
Immediate and Long-Term Impacts of Child Sexual Abuse

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Abstract

Research conducted over the past decade indicates that a wide range of psychological and interpersonal problems are more prevalent among those who have been sexually abused than among individuals with no such experiences. Although a definitive causal relationship between such difficulties and sexual abuse cannot be established using current retrospective research methodologies, the aggregate of consistent findings in this literature has led many to conclude that childhood sexual abuse is a major risk factor for a variety of problems. This article summarizes what is currently known about these potential impacts of child sexual abuse. The various problems and symptoms described in the literature on child sexual abuse are reviewed in a series of broad categories including posttraumatic stress, cognitive distortions, emotional pain, avoidance, an impaired sense of self, and interpersonal difficulties. Research has demonstrated that the extent to which a given individual manifests abuse-related distress is a function of an undetermined number of abuse-specific variables, as well as individual and environmental factors that existed prior to, or occurred subsequent to, the incidents of sexual abuse.

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Research conducted over the past decade indicates that a wide range of psychological and interpersonal problems are more prevalent among those who have been sexually abused than among individuals with no such experiences. Although a definitive causal relationship between such difficulties and sexual abuse cannot be established using current retrospective research methodologies,¹ the aggregate of consistent findings in this literature has led many researchers and clinicians to conclude that childhood sexual abuse is a major risk factor for a variety of problems, both in the short term and in later adult functioning.² Further, longitudinal studies currently under way³ suggest that sexual abuse, as well as other forms of child maltreatment, does in fact lead to subsequent psychological difficulties in the short and longer term. As a result, the contention of some earlier clinicians⁴ that childhood sexual abuse is a neutral or even benign event has little current acceptance in the field.

This article summarizes what is currently known about the potential impacts of child molestation. The long-term impacts in adults have been documented across a wide variety of samples, including university, general population, psychiatric inpatient, psychotherapy outpatient, and professional subjects. Although individual studies may not include a fully representative sample of adults abused as children, a confluence of findings suggests that there are predictable sequelae to sexual abuse in the long term. In contrast to the study of adult survivors, the scientific study of the impact of sexual abuse on children is a relatively recent endeavor. Many of the studies on children have relied on clinical or forensic samples and may not be generalizable to all sexually abused children. These studies may underrepresent the impact of abuse in children who are motivated to deny their abuse⁵ or children whose reaction to abuse is significantly delayed.⁶

These various issues decrease the likelihood that there is a “sexual abuse syndrome” present in all those molested as children. A substantial minority of sexually abused children (10% to 28%) report no psychological distress.^{7,8} This may be because the term “sexual abuse” covers a range of abusive behaviors of varying intensity and duration. Survivors who experience, for example, a single incident of less intrusive sexual abuse that is disclosed to a supportive parent who takes protective action may be more likely to report minimal or none of the typical sequelae documented in research studies and outlined in this paper. Thus, it cannot be assumed that the relative presence or absence of a given symptom or symptom complex is indicative of a sexual abuse history in any given individual.

This paper highlights some of the key studies on the potential psychological and interpersonal impacts of childhood molestation. While literally hundreds of studies have been completed in the past decade, the authors have included only those with larger sample sizes and those with similar

behavioral definitions of sexual abuse (that is, sexual contact prior to the age of 16 or 18 either [a] with someone five or more years older or [b] by the use of force). Unless specifically stated, all studies cited are retrospective in nature.

With these precautions in mind, the primary psychological impacts of sexual abuse are thought to occur in at least three stages: (1) initial reactions to victimization, involving posttraumatic stress, disruptions of normal psychological development, painful emotions, and cognitive distortions; (2) accommodation to ongoing abuse, involving coping behaviors intended to increase safety and/or decrease pain during victimization; and (3) the more long-term consequences, reflecting the impacts of initial reactions and abuse-related accommodations on the individual’s ongoing psychological development and personality formation.⁹ Although some initial reactions of victims to their abuse may abate with time, other reactions, along with abuse-specific coping behaviors, appear to generalize and elaborate over the long term.

The various problems and symptoms described in the literature on child sexual abuse can be divided into a series of broad categories or spheres of impact that the authors have found useful in understanding sexual abuse sequelae. These are posttraumatic stress, cognitive distortions, emotional pain, avoidance, an impaired sense of self, and interpersonal difficulties.

Posttraumatic Stress

Posttraumatic stress refers to certain enduring psychological symptoms that occur in reaction to a highly distressing, psychically disruptive event. A diagnosis of posttraumatic stress disorder (PTSD) requires the occurrence of a traumatic event, as well as (1) frequent reexperiencing of the event through nightmares or intrusive thoughts, (2) a numbing of general responsiveness to, or avoidance of, current events, and (3) persistent symptoms of in-

creased arousal, such as jumpiness, sleep disturbance, or poor concentration.¹⁰

Although PTSD was initially associated with adult response to disasters, accidents, and combat experiences, more recent research has linked short- and long-term posttraumatic symptoms to childhood sexual abuse.¹¹ For example, children who have been abused exhibit more posttraumatic fear, anxiety, and concentration problems than do their nonabused peers.¹² Research focusing on assessing sexually abused children has found that these children are more likely to receive the diagnosis of PTSD than their non-abused peers, at rates of up to 48%.¹³ Although most child sexual abuse victims do not meet the full diagnostic criteria for PTSD, more than 80% are reported to have some posttraumatic symptoms.¹⁴

Both clinical and nonclinical groups of adult sexual abuse survivors have been found to display more intrusive, avoidant, and arousal symptoms of PTSD than those not abused as children.¹⁵ Especially prominent for adult survivors are PTSD-related flashbacks—sudden, intrusive sensory experiences, often involving visual, auditory, olfactory, and/or tactile sensations reminiscent of the original assault, experienced as though they were occurring in the present rather than as a mem-

ories involve unexpected recall of specific abusive events. Nightmares with violent abuse-related themes are also commonly associated with sexual abuse-related PTSD.

Cognitive Distortions

People make significant assumptions about themselves, others, the environment, and the future based upon childhood learning. Because the experiences of children who are abused are often negative, these assumptions and self-perceptions typically reflect an overestimation of the amount of danger or adversity in the world and an underestimation of the abuse survivor's self-efficacy and self-worth. A variety of studies document chronic self-perceptions of helplessness and hopelessness, impaired trust, self-blame, and low self-esteem in abused children.¹⁷ These cognitive alterations often continue on into adolescence and adulthood.¹⁸

Such negative thoughts probably arise from multiple sources, including psychological reactions to abuse-specific events, stigmatization of the victim by the abuser and society, and the victim's attempt to make sense of his or her maltreatment.^{9,19} Chronic perceptions of helplessness and danger are thought to result from the fact that the child abuse occurred when the victim was physically and psychologically unable to resist or defend against the abuser. This expectation of injury may lead to hyperreactivity or "overreaction" to real, potential, or imagined threats. The most predictable impact of this dynamic is the victim's growing assumption that he or she is without recourse or options under a widening variety of circumstances. Because such experiences are often chronic and ongoing, feelings of hopelessness regarding the future are also likely. Similarly, the child may make assumptions about his or her inherent badness, based on misinterpretation of maltreatment as, in fact, punishment for unknown transgressions.⁹

As would be predicted from the above, the study of cognition in the adjustment of victims of sexual molestation has linked such abuse to subsequent guilt, low self-esteem, self-blame, and other dysfunctional or inaccurate attributions.²⁰ Gold found that women with a history of child sexual abuse were more likely to attribute the cause of negative events to internal, stable, and global factors, as well as to their character and to their behavior (that is,

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ory of a past event. Triggers of flashbacks include sexual stimuli or interactions, abusive behavior by other adults, disclosure of one's abuse experiences to others, and reading or seeing sexual or violent media depictions.¹⁶

Other PTSD symptoms involve repetitive, intrusive thoughts and/or memories of childhood sexual victimization—difficulties that many survivors of sexual abuse find both distressing and disruptive. These differ from flashbacks in that they are thoughts and recollections rather than sensory experiences. Typically, intrusive thoughts center around themes of danger, humiliation, spontaneous sexual contact, guilt, and "badness," whereas intrusive

“this negative event occurred because I am an inherently bad person and I will never change”).²¹ These same women tended to attribute the cause of good events to external factors. Such cognitive distortions may contribute to or, alternatively, act as mediators of the emotional distress evident among many adult survivors of child sexual abuse.²²

Emotional Distress

Clinicians have long noted the emotional pain reported by many survivors of sexual abuse.²³ This distress is also well documented in the research literature, primarily in terms of increased depression, anxiety, and anger.

Depression

Browne and Finkelhor note that, “in the clinical literature, depression is the symptom most commonly reported among adults molested as children.”²⁴ A variety of studies have documented greater depressive symptomatology among child victims,²⁵ as well as adult survivors.²⁶ Lanktree, Briere, and Zaidi found that child victims in outpatient therapy were more than four times as likely to have received a diagnosis of major depression than were nonabused patients.²⁷ Similarly, adults with a history of sexual abuse may have as much as a four-time greater lifetime risk for major depression than do individuals with no such abuse history.²⁸ These findings are supported by a wide variety of other studies documenting

greater depressive symptomatology in adolescents and adults with sexual abuse histories.²⁹

Anxiety

Child abuse is, by its nature, threatening and disruptive, and may interfere with the child’s developing sense of security and belief in a safe, just world.⁹ Thus, it should not be surprising that victims of such maltreatment are prone to chronic feelings of fearfulness or anxiety. Elevated anxiety has been documented in child victims of sexual abuse,^{6,30} as well as in adults who were molested as children.³¹ In the general population, survivors are more likely than nonabused individuals to meet the criteria for generalized anxiety disorder, phobias, panic disorder, and/or obsessive compulsive disorder, with sexual abuse survivors having up to five times greater likelihood of being diagnosed with at least one anxiety disorder than their non-abused peers.^{28,32}

Clinical experience suggests that the anxiety frequently has a conditioned component, in that sexual abuse usually takes place in human relationships where closeness and nurturance is expected, yet intrusion, abandonment, devaluation, and/or pain occur. As a result, a learned association may form between various social or environmental stimuli and danger, such that a variety of otherwise relatively neutral interpersonal events elicit fear.³³ For example, the formerly abused individual may become anxious in the presence of intimate or close relationships, especially

fearful of evaluation, or frightened when in interacting with authority figures.

Perhaps the most obvious example of conditioned, abuse-related fear among adult survivors is that of sexual dysfunction. Because childhood sexual molestation is likely to create an association between sexual stimuli and invasion or pain, many adults molested as children report fear or anxiety-related difficulties during sexual contact. Meiselman, for example, reported that 87% of her clinical sample of adults molested as children had "serious" sexual problems, as opposed to 20% of those clients without a sexual abuse history.³⁴ Similarly, Maltz and Holman found that 60% of the incest survivors they studied reported pain during sexual inter-

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course, and 48% were unable to experience orgasms during sex.³⁵ A number of other studies also report an empirical connection between childhood sexual abuse and sexual problems or dysfunction in childhood, adolescence, and adulthood.³⁶

Abuse-related anxiety can also be expressed physically, resulting from the impacts of sustained fearfulness on bodily functioning or perception. These somatic difficulties arise as a natural extension of hyperarousal of the sympathetic ("fight or flight") nervous system. Physical problems that have been associated with child sexual abuse histories include headaches, stomach pain, asthma, bladder infections, and chronic pelvic pain.³⁷ Such findings suggest that some proportion of medical complaints presented to physicians and other health care practitioners may less reflect inherent bodily dysfunction than somatic equivalents of anxiety that arise from unresolved childhood maltreatment experiences.³⁸

Anger

Another common emotional sequel of child sexual abuse is that of anger. Chronic irritability, unexpected or uncontrollable

feelings of anger, and difficulties associated with the expression of anger have been reported by child victims.^{5,39} Such feelings can become internalized as self-hatred and depression, or be externalized and result in the perpetration of abuse against others.⁴⁰

In children, anger is frequently expressed in behavioral problems, with abused children and adolescents displaying significantly more difficulties in this area than what is found typically in the general population.⁴¹ These data suggest that children's aggressiveness toward others—commonly expressed as fighting, bullying, or attacking other children—is a frequent short-term sequel of sexual molestation. Although such behavior may represent an externalization of children's distress from their own abuse trauma, and, perhaps, a cry for help, the net effect of this angry aggression is often increased social isolation and unpopularity.⁴²

Less research has been done on the extent of anger experienced by adolescent and adult survivors, although the data available suggest that difficulties in this area are also a long-term sequel of sexual abuse.⁴³ In these studies, adult sexual abuse survivors score higher on measures of anger and irritability than do adults without childhood sexual abuse histories. One possible form of abuse-related anger is that of sexually aggressive behavior toward others. As a group, adolescent and adult sexual abuse survivors are more prone than others to victimize children and women sexually.⁴⁴ It should be noted, however, that most studies in this area indicate that the majority of survivors do not go on to perpetrate such abuse against others.⁴⁵

Impaired Sense of Self

The development of a sense of self is thought to be one of the earliest developmental tasks of the infant and young child, typically unfolding in the context of early relationships.⁴⁶ How a child is treated (or maltreated) early in life influences his or her growing self-awareness. As a result, severe child maltreatment—including early and sustained sexual abuse—may interfere with the child's development of a sense of self.⁴⁷

Without such an internal base, individuals may lack the ability to soothe or comfort themselves adequately, leading to what appear to be overreactions to stress

or painful effects. This impairment can also cause difficulties in separating self from others. Adults molested early in life have more problems understanding or relating to others independent of their own experiences or needs, and they may not be able to perceive or experience their own internal states independent of the reactions or demands of others.⁴⁸ These difficulties may translate into a continuing inability to define one's own boundaries or reasonable rights when faced with the needs or demands of others in the interpersonal environment. Such problems, in turn, are associated with subsequent psychosocial difficulties, including increased suggestibility or gullibility, inadequate self-protectiveness, and a greater likelihood of being victimized or exploited by others.⁹

Avoidance

Avoidant behavior among victims of sexual abuse may be understood as attempts to cope with the chronic trauma and dysphoria induced by childhood victimization. Among the dysfunctional activities associated with avoidance of abuse-specific memories and feeling are dissociation, substance abuse, suicidality, and various tension-reducing activities.⁹ In each instance, the problem behavior may represent a conscious or unconscious choice to be involved in seemingly dysfunctional and/or self-destructive behaviors rather than fully experience the considerable pain of abuse-specific awareness. Unfortunately, although sometimes immediately effective in reducing distress, avoidance and self-destructive methods of coping with child abuse experiences may lead ultimately to higher levels of symptomatology, lower self-esteem, and greater feelings of guilt and anger.⁴⁹

Dissociative Phenomena

Dissociation can be defined as a disruption in the normally occurring linkages between subjective awareness, feelings, thoughts, behavior, and memories, consciously or unconsciously invoked to reduce psychological distress.⁹ Examples of dissociation include: (1) derealization and depersonalization, that is, the experience of self or the environment as suddenly strange or unreal; (2) periods of disengagement from the immediate environment during times of stress, for example, via "spacing out" or excessive daydreaming; (3) alterations in bodily perception; (4) emotional numbing; (5) out-of-body

experiences; (6) amnesia for painful abuse-related memories; and (7) multiple personality disorder.⁵⁰ Dissociative symptomatology has been linked to sexual trauma in children^{5,51} and adults.⁵² Such symptoms are apt to be prevalent among child and adult survivors because they reduce or circumvent the emotional pain associated with abuse-related experiences or recollections, permitting superficially higher levels of psychological functioning.⁵³

Dissociation is thought to underlie many individuals' reports of periods of amnesia for their childhood abuse in that such memories are believed to have been defensively excluded from conscious awareness.⁵⁴ Two studies suggest that adults in psychotherapy quite commonly report some period in their lives when they had incomplete or absent memories of their childhood abuse. Herman and Schatzow found that 64% of 53 women undergoing group therapy for sexual abuse trauma had some period of time prior to treatment when they had incomplete or absent memories of their moles-

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tation.⁵⁵ Among 450 men and women in psychotherapy to deal with abuse-related difficulties, 59% reported having had some period before age 18 when they had no memory of being abused.⁵⁶ In both of these studies, self-reported abuse-related amnesia was associated with more severe and extensive abuse that occurred at a relatively earlier age. Loftus, Polonsky, and Fullilove found that 19% of more than 50 sexual abuse survivors in treatment for chemical dependency stated that, at some point in the past, they had no sexual abuse memories and that an additional 12% had only partial memories of their childhood sexual victimization.⁵⁷ Interestingly, in the latter study, the authors interpreted their data as not necessarily supporting the notion of psychogenic amnesia, per se, but rather referred to this process, at least in some instances, as "forgetting."

In a methodological improvement over the above retrospective studies,

Williams followed up 129 women who, as children, had been seen in an urban emergency room with a primary complaint of having been sexually abused.⁵⁸ These subjects were interviewed approximately 18 to 20 years later—without knowledge that the interviewers were aware of their childhood ER visit—and asked whether they had ever been sexually abused as children. Thirty-eight percent of this sample reported no memory of having been sexually abused, despite records that sexual abuse had, in fact, taken place. Unlike previous investigations, this new study cannot be

matic stress. From this perspective, treatment or forensic interventions that merely detoxify and/or punish substance abuse are unlikely to be effective—especially in the longer term. Instead, addicted survivors may respond more definitively to therapeutic or self-help interventions that reduce the abuse-related internal distress motivating chemical dependency.

Suicide

The ultimate avoidance strategy may be suicide. As noted by Schneidman, Farberow, and Litman, escape from extreme psychic pain—that is, depression, anxiety, or extreme hopelessness—is a commonly expressed motivation for suicide.⁶³ Thus, it should not be surprising that increased suicidal ideation and behaviors have been linked to sexual abuse in child victims.^{27,64} Similarly, several studies of adults who were molested as children document more frequent suicidal behavior and/or greater suicidal ideation among survivors relative to their nonabused peers. Rates of a previous suicide attempt, for example, were 51% in a subsample of 67 sexually abused female crisis clients⁶⁵ and 66% in a subgroup of 50 sexually abused female psychiatric emergency room patients,⁶⁶ as compared with an average rate of 27% for nonabused patients in these studies. In a community sample, approximately 16% of survivors had attempted suicide, whereas fewer than 6% of their nonabused cohorts had made a similar attempt.³²

Tension-Reducing Activities

Certain behaviors reported by adult survivors of child sexual abuse, such as compulsive and indiscriminate sexual activity, bingeing or chronic overeating, and self-mutilation, can be seen as fulfilling a need to reduce the considerable painful affect that can accompany unresolved sexual abuse trauma. Often these activities are seen as “acting-out,” “impulsivity,” or, most recently, as arising from “addictions.” For the abuse survivor, however, such behaviors may best be understood as problem-solving behaviors in the face of extreme abuse-related dysphoria.

Chronic abuse-related distress may be reduced by activities that provide temporary distraction, interrupt dysphoric states, anesthetize psychic pain, restore a sense of control, temporarily “fill” perceived emptiness, and/or relieve guilt or self-hatred.⁹ These behaviors are frequently effective in creating a temporary sense of

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faulted in terms of potential biases to recall, because the original abuse had been verified and the subjects were currently denying (as opposed to alleging) a sexual abuse history. Assuming that their non-report was not caused by inhibition, modesty, or other conscious influences (a doubtful explanation because many reported other painful or upsetting childhood events, including other sexual abuse experiences), Williams's subjects appear to provide data that childhood abuse experiences can, in fact, be excluded from current memory.⁵⁹

Substance Abuse and Addiction

A number of studies have found a relationship between sexual abuse and later substance abuse among adolescent⁶⁰ and adult survivors.⁶¹ Briere and Runtz report that sexually abused female crisis center clients had ten times the likelihood of a drug addiction history and two times the likelihood of alcoholism relative to a group of nonabused female clients.⁶² It seems likely that sustained drug or alcohol abuse allows the abuse survivor to separate psychologically from the environment, anesthetize painful internal states, and blur distressing memories. Thus, some significant proportion of those currently addicted to drugs or alcohol may be attempting to self-medicate severe abuse-related depression, anxiety, or posttrau-

calm and relief, at least for some period of time. Ultimately, the use of tension-reducing mechanisms in the future is reinforced through a process of avoidance learning: behavior that reduces pain is likely to be repeated in the presence of future pain.

Indiscriminate Sexual Behavior

It is widely noted by clinicians that adolescents and adults molested as children are prone to episodes of frequent, short-term sexual activity, often with a number of different sexual partners.^{34,67} This may explain why, compared with their nonabused peers, survivors of sexual abuse are at greater risk for unintended and terminated pregnancies, as well as for contracting sexually transmitted diseases.⁶⁸

In addition to temporarily addressing the need for closeness and intimacy—arising from deprivation in these areas during childhood—indiscriminate sexual behavior by some sexual abuse survivors may provide distraction and avoidance of distress for some adults molested as children. Sexual arousal and positive sexual attention can temporarily mask or dispel chronic abuse-related emotional pain by providing more pleasurable or distress-incompatible experiences. For such individuals, frequent sexual activity may represent a consciously or unconsciously chosen coping mechanism, invoked specifically to control painful internal experience.

Bingeing and Purging

Specialists in eating disorders have suggested recently that both adolescent and adults with bulimia (episodes of bingeing on food, then purging via vomiting or laxatives) may be especially likely to report child sexual abuse histories.⁶⁹ Although this is a relatively new area of research related to sexual abuse, it appears that childhood molestation is associated specifically with bulimic bingeing and purging, whereas (nonbingeing) anorexia nervosa is less relevant to sexual molestation history, *per se*.⁷⁰ It should be noted, however, that at least one review of the literature questions the validity of a sexual abuse–bulimia relationship.⁷¹ Root and Fallon suggest that binge-purge behaviors can operate as “both a reaction to and a method of coping with physical and sexual abuse.”⁷² The tension-reducing aspects of bulimia include self-soothing, distraction from non-food-related concerns, and a (literal) filling of perceived emptiness.

Self-Mutilation

Self-mutilation is defined by Walsh and Rosen as “deliberate, non-life-threatening, self-effected bodily harm or disfigurement of a socially unacceptable nature.”⁷³ It most typically involves repetitious cutting or carving of the body or limbs, burning of the skin with cigarettes, or hitting of the head or body against or with objects.⁷⁴ Each of these forms of self-injury has been found to occur among recent or former victims of child sexual abuse.^{74,75} Various authors have hypothesized that self-mutilatory behavior serves to temporarily reduce the psychic tension associated with extremely negative affect, guilt, intense depersonalization, feelings of helplessness, and/or painfully fragmented thought processes—states all too common among survivors of severe sexual abuse.⁷⁶ Although often immediately effective, such behavior is rarely adaptive in the long term, leading to repeated cycles of self-injury, subsequent calm, the slow building of further tension, and, ultimately, further self-mutilation.

Interpersonal Difficulties

Research and clinical observation have long suggested that child sexual abuse is associated with both initial and long-term alterations in social functioning.^{9,77} Interpersonal difficulties arise from both the immediate cognitive and conditioned responses to victimization that extend into the long term (for example, distrust of others, anger at and/or fear of those with greater power, concerns about abandonment, perceptions of injustice), as well as the accommodation responses to ongoing abuse (for example, avoidance, passivity, and sexualization).

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Sexual abuse usually occurs in the context of human relationships, with as many as 85% of cases perpetrated by individuals known to the victim.⁷⁸ The violation and betrayal of boundaries in the context of

developing intimacy can create interpersonal difficulties in many survivors. These intimacy problems appear to center primarily on ambivalence and fear regarding interpersonal vulnerability. Although in-

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terpersonal difficulties are commonly reported by survivors, they are more prominent when the victimization begins at an especially early age, lasts over an extended period of time, or occurs within the nuclear family.⁴⁸

It has been observed that sexually abused children tend to be less socially competent, more aggressive, and more socially withdrawn than nonabused children.⁷⁹ These children, as a group, tend to perceive themselves as different from others and tend to be less trusting of those in their immediate environment.⁸⁰ They have fewer friends during childhood, less satisfaction in relationships, and report less closeness with their parents than do nonvictims.

A specific interpersonal effect of sexual abuse among children is that of increased sexual behavior. Sexually abused children are consistently reported to have more sexual behavior problems than nonabused children or children whose abuse was restricted to (nonsexual) physical or emotional maltreatment.^{30,81} Although some kinds of sexual behaviors are quite common among nonabused children (for example, kissing, touching genitals manually), sexually abused children tend to engage in a greater number of sexual behaviors than their nonabused peers, many of which are developmentally precocious and seemingly imitative of adult sexual activity.⁸² Such behavior not only may result in interpersonal rejection or stigmatization by the victim's peer milieu, but also may lead to social sanctions and punishments when it escalates into the victimization of other children.⁸³

As adults, survivors report a greater fear of both men and women.⁸⁴ They are more likely to remain single and, once married, are more likely to divorce or separate from their spouses than are those without sexual abuse histories.⁸⁵ Sexual abuse survivors typically report having fewer friends,²¹ less interpersonal trust,⁸⁴ less satisfaction in their relationships, more maladaptive interpersonal patterns,⁴⁸ and greater discomfort, isolation, and interpersonal sensitivity.

Conte and Schuerman speculate that adults victimized as children may see themselves as unworthy of relationships with people they consider good or healthy, and that some victims may attempt to gain mastery over the abuse experience by recreating it in the form of involvement in poor or abusive relationships.⁸⁶ In this regard, sexual or physical revictimization (that is, rape or spousal abuse) has been associated with prior child sexual abuse in a number of studies.⁸⁷

Adults who were sexually abused as children are particularly likely to report difficulties with sexual intimacy. Such problems may present as: (1) sexual dysfunction related to fears of vulnerability and revictimization,³⁵ (2) as noted earlier, a tendency to be dependent upon or to overidealize those with whom they form close relationships,^{16,88} and (3) also as previously noted, a history of multiple, superficial, or brief sexual relationships that quickly end as intimacy develops. The effects of abuse on the survivor's later sexuality is thought to contribute to the high incidence of sexual abuse histories found among adolescent and adult prostitutes,⁸⁹ many of whom appear to view their current occupation as an extension of their childhood experiences.⁹⁰

Mitigating Factors

Because the literature summarized above is relatively unanimous with regard to the potential negative psychological impacts of childhood sexual abuse, there is a risk that the reader will assume that such victimization has an inevitable, uniform, and massive impact on victims. This impression results in part from the way in which most sexual abuse research is done: A group of subjects with childhood sexual abuse histories are compared with another group who were not abused on a variety of psychological measures. This nomothetic approach (that is, an approach involving the

comparison of groups of subjects) is well known for glossing over individual differences and producing generalizations that, although valid for the group, may not be accurate for any given individual subject. In the present context, this approach tends to mask individual protective or pathogenic factors in the abuse-symptom relationship. A careful examination of the data suggests that, although child and adult survivors tend, as groups, to have more problems than their non-abused peers, there is no single universal or uniform impact of sexual abuse, and no certainty that any given person will develop any posttraumatic responses to sexual abuse (for example, sexual concerns and dissociation).

As previously stated, as many as one-fourth of all sexually abused children either report no initial abuse-related problems or may no longer present with demonstrable symptomatology within two years of their abuse.^{7,8} However, as reported in an 18-month longitudinal study, children who were initially asymptomatic had more problems at an 18-month follow-up than did children who were initially highly symptomatic.⁶ Additionally, it is likely that some abuse-related problems are overlooked by research that utilizes measures of general psychological distress rather than abuse-specific measures. Studies that use generic non-abuse-specific measures potentially overestimate the number of "asymptomatic" abuse victims in a given sample.⁹¹ This occurs because such measures do not tap the effects most often associated with sexual abuse (for example, sexual concerns and dissociation).

Although research on mediators of sexual abuse effects is in its infancy, a number of factors appear to be associated with increased distress for survivors. Significant, yet modest, correlations have been demonstrated between specific aspects of a sexual abuse event and subsequent symptomatology. Variables associated with increased distress include molestation at an especially early age, extended and frequent abuse, incest by a biological parent, the presence of force, and a greater number of perpetrators.⁹² More extreme psychological problems are also predicted by the presence of other concomitant forms of child maltreatment, including physical and psychological abuse or neglect, and/or subsequent revictimization in adulthood.⁹³

Family characteristics and response to abuse disclosure also tend to predict subsequent levels of distress. Child victims and adult survivors are often more distressed if their families are characterized by greater dysfunction, especially in terms of conflict and low intrafamilial cohesion.⁹⁴ Additionally, parental response to a child's disclosure is significantly associated with the survivor's symptomatic outcome. Belief in the victim's disclosure and support for his or her experience are associated with decreased symptomatology, whereas disclosures that were met with disbelief or punishment appear to be associated with increased psychological disturbance.⁹⁵

Most parents appear to believe their children when they disclose sexual abuse and often take some protective action.^{61,96} However, at least for sexual abuse perpetrated by males, the closer the relationship of the offender to the mother (for exam-

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ple, if he is her spouse or boyfriend), the more likely it is that support will be compromised.^{5,6} This is especially unfortunate because enjoying maternal support or having a supportive relationship with an adult tends to decrease the impact of the abuse on the survivor.^{6,86}

Finally, it is the impression of clinicians and researchers in the field that a child's preabuse functioning may have significant impacts on how he or she responds to subsequent abuse events and the extent to which abuse-related symptoms persist over time. These may include inborn temperamental differences and antecedent psychological disorder or distress. Especially intriguing at this juncture is the possibility that problems in the early infant-caregiver attachment ("bonding") relationship may exacerbate or complicate the impacts of later sexual abuse,⁹⁷ leading to subsequent difficulties in the victim's developing sense of self.⁹

Directions for Future Research

This first wave of scientific inquiry has demonstrated the wide variety of psychological problems that can be associated with childhood sexual abuse. However, the data on both adult and child victims have certain limitations. As indicated in the previous section, certain pre- and post-abuse variables may affect the victim and his or her response to the abuse in either a positive or a negative direction. Studies often do not have large enough samples to examine these variables while, at the same time, controlling for the potential impact of other forms of concomitant child abuse. As a result, it is not always clear to what extent a given study has identified the *unique* effects of sexual abuse.⁹

Only a second wave of research—focusing on potential ameliorating or exacerbating variables in the genesis of abuse effects—can provide a more complete picture of the complexities of childhood sexual victimization and its psychological impacts. Such research should continue to examine the impacts of abuse in a variety of large samples (for example, general population, clinical samples, university studies) and to utilize multivariate ap-

proaches to the study of sexual abuse. Ultimately, the issues will be best addressed with longitudinal and prospective studies, rather than with the heavy reliance on retrospective studies in the work described in this paper.

Conclusion

This paper outlines the results of a decade of research on the association between childhood sexual victimization experiences and a variety of later psychological symptoms and difficulties. Taken together, the data provide strong support for the negative psychological effects of sexual abuse. Childhood sexual abuse appears both to have sustained impacts on psychological functioning in many survivors and to have the potential for motivating the development of behaviors that, while immediately adaptive, often have long-term self-injurious consequences. At the same time, these data suggest that the extent to which a given individual manifests abuse-related symptomatology and distress is a function of an undetermined number of abuse-specific variables, as well as individual and environmental factors that existed prior to, or occurred subsequent to, the incidents of sexual abuse.

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