Dear Committee,
At the hearings with regard to the Family Violence Amendment Bill I undertook to provide some material on notice - specifically, cases where child protection department recommendations have not been followed in the judgement. See Davidson v Davidson FCA for an example of this.

I was also asked to give examples of where judgements would not adhere to Family Violence Best Practice Principles. These Principles direct decision-makers to consider various aspects of the case in reaching a determination. They direct procedural consideration rather than determination.

I have also attached 3 recent judgements where children are ordered to spend time in households with child sex offenders.
In Robins v Ruddock (FCA) the father is a convicted child sex offender. His 2 daughters have to spend time with him every second weekend and half the school holidays as it is supposed his risk of offending against them can be prevented by them being awake alert and together and having a door on their room with another person staying over at night.

In Rivas v Rivas the FMC accepts the father has behaved sexually with his stepdaughter and perhaps his other two children yet orders the children to have contact with the father under supervision of his mother because she is a Christian. It is worth noting that skilled child sex offenders can abuse a child whilst in the company of others. Queensland child sex offender, Bill D'Arcy, would abuse children in his class, during class. It is unlikely that a mother of a child sex offender would have the (a) skills & knowledge (b) authority to stop the father offending.

In Asikas & Morikas (FMC) the child has been photographed sexually by the brother of the father's new girlfriend whilst spending time with the father. The child is ordered to live in the father's care because the mother has been very upset by the sexual abuse of her child.
These cases have been published on austlii at http://www.austlii.edu.au

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I have also attached Murphy v Murphy our of the Family Court which gives extensive consideration to the question of child abuse and violence and its impact on decisions
A relevant extract is copied below:

Murphy & Murphy [2007] FamCA 795 (20 July 2007)

extract

http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/cth/FamCA/2007/795.html?stem=0&synonyms=0&query=child%20protection

80. In contact contests the Family Court intervenes in the parent-child relationship only on convincing evidence that the child is likely to be at future risk of harm. Though often important, the substantiation or rejection of the specific allegation often has more to do with the interests of the adults than the child and is not always essential in assessing risks and needs.

81. When in doubt the court should resolve the issue in favour of the outcome which best ensures the protection and overall welfare of the child.

82. According to Nicholson CJ in *M*[42] and Kay J in *K and B*,[43] the mere existence of a possible threat to a child is insufficient justification to disrupt a relationship between parent and child.

83. Arguably, the failure to negate a disputed allegation of abuse or a judge's unwillingness to reject abuse allegations as groundless[44] is also an insufficient basis for denying the child a relationship with its parent because such an allegation is almost impossible to disprove affirmatively. In Kay J's view it:

"...is grossly unjust to both the child and the non-custodial parent to remove any contact between them on a test that is 'there is most probably nothing in it but I might be wrong'." [45]

84. The consequences of denying contact between the abusive parent, usually the father, and the child may well be as serious as the risk of harm from abuse. **(Please note that this is factually wrong. There is ample evidence that child sexual abuse has serious short and long term impacts on victims. I attach a paper detailing short-term effects. If an absence of relationship with a father were as harmful as child sex abuse then the children of fathers who are killed in the armed services, or who work for long periods away from home, or who do not otherwise see their children would be filling the psychiatric wards and suicide lists alongside the child sexual abuse victims.)**

85. Thus, in *D'Agostino*[46] a father who was convicted of sexually interfering with his 11 year old daughter was not denied contact either with her or her two younger sisters but was allowed contact on condition that all three children were together at the same time and another adult was also present.[47]

86. Marital or criminal misconduct itself does not create an automatic or absolute bar to contact. There is no presumption or a priori rule that even gross misbehaviour such as child sexual abuse or family violence disqualifies the offending parent or puts up an insurmountable barrier in the way of having contact with a child victim. While domestic violence is always unacceptable and never justified or excusable, not all men with anger management problems or those who have unlawfully beaten their wives (or vice versa) are dangerous to their children. But some certainly are.[48] Violence in the home is one highly relevant and influential factor in the difficult balancing exercise. It is not decisive. Nor is either proven child abuse or neglect.

87. In *V and R*[49] the Full Court identified the real issue in a parenting case in which abuse (or violence) is alleged as whether or not the benefits of contact outweigh any apparent detriment to the children. The starting point in answering that question is the proposition (still enshrined in s60B(1)) that unless the welfare of the child otherwise dictates, he or she is entitled to have proper parental relationships. The next step is to determine what form that relationship should take and whether the circumstances of the case contain the necessary elements to justify limiting that relationship or even terminating it either permanently or temporarily.

These judgements demonstrate that the family law decision-makers do not regard placing children in the care of convicted child sex offenders as being against their best interests. A common assertion is that children love their alleged perpetrator. In Robins v Ruddock, the evidence details at par 88 the Child Protection worker's report in the following terms:

88. In relation to that interview Ms SA said:-

6. In the interview with me [child A] did not volunteer any facts about the incident to us. She indicated that she loves her father and does not want to upset him, but she was not comfortable staying at her father's house at night, particularly on her own. She stated that she was happy with the current situation and her wish was that it remains as it was.

7. When I asked her if she would like to talk about the thing that happened to her with her father she got extremely distressed.

8. She had her teddy bear with her and she started feeding lollies to him furiously. She was very anxious and implored us "please don't tell Dad". "Don't tell anybody anything".

9. She indicated that she did not want to spend time alone with her father. We asked her why she didn't and she said "because of what I told the police". "I do not like it. It makes me feel weird". "I don't want to be alone with him". She kept repeating "please don't tell Dad".

89. Before the interview Ms SA had concerns about the mother's bona fides with regard to A's alleged disclosure. After the interview Ms SA formed a professional view that something had happened to the child. It was Ms SA's professional opinion was that there were no signs that A had been coached.

The judge represents the children's relationship with the father at par 168

168. Because of the close bond between the children and their father I have reached the conclusion that the best interest of A and M are most likely to be served by an order that the father spend time with the children, but that any overnight time be supervised by another adult. This will address A's nervousness in relation to spending unsupervised overnight time with the father.

It is notable that none of the judgements has regard to the level of responsibility being placed on children to prevent their own victimisation. How does a 10 year old control or stop a father with a 'forceful dominant personality'(as in Robins & Ruddock) if he wants to have sex with her? If you were ten, how would you stop him? Would you want your ten year old placed in such circumstances?

There is no apparent consideration of how the parenting relationship is affected by children being placed in the care of a parent who has used them sexually and/or may do so in the future. Children's statements of love for their perpetrator parents cannot be understood outside of the context of the following factors:

- Offenders tell children that this (sexual acts) is what people do when they love each other and children do not know any different
- Children learn that if they say anything adverse about their perpetrator parent they will be vulnerable to punishment because their statements will be passed on to the parent and they will be alone with the parent at some time
- Children can be threatened that if they tell anyone then certain consequences will follow – eg 'they will be taken away'; 'daddy will go to jail':' I will harm you/your mum/ your pet'
- Children can have conflicted feelings, loving the parent but not liking having their bodies penetrated or otherwise used sexually
- Children can learn to accept and normalise sex with a parent and see it as a way of feeling special and cared for

I have attached a research report on the modus operandi and characteristics of child sex offenders to inform the committee on this issue.

Many cases with which we have come to be familiar have allegations vs counter-allegations of child abuse. In such cases, mothers are commonly held to be deluded, children are said to be coached and fathers are given residence of the child – often never having had primary care of the child previously. Documentation of these cases will be forwarded by other members of Justice for Children.

The Family Violence Amendment Bill is a good first step in improving protection of children but it will not prevent judges from placing children with convicted child sex offenders. The law needs to stipulate that decision-makers cannot place children in the care of parents who would fail a 'working with children check'. All parties should be subject to such checks when allegations of violence or abuse are made. It would also be appropriate to ensure that all family law system professionals who make determinations or recommendations about children should pass a 'working with children check'. This organisation has received numerous reports with regard to legal professionals who have been charged, and in some cases convicted, of child abuse, who are active in the system. It is not appropriate that anybody with a record of child abuse should make determinations about abused children.

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Child Sexual Abuse: Offender Characteristics and Modus Operandi

Stephen W. Smallbone and Richard K. Wortley

There is no question that public awareness and concern about child sexual abuse has increased in Australia in recent years. In Queensland, for example, official statistics indicate that the rate of sexual offences reported to police doubled between 1994 and 1998 from about 92 per 100,000 to more than 190 per 100,000. The majority of these offences were committed against children younger than 16 years of age (Criminal Justice Commission 1999).

There is no clear evidence, however, that the incidence of child sexual abuse itself is increasing; rather, increased reporting rates appear partly to reflect a greater willingness by victims and others to report allegations of child sexual abuse. Indeed, many alleged child sexual offences are not reported until long after they have occurred. Nevertheless, there is widespread agreement that child sexual abuse is a major social problem.

This paper suggests that developmental and early intervention programs that are known to reduce rates of general crime may be equally effective in the reduction of sexual crime.

Adam Graycar
Director

International efforts to understand the perpetration of child sexual abuse have been constrained by a number of important conceptual and methodological problems. First, there is a broad consensus among researchers that child sexual offending and child sexual offenders are heterogenous. That is, there is considerable variation both in the ways sexual offences against children are perpetrated (for example, tactics employed to select and "groom" children; sexual and other behaviours involved in the commission of offences; methods of avoiding detection) and in the characteristics of the perpetrators themselves (for example, age, ethnicity, education, psychosocial and psychosexual background, level of sexual interest in children, relationship with victims, general criminality). Causal explanations are similarly varied and, although there are several established theoretical formulations (psychoanalytic, biological, behavioural), none enjoys the support of a strong empirical base. Perhaps in lieu of a clearer conceptual consensus, most researchers agree that sexual offending against children is a multi-dimensional and multi-determined phenomenon.

Although research efforts are expanding rapidly, sexual offending against children has, for a variety of reasons, remained a difficult phenomenon to study, not the least because of the secrecy which typically surrounds the commission of these offences. The majority of research data on child sexual offending has been derived from clinical studies of convicted (usually incarcerated) offenders undergoing treatment. Although such studies have produced a large and rich empirical literature, it is unclear the extent to which these findings can be generalised, even to the larger population of convicted offenders. The reliability and validity of these data are typically compromised by the absence of confidentiality, since such offenders would normally be aware that information provided by them may affect decisions concerning

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their progress in treatment and their release from prison. Further, many studies do not provide sufficient descriptive data to allow comparison of findings from different samples and from different jurisdictions. Finally, comparisons between different subtypes of sexual offenders are often made difficult by the use of small samples and / or by differences in the typological frameworks employed by researchers.

One study that overcame many of the above methodological problems was conducted by Abel et al. in the United States in the late 1980s. This was an unusual study insofar as it was based on confidential self-report data from a large number of known sexual offenders. Although the findings have not been fully replicated, the reports from this study (Abel et al. 1987, 1988; Abel & Osborn 1992) have continued to have a major impact, especially on the development of treatment programs for sexual offenders. The main findings were that:

a) sexual offenders usually begin offending in adolescence (early onset);

b) they are likely to have committed many more sexual offences than ever become officially known; and

c) they are likely to experience a broad range of sexually deviant interests and urges (multiple paraphilias).

The emphasis on sexual deviance as the central feature of interest added weight firstly to the popular conception that sexual offending, unlike non-sexual offending, is a specialised form of criminal activity, and secondly to the clinical programs of the time which tended to concentrate on changing the "deviant sexual preferences" of known sexual offenders.

More recently, a number of large-scale correctional studies (for example, Broadhurst & Maller 1992; Bureau of Justice Statistics 1997; Hanson & Bussiere 1998; Soothill et al. 2000) have shown that incarcerated sexual offenders are more likely to have previous convictions for non-sexual offences than for sexual offences, and that after release they are more likely to commit new non-sexual offences than they are to commit new sexual offences. Such findings clearly suggest that sexual offenders, including sexual offenders against children, are more versatile in their criminal "career" than is generally accepted. Nevertheless, treatment programs for sexual offenders remain highly specialised, and sexual abuse prevention initiatives continue largely to ignore the growing body of knowledge available from the broader crime prevention literature.

The present study aimed to gather both official demographic and offence history data, and confidential self-report data, from a large sample of men currently serving sentences in Queensland for sexual offences against children. In particular, the study aimed to investigate a number of features that were considered to be of theoretical and practical significance, and which might inform preventative, investigative and corrective efforts, namely:

- offenders' psychosocial and psychosexual histories;
- differences between official and unofficial rates of child sexual offending;
- the extent of offenders' non-sexual criminal activity;
- the extent to which offenders have engaged in multiple "paraphilias" (that is, a variety of forms of sexual deviance, such as voyeurism or exhibitionism);
- the offenders' modus operandi; and
- the extent of formal and informal networking among offenders.

A more comprehensive description of the method and results of this study is available elsewhere (see Smallbone & Wortley 2000). The present paper provides a brief description of the method and summarises selected findings.

Method

Adult males currently serving sentences in Queensland for sexual offences against children were approached individually and invited to participate in the study. Official demographic and offence history data were gathered on all 323 prospective participants. Of these, 182 (56.3%) agreed to anonymously complete a 386-item self-report questionnaire developed in large part from Kaufman's (1989) modus operandi questionnaire.

Based on their confidential self-reports, the 182 responders were categorised into one of four mutually exclusive groups:

- intrafamilial offenders (those who had offended only within family settings);
- extrafamilial offenders (those who had offended only outside family settings);
- mixed-type offenders (those who had offended both within and outside family settings); and
- deniers (those who denied ever having committed a child sexual offence).

The sample consisted of 79 intrafamilial offenders, 60 extrafamilial offenders, 30 mixed-type offenders and 13 deniers.

Results

Offender Characteristics

Selected offender characteristics are summarised in Table 1. Data on education and marital status were obtained from official records. Data on current sexual orientation and childhood sexual abuse were obtained from offender self-reports.

A substantial majority of offenders had not completed secondary education. There were no differences in education between offender subgroups, but less educated offenders were significantly less likely to agree to participate in the study.

There were differences between offender subgroups with respect to their marital status. Perhaps the most striking of these is that extrafamilial offenders were significantly more likely than the other offenders to have never been married.

More than three-quarters of the offenders reported an exclusively heterosexual orientation. Extrafamilial and mixed-type offenders were more

Table 1: *Selected offender characteristics (%)*

	Offender subtypes				
	Intra-familial	Extra-familial	Mixed-type	Deniers	Non-responders
Education					
Grades 1 to 7	15.5	14.3	14.8	0.0	21.5
Grades 8 to 10	53.5	53.6	55.6	33.3	62.8
Grades 11 to 12	19.7	19.6	18.5	16.7	12.4
Other (trade / university)	11.2	12.3	11.1	33.3	3.3
Marital status					
Married / de facto (current)	38.5	18.3	24.1	30.8	–
Separated / divorced	52.6	21.7	34.5	53.9	–
Never married	7.7	51.7	37.9	15.4	–
Sexual orientation (to adults)					
Heterosexual	94.9	59.3	53.3	91.7	–
Homosexual	2.5	15.3	13.3	0.0	–
Bisexual	2.5	23.7	20.0	8.3	–
Asexual	0.0	1.7	13.3	0.0	–
Sexually abused as a child	57.7	53.3	73.3	7.7	–

likely to report either a homosexual or bisexual orientation.

About 55 per cent of the combined offenders reported at least one episode of childhood sexual abuse, with the mixed-type offenders (73.3%) more likely than other offenders to have been sexually abused.

Offending Histories

Table 2 presents selected official and self-report data relating to offending histories. Almost two-thirds (62.9%) of the offenders had at least one previous conviction, and this was almost twice as likely to have been for non-sexual offences (40.6%) than for sexual offences (22.2%). Of the 199 offenders with previous convictions, 82.2 per cent had first been convicted of a non-sexual offence. The most common offence for which first convictions were recorded was theft. Intrafamilial offenders (10.8%) were the least likely to have previous convictions for sexual offences, but were somewhat more likely to have previous convictions for non-sexual offences (48.6%).

According to the offenders' self-reports, they were, on average, 31.5 years of age (range: 14 to 61 years) at the time they first had sexual contact with a child, and 38.4 years (range: 17 to 73 years) at the time they last had sexual contact with a child. Intrafamilial offenders offended over a shorter average period (4.4 years) than extrafamilial (7.8 years) and mixed-type offenders (11.0 years).

Multiple Paraphilias

The number of offenders with diagnosable paraphilias other than paedophilia was quite low, although there were some significant differences between offender subtypes. Mixed-type offenders (13.3%) were more likely than either extrafamilial (3.4%) or intrafamilial offenders (3.8%) to have engaged in exhibitionism (exposing genitals to a stranger). Mixed-type offenders (16.7%) were also more likely than extrafamilial (8.6%) or intrafamilial offenders (6.4%) to have engaged in frotteurism (rubbing sexually against strangers).

Apart from exhibitionism (5.4%), frotteurism (9.0%) and voyeurism (5.4%), fewer than five per cent of offenders could have been diagnosed with a paraphilia other than paedophilia.

Networking Among Offenders

Almost one-third of the offenders (29.6%) had knowledge of other child sexual offenders prior to themselves first being charged with a child sexual offence. Mixed-type offenders (53.6%) were significantly more likely to have known of other child sexual offenders than were either the extrafamilial (24.1%) or intrafamilial offenders (25.0%).

Only 8.6 per cent said they had talked to other child sexual offenders prior to themselves first being charged. Again, mixed-type offenders (25.0%) were more likely than the extrafamilial (8.5%) and intrafamilial offenders (2.6%) to do so.

Few offenders (3.7%) became involved with another individual or a group who organised sexual contact with children. Once again, the mixed-type offenders (13.8%) were more likely than the extrafamilial offenders (3.4%) and the intrafamilial offenders (0.0%) to do so.

Mixed-type offenders were more likely than other offenders to report prison-based networking activities. For example, 17.9 per cent of the mixed-type group reported having been provided with information about access to children for sexual contact, compared to 3.7 per cent of the extrafamilial offenders. None of the intrafamilial offenders reported such contact.

Only one offender (a mixed-type offender) reported having used the Internet to gain contact with clubs, chat groups or individuals concerned with child sexual activity.

Modus Operandi

Five aspects of offender modus operandi were examined:

1. victim characteristics;
2. details of the offender's first sexual encounter;

Table 2: *Selected offence history data*

	Offender subtypes				
	Intra-familial	Extra-familial	Mixed-type	Deniers	Non-responders
Mean age (years)					
First sexual contact with a child	33.1	29.4	31.1	–	–
Last sexual contact with a child	37.8	37.1	42.1	–	–
First sentenced for any offence	31.0	30.0	28.4	26.4	30.7
Sentenced for current offence	41.7	40.0	42.6	35.6	42.3
Previous convictions (%)					
Property	36.5	30.5	44.8	41.7	40.4
Violent	16.4	18.6	27.6	41.7	22.0
Sexual	10.8	30.5	41.1	25.0	20.6
Any offence	61.6	61.0	69.0	58.3	60.3

3. behaviours employed by the offender prior to having sexual contact with a child;
4. the offending behaviours themselves; and
5. behaviours employed by the offender after sexual contact with a child.

Victim Characteristics

The 169 offenders who admitted having committed at least one sexual offence against a child disclosed offences concerning a total of 1,010 children (748 boys and 262 girls), of which 393 (38.9%) were reported to have been associated with official convictions. Whereas boys accounted for about half (52%) of the officially recognised victims (that is, those associated with official convictions), according to offender self-reports about 74 per cent of victims were boys. This suggests that the sexual victimisation of boys may be even more underestimated, perhaps both in victimisation surveys and official statistics, than that of girls.

The level of victimisation was not evenly distributed. Intrafamilial offenders disclosed on average 1.5 victims, extrafamilial offenders 6.1 victims, and mixed-type offenders 20.0 victims. Almost half (47.3%) of the combined offenders reported having offended against just one child and a further 16.4% reported having offended against two children. Fewer than 10 per cent of offenders reported more than 10 victims, and only two offenders reported 100 or more victims.

Details of First Sexual Contact

In order to examine factors relating to the onset of the abusive behaviour, participants were asked to provide details of their first sexual encounter with a child.

The ages of the offenders' first victim were fairly evenly distributed across middle childhood and early adolescence, with 75.6 per cent between nine and 16 years of age, and 22.8 per cent between five and eight years. Fewer than two per cent of victims were reported to have been younger than four years of age.

Whereas intrafamilial offenders, by definition, were related to or lived with their victims, 13.3 per cent of extrafamilial offenders and 10.3 per cent of mixed-type offenders reported having had their first sexual contact with a child they regarded as a "stranger". Overall, only 6.5 per cent of offenders had their first sexual contact with a stranger.

Seventy-two per cent of offenders had more than one sexual encounter with their first victim and 28 per cent had more than 10 sexual encounters. Not surprisingly, multiple sexual contacts with the first victim were more likely for intrafamilial and mixed-type offenders than for extrafamilial offenders. Similarly, intrafamilial and mixed-type offenders tended to have a relationship with their first victim that extended over a longer period of time than was the case for extrafamilial offenders. Overall, 29.5 per cent of offenders had a sexual relationship that lasted less than one day, while 36.7 per cent had a relationship that lasted longer than 12 months.

Pre-Offence Behaviours

For extrafamilial offenders, the most common locations for finding children with whom sexual contact later occurred were at a friend's home (36.5%) and through organised activities such as sporting associations and scouts (18.9%). For mixed-type offenders, the most common locations were at a friend's home (47.8%), in the nearby neighbourhood (30.4%) and while babysitting (30.4%). Intrafamilial offenders, by definition, offended against children with whom a prior familial relationship existed.

For intrafamilial offenders, the most common means for organising time alone with a victim were being at home alone with the knowledge of his wife/girlfriend (57.7%) and watching television with the child (36.6%). For extrafamilial offenders, the most common means were watching television with the child (32.2%), letting the child sleep in the same bed (30.5%) and going for car rides with the child (30.5%). For mixed-type offenders, the most common means were watching television with the child (73.3%), sneaking into the child's bedroom at night (63.3%) and letting the child sleep in his bed (60.0%).

For extrafamilial offenders, the most commonly used strategies directed toward victims' parents were making friends with the child's parents or caretaker (44.4%) and spending time with the child while his/her parent was present (44.4%). For mixed-type offenders, the most common means were spending time with the child while his/her parent was present (50%), making friends with the child's parent/caretaker (45.8%) and helping the child's parent(s) around the house (45.8%).

For intrafamilial offenders, the most common means of developing a victim's trust prior to sexual contact were spending a lot of time with them (70.9%), touching the child non-sexually (67.1%) and giving them a lot of attention (64.6%). For extrafamilial offenders, the most common means were touching them non-sexually (64.4%), giving them a lot of attention (59.3%), spending a lot of time with them (55.9%) and doing things the child wanted to do (55.9%). For mixed-type offenders, the most common means were playing with them (83.3%), spending a lot of time with them (82.8%) and giving them a lot of attention (79.3%).

The strategies employed by offenders to get the child to take part in sexual activity tended to involve gradual desensitisation. Intrafamilial offenders tended to touch the child non-sexually (55.7%), give the child non-sexual attention (50.6%) and say nice things about them (45.6%). Extrafamilial offenders tended to give the child non-sexual attention (55.9%), touch the child non-sexually (54.2%) and progressively touch the child more and more sexually (49.2%). Mixed-type offenders gave the child non-sexual attention (86.7%), said nice things about them (80.0%), touched the child non-sexually (73.3%) and said loving, caring things to them (73.3%).

Offence Behaviours

Offenders usually knew the child, often for significant periods of time, before sexual contact occurred. For example, 76.3 per cent of the intrafamilial offenders, 27.8 per cent of the extrafamilial offenders and 39.1 per cent of the mixed-type offenders had known the child for more than one year before having sexual contact with them.

Offences usually occurred in the offender's home (83.3% for intrafamilial offenders; 45.8% for extrafamilial offenders; and 76.7% for mixed-type offenders). Other common locations where offences occurred were going for a car ride (21.5% for intrafamilial; 25.4% for extrafamilial; and 46.7% for mixed-type offenders) and in isolated places (16.5% for intrafamilial; 23.7% for extrafamilial; and 53.3% for mixed-type offenders).

The duration of single sexual contacts with children ranged from less than five minutes to, in some rare cases, more than one hour. More than half of the combined offenders (59.7%) reported the duration of their sexual contacts with a child to have been 15 minutes or less.

The most common behaviours employed by offenders during sexual contact with victims were touching the child's buttocks, breasts or genitals (82.1%) and putting his mouth on the child's genitals (42.9%). Patterns of offence behaviours were similar for the three offender subtypes, although extrafamilial offenders (40.0%) were somewhat more likely to perform oral sex on their victims than were intrafamilial (26.6%) and mixed-type offenders (20.3%).

The most common behaviour the offenders had children do to them was having the child touch his penis (66.7% of the combined offenders). Other common behaviours were having the child perform oral sex on him (43.5%) and having the child masturbate him to ejaculation (39.3%). Mixed-type offenders were somewhat more likely to have the child masturbate him to ejaculation (60.0%) and to have the child perform anal sex on him (the offender) (23.3%).

According to the offenders, the most common means employed by victims to stop the sexual contact were telling the offender they did not want to do it (40.2%), saying no (31.2%), demanding to be left alone (25.9%) and crying (19.2%). These also tended to be the strategies that were the most successful in deterring offenders from continuing to abuse a child.

Post-Offence Behaviours

It tended to take less than an hour for offenders to take a child to the place where sexual contact occurred and then to return the child (64 per cent of the combined offenders). However, nearly half (44.4%) of the extrafamilial offenders and 31.7 per cent of the mixed-type offenders took more than one hour to return the child.

The most commonly used means of keeping a child from disclosing the abuse were saying he (the offender) would go to jail or get into trouble if the child told anyone (60.5% of the combined offenders), hoping the child would not want to lose the offender because he provided affection (35.7%) and giving the child special rewards or privileges if they did not tell anyone (20.8%).

Offenders reported that the child's parents usually knew he (the offender) had been spending time alone with their child (71.1%). One-third (33.3%) of the combined offenders considered that the child's parents liked them (the offender). Alarmingly, 21.4 per cent of the offenders believed the child's parent(s) knew about the sexual contact but did not report it.

Discussion

Results of the study challenge a number of commonly held assumptions about sexual offending against children. First, the findings reinforce what researchers have known for some time—but what is frequently ignored in public debates—that child sexual abuse overwhelmingly involves perpetrators who are related to or known to the victim. Even where the victim was not related to or living with the offender, in most cases the parents knew that their child was spending time with the perpetrator. According to the offenders, it was not uncommon for the parents of the child victim to know about the abuse but not report it.

Second, the strategies employed by offenders to gain the compliance of children more often involve giving gifts, lavishing attention and attempting to form emotional bonds than making threats or engaging in physical coercion. Many sexual encounters with children were preceded by some form of non-sexual physical contact. According to the offenders, there were relatively few cases where other forms of violence were part of the sexual abuse.

Third, serial child sexual offending is relatively uncommon. Almost half of the current sample reported that they had been involved with just one victim, and fewer than 10 per cent were involved with more than 10 children. Further, there is little evidence in these findings of organised paedophile networks. Prison clearly provides opportunities for informal networking, but it appears that relatively few offenders become actively involved in prison-based networking.

Fourth, perpetrators of child sexual abuse are three times more likely to abuse female than male children. In the case of intrafamilial abuse, girls are over 10 times more likely to be victims. However, more generally, males are nearly three times more likely than females to be abused. This is because the relatively few chronic offenders in the sample were more likely to target male victims.

Finally, child sexual offenders do not necessarily form a distinct offender category. Two-thirds of the offenders in the present study had previous convictions, and these were twice as likely to be for non-sexual offences as for sexual offences. Remarkably, a large majority of offenders (82.2%) with previous convictions were first convicted of a non-sexual offence.

Highlighting these findings is not meant to diminish the seriousness of child sexual abuse, nor to deny the existence of the stereotypic paedophile. However, these findings do provide a guide for more focused prevention, investigation and treatment efforts.

In terms of prevention, the findings suggest, for example, that developmental and early intervention programs that are known to reduce rates of general crime may be equally effective in the reduction of sexual crime, since childhood problems (including harsh parental discipline, parental rejection, marital conflict and sexual abuse) appear to be quite common in the backgrounds of child sexual offenders.

The findings also suggest that public education campaigns focusing on "stranger danger" need to be balanced with programs that recognise the danger that exists for many children in the home and among friends. The data on the modus operandi of perpetrators will need to be given very careful consideration because the kinds of behaviours typically employed prior to the commission of these offences are the kinds of behaviours that would normally indicate *positive* parenting. In this sense, it may be very difficult to identify important warning signs for carers. Nevertheless, parents should be aware of the common tactic of intrafamilial offenders to seek (perhaps unusual) opportunities to have time alone with their victim, and for extrafamilial offenders to ingratiate themselves with their victim's parents. With due caution, children can also be made aware of the grooming behaviours of perpetrators and be taught self-protective strategies. Post-offence behaviours may be somewhat more easily observed, since these typically involve subtle but very manipulative efforts by the offender to avoid detection. It would be unsurprising, for example, to find discrete changes in victims' behaviour following sexual contact with an offender.

Investigating child sexual offending is likely to be fraught with difficulty, since offender strategies for avoiding detection appear subtly directed toward their child victim, and often involve strategies that are likely to result in children themselves feeling responsible for not disclosing the abuse. The targeting of active child sexual offenders may need to consider whether extrafamilial offenders or intrafamilial offenders should be given priority. On one hand, extrafamilial offenders are responsible for many more victims. On the other hand, intrafamilial offenders may cause much more overall harm, since they tend to offend repeatedly against one or two children who, because of the context of the abuse, may be limited in their ability to secure much-needed familial support.

With respect to treatment, the findings challenge the tendency in many programs to emphasise the deviant sexual preferences of child sexual offenders, that is, to treat child sexual offending as a specialised and distinct crime problem. The current findings reveal that a substantial majority of child sexual offenders are involved more generally in criminal activity. Many child sexual offences may therefore be explained as extensions of more general antisocial patterns of behaviour, perhaps involving opportunism, the exploitation of interpersonal relationships, or the disregard of socially accepted codes of behaviour. Such a reconceptualisation of child sexual offending would allow a considerable body of knowledge and expertise from the broader crime prevention and offender treatment literatures to be brought to bear on this important problem.

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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.