

The long-term effects of child sexual abuse

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This paper reviews recent Australian and international research on the long-term effects of child sexual abuse. It aims to assist practitioners and policy-makers who work with survivors of sexual abuse and their families to understand the significant findings from this large and sometimes complex body of research.

Please note

Some of the content in this report contains information that may cause distress to some readers.

If you have been affected by child sexual abuse and are distressed, support services are available if you want to talk to someone <www.aifs.gov.au/institute/pubs/carc/index.html#support>.

KEY MESSAGES

- Child sexual abuse (CSA) covers a broad range of sexual activities perpetrated against children, mostly by someone known and trusted by the child.
- The research on the longer-term impact of child sexual abuse indicates that there may be a range of negative consequences for mental health and adjustment in childhood, adolescence and adulthood.
- Not all victims experience these difficulties—family support and strong peer relationships appear to be important in buffering the impact.
- Recent research indicates that male victims are less likely to disclose their abuse and take longer to do so. Male and female victims may be impacted in different way.
- It is not straightforward to tease out the effects of child sexual abuse and other adverse experiences in childhood and adulthood (including being victimised again), but more recent rigorous research is better able to do so.
- Aspects of the abuse, including the relationship with the perpetrator and the betrayal of trust, the age and gender of the child, and the particular form of abuse are significant factors.

Terminology

For consistency and clarity the current paper uses the term “victim” for the childhood experience and “survivor” for the adult experience or impact.

For further information on the definition of child sexual abuse and other child maltreatment subtypes see *What is Child Abuse and Neglect?* <www.aifs.gov.au/cfca/pubs/factsheets/a142091/index.html>.

Introduction

What do we know now about the long-term impact of child sexual abuse? Since the 1998 NCPC Issues Paper (Mullen & Fleming, 1998) and a number of earlier reviews (e.g., Browne & Finkelhor, 1986; Beitchmann et al., 1992; Green, 1993) on this topic, there have been numerous studies across a range of areas that highlight the long-term impact of child sexual abuse on mental health and social, sexual and interpersonal functioning as well as physical health. There has also been more attention to the scientific rigour of studies and to the conceptual underpinnings of these effects. In addition, there is more recent awareness of the continuing and long-term impact on those who were sexually abused as children or adolescents in societal institutions, such as the Catholic Church and the Scouts, as well as the failure of those institutions to deal with these allegations over a number of decades (Fogler, Shipherd, Clarke, Jensen, & Rowe, 2008).

As Mullen and Fleming (1998) outlined more than a decade ago, there is a consistent picture of significant links between a history of child sexual abuse and a range of adverse outcomes both in childhood and adulthood. This paper outlines the findings of a range of research studies since then concerning mental health and functioning for survivors of child sexual abuse. It starts with a discussion of the methodological issues posed by this area of research and concludes with some of the gender differences and conceptual challenges presented by the findings of this body of research.

Determining the association between child sexual abuse and later outcomes

Research concerned with the links between child sexual abuse and later outcomes covers a broad range of areas and methodologies. It is important to be aware of the types of studies in which these findings have emerged, and to understand some of the methodological considerations and limitations of the research.

Determining the association between children’s experiences of sexual abuse and later outcomes is not straightforward. Not least among the difficulties is the fact that child sexual abuse is usually hidden as a result of the very nature and underlying dynamics of this form of abuse (Priebe & Svedin, 2008). Many children who are sexually abused take years to disclose such abuse and some never do (Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; London, Bruck, Ceci, & Shuman, 2005; Putnam, 2003).

Retrospective reporting of abuse

Most studies rely on the retrospective recall of adults about their childhood experience, often because of the ethical issues of asking children to answer questions about sexual abuse and sexual activity while they are still children. There is likely to be some bias in recall and error in these retrospective reports, which rely on the willingness of the respondent to report on them at that time. Fergusson, Horwood, and Woodward (2000), for example, found that when they asked the

participants (aged 18–21 years) in their longitudinal study “whether, before the age of 16, anyone had ever attempted to involve them in any of a series of 15 sexual activities when they did not want this to happen”,¹ there was “considerable instability and change” between the responses given to this question at 18 years of age and 3 years later at age 21, several years after the cut-off age of 16. While there was no evidence to suggest that these reports were influenced by the psychological state of participants at the time, it does indicate that using different ages for retrospective reporting is likely to provide different results. Other research has also found evidence of a bias in recall in relation to false negatives that can lead to under-reporting of sexual abuse and other adversities in childhood (Hardt & Rutter, 2004). The level of reporting of sexual abuse in childhood is also significantly lower for people in older generations than for younger people (Green et al., 2010). The unwillingness of participants to disclose their childhood experiences or unreliability in doing so (Briere, 1992; Hardt & Rutter, 2004) means that any comparison between those allocated to the non-abused group may include some of those who were actually abused, and vice versa.

One way of overcoming the need for retrospective reporting by those potentially victimised as children is to use cases where the abuse was disclosed in childhood and recorded in administrative data or medical or forensic records. This of course means that any association with later outcomes is tied up with the disclosure experience and subsequent events connected with the formulation of these records. As Fergusson et al. (2008) pointed out, this introduces a sample selection bias as these “populations” differ from the general community base and do not include the unknown cases that have never been reported. Reported cases are more likely to involve perpetrators outside the family² and therefore reflect different responses/reactions from carers/adults (Australian Bureau of Statistics [ABS], 2005; Lamont, 2011).

Specialised populations

There is a range of “specialised populations” that provide evidence for a link between child sexual abuse and later outcomes. These special populations include those who have been referred for counselling, those attending specialised clinics, those seeking medical or psychiatric treatment, those in prison or detention, child victim-witnesses (child victims who have been through the legal process), and university or college students. Clearly findings might be expected to vary among these “populations”, so generalising to the population at large from such specialised samples is risky (Boden, Horwood, & Fergusson, 2007; Frothingham et al., 2000). Those in detention or in prison or seeking psychiatric treatment are clearly sub-populations showing adverse outcomes, but the question is to what extent is this related to their experience of sexual abuse?

Other important methodological considerations concern the definitions of child sexual abuse and the measurement of outcomes, and the need to take into account other possibly “confounding” factors in disentangling the effects of related and other experiences on later outcomes. Child sexual abuse covers an “array of sexual activities” with children (Putnam, 2003, p. 269), and the experience and impact is also likely to vary in association with a number of factors. These include the relationship between the child and the perpetrator, the age and gender of both the child and perpetrator, and the frequency, duration and form of the abuse. In addition, the child’s family circumstances and context are important background and possibly protective factors.

The definition of sexual abuse

It is important to understand how child sexual abuse is defined and how that may vary across a range of studies since this affects the way findings may be compared and the conclusions that can be drawn. Studies on the prevalence and impact of sexual abuse vary in terms of the cut-

1 These activities spanned: (a) non-contact episodes involving indecent exposure, public masturbation or unwanted sexual propositions; (b) episodes involving sexual contact in the form of sexual fondling, genital contact or attempts to undress the respondent; and (c) episodes involving attempted or completed vaginal, oral or anal intercourse (Fergusson, Boden, & Horwood, 2008, p. 610).

2 With the likely exception of clergy-related abuse (Fogler et al., 2008).

off age used for “defining” childhood sexual abuse and the various characteristics of the abuse such as the types of sexual behaviours that are included. In addition, studies vary as to how the relationship between the victim and the perpetrator is categorised (often as “within the family” and “outside the family”). For example, in an early Australian prevalence study, Goldman and Goldman (1988) defined child sexual abuse as “some form of sexual abuse or exploitation by age 18 years by a person five or more years older” that included behaviours such as: “being hugged in a sexual way”, “adult showing genitals” and being “invited to do something sexual” (p. 99). Such acts were reported to have been experienced by 28% of the girls and 9% of the boys. A telephone survey asked a random sample of 4,449 adults aged 18–59 on the electoral roll whether “someone” had engaged them in a range of both penetrative and non-penetrative sexual experiences when they “did not want them to” before they were 16 years of age (Dunne, Purdie, Cook, Boyle, & Najman, 2003).³ The reported prevalence rates for females were 34% for non-penetrative and 12% for penetrative experiences, and for males, 16% and 5% respectively. In a more recent Australian study, Moore et al. (2010) asked the 24 year-old participants in their 10 year follow-up of a cohort of 14–15 year old Victorian students, whether “any adult or older person involved” them in a range of similar *unwanted* incidents of sexual activity before the age of 16.⁴ This study reported that the prevalence of “any sexual abuse with/without contact” was 17% for girls and 7% for boys.

The importance of the definitional issue is that the types of sexual abuse that are included will affect the findings in relation to outcomes, not just prevalence. As Briere (1992) pointed out, it is likely that studies which use a definition of sexual abuse that is restricted to more intrusive and severe forms of abuse involving penetration will report more severe adverse outcomes than those using broader definitions.

Outcome measures

There are a range of outcomes associated with child sexual abuse, related to mental health, behaviour and interpersonal relationships. Different studies may use different measures for similar outcomes. For example, studies on mental health outcomes may include clinical frameworks such as the DSM-IV (Green et al., 2010; McLaughlin, Conron, Koenen, & Gilman, 2010; Scott, Smith, & Ellis, 2010; Ystgaard, Hestetun, Loeb, & Mehlum, 2004), or standardised measures such as the Trauma Symptom Inventory (Briere & Elliott, 2003) or the Symptom Checklist 90-Revised (Gold, Lucenko, Elhai, Swingle, & Sellers, 1999), whereas others have used their own study-specific measures. Clearly, it is easier and more reliable to compare the findings from studies that use commensurate measures. Other studies have relied upon official records for hospitalisation or psychiatric admissions, imprisonment, referral to child protection agencies for parenting problems or positive measures of educational achievement. There is a similar picture of diversity with the use of some standardised measures in relation to other types of outcomes as well.

Taking account of other factors

An important methodological issue is the need to disentangle the effects of abuse from other influences by taking account of a range of individual, family and social factors that might affect or contribute to adverse long-term outcomes. The most significant of these are various aspects of the family environment in which the child was living, including the quality of parenting, parental mental health and possible substance abuse, as well as socio-economic status (parental education and employment), and the possibility that the child was exposed to other forms of abuse and adversity, not sexual abuse alone (Higgins & McCabe, 2001; Noll, 2008). Green et al. (2010), for example,

³ The age of consent to sexual activity is 16 in all states and territories in Australia except South Australia and Tasmania, where it is 17 for both males and females (unless the other person is in a position of “care, supervision or authority”). The Dunne et al. (2003) study was criticised by Stanley and Kovacs (2004) on several grounds, including the likely absence of Indigenous respondents and the use of the term “when you did not want them to” in the question because of their concern that children who are sexually abused may not have objected and may feel responsible and ashamed of their involvement.

⁴ These activities included: inviting/requesting you to do something sexual; kissing or hugging you in a sexual way; touching or fondling private parts; showing their sex organs to you; and making you touch them in a sexual way.

found that while 6% of people in their large-scale community survey reported sexual abuse in their childhood, 72% reported having at least one other childhood adversity such as family dysfunction, parental death or divorce, physical illness or economic adversity. In a critical review of 29 earlier studies in which adult retrospective reports of more than one form of child maltreatment (sexual abuse, physical abuse, psychological maltreatment, neglect, or witnessing family violence) were assessed, Higgins and McCabe (2001) found that “the specific impact of multi-type maltreatment ... was associated with greater impairment than single forms of abuse or neglect” (p. 547).

Other likely significant contributing and possibly confounding factors for long-term outcomes include the person’s more recent and current circumstances and life experiences. However, there is also evidence that suggests some of these life experiences are likely to have been influenced by childhood sexual abuse itself or by the particular vulnerabilities of the child at the time. As outlined later, for example, children who have been sexually abused are more likely than other children to be re-victimised both as adolescents and adults. They are also more likely to have been targeted by the perpetrator specifically because of their particular vulnerabilities including having socially isolated parents who lack partners and other supports (Conte, Wolf, & Smith, 1989; Elliot, Browne, & Kilcoyne, 1995).

There are various ways of trying to control for the likely influence of other adversities in childhood as well as family background, and these include using matched or comparison groups and taking account of these factors statistically. Matching groups and using statistical means of equivalence are by no means foolproof, however, as Briere and Elliott (2003) pointed out:

there are significant statistical issues associated with controlling for abuse-correlated variables when abuse is antecedent to such variables (Davis, 1985; Pedhazur, 1982) or when the abuse variable is, itself, logically inseparable from the controlled variable (Briere & Elliott, 1993). For example, in the case of family environment, child abuse may further disrupt an already dysfunctional family, and a dysfunctional family may be an important aspect of child abuse (especially intra-familial sexual and physical abuse). As a result, controlling for family environment when examining the relationship between abuse and later psychological symptoms may be a highly conservative, or even nonsensical procedure (e.g., examining the effects of incest after removing variance associated with living in a disturbed or dysfunctional family environment). (p. 1206)

Twin studies, involving one twin known to have been abused and the other not, provide a particularly strong research design because they provide a comparison that controls for family background for twins raised together, and also genetic make-up for identical versus mono-zygotic twins (Dinwiddie et al., 2000; Kendler et al., 2000; Nelson et al., 2002).

Causality and design issues

Many studies in this field have relied on cross-sectional designs whereby participants simultaneously provide information about their experience of abuse (or not) as well as their current outcomes such as their mental health or functioning. This can be problematic for several reasons. First, causality cannot be inferred from correlational analyses and, as Briere (1992) pointed out, cause and effect can become blurred in correlational and retrospective designs. It is possible, for example, that “current distress or symptomatology” may affect the way earlier experiences are perceived and reported. It is also possible that “abuse-related symptomatology can wax and wane across the life span”, particularly in relation to current life experiences and developmental stages with the emergence, for example, of intimacy and sexual problems in adolescence or “sleeper effects” later in adulthood with the birth of a child (Briere, 1992, pp. 196–197). More importantly, however, cross-sectional studies cannot differentiate “abuse-specific from abuse-concurrent or abuse-antecedent events” (Briere, 1992, p. 197). To what extent are the problems that sexually abused adolescent and adults exhibit a direct or indirect result of the sexual abuse, of other forms of co-existing abuse

and family dysfunction, of pre-existing vulnerabilities and problems, or later problems that are not related to the sexual abuse?

The most effective design to overcome these problems is a *longitudinal prospective design* in which a random selection of children is followed from birth. This allows a comparison between those who experience various forms of abuse, including sexual abuse, and those who were not abused at all. Of course, sexual abuse may not be revealed until later, and perhaps not at all, so weakening any comparison concerning the effects of sexual abuse. Attrition or the loss of participants to the study also reduces the power of the analyses, and there is still the need to take account of other factors apart from abuse that may contribute to adverse outcomes.

Box 1: Towards better methodology

The Christchurch Health and Development Study—A large prospective longitudinal study

The best known substantial prospective longitudinal study which provides useful findings in this field is the Christchurch Health and Development Study (CHDS), a longitudinal study of a birth cohort of 1,265 children born in the Christchurch (New Zealand) urban region in mid-1977, with information from a variety of sources including: parental interviews, teacher reports, self-reports, psychometric assessments, medical, and other record data.

Sexual abuse was assessed by asking whether, before the age of 16, anyone had ever attempted to involve them in any of a series of 15 unwanted sexual activities, including: (a) non-contact episodes involving indecent exposure, public masturbation, or unwanted sexual propositions; (b) episodes involving sexual contact in the form of sexual fondling, genital contact, or attempts to undress the respondent; or (c) episodes involving attempted or completed vaginal, oral, or anal intercourse (Fergusson, Horwood, & Lynskey, 1996; Fergusson, Lynskey, & Horwood, 1996). Using these data, participants were classified into one of four exposure groups reflecting the extent/severity of child sexual abuse reports: (a) no sexual abuse (85.9% of the sample); (b) non-contact sexual abuse only (2.7% of the sample); (c) contact sexual abuse not involving attempted or completed sexual penetration (5.1% of the sample); and (d) attempted or completed sexual penetration including vaginal, oral and anal intercourse (6.3% of the sample) (Boden et al., 2007, p. 1104).

Other longitudinal studies have followed a cohort of children who were identified at some point following the abuse—for example, after coming to the attention of the police or statutory child protection agency (Brown, Cohen, Johnson, & Smailes, 1999; Scott et al., 2010; Trickett, Noll, Reiffman, & Putnam, 2001), attending a child sexual assault unit at a hospital (Swanston et al., 2002), or appearing as witnesses in child sexual assault prosecutions (Quas et al., 2005). The main comparisons in these studies are within group comparisons, looking at the factors that differentiate between better versus poorer later outcomes. Other studies, including a reputable large-scale study in Victoria Australia (Cutajar et al., 2010a, 2010b), have matched official or administrative records indicating the disclosure or investigation of sexual abuse during childhood with later records for various outcomes (for example, a public psychiatric database or corrective service/prison records). This allows an analysis of those cases where the abuse precedes the mental health outcome and overcomes the problem of retrospective recall but of course misses all those cases that do not come to official attention.

Meta-analyses

Another important type of study is meta-analysis, a systematic review of a body of empirical studies that “looks at the results within each study, and then calculates a weighted average” of the effect size across a number of studies (Cochrane Collaboration, 2002, p. 2). Several meta-analyses have been conducted in relation to the association between child sexual abuse and various adverse outcomes. These include: a meta-analysis of the relationship of child sexual abuse to HIV risk behavior among women (Arriola, Loudon, Doldren, & Fontenberry, 2005); a review of meta-analyses

on the association between child sexual abuse and adult mental health outcomes (Hillberg, Hamilton-Giachritsis, & Dixon, 2011); a meta-analysis of the risk-factors for perpetration of child sexual abuse (Whitaker et al., 2008); and an earlier meta-analysis on 6 different outcomes (Paolucci, Genuis, & Violato, 2001; see Box 2).

Box 2: A meta-analysis of the published research on the effects of child sexual abuse

Paolucci, E. O, Genuis, M. L., & Violato C. (2001). *Journal of Psychology*, 135(1), 17–36.

A meta-analysis of published research on the effects of child sexual abuse for 6 outcomes: post-traumatic stress disorder (PTSD), depression, suicide, sexual promiscuity, victim–perpetrator cycle, and poor academic performance. Thirty-seven studies published between 1981 and 1995, mostly US studies, involving 25,367 people were included. The meta-analyses found a significant effect of child sexual abuse on depression ($d = 0.44$), suicide ($d = 0.44$), PTSD ($d = 0.40$), and sexual promiscuity ($d = 0.29$).

Paolucci et al. concluded that the analyses provide clear evidence confirming the link between child sexual abuse and subsequent negative short- and long-term effects on development. There were no statistically significant differences or effect size when various potentially mediating variables such as gender, socioeconomic status, type of abuse, age when abused, relationship to perpetrator, and number of abuse incidents were assessed. The results support the multi-faceted model of traumatisation rather than a specific sexual abuse syndrome of child sexual abuse.

In summary, research in this area has utilised a range of study designs but recent research increasingly has used more rigorous designs that take into account possible confounding factors and use more standardised measures.

A range of outcomes

Studies concerned with the short- and longer-term outcomes associated with child sexual abuse cover a diverse range of outcomes, including mental health and functioning, behavioural outcomes, interpersonal and social outcomes, educational outcomes, and increasingly, physical health and brain development. As Kendall-Tackett (2002), among others, has pointed out, child abuse is related to “health via a complex matrix of behavioural, emotional, social, and cognitive factors” which relate to a complex array of outcomes (p. 715). The main focus in this paper is on mental health functioning and behaviours and interpersonal aspects.

The impact of child sexual abuse on mental health

Research has established a strong, albeit complex relationship between child sexual abuse and adverse mental health consequences for many victims (Fergusson & Mullen, 1999; Walsh, Fortier, & DiLillo, 2010). While much of the earlier research in this area used cross-sectional studies with clinical or convenience samples, more recent studies have increasingly used large random community samples, birth and twin cohorts. These more rigorous studies have arguably generated more reliable and generalisable findings, despite the assessment of child sexual abuse still being predominantly retrospective in design (Cutajar et al., 2010a, 2010b).

Noteworthy is a series of twin studies conducted over the last decade, which have consistently revealed a link between child sexual abuse and adverse mental health and related outcomes for survivors. Kendler et al. (2000), in an epidemiological and co-twin controlled analysis of 1,411 twin pairs, reported significant odds ratios for a range of psychiatric disorders in sexually abused

women after controlling for family environment. The effects were strongest for drug and alcohol dependence and bulimia nervosa. Dinwiddie et al. (2000), in an Australian twin study with 5,995 twin pairs, also found significant odds ratios for child sexual abuse and major depression, panic disorder, and alcohol dependence. Similarly, Nelson et al. (2002) in another Australian study involving 1,991 twin pairs found that in twins where one had been sexually abused and the other not, the abused twins had significantly higher rates of major depression, attempted suicide, conduct disorder, alcohol dependence, nicotine dependence, social anxiety, rape as an adult, and divorce.

Negative mental health effects that have been consistently associated in the research with child sexual abuse include post-traumatic symptoms (Canton-Cortes & Canton, 2010; O'Leary & Gould, 2009; Ullman, Filipas, Townsend, & Starzynski, 2007); depression (Fergusson et al., 2008; Nelson et al., 2002); substance abuse (Lynskey & Fergusson, 1997; O'Leary & Gould, 2009); helplessness, negative attributions, aggressive behaviours and conduct problems; eating disorders (Jonas et al., 2011); and anxiety (Banyard, Williams, & Siegel, 2001; Nelson et al., 2002). More recently child sexual abuse has also been linked to psychotic disorders including schizophrenia and delusional disorder (Bendall, Jackson, Hulbert, & McGorry 2011; Lataster et al., 2006; Wurr & Partridge, 1996) as well as personality disorders (Cutajar, 2010b). Child sexual abuse involving penetration has, in particular, been identified as a risk factor for developing psychotic and schizophrenic syndromes (Cutajar et al., 2010a).

At the most serious extreme of mental health problems, the findings related to suicide ideation, suicide attempts and actual suicides are of particular concern, especially since the Victorian Parliamentary Inquiry into the Handling of Child Abuse by Religious and Other Organisations was instituted at least partly on the basis that 40 Victorian people allegedly abused by Catholic clergy had committed suicide in recent years.⁵ A number of studies indicate that sexual victimisation, both in childhood and beyond, is a significant risk factor for suicide attempts and for (accidental) fatal overdoses, among both men and women. This evidence comes from community and clinical samples, as well as epidemiological record-matching studies and several prospective longitudinal studies in various countries. Some earlier studies and reviews (Briere & Zaidi, 1989; Fondacaro & Butler, 1995) reported mixed findings, but other factors—such as co-existing child physical abuse, family dysfunction, depression, and the consequences of disclosing child sexual abuse—were often not considered. Some more recent and rigorous studies, however, have used large-scale data sources or longitudinal or follow-up designs, and reported significant links between child sexual abuse and later suicidal behaviour or ideation (Dube, Anda, & Whitefield 2005; Fergusson et al., 2008; Molnar, Berkman, & Buka, 2001).

In particular, the Christchurch longitudinal study in New Zealand (noted in Box 1) showed that exposure to childhood sexual abuse was related to “clear increases in the risks of later mental health problems” (Fergusson et al., 2008, p. 617). These included suicidality and depression, as well as anxiety disorders, conduct/anti-social personality disorder, and substance use. This association, from age 16 to 25 years, persisted after taking account of other adverse factors in childhood such as physical abuse, problematic parent–child attachment, and parental history of illicit drug use (Fergusson et al., 2000, 2008). There was no significant association between child sexual abuse and the family's socio-economic status. While *physical* abuse was also related to a range of mental health disorders including suicide attempts, but not suicide ideation, the long-term effects of child sexual abuse were generally larger than the long-term effects of physical abuse. Overall, after adjusting for a range of other factors, children exposed to sexual abuse involving attempted or completed sexual penetration had rates of mental health disorders, including suicidality, that were 2.4 times higher than those of children not so exposed. Estimates of the population attributable risk (PAR) suggested that the elimination of child sexual abuse within the Christchurch cohort would have reduced the overall rates of mental health disorder in adulthood by 13% (Fergusson et al., 2008, p. 617).

A recent Australian study using quite a different methodology focused on completed suicides and fatal drug overdoses. This study did not rely on self-report data but was not able to take account of other contributory factors either early in life or closer to the fatality. In this study, Cutajar et al.

5 See Inquiry into the Handling of Child Abuse by Religious and Other Organisations <www.parliament.vic.gov.au/fcdc/inquiry/340>.

(2010b) linked the forensic medical records of over 2,500 victims of child sexual assault in Victoria over a 30-year period with the coronial data for a 44-year-span follow-up. They concluded that “child sexual abuse victims are at increased risk of suicide and accidental fatal drug overdose” but that “it is not possible to reliably attribute the association entirely to the experience of CSA” (p.186), given the non-random nature of the children who come to the attention of child protection services and the police as a result of child sexual abuse allegations.

Table 1 (on page 11) provides a summary of the findings from a number of studies on the impact of child sexual abuse on mental health and psychiatric disorder, including suicide.

Importantly, not all victims of child sexual abuse develop mental health or adjustment difficulties in adulthood. Lynskey and Fergusson (1997), for example, reported that one-quarter of those exposed to child sexual abuse in their cohort study, did not meet the criteria for any psychiatric diagnoses or adjustment difficulties in early adulthood. However, it is important to be alert to sleeper effects with problems possibly emerging at later stages in life or triggered by significant life events.

Walsh et al. (2010) have characterised child sexual abuse as a “*non-specific* risk factor” (p. 2) for adjustment difficulties, since up to 25% of victims experienced no direct psychological problems in childhood and up to 40% of victims exhibited no clear symptomatology in adulthood. Green et al. (2010) also found that there was little specificity for a range of childhood adversities, including sexual abuse and maladaptive family functioning, being associated with various psychiatric disorders in a large-scale community survey. Further, while there was a cumulative impact, this was not a straight additive effect and it also declined with age.

Although a robust body of research demonstrates the link between child sexual abuse and mental health problems, it is important to note that some studies fail to control adequately for potentially confounding variables. As outlined earlier, these include other childhood adversities, such as other forms of abuse, family functioning and socio-demographic factors. The picture is complex, however, for two reasons. First, there is evidence (see following section) that children who have already been victimised in various ways are more likely to be re-victimised sexually or physically both as adolescents and adults. Second, recent large-scale studies in the US have found evidence of a stress sensitisation effect—that is, being exposed to a range of childhood adversities including sexual abuse exacerbates the impact of stressful life events in adulthood (Kendler et al., 2004; Espejo et al., 2006). McLaughlin et al. (2010) found, for example, that both men and women with such adversities in childhood were more likely to have psychiatric disorders when exposed to stressful life events in adulthood than those without such early adversities. Finkelhor, Ormrod, and Turner (2007) also found a similar effect *within childhood*, with children revealing elevated risks of trauma symptoms if they had been subjected to several kinds of victimisation within the past year. Maker, Kemmelmeier, and Peterson (2001) highlighted that victims of child sexual abuse are at greater risk of adult sexual assault and that the negative psychological outcomes attributed to child sexual abuse may in fact be more strongly associated with sexual assault in adulthood “as measures of psychological functioning may be more sensitive to the effects of recent sexual trauma than the impact of more distal child abuse” (p. 353). Importantly, more research is needed to examine the extent to which interventions like counselling may improve the outcomes for survivors and mediate some of the potentially negative consequences.

Studies that have specifically examined the long-term mental health outcomes for *male* survivors of child sexual abuse are limited. Overall, research findings have indicated that women survivors either experience more severe problems following child sexual abuse (Ryan, Kilmer, Cauce, Watanabe, & Hoyt, 2000) compared with men, or that their experiences are largely comparable (Boudewyn & Huser Liem, 1995; Roesler & McKenzie, 1994). However, some research findings suggest that male victims of child sexual abuse may experience different and, in some respects, more adverse mental health outcomes than female victims. For example, J. Hunter (1991) found that male victims were more likely than women to experience anxiety, rumination and worry. Gold et al. (1999) found that relative to their respective normative samples, male survivors drawn from a clinical sample demonstrated greater symptomatology compared with women survivors on measures of

interpersonal sensitivity, depression, anxiety and phobic anxiety. The picture, however, may be more complex than the findings using various measures and diagnoses indicate. For example, Hillberg et al. (2011) concluded that while a series of meta-analyses have failed to demonstrate significant gender differences on mental health difficulties, there is empirical evidence of gender differences at least in victims' *perceived* mental health consequences. This finding is consistent with research that suggests that male survivors of child sexual abuse are more susceptible to internalising effects, while women are more likely to experience externalising effects (Dorahy & Clearwater, 2012; Romano & De Luca, 2001). This contrasts with findings from research in other areas indicating that men are more likely to externalise their problems. The difference may be related to gender norms that make it difficult for men to discuss sexual abuse, and possibly even to a cultural bias that sees women's, but not men's, promiscuity as an "externalising" problem.

A small number of recent studies on clergy-perpetrated sexual abuse also indicates that boys may be particularly susceptible to abuse of this type and to the effects that play out in adulthood. A large-scale study on abuse allegations in the Catholic Church in the US and a smaller study in Australia on allegations against Anglican clergy found that the majority of these allegations involved male victims. In the US study by the John Jay College Research Team (2004), 81% of the victims were male, and 40% of all victims were males aged 11–14 years.⁶ In the Australian study, 75% of the 180 victims in 191 complaints were male (Parkinson, Oates, & Jayakody, 2010). The average time from the alleged abuse to making a complaint was 25 years for males, and 18 years for females. Neither of these studies was designed to look at the impact of the abuse on the victims, and as Fogler et al. (2008) pointed out, "our knowledge of the effects of CPSA [clergy-perpetrated sexual abuse] is still in its infancy" (p. 349).

There are indications, however, that sexual abuse by clergy and other powerful authority figures may have particularly devastating effects. Brady (2008) drew strong parallels here with the features of abuse within the family that are deemed particularly damaging and difficult for children to deal with. These include the fact that:

the families of many victims were closely allied with the life of their church—a spiritual family; the abuse tended to occur over an extended period of time, similar to many cases of incest; adults frequently did not believe reports of abuse when alerted to it, which often also occurs in cases of incest; church leaders tried to silence victims to avoid scandal, also a repeated theme in incest; and many victims did not disclose the abuse until adulthood, again similar to many cases of incest. (Doyle, 2003, as cited in Brady, 2008, p. 360)

In the same special issue of the *Journal of Child Sexual Abuse*, which was concerned with the trauma of clergy sexual abuse, Fogler et al. (2008) drew together the literature and provided some theoretical foundations for their conclusion that clergy-perpetrated sexual abuse "can catastrophically alter the trajectory of psychosocial, sexual, and spiritual development" (p. 330). Fogler et al. attributed the damaging impact of sexual abuse by clergy, which commonly occurs around the ages of 11–14 years, to the way in which it undermines the victims' trust, sense of self, sexual identity, and social and cognitive development.

As the body of research on the mental health consequences of child sexual abuse continues to grow, more sophisticated and focused research is needed to tease out possible gender differences as well as the influence of potential mediating factors on the mental health outcomes for victims of child sexual abuse.

⁶ This study identified 10,667 claims of child sexual abuse by Catholic priests between 1950 and 2002; the claims were made against 4,392 priests, comprising about 4% of all Catholic clerics in the United States.

Table 1. Studies reporting on mental health disorders and suicidality

Authors	Sample/type of study	Findings	Gender differences
Australia			
Cutajar et al. (2010b)	Data linkage for cohort of 2,759 victims of child sexual abuse in forensic medical records 1964–1995 with coronial records up to 44 years later.	Significantly higher rate of suicide or accidental fatal overdose among child sexual abuse victims than in general population.	Female sexual abuse victims had 40 times higher risk of suicide, 88 times higher for fatal overdose; for males, 14 times and 38 times respectively.
Martin, Bergin, Richardson, Roeger, & Allison (2004)	Cross-sectional community survey with 2,485 adolescents at 27 SA schools.	Strong association between sexual abuse and suicidal ideation and behaviour (plans, threats and attempts), especially for boys: <ul style="list-style-type: none"> ■ 10-fold increased risk for suicidal plans and threats compared with non-abused peers; ■ 15-fold increase for attempted suicide; and ■ 3-fold increase for girls that was mediated by distress, hopelessness and family functioning. 	Prevalence of self-reported child sexual abuse (undefined) was 5% for girls and 2% for boys; stronger association between sexual abuse and suicidality among males.
Nelson et al. (2002)	Co-twin: Examined 1,991 same-sex pairs of twins (1,159 female and 832 male pairs).	The twin reporting child sexual abuse had significantly greater risk for all 8 adverse outcomes (major depression, suicide attempt, conduct disorder, alcohol dependence, nicotine dependence, social anxiety, rape after the age of 18 years, and divorce) than their non-abused twin. Increased risks associated with child sexual abuse involving intercourse.	Prevalence of child sexual assault of 17% for women and 5% for men; significantly increased risk for suicide among both women and men, after taking account of family background.
Plunkett et al. (2001)	Prospective 9-year follow-up of 183 male and female sexually abused children.	The observed suicide rate in sexually abused children was 10.7–13.0 times that of the Australian national rate.	24% females and 9% of males had attempted suicide by 9-year follow-up.
New Zealand			
Fergusson et al. (1996) Fergusson, Beautrais & Horwood (2003) Fergusson et al. (2008)	Prospective longitudinal cohort study of 1,265 children born in 4-month period in mid 1977, followed regularly to age 25 years in this New Zealand study (Christchurch Health and Development Study).	25 year-olds who experienced attempted or completed sexual penetration as children had rates of mental health disorder (including suicide ideation and attempts, depression and anxiety, substance dependence) that were 2.4 times higher than those not exposed to child sexual abuse; this effect remained significant after taking into account various measures of family functioning and socio-economic status.	No gender difference found.
Martin, Anderson, Romans, & Herbison (1993)	Random, stratified community sample of 1,376 adult women.	Significant associations found between child sexual abuse and higher levels of psychopathology, with higher rates of substance abuse and suicidal behaviour, after controlling for family dysfunction; more severe the abuse, the higher the level of psychopathology.	Female sample only.
Scott et al. (2010)	Retrospective nationally representative cohort study of 2,144 16–27 year-olds from a mental health survey; 221 were identified as having records on a national child protection agency database.	After adjusting for demographic and socio-economic correlates, child protection agency history was associated with several individual mental disorders, mental disorder co-morbidity, and all mental disorder groups, both 12-month and lifetime.	Adjusted for <i>sex, as well as</i> age, ethnicity, maternal education, respondent education, and current household income.

continued on next page

Table 1 (cont.)

Authors	Sample/type of study	Findings	Gender differences
USA			
Briere & Elliott (2003)	Random: Geographically stratified, general population sample of 1,442 adults.	Child sexual abuse was associated with a range of trauma symptoms including depression, anxiety, anger, intrusive experiences and sexual concerns after controlling for age, sex, race and income and history of physical abuse.	14% of males and 32% of females reported child sexual abuse.
Brown et al. (1999)	Prospective: A cohort of 776 randomly selected children, followed for 17 years.	Compared with physical abuse and neglect, child sexual abuse was found to carry the greatest risk for depression and suicide, independent of demographic, parent and child characteristics.	Gender and age were taken into account in the analyses but no differences were reported.
Kendler et al. (2000)	Twin study in which one twin had been sexually abused, drawn from a sample of 1,411 adult female twins.	The twin reporting child sexual abuse was consistently at higher risk for lifetime psychiatric and substance use disorders compared with their non-abused co-twin; as severity of the abuse increased, so did the odds ratios.	Female sample only.
Molnar, Berkman et al. (2001)	Nationally representative sample of 5,877 Americans aged 15 to 54 years.	Among those sexually abused as children, odds of suicide attempts were 2–4 times higher among women and 4–11 times higher among men, compared with those not abused, after controlling for other adversities.	Higher odds suicide for males than females.
Trickett, Noll, & Putnam (2011)	84 females (6–16 years old) with Child-Protection-Service-substantiated sexual abuse, including genital contact and/or penetration by a family member and a demographically similar comparison group ($n = 82$); children and older caregivers for key participants included.	Sexually abused women at follow-up aged 25 more likely to engage in self-mutilation, risky sexual activity, abuse drugs and alcohol, experience more lifetime traumas, PTSD, fail to complete high school, and qualify for at least one DSM diagnosis. Potent “sleeper effects” emerge over longer developmental time spans than previously documented, including increasing obesity and high rates of intimate partner abuse in early adulthood.	Female sample only.
Various—meta-analyses			
Neuman, Houskamp, pollock, & Briere (1996)	Meta-analysis of 38 studies involving adult women.	Significant associations between sexual abuse and a number of measures of psychological adjustment—anxiety, anger, depression, suicidality, self-mutilation, sexual problems, substance abuse, impairment of self-concept, interpersonal problems, obsessions and compulsions, dissociation, post-traumatic stress responses, and somatisation as well as re-victimisation.	Females examined only.
Paolucci, Genuis, & Violato (2001)	Meta-analysis of 37 studies published between 1981 and 1995 involving 25,367 people.	Strong effect sizes before and after taking account of various factors, with average unweighted and weighted d 's for each of the outcome variables: for PTSD .50 and .40; for depression .63 and .44; for suicide .64 and .44; for sexual promiscuity .59 and .29; for victim–perpetrator cycle .41 and .16; and for academic performance .24 and .19.	Factors taken into account included gender, socioeconomic status, type of abuse, age when abused, relationship to perpetrator, and number of abuse incidents.

Behavioural aspects of mental health functioning

The behavioural manifestations of emotional distress and mental health problems present a quite consistent pattern in relation to the association between child sexual abuse and substance abuse problems, suicide, sexual risk-taking and other risky behaviours.

Alcohol and substance abuse in child sexual abuse victims

Research has long indicated a relationship between childhood abuse, including sexual victimisation, and subsequent alcohol and substance abuse (Mullen & Fleming, 1998). Victims of childhood abuse and neglect generally have been reported to be at greater risk of abusing alcohol and drugs (Min, Farkas, Minnes, & Singer, 2007), and survivors of child sexual abuse are at a heightened risk of developing an alcohol disorder and with an earlier age of onset (Zlotnik et al., 2006).

Population based studies also indicate that victims of child sexual abuse are more often found among adolescents and adults with alcohol and/or drug related disorders compared with non-abused populations (odds ratios ranging from 1.01 to 8.9) (Cutajar et al., 2010b, p. 814; Kendler et al., 2000). Survivors of child sexual abuse are also at greater risk of substance dependencies including not only alcohol but also nicotine dependency (Nelson et al., 2002). Moreover, research suggests that survivors of child sexual abuse are more likely than the non-abused population to struggle with alcohol and substance disorders over their entire lifetime. Molnar, Buka, and Kessler (2001) found that the percentage of women with lifetime alcohol dependence was 16% among child sexual abuse survivors, compared with 8% for non-abused women. The frequency was markedly higher for men, with 39% of male child sexual abuse survivors found to have lifetime alcohol dependence, compared with 19% of non-abused men.

There is increasing evidence of the bio-chemical underpinnings to alcohol and other drug abuse by adolescents and adults subjected to high levels of adversity and stress in childhood. Delima and Vimpani (2011), for example, pointed to the dampening effect of “alcohol and several of the commonly used illicit recreational substances” on the hyper-arousal PTSD symptoms. The use of such substances is therefore a means of “self-medication” in adolescents who have experienced maltreatment (p. 47). As indicated above, the link between child sexual abuse and PTSD and alcohol dependence is not straightforward and research suggests a series of indirect links are involved in these effects.

Risky behaviours and adjustment difficulties of child sexual abuse victims

Research and clinical experience indicates that survivors of child sexual abuse may be at greater risk of engaging in risky behaviours both as adolescents and as adults (Mason, Zimmerman, & Evans, 1998). In particular, this includes risky sexual behaviours but anecdotal and clinical information also point to other behaviours such as gambling and drug use, although there is little research that has specifically examined the link between child sexual abuse and gambling.

In adolescence, child sexual abuse has been associated with early onset consensual sexual activity, unprotected sexual intercourse, multiple sexual partners and teenage pregnancy (Senn, Carey, & Vanable, 2008; Upchurch & Kusunoki, 2004). In adulthood, similar sexual risk behaviours have been documented for survivors of child sexual abuse (Arriola et al., 2005; Cohen et al., 2000; Fergusson, Horwood, & Lynskey, 1997). For example, Wyatt, Guthrie, and Notgrass (1992) found that victims of child sexual abuse were more likely to engage in group sex and partner swapping on a frequent basis and in other types of sexual behaviours that increase the risk of sexually transmitted infections (STI). The findings of van Roode, Dickson, Herbison, and Paul (2009) suggest that risky sexual behaviours in survivors of child sexual abuse may vary with age and gender; for women survivors, increased rates were observed for the number of sexual partners, unhappy pregnancies, abortion, and STIs from age 18 to 21; thereafter the rates approached those of non-abused women. In contrast, for male survivors, the number of partners was significant from age 26 to 32 and the acquisition of herpes simplex virus

type 2 from age 21 to 32. There is also evidence that gay men and bisexual men who were sexually abused in childhood were more likely than their non-abused counterparts to engage in unprotected anal sex, to trade sex for money or drugs, to self-report having HIV, and to have been involved in non-sexual violence (Jinich et al., 1998; Kalichman, Gore-Felton, Benotsch, Cage, & Rompa, 2004). These findings are consistent with other research which suggests that child sexual abuse is associated with later sexual risk behaviour in men as well as women (Senn et al., 2008). However, more research is needed that specifically examines the sexual risk-taking behaviour of male victims of child sexual abuse, and particularly those who have been subjected to clergy-perpetrated sexual abuse.

Some researchers have suggested that sexual risk taking by child sexual abuse survivors serves as a way of avoiding the emotional distress associated with abuse (Steel & Herlitz, 2005; Wright, Crawford, & Sebastian, 2007). However, other theoretical frameworks have also been put forward to explain sexual and other risk-taking behaviour among the victims of child sexual abuse. A number of researchers have focused on child sexual abuse as a key sexual experience characterised by negative elements and emotions including physical and cognitive exploitation and feelings of stigmatisation and social isolation; these in turn increase the victim's vulnerability to sexual experiences, particularly negative ones (Browning & Laumann, 1987; Finkelhor & Browne, 1985). Some researchers have also suggested that child sexual abuse leads to distortions that undermine the survivor's critical motivational, coping, and interpersonal factors, and that these in turn influence adult sexual behaviour and choices (Catania et al., 2008). More research is needed to better understand the relationship between child sexual abuse and subsequent risk-taking behaviour by victims generally, as well as the mediating role of other factors such as PTSD and alcohol and substance abuse.

Interpersonal outcomes

There is increasing evidence that children who have been abused, and in particular sexually abused, have greater difficulties with interpersonal relationships and especially trust compared with non-abused individuals. Given the betrayal of trust and violation of personal boundaries involved in child sexual victimisation, this is not surprising. In addition, the secrecy and often the fear of exposure creates a sense of shame, guilt and confusion that disrupts the child's "internal working model" according to which we all interpret the world. This affects how children and then adults understand and construe the motives and behaviours of others, and how they handle stressful life events. Medical and neurobiological research is throwing new light on the mechanisms underlying atypical and over-reactive stress reactions (see below).

Intimate relationships and parenting

There is some evidence for greater difficulties in interpersonal and particularly intimate relationships among adults who were sexually abused in childhood. These include increased instability in relationships, more sexual partners, an increased risk of sexual problems and greater negativity towards partners (Isley, Isley, Freiburger, & McMackin, 2008; Roberts, O'Connor, Dunn, Golding, & ALSPAC Study Team, 2004). Qualitative research including reports from women, indicates that pregnancy, childbirth and motherhood can trigger difficulties, emotional distress and lack of confidence and self-esteem (Sperlich & Seng, 2008). In a large-scale longitudinal prospective study in England, the Avon Longitudinal Study of Parents and Children, Roberts et al. (2004) reported that after adjusting for other childhood adversities, child sexual abuse was associated with "poorer psychological well-being, teenage pregnancy, parenting behaviours, and adjustment problems" (p.525) in their own children. The mothers' anxiety and lack of confidence in parenting mediated the association between child sexual abuse and the perceived quality of their relationships with their own children and their children's adjustment. In a smaller US study, the association between child sexual abuse and parenting outcomes (including parental stress, feelings of competence and

discipline strategies) disappeared after accounting for the mother's depression and the current partner's violence (Schuetze & Das Eiden, 2005).

There is little research concerning fathering after childhood sexual abuse, but sufficient to indicate significant concerns among such fathers in relation to them being over-protective, nervous about physical contact with their children, and being fearful of becoming abusers themselves (Price-Robertson, 2012a). Fatherhood for some may be a "healing experience", but for others it may represent "a catalyst for the resurfacing of trauma" (Price-Robertson, 2012a, p. 4). The implications are for appropriate awareness and sensitive support and services for these men.

Re-victimisation of child sexual abuse victims

A large body of research has focused on the relationship between sexual victimisation in childhood and later "re-victimisation" in adolescence and adulthood. The research in this area has expanded its conception of re-victimisation from an initial narrow focus on the risk of future sexual assault (Shields & Hanneke, 1988; Wyatt et al., 1992; Stevenson & Gajarsky, 1991) to include a range of different types of traumas and victimisation experiences across a child victim's lifetime (Banyard et al., 2001). Research in this area has used college and community samples as well as specialised (e.g., psychiatric inpatients, outpatients and incest group members) or convenience samples (Widom, Czaja, & Dutton, 2008). Most studies have used cross-sectional and retrospective designs; very few studies have examined the risk of re-victimisation longitudinally. There has also been little attention to possible gender differences in re-victimisation.

Some earlier studies reported no association between child sexual abuse and the risk of later victimisation (Briere & Runtz, 1987; Mandoki & Burkhart, 1989). More recently, Widom et al. (2008) examined the relationship between child abuse and neglect (including child sexual abuse) and re-victimisation, in one of the few large-scale prospective long-term studies. Spanning a wide range of traumatic and victimisation experiences, this study found that victims of *multiple* forms of childhood abuse and neglect were most at risk of lifetime traumas and re-victimisation experiences. Victims of child sexual abuse (in the absence of other forms of abuse or neglect) were only marginally at greater risk of re-victimisation compared with a comparison group and were not at any greater risk of re-victimisation compared with victims of other types of childhood abuse and neglect. This study also specifically examined the effect of gender on the risk of re-victimisation, reporting that overall women with a history of childhood abuse were more likely to experience trauma and re-victimisation in adulthood. However, when it comes to *sexual* re-victimisation specifically, although both genders were at greater risk compared with the comparison group, the risk was significantly stronger for men with a history of childhood abuse and neglect.⁷

Overwhelmingly, however, the findings of other research suggest that victims of child sexual abuse are generally at an increased risk of re-victimisation. More specifically, women who have a history of child sexual abuse are at least twice as likely to experience adult sexual victimisation (Classen, Palesh, & Aggarwal, 2005; Maker et al., 2001). The severity of child sexual abuse may also be associated with the risk of re-victimisation, with those who have been subjected to more intrusive types of child sexual abuse, to multiple experiences and of longer duration at an increased risk of sexual victimisation (Arata 2000; Nelson et al., 2002). Fleming, Mullen, Sibthorpe, and Bammer (1999), for example, found that child sexual abuse involving penetration tripled the risk for rape as an adult. Other research, however, has found that less severe child sexual abuse may be sufficient to place the victim at higher risk of later sexual assault (Maker et al., 2001; West, Williams, & Siegel, 2000). The relationship between the perpetrator of child sexual abuse and the victim may also affect the risk of re-victimisation, although the results have been mixed. Kessler and Bieschke (1999) reported that incestuous abuse increased the risk of adult victimisation more than peer abuse and non-familial abuse.

⁷ One problem with this study, though, is that it did not examine gender effects specifically in relation to child sexual abuse only, but rather child abuse and neglect generally (inclusive of child sexual abuse). Although arguably this design characteristic limits the conclusions that may be drawn, in fact, it more accurately reflects the reality of co-occurrence of multiple types of child maltreatment and abuse (Pears, Kim, & Fisher, 2008).

Various explanations have been advanced to explain the relationship between child sexual abuse and later re-victimisation. These include: (i) the acquisition of inappropriate sexual behaviours; (ii) learned helplessness; and (iii) diminished self-efficacy (Krahe, Scheinberger-Olwig, Waizenhofer, & Kolpin, 1999). Some research suggests that the link between child sexual abuse and later sexual re-victimisation is not a direct one but rather one mediated by other variables, such as higher levels of consensual sexual activity and a greater number of sexual partners (Fergusson et al., 1997; Krahe et al., 1999). One area that has more recently attracted attention is the possible role of PTSD as a potential mediator in the abuse–re-victimisation relationship. Theorists have suggested that PTSD symptoms may impair a woman’s ability to accurately detect danger cues, impair responsiveness to trauma-related cues, or possibly inhibit self-protective behaviours (Risser, Hetzel-Riggin, Thomsen, & McCanne, 2006). Risser et al. (2006) found that the hyper-arousal symptoms of PTSD play the primary role in explaining the association between child sexual abuse severity and adult sexual re-victimisation. Put simply, the findings of this research suggest that if:

a woman experiences high levels of hyper-arousal on a consistent basis ... she may lose her ability to discriminate between real threats and false alarms, and she may therefore begin to disregard legitimate warning cues. In turn, this could increase her risk of future sexual victimization. (Risser et al., 2006, p. 688)

Ullman, Najdowski, and Filipas (2009) found that substance abuse and problem drinking may play a role in both “numbing” PTSD symptoms and increasing the risk of further sexual victimisation. The findings of this study suggested that “once PTSD symptoms and problem drinking behaviours are accounted for, CSA does not directly predict future victimization” (p. 379). In other words, “child sexual abuse-related sequelae may indirectly contribute to increased risk of additional re-victimization, even in women who have experienced [adult sexual assault]” (p. 379).

Although still sparse, some research has started to emerge on the link between child sexual abuse of boys and sexual re-victimisation. For example, Elliot, Mok, and Briere (2004) found that men who reported being sexually assaulted as adults were 5 times more likely to have experienced childhood sexual abuse. More recently, in a large study of US male college students ($n = 1,002$), Aosved, Long, and Voller (2011) reported that men with a history of child sexual abuse were more likely to report a sexual assault in adulthood than men without. They were also more likely to indicate that they had adjustment difficulties in adulthood (37% compared with 15%, respectively). Overall, victims of child sexual abuse have been found to experience more traumatic events over time compared with non-victims, particularly traumatic events of a personal nature (Banyard et al., 2001).

Research also suggests that children and adolescents who have experienced child sexual abuse are at a heightened risk of re-victimisation even prior to adulthood. Swanston et al. (2002), in a NSW based study of 183 children with substantiated sexual abuse, found these children were at an increased risk of all forms of abuse and neglect subsequently. One in three children was subsequently the subject of an abuse or neglect notification. Krahe et al. (1999) reported that female victims of child sexual abuse were at greater risk of subsequent unwanted sexual contact in adolescence; in particular, this study reported that victims of child sexual abuse were especially at risk of experiencing severe forms of sexual aggression.

Further research on the risk of later re-victimisation of victims of child sexual abuse is important so that pathways to re-victimisation can be better understood and targeted interventions can be directed to prevent re-victimisation and build the resilience of victims.

Subsequent offending by child sexual abuse victims

Research in this area comprises two main sources of data: (i) follow-up studies of child sexual abuse victims; and (ii) retrospective studies involving offender and prisoner samples. A number of studies deal with offending in general and others focus on sexual offending. Whether or not there is a comparison group as well as the particular starting point—either starting with those who are known to have offended in various ways, or starting with children who were sexually abused—

makes a difference to the type of conclusions that can be drawn. The conclusions from these studies therefore need to be interpreted with some care, and must be clear about the dangers of suggesting that there is a causal “victim-to-offender” link, particularly for sexual offending (Price-Robertson, 2012b).

Starting with children who have been sexually abused, there is evidence in several comparison and follow-up studies of a greater likelihood of behavioural problems, running away, vandalism and juvenile offending among those who had been sexually abused than those who were not sexually abused (Chandy, Blum, & Resnick, 1996; Smith & Thornberry, 1995; Widom, 1996). Running away is of course likely to render children and adolescents more vulnerable and more likely to commit survival crimes, including stealing and prostitution (Chandy et al., 1996). Adolescents and adults who were sexually abused have also been found to be more likely to be arrested for drug offences (Siegel & Williams, 2003; Widom, 1989) and property crime (Widom, 1989). The findings in relation to violence are mixed, with some studies finding an increased likelihood of violence and aggression (Hussey, Chang, & Kotch 2006; Siegel & Williams, 2003; Swanston et al., 2003) and others finding less risk or no greater likelihood (Widom, 1989; Widom & Maxfield, 2001). In Widom’s US studies reporting on children who were physically or sexually abused at or before the age of 11, those who were sexually abused were less likely to be arrested for any sex crime than those who had been physically abused or neglected (Widom, 1996).

In a large-scale Australian study, Ogloff, Cutajar, Mann, and Mullen (2012) followed-up 2,759 substantiated cases of child sexual abuse in Victoria over a 31 year period and compared this group with 2,677 people drawn from the general population. They found that almost a quarter (24%) of child sexual abuse victims had a recorded offence compared with only 6% of the comparison group. Further, the average number of charges was significantly higher for child sexual abuse victims (32%) compared with the comparison group (19%). Child sexual abuse victims were also more likely to have received a custodial sentence compared with their general population peers (4% vs 0%). Overall, both male and female child sexual abuse victims were more likely to have been charged with an offence than those in the general population, with women 6.71 times more likely and men 4.34 times more likely to have been charged. In terms of the nature of offences, child sexual abuse victims were significantly more likely to be charged with all types of offences with a significantly higher charge rate particularly for sexual offences (7.6 times), violent offences (8.2 times) and breach of orders (10 times). Male victims of child sexual abuse were particularly likely to have been charged with a sexual crime; 5% of male victims of child sexual abuse were convicted of a sexual offence compared with 1% of male controls. An association was also found between the age of victimisation for males and offending behaviour; 9% of males victimised at 12 years of age or older had been convicted of a sexual offence, compared with only 3% of males sexually abused under 12 years of age. This difference was not found for female victims.

Starting with those who have committed offences and have been “caught” offers a different perspective. While the vast majority of those who have been sexually abused do not go on to abuse others, retrospective self-report studies of child sex offenders indicate that possibly as many as 75% of *offenders* were sexually abused as children, with rates generally reported in the range of 41–43% (Johnson et al., 2006; Nathan & Ward, 2002; Ogloff et al., 2012). Overall, studies of offender populations indicate a higher rate of child sexual victimisation amongst juvenile and adult offenders compared with the general population.

In a recent Australian study of 361 young people in juvenile detention centres in New South Wales, Indig et al. (2011) reported that 5% of the males and 39% of the females indicated they had been sexually abused as children, with little difference between Aboriginal and non-Aboriginal participants (about 10%). The reported levels of high psychological distress were similarly markedly higher for females than for males (55% compared with 24%) as were their reports of ever having considered committing suicide (28% compared with 14%). A sexual or aggravated crime was the most serious offence in relation to their current detention for 4% of males, and for none of the females. In a study of male ($n = 1,030$) and female ($n = 500$) prisoners in the US, McClellan,

Farabee, and Crouch (1997) found the same gender difference but a lower overall rate of sexual abuse, mistreatment or rape among male (5%) and female (26%) inmates during their childhood. This prevalence rate for males is comparable to that in the general population. In contrast, Johnson et al. (2006) in a study of 100 incarcerated males found that 59% of the men reported some form of contact sexual abuse during childhood. What is interesting about the findings of this study is that most of the men (95%) reported child sexual abuse perpetrated by a female. This finding is not consistent with previous studies of general populations in which the overwhelming majority of perpetrators are male (McCloskey & Raphael, 2005; Peter, 2009). In an extensive review and meta-analysis of the published research relevant to risk-factors for perpetration of child sexual abuse, Whitaker et al. (2008) found a strong relationship in the literature between being a victim of childhood sexual abuse and perpetrating child sexual abuse. Child sex offenders were found to be much more likely to have been victims of child sexual abuse than either non-sex offenders and non-offenders.

It is important to note, however, that these findings indicate that *most* victims of child sexual abuse *do not* go on to offend sexually or in other ways, although the risks are higher than for those in the general population who were not sexually abused. Although the Ogloff et al. (2012) study clearly indicated that victims of child sexual abuse are at greater risk of subsequent offending behaviour, most child sexual abuse victims (77%) did not have a criminal record.

Physical health and overall developmental outcomes

Research indicates that child sexual abuse may be associated with a range of physical and health risk behaviours as well as adverse health outcomes for survivors of such abuse (Zink, Klesges, Stevens, & Decker, 2009). The evidence suggests that health problems for survivors of child sexual abuse stem from a complex matrix of inter-relationships between behavioural, emotional, social, and cognitive factors (Kendall-Tackett, 2002). Research has found that survivors of child sexual abuse: are sick more often (Felitti, 1991); have surgery more often (Kendall-Tackett, Marshall, & Ness, 2000); and are at an increased risk of having chronic pain syndromes (Kendall-Tackett, 2002). Associations have also been found between child sexual abuse and ischemic heart disease, cancer, chronic lung disease, irritable bowel syndrome, and fibromyalgia (Runyan, Wattam, Ikeda, Hassan, & Ramiro, 2002). Scott et al. (2011) found a set of independent predictors in a 10-country study of multiple childhood adversities and early onset chronic physical conditions. Child sexual abuse was most strongly associated with heart disease, osteoarthritis, chronic spinal (back or neck) pain, and frequent or severe headaches. Female victims of child sexual abuse were also at greater risk of sex related health problems such as unintended and aborted pregnancies (Wyatt et al., 1992).

There is now increasing attention to the association between stress and childhood adversity (including child sexual abuse) on the one hand, and brain development and related dysfunction of the immunological and neuroendocrine responses on the other (Odebrecht et al., 2010). Much of this work is focusing on the hypothalamic–pituitary–adrenal (HPA) stress response, with numerous studies indicating an association between early adversity and atypical development of this system that increases the risk for later psychopathology (McCrory, De Brito, & Viding, 2010). The review of research by McCrory et al. also outlined the evidence from neuro-imaging, pointing to “structural and functional brain differences that may underpin the psychological and behavioural problems associated with childhood maltreatment” (p. 1090). In this area too, “there is a need for prospective studies to provide a biological basis for the link between CSA with neuroendocrine and immunological consequences and illness in later life” (Odebrecht et al., 2010, p. 445).

Gender differences in the long-term impacts of child sexual abuse and gaps in understandings of male victims/survivors

Research continues to depict child sexual abuse as predominantly perpetrated against female children. In Australia, in 2003, 76% of recorded sexual assault victims aged under 15 years of age were female and 24% were male (ABS, 2004). However, it is clear that definitional differences may influence the rate of sexual assault identified in male and female populations (methodological differences are likely to do likewise). A recent review of the prevalence of child sexual assault reported in comprehensive contemporary Australian studies found that males had prevalence rates of 4–8% for penetrative abuse and 12–16% for non-penetrative abuse, while females had prevalence rates of 7–12% for penetrative abuse and 23–36% for non-penetrative abuse (Price-Robertson, Bromfield, & Vassallo, 2010). These findings are consistent with earlier research that has reported that severely intrusive forms of abuse, including attempted or completed vaginal, oral, or anal penetration, did not greatly differ between boys and girls, with the majority of studies reporting prevalence figures in the range of 5–10% for both males and females (Fergusson & Mullen, 1999).

Child sexual abuse is clearly an issue in need of a nuanced understanding of both male and female victims. Research suggests that the sexual abuse of boys is far more common than generally believed (Dorahy & Clearwater, 2012). This is emerging from studies of clergy-perpetrated sexual abuse and from studies of gay and bisexual men. The prevalence rates for both groups are significantly higher than the more commonly cited figures for males in the general population (Jinich et al., 1998; Wilson & Widom, 2010). In relation to clergy-perpetrated abuse, it is becoming clear, as outlined earlier, that boys are much more likely than girls to be the victims of this type of abuse, though it may not be formally reported to authorities for some time, if ever (John Jay College, 2004; Parkinson et al., 2010).

Difficulties in teasing out the effects of child sexual abuse on male victims are compounded not only by definitional and methodological variations in the research as noted above, but also by a paucity of research that specifically compares the psycho-social attributes of male victims in clinical and non-clinical samples with non-victims as well as with female victims of child sexual abuse. Moreover, the findings in this area may be complicated by factors such as the nature and characteristics of abuse, and the homosexual overlay in the sexual abuse of boys. For example, there is evidence that male victims are more likely than female victims to have experienced same-sex molestation, greater violence and physical harm during the abuse, and are more likely to have been victimised by multiple perpetrators (Steever, Follette, & Naugle, 2001).

Importantly, there is increasing research evidence that the disclosure rates of sexual abuse by boys and men are lower than those for girls and women. Earlier research such as Eastaer's (1992) study found that 53% of male respondents compared with 37% of female respondents had never, prior to this study, disclosed their abuse to anyone. Similarly, Roesler and McKenzie (1994) for example, found that 61% of adult women had told someone as a child compared with 31% of men. More recent research also indicates that men are less likely to disclose child sexual abuse during childhood compared with women and to make fewer and more selective disclosures (Hunter, S. V., 2011; O'Leary & Barber, 2008). O'Leary and Barber, for example, reported that 64% of women but only 26% of men had told someone about the abuse when they were children. Men took significantly longer than women to discuss it with someone, and "it was not uncommon ... for men to report taking in excess of 20 years to talk about their experiences" (p. 139).

Boys may be especially inhibited from disclosing sexual abuse for various reasons that are different to why girls generally delay in disclosing or never disclose such abuse (Foster, Boyd, & O'Leary, 2012). Price-Robertson (2012a), drawing on the findings of his recent research in the area, argued that cultural images of how "real men" should think, feel and act can create:

powerful barriers to male victim/survivors of child sexual abuse disclosing their experiences to others, accepting their experience as one that may have had a formative influence on their

lives, and healing from the trauma of the abuse ... [This] means that many in society have difficulty fully acknowledging and accepting the reality of the sexual abuse of males during childhood/adolescence, and the trauma it can inflict. (p. 5)

Spataro, Moss, and Wells (2001) have pointed to individual factors—including “the male ethos of self-reliance, the fear of homosexuality, and notions of youthful male sexuality” (p. 177)—as key factors that may perpetuate nondisclosure by boys, arguing that “boys are usually socialised with an ethos where self-reliance, independence, and sexual prowess are valued, and both a victim role and homosexuality are denigrated” (p. 177). Further, Spataro et al. argued that differences in adult expectations of children based on gender may also inhibit disclosure of child sexual abuse, as the “masculine stereotype does not sanction the expression of feelings of dependency, fear, vulnerability, or helplessness” (2001, p. 177)—feelings that are commonly associated with child sexual abuse.

Other researchers have similarly suggested that under-reporting of sexual abuse by boys may be linked to “community assumptions that have often labelled them as future perpetrators: as homosexual; or, because they fear being treated as social outcasts, liars, or as emotionally weak” (Mezey & King, 1989, cited in Neame & Heenan, 2003, p. 4; Stott, 2001, in Fergus & Keel, 2005).

Some researchers have suggested that the nature of the abuse situation for boys may also be a complicating factor that reduces the likelihood of disclosure since “boys are more likely than girls to be assaulted by siblings or other boys” and are then more likely to experience “confusion about whether the experience is an assault or is typical and appropriate for their gender” (Spataro et al., 2001, p. 178). Boys may also harbour greater fears about being perceived as the instigator of the abuse (Dorahy & Clearwater, 2012). Where the abuser is a sibling, this is likely to be even more confusing and difficult to deal with (Stathopoulos, 2012). Where the abuser is a priest or trusted authority figure, as is more often the case for boys than girls, this is also confronting and confusing, bringing in spiritual development concerns as well (Brady, 2008; Fogler, et al., 2008).

Importantly, research also indicates that even if boys disclose sexual abuse, they are less likely to receive counselling and other professional support compared with girls (Foster et al., 2012; Holmes, Offen, & Waller, 1997). This may be a consequence of either male victims themselves and/or clinicians and other professionals minimising the abusive nature of the alleged sexual abuse and/or the effects of such abuse. In other words, “a history of childhood sexual abuse in adult males is both under-reported and under-identified” (Homes et al., 1997, p. 71), a situation that of itself is likely to impact on the long-term outcomes following child sexual abuse.

A continued focus on girls as the primary victims of child sexual abuse means that much of the research and literature in the field is heavily skewed towards investigating and understanding the long-term impacts of such abuse on women and much less so on men. More research is needed on the extent, nature and dynamics of sexual victimisation perpetrated against boys and the impact of such abuse on male survivors specifically. As noted above, there is a growing body of research that indicates that boys may not only be especially inhibited from disclosing sexual abuse but that the impacts of non-disclosure or disclosing and getting an unsatisfactory response, as well as the characteristics of the sexual abuse itself, are different for boys compared with girls and may be particularly severe for male survivors, at least in some respects.

Table 2 summarises the findings from a number of studies on the impact of child sexual abuse on males and a comparison between male survivors of child sexual abuse and female survivors and non-abused men. Overall, research on the effects of child sexual abuse amongst male victims indicates that male survivors often “experience the event as traumatic and that psychological distress is a common long-term correlate” of such abuse (Steever et al., 2001). Despite a less robust body of research on the effects of child sexual abuse on adult male survivors there is “ample evidence that male CSA is associated with a broad spectrum of detrimental sequelae” (Schraufnagel, Davis, George, & Norris, 2010, p. 370). More specifically, research indicates that male survivors of child sexual abuse are at a substantially increased risk for depression, PTSD, personality disorders, poor

self-image, substance abuse problems, suicidality, and sexual disorders (Romano & De Luca, 1996). Compared with women survivors, research seems to indicate that male survivors are particularly at risk of anxiety related symptoms and disorders (Hunter, J., 1991) and may be particularly susceptible to internalising effects (Dorahy & Clearwater, 2012; Romano & De Luca, 2001).

Table 2: Impact of child sexual abuse on males and gender differences

Study	Type	Child sexual abuse vs non-abused	Males vs females
Coohey (2010)	National US probability sample of children aged 11–14 who were investigated by protective services for child maltreatment with child sexual abuse as most serious or only type of maltreatment (<i>n</i> = 127 girls and 31 boys).	N/A	Twice as many boys (52%) as girls (24%) were in the clinical range on internalising behaviour problems. The effect for gender was not altered when the following factors were controlled: abuse characteristics, multiple victimisation, efficacy, relatedness, and autonomy.
Colman & Spatz Widom (2004)	Comparison of 676 abused and neglected adults abused as children (substantiated cases 1967–71) with matched controls on gender, age, race, and approx family SES—prospective study interviewed 1989–95 with standardised rating scales.	Male and female abuse and neglect victims reported higher rates of cohabitation, walking out, and divorce than controls.	Females less likely to have positive perceptions of current romantic partners and to be sexually faithful.
Dorahy & Clearwater (2010)	Study of seven adult males sexually abused as children attending a service for male sexual abuse. Measures completed for shame, guilt dissociation and childhood trauma. Focus group also conducted with participants.	N/A	Male victims in this study showed considerably higher levels of trait shame and guilt scores compared with college samples.
Dube et al. (2005)	Retrospective large-scale cohort study of 17,337 adults.	After controlling for exposure to other forms of adverse childhood experiences that co-occur with child sexual abuse, history of suicide attempt was more than twice as likely among both men and women who experienced child sexual abuse, and a 40% increased risk of marrying an alcoholic, and 40% to 50% increased risk of reporting current marital problems.	Contact child sexual abuse was reported by 16% of males and 25% of females. Men reported female perpetration of child sexual abuse nearly 40% of the time, and women reported female perpetration of child sexual abuse 6% of the time. Increased risk of adverse outcomes similar for men and women.
Garnefski & Dijkstra (1997)	Large representative community sample of adolescents: see below.	Strong association between being sexually abused and the existence of a multiple problem pattern in both sexes.	Impact for boys worse and more complex than for girls.
Garnefski & Arends (1998)	Large representative community sample of adolescents: 745 secondary school students, aged 12–19 with a self-reported history of sexual abuse (151 boys and 594 girls) and 745 matched students without such a history.	More emotional problems, behavioural problems, suicidal thoughts and suicide attempts for both male and female.	More severe for boys than for girls: <ul style="list-style-type: none"> ■ use of alcohol/drugs ■ aggressive/criminal behaviour ■ truancy ■ suicidal thoughts and behaviour (e.g., 3% cf. 27% for non-abused cf. abused boys [13 times higher]).

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Table 2 (cont.)

Study	Type	Child sexual abuse vs non-abused	Males vs females
Gold et al. (1999)	162 women and 25 men entering an outpatient treatment program for adult survivors of childhood sexual abuse in a university-based community mental health centre.	N/A	Significantly more interpersonal sensitivity, depression, anxiety, and phobic anxiety for men than women.
Molnar, Berkman et al. (2001)	Nationally representative sample of 5,877 Americans aged 15 to 54 years.	Among those sexually abused as children, odds of suicide attempts were 2–4 times higher among women and 4–11 times higher among men, compared with those not abused, after controlling for other adversities.	Prevalence for child rape or molestation for women of 14% and 3% for men. Reported suicide attempts slightly greater for men (31%) compared to women (27%).
Schraufnagel et al. (2010)	<i>N</i> = 280 heterosexual men aged 21–35 recruited from the Greater Seattle area via newspaper ads and flyers circulated at community colleges, universities and other social environments.	N/A	Increased severity of child sexual abuse was associated with early age of drinking initiation. Child sexual abuse severity also directly associated with the number of partners participants reported.
Steever, et al. (2001)	60 participants recruited from university undergrads aged 18–56. 20 were recruited for each group of: (i) men who reported no history of child sexual abuse; (ii) men who did not identify self as survivor of child sexual abuse but reported history of childhood or adolescent sexual experiences that were coercive/forced in nature; (iii) men who report a history of child sexual abuse.	N/A	Men who self-identified as child sexual abuse survivors reported significantly higher levels of psychological distress. No significant differences were found across the three groups in the following behavioural correlates: alcohol abuse, anger and aggression, compulsive sexuality, relationship stability.
van Roode et al. (2009)	Large prospective birth cohort longitudinal study (Dunedin) 1972–73: Contact child sexual abuse reported by 30% of 465 women and 9% of 471 men.	Women: increased rates in number of sexual partners, unhappy pregnancies, abortion, and sexually transmitted infections from age 18 to 21 but then reduced Men: greater number of partners from age 26–32 and more STD (herpes) age 21–32.	Gender and age are critical when considering the effect of child sexual abuse. While the profound early impact of child sexual abuse demonstrated for women appears to lessen with age, abused men appear to carry increased risks into adulthood.

A complex interplay

There is now some clear evidence of the links between child sexual abuse and a number of adverse outcomes for many children in adolescence and adulthood. These links remain even after taking other factors into account, including other forms of abuse and adversities in childhood. The physical health and behavioural difficulties observable in survivors of child sexual abuse reflect emotional distress and mental health problems related to various vulnerabilities, including later atypical stress responses.

Like other forms of abuse and childhood adversity, there is a complex interplay between many aspects of the child's life and circumstances. These include children's individual characteristics and make-up, their caregiving experiences and family and social support, as well as the various aspects of their school, community and society that protect or put them at risk (Banyard et al., 2001; Canton-

Cortes & Canton, 2010; Roche, Runtz, & Hunter, 1999; Shapiro, Kaplow, Amaya-Jackson, & Dodge, 2012; Walsh et al., 2010). For example, research has identified the importance of family support and stability and positive parental relationships as important factors in how children respond to child sexual abuse in the short and long term (Andrews, Corey, Slade, Issakidis, & Swanston, 2004; Fergusson & Horwood, 2001; Lynskey & Fergusson, 1997). Peer and partner relationships in adolescence and early adulthood have also been implicated as playing a potentially protective role in the development of psychopathology. Low affiliations with delinquent peers for example, have been associated with less risk of later adjustment difficulties (Lynskey & Fergusson, 1997). There is also evidence of inter-generational effects from parents who were abused, mediated through anxiety and mental health problems and parenting stresses (Roberts et al., 2004).

The complexity of these inter-relationships has significant implications for the policy and practical therapeutic responses to child sexual abuse. Increasingly, a trauma response is being tried and the results are looking promising, but await replication in more rigorous studies. As Green et al. (2010) pointed out, the way “factors” work together (whether they are additive, for example), “has important implications for intervention because it means that prevention or amelioration of only a single CA [childhood adversity] in youths exposed to many CAs is unlikely to have important preventive effects” (p. 121). As Odebrecht et al. (2010) pointed out, it is now increasingly possible to explore the biological basis and psycho-biological markers underpinning the links between child sexual abuse and the longer-term psychological, behavioural, and physical neuroendocrine and immunological consequences. There is also a need for long-term prospective research of this type to do so. Walsh et al. (2010) also pointed to the need for “longitudinal designs that establish the temporal sequencing of CSA, coping, and psychological functioning ... to demonstrate causation within a mediational framework and to better understand how victims cope across the lifespan” (p. 12).

Conclusion

Childhood sexual abuse is associated with a broad array of adverse consequences for survivors throughout their lifetime. As a result of more rigorous research studies in this field our understanding of the impacts of childhood sexual abuse is becoming more nuanced and a robust body of research evidence now clearly demonstrates the link between child sexual abuse and a spectrum of adverse mental health, social, sexual, interpersonal and behavioural as well as physical health consequences. To date, the strongest links have been found between child sexual abuse and the presence of depression, alcohol and substance abuse, eating disorders for women survivors, and anxiety-related disorders for male survivors. An increased risk of re-victimisation of survivors has also been demonstrated consistently for both men and women survivors. Some more recent research has also revealed a link between child sexual abuse and personality, psychotic and schizophrenic disorders, as well as a heightened risk for suicide ideation and suicidal behaviour.

Many questions still remain unanswered. For example, we need to better understand the experiences of boy victims of child sexual abuse particularly within the context of institutional cases of child sexual abuse and the impact of such experiences on key areas of victims’ functioning.

Future research in this area needs to continue to tease out gender differences in victims’ experiences of childhood sexual abuse, the impact of mediating variables on survivors’ future functioning and their adjustment in all spheres of their life. This understanding will assist in the identification, treatment and prevention of child sexual abuse. Importantly, this knowledge is key to survivors of childhood sexual abuse being able to disclose their experiences in a safe and supportive environment and gaining access to effective services and the support they need to deal with those experiences and all its effects.

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