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A REVIEW OF THE SHORT-TERM EFFECTS OF CHILD SEXUAL ABUSE

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Abstract—This is the first of a two-part report that critically evaluates empirical studies on the short- and long-term effects of child sexual abuse. With the exception of sexualized behavior, the majority of short-term effects noted in the literature are symptoms that characterize child clinical samples in general. Among adolescents, commonly reported sequelae include sexual dissatisfaction, promiscuity, homosexuality, and an increased risk for revictimization. Depression and suicidal ideation or behavior also appear to be more common among victims of sexual abuse compared to normal and psychiatric nonabused controls. Frequency and duration of abuse, abuse involving penetration, force, or violence, and a close relationship to the perpetrator appear to be the most harmful in terms of long-lasting effects on the child. The high prevalence of marital breakdown and psychopathology among parents of children who are sexually abused makes it difficult to determine the specific impact of sexual abuse over and above the effects of a disturbed home environment. Given the broad range of outcome among sexual abuse victims, as well as the method-

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ological weaknesses present in many of the studies reviewed, it is not possible at this time to postulate the existence of a "post-sexual-abuse-syndrome" with a specific course or outcome.

Key Words— Child sexual abuse, Short-term effects, Abuse-specific effects.

INTRODUCTION

RECENT REVIEWS OF STUDIES on sexual abuse during childhood have concluded that it has harmful effects (Alter-Reid, Gibbs, Lachenmeyer, Sigal, & Massoth, 1986; Browne & Finkelhor, 1986; Lusk & Waterman, 1986). Unfortunately, much of the research surveyed in these reviews suffers from a variety of serious methodological and interpretive constraints. For example, the literature has been vague in separating effects directly attributable to sexual abuse from effects that may be due to preexisting psychopathology in the child, family dysfunction, or to the stress associated with disclosure. Another problem concerns the relatively small number of studies that have actually examined children. In the review by Alter-Reid et al. (1986), for example, only one of the 39 references was an empirical study of sexually abused children in which there was a control group. Similarly, of the 49 references in the Browne and Finkelhor (1986) review, there was only one controlled study of children published in a peer-reviewed scholarly journal. Perhaps the most serious methodological problem that currently exists is the lack of appropriate control or comparison groups, which limits the degree to which firm conclusions can be drawn. At this point in time, then, findings may be best viewed as heuristic, that is, pointing to potential variables that will eventually be of importance in understanding the sexual abuse phenomenon.

The present review will attempt to clarify the range of observed short-term effects attributable to child sexual abuse and the possible determinants of these effects based on studies of children and adolescents. The companion review to this article will focus on long-term effects, based primarily on studies with adults (Beitchman et al., in press). The role of abuse-specific variables, such as type of abuse and its duration, the relationship of the offender to the victim, and the victim's age (or developmental level) and sex will also be examined. Clarification of these issues is of paramount importance if we are to understand the scope of the problem and to refine approaches to treatment and prevention. In addition, understanding the range of observed effects may help to unravel the psychological mechanisms by which children cope with, or succumb to, the experience of sexual abuse. Sample and design characteristics of the studies reviewed are presented in Table 1.

SHORT-TERM EFFECTS: CHILD AND ADOLESCENT STUDIES

While some effects of sexual abuse may show continuity throughout childhood, others appear to be age-specific. Guilt, for example, which is believed to have an adverse effect on victims as they mature (Conte & Schuerman, 1987), is less likely to be observed among preschoolers (Lusk & Waterman, 1986). Although many studies include a broad age range of subjects, more often than not these developmental differences in symptomatology are not addressed. The following summary will attempt to delineate the short-term effects of child sexual abuse observed in preschool children, school-age children, and adolescents based on studies in which the sample was restricted to one of these age groups or in which data were analyzed as a function of age.

From a methodological standpoint, the following general constraints must be noted as these studies are reviewed. Our review identified 42 separate publications in which sexually abused children and/or adolescents were employed as subjects though some of these studies represent

multiple reports using the same, or overlapping, participants. Of these 42 articles, 18 (43%) did not employ a control group, 8 (19%) employed only normal controls, 13 (31%) employed only clinical (psychiatric) controls, and only 3 (7%) used both clinical and normal controls simultaneously. The measures employed varied in their reliability and validity, and sometimes only one source of information (e.g., the nonoffending parent, usually the mother) was relied upon. Finally, it was the rare study that attempted to partition the sexual abuse experience into its varied components, such as who the offender was and the frequency, intensity, duration, and type of sexual abuse. One would think that such variables would be important in accounting for individual differences in reaction to sexually atypical experiences.

Preschool Children

In studies of preschoolers, a purported effect of sexual abuse is the display of some form of sexual behavior judged to be abnormal. For example, in Mian, Wehrspann, Klajner-Diamond, LeBaron, and Winder's (1986) chart review study, abnormal or "sexualized" behavior was operationalized to include sexual play with dolls, putting objects into the vagina or anus, masturbation, seductive behavior, requesting sexual stimulation, and age-inappropriate or precocious sexual knowledge. Unfortunately, Mian et al. did not employ a comparison group; however, two subsequent chart review studies (Gale, Thompson, Moran, & Sack, 1988; Goldston, Turnquist, & Knutson, 1989) employed nonsexually abused clinical controls and found that various signs of inappropriate sexual behavior were considerably more prevalent in the sexually abused group. In addition to clinical chart data, the presence of some type of inappropriate sexual behavior has been found with a variety of assessment tools, including parent ratings on the Child Behavior Checklist (CBCL) (Friedrich, 1987, 1989; Friedrich, Beilke, & Urguiza, 1987, 1988; Friedrich, Grambsch, Broughton, & Beilke, 1988; Friedrich & Reams, 1987) or other parent report instruments (White, Halpin, Strom, & Santilli, 1988), observation of free play with anatomically correct dolls (Boat & Everson, 1988; Glaser & Collins, 1989; Jampole & Weber, 1987; Sivan, Schor, Koeppl, & Noble, 1988; White, Strom, Santilli & Halpin, 1986), and ratings of children's human figure drawings (Cohen & Phelps, 1985; Hibbard, Roghmann, & Hoekelman, 1987). The occurrence of such behavior in individual children varied widely, however, depending in part on the assessment procedure employed, ranging from 10% (Hibbard et al., 1987) to 90% (Jampole & Weber, 1987). Therefore, considerable caution appears to be required in inferring the occurrence or nonoccurrence of sexual abuse based on the presence of sexualized behavior, given the rates of both false positives and false negatives in these studies.

A couple of early reports of sexually abused preschoolers indicated that they were less disturbed behaviorally than were older children (Adams-Tucker, 1982; Gomes-Schwartz, Horowitz, & Sauzier, 1985). Subsequent studies, however, have not provided strong support for the possibility that age per se is related to degree of measured psychopathology (Friedrich, Urquiza, & Beilke, 1986; Goldston et al., 1989). Also unclear is whether preschoolers manifest specific types of psychopathology. Friedrich et al. (1986) reported that the preschoolers in their study were more likely to have clinically elevated Internalizing scores than Externalizing scores on the CBCL (51% vs. 36%) whereas their school-age children showed the reverse pattern (31% vs. 44%). These percentages were not tested for significance, and other data in the Friedrich et al. (1986) report suggest that age was unrelated to degree of internalizing or externalizing psychopathology. Fagot, Hagan, Youngblade, and Potter (1989) found that sexually abused preschoolers were more passive than were normal controls during free play, which is suggestive of internalizing symptomatology; however, physically abused preschoolers were even more passive and withdrawn. The sexually abused preschoolers and normal

Table 1. Studies of Effects of Child Sexual Abuse

Study	Source of Victim Sample	Total *N*	Victims	Nonvictims	Age Group	Intra/Extra Familial	Comparison Group(s)	Outcome Measure(s)
Adams-Tucker (1981, 1982)	Child guidance clinic	28	6 M 22 F	—	C, Ad	I, E	—	VI, PI, ST, CR
Brooks (1985)	Residential treatment center	26	16 F	10 F	Ad	I, E	PC	ST
Burgess, Hartman, McCausland, & Powers (1984)	Law enforcement agency	66	49 M 17 F	—	C, Ad	I, E	—	VI, PI
Burgess, Hartman, & McCormack (1987)	Law enforcement agency	68	23 M 11 F	23 M 11 F	Ad	I, E	NC, O	VI, PI, ST
Cohen & Mannarino (1988)	Rape crisis center	24	24 F	—	C	I, E	—	ST
Cohen & Phelps (1985)	Child protective services	166	14 M 75 F	47 M 30 F	C, Ad	I	PC	VI
Conte & Schuerman (1987)	Sexual assault center	687	85 M 284 F	134 M 184 F	C, Ad	I, E	NC	VI, PI
Deblinger, McLeer, Atkins, Ralphe, & Foa (1989)	Psychiatric inpatients	87 (46 M) (41 F)	29	58	C	I, E	PC	CR
Einbender & Friedrich (1989)	Child protection agency Private referrals	92	46 F	46 F	C, Ad	I, E	NC	ST
Elwell & Ephross (1987)	Hospital, child protective services	20	3 M 17 M	—	C	I, E	—	PI
Emslie & Rosenfeld (1983)	Psychiatric inpatients	65	3 M 9 F	36 M 17 F	C, Ad	I, E	PC	VI
Fagot, Hagan, Youngblade, & Potter (1989)	Private treatment agency/ child protection agency	36	4 M 11 F	8 M 13 F	C	—	PC, NC	BO
Friedrich, Beilke, & Urquiza (1987)	Psychiatric outpatients	235	35 M 58 F	54 M 88 F	C	I, E	PC, NC	VI, PI, ST
Friedrich, Beilke, & Urquiza (1988)	Psychiatric outpatients	64	31 M	33 M	C	I, E	PC	ST
Friedrich & Luecke (1988)	Psychiatric outpatients	44	11 M 4 F	29 M	C	I, E	PC	VI, PI, ST
Friedrich & Reams (1987)	Psychiatric outpatients	8	1 M 7 F	—	C	I, E	—	ST
Friedrich, Urquiza, & Beilke (1986)	Psychiatric outpatients	85	24 M 61 F	—	C	I, E	—	ST

Gale, Thompson, Moran, & Sack (1988)	Community mental health center	202	9 M 28 F	92 M 73 F	C	I, E	PC	CR
Goldston, Turnquist, & Knutson (1989)	Mental health center Private practice Psychiatric Inpatients and Outpatients	195	128 F	67 F	C, Ad	I, E	PC	CR
Gomes-Schwartz, Horowitz, & Sauzier (1985)	Hospital family crisis program	156	34 M 122 F	—	C, Ad	I, E	—	SR, ST
Gruber & Jones (1983)	Delinquency intervention program	40	19 F	21 F	Ad	I, E	PC	No
Hibbard, Roghmann, & Hoekelman (1987)	Child protective services	112	14 M 43 F	16 M 39 F	C	I	NC	ST
Jampole & Weber (1987)	Wards of State	20	2 M 8 F	2 M 8 F	C	I	NC	VI
Johnson & Shrier (1985)	Hospital outpatient department	80	40 M	40 M	Ad, A	I, E	NC	VI
Johnston (1979)	Child abuse prevention & treatment center	10	1 M 9 F	—	C	I, E	—	VI, PI, ST
Kiser, Ackerman, Brown, Edwards, McColgan, Pugh, & Pruitt (1988)	Child protection agency	10	5 M 5 F	—	C	E	—	PI
Kolko, Moser, & Weldy (1988)	Psychiatric inpatients	103	14 M 15 F	61 M 13 F	C	I, E	PC	CR, ST
Krener (1985)	Child psychiatric service	22	22 F	—	C, Ad	I	—	CR
Lindberg & Distad (1985)	Wards of State	27	3 M 24 F	—	Ad	I	—	VI

Table 1. (*Continued*)

Study	Source of Victim Sample	Total *N*	Victims	Nonvictims	Age Group	Intra/Extra Familial	Comparison Group(s)	Outcome Measure(s)
Livingston (1987)	Psychiatric inpatients	100	4 M 9 F	87	C	I, E	PC	VI
McLeer, Deblinger, Atkins, Foa, & Ralphe (1988)	Psychiatric outpatients	31	6 M 25 F	—	C, Ad	I, E	—	ST, PI, VI
Meiselman (1978)	Psychiatric clinic	158	47 F 11 M	100	Ad, A	I	PC	VI, CR
Mian, Wehrspann, Klajner-Diamond, LeBaron, & Winder (1986)	Hospital sexual abuse team	125	29 M 96 F	—	C	I, E	—	CR
Peters (1976)	Sexual assault center	64	64 F	—	C	I, E	—	VI, PI
Pierce & Pierce (1985)	Child abuse hotline	205	25 M 180 F	—	C	I, E	—	CR
Sansonnet-Hayden, Haley, Marriage, & Fine (1987)	Psychiatric inpatients	54	6 M 11 F	19 M 18 F	Ad	I, E	PC	VI
Sirles, Smith, & Kusama (1989)	Psychiatric outpatients	207	37 M 170 F	—	C, Ad	I	—	CR
Smith & Israel (1987)	Social services sexual abuse team	25	3 M 22 F	—	C	I	—	VI, PI
Tong, Oates, & McDowell (1987)	Sexual assault center	98	12 M 37 F	12M 37F	C, Ad	I, E	NC	PI, ST
White, Halpin, Strom, & Santilli (1988)	Hospital parenting program	58	17	41	C	ND	PC, NC	ST
White, Strom, Santilli, & Halpin (1986)	Hospital sexual abuse team	50	9 M 16 F	12 M 13 F	C	I, E	NC	VI
Wolfe, Gentile, & Wolfe (1989)	Child protective services	71	8 M 63 F	—	C, AD	I, E	—	ST

M = Male; F = Female; C = Child; Ad = Adolescent; A = Adult; I = Intrafamilial; E = Extrafamilial; NC = Normal Control; PC = Psychiatric Control; O = Other Comparison Group; SR = Self-Report; ST = Standardized Test(s); BO = Behavioral Observation; CR = Chart Review; PI = Parent Report/Interview; ND = No Data; VI = Victim Interview.

controls were both less aggressive than were the physically abused preschoolers; thus, at least within the context of free play with peers, sexually abused children in this sample appeared to show more withdrawn than acting out behavioral difficulties. Because the majority of the youngsters in this study were girls, this possibly increased the likelihood of finding internalizing rather than externalizing behavioral patterns (cf., Achenbach, 1966).

Regarding the question of age-specific symptoms, researchers need to better distinguish between behaviors that are related to age (e.g., enuresis, suicide attempts) from those that are less so. Probably only those behaviors that are highly specific to a particular developmental period will show gross differences across age (e.g., Goldston et al., 1989).

School-Age Children

Behavioral and academic problems at school are commonly reported symptoms for sexually abused school-age children, ranging from 32% to 85% of the samples studied (Adams-Tucker, 1981; Elwell & Ephross, 1987; Johnston, 1979; Tong, Oates, & McDowell, 1987). Adams-Tucker (1981) reported that over half of her sample was at least one grade behind at school, but many of these children had a pre-abuse history of psychiatric and/or developmental difficulties. Compared to normal children matched on a number of demographic characteristics, Tong et al. (1987) found that teachers rated sexually abused children as performing significantly less well in their school work. Friedrich and Luecke (1988) found that all of the school-age children in their sample of sexually abused and sexually aggressive children had school problems, including 73% who were in learning disabled or special education classes; however, the sexually aggressive children had a significantly lower IQ ($M = 97.8$) compared to a psychiatric control group of nonaggressive children also referred for psychotherapy ($M = 107.5$).

Unfortunately, none of the studies reporting school problems included clinical control groups, so it was not possible to determine whether these difficulties were attributable to sexual abuse per se. Gomes-Schwartz et al. (1985) found evidence for developmental immaturity and cognitive deficits in their sample of sexually abused preschoolers, but argued that these symptoms most likely predated the abuse. Children who are developmentally delayed may be at greater risk for sexual abuse, and that experience may contribute to further deterioration of their performance at school. Studies of school-age children and adolescents could make use of school records to determine if academic problems existed prior to the onset of the sexual abuse or if a marked change in performance began after the occurrence of abuse.

Both parent- and teacher-report on standardized questionnaires indicated that sexually abused school-age children showed more behavioral and emotional problems than nonclinical controls (Cohen & Mannarino, 1988; Einbender & Friedrich, 1989; Friedrich et al., 1986; Gomes-Schwartz et al., 1985; Tong et al., 1987); in contrast, self-report by the children themselves (e.g., on measures of self-esteem) have yielded more equivocal differences (Cohen & Mannarino, 1988; Einbender & Friedrich, 1989; Tong et al., 1987). The evidence was also equivocal with regard to whether sexually abused school-age children were substantially more or less disturbed than other children referred for clinical problems (Cohen & Mannarino, 1988; Goldston et al., 1989; Kolko, Moser, & Weldy, 1988) although it should be noted that only a few studies have employed concurrent clinical controls.

It was also unclear if sexually abused children manifested any specific general psychopathology as compared to clinical controls. Goldston et al. (1989) found that sexually abused girls were more likely to show depressive symptoms but less likely to show acting-out symptoms than were nonabused clinical controls. Kolko et al. (1988) also found that sexually abused children had more internalizing difficulties than clinical controls, although interpretation of these results was made difficult by large differences in the sex composition of the two groups.

Other studies, however, have reported that sexually abused children were more similar to, rather than different from, clinical controls (Cohen & Mannarino, 1988; Gomes-Schwartz et al., 1985).

Although the evidence for symptom specificity with regard to general psychopathology was unclear, sexually abused school-age children of both sexes, like their sexually abused preschool counterparts, appeared more likely to manifest inappropriate sexual behaviors (e.g., excessive masturbation, sexual preoccupation, and sexual aggression) than did both normal and clinical controls (Deblinger, McLeer, Atkins, Ralphe, & Foa, 1989; Einbender, & Friedrich, 1989; Friedrich, & Luecke, 1988; Goldston et al., 1989; Kolko et al., 1988; Livingston, 1987). Thus, sexualized behavior appeared to be a type of symptom that was a relatively constant marker of sexual abuse during the years prior to puberty.

Adolescents

A review of studies reporting symptomatology among sexually abused adolescents revealed evidence for the presence of depression, low self-esteem, and suicidal ideation or behavior (Brooks, 1985; Burgess, Hartman, McCausland, & Powers, 1984; Gomes-Schwartz et al., 1985; Lindberg & Distad, 1985; Sansonnet-Hayden, Haley, Marriage, & Fine, 1987). Lindberg and Distad's study of 27 adolescents with incest histories revealed that one-third had attempted suicide, and clinically, all of the adolescents presented with poor self-concepts. Sansonnet-Hayden et al. found that depressive symptoms and schizoid/psychotic symptoms (hallucinations) significantly differentiated adolescent inpatients with a history of sexual abuse from those with no history of sexual abuse although it was not clear if these behaviors preceded or followed the abusive experiences.

"Acting out" behaviors, such as running away, truanting, alcohol/drug abuse, and promiscuity, were also frequently reported sequelae of sexual abuse among adolescents (Gomes-Schwartz et al., 1985; Lindberg & Distad, 1985; Runtz & Briere, 1986; Sansonnet-Hayden et al., 1987); however, Goldston et al. (1989) found only limited evidence that acting out behaviors were more common among sexually abused girls than among clinical control girls—running away was more common among the sexually abused girls but drug abuse was more common among the controls, and four other indices of acting out did not differentiate the two groups. In the only other study with a clinical control group (Johnston, 1979), the sexually abused subjects were from lower income families and had higher scores for psychosocial stressors during the past year compared to controls, which may have contributed to observed differences in promiscuity and suicidality.

In a study of adolescents who had been involved in sex rings, Burgess, Hartman, and McCormack (1987) found a significantly higher occurrence of illicit drug use, compulsive masturbation, prostitution, physical fights with friends and parents, and delinquent/criminal behaviors among the sexually abused boys compared to a normal control group matched for age, sex, race, and family structure. These self-destructive and acting out behaviors observed among adolescent victims of sexual abuse may be early manifestations of borderline personality disorder, which has been observed in several studies of adults (Briere, 1984).

Brooks (1985) compared scores on the Brief Symptom Inventory (BSI) of 16 adolescent inpatients who had been sexually abused to adolescent norms and to scores of nonabused psychiatric controls. Ten (63%) of the sexually abused girls had significant elevations. Their profiles indicated a preoccupation with suicidal and self-destructive ideation and psychological characteristics of depression, hostility, somatization, and paranoid and schizoid/psychotic trends. Brooks (1985) offered no explanation, however, why the BSI scores for the nonabused inpatient controls did not differ significantly from the tabled norms.

In order to gain some perspective on the developmental course of symptomatology among

incest victims, Scott and Stone (1986) compared MMPI profiles of adolescent and adult psychotherapy patients who had been molested as children by a father figure. Adults scored significantly higher than adolescents for depression whereas adolescents obtained significantly higher scores than adults for hypomania. Elevations on the hypomania scale indicated the presence of excitability, irritability, elevated mood, flight of ideas, brief periods of depression, and purposeless behavior. Interestingly, both groups of patients had clinical elevations on the schizophrenia scale, which measures feelings of alienation and withdrawal from the social environment and interpersonal relationships.

There was also some evidence to suggest that child sexual abuse may predispose victims to later homosexuality or gender identity disturbance, although this finding was observed more frequently in males than females. Johnson and Shrier (1985) found a significantly higher prevalence of homosexuality (48% vs. 8%) and bisexuality (10% vs. 3%) among young adult males who had a history of childhood sexual abuse compared to nonabused controls. Nonorganic sexual dysfunction was also more frequent in the sexually abused group (25% vs. 5%). Sansonnet-Hayden et al. (1987) reported that five of the six males in their sample of sexually abused adolescent inpatients had a history of cross-dressing compared to only 5% of a psychiatric control group. Three of the sexually abused boys also reported having sexually abused younger children, while none of the controls reported this behavior. Finally, in Runtz and Briere's (1986) retrospective study of female undergraduates, sexual abuse victims reported they were more likely to have homosexual contact during their teenage years compared to normal controls. These studies need to be interpreted cautiously, however, since most people with a homosexual erotic orientation have not been sexually abused as children; moreover, it is not clear whether a nascent homosexual orientation itself predisposes to homosexual contact which may be abusive.

Diagnostic Status

Several studies that obtained their samples from child and adolescent psychiatric facilities reported on diagnostic status. All but one of the 28 sexually abused children assessed by Adams-Tucker (1982) received a DSM-II diagnosis (American Psychiatric Association, 1968). For 57% of the cases, the diagnosis was a behavior disorder (overanxious reaction, withdrawal, or other reaction) and for another 25%, a diagnosis of adjustment reaction was made. In a chart review of 22 girls who had experienced incest, Krener (1985) found that 68% had received a DSM-III diagnosis (American Psychiatric Association, 1980), most often adjustment disorder with mixed emotional features. Most recently, Sirles, Smith, and Kusama (1989) reported on the diagnostic status of 207 children and adolescents who had experienced intrafamilial sexual abuse. DSM-III was used to derive diagnoses from written psychiatric evaluation summaries prepared by child psychiatry residents and fellows. Most cases (61.8%) received a "V-code" diagnosis for conditions "not attributable to a mental disorder," such as Phase of Life or Other Life Circumstance Problem. Of the 38.2% within a DSM-III clinical syndrome, the most common diagnosis was adjustment disorder. All of these diagnostic studies need to be gauged with some caution, since none provided evidence for interrater reliability, the interviewers were not blind to the presenting problem (i.e., sexual abuse), and none employed comparison groups.

A study of adolescent inpatients conducted by Sansonnet-Hayden et al. (1987) compared diagnoses obtained from the Diagnostic Interview Schedule for Children for subjects with and without a history of sexual abuse. Major depression was the most common diagnosis in the sexually abused group (71%), but was not significantly more prevalent than in the nonsexually abused group (57%).

Using the Diagnostic Interview for Children and Adolescents, Livingston (1987) examined

diagnoses assigned to 100 consecutive referrals to an inpatient psychiatric service (age range, 6 to 12 years) and found that sexually abused children were most likely to receive diagnoses of major depressive episode, psychosis, or anxiety disorder while physically abused children were most often diagnosed as having a conduct disorder. Girls were overrepresented in the sexual abuse group (69%) compared to the physical abuse group (13%), which may partially account for the observed differences in diagnostic status. Oppositional disorder was more common among both sexually abused and physically abused children compared to non-abused psychiatric controls.

Friedrich and Luecke (1988) compared diagnostic status in two groups of sexually abused children referred for psychotherapy. One group was comprised of sexually aggressive children, all of whom met the criteria for a DSM-III diagnosis, the most frequent of which was conduct or oppositional disorder. The second group consisted of boys who had completed a treatment program for behavior problems. These boys were usually described as having adjustment disorders with mixed features. Interestingly, the abuse of children in the sexually aggressive group was more severe (all had performed fellatio or experienced anal or vaginal intercourse) than that of children in the treatment group. A comparison of these findings to those of Livingston (1987) suggests a parallel between the responses of physically and sexually abused children when sexual abuse involves force and/or penetration.

Summary of Short-Term Effects

Since the majority of studies examining the short-term effects of child sexual abuse were based on samples drawn from child protective services or psychiatric facilities, they may overestimate the prevalence and severity of symptomatology associated with child sexual abuse in the general population. With the exception of sexualized behavior, most of the symptoms found in child and adolescent victims of sexual abuse were characteristic of clinical samples in general. Specifically, children from disadvantaged or disturbed families often displayed behavior problems, difficulties at school, and low self-esteem. Internalizing behaviors such as sleep disturbance, somatic complaints, fearfulness and withdrawal were also common symptoms in child psychiatric populations and so cannot be automatically conceptualized as sequelae specific to sexual abuse.

There was some indication that children who were sexually abused were more likely to manifest depressive or schizoid symptomatology compared to children who were physically abused; however, sex differences existed with regard to type of abuse and behavioral symptomatology, in that boys were more often victims of physical abuse and were also more likely to exhibit conduct problems. While it cannot be stated that child sexual abuse has no short-term effects, there does not appear to be sufficient evidence at this time to postulate the existence of a unique "sexual abuse syndrome" with a specific course or outcome. However, the global assessment measures used in many of these studies may lack sensitivity to more subtle psychological or behavioral responses to sexual victimization.

Most recently the suggestion has been made that many sexually abused children suffer from a specific syndrome, "post-traumatic stress disorder" (PTSD) (Deblinger et al., 1989; Kiser et al., 1988; McLeer, Deblinger, Atkins, Foa, & Ralphe, 1988; Wolfe, Gentile, & Wolfe, 1989). Unfortunately, these studies varied in how PTSD was defined and reliability procedures were weak or nonexistent. The only study with comparison groups (Deblinger et al., 1989) found that sexually abused children did not have a significantly higher rate of PTSD than physically abused and nonabused psychiatrically hospitalized children. Nevertheless, the high percentage of children manifesting traits putatively associated with PTSD suggests that the syndrome should be further studied to examine to what extent it is specific to sexual abuse per se or

implicates sexual abuse under the general class of severely traumatic events to which children might be exposed.

EFFECTS BY ABUSE-SPECIFIC VARIABLES

Typically, a sample within a single study includes some children who experienced intrafamilial abuse and others who experienced extrafamilial abuse. In addition, the parameters of sexual abuse, such as age of onset, frequency, duration, severity, and type of sexual abuse, vary widely across subjects. Studies that have examined the relation of these abuse-specific variables to outcome provide some insight as to which types of abusive experiences place victims at greater risk for disturbance. However, these variables are often intercorrelated, and most investigators have not employed multivariate statistical analyses in order to assess their independent contribution to outcome.

Age of Onset

At present, findings regarding the relation between age of onset and severity of outcome are inconclusive. Studies of children and adolescents have reported greater disturbance in children abused during the pre-teen and teenage years compared to children abused at younger ages (Adams-Tucker, 1982; Peters, 1976; Sirles et al., 1989). Adams-Tucker, for example, examined DSM-II diagnoses by age of first molestation (age 2 to 15 years) and found that children who were first sexually molested between the ages of 10 and 15 received more severe diagnoses and were more likely to be referred for inpatient treatment compared to children first molested prior to age 10. Similarly, Sedney and Brooks (1984) found age of onset after puberty to be associated with higher levels of self-reported symptomatology in their sample of university undergraduates. Peters also reported that child victims of sexual assault exhibited fewer changes in behavior compared to adolescent and adult victims. Finally, Sirles et al. found that adolescents were more likely to be diagnosed with a DSM-III clinical syndrome than were younger children.

Several studies that have examined outcome in adults have reported an opposite trend, with abuse at younger ages associated with greater trauma (Courtois, 1979; Meiselman, 1978; Russell, 1986). In a study of adult incest victims seeking psychotherapy, Meiselman found that 76% had first experienced incest prior to puberty; unfortunately, little detail was provided about how puberty was defined. A comparison of these women to those who were first victimized as adolescents showed a higher frequency of serious disturbance (psychoses, borderline personality, serious suicide attempts) in the prepubertal group (37% vs. 17%). In Russell's sample of incest victims, 66% of the women who were abused prior to age 9 reported extreme or considerable trauma compared to 45% of those abused as teenagers. Other studies of adult victims of childhood sexual abuse have found no relation between age of onset and later disturbance (Alexander & Lupfer, 1987; Finkelhor, 1979).

There are at least two plausible explanations for the discrepancy in findings noted for studies of child and adult victims of sexual abuse. First, when victims are assessed as children, the full extent of the effects of abuse may not be evident. As children mature, possibly new symptoms associated with their abuse will emerge (Beitchman et al., in press); however, long-term prospective studies are necessary in order to test this hypothesis. Second, age of onset may also be related to duration of abuse and type of abusive experience. Since studies of short-term effects were based on samples of children where the abuse had recently been disclosed, younger children in these samples would usually not have been subjected to the

abuse for as long as older children. In addition, use of force and/or threats and sexual intercourse were more frequent aspects of sexual abuse with older children and adolescents (Gomes-Schwartz et al., 1985; Peters, 1976). Thus, retrospective studies of adults who did not receive intervention in childhood, controlling for duration and severity of abuse, may in the future provide more accurate data regarding differential outcome as a function of age of onset.

Sex of Child

Because child sexual abuse most commonly involves the victimization of young girls by adult males, testing for sex differences is not often possible. In addition, retrospective studies of adults who were sexually victimized as children have been conducted almost exclusively on women (Beitchman et al., in press).

Pierce and Pierce (1985) conducted a chart review on 25 male and 180 female victims of child sexual abuse and reported a number of abuse-specific sex differences. Boys were more often abused by a stepfather whereas girls were more often abused by their natural father. The use of force and/or threats occurred significantly more often among male victims as did emotional illness in the child's nonoffending parent. Girls were five times more likely than boys to be removed from their home following disclosure whereas perpetrators of sexual abuse of males were more likely to be imprisoned. Adams-Tucker (1982) found that girls were more likely to be abused by more than one perpetrator, experienced more types of molestation, and of longer duration, although her sample included only six males. Boys represented 73% of the children involved in sex rings and pornography in the study by Burgess et al. (1984), and a follow-up study found that the boys were more likely to remain in the sex rings for more than a year and that they were more often victims of parental physical abuse compared to girls (Burgess et al., 1987). Sexually abused males in Sansonnet-Hayden et al.'s (1987) study were also more likely to have been physically abused (67%) compared to both sexually abused girls (27%) and nonsexually abused inpatient boys (47%) (cf., Sirles et al., 1989). Future studies should attempt to employ "pure" groups with respect to sexual versus physical abuse, in order to determine the differential impact of these two types of experiences.

Whether the sexes differ in either the degree or type of psychopathology expressed during childhood is unclear. Some studies reported sex differences in these two domains, but others did not (Friedrich et al., 1986; Kolko et al., 1988; Livingston, 1987; Tong et al., 1987). However, none of these studies have attempted to study systematically sex effects; rather, sex differences were tested in a post hoc manner if sufficient numbers of both boys and girls were available.

Relationship to Offender

In general, sexual abuse perpetrated by a biological or stepfather has been associated with greater trauma in the victim (Adams-Tucker, 1982; Courtois, 1979; Friedrich et al., 1986; McLeer et al., 1988; Meiselman, 1978; Peters, 1976; Sirles et al., 1989). Adams-Tucker found that children who had been abused by father figures (50% of the sample) were the most disturbed, with depression and withdrawal the most common sequelae; however, other studies comparing victims of intrafamilial vs. extrafamilial abuse have found no differences in degree or type of symptomatology (Friedrich et al., 1986; Johnston, 1979; Mian et al., 1986).

The relationship to offender may also interact with the sex and age of the child. For example, Tong et al. (1987) found that boys were more likely to be victims of sexual assault by a stranger (58%) whereas girls were more often abused by a relative or acquaintance (78%). When results on the Piers-Harris Self-Concept Scale were analyzed separately by sex of child, only girls were found to have significantly lower self-concept scores compared to controls.

Pierce and Pierce (1985) have also reported significant differences in the relationship of child to offender, and in family composition, of male versus female victims of child sexual abuse.

The chart review study by Mian et al. (1986) found that when a relationship to offender was examined by age of child, 73% of the preschool children had been involved in intrafamilial abuse whereas only 42% of the 5 to 6-year-olds were abused by a family member. Since clinical investigations of sexual abuse victims have suggested that the psychological impact of abuse is more extreme when the perpetrator is known to the child (Finkelhor, 1979), the relationship to offender may interact with the child's age and sex.

Frequency and Duration

Intuitively, we might reasonably expect that sexual abuse that occurs more frequently and/or over a longer period of time might have a greater impact on the victim. Surprisingly, few child studies have examined the issue. The available data, however, support the hypothesis that these abuse-specific variables are associated with more negative outcome. Johnston's (1979) study of school-age sexual abuse victims showed that depression was most severe among children who had been abused for more than two years. Burgess et al. (1984) reported that among children and adolescents involved in sex rings, those who were abused for more than one year were more likely to remain symptomatic or to identify with the perpetrator (i.e., through exploiting others or engaging in antisocial behavior).

Sexual abuse by more than one perpetrator has also been associated with more severe outcome. Using multiple regression, Friedrich et al. (1986) examined the relation between a number of abuse-specific variables and parent ratings on the CBCL. Internalizing behavior was significantly associated with being female, having a close relationship to the perpetrator, and with frequency and severity of abuse. Externalizing scores were predicted by being male, less time elapsed since abuse, and abuse of long duration by an emotionally close perpetrator. Finally, sexual behavior was related to greater frequency of abuse and number of perpetrators. Sirles et al. (1989) also employed multiple regression and found that duration of abuse accounted for the most variance (10%) vis-a-vis psychiatric impairment.

Type of Sexual Act and Use of Force

Some short-term studies suggest that childhood sexual experiences that involve force or a high degree of physical violation (vaginal, anal, or oral penetration) contribute to greater trauma in the victim. In Elwell and Ephross' (1987) sample of school-age sexual abuse victims, more severe symptomatology was associated with physical injury to the child, force applied by the perpetrator, and vaginal or rectal penetration.

Summary of Effects by Abuse-Specific Variables

A review of studies that have examined the relation between abuse-specific variables and outcome suggests that several factors are consistently associated with greater trauma in the victim. These are severity of abuse (i.e., abuse involving penetration), abuse involving force or violence, and a close relationship to the offender. These variables are probably intercorrelated, however, since penetration will generally involve greater force or coercion and father figures are more likely than other perpetrators to engage their daughters in sexual intercourse (Russell, 1986). Findings concerning age of onset, sex of child, duration, and frequency are still equivocal. Future studies should attempt to control for the effects of these variables through improved study designs and/or use of appropriate statistical techniques.

FAMILY FUNCTIONING

Family Composition

The majority of children who were sexually abused (and reported in the literature) appeared to have come from single or reconstituted families. Whether this was, in part, a function of sample recruitment techniques (e.g., from child protection agencies or child psychiatric clinics) was not clear. In any case, family composition appeared to differ between victims of intrafamilial vs. extrafamilial abuse. Mian et al. (1986), for example, found that victims of intrafamilial abuse were significantly more likely to come from families where parents separated or divorced (67%) compared to children who were abused by perpetrators outside of the family (27%).

In a sample of delinquent adolescent females, Gruber and Jones (1983) found that sexual abuse victims were more often from single or stepparent families compared to psychiatric controls (85% vs. 47%), and that the sexually abused girls reported a higher incidence of parental marital conflict (65% vs. 19%). Results of a discriminant analysis indicated that variables measuring marital conflict, living with a step or foster parent, and poor relations with mother correctly classified 80% of their sample. Burgess et al. (1987) conducted follow-up studies of two groups of adolescents who had been involved in sex rings as children. Among adolescents who had been abused for more than one year, 70% were from single-parent families compared to 47% of the adolescents who were involved in the sex rings for less than a year.

Family Psychopathology

Families of sexually abused children were also reported to have multiple problems in addition to frequent separation and divorce. Depression and chemical dependency were the most commonly reported symptoms in parents (Adams-Tucker, 1981; Friedrich & Luecke, 1988; Smith & Israel, 1987). In Adams-Tucker's (1982) sample, 79% of the families had a history of psychiatric problems, with drug/alcohol abuse, depression and/or suicide the most commonly reported. Burgess et al.'s (1987) follow-up study showed that children who had been abused for more than one year were more likely to have fathers with a history of alcohol abuse (59% vs. 29%) and/or criminal behavior (24% vs. 6%) compared to children who had been abused for less than a year. In addition, more of the adolescents in the long duration group had been physically abused as children (82% vs. 18%). Not surprisingly, these children perceived their families as having more conflict (openly expressing anger and aggression) compared to a control group of nonabused peers.

Interestingly, a history of sexual abuse in the mothers of sexually abused children was not an uncommon finding. Friedrich and Reams (1987) found that 5 of the 8 mothers (63%) in their case study of sexually abused preschoolers had been sexually abused as children. Sansonnet-Hayden et al. (1987) reported a significantly higher proportion of maternal history of sexual abuse among sexually abused adolescents compared to psychiatric controls (67% vs. 3%). Finally, Smith and Israel (1987) reported that 72% of the families in their study of sibling incest had a parent who had been sexually abused.

Krener (1985) reported that 54% of the incest victims in her sample were from "disorganized" families, and that these children presented with more symptoms than girls from "organized" families. Emslie and Rosenfeld (1983), however, compared two groups of adolescents hospitalized for psychiatric problems and found no evidence for greater disturbance in family functioning (e.g., parental alcoholism, divorce) among subjects who had been victimized by incest. Both groups were from chaotic, single-parent families, leading the authors to conclude that the single factor common to children and adolescents with severe psychopathology is

family disorganization, whether or not it involves incest. Livingston (1987) also found no differences between sexually abused and physically abused inpatient children on variables measuring psychosocial stress within the family such as marital conflict, separation or divorce, and economic problems.

There have been some recent attempts to examine the contribution of family variables to outcome in sexually abused youngsters using multivariate statistical techniques such as multiple regression. Conte and Schuerman (1987) found, in a large sample ($N = 369$) of children seen at a sexual assault center, that variables indicating the presence of supportive relationships and the general functioning of the victim's family together explained the largest proportion of variance in both social worker and parent measures of child functioning. Variables related to family stress accounted for 22% of the variance in child behavior ratings, although differences between abused and nonabused children were still significant after these family/demographic variables were controlled for, with sexual abuse explaining an additional 11% of the variance in behavior scores.

Friedrich et al. (1988) found that variables measuring family conflict and family cohesion explained the greatest proportion of variance in sexually abused children's internalizing and externalizing scores on the CBCL. Time elapsed since abuse and severity of abuse explained additional, but smaller proportions of variance for these outcome measures.

Family Response to Disclosure

A long-standing history of parent–child problems was common in families of sexually abused children (Friedrich & Luecke, 1988; Gruber & Jones, 1987), so the failure of many parents to react in a supportive manner following disclosure does not seem surprising. Friedrich et al. (1988) reported that duration of abuse and lack of family support explained 24% of the variance in sexual problems as measured by the CBCL. Adams-Tucker (1982) found that children who were not supported by their parents following disclosure of the abuse (65% of her sample) had more severe symptoms and were more likely to be hospitalized compared to children whose families were supportive; however, duration of abuse was longer among the unsupported children, and the number of incest victims in the two groups was not reported. One would expect support to the child to be less forthcoming in cases of intrafamilial as opposed to extrafamilial abuse.

Summary of Family Functioning

A comprehensive analysis of the effects of child sexual abuse must acknowledge the effects of family functioning on the child. Our review of the literature indicates a high prevalence of family breakdown and psychopathology in the histories of sexual abuse victims. Since many of the symptoms reported in the literature tend to characterize children and adolescents from disturbed families in general, to attribute outcome in these samples solely to effects of sexual abuse it is difficult. Matching of sexually abused and control subjects on family and demographic variables is necessary if we are to fully comprehend the impact of sexual abuse over and above the effects of a disturbed home environment.

SUMMARY OF MAJOR FINDINGS

Since the majority of studies reviewed here did not include appropriate control groups, drawing any firm conclusions regarding sequelae specific to child sexual abuse is difficult. At this juncture, however, there does seem to be enough evidence to make the following general statements:

1. Victims of child sexual abuse are more likely than nonvictims to develop some type of inappropriate sexual (or sexualized) behavior. In children, this tendency is observed in a heightened interest in, and a preoccupation with, sexuality which is manifested in a number of ways including sexual play, masturbation, seductive or sexually aggressive behavior, and age-inappropriate sexual knowledge. In adolescents, there is evidence of sexual acting out, such as promiscuity and a possibly higher rate of homosexual contact.
2. The frequency and duration of sexual abuse is associated with more severe outcome.
3. Childhood sexual abuse which involves force and/or penetration is associated with greater trauma in the victim.
4. Sexual abuse perpetrated by the child's biological or stepfather is associated with greater trauma in the victim.
5. Victims of child sexual abuse are more likely than nonvictims to come from disturbed families, with a high incidence of marital separation/divorce, parental substance abuse, and psychiatric disturbance.

RECOMMENDATIONS FOR FUTURE RESEARCH

Despite advances in documenting the prevalence of child sexual abuse (Badgley, 1984; Finkelhor, 1987; Leventhal, 1988), there is still a lack of consensus regarding the proportion of children who have been psychologically harmed by the experience, or the nature of the harm they have sustained. We do not know whether many of the symptoms reported in the literature are specific to sexual abuse or whether they are attributable to other factors such as the child's level of premorbid functioning or a disturbed home environment. The contribution of these preexisting constitutional and familial factors to observed psychopathology needs to be more carefully examined.

The development, course, and stability of symptomatology associated with child sexual abuse have not been adequately investigated. Studies have failed to delineate with precision which aspects of sexuality are affected, particularly in young children. For example, there have been no reports evaluating possible organic or physiological changes resulting from sexual abuse. There has also been insufficient attention given to the victim's own perceptions and/or attributions regarding his or her role in the abusive experience. Few studies have addressed the impact of disclosure, and specifically in what instances disclosure, and subsequent intervention on the part of medical, legal, or social agencies, can be expected to have an adverse or helpful effect on the sexual abuse victim.

METHODOLOGICAL GUIDELINES

The findings of many of the studies reviewed here remain inconclusive, at least partially, as a result of poor study designs. A better understanding of the impact of child sexual abuse may be obtained if researchers take the following methodological guidelines into account:

1. Control groups should be included, matched to sexually abused samples for relevant social/demographic variables such as age, sex, family configuration, and socioeconomic status. Inclusion of both normal nonabused controls as well as a control group of psychologically disturbed individuals (e.g., physically abused children) is required to best test for specificity effects.
2. The influence of abuse-specific variables (e.g., age and sex of child, relationship to offender, type of sexual act, use of force, duration, and frequency of abuse) on outcome

should be controlled for either experimentally (i.e., through study design) or statistically. Thus, samples of sexual abuse victims should be more homogeneous with respect to these variables, or else their relative importance should be assessed using multivariate statistical techniques.

3. The impact of different methods of sampling subjects needs to be more carefully assessed. Many of the studies reviewed here included children who were referred for treatment. Whether these children represent a biased sample is unclear. For example, one could argue that these children come from situations that are less disruptive or disturbed because treatment is being allowed; on the other hand and equally plausible, children deemed less affected by the sexual abuse experience may not have been referred for treatment. Greater recognition is needed of the biased sampling nets in child abuse research.
4. While chart reviews and clinical interviews are useful sources of information, standardized outcome measures should be employed to enable comparison of findings between studies. Chart reviews are particularly subject to bias in sampling and in reliability (Gale et al., 1988; Mian et al., 1986). There is a need to develop standardized outcome measures for use with sexually abused populations. Since symptomatology tends to vary across developmental levels, alternate forms of standardized measures for different age groups will be required.
5. Some measure of family disturbance should be included in assessment batteries, and the effects due to these variables in both sexually abused subjects and controls should be taken into account. Variables of interest include parents' marital status, marital conflict, substance abuse, mental illness and/or psychiatric hospitalization, history of sexual or physical abuse in parents, and parent-child conflict. Inclusion of nonabused siblings as controls would allow an examination of effects specific to sexual abuse, as opposed to those associated with family pathology.

The appropriate provision of treatment services to sexually abused children and their families, as well as effective evaluation of these services, requires a sound knowledge base. Unfortunately, the existing body of empirical research on the impact of child sexual abuse fails to provide answers to a number of important questions. This review has highlighted some of the more consistent findings and has provided suggestions that should be of use to investigators in designing future studies.

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Résumé—Cette partie est la première d'un rapport qui évalue les études empiriques sur les effets à court et à long terme des sévices sexuels à l'égard des enfants. A l'exception du comportement sexualisé, la majorité des effets à court terme signalés dans la littérature sont des symptômes qui caractérisent n'importe quel échantillon clinique d'enfants. Parmi les adultes et les adolescents, les séquelles généralement rapportées concernent la dissatisfaction sexuelle; la promiscuité, l'homosexualité et un risque accru de revictimisation. Les dépressions, les idées suicidaires ou le comportement suicidaire semblent également être plus fréquents parmi les victimes d'abus sexuel que parmi les contrôles normaux et psychiatriques non-abusés. La fréquence et la durée de l'abus, l'abus avec pénétration, l'appel à la force ou l'utilisation de la violence et la relation proche avec l'abuseur semblent être les éléments les plus néfastes en terme d'effets à long terme sur l'enfant. La prévalence élevée de rupture conjugale et de pschopathologie parmi les parents d'enfants ayant subi des sévices sexuels ne permet pas de déterminer l'impact spécifique de l'abus sexuel par rapport aux effets d'un environnement familial perturbé. Etant donné l'ampleur des effets décrits parmi les victimes d'abus sexuels et les faiblesses méthodologiques présentées dans deaucoup d'études passées en revue, il n'est pas possible

actuellement de postuler l'existence d'un "syndrome post-abus-sexuel" avec un développement et un pronostic spécifique. Des directives méthodologiques et des recommendations pour des recherches futures sont discutées.

Resumen—Este es el primero de un reporte en dos partes, que evalúa críticamente las investigaciones empíricas de las consecuencieas a corto y a largo plazo del abuso sexual contra los niños. Con la excepción de la conducta sexualizada, la mayoría de las consecuencias a corto plazo que se describen en la literatura, son síntomas que caracterizan las muestras clinicas de menores en general. Entre los adolescentes y adultos, las secuelas comunmente mencionadas incluyen insatisfacción sexual, promiscuidad, homosexualidad, y un aumento en el reisgo de revictimización. La depresión y la ideación o concuducta suicida también parecen ser más comunes en las víctimas de abuso sexual al compararlos con grupos de control normales y de pacientes psiquiátricos no abusados. Las consecuencias que parecen ser las más dañinas en cuanto a que tienen efectos más duraderos en el niño(a) son: la frecuencia y duración del abuso, el uso de fuerza, violencia o penetración, y una relación íntima con el perpetrador. La elevada prevalencia de rompimientos maritales y psicopatología en los padres de niños que son sexualmente abusados dificulta determinar el impacto específico del abuso sexual además de los efectos de un ambiente familiar perturbador. Considerando la amplia gama de consecuencias que presentan las víctimas de abuso sexual, así como las debilidades metodológicas presente en muchas de las investigaciones revisadas, no es posible postular en estos momentos la existencia de un "síndrome post-abuso-sexual" con un curso y consecuencias específicas. Se discuten ciertas recomendaciones y sugerencias metodológicas para las investigaciones futuras.