

The impacts of child sexual abuse: A rapid evidence assessment

Summary report

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Disclaimer

This research report has been prepared at the request of IICSA's Chair and Panel.
The views expressed are those of the authors alone.

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Background

The aim of the Independent Inquiry into Child Sexual Abuse (IICSA or ‘the Inquiry’) is to investigate whether public bodies and other non-state institutions have taken seriously their responsibility to protect children from sexual abuse in England and Wales, and to make meaningful recommendations for change, to help ensure that children now and in the future are better protected from sexual abuse. Child sexual abuse (CSA) involves forcing or enticing a child or young person under the age of 18 to take part in sexual activities. It includes contact and non-contact abuse, child sexual exploitation (CSE) and grooming a child in preparation for abuse.

As part of its work, the Inquiry is seeking to examine the impacts of child sexual abuse on the lives of victims and survivors and their families, as well as the impacts on wider society. These questions are of cross-cutting relevance to the work of the Inquiry. They have particular salience for its ‘Accountability and Reparations’ investigation, which is exploring the extent to which existing support services and legal processes effectively deliver accountability and reparation to victims and survivors.

This rapid evidence assessment (REA) had two overarching aims:

- to summarise the existing evidence base for the impacts of CSA on:
 - victims and survivors throughout their life course
 - the families of victims and survivors
 - wider society
- to identify gaps in the evidence base on the above issues which could be filled by further primary research

This REA has been prepared by the Inquiry Research Team for consideration by the Inquiry Chair and Panel. The resulting report will also be of relevance and interest to policy makers, practitioners and other researchers working in the field of CSA. The views expressed are those of the authors alone.

Method

An REA method was used to identify and synthesise existing evidence relating to the two overarching issues set out above. Following a pilot phase, searches were conducted of peer-reviewed journal databases and sources of grey literature, using an agreed set of search terms and inclusion criteria. The searches took place during December 2016. The resulting literature was prioritised, and over 200 of the most relevant and robust studies were subsequently coded, analysed and synthesised for this report. Their methodological rigour was measured using a quality assessment (QA) tool. The outcome of this process informed the relative weight that each study was given in the final report. Additional studies are referred to in several places to provide further context.

Limitations of the evidence base

Before considering the research findings from this REA, it is important to note that, in practice, it is very challenging to determine clearly whether an outcome has actually been **caused** by CSA, either directly or indirectly, or whether instead it is **linked to it** in some other way. There are also limitations concerning the way in which some of the current evidence was generated, which means that some study findings cannot be confidently generalised to the wider victim and survivor population. As a result, much of the evidence reviewed in this REA can only indicate a possible link or association between CSA and a specific life outcome or medical condition; it cannot indicate that CSA caused the outcome under consideration.

Research findings

1. Impacts of CSA on victims and survivors

The research reviewed as part of this REA shows that being a victim and survivor of CSA is associated with an increased risk of adverse outcomes in all areas of victims and survivors' lives. Additionally, long-term longitudinal research suggests that – in many cases – these adverse outcomes are not just experienced over the short and medium term following abuse, but instead can endure over a victim and survivor's lifetime.¹

In the words of victims and survivors, taken from one of the qualitative studies included in this review:

“What he did to me affected my whole life, every relationship, my personal identity and the general trajectory of my life's path. Childhood sexual abuse manifested in all aspects of my life.”²

“The effects of what happened have stayed with me, un-dealt with and unprocessed, throughout my life. The damage from my early years has coloured everything else at all stages of my life. I know it sounds dramatic but I'm just telling it like it is.”³

The outcomes which emerged from the studies reviewed can be grouped into seven areas, as shown in Figure 1 below.

Figure 1: CSA victim and survivor outcome areas with example outcomes

Physical health	Emotional wellbeing, mental health and internalising behaviours	Externalising behaviours	Interpersonal relationships	Socio-economic	Religious and spiritual belief	Vulnerability to revictimisation
<ul style="list-style-type: none"> Physical injuries High BMI Problems related to childbirth Unexplained medical problems 	<ul style="list-style-type: none"> Emotional distress Trauma/PTSD Anxiety Depression 	<ul style="list-style-type: none"> Substance misuse 'Risky' and inappropriate sexual behaviours Offending 	<ul style="list-style-type: none"> Reduced relationship satisfaction and stability Issues with intimacy and parent-child relationships 	<ul style="list-style-type: none"> Lower educational attainment Higher unemployment Financial instability Homelessness 	<ul style="list-style-type: none"> Disillusionment with religion Faith as a coping mechanism 	<ul style="list-style-type: none"> Sexual revictimisation in childhood and adulthood Other types of victimisation

The way in which the outcomes or impacts in each of these areas emerge and subsequently play out in the lives of victims and survivors constitutes a complex and dynamic process. The outcomes in these areas have been shown to interact with, cause, compound or (in some cases) help to mitigate outcomes in other areas. Outcomes can occur, or recur, at any stage of the victim and survivor's life course.

Simply because victims and survivors are not experiencing a particular outcome at one point in their lives does not mean they will not experience it at a later stage.

Victims and survivors are not a homogeneous group, and as a result the nature and extent of the consequences of CSA can differ significantly between groups of victims and survivors – and indeed between individual victims and survivors. Indeed, the evidence suggests that it is not inevitable that a victim and survivor will experience significant long-term harm as a result of CSA. Some victims and survivors are said to display resilience or to achieve recovery following CSA if they either appear to experience no major adverse consequences, or else find their way back to ‘adaptive’ or ‘positive’ functioning after a period of difficulty (which might last several years or even decades). Some studies suggest that a minority of victims and survivors even appear to display post-traumatic growth or positive adaptation following CSA victimisation.

The outcomes experienced by victims and survivors across these seven areas are explored in more depth below.

Physical health

Experiencing CSA has been associated with a wide range of adverse physical health outcomes. Acute physical injuries to the genital area can result from penetrative abuse, as can sexually transmitted infections.⁴ In the longer term, CSA has been linked to a range of illnesses and disabilities: in one study, one CSA victim and survivor in four reported a long-standing illness or disability, compared with one in five of the general population.⁵

Physical health outcomes include increased body mass index (BMI),⁶ heart problems⁷ and issues surrounding childbirth.⁸ Research suggests that people with a history of CSA have a greater number of doctor and hospital contacts – 20 per cent higher than those who have not experienced CSA⁹ – which can be an indicator of poor physical health. Some victims and survivors report ‘medically unexplained’ symptoms, which can include non-epileptic seizures¹⁰ and chronic pain.¹¹

Emotional wellbeing, mental health and internalising behaviours

The experience of CSA can have a detrimental effect on general emotional wellbeing, leading to low self-esteem and loss of confidence.¹² Mental health outcomes/internalising behaviours include depression, anxiety disorders, post-traumatic stress disorder (PTSD), self-harm and suicide, as well as a range of other mental health conditions.¹³

Depression has been found in 57 per cent of young people who have experienced CSE.¹⁴ The increased likelihood of major depression following a history of CSA has been shown to be 2.05¹⁵ in young adults and 1.83¹⁶ in women victims and survivors, relative to comparison groups. Among victims and survivors of CSE, 37 per cent had generalised anxiety disorder, 58 per cent had separation anxiety disorder, and 73 per cent had PTSD.¹⁷ Rates of self-harm have been shown to be as high as 49 per cent among adult survivors in treatment¹⁸ and 32 per cent among victims and survivors of CSE.¹⁹ The risk of CSA victims and survivors attempting suicide can be as much as six times greater than in the general population.²⁰

There are some gender differences noted in the prevalence of mental health conditions. In particular, it has been argued that females are more likely to demonstrate internalising behaviours and males are more likely to demonstrate externalising behaviours.²¹ The quality of interpersonal relationships has been shown to be instrumental in mitigating or compounding the impacts of CSA on mental health conditions.²²

Externalising behaviours

Victims and survivors of CSA may exhibit a range of externalising behaviours in response to the abuse they have experienced. These are often maladaptive coping strategies, adopted as a way of dealing with or gaining temporary relief from the distress of the abuse, including distress caused by other outcomes (such as mental health problems).²³

Behaviours exhibited following CSA can vary depending on the age and gender of the victim and survivor.²⁴ However, limited evidence was found on younger children's behaviour; most research has focused on behaviour in adolescence and adulthood, often illustrating how behaviours in adolescence can persist into adulthood.²⁵

Research suggests that CSA is associated with an increased risk of externalising behaviours, including substance misuse, inappropriate or 'risky' sexual behaviours, anti-social behaviour and offending.²⁶ Additionally, one study found that young victims and survivors are up to 12 times more likely than comparison groups to report conduct disorder.²⁷

Victims and survivors have been found to be 1.4 times more likely to have contact with the police, and almost five times more likely to be charged with a criminal offence, than those who have not experienced CSA.²⁸

Externalising behaviours can serve as an indicator of CSA, and as a means of communicating that something is wrong and signalling a need for help.²⁹ Supportive family relationships and increased levels of education among victims and survivors have been found to reduce the risk of these maladaptive behaviours.³⁰

Interpersonal relationships

CSA can have a profound effect on victims and survivors' ability to form and/or maintain positive relationships. Only 17 per cent of CSA survivors are said to have a secure attachment style,³¹ important for forming strong emotional connections, behaviours and interactions between people.

One of the most prominent themes to emerge in this section relates to the impacts of CSA on intimate relationships. Victims and survivors are at increased risk of experiencing issues such as poor relationship stability, interpersonal violence and sexual dysfunction.³² Health and behavioural impacts can also negatively affect intimate relationships.³³

In relation to parent-child relationships, the evidence suggests that having children can have a positive influence on victims and survivors and can even help to aid recovery.³⁴ However, the role of parenthood can also activate a range of emotions and initiate particular parenting practices which can ultimately harm the parent-child relationship. Negative parenting outcomes can also manifest as a result of victims and survivors' internal lack of belief or confidence in their own parenting capability.³⁵ These can be compounded if individuals also suffer from depression.³⁶

A clear gender bias can be observed in the literature relating to interpersonal – and particularly parent-child – relationships. For example, studies looking at the risks associated with 'negative' parenting practices of CSA victims and survivors tend to focus on mothers.³⁷

Socioeconomic outcomes

There is evidence of an enduring association between CSA and reduced life chances that begins during the school years and extends well into adulthood, affecting victims and survivors' educational attainment, employment rates and income levels.

CSA has been associated with an overall reduction in educational engagement and attainment at school and in higher/further education.³⁸ In some individual cases, however, it has also been linked to increased attainment.³⁹ In these cases, educational engagement appears to function as a coping strategy for dealing with – or escaping mentally and physically from – the abuse.

CSA has also been associated with increased unemployment/time out of the labour market,⁴⁰ increased receipt of welfare benefits,⁴¹ reduced incomes⁴² and greater financial instability.⁴³ The evidence suggests that poor physical or mental health could be the link between CSA and lower socioeconomic outcomes in many cases.⁴⁴ As with education, it is important to recognise that some victims and survivors use work and career achievement, or 'overwork', as a means of coping with the after-effects of abuse, including psychological impacts such as low self-esteem.⁴⁵

Recent studies which have explored the links between CSA and homelessness are limited in quantity and quality. Those that do exist point to possible links between CSA victimisation and homelessness/housing issues during both youth⁴⁶ and adulthood,⁴⁷ suggesting that this issue warrants further research.

Religious and spiritual belief

The evidence suggests that feelings of disillusionment with religion and spiritual belief are common among victims and survivors following CSA, with victims reporting feeling abandoned or punished by a cruel god.⁴⁸

Studies on the impacts of CSA perpetrated by church clergy talk in particularly strong terms about the "spiritual devastation" and "deep spiritual confusion" which can result when the abuse is perpetrated by someone who is a representative of God in the eyes of the victim – an experience which can cause victims and survivors to question their entire belief systems and ways of understanding the world.⁴⁹ The literature suggests that these impacts can be compounded by church responses, which minimise or deny the CSA, or require victims and survivors to forgive the perpetrators of the abuse.⁵⁰

To a lesser extent, the role of faith as a coping mechanism and protective factor for resilience and recovery also emerged from the studies reviewed.⁵¹

Vulnerability to revictimisation

The evidence shows that victims and survivors of CSA can be vulnerable to subsequent revictimisation, and may be two to four times more likely to be revictimised compared with the likelihood of those who have not experienced CSA becoming victims for the first time.⁵² Health and behavioural outcomes of CSA have been found to increase victims and survivors' vulnerability to revictimisation (for example, PTSD and feelings of self-blame).⁵³

Revictimisation can take a range of forms and is not limited to sexual victimisation. For example, victims and survivors of CSA have been found to be twice as likely as those without experience of CSA to be physically abused during adolescence or early adulthood.⁵⁴

The research suggests a complex relationship between initial and subsequent victimisation, and some research suggests that the revictimisation of CSA victims and survivors should be understood as a perpetuating condition, rather than in terms of isolated or episodic incidents.⁵⁵

Outcomes by life stage and gender

While the studies reviewed suggest that there is significant variation in outcomes and impacts at both the sub-group and the individual victim and survivor level, it is challenging to draw conclusions from the current evidence base about how these outcomes differ by demographic and other characteristics. The research findings reviewed only enable tentative conclusions to be drawn about differences according to victim and survivor life stage and gender.

Following a developmental approach, the evidence suggests that certain outcomes are only relevant for – or may emerge during – particular life stages. For example, physical injuries resulting from CSA,⁵⁶ early onset of puberty,⁵⁷ conduct disorders,⁵⁸ sexually inappropriate behaviours⁵⁹ and low educational attainment⁶⁰ are more salient for victims and survivors during childhood and adolescence, while longer-term chronic physical health conditions,⁶¹ challenges in relation to emotional and sexual intimacy and interpersonal relationships,⁶² and employment issues⁶³ tend to affect victims and survivors in adulthood. Various outcomes, such as mental health conditions, including PTSD and anxiety⁶⁴ and an increased vulnerability to sexual revictimisation,⁶⁵ have been found to cut across life stages.

Where evidence of an association between CSA and an outcome at a particular life stage is lacking, it is not necessarily proof that an individual is not at increased risk of that outcome during the life stage in question. Instead, studies exploring this issue may simply not yet have been undertaken.

Differences in outcomes by victim and survivor gender can also be identified in the research reviewed, although in some cases study findings are contradictory, and the lack of specific evidence on male victims and survivors makes it hard to draw robust conclusions. Outcomes that the evidence suggests differ along gender lines include those relating to mental health conditions,⁶⁶ internalising and externalising behaviours,⁶⁷ offending,⁶⁸ intimate relationships and sexuality,⁶⁹ and pregnancy and childbirth.⁷⁰

Resilience and recovery: risk and protective factors and triggers

The concepts of resilience and recovery are used to describe how victims and survivors can maintain or recover a healthy level of functioning following CSA.⁷¹ Resilient individuals are said to sustain relatively healthy levels of functioning after exposure to a potentially traumatic event. Recovery, on the other hand, is characterised by a significant decline in wellbeing in the immediate aftermath of the traumatic events; this decline may last several months, years or even decades. Subsequently, there is a gradual improvement in functioning and a reduction in symptoms, until the individual achieves a level of functioning and wellbeing which is more or less equivalent to that which they experienced before the trauma. Both resilience and recovery are thought to be dynamic rather than static states, and to be influenced by an individual's interaction with the social environment.⁷²

A number of risk/protective factors have been identified which may increase or reduce the likelihood of a victim and survivor experiencing resilience or recovery following CSA. Risk and protective factors include:

- characteristics of the individual victim and survivor (for example, emotions, beliefs and attitudes)⁷³
- circumstances of the abuse (for example, identity of the perpetrator, age at onset)⁷⁴
- the victim and survivor's interpersonal relationships and immediate environment (for example, attitudes of caregivers,⁷⁵ partners and peers;⁷⁶ experiences of parenthood⁷⁷)
- the victim and survivor's wider social and environmental context (for example, experiences of disclosure to professionals,⁷⁸ experiences of other services, such as education⁷⁹ and healthcare⁸⁰)

In addition to these longer-term risk and protective factors, certain shorter-term situations, events or sensations can (re)trigger the trauma associated with the CSA for victims and survivors. These situations can cause distressing emotions and traumatic memories to resurface, and can lead to victims and survivors feeling as though they are back in the abusive situation, thereby disrupting resilience and recovery.⁸¹

Common features of triggering situations identified in the literature include:

- physical or sexual contact
- feeling powerless or vulnerable
- having to talk about or recount abusive experiences
- sights, sounds or smells which remind victims and survivors of the CSA

Specific triggering situations include medical and dental examinations⁸²; childbirth⁸³; coming into contact with the perpetrator following abuse⁸⁴; therapy⁸⁵; sexual activity⁸⁶; going through legal proceedings relating to the CSA⁸⁷; their own child experiencing CSA⁸⁸; and needing to seek emotional support.⁸⁹

In particular, the experience of childbirth has been found to be deeply traumatic for some female victims and survivors.⁹⁰ While they are at increased risk of dissociation and perinatal mental health issues, sensitive and caring practice by medical professionals can help to reduce the risks of these outcomes occurring.⁹¹

The role of wider society

The response of society to victims and survivors of CSA can impact on their resilience and recovery in a variety of ways, for example by maximising protective factors or (re)triggering traumatic experiences. Although this review was not designed to produce an exhaustive list, it has identified a number of ways in which society might be helping or hindering resilience and recovery within this group.

Unsupportive responses by caregivers or professionals to a disclosure of CSA may exacerbate victims and survivors' feelings of guilt and shame, and may deter them from seeking support in the future.⁹² Supportive responses to disclosure,⁹³ and supportive relationships,⁹⁴ have been found to be significant factors in promoting recovery.

The research suggests that specialist support services following CSA are likely to be most effective if they are tailored to the needs of particular sub-groups of victims and survivors,⁹⁵ and are based on an assessment of the individual's needs.⁹⁶ Studies have found that the availability of specialist services for children and young people falls short of the demand.⁹⁷ Inappropriate responses by services can compound the impacts of CSA and place victims and survivors at greater risk.⁹⁸

Wider services including health,⁹⁹ social services and the criminal justice system,¹⁰⁰ and domestic violence and substance misuse services,¹⁰¹ can support patients or service users with a history of CSA by delivering sensitive practice that accommodates individuals' needs and avoids triggering trauma.

Participation in the criminal justice process can be a risk factor for experiencing harm following CSA,¹⁰² although sensitive practice by professionals can help to mitigate these impacts.¹⁰³ Fear of blame and retraumatisation can discourage victims and survivors from seeking accountability and reparations for CSA.¹⁰⁴ There has been a recent international trend towards legislative and policy changes that aim to improve victims and survivors' access to justice.¹⁰⁵

2. Impacts of CSA on the families of victims and survivors

Evidence shows that CSA does not just impact on the lives of victims and survivors, but can also have adverse effects on their families.¹⁰⁶ The impacts experienced by non-offending parents – and, in particular, mothers – as a result of their children’s CSA victimisation can mirror those outcomes experienced by victims and survivors.¹⁰⁷ CSA can affect all aspects of parents’ lives, including areas like physical health, personal relationships, employment and financial stability, over the medium to long term.¹⁰⁸ Rates of trauma (in this case in the form of ‘secondary’ or ‘vicarious’ trauma) and emotional distress were found to be high among non-offending parents.¹⁰⁹

Parents can find it challenging to support a child who has been victimised at a time when they themselves might be struggling to cope with the emotional and practical strain following CSA. This can create a vicious circle in which the support that parents are able to provide to their child is compromised, thereby reducing the child’s chances of experiencing resilience or recovery.¹¹⁰

Minimal evidence was found on the impacts of CSA on siblings and partners of victims and survivors, although what was found suggested that CSA can also have detrimental impacts on these groups.¹¹¹ In particular, non-abusing siblings of child victims of CSA have been found to experience mental health/internalising behaviours and externalising behaviours similar to those experienced by victims and survivors, including depression and anxiety. They have also been found to suffer the impacts of family upheaval, stress and breakdown following the discovery of CSA.¹¹²

3. Impacts of CSA on wider society

Research shows that CSA can also impact on wider society, through the increased uptake or usage of public services both by victims and survivors and by perpetrators. These public services include the criminal justice system, healthcare system, social services, welfare benefits system and special educational provision.¹¹³

A study by the National Society for the Prevention of Cruelty to Children (NSPCC) calculated that CSA costs the UK around £3 billion a year (2012/13 prices).¹¹⁴ Of this total estimated cost, by far the greatest part – around £2.7 billion – was linked to lost labour market productivity due to higher unemployment and lower incomes among victims and survivors. The remainder of this total – around £424 million – was primarily made up of costs to the public purse resulting from the provision of health, criminal justice and child social services.

The NSPCC also attempted to monetise the human and emotional costs of CSA to victims and survivors.¹¹⁵ They estimated that the human and emotional costs experienced by victims and survivors in the UK amounts to around £38 billion annually (2012/13 prices). Although it is debatable whether any methodology can meaningfully put a price on human pain and suffering, this figure is useful for emphasising how substantial the impacts of CSA are at both a personal and a societal level.

Evidence suggests that additional impacts on wider society include changes in perceptions of institutions in which CSA has occurred among certain groups,¹¹⁶ and emotional distress experienced by children who accidentally view indecent images of other children online.¹¹⁷

Conclusions and evidence gaps

While further research would be valuable in specific areas, overall the evidence is compelling that CSA is associated with an increased risk of adverse outcomes in almost every sphere of victims and survivors' lives, and that this risk can persist across their lifespan. This harm also has knock-on impacts for family members of the victims and survivors, and for wider society in both financial and less tangible ways. It is apparent from the evidence reviewed, however, that sustained adverse outcomes are not inevitable. Both resilience and recovery are possible for victims and survivors, and a number of protective factors have been identified which increase their likelihood. These include the receipt of effective support services and a positive and sensitive response from family, friends and professionals following disclosure of CSA.

In spite of the extent of the available evidence on this issue, this review has nonetheless identified a wide range of gaps in knowledge about the impacts of CSA, the way in which those impacts differ for various groups of victims and survivors, and the risk and protective factors which can impede or promote resilience and recovery.

In the view of the authors of this review, and in relation to the research questions stated in Chapter 1, the key evidence gaps include:

Impacts of CSA

- the impacts of CSA on younger (pre-adolescent) and older (65 plus) victims and survivors, as well as on black and minority ethnic (BME), lesbian, gay, bisexual and transgender (LGBT) and disabled people
- the impacts of CSA on male victims and survivors, and on the non-abusing fathers of victims and survivors
- the impacts of CSA on siblings, partners and children of victims and survivors
- the impacts of online-facilitated CSA, particularly cases involving online grooming, the live streaming of abuse, and the creation and distribution of indecent images online
- any differences in the impacts of institutional CSA and/or CSA in which there has been an institutional failing, compared with CSA in which institutional failings are not involved
- any differences in impacts following CSA perpetrated by peers ('peer abuse') compared with that perpetrated by adults
- victim and survivor trajectories requiring longitudinal research, which follows victims and survivors over the long term and collects data on their circumstances and outcomes at key points in their life course

Risk and protective factors

- the neurobiological mechanisms that influence resilience following CSA
- the relative influence of different risk and protective factors following CSA on resilience and recovery, and if and how that relative influence differs for different groups of victims and survivors and at different life stages
- the ways in which individual risk and protective factors interact
- the most effective ways for society to support resilience and recovery among victims and survivors of CSA by minimising risk factors and maximising protective factors

There is also a general paucity of high-quality studies which use random probability samples and matched comparison groups to draw conclusions about the relative prevalence of outcomes of interest among victims and survivors, compared with the general population. Further studies of this type, along with longitudinal studies which allow the trajectories of victims and survivors across their life course to be explored, would add significant value to the evidence base on the impacts of CSA.

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- 13 Maniglio (2009), *op. cit.*
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