A good man leans his weight upon my back, breathes in my ear, wraps his arm in affection high on my chest, near my neck. He means well, and whispers words of healing neither he nor I have ever heard said to us. “I’m glad you’re here, son. I’m glad you’re a boy.” Memory floods and overwhelsms me, rushing me back to a bedroom of a tenement on the South Side of Chicago... My father’s arm is tight across my throat, arching my back. He is exhaling hard, in rhythm, as he shows me why he is glad I am his son. Twenty years since I found his body, dead by his hand. I rage that he is not alive today, so I could strangle him with my own hands. I hunger for a dish of vengeance, a repast of revenge... My predatory, molesting grandmother died in her sleep. The neighbor lady, at 32, seduced me at 14. Two months later, she ate a 22. The coach who groomed me drowned in alcohol. The apostate priest who raped me now lives down south, troubled only by the knowledge that his secret is broken. My mother... lives a mile from me. She shares a dilapidated apartment with my brother. He is forty years old, and still lives with her. He has never married. She has never remarried. No need to. She raised her sons to be her husbands. None of these baby-raping monsters will ever spend a day behind bars. None will pay a penny of recompense. None will know the thump of my fist, the crack of my boot... I have not been avenged. I shall never be avenged. Vengeance is the Lord’s... I hope. But it is my experience that He leaves justice to mere mortals, and His servants have done a lousy job. (Abraham, 1997, pp. 1–3)

This extreme example of child sexual abuse (CSA) described by the victim, Scott, portrays the myriad perpetrators who have been shown to victimize children sexually. Scott was sexually abused by his father, mother,
grandmother, a neighbor, a priest, and a coach. In addition to these perpetrators, grandfathers, uncles, aunts, and siblings have all been implicated in the sexual abuse of both girls and boys. The current chapter deals solely with the sexual abuse of children by adult family members. The bulk of the chapter deals primarily with the most-researched type of CSA: father-daughter incest. However, we also give consideration to other types of incest, including incest perpetrated by mothers and sustained by boys.

Consider Scott’s case. What consequences, both physical and psychological, do you think he suffers from as an adult? He was probably first sexually victimized by his parents and grandmother, and later by a neighbor, priest, and coach. Do you think this pattern of revictimization might be common among survivors of CSA? Why? Scott is very angry because his perpetrators were never held responsible for what they did to him. Sexual abuse, in some instances, can leave physical evidence (e.g., sexually transmitted diseases, pregnancy, and physical injuries such as vaginal tears), but it is often less detectable than physical abuse, in part because the child victims may not reveal the evidence. How often do you think children are willing to reveal their abuse, and how often do you think they are believed? What particular circumstances would dictate both the disclosure of sexual abuse and whether or not the child victims are believed? With the possible exception of the priest, Scott’s abusers were never held accountable, and in the case of his mother, it seems as if the incest is ongoing. Perhaps one of the reasons his perpetrators were never prosecuted was because the CSA occurred at a time when people did not discuss or even acknowledge that the problem existed. How often do you think child sexual abusers are held accountable these days? What circumstances do you think mitigate whether they are held accountable? The questions posed here are among the issues we discuss in the current chapter. Think about your answers to these questions as you read the sections on the prevalence, predictors, and consequences of CSA, and approaches to intervention.

Scope of the Problem

Before we discuss the incidence and rates of CSA by family members, it is important to define exactly what CSA is. This is not easy, as researchers have been unable to formulate a consistent definition. Most studies have, as one criterion for judging sexual acts as abusive, an arbitrary age difference of at least five years between the victim and perpetrator (e.g., Finkelhor, 1979); however, this criterion does not take into consideration that siblings with less of an age discrepancy can be perpetrators of sexual abuse. Furthermore, there is no consensus on what acts constitute abuse. Sometimes noncontact
acts such as voyeurism, exhibitionism, and exposure to pornography are included in operational definitions (i.e., measures) of sexual abuse, which leads to very high incidence rates. If only contact sexual abuse is included (e.g., fondling; oral, anal, vaginal intercourse), rates are lower. Most studies do not specify the frequency or duration of sexual contact necessary for it to be considered abuse, although many workers indicate that just one instance of sexual contact (or noncontact) is enough to label an act abusive. When we consider the causes and consequences of CSA, a child intentionally exposed once to pornography is going to differ dramatically from the children who experienced the abuse described in Box 5.1.

Box 5.1  Case of Child Sexual Abuse

The sexual abuse of Ann and Marie by their father began around the same time, when Ann was five and Marie was four. At the time of their evaluation by a psychologist, both were adolescents, and Marie was the one who had reported the abuse. Ann had mixed feelings about the fact that Marie had disclosed the abuse—she was happy that at least now the abuse would stop because her father would get help, but she was also upset that her father was in trouble.

“Ann reported that, most commonly, her father would fondle her in the breast area and between the legs. At different stages of her life, he would perform different sexual acts on her, which she and Marie would discuss on occasion. The most extensive abusive act Ann experienced was what the girls called the ‘full treatment.’ This consisted of the father’s undressing her, fondling her, and lying in bed with her back to his chest. He would roll her around his genital area and touch her on her breasts and vaginal area. During the course of the interview, Ann related many incidents of this type being perpetrated against her, almost on a weekly basis during certain periods of her life. . . Marie described the same type of fondling as Ann. . . As Marie got older, the father would perform oral sex on her as well. In describing this, Marie became quite tearful and felt guilty and ‘dirty’ because of this particular abuse. She wondered if it was her fault and if she should be blamed for not stopping her father sooner.”


The first source of data on rates of sexual abuse is the official NCANDS statistics provided annually to the U.S. Department of Health and Human
Services (DHHS). All states have laws prohibiting the sexual abuse of children (Myers, 1998), but each state has its own definition of what is considered sexual abuse and therefore what is prohibited. Because sexual abuse statutes vary from state to state, the official statistics need to be interpreted with caution. Generally, though, adult sexual contact with a child under the age of 14 is illegal, as is any kind of incest. According to the 2001 NCANDS statistics, 9.6% of all substantiated maltreatment cases were CSA cases, and nationwide 86,830 children, or 1.2 per 1,000 children, were victimized by sexual abuse. Parents were the perpetrators in approximately 40%, and other relatives in approximately 60% of these cases. Although these rates of substantiated cases of sexual abuse are high, they reflect a decrease from 1997, when the abuse rate was 1.7 for every 1,000 children (DHHS, 2001). All abusers were relatives of the children because CPS generally does not get involved in cases of extrafamilial child maltreatment (Finkelhor, 1994).

The Third National Incidence Study (NIS-3; Sedlak & Broadhurst, 1996; see Chapter 4), based on child maltreatment cases reported to CPS as well as cases known to community professionals, shows a similar picture of CSA in the United States. According to the Harm Standard, the number of sexual abuse cases rose from 119,200 in 1986 to 217,700 in 1993, an increase of 83%. Similarly, according to the Endangerment Standard, the number of cases rose from 133,600 to 300,200, an increase of 125%. Overall, the data indicate that the reporting of CSA was on the rise during the latter half of the 1980s and then declined in the mid- to late 1990s. According to NIS-3, reported cases of sexual abuse were three times more likely to be girls than boys. The lowest rate of CSA was in children in the zero- to two-year age range; the rates were constant for children over age three. Children in the poorest income category (less than $15,000/year) were 18 times more likely to be reported for sexual abuse than children whose parents earned more than $30,000 per year. In contrast to the official CPS statistics reported by the DHHS, only one fourth of children were abused by their birth parents (Sedlak & Broadhurst, 1996).

Although official statistics are very informative, Finkelhor et al. (1990) point out that most sexual abuse is not reported at the time it occurs; in fact, sexual abuse is often never reported. In addition, there is reason to believe that sexual abuse perpetrated by a family member is even less likely to be reported to officials than extrafamilial sexual abuse. Consequently, better sources for an estimate of the prevalence of CSA may be retrospective reports of CSA in non-clinical populations (Berliner & Elliott, 2002). In a review of these studies, a sexual abuse rate of 20%–25% for women and 5%–15% for men was determined (Finkelhor, 1994). This sexual abuse included both intra- and extrafamilial contact sexual abuse. The age range of victimization was from infancy
through 17 years, with a peak age range of 7 to 13 years, and a mean of 9 years. In the general population, parents are the perpetrators 6%–16% of the time, and any relative is the perpetrator in one third of the cases. Strangers account for only 5%–15% of the cases; thus, 85%–95% of the perpetrators are known to the child victim (Finkelhor, 1994). Half of the victims seem to experience multiple episodes of abuse, and 25% experience completed or attempted oral, anal, and/or vaginal intercourse (Saunders et al., 1999).

These self-reported rates of CSA in nonclinical samples are dramatically lower than rates found in clinical samples. People who seek mental health help because of a history of CSA probably have had more severe abuse experiences, and the data confirm that supposition. Participants in clinical samples have identified 25%–33% of sexual abuse perpetrators as parents, and any relative as the perpetrator in half of the cases. Three fourths of the clinical victims experienced multiple episodes of abuse, and in the great majority of the cases, the multiple episodes consisted of completed or attempted oral, anal, and/or vaginal intercourse (Elliott & Briere, 1994; Ruggiero, McLeer, & Dixon, 2000).

In the recent research literature on sexual abuse, more attention is given to girl than to boy victims—possibly because, given the likely social stigma and social mores, boys are less likely to report abuse and less likely to label an abusive sexual experience as such. The reported cases do provide some evidence of differences in sexual abuse experiences, based on the gender of the victim. Boys are more likely to be older when their abuse begins, to have a nonfamily member as the perpetrator, and to have a woman as their perpetrator (Holmes & Slap, 1998).

Predictors and Correlates

Macrosystem

The sexualization of children in the media and elsewhere, the view of children as property, and male entitlement have all been implicated as providing cultural sanctions for the sexual abuse of children (e.g., Russell, 1995), although an empirical link has yet to be established. The availability of child and adult pornography may lead to adult sexual interest in children (Russell, 1995); however, the link between pornography and CSA appears to be indirect (Knudsen, 1988). One study showing this indirect link looked at incarcerated sexual offenders: The offenders who reported experiencing sexual abuse as children and early exposure to pornography displayed less empathy toward abused children and had more child victims (Simons, Wurtele, & Heil, 2002).
Furthermore, although empirical evidence is lacking, the proliferation of child pornography since the introduction of the Internet cannot be helping to end CSA. In fact, the percentage of pornographic images displaying children and adolescents on the Internet seems to be on the rise (Mehta, 2001). A recent national study of law enforcement agencies showed that between July of 2000 and June of 2001, over 1,700 arrests were made in this country for Internet-related possession of child pornography (Wolak, Finkelhor, & Mitchell, 2003).

Microsystem

The majority of research on predictors of CSA has focused on the microsystem level, specifically on problems and dynamics within the family and the specific relationship between the perpetrator and the victim. Possibly the most researched family structure implicated in CSA is the stepfamily. Russell (1986) found that a stepdaughter is seven times more likely to be a victim of CSA than a natal daughter. Similarly, Finkelhor (1984) found that a stepfather was five times more likely to abuse a daughter than a natal father. In addition, girls with stepfathers were more likely to be sexually abused by other men than girls who lived with both natural parents or only their mother. It has been speculated that stepfathers may be more likely to abuse their daughters because they do not have an incest taboo to overcome. However, this leaves some questions unanswered. For example, why would these stepfathers find children sexually attractive? Possible reasons are discussed in the section on individual/developmental predictors.

Relationships with mothers may also play a role in risk for CSA. According to Finkelhor (1984), if a girl ever lived without her natural mother, she is three times more likely to be sexually abused than girls who never lived without their mothers. Moreover, if the mothers are perceived as unavailable (e.g., emotionally distant, often ill, or unaffectionate), girls are also at increased risk (Finkelhor, 1984; Finkelhor et al., 1990). Finally, in families in which both biological parents are present, CSA is most likely to occur if the father is a nondrinker but the mother drinks (Vogeltanz, Wilsnack, Harris, Wilsnack, Wonderlich, & Kristjanson, 1999); the mother’s drinking behavior may lead her to be unavailable to her daughter, which may leave the girl emotionally needy and more vulnerable to the advances of a sexual predator.

In addition to the relationships between the child victim and her parents, other dynamics within the family are also predictive of CSA. Less cohesive families that are disorganized and generally dysfunctional, with perhaps other forms of child maltreatment, are more vulnerable to having a child victimized by sexual abuse (Elliott, 1994; Madonna, VanScoy, & Jones, 1991; Mannarino & Cohen, 1996; Mullen, Martin, Anderson, Romans, & Herbison, 1994). These families may also be subject to much disruption, such
as parental separation, absence, and conflict, and frequent moves (Mullen et al., 1994). Moreover, the parents may be characterized as uncaring, over-controlling, and rejecting (Fleming, Mullen, & Bammer, 1997; McLaughlin et al., 2000; Mullen et al., 1993). These dysfunctional families have been profiled as headed by a young mother who has had many negative life events and an unwanted pregnancy (Brown et al., 1998); the mother may also have mental health problems (Brown et al., 1998; Fleming et al., 1997). Furthermore, the families may lack emotional closeness and flexibility, have problems with communication, and be socially isolated (Dadds et al., 1991).

Much research has been done on the types of incest described in Box 5.1: father-daughter incest. As in the case described here, families with father-daughter incest tend to be characterized by very traditional family values. Now read Box 5.2, a clinical description of the family from Box 5.1. What do you notice about this family? What characteristics do they have that may distinguish them from more functional families?

**Box 5.2  Ann and Marie’s Family**

Ann and Marie’s family did not interact or communicate in a healthy manner, which allowed the father’s sexual abuse of the girls to commence and continue for many years. The family members were overdependent on each other and emotionally enmeshed, such that if something threatened the family’s stability, each person’s survival was at stake. The family was also characterized by an unhealthy marriage and the parentification of the children (i.e., the children were given adult responsibilities). The family members did not want to confront issues that were threatening to family stability; and therefore, their communication was vague and served to placate issues rather than to constructively resolve problems. Therefore, it is not surprising that Ann and Marie stated that they were afraid of reporting their father’s sexual abuse because they feared the family would disintegrate, and they thus also felt an overwhelming sense of responsibility to hold together this dysfunctional family unit. Their mother’s attitudes and behaviors contributed as well: She told the girls that she would fully support them during this time, but also stated that she could not choose her daughters over her husband. In other words, she could not support her daughters over her husband. Ann and Marie subsequently began displaying signs of empathy towards their father.

Consistent with the family described in Boxes 5.1 and 5.2, families characterized by father-daughter incest tend to be patriarchal in structure, with the children subservient to the adults (Alexander & Lupfer, 1987; Wealin, Davies, Shaffer, Jackson, & Love, 2002). The most at-risk situation for a daughter is when her father is well educated and her mother is not (Finkelhor, 1984). Role reversal between the mother and daughter is also characteristic of father-daughter incest families (Ray et al., 1991), probably because there is a lack of intimacy between the parents (Hubbard, 1989) and marital problems or instability (Lang et al., 1990). Examples of some marital problems that incest offenders seem to have include mistrustfulness, lack of mutual friends and time together, low mutual give-and-take in disagreements, tendency to not confide in each other, poor quality of sexual relations, and being lonely within the marriage (Lang et al., 1990). Alcohol problems seem to be characteristic of both parents (Nelson et al., 2002).

As is probably self-evident, in father-daughter incest families, there is role and boundary confusion, affective enmeshment, and poor adaptation and problem-solving skills (Hoagwood & Stewart, 1989). When natal fathers are the abusers, they tend to have been out of the home or infrequently in the home during the daughter’s first three years. If the abusing natal fathers were in the home during those years, they tended to be less involved in caregiving. Possibly because there was no opportunity for early bonding, there was no insulation from sexual desires for the daughter (Parker & Parker, 1986). In addition, sexual problems between the father and his wife may lead him to seek sex from his daughter as a surrogate source of affection (Ganzarain, 1992).

Individual/Developmental

Even though the culture may in some ways sanction CSA through the sexualization of children and child pornography, and even though some families may be characterized by dysfunctions, there are still many questions left unanswered as to why a person would sexually abuse a child, especially his/her own child. Finkelhor (1984) posed four questions that need to be answered in order for CSA to be understood more fully: “1) Why does a person find relating sexually to a child emotionally gratifying and congruent? 2) Why is a person capable of being sexually aroused by a child? 3) Why is a person blocked in efforts to obtain sexual and emotional gratification from more normatively approved sources? 4) Why is a person not deterred by conventional social inhibitions from having sexual relationships with a child?” (p. 17).

These questions need to be answered at the individual/developmental level. Motivations to sexually abuse children are vastly divergent (Ferrara, 2002). Moreover, much research is needed concerning gender preferences among
sexual abusers—that is, why do some pedophiles prefer boys and others prefer girls—and on any differences between male and female sexual abusers. The research that follows has been done solely on male sexual abusers.

In answer to the first question concerning why a person would find relating sexually to a child emotionally gratifying and congruent, it has been shown that incarcerated child sex abusers have higher rates of psychopathology than other incarcerated individuals and that increased psychopathology is associated with increased sexual deviancy (Herkov, Gynther, Thomas, & Myers, 1996). However, incarcerated child sex abusers represent a very small minority of child sex abusers and probably are not representative of the offenders who are never reported or caught; this latter group probably has fewer detectable psychological abnormalities (Finkelhor, 1984).

It has been suggested that child sexual abusers have arrested psychological development, such that they experience themselves emotionally as children and can therefore relate better to children (Groth, Hobson, & Gary, 1982). However, arrested psychological development does not explain why adults would be sexually aroused by a child. In answer to Question 2, it has been shown that there is more childhood sexual victimization in the backgrounds of child molesters than in several comparison groups (e.g., Bard et al., 1983; Langevin et al., 1983), and that the families of child sexual abusers may be characterized by sexual abuse through the generations (New, Stevenson, & Skuse, 1999). This history of childhood sexual abuse is theorized to lead to a sexual interest in children. However, only about 28% of child sexual abusers report being sexually abused as children, and not all sexually abused children will become child sexual abusers; therefore, the relationship between childhood victimization and adult perpetration does not appear to be straightforward (Hanson & Slater, 1988).

Exposure to child pornography, especially when child sex is mixed with adult sex, may also lead to sexual interest in children (Russell, 1982). In partial support of this conjecture, Briere and Runtz (1989) found that masturbation to pornography was predictive of college males’ sexual interests in children. Among those male students, 21% had experienced some sexual attraction to small children; 9% at some time had fantasies about sex with a child; 5% had masturbated during fantasies about sex with a child; and 7% stated it was at least somewhat likely that they would have sex with a child if there was no likelihood of detection or punishment. Along with masturbation to pornography, variables predicting attraction to children included negative early sexual experiences and self-reported likelihood of raping a woman.

Even if there is a relatively high rate of sexual attraction to children, the variables associated with this attraction do not explain why some men act upon it while others do not. In answer to Question 3 as to why some men are unable to get their sexual and emotional needs met in adult relationships, it has
been found that child sex abusers tend to be “timid, unassertive, inadequate, awkward, even moralistic types with poor social skills who have an impossible time developing adult social and sexual relationships” (Finkelhor, 1984, p. 43). It has also been suggested that sexual abusers suffer from narcissistic personality disorder, as they display low self-esteem, lack of empathy for their victims, and self-centeredness (Ganzarain, 1992). In addition to these personality traits, some family-level characteristics, such as marital instability, may contribute to the men’s inability to gain emotional and sexual satisfaction in adult relationships (Finkelhor, 1984).

Finally, even though all of these characteristics may exist, they do not explain why some men overcome the societal taboos against sex with children and/or incest. Several individual-level factors have been found to contribute to this disinhibition, including poor impulse control (e.g., Cohen et al., 2002), multiple major life stressors (e.g., Hermin, 1981), alcohol and drug abuse (e.g., Gordon, 1989), and psychosis (e.g., Marshall & Norgard, 1983). Although poor impulse control and psychosis have been implicated in some cases, alcohol and drug abuse seems to be the disinhibitor in a majority of cases (e.g., Greenfield, 1996).

Consequences

In addition to being correlates of sexual abuse, many of the variables already discussed also mediate the consequences of sexual abuse. Factors such as poverty, family dysfunction, parental psychopathology, and parental alcohol or drug abuse can serve to worsen the consequences of CSA. Other mediating factors that serve to worsen outcomes are longer duration of abuse, greater intensity of abuse, closer relationship to the abuser, greater frequency of abuse, and the use of force (e.g., Elwell & Ephross, 1987; Kendall-Tackett et al., 1993; Ruggiero et al., 2000).

In addition to mediating factors that can make outcomes worse, other factors, such as age and gender, can contribute to the outcome. Abused younger children tend to have more sexual and nonsexual behavior problems than abused older children, who have more internalizing problems (e.g., Ruggiero et al., 2000). Abused boys tend to have more externalizing problems than abused girls (e.g., Holmes & Slap, 1998). Other factors such as attributional style, coping strategies, and level of cognitive functioning have been implicated as mediating factors for outcome (e.g., Mannarino & Cohen, 1996; Shapiro et al., 1992; Spaccarelli, 1994). One of the most important mediators seems to be maternal belief in the child’s disclosure of sexual abuse and her subsequent support of the child (Elliott & Briere, 1994).
This last point brings up a very important question: Why wouldn’t a mother believe her own child’s disclosure of sexual abuse? Several factors appear to have an influence (Sirles & Franke, 1989). In one study, a younger victim was believed more often than an older victim; the more severe the abuse (e.g., intercourse versus fondling), the less likely the mother was to believe the child; if the mother was home during an abusive incident, she was less likely to believe the child; if the perpetrator was a stepfather, only 56% of the mothers believed their children, but if he was a biological father, 86% believed their children; if the abuser was another relative, 92% believed their child’s disclosure; if the child was also physically abused, the child was less likely to be believed; and if the perpetrator abused alcohol, the child was less likely to be believed (Sirles & Franke, 1989). Think about the logic behind these findings: Why might a mother be less likely to believe her child in the above instances? What would be the implications for her existence, family life, and well-being if she were to believe the child? On the other hand, think of the effects on the child: If a child is less likely to be believed when there is physical abuse and alcohol abuse on top of the sexual abuse, what are the implications of this “quadruple whammy” (not being believed, being sexually and physically abused, and living in a home with an alcoholic) on the child’s mental health?

Short-Term Outcomes

The effects of CSA are pervasive; the mental health outcomes can affect almost every aspect of functioning. In the short term, sexual abuse has been found to affect a child’s emotional, behavioral, cognitive, and interpersonal health. For instance, sexually abused children have been found to be more depressed, anxious, suicidal, and aggressive than nonabused children (e.g., Boney-McCoy & Finkelhor, 1995; Hotte & Rafman, 1992; Lanktree et al., 1991). They have lower self-esteem, suffer more often from post-traumatic stress disorder (PTSD), and engage in more sexualized behavior, such as mimicking intercourse, inserting objects into the vagina or anus, or exposing genitals (e.g., Boney-McCoy & Finkelhor, 1995; Friedrich et al., 2001; Wozencraft, Wagner, & Pellegrin, 1991). Cognitively, they achieve less well in school, perceive themselves as different from their peers, blame themselves for negative events, and distrust others (e.g., Mannarino et al., 1994). They are also less socially competent (Mannarino & Cohen, 1996).

Long-Term Outcomes

Usually, children’s symptoms in reaction to sexual abuse improve over time; however, sometimes symptoms do not abate and may actually worsen
into adolescence and adulthood (Kendall-Tackett et al., 1993). Individuals whose symptoms persist are more depressed and suicidal than nonabused adults (Briere & Runtz, 1987; Browne & Finkelhor, 1986). They seem to suffer from more anxiety disorders, including PTSD, than the general population (Saunders et al., 1999; Stein et al., 1988). They also tend to be more violent, angry, self-mutilating, and irritable than their nonabused counterparts (Briere & Gil, 1998; Briere & Runtz, 1987; Duncan & Williams, 1998). In addition, they may suffer from self-blame, low self-esteem, a negative attributional style, low self-efficacy, helplessness, and hopelessness (Jehu, 1988). They may externalize their emotional distress through such activities as self-mutilation (e.g., cutting, burning, hair pulling), heightened sexual activity, bingeing and purging, and alcohol or substance abuse (Briere & Gil, 1998; Briere et al., 1997; Piran et al., 1988). Finally, a history of CSA can greatly affect adult intimate relationships: Sexually abused females are more likely to divorce or never marry; they have fewer friends, are less satisfied with their relationships, and are more interpersonally sensitive than women without a history of abuse (Elliott, 1994; Gold, 1986; Russell, 1986).

Although all these possible consequences of CSA have been observed in adulthood, very few studies consider that many mediating factors, such as other aspects of family functioning, could also be contributing to the negative outcomes. In one study of the consequences of CSA, researchers compared the outcomes of twins who had been sexually abused as children with their co-twins who had not been abused (Nelson et al., 2002). They found that the nonabused co-twins of sexually abused twins functioned more poorly than those twin pairs in which neither twin had been abused, suggesting that many of the family background factors associated with CSA, namely parental alcohol abuse, physical and emotional abuse, and childhood neglect must have contributed to negative outcomes. However, the nonabused co-twins fared better than their abused twins, suggesting that the CSA had an independent effect on the abused twins’ poor outcomes. The outcomes that the sexually abused twins were at an increased risk for included major depression, suicide attempts, conduct disorder, alcohol dependence, nicotine dependence, social anxiety, rape after the age of 18, and divorce (Nelson et al., 2002).

Dissociation

One controversial outcome that has been attributed to CSA is dissociation. **Dissociation** has been defined as the mind’s ability to remove itself from the reality of an abusive situation, and the thoughts, feelings, and memories that go along with the abuse. Although several researchers have found a relationship between CSA and dissociation (e.g., Chu & Dill, 1990; Elliott & Briere,
1992; Zanarini et al., 2000), especially when it is combined with physical abuse (e.g., Mulder et al., 1998), others (e.g., Pope et al. 1998) have argued against the existence of dissociation and do not believe that a person can forget traumatic events. In one recent review of the relevant literature, Joseph (1999) argued that there is significant neurological support for the reality of dissociation as a phenomenon, and that it exists as a possible consequence of CSA. In the review, Joseph presented evidence that memory deficits of emotionally traumatizing events are due to disturbed hippocampal activation and arousal. An emotionally traumatizing event can cause the release of corticosteroids, which suppress neural activity associated with learning and memory and can cause hippocampal atrophy. Because the hippocampus is involved in memory processes, it is possible that emotionally traumatizing events will not be remembered.

There is also anecdotal evidence that memories of CSA can be forgotten but later remembered. Consider the case in Box 5.3 of a woman who, in adulthood, remembered an incident of CSA. What is unique about this case is that the offender admitted to sexually abusing her; in most cases of this type, the offender denies the abuse, and therefore, it is unknown whether the recovered memory of CSA is true or not, as there is also evidence that false memories can be induced in people (see e.g., Loftus & Ketcham, 1994).

**Box 5.3 Can People Forget and Later Remember CSA?**

David A. Hoffman, a former child psychologist . . . pleaded guilty in April [1994] to gross sexual exploitation . . . Hoffman was charged with the crime after a woman remembered being sexually abused during a two-year period, beginning when she was 8 and living in Columbus with her mother . . . The woman is now 26 and lives in Michigan. She had no recollection of the abuse until July 1992, said detective John Harris . . . “She worked in a probation office in Grand Rapids, Mich., typing reports,” Harris said. “Her first memory of the abuse came when she was typing a report regarding a sexual abuse case. Then, whenever she had to type reports involving sexual abuse, she would become very distraught.” . . . The woman sought therapy. She called Harris after her psychologist urged her to file a police report. In 1993 . . . [Hoffman] “admitted committing the molesting offenses,” Harris said.

Several questions arise in regard to this case. One, why would individuals forget such traumatic memories? Two, how do they forget? And three, how do they later remember? In answer to the first question, it has been theorized that children forget incidences of CSA because not remembering abuse by a trusted caregiver is necessary for survival (Freyd, 2002). Children need to preserve their relationships with their caregivers for their security and survival, and to admit that their caregivers are betraying them would lead to a disruption in that relationship and a probable disruption in their security. Indeed, studies show that children are more likely to forget abuse by a trusted caregiver than they are to forget abuse by a stranger (e.g., Williams, 1994). How does the child forget and later remember the CSA? One mechanism through which children forget is the neurological changes in response to traumatic events mentioned previously. Another means is through selective attention—that is, during a CSA experience children can focus their concentration on other events that are occurring simultaneously, such as music playing in the background. Concentrating on the music allows the child to avoid completely processing the traumatic event; however, because some of the event will necessarily be processed, cues—such as the same music playing again in the future—can prompt a child to later remember the CSA (Freyd, 2002). Consider again the case in Box 5.3. How did these factors play into (1) why the woman forgot her abuse; (2) how she forgot; and (3) how she remembered?

Not only is there anecdotal evidence of forgotten episodes of CSA, there is also empirical evidence. In one study, a group of 129 girls originally brought to an emergency room because of sexual abuse were interviewed 17 years later. Among the issues addressed were questions regarding childhood histories of sexual abuse (Williams, 1994, 1995). Of these women, 38% reported no recollections of CSA. An additional 10% more reported periods of forgetting and later remembering the abuse (Williams, 1994, 1995). Thus, close to one half of this group of women, in which there was documented evidence of CSA, had periods of time in which they forgot the CSA. Although women who were younger at the time of the abuse were more likely to forget it, 26% of those who were 11–12 years old, 31% who were 7–10 years old, and 62% who were 4–6 years old at the time of the CSA had no memories of the abuse (Williams, 1994).

Does CSA Really Have Negative Consequences?

Another controversy surrounding the consequences of CSA comes from the contentious article published in 1998 by Rind, Tromovitch, and Bauserman. They argued that (1) the majority of studies on the consequences of CSA are
based on clinical samples, and therefore, the findings cannot be generalized to the population as a whole; (2) there is no evidence of a direct link between CSA and adult psychopathology, nor is there evidence that everyone who experiences sexual abuse as a child will suffer psychologically or socially; and (3) clinical studies suffer from a possible flaw of “effort after meaning.” That is, when people seek clinical help for their current functioning, and search for reasons for their problems, they may pick out an event such as sexual abuse that happened earlier in their lives. To support their criticisms, Rind, Tromovitch, and Bauserman (1998) conducted a meta-analysis of 59 CSA studies done with college students. They found that although students who had a history of CSA functioned less well than those who did not report such a history, the effects were only slight. That is, non-CSA students were only slightly better adjusted than CSA students, and the sexually abused men showed fewer negative reactions to their experience than the sexually abused women.

The Rind et al. (1998) report created a huge public controversy in this country. Their results were lauded by pedophiles, subjected to intense criticism in the media, and condemned by Congress. Defense lawyers have used their results to suggest that the victims of CSA in court proceedings were not harmed by the CSA. Because of this backlash, several researchers (e.g., Dallam et al., 2001, Ondersma et al., 2001) have reassessed the conclusions made by Rind et al. by reanalyzing the data and critically evaluating the original studies used in the analysis. For instance, Ondersma et al. (2001) pointed out that the effect sizes that Rind et al. found for the relationship between CSA and 17 negative outcomes are similar the effect size between smoking and lung cancer, but the smaller effect size between smoking and lung cancer does not lead people to assume that smoking has nothing to do with lung cancer, or to smoke more and more because there are no negative outcomes. This analogy can be taken one step further: Smoking is associated with more than just lung cancer (e.g., emphysema, heart disease, etc.), and not every person who smokes will get lung cancer, but is at risk for one of a whole host of outcomes. Similarly, CSA is associated with not just one particular negative outcome and not every person who is victimized by CSA will suffer from one particular outcome, but is at risk for a whole host of outcomes.

Furthermore, Dallam et al. (2001) pointed out many inherent flaws in the Rind et al. analysis, including: (1) use of inappropriate statistics to detect effects sizes in various analyses, including the association of CSA with outcomes and of gender and CSA with outcomes; (2) misreporting of some key data, such as reporting the percentages of subjects in some studies who said they were negatively affected by CSA as being lower than they really were; (3) lack of inclusion or exclusion criteria for studies to be used in the
meta-analysis—that is, they included studies that varied greatly in their definition of CSA, including one (Landis, 1956) whose definition was experiences with “sexual deviants” at any age (even over the age of 17), another (Sedney & Brooks, 1984) whose definition included any sexual experiences during childhood, and others (Greenwald, 1994; Landis, 1956; Sarbo, 1985) that included sexual experiences that occurred after age 17; (4) exclusion of other relevant outcomes shown to be highly related to CSA but not systematically studied in college students, such as PTSD, antisocial behavior, substance abuse, early and risky peer sexual experiences, and revictimization of sexual abuse in adulthood; and (5) the generalization of the results from studies of college students to the general population, even though college students are a highly functioning group of people, and fewer victims of CSA who have debilitating outcomes would be found among them, as CSA victims tend to suffer from academic difficulties and are less likely to finish high school.

In response to the fifth criticism, Rind and Tromovitch (1994) also published a meta-analysis on seven nationally representative studies of CSA and found the same results—i.e., more dysfunction among CSA victims, but small effect sizes. However, many of the previous criticisms may apply to this meta-analysis, as well. The studies of Rind and associates do raise some important points: (1) differing definitions of CSA can cause problems when conducting research on its causes and consequences; and (2) when conducting research on the causes and consequences, we need to pay special attention to possible mediating variables. There may not be any direct route between CSA and adverse consequences, but CSA can certainly indirectly cause negative outcomes through these mediating factors.

Special Issue: Female Sexual Abuse of Children

Most of the above literature concentrated on one type of CSA: adult male to female child. This type of CSA was the first to come to public attention back in the 1970s and 1980s, when adult females victimized as children started coming forward. Then male victims of CSA also began to talk about their sexual victimization by men, and it seemed that young boys were at almost equal risk as young girls for CSA from adult males (Elliott, 1993). Currently, there is growing attention to another, hidden perpetrator of CSA: that of the female child sexual abuser. Traditionally, it has been assumed that women cannot and would not sexually abuse children. After all, women do not have penises, so how can they sexually abuse someone? Furthermore, female-perpetrated CSA goes against our long-held, cherished views of women as nurturers of children; if females can and do sexually abuse children, it undermines our views of how females relate to children. Finally, female-perpetrated CSA stands in direct
contrast to our traditional explanations for male-perpetrated CSA, those of male power and aggression: If females are also sexual abusers, then male power and aggression do not lie at the heart of CSA (Elliott, 1993).

It has been argued (e.g., Hetherton, 1999) that females, particularly mothers, perpetrate CSA much more than believed, and that they may “hide” their CSA in the guise of maternal caretaking acts, such as bathing and dressing the child; during such acts mothers may fondle the child’s genitals, for instance. Sometimes females’ sexual abuse can become much more severe and overt, as is described in Box 5.4. Acts that have been reported include the insertion of objects into the anus and vagina; the rough handling of boys’ penises in an attempt to get them erect; oral sex and masturbation of the child and forcing the child to reciprocate; forcing the child to watch adults having sex; and bestiality (Longdon, 1993).

**Box 5.4 Female-Perpetrated Child Sexual Abuse**

My father was absent most of the time due to his work. Mother slept with me nearly every night as far back as I can remember. The initial memories of abuse were that of being fondled, which probably began in infancy. By the time I was three years old, Mother was having me touch her as well. Later I was introduced to oral sex. This sort of behaviour occurred almost nightly until I was twelve years of age. This in itself was horrible enough; but by the time I entered school, Mother started torturing me in sexual ways.

The first time I remember being sexually tortured was when Mother took me into a wooded area and fondled me, had oral sex with me, and inserted her fingers into my vagina. I cried and screamed because of the severe pain. This only made Mother angry; so to shut me up and to threaten me, she picked up a large stick and shoved it inside my vagina. This incident taught me the lesson of silence and to turn off feelings of pain.

—Lynne Marie, now 40 years old.


How common is female-perpetrated CSA? The current statistics indicate that over 90% of sexual abusers are male (Jennings, 1993). Two things need to be considered when interpreting these statistics: Before CSA itself became
known as a social problem, it was assumed that one in 1 million children were the victims of CSA. Now that we are able to acknowledge that children can be sexually abused, we know that the numbers are closer to one in five children. Once we acknowledge that women can sexually abuse children, we may see a rise in reports of female-perpetrated CSA (Elliott, 1993). Moreover, if we accept that the current statistics are correct (that one in five children is sexually abused and that of those, 10% are abused by females), then close to 6 million people in the United States today were, are being, or will be sexually abused by females.

Several researchers have tried to address the problem of female-perpetrated CSA by studying mother-son incest cases. In one of the first studies on this issue, the mother-son incest experienced by the eight men studied were typically cases where the mother attempted to satisfy her own emotional and physical needs for intimacy and security (Krug, 1989). She would seek out her son, in many cases when she was in conflict with the adult male in her life; in some cases, she made overt sexual overtures towards her son. Consider the case of mother-son incest in Box 5.5. What types of sexual acts occurred? Would you consider this sexual abuse? Why do you think the mother perpetrated the act? Do you think that the son was complicit and/or wanted the sexual activity? What were the effects on this man’s life?

Box 5.5 A Case of Mother-Son Incest

A 29-year-old, lower middle class white male, named Bob*, who was in a methadone maintenance program, entered psychotherapy because of symptoms of depression which were not related to the methadone treatment. During treatment, Bob revealed incidents of sexual abuse by his mother, who was on the faculty of a prestigious university, had divorced his father when he was two years old, and never remarried. During his childhood, Bob served as both his mother’s confidant and her advisor, and from the time of the divorce until Bob was in his mid-teens, Bob’s mother continually slept with him. Starting when Bob was seven years old, his mother insisted that they have intimate sexual contact, which on some occasions included sexual intercourse. At 10 years of age, Bob started using recreational drugs, and by age 15, he began using heroin. At age 18, Bob married and left home, but the marriage lasted only three years, as both Bob and his wife were heavy drug users.


NOTE: *This name has been fabricated to facilitate the telling of the story.
Krug (1989) found that the eight men in his study suffered many problems in adulthood that could be related to their mother-son incest experiences. Specifically, most were anxious, depressed, had extra-relationship sexual contacts, and abused substances. Kelly et al. (2002) reported similar symptoms in their clinical study of 17 cases of mother-son incest. They found that men who were abused by their mothers experienced more adjustment problems than men whose perpetrators were not their mothers, even though the abuse experiences were somewhat subtle (e.g., genital fondling) and possibly difficult to distinguish from normal caregiving.

The mother-son incest victims in the Kelly et al. (2002) study experienced more sexual problems, dissociation, aggression, and interpersonal problems than the father-son incest victims. Moreover, these problems were mediated by their initial perceptions of abuse: If they initially perceived the sexual abuse as nonabusive, they were more likely to report more PTSD symptoms and aggression. If they had any positive feelings about the abuse at the time it occurred, they were more likely to suffer from later aggression and self-destructiveness. Why is it that these positive feelings might be associated with more maladjustment? Might it be that experiencing an incest experience as somewhat pleasurable might lead to a later strong reaction of shame, guilt, and disgust? Is it possible that the victims may not understand how they could experience something so wrong as remotely pleasurable, and therefore might perceive themselves as being even more deviant for having these feelings? As an example of such a dynamic, consider this victim of mother-son incest:

One male survivor described feeling that his most intense orgasm occurred at age 13 while having intercourse with his mother, who immediately ridiculed and verbally abused him after he ejaculated. He recalled running into the bathroom and scrubbing his genitals in a manic attempt to wash away the incest. He then cried and vomited when he realized he could not wash it away. In therapy, he stated that the abuse would have been less harmful if he had not experienced pleasure, because “I am now associated with something that is disgusting that I liked. I have incest tendencies. I am a part of the incest. I am as screwed up as my mother. I am as tainted, I am as damaged, I am as dirty as she is... The incest has cheapened and dirtied my manhood.” (Kelly et al., 2002, p. 437)

Consider this case further. What role do you think the mother’s ridicule and verbal abuse played in his response to the experience? Why would the mother ridicule and verbally abuse him under the circumstances?

Several researchers and victims argue that female-perpetrated CSA may be more harmful than male-perpetrated CSA (e.g., Elliott, 1993), although there is as yet no empirical support for this proposition. One basis for this argument is that the experiences of survivors of female-perpetrated CSA are often silenced. Consider this victim’s story:
My mother and grandmother sexually abused me from the time I was four. I hated going home and spent most of my time figuring out how to get out of the house . . . I begged my aunt to let me live with her. In my life I have taken most drugs, been alcoholic, had a nervous breakdown and have never had a happy relationship with a man or woman. Yet, I have managed to hide the real reason from everyone. I felt that I must be a complete freak of nature for this abuse to have happened to me. No one is sexually abused by a woman. I must be crazy. (Elliott, 1993, p. 1)

In addition, if survivors of female-perpetrated CSA do speak out, they may not be believed, even by their own therapists. In fact, one study showed that 78% of the victims of female-perpetrated CSA are not believed when they disclose their abuse experiences (Elliott, 1993). To receive help, many of these victims, both male and female, fabricate their abuse experiences and say that the abuser was male (Longdon, 1993). Therefore, the consequences of the CSA in and of itself are compounded by the fact that no one takes their abuse experiences seriously (Longdon, 1993). Consider how these victims’ experiences influence our current estimated rates of female-perpetrated CSA. In what way would our estimates be affected? Finally, some survivors report that female-perpetrated CSA is worse than male-perpetrated CSA because it goes against the stereotype of what a mother is supposed to be. Survivors of female-perpetrated CSA experience the same possible consequences as discussed in the previous section of this chapter. Although there are no systematic studies, it has been documented that victims of female-perpetrated CSA have suffered from substance and alcohol abuse, suicide attempts, gender identity problems, difficulties in maintaining relationships, unresolved anger, shame, guilt, self-mutilation, eating disorders, depression, and agoraphobia (Elliott, 1993).

Why would females abuse children? Although systematic studies are rare, a few studies give some indication as to the dynamics of female-perpetrated CSA. First, female perpetrators are much more likely than male perpetrators to act in concert with another person, and many times the female is acting in order to please her “partner in crime.” However, many females do act alone. Females tend to use violence less frequently than male perpetrators, and instead resort to coercion. Females are more likely than males to know their victims, and they tend to have fewer victims than males. It appears that, like male perpetrators, females abuse girls more often than they abuse boys. However, this last finding may be merely a result of reporting bias—that is, because of certain social mores, males are less likely to report any type of abusive experience, and this tendency may be compounded when the abuser is female (Jennings, 1993).
There is an association between a past history of sexual abuse and females’ current offending and between substance abuse and current offending. Moreover, female sexual abusers seem to be particularly dependent on men’s attention for their self-esteem and their survival (Jennings, 1993). However, none of these traits fully describes every female sexual abuser, and some researchers have attempted to create typologies of abusers. One particularly interesting typology was created by Matthews (1993) from her experiences as a therapist to female sexual abusers. She postulates that there are three types of female sexual abusers: (1) the teacher/lover offender, who sees her victim as her partner and believes that the experience is a positive one for both of them; this type of abuser tends to be psychologically a child herself, but responds very well to therapy; (2) the predisposed offender, who generally has a history of being sexually abused herself; these women act alone in their abuse and generally abuse family members; they have very deviant sexual fantasies and have problems with self-destructive and suicidal behaviors because they hate themselves and believe they were born evil; these women are often very hard to treat; and (3) the male-coerced offender, who is coerced into abusing children by her male partner(s); these women are often passive and powerless in their relationships, and fear violence and abandonment if they do not participate in the abuse; they do not feel loved or lovable, and stay in these relationships in order to avoid being alone; many times and for whatever reason, they will initiate the sexual abuse of children themselves, though. Through her work with treating female sexual abusers, Matthews (1993) has found that the best interventions occur when long-term treatment is combined with short-term incarceration.

Prevention and Intervention

As you may have discerned from this discussion of CSA, many of the victims and perpetrators appear in great need of some sort of therapeutic intervention. Some workers in the field (e.g., Cohen & Mannarino, 2000) believe that the entire family of incest victims should undergo therapy. Most programs for intervention combine several, if not all, of the following elements: group therapy for the perpetrator; group therapy for the spouse of the perpetrator; group therapy for the child victim; dyadic therapy for the nonabusing parent and the victim; individual therapy for the victim; and eventual family therapy for the perpetrator, victim, nonabusing spouse, and any siblings. However, if the perpetrator is unwilling to admit to the abuse and/or if the nonabusing parent is unwilling to adequately protect the children from the perpetrator,
families will not qualify for these programs. Unfortunately, this is the problem for the majority of sexual abuse cases (Cohen & Mannarino, 2000). The most empirically validated individual treatment program for children who are victims of CSA is abuse-specific cognitive behavioral therapy, which involves psychoeducation (educating the child about sexual abuse and the therapy procedure); anxiety management (how to use relaxation and cognitive and emotional strategies to reduce anxiety-provoking thoughts about the abuse); exposure (talking, drawing, and writing about the abuse experience to reduce negative emotions and avoidance); and cognitive therapy (challenging cognitive distortions about the event and the consequent negative thoughts about the self and others) (Cohen, Berliner, & Mannarino, 2000).

Although treating the victims of CSA is necessary, a more effective approach to ending the suffering associated with it would be to prevent it from happening in the first place. All states, as mentioned previously, have laws against CSA; however, these laws are obviously not enough to deter potential perpetrators. The most widely used, and most controversial, CSA prevention programs in this country are programs that target children. These programs all tend to have the following goals: “educating children about what sexual abuse is; broadening their awareness of possible abusers to include people they know and like; teaching that each child has the right to control access to his or her body; describing a variety of ‘touches’ that a child can experience; stressing actions that a child can take in a potentially abusive situation, such as saying no or running away; teaching that some secrets should not be kept and that a child is never at fault for sexual abuse; and stressing that the child should tell a trusted adult if touched in an inappropriate manner until something is done to protect the child” (Reppucci & Haugaard, 1993, p. 312).

The controversy surrounding these programs stems from the fact that they were modeled on sexual assault programs for women, which sought to empower women by educating them about sexual assault and how to protect themselves in the event of an assault (Berrick & Gilbert, 1991). Therefore, these programs try to empower elementary school students by educating them about what sexual abuse is and ways in which they can ward off an assault (Reppucci & Haugaard, 1993). The problem is this: Are all children developmentally mature enough to understand the distinctions of “good” versus “bad” touches and by whom and when can they be touched in private places? To give an example, can a four-year-old understand the following: “A good touch is when someone close to you gives you a hug. A bad touch is when someone touches you in a private place. Someone close to you can touch you in a private place and it may not be bad, such as when they are touching you there to clean you. However, someone close to you
can touch you in a private place and it can be bad even if it is in the context of bathing.”

If we find that some children, particularly older ones, are capable of understanding the intricacies of sexual abuse, as some (but not all) have been shown to be, should we then also be giving them the responsibility of protecting themselves? This seems to be the major question here. What are some of the implications of placing this responsibility on children? Is it possible that if they do subsequently become the victims of sexual abuse, the normal self-blame reaction that tends to follow an abusive experience may be compounded by their perception that they were supposed to have protected themselves? Can you think of ways to improve programs designed to help children protect themselves without giving them developmentally inappropriate responsibilities?

In response to such criticisms about typical prevention programs, Plummer (1993) countered that such programs have had some positive influence on the prevention of CSA. According to Plummer, millions of people, including adults, have become educated as to the extent and nature of the CSA problem, and children are now more willing to come forth and disclose sexual abuse that occurred to them. These certainly are positive results, but do not resolve the problem of putting the responsibility of protection solely on the child. As Finkelhor and Strapko (1992) recommended, we should call these programs disclosure programs instead of prevention programs. Furthermore, as both sides (Plummer, 1993; Reppucci & Haugaard, 1993) emphasize, parents should be brought into these programs as the primary protectors of their children; unfortunately, as research has shown, parents do not attend such programs, nor do they learn very much about the prevalence, indicators, or appropriate responses to CSA when they do attend (Berrick, 1988).

Summary

Child sexual abuse by caregivers is a major problem in this country; however, its exact rate is difficult to ascertain, as the research is plagued with controversy as to which acts should be considered abusive. Our best estimates suggest that as many as one fourth of women and one fifth of men may have experienced sexual abuse as a child. Predictors of CSA come at most levels of the ecological model, but it is factors at the individual/developmental level that may be most important in figuring out why adults would find sexual gratification in children, particularly children who are related to them. CSA can have devastating consequences to its victims, both in the short and long
term, and these victims (as well as their perpetrators and their families) are in need of psychological help. Most of the research and resources have focused on father-daughter incest; however, current research shows that mothers can sexually abuse their children, too, at a rate that is probably much higher than we expect. Future research should be directed towards not only males-as-perpetrators, but females-as-perpetrators as well. Consider again the case of Scott that opened this chapter. He was sexually abused by many members of his family, including both his mother and father. Do you think that each of his parents had different reasons for sexually abusing him? What were those reasons? What were the consequences for Scott?