los Angeles, USA</td>
<td>&lt;15</td>
<td>Q</td>
<td>Not specified (Abuser &gt; 15y)</td>
<td>15 (f)</td>
</tr>
<tr>
<td>Calam &amp; Slade (1989)</td>
<td>Undergraduate students</td>
<td>130</td>
<td>Liverpool, UK</td>
<td>&lt;14</td>
<td>Q RR=37%</td>
<td>Not specified</td>
<td>31 (f)</td>
</tr>
<tr>
<td>Finkelhor (1979)</td>
<td>College students</td>
<td>530 (f)</td>
<td>New England, USA</td>
<td>&lt;17</td>
<td>Q</td>
<td>contact &amp; non-contact</td>
<td>19 (f)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>266 (m)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9 (m)</td>
</tr>
<tr>
<td>Fritz et al. (1981)</td>
<td>College students</td>
<td>540 (f)</td>
<td>Seattle, WA, USA</td>
<td>&lt;12</td>
<td>Q</td>
<td>contact</td>
<td>8 (f)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>412 (m)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 (m)</td>
</tr>
<tr>
<td>Fromuth (1984)</td>
<td>Undergraduate psychology</td>
<td>482 (m&amp;f students)</td>
<td>Auburn Uni., USA</td>
<td>&lt;16</td>
<td>Q</td>
<td>contact &amp; non-contact</td>
<td>22 (m&amp;f)</td>
</tr>
<tr>
<td>Landis (1956)</td>
<td>University students</td>
<td>1028 (f)</td>
<td>California, USA</td>
<td>-</td>
<td>I</td>
<td>contact &amp; non-contact</td>
<td>35 (f)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>772 (m)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>30 (m)</td>
</tr>
<tr>
<td>Levett (1989)</td>
<td>University students</td>
<td>94 (f)</td>
<td>Capetown, South Africa</td>
<td>&lt;18</td>
<td>assignment after discussion</td>
<td>non-contact</td>
<td>44 (f)</td>
</tr>
<tr>
<td>Nash &amp; West (1985)</td>
<td>1. GP’s list random</td>
<td>223 (f)</td>
<td>UK</td>
<td></td>
<td>Q</td>
<td>Not specified</td>
<td>42 (f)</td>
</tr>
<tr>
<td></td>
<td>2. Postgrad students</td>
<td>92 (f)</td>
<td></td>
<td></td>
<td>I</td>
<td>Not specified</td>
<td>55 (f)</td>
</tr>
<tr>
<td>Priest (1992)</td>
<td>Afro-American college students</td>
<td>684 (f)</td>
<td>USA</td>
<td>&lt;17</td>
<td>Q RR=59%</td>
<td>contact and non-contact</td>
<td>24 (f)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>356 (m)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12 (m)</td>
</tr>
<tr>
<td>Rew et al. (1991)</td>
<td>University students</td>
<td>111 (f)</td>
<td>Austin, USA</td>
<td>&lt;18</td>
<td>Q RR=49%</td>
<td>contact &amp; non-contact</td>
<td>50 (f)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>160 (m)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>22 (m)</td>
</tr>
<tr>
<td>Seiden &amp; Calboun (1984)</td>
<td>Undergrad psychology students</td>
<td>595 (f)</td>
<td>Uni. of Georgia, USA</td>
<td>&lt;18</td>
<td>Q</td>
<td>sexual experiences with older partners</td>
<td>11 (f)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>490 (m)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 (m)</td>
</tr>
<tr>
<td>Sorrenti-Little et al (1984)</td>
<td>University students</td>
<td>406 (f)</td>
<td>Canada</td>
<td>&lt;17</td>
<td>Q</td>
<td>contact with force (Abuser &gt;3y older)</td>
<td>20 (f)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>164 (m)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9 (m)</td>
</tr>
</tbody>
</table>

Note: * Refers to age at which abuse occurs. I= interview; Q= questionnaire; (f)=female; (m)=male; RR= response rate. Adapted from "A review of epidemiological research on child sexual abuse: Community and college student samples" by B. Pilkington and J. Kremer, 1995, Child Abuse Review, 4, 84-98.

College students tend to come from relatively homogeneous middle class families, while community samples include a greater diversity of individuals in terms of age, education and ethnicity (Peters, Wyatt & Finkelhor, 1986) These facts might lead us to expect that there would be fewer victims of sexual abuse in college student samples, particularly because the psychological impairment of abuse may interfere with academic attainment. From Table 2.2 it may be seen
that this is not in fact the case. For female college students prevalence rates of sexual abuse ranged from 8-50% for all forms of contact and non-contact abuse. For contact abuse the rates ranged from 8-20% for females. For male college students prevalence rates for contact and non-contact abuse ranged from 5-30%. For contact abuse the rates ranged from 5-9% for males. The majority of these abusive experiences, for both males and females had never been reported to a child protection or medical professional (Briere & Runtz, 1988).

A number of the studies summarized in Table 2.2 deserve specific comment. Finkelhor (1979) in a study of a sample drawn from six New England colleges, found a prevalence rate of 19% among women students and 9% among male students. He employed a broad definition of sexual abuse which ranged from penetrative intercourse to non-contact forms of abuse such as exhibitionism. Information was elicited through the use of self-administered questionnaires. Similar prevalence rates have been reported by Fromuth (1984), Sorrenti-Little, Bayley & Robertson (1984), Binder (1981) and Priest (1992). All of these studies used similar methodologies and definitions of abuse. Narrower definitions of abuse tend to yield lower prevalence rates. For instance, Fritz et al. (1981) defined abuse as prepubertal sexual encounters with adults involving sexual contact and found rates of 8% and 3% for female and male students, respectively. However, Briere and Runtz (1988) reported a rate of 13% for their sample of undergraduates, despite having utilised a strict, contact only, definition of abuse.

Some studies have found surprisingly high prevalence rates, which cannot be accounted for on the basis of sample characteristics or definition alone. Levett (1989) for example, in a survey of female students in South Africa, reported a prevalence rate of 43.6%. This high rate is probably due to her unique method of eliciting information in which written assignments concerning students experiences were preceded by structured group sessions dealing with sexual abuse. This procedure probably served the purpose of building trust and legitimising any experiences they might have had, thus escalating the disclosure rate.
Response rate bias may also account for some of the high rates reported in other prevalence studies (e.g. Calam & Slade, 1989; Nash & West, 1985; Rew, Esparaza & Sands, 1991). All these studies had high non-response rates of about 50%. It is therefore unclear whether their findings reflect the true scope of the problem or whether the prevalence rates were inflated by a bias toward participation operating among victims of sexual abuse.

In summary, while results of studies of samples of college students show considerable variation and our confidence in them is tempered by their methodological limitations, all have found significant rates of child sexual abuse which are not markedly different from those found in studies of community samples.

PREVALENCE STUDIES OF CLINICAL SAMPLES

A summary of the results of 33 studies of the prevalence of sexual abuse among patients with psychological problems is presented in Table 2.3. Not unexpectedly, given the hypothesised traumagenic impact of child sexual abuse, studies of clinical samples have found a high rate of sexual abuse among psychiatric populations. Again, a large variation in the prevalence rates, ranging from 3% to 90% is evident. These variations are due in part to many of the same factors previously discussed in relation to community samples and college student samples; the characteristics of the sample studies, the breadth of the definition used, the method of eliciting information and the response set induced by the pattern of questioning.

While a large number of studies have attempted to investigate the prevalence rates in psychiatric inpatient samples, it is difficult to compare results across studies meaningfully. For example, a variety of approaches have been used to elicit information on abusive experiences. Retrospective chart reviews of psychiatric records is one commonly employed technique within clinical samples (e.g. Carmen, Reicker & Mills, 1984; Herman, Russell & Trocki, 1986). This
Prevention of CSA

method is beset with problems, dependent as it is on accurate recording by the
clinician and candid self-report by the victim. An increasing number of studies
now use face to face interviews, and this is now recognised as the preferred
method (e.g. Briere & Zaidi, 1989; Coons & Milstein, 1984). A number of
studies have restricted their definitions of abuse to incestuous relationships (e.g.
Lukianowicz, 1972) and not surprisingly, therefore, have found low prevalence
rates. Benward and Densen-Gerber (1975), similarly restricted their focus of
inquiry to incest and found rates of a much greater magnitude than
Lukianowicz’s study (44% versus 4%). This is probably due to their sample
which comprised female inpatients in a drug rehabilitation unit.

There is considerable empirical evidence which suggests that there may
be a higher rate of sexual victimisation among women who abuse alcohol or other
drugs (Edwall, Hoffman & Harrison, 1989; Ladwig & Anderson, 1989)

Those studies which extend the definition of abuse to include
extrafamilial contact experiences, once again, report a high degree of variability
in prevalence rates. These range from 60% reported by Friedman and Harrison
(1984) to 40% reported by Carlin and Ward (1994) and 21% or 22% prevalence
rates, reported by Jacobson and Richardson (1987) and Bryer, Nelson, Miller and

Consistently high rates are found again in those studies which employ
even broader definitions inclusive of non-contact and extrafamilial abuse (e.g.
Beck & Van der Kolk, 1987; Palmer, Chaloner & Oppenheimer, 1992;
Table 2.3. Prevalence of child sexual abuse among clinical populations

<table>
<thead>
<tr>
<th>Author</th>
<th>Sample</th>
<th>N</th>
<th>Location</th>
<th>Age</th>
<th>Method</th>
<th>Abuse type</th>
<th>% Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baisden &amp; Baisden (1979)</td>
<td>OPs with sexual dysfunction</td>
<td>240</td>
<td>CA, USA</td>
<td>&lt;18</td>
<td>CR</td>
<td>contact</td>
<td>90 (f)</td>
</tr>
<tr>
<td>Beck &amp; Van der Kolk (1978)</td>
<td>Psychiatric IPs</td>
<td>23</td>
<td>Boston, USA</td>
<td></td>
<td>I &amp; CR</td>
<td>childhood (incest)</td>
<td>46 (f)</td>
</tr>
<tr>
<td>Benward &amp; Densen-Gerber (1975)</td>
<td>Patients in drug therapy</td>
<td>118</td>
<td>USA</td>
<td></td>
<td>I</td>
<td>contact</td>
<td>44 (f)</td>
</tr>
<tr>
<td>Briere &amp; Zaidi (1989)</td>
<td>OPs in counselling</td>
<td>153 (f)</td>
<td>Manitoba, Canada</td>
<td>&lt;15</td>
<td>I</td>
<td>contact</td>
<td>44 (f)</td>
</tr>
<tr>
<td>Briere &amp; Zaidi (1989)</td>
<td>Psychiatric emergency OPs</td>
<td>50 (f)</td>
<td>USA</td>
<td>&lt;17</td>
<td>I &amp; CR</td>
<td>contact with abuser &gt; 5y older</td>
<td>61 (f)</td>
</tr>
<tr>
<td>Brown &amp; Anderson (1991)</td>
<td>Psychiatric IPs</td>
<td>346 (f)</td>
<td>USA</td>
<td>&lt;18</td>
<td>I</td>
<td>contact</td>
<td>21 (f) 7 (m)</td>
</tr>
<tr>
<td>Browne &amp; Anderson (1991)</td>
<td>Psychiatric IPs</td>
<td>346 (f)</td>
<td>USA</td>
<td>&lt;18</td>
<td>I</td>
<td>contact</td>
<td>21 (f) 7 (m)</td>
</tr>
<tr>
<td>Bryer et al (1987)</td>
<td>Psychiatric IPs</td>
<td>66</td>
<td>USA</td>
<td>&lt;16</td>
<td>Q RR=54%</td>
<td>contact</td>
<td>21 (f)</td>
</tr>
<tr>
<td>Carlin &amp; Ward (1992)</td>
<td>Psychiatric IPs</td>
<td>149 (f)</td>
<td>Washington, USA</td>
<td>&lt;16</td>
<td>I</td>
<td>contact</td>
<td>40 (f)</td>
</tr>
<tr>
<td>Carmen et al. (1984)</td>
<td>Psychiatric IPs</td>
<td>123 (f)</td>
<td>USA</td>
<td>&lt;16</td>
<td>chart review</td>
<td>serious sexual abuse</td>
<td>19 (f &amp; m)</td>
</tr>
<tr>
<td>Coons &amp; Milstein (1984) MPD patients</td>
<td>17</td>
<td>Indianapolis, USA</td>
<td>I &amp; FI</td>
<td></td>
<td>forcible rape</td>
<td>35 (f)</td>
<td></td>
</tr>
<tr>
<td>Coons et al (1987)</td>
<td>MPD patients</td>
<td>50</td>
<td>Indianapolis, USA</td>
<td>N/A</td>
<td>I &amp; FI</td>
<td>not specified</td>
<td>68 (f) 4 (m)</td>
</tr>
<tr>
<td>Edwall et al (1989)</td>
<td>OPs with personality disorders</td>
<td>597 (f)</td>
<td>USA</td>
<td>&lt;18</td>
<td>I</td>
<td>not specified</td>
<td>35 (f)</td>
</tr>
<tr>
<td>Ernstle &amp; Rosenfeld (1983)</td>
<td>Psychiatric IPs</td>
<td>26 (f)</td>
<td>San Jose, CA, USA</td>
<td>&lt;17</td>
<td>I</td>
<td>not specified</td>
<td>34 (f) 26 (f)</td>
</tr>
<tr>
<td>Friedman &amp; Harrison (1984)</td>
<td>Schizophrenic IPs</td>
<td>20</td>
<td>USA</td>
<td>I RR=56%</td>
<td>sexual contact</td>
<td>60 (f)</td>
<td></td>
</tr>
<tr>
<td>Gross et al (1980)</td>
<td>Psychogenic pelvic pain OPs</td>
<td>25</td>
<td>USA</td>
<td>I</td>
<td>contact (incest)</td>
<td>36 (f)</td>
<td></td>
</tr>
<tr>
<td>Herman et al. (1986)</td>
<td>Psychiatric OPS</td>
<td>105 (f)</td>
<td>USA</td>
<td>CR</td>
<td>contact &amp;/or assault</td>
<td>13 (f)</td>
<td></td>
</tr>
<tr>
<td>Jacobson &amp; Richardson (1987)</td>
<td>Psychiatric IPs</td>
<td>50 (f)</td>
<td>DC, USA</td>
<td>&lt;16</td>
<td>I RR=42%</td>
<td>contact</td>
<td>22 (f) 16 (m)</td>
</tr>
<tr>
<td>Jacobson et al (1987)</td>
<td>Psychiatric IP</td>
<td>50 (f)</td>
<td>Seattle, USA</td>
<td>&lt;16</td>
<td>CR &amp; I</td>
<td>contact</td>
<td>22 (f) 16 (m)</td>
</tr>
<tr>
<td>Ladwig &amp; Anderson (1989)</td>
<td>Drug-dependent prisoners</td>
<td>118 (f)</td>
<td>USA</td>
<td>&lt;16</td>
<td>I</td>
<td>not specified</td>
<td>20 (f)</td>
</tr>
<tr>
<td>Lanktree et al (1991)</td>
<td>Psychiatric OPs</td>
<td>33 (m)</td>
<td>UCLA, USA</td>
<td>&lt;16</td>
<td>CR &amp; I</td>
<td>contact</td>
<td>71 (m &amp; f)</td>
</tr>
<tr>
<td>Lukianowicz (1972)</td>
<td>OP</td>
<td>650 (f)</td>
<td>Co. Antrim, Ireland</td>
<td>&lt;17</td>
<td>I</td>
<td>contact (incest)</td>
<td>4 (f)</td>
</tr>
<tr>
<td>Margo &amp; McLees (1991)</td>
<td>Psychiatric IPs</td>
<td>38 (f)</td>
<td>Syracuse, USA</td>
<td>&lt;16</td>
<td>Q</td>
<td>forced contact</td>
<td>19 (f)</td>
</tr>
</tbody>
</table>
Oppenheimer et al (1985)  
Eating disorder OPs  
78  
UK  
I  
RR=86%  
contact & non-contact  
30 (f)

Palmer et al (1992)  
Psychiatric IPs and OPs  
115 (m & f)  
Leicestershire, UK  
<16  
I  
contact & non-contact  
50 (m & f)

Palmer et al (1990)  
Eating disorder OPs  
158 (f)  
Leicester, UK  
<15  
I  
contact & non-contact  
31 (f)

Rosenfeld (1979)  
Psychiatric IPs  
18  
CA, USA  
I  
RR= 86%  
contact (incest)  
3 (f)

Ross et al. (1989)  
MPD OPs  
207 (f)  
29 (m)  
Canada  
I  
unspecified  
82 (f)

Ross et al. (1991)  
MPD OPs  
92 (f)  
10 (m)  
USA & Canada  
<16  
I  
contact  
90 (m & f)

Sansonnet et al. (1987)  
Adolescent psychiatric IPs  
29 (f)  
25 (m)  
Canada  
<17  
I  
contact & non-contact  
38 (f)  
24 (m)

Sheldon (1988)  
Psychotherapy OPs  
115  
Manchester, UK  
I  
not specified  
17 (f)

Waller (1991)  
Eating disorder OPs  
67 (f)  
Manchester, UK  
<14  
I  
contact & non-contact  
48 (f)

Personality disorder OPs  
34 (f)  
16 (m)  
Boston, USA  
<18  
I  
not specified  
26 (m & f)

Note: * refers to age at which abuse occurs; I= interview; FI= family interview; Q= questionnaire; CR= chart review; (f)=female; (m)=male; RR= response rate; IP= Inpatients; OP= Outpatients. MPD=multiple personality disorder. Adapted and expanded from 'A review of epidemiological research on child sexual abuse: Clinical samples' by B. Pilkington and J. Kremer, 1995, Child Abuse Review, 4, 191-206.

The discrepant findings inherent in differing methodologies are demonstrated by a number of studies involving psychiatric outpatients which compared prevalence rates gleaned from chart reviews with the results from structured interviews. Specifically, Jacobson, Koehler and Jones-Brown’s (1987) study found that interviews increased the prevalence rate from 4% to 22%. The value of all the aforementioned studies, despite their varying methodologies, definitions and discrepant findings is that they confirm that child sexual abuse represents a significant problem and affects the psychological development of a great many children. The higher prevalence rates found in clinical samples lend weight to the view that child sexual abuse constitutes a major risk factor for psychological problems.

Some researchers have found higher prevalence rates within certain diagnostic categories, and have attempted to posit and investigate the causal link between child sexual abuse and certain psychological problems. For example, prevalence rates among multiple personality disorder (MPD) patients have been found to be consistently high. Coons, Bowman and Milstein (1987) found that
50% of their sample of MPD patients had been sexually abused. All but one of these patients had their abuse confirmed by child abuse investigators or witnesses to the abuse. Ross, Miller et al. (1991) reported a rate of 90% for their sample of MPD sufferers. This serious disorder is associated with the most severe and prolonged forms of sexual abuse.

It makes intuitive and clinical sense that child sexual abuse should result in psychosexual problems, it is therefore not surprising to find that Baisden and Baisden (1979) reported 90% of their sample of 240 women disclosed a childhood history of sexual abuse.

Other specific diagnostic groups with an increased prevalence of child sexual abuse include women with eating disorders e.g. (Waller, 1991), depression (e.g. Margo & McLees, 1991), anxiety disorders (e.g. Herman & Shatzow, 1987), chronic pelvic pain (e.g. Gross, Doerr, Caldirolas, Guziuski & Ripley, 1980) and, as previously mentioned, women with substance abuse problems.

In summary, prevalence rates of child sexual abuse in clinical populations were consistently higher than those found in community and college student samples. There is some evidence that inflated prevalence rates occur for specific disorders.

**CONCLUSIONS**

Results of incidence studies show that in the decade from the late 70s to the late 80s on both sides of the Atlantic fewer that 2 cases of sexual abuse per 1000 children in the population were identified by child protection services. In contrast, the results of prevalence studies suggest that the problem is far more widespread. Collapsing the results of community and college studies together and using round numbers, prevalence rates for females ranged from under 10% to just over 60% for contact and non-contact abuse. For males the figure for contact and non-contact abuse ranged from 10% to 30% respectively. Prevalence rates in clinical populations were higher, with the highest rates of up to 90% being
associated with particular disorders notable multiple personality disorder and psychosexual dysfunction's.

This review of epidemiological studies of child sexual abuse has clear implications for service development. First, there is a need for child abuse prevention services to be developed in a way that promotes a climate which helps children develop the skills required to resist potential abusers. Second, child abuse prevention programmes should foster a climate that helps children have the courage to disclose abuse that is occurring and that protects them once they have done so.

Third, there is a need for child protection assessment services and related treatment services to take account of the fact that the a lower estimate of the prevalence of serious child abuse cases in the community is about 10%. Thus, in the Republic of Ireland where there are approximately 1 million children under the age of 18, the lowest estimate for the number of seriously sexually abused children is about 100,000. In planning the availability of assessment and treatment services, staffing levels should be established which can effectively deal with 100,000 serious cases. In establishing treatment services for children and adolescents the risk of victims of abuse, particularly male victims, becoming perpetrators should be taken into account and resources must be devoted to the treatment of adolescents who engage in coercive sexual practices (O'Reilly & Carr, 1997).

Fourth, in developing services for adult mental health problems, account should be taken of the strong links between psychological problems and a history of child sexual abuse. Screening for a history of child sexual abuse should be a routine part of the psychological assessment of adults with psychological difficulties. Adults who have suffered sexual abuse as children may require three main types of mental health service. In the first instance, adults abused as children may require trauma management treatment programmes in which the aim is to help the adult deal with and resolve personal distress arising from the abusive experiences. A second important service, is assistance in managing deviant sexual urges and behaviour patterns. A proportion of adults abused as
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children go on to become abusers themselves and community based treatment services for such individuals is an important aspect of prevention. The third type of services adults abused as children may require is parent training, since in some instances abusive childhood experiences compromise parents' capacity to meet their children's needs.

The results of this review also have implications for further research. There is a need for a more ongoing consistent, rigorous and standardised approach to the investigation of both the incidence and prevalence of child sexual abuse in Ireland. Such research will throw light on the changes in the scale of the problem as preventative measures begin to take effect.

REFERENCES


Prevention of CSA


Prevention of CSA


