

Long-term effects of sexual abuse which occurred in childhood: A review

C. Cahill, S. P. Llewelyn* and C. Pearson

Branksome Clinic, Layton Road, Parkstone, Poole, Dorset BH12 2BJ, UK

The psychological problems and difficulties experienced by adults who report having been sexually abused in childhood are reviewed. These long-term effects include damage to the victims' emotional reactions and self-perceptions, relationship problems, problems with sexuality and difficulties in social functioning. Common presenting problems of victims of childhood sexual abuse (CSA) are described. Also discussed are the characteristics of incestuous abuse in terms of the victim, the abusive relationship and its termination; the contributions of the various aspects of CSA to the psychological impact of such abuse; and psychodynamic explanations of the development of long-term effects. The bulk of the published material regarding the long-term effects of CSA refers to female victims only, and this 'bias' is reflected in the review.

Childhood sexual abuse (CSA) has received much public attention in recent years. However, most authors have been concerned with the victims as children, and comparatively little work has been published on the long-term consequences for the victims. This review is primarily concerned with victims of CSA as adults, and considers the long-term effects of abuse. Due to the very large number of publications in this field, we have for practical reasons drawn heavily on previous reviews in this area. We have also limited ourselves by focusing mainly on studies of a comprehensive nature, or which could be generalized to the broad population of adult victims who have experienced CSA. Whilst our review is, therefore, for the most part based on publications in the professional literature, we are also aware of the important and rich source of understanding of CSA to be found in the writings of the victims/survivors of CSA (e.g. Allen, 1980; Spring, 1987). Most of our discussion concerns female victims, as there is as yet little research evidence concerning male victims.

It is important to point out at this stage that the use of the phrase 'long-term effects', with its connotation of causality, is not entirely satisfactory. It must be emphasized that a causal relationship between a history of CSA and the proposed long-term effects is not proven by the research discussed below. Briere & Runtz (1987) draw attention to the fundamental problem in identifying causal relationships on the basis of the currently available data:

although symptomatology in adulthood may covary with earlier sexual abuse, in the absence of further data it is not clear whether the former is caused by the latter, or whether both are actually a function of some third variable, such as dysfunctional family dynamics (p. 51).

* Requests for reprints.

Thus, we can only infer an association between a history of CSA and certain problems or difficulties in adult functioning.

In the past decade, the study of CSA and its long-term effects has become firmly established in mainstream psychological research. Investigations include large-scale studies based on samples drawn from the general population (e.g. Baker & Duncan, 1985; Briere & Runtz, 1987; Murphy *et al.*, 1988), and more narrowly defined studies of issues such as long-term effects and treatments in female clinical populations (e.g. Fromuth, 1986; Tsai & Wagner, 1978). Only very recently has male victimization become a subject of investigation.

A great many different operational definitions of sexual abuse have been employed in research, and this creates difficulties when comparing results, particularly in regard to the question of prevalence of CSA. CSA may refer exclusively to acts which involve physical contact, or it may include attempted contact or verbal propositions. Definitions usually require an age disparity between the child-victim and the perpetrator (typically five years minimum) as this underwrites the abuse dimension, implying as it does a concomitant disparity in power. CSA can be subdivided into that which is perpetrated by individuals outside the family – extra-familial abuse – and that which occurs within the family – incest – though definitions of ‘family’ vary. Baker & Duncan (1985) reported figures of 0.25 per cent for incestuous abuse and 10 per cent (12 per cent females, 8 per cent males) for all types of sexual abuse in a nationally representative UK population sample. On the basis of these figures they estimated that a possible 4.5 million adults in the UK have been sexually abused as children. However, Russell (1983) reported considerably higher figures in her random community sample of women in San Francisco. She revealed a prevalence of 38 per cent reporting at least one experience of sexual abuse before 18 years; 16 per cent reporting at least one experience of intra-familial abuse before 18 years, and 4.5 per cent reporting sexual abuse by their biological or stepfathers. Peters & Wyatt (1986) suggested that differences in methodology may well account for much of the variation in the levels of victimization discovered in various studies.

Of particular importance to clinicians are the prevalence rates of 30 per cent (Spencer, 1978, cited in Gelinias, 1983) and 33 per cent (Rosenfeld, 1979, cited in Gelinias, 1983) reported in psychiatric out-patient caseloads. Sheldon (1988) found that 16 per cent of women referred to a regional psychotherapy unit reported sexual abuse in their childhood, and 4.3 per cent made covert reference to it prior to assessment interview.

Characteristics of CSA

The average age of onset of abuse is approximately 11 years of age for girls and 12 years for boys, although girls are significantly more likely to be abused before age 11, whereas boys are significantly more likely to be abused after (Baker & Duncan, 1985).

Father-daughter incest is more likely to occur if the mother is absent from the home, through work commitments, illness or pregnancy. Finklehor (1979, cited in Herman & Hirschman, 1981) found that girls whose mothers were frequently absent or ill were twice as likely to be abused as girls whose mothers were present.

Russell (1986) reported that none of the incest victims in her sample considered themselves to have initiated the sexual contact, though 12 per cent made comments which suggested a degree of self-blame. In 43 per cent of cases the abuse occurred only once, and in 68 per cent it took place in either the victim's, perpetrator's or a shared home. In 68 per cent of cases the abuse lasted for less than two years; 95 per cent of the victims were living with their parents at the time. It appears that father-daughter incest is more likely to involve more than one incident and to be of a longer duration. Meiselman (1978) reported that 25 per cent of such abuse involved only one incident, although on average the duration of abuse was three years. Russell (1986) reported that 16 per cent of cases of incestuous abuse in her sample 'progressed' from non-sexual contact and this is also found in father-daughter incest, which progresses to more intrusive and severe acts of abuse (Herman & Hirschman, 1981; Meiselman, 1978).

Initially at least, most victims react with passivity. Russell (1986) reports the following reasons given by victims for not resisting the abuse: fear of use of physical force; ignorance; being disarmed by deception; feelings for the perpetrator; threats to the family; feeling powerless; fear of mother finding out; feeling needy and craving attention; perpetrator in authority and economic dependence. A few victims said they did not resist because they found it pleasurable. In many cases there was a combination of the above reasons.

Few victims tell anyone at the time, though many victims do try to tell someone, usually mother, relative, teacher or other adult (Herman & Hirschman, 1981; Meiselman, 1978). In the majority of cases that person refuses to believe the victim or refuses to get involved. Russell's (1986) data suggested that, where abuse is severe and involves a family member, it is even less likely that the response to disclosure will be supportive. Victims of father-daughter incest are therefore particularly disadvantaged and perhaps it is this which condemns them to secrecy. Meiselman found that only five out of 20 mothers in her sample expelled the father from the home, and she commented that this usually occurred when the mother wanted to be rid of the father.

Thus, in the vast majority of father-daughter incest cases, it is up to the victim to find a way of terminating the abuse. There are no accounts in the literature of the abuser ceasing voluntarily. High proportions of father-daughter incest victims therefore repeatedly run away or leave the home as soon as they can (50 per cent reported by Meiselman). Herman & Hirschman (1981) commented that many victims seek dominant males to protect them. Russell (1986) asked her sample of incest victims what finally brought the abuse to an end. Forty-four per cent replied that it was due to action, typically avoidance, taken on their part, 27 per cent attributed it to action taken by someone else, and 21 per cent said it was a combination of the two. It is clear from the accounts in the literature that victims start to take action and assert themselves around the age of 14 or 15, as they become aware of the significance of the abuse and the danger of pregnancy, and realize they may now be in a position to do something about it themselves.

Long-term effects of CSA in female victims

In their comprehensive review, covering empirical research findings in respect of female victims of CSA, Browne & Finklehor (1986) state that 'all the studies which have looked for long-term impairment have found it, with the exception of one (Tsai, Feldman-Summer & Edgar, 1979)' (p. 72).

In the following section we reiterate the main findings detailed by Browne & Finklehor (1986) and, in addition, consider data which have come to light in the intervening period, along with insights drawn from the writings of clinicians, therapists and CSA survivors. Unfortunately, the results of many studies are not as clear cut as one would like them to be, due to the fact that they often do not distinguish women who have suffered extra-familial abuse from those incestuously abused. Clinical and empirical findings on male victimization are dealt with separately at the end of the section.

Jehu, Klassen & Gazan (1985) identified three populations of female sexual abuse victims: firstly, the total population of abused women; secondly, a subgroup of this population who experience psychological problems; and, finally, a further subgroup of this group who seek help for these problems. Most research has been directed at this third subgroup. The relative sizes of these subgroups, or the factors which determine membership, have not yet been identified, but we do know that women who seek therapy have a more severe and diverse symptomatology (Courtois, 1979) and report abuse histories comparable to the most severe traumatic histories reported by victims from a non-clinical sample (Herman, Russell & Trocki, 1986). It has been well established that a substantial proportion of women from the total population of abused women, who are living in the community, believe they have suffered in the long term as a result of their childhood experience. In her random sample survey, Russell (1986) found that 26 per cent of her respondents who had been the victims of childhood sexual abuse reported a 'great' effect, 26 per cent reported 'some' effect, 27 per cent 'little' effect and only 22 per cent 'none'. Similarly, Baker & Duncan (1985) found that 54 per cent of both men and women abused as children reported a damaging effect on their lives. This percentage increased to 67 per cent of those who experienced intra-familial abuse, and 75 per cent of those abused by a parental figure.

Recently, the use of objective measures has provided more robust evidence of long-term psychological sequelae. On objective assessment scales, women sexually abused as children, when compared with women who do not report experiencing abuse, have been found to be more depressed and more anxious (Bagley & Ramsay, 1986; Briere & Runtz, 1987; Murphy *et al.*, 1988), to have lower levels of self-esteem (Bagley & Ramsay, 1986), and to have higher levels of dissociation (Briere & Runtz, 1987). Murphy *et al.* (1988) reported that women abused before age 12 years displayed significantly more psychological symptoms on a global health measure than non-abused women, and those abused between the ages of 12 and 17 years were rated as having elevated levels of obsessive-compulsive symptoms, heightened interpersonal sensitivity and elevated signs of hostility and paranoid ideation, by comparison with non-abused women.

Community survey findings, clinical research data, case studies and the writings of victims generally support each other, and it is possible to construct an outline of the

psychological problems and difficulties commonly experienced by CSA victims. These problems can be loosely categorized into emotional reactions and self-perceptions, relationship problems and problems with sexuality.

Emotional reactions and self-perceptions

Depression is the symptom most commonly reported in the clinical literature, and empirical findings seem to support this (Browne & Finklehor, 1986). In a survey of undergraduate women, Briere & Runtz (1985, cited in Browne & Finklehor, 1986) found that sexual abuse victims reported experiencing more depressive symptoms during the 12 months prior to the study than did non-abused subjects. When incest victims in therapy are compared with other therapy clients, however, no significant differences have been found in the rates of depression (Herman & Hirschman, 1981; Meiselman, 1978).

Low self-esteem is one of the most commonly reported characteristics of incest victims, and also features in empirically based studies of CSA (as in Bagley & Ramsay, 1986). Eighty-seven per cent of Courtois' (1979) community sample of incest victims said that their sense of self had been moderately to severely affected by their experience of sexual abuse, and Herman & Hirschman (1981) found that 60 per cent of the father-daughter incest victims in their clinical sample reported a 'predominantly negative self-image', compared with 10 per cent of a control group, who had 'seductive' but not incestuous fathers, i.e. they engaged in behaviour that was sexually motivated but did not involve physical contact. One finds many examples of these negative self-images in the clinical literature, with abused women referring to themselves as 'dirty', 'bad', 'shameful' or 'damaged property' (see Herman & Hirschman, 1981). Jehu (1988) reported that very high percentages of CSA victims in therapy have distorted beliefs. Examples of such beliefs are: 'It is dangerous to get close to anyone because they always betray, exploit, or hurt you' (92 per cent); 'I am inferior to other people because I did not have normal experiences' (90 per cent); 'No man can be trusted' (90 per cent); 'No man could care for me without a sexual relationship' (86 per cent); 'I must have been responsible for sex when I was young because it went on so long' (86 per cent).

Herman & Hirschman (1981) reported that all of the incestuously abused women in their sample had a sense of being branded or stigmatized by the experience of father-daughter incest. This feeling of stigmatization is not unique to incest victims, however, but extends to many women sexually abused regardless of relation to the offender: Briere (1984, cited in Browne & Finklehor, 1986) found that 64 per cent of his sample of sexually abused women attending a community health clinic reported feelings of isolation, compared with 49 per cent of the non-abused control group.

Incest victims appear to experience the most severe emotional reactions. Clinicians studying and treating these clients invariably find a great deal of guilt, anger and self-blame. Guilt and self-blame are often rooted in the facts that (i) many child victims do not resist the advances of the perpetrator; (ii) some victims get emotional and/or physical satisfaction from the experience and (iii) abuse may extend over a long period of time and victims may therefore feel they 'allowed' it to continue (Tsai & Wagner, 1978). In cases of father-daughter incest, anger is most often directed at the

mother, whom many victims feel abdicated responsibility for protecting them, preferring to 'turn a blind eye'. Meiselman (1978) reported that 60 per cent of the incest victims in her psychotherapy sample disliked their mothers, while only 40 per cent continued to hold hostile attitudes towards their fathers. Other feelings commonly reported in the clinical literature which may have their provenance in the experience of childhood incest are helplessness and powerlessness.

Relationship problems

The kinds of difficulties reported by female incest victims in the clinical literature appear understandable, in the light of the victims' experience in the abusive relationship. These difficulties include inability to trust and to love, anxiety surrounding emotional and/or physical intimacy, fear of being abused, rejected, betrayed or abandoned, and feeling undeserving, misunderstood and overly dependent in relationships. The lack of ability to trust anyone in a relationship has been noted many times in the literature, and is considered a major and significant problem, often targeted for therapeutic intervention. Courtois (1979) found that 79 per cent of her sample of incestuously abused women experienced moderate or severe problems in relating to men. Their problems, however, are not limited to relationships with members of the opposite sex. Clinical reports also show that many women are unable to build friendships with other women.

Contributing to these problems in some father-daughter incest victims may be their highly polarized view of the sexes. Typically, in these cases men are idealized, being seen as strong, powerful and able to satisfy their needs, while women, by contrast, are viewed as weak, submissive and ineffectual. Women are seen as rivals in the competition for men, and may be regarded with suspicion, hostility and contempt (Herman & Hirschman, 1981; Meiselman, 1978).

Many female CSA victims, particularly incest victims, report experiencing further abuse, both physical and sexual, and this has received attention in the research literature under the label of 'revictimization'. In Briere's study (1984, cited in Browne & Finklehor, 1986), 49 per cent of the CSA victims in his community sample reported having been battered in adult relationships, compared with 18 per cent of the non-victim group. Russell (1986) found that incest victims were almost twice as likely to report being seriously assaulted at some time in their lives, and 68 per cent reported being the victim of rape or attempted rape, excluding incestuous rape, at some time later in their lives, compared with 17 per cent in the non-abused group. Herman & Hirschman (1981) also noted this phenomenon, but what they found more striking was that most of the incest victims said they 'deserved it'.

Marital and family problems. The clinical literature reports that many incest victims get married, have children, or live with a partner almost immediately on leaving the abusive home. Quite often the male partner is seen as the 'protector', and marriage is an escape route. For a few it is also a way of avoiding relationships with other men (see Herman & Hirschman, 1981; Meiselman, 1978). Many view marriage in an ideal light, as a place where they can find love and affection, safety and security. However, 38-48 per cent of incest victims report physically violent husbands, compared with

17 per cent in a non-abused control group, and 40–62 per cent report having been sexually assaulted by their husbands, compared with 21 per cent in the control group (Russell, 1983, cited in Browne & Finklehor, 1986). In Meiselman's (1978) clinical study of incest victims, 64 per cent reported conflict with, or fear of, their husbands or sex partners, compared with 40 per cent of the control group of clients in therapy who had not been the victims of sexual abuse. Fromuth (1986) reported that CSA victims were more likely to be involved in non-consensual sexual relations than non-abused respondents.

On the subjects of marital and maternal status Russell (1986) found a perfect linear, and significant, relationship between degree of trauma experienced and marital status at time of interview. The most traumatized group was more likely to marry yet to be separated or divorced at time of interview, while victims in the categories of 'severe' and 'considerable' trauma were more likely to have raised one or more children, compared to those in the categories of 'some' or 'none' (63 vs. 43 per cent). Some CSA victims are particularly anxious and express concern about the maternal role. They feel they cannot cope with their children's demands, have difficulty expressing affection for them, or are confused as to how to discipline or respond to them (see Goodwin, McCarthy & DiVasto, 1981, cited in Browne & Finklehor, 1986; Spring, 1987).

Problems with sexuality

Long-term effects on sexuality have been well documented: 'Almost all clinical studies show later sexual problems among child sexual abuse victims, particularly among the victims of incest' (Browne & Finklehor, 1986). Briere (1984, cited in Browne & Finklehor, 1986), using a walk-in sample at a community health clinic, found that of those women who had been sexually abused as children, 45 per cent reported difficulties with sexual adjustment as adults, compared with 15 per cent of the control group. A typical clinical profile of women who have experienced traumatic childhood sexual experience is characterized by (i) difficulties in the arousal phase (e.g. feeling revulsion about their own or partners' bodies, difficulty in touching or caressing, reduced sexual appetite before having contact or minimal arousal during contact); (ii) arousal contingent upon control; and (iii) an ability to achieve orgasm without experiencing pleasure (McGuire & Wagner, 1978).

Studies of female incest victims invariably report very high rates of sexual problems. Meiselman (1978), for example, found that 87 per cent of her sample of father-daughter incest victims had had a serious problem with sexual adjustment at some time since the abuse, compared with 20 per cent in her control group of non-abused clients in therapy. The kinds of sexual problems reported cover the whole spectrum of sexual dysfunctions, such as frigidity, vaginismus, orgasmic dysfunction, achievement of orgasm or sexual satisfaction only under certain specific conditions, such as in casual relationships or when the woman is 'in control', and 'flash-backs' related to the incestuous experience during sex (see Meiselman, 1978). Langmade (1983, cited in Browne & Finklehor, 1986) found incest victims to be more sexually anxious and dissatisfied with their sexual relationships than a matched control group

of women in therapy, and Courtois (1979) has reported avoidance of or in some cases compulsion towards sexual activity in incestuously abused women. An ability to dissociate from their bodies, or induce an anaesthesia, which may be used at a time of sexual activity, has been reported in a few cases (see Gelinas, 1983).

Periods of promiscuity and celibacy are often reported by incest victims, and in some cases individuals go through both over a period of time (Herman & Hirschman, 1981). Until recently, it was accepted, almost without qualification, that there was an association between childhood sexual abuse and promiscuity in adolescence and adulthood, though the validity of this finding is now being questioned (Browne & Finklehor, 1986). These findings (e.g. DeYoung, 1982; Courtois, 1979; cited in Browne & Finklehor, 1986) have been based on self-reports, but Fromuth (1986) found no significant differences in this variable between abused and non-abused female college students, and observed that having experienced child sexual abuse only predicted whether subjects would describe themselves as promiscuous, not their actual number of partners. Clinicians have also noted a tendency in incest victims to 'sexualize' relationships alongside a difficulty in distinguishing affection from sexual advances (see Herman & Hirschman, 1981; Meiselman, 1978).

Experience of CSA has been linked to prostitution. Very high proportions of prostitutes report a history of CSA (55 per cent, Meyerding, 1977; 65 per cent, Silbert & Pines, 1981, cited in Browne & Finklehor, 1986).

The question of an association between childhood sexual victimization and homosexuality has not been researched directly. Browne & Finklehor (1986) point out that studies have found little evidence of a connection between these two variables. However, there are reports in the clinical literature of abused women becoming involved in lesbian relationships, but it is not known whether there is a larger proportion of lesbians in the victimized population than in the non-abused population. Meiselman (1978) reported that seven out of 23 of her sample of father-daughter incest victims described lesbian relationships or significant experiences of conflicts centred on homosexual feelings. She commented that these cases 'presented evidence that a significant minority of psychologically disturbed women with histories of father-daughter incest later experience homosexual feelings that are sufficiently intense to motivate experimentation with lesbian relationships' (p. 257). In conclusion, however, she cautioned that 'the life-histories of the lesbian women in the psychotherapy sample were replete with factors other than incest that may have played a role in the development of their adult sexual orientations' (p. 260).

Social functioning in CSA victims

It has been suggested that female CSA victims are prone to revictimization by virtue of the fact that many of them end up in social groups where violent behaviour is more prevalent. It is known, for instance, that a significant proportion of CSA victims become alcohol or drug abusers. Peters (1984, cited in Browne & Finklehor, 1986) quotes figures of 17 per cent of victims reporting symptoms of alcohol abuse and 27 per cent reporting symptoms of drug abuse. CSA victims may therefore be more likely to encounter, or get themselves into, violent situations.

Whether or not the experience of CSA can have an impact on social mobility is a research issue fraught with methodological problems. To date, only Russell (1986) has attempted to address this question systematically. Her findings indicated that the experience of extremely traumatic CSA may contribute to a drop in socio-economic status for the victim. There was a linear inverse, though not significant, relationship between attendance at college and degree of trauma experienced, while those suffering the most severe trauma had the lowest household income in the year preceding the study, were more likely to have husbands in lower class occupational status, and were more likely themselves to have a lower educational status. These results contrast with her finding that girls reared in high income families were more frequently victimized by incest than girls in lower income families. Interestingly, however, clients who had suffered 'some' or 'considerable' trauma quite often had better results on the above measures than those who reported no trauma.

The above constitute the most commonly reported problems of CSA victims, and one is likely to find a considerable number of these present in any one typical case study. Miscellaneous problems which are also reported are: somatic complaints (usually headaches); obsessive/compulsive behaviour; eating disorders; suicidal tendencies; self-injurious behaviour; and, in rare cases, psychotic episodes. Some incest victims express confusion as to whether or not they have been abused as children. Clinicians have noted, however, that in many of these cases abuse of a very severe or traumatic nature has occurred (see Gelinis, 1983; Herman & Schatzow, 1984).

To close this section on a positive note, Herman *et al.* (1986) reported that about half of the abused women in their community sample said they had recovered well from their trauma. Also, Brunngraber (1986) and Russell (1986) have reported that some victims report positive consequences of having experienced incest; examples of such consequences are increased sensitivity and autonomy, self-reliance and independence.

Long-term effects of CSA in male victims

Bruckner & Johnson (1987; cited in Dimock, 1988) describe symptoms in a sample of adult male victims referred for group therapy. These are very similar to those outlined above in female CSA victims. The men reported depression, isolation, poor self-concept, difficulty in establishing and maintaining relationships, and sexual problems. Many abused men are also similar to female victims in that they blame themselves for what happened, or see themselves as having been in some way responsible or weak for letting it happen (Dimock, 1988). The nature of their sexual problems, however, is different in some respects from that of female victims. Male CSA victims report a lack of identity with, or problems in coming to terms with, their own gender (Bruckner & Johnson, 1987; cited in Dimock, 1988), sexual preference conflict (Dean & Woods, 1985; cited in Dimock, 1988), sexual dysfunction, sexual fantasies or attraction towards children, and sexual compulsion (Dean & Woods, 1985; cited in Dimock, 1988; Dimock, 1988).

The presenting problems of female victims of CSA

It is widely accepted that women who seek therapy come from that segment of the population of CSA victims with the most severe symptomatology (Courtois, 1979; Herman & Hirschman, 1981; Meiselman, 1978). Significantly, 'normal' life-events, or situations which are centred on the development of loving and intimate relationships, often act as catalysts in precipitating the occurrence of problems, and thus move victims to seek help. Gelinias (1983) refers to these as 'developmental triggers'. One example is the onset of psychotic episodes in a woman who has recently become pregnant (Forward & Buck, 1981) or, less dramatically, of women who prior to marriage engaged in sex with their partners, yet feel disinclined to do so afterwards (McGuire & Wagner, 1978). Many victims also present with interpersonal, sexual and/or child-rearing problems. The most commonly represented symptom is depression (Browne & Finklehor, 1986), but anxiety states, eating disorders, alcohol and drug abuse, and suicidal behaviour are also reported.

Incest victims are likely to present with more severe problems. Gelinias (1983) constructed an Incest Recognition Profile which involved the following three components: (i) chronic depression with recent exacerbation, characterized by depressed mood and affect, very low self-esteem and guilt; (ii) atypical elements of a dissociative nature, i.e. complaints of 'confusion', recurrent nightmares, episodes of depersonalization and/or a compulsive nature, including eating disorder, child abuse, drinking or spending sprees; and (iii) a history of 'parentification' (taking the place of a parent, typically the mother). The similarity of the clinical symptom clusters found in incest victims to borderline personality and post-traumatic stress disorder has been noted, and some authors have suggested that many women given these diagnoses may, in fact, be victims of childhood sexual and particularly incestuous abuse (Briere & Runtz, 1987; Sheldon, 1988).

Factors contributing to the development of long-term effects

In attempting to isolate the factors which determine the development of long-term effects, researchers have studied the relationships between various characteristics of the abuse and the degree of trauma reported by the victim. This concept of trauma can be very vague and it is not always possible to ascertain whether it refers to trauma at the time of the abuse, or long-term impact. Russell (1986), for example, used a measure of trauma which was based on responses to questions concerning degree of upset around the time the abuse occurred and consideration of long-term effects. In their review, however, Browne & Finklehor (1986) reported that, irrespective of what research method is used, abuse by a parental figure, severity of abuse and use of force and violence are invariably associated with greater trauma. Evidence of an influence of other factors, such as age of onset and frequency/duration of the abuse, is inconclusive. Only in the last few years have investigators begun to use objective and standardized methods in addressing the question of causal factors. Briere & Runtz (1987), for example, reported a number of significant relationships between

abuse variables and symptomatology, using a modified Hopkins Symptom Checklist. They found that parental incest was related to chronic somatization, anxiety and dissociation. Total duration of abuse related to higher chronic somatization, anxiety and depression, along with acute and chronic dissociation. Number of abusers was correlated with chronic anxiety and depression, and age of oldest abuser was positively related to chronic anxiety and acute and chronic dissociation. They also found that the use or threat of force was associated with higher acute somatization.

Looking at factors which contribute to adjustment, Brunngraber (1986) found that father-daughter incest victims felt that having supportive relationships, being involved in therapy, having time away from the incestuous situation, achieving in school or career, disclosing the secret and viewing CSA from an adult perspective helped them to overcome the trauma of the abuse.

It is clear from the range of accounts and case histories in the literature that women's reactions to various sexually abusive experiences, and the consequent effect these have on them, are very wide-ranging and individual. Moreover, the nature of the act itself is not the only, or even most significant, factor. One must also consider the role played by the personality of the victims, attitudes in the family and support available to them from friends or family, either at the time of the abuse, or at disclosure, or in later life. Courtois (1979) commented that 'severity of ratings of the impact of abuse, both in the long and the short term, are not predictable by situation', and she concurred with Burgess & Holstrom (1974; cited in Courtois, 1979) that response [to CSA] is dependent on many aspects of the experience, its aftermath, and the individual's personality and mental health taken together' (p. 342).

Dynamics of the development of long-term effects

According to Finklehor (1987), post-traumatic stress disorder (PTSD) is the descriptive model most frequently proposed to characterize the impact of CSA. These proposals are based on the observation that all of the symptoms indicated in the DSM-III criteria of PTSD have been reported, both singly and in combination, by victims of CSA. Examples of such symptoms are: re-experiencing the trauma through recurrent intrusive recollections; avoidance of activities, or the intensification of symptoms, when exposed to stimuli related to the traumatic event; problems with memory or concentration. Finklehor, however, draws attention to a number of problems with this classification. In the first instance, he contends, the PTSD model is necessarily 'forced' on CSA symptomatology. Distinguished as it is by an emphasis on the affective realm (intrusive imagery, nightmares, and numbing and deadness of affect) and social relations components, PTSD is, in his opinion, essentially a fundamentally different construct from that which presents itself in much CSA symptomatology. In support of his thesis he cites a study by Kilpatrick, Amick-McMullan, Best, Burke & Saunders (1986), who specifically evaluated PTSD symptomatology in CSA victims, and reported figures of 10 per cent (symptoms currently present) and 36 per cent (symptoms ever present). Finally, he concludes that none of the explanatory theories associated with PTSD fits the problem of sexual abuse very well.

Finklehor, therefore, proposes an alternative explanatory system which he describes as the 'traumagenic dynamics model of child sexual abuse'. An eclectic and comprehensive model, it employs four 'traumagenic dynamics' to explain the effects of CSA: traumatic sexualization, betrayal, stigmatization and powerlessness. He suggests that:

A 'Traumagenic Dynamic' is an experience that alters a child's cognitive or emotional orientation to the world and causes trauma by distorting the child's self-concept, world-view, or affective capacities. For example, the dynamic of stigmatization distorts the children's sense of their own value or worth. The dynamic of powerlessness distorts the children's sense of their ability to control their own life. When a person tries to cope with the world through these distortions, what we see are the psychological and behavioural problems that are characteristic of abused children and adults (Finklehor, 1987, pp. 354-355).

Finklehor's explanatory model is the most comprehensive and ambitious theoretical framework yet developed in this area. Its main rival is the 'post sexual abuse trauma' of Briere & Runtz (1987). Their construct refers to 'symptomatic behaviours that were initially adaptive responses, accurate perceptions, or conditioned reactions to abuse during childhood, but that were elaborated and generalized over time to become contextually inappropriate components of the victim's adult personality' (p. 374). Examples of these behavioural dynamics are self-induced dissociation during sex (once an adaptive response), powerlessness (once an accurate perception), and fear or anxiety in relation to sex or men (a conditioned response). It seems to the present authors that such 'higher order' dynamics most likely underlie Finklehor's system and, taken together, these two formulations provide much needed and highly valuable conceptual material for therapists, researchers or anyone interested in understanding the long-term effects of CSA.

Summary and conclusions

It has been shown that a significant proportion of women questioned in community random sample surveys report having experienced some form of sexual abuse in childhood. Furthermore, many of these women report that this has negatively affected their lives. In clinical samples, a significant number of women report having experienced abuse at a severe level. These women have been found to have problems which fall into the following categories: emotional reactions and negative self-perceptions, problems in relationships and sexual problems. Although the evidence concerning long-term effects in male victims is very sparse, it appears that their problems also lie in these domains. With regard to understanding the development of long-term effects, there have been advances on both the empirical and theoretical fronts. Research on female victims strongly implicates abuse by a parental figure, severity of abuse, and use of force or violence as traumagenic factors. The theoretical formulations of Finklehor (1987) and Briere & Runtz (1987) are of value to researchers and therapists alike, providing a comprehensive, higher order conceptual framework with the potential to generate testable hypotheses.

Obviously, a great deal more empirical research is needed to enable us to

understand the mechanisms, processes, necessary and sufficient conditions, and the many variables in operation in the development of the kinds of problems which have been identified in adults who have been the victims of childhood sexual abuse.

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