

The impacts of child sexual abuse: A rapid evidence assessment

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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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Executive summary

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

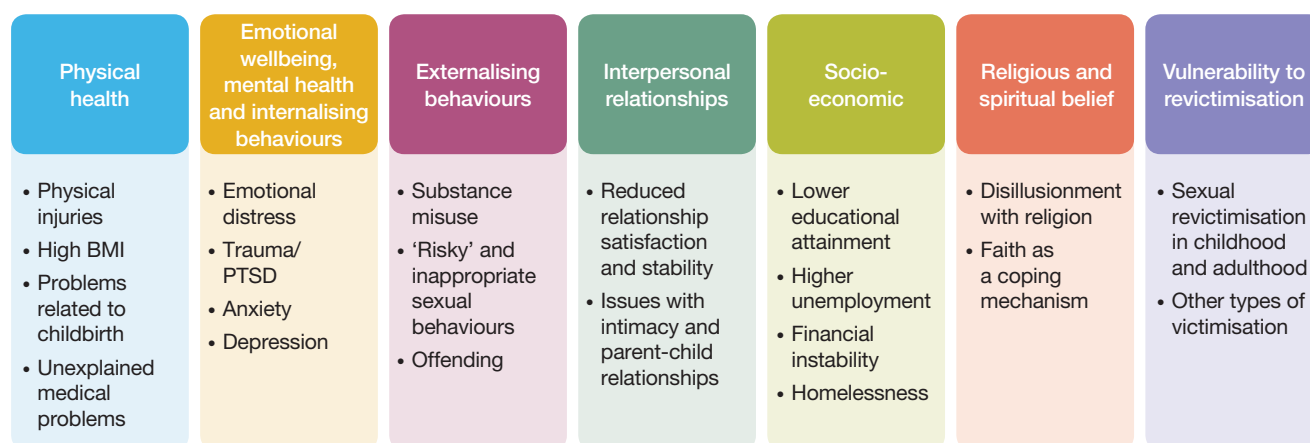
In the words of victims and survivors, taken from one of the qualitative studies included in this review:

*“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



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.

- 1 In other words the initial months and years following the onset of abuse.
- 2 One In Four (2015) *Survivors' voices: breaking the silence on living with the impact of child sexual abuse in the family environment*, p.16
- 3 *Ibid.*, p.24
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- 91 Montgomery et al. (2015), *op. cit.*
- 92 Bick et al. (2014), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Montgomery et al. (2015), *op. cit.*; Cecchet and Thoburn (2014), *op. cit.*
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- 94 Knott (2014), *op. cit.*; Marriott et al. (2014), *op. cit.*; Seltmann and Wright (2013), *op. cit.*
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- 114 Saied-Tessier (2014), *op. cit.*
- 115 *Ibid.*
- 116 Mancini and Shields (2014), *op. cit.*
- 117 Jutte, S. (2016) Online child sexual abuse images: Doing more to tackle demand and supply. NSPCC



Chapter 1: Introduction

1.1 Background to the Inquiry

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.¹¹⁸ CSA is both a life-altering crime and a significant social problem. Although it is challenging to measure CSA accurately, on account of its hidden nature, the latest evidence suggests that in England and Wales at least 1 adult in 14 (seven per cent) was sexually abused as a child.¹¹⁹ Additionally, a UK-wide study found that 17 per cent of 11–17-year-olds reported having experienced sexual abuse.¹²⁰ These figures equate to several million children and adults in England and Wales living with the impacts of CSA.

The aims of the Independent Inquiry into Child Sexual Abuse (IICSA or ‘the Inquiry’) are 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, in order to help ensure that children now and in the future are better protected from sexual abuse. The Inquiry will also make recommendations about improving the support services and the legal remedies available to victims and survivors of CSA to help them achieve accountability and reparation.

The Chair of the Inquiry, Professor Alexis Jay, is supported in her task by an expert Panel; a Victims and Survivors’ Consultative Panel; and other expert advisers including an Academic Advisory Board). The Inquiry was established in March 2015 by the Home Secretary, under the Inquiries Act 2005. It is independent of government.

The Inquiry consists of three main strands:

- public hearings, where witnesses relevant to the Inquiry’s specific investigations give evidence under oath and are subject to cross-examination
- the Truth Project, where victims and survivors of child sexual abuse are supported to share their experiences with the Inquiry, either in writing or in person
- research and analysis, in which the evidence base on CSA will be further developed by synthesising what is currently known and by conducting new primary research projects

Information generated through these three strands of activity will be used to inform the Inquiry’s final recommendations, to help ensure that they meet the Inquiry’s guiding principles of comprehensiveness, inclusivity and thoroughness.

1.2 Background to the rapid evidence assessment

As part of its work, the Inquiry is seeking to examine the impacts of CSA on victims and survivors, their families and 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 of CSA.

118 A detailed definition of CSA, CSE and other key terms can be found in the glossary in Appendix A.

119 Office for National Statistics (2016) *Abuse during childhood: Findings from the Crime Survey for England and Wales, year ending March 2016*

120 Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N., and Collishaw, S. (2011) *Child abuse and neglect in the UK today*. NSPCC

The rationale for focusing on victims and survivors in this report is the importance of understanding their support needs following CSA, as well as how society can help to reduce, and provide reparation for, the adverse consequences of CSA. Victims and survivors are never in any way responsible for the abuse they have experienced. Responsibility lies solely with the perpetrators of CSA, and with any individuals, structures or institutions that have facilitated it or have failed to prevent it. Other streams of Inquiry work focus on the perpetrators of CSA, including how they target and access their victims; and on how to ensure that they – and any institutions they operate within – are held to account for abuse committed.

This rapid evidence assessment (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.

1.3 REA aims and research questions

The overarching aims of the REA are:

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

More specifically, the review sought to answer the following research questions:

1. What are the impacts of CSA on victims and survivors across the life course?
2. How do these impacts differ for different groups of victims and survivors?
3. What are the key risk and protective factors surrounding the experience of significant adverse consequences from CSA?
4. What are the impacts of CSA on the families (including parents, carers, siblings and children) of victims and survivors, both at the time the abuse occurs and once the victims have reached adulthood?
5. What are the impacts of CSA on wider society, including the financial impact?

In some cases a lack of evidence has made it difficult or impossible to answer all or part of the questions above. Key evidence gaps are listed in Chapter 7.

1.4 Scope of the REA

Although the Inquiry focuses on cases of CSA where there has been an institutional failing (for example, by social services or the criminal justice system), the scope of this REA is broader and includes research on various types of CSA. These include intra- and extra-familial, institutional, contact and non-contact, online only and child sexual exploitation. Institutional failings can occur in relation to any of these types of CSA, and focusing solely on those research studies which only involve definite cases of institutional

failure would lead to a very limited and partial review.¹²¹ Where the evidence reported relates to a specific kind of CSA, this is made clear in the text.

The REA synthesises evidence from English and Welsh/UK and international studies. The latter have been restricted to those from high-income, economically developed countries, in order to maximise the likelihood of the research findings being transferable to the English and Welsh context.

Outside the scope of the REA are:

- the impacts of CSA on professionals who support or work with victims and survivors (often discussed in relation to the experience of 'vicarious trauma')
- the impacts of child maltreatment generally, or other kinds of child abuse and neglect specifically

1.5 Report structure

The report is structured as follows:

- Chapter 2 provides detail on the method used in this REA to robustly identify, assess and synthesise relevant literature. Additional information on the method (including full details of the search strategy) is provided in Appendix B.
- Chapter 3 contains an overview of the evidence base on the impacts of CSA, including the main ways in which researchers have explored the impacts of victimisation, and the challenges involved in attempting to robustly identify the impacts of CSA.
- Chapter 4 summarises the evidence on the impacts of CSA on victims and survivors. Section A presents information on the nature and extent of the impacts experienced, organised by broad outcome area, and draws out sub-group differences according to the life stage and gender of victims and survivors. Section B explores the factors which may influence the extent to which victims and survivors exhibit adverse impacts following CSA. It summarises the evidence on resilience, recovery, and risk and protective factors as well as triggers. This section also explores some of the ways in which wider society can affect the resilience and recovery of victims and survivors.
- Chapter 5 covers the research findings on the impacts of CSA on the families of victims and survivors in both childhood and adulthood, including on non-offending parents, siblings, partners and children.
- Chapter 6 summarises the evidence on the impacts of CSA on wider society, including on the usage of public services, and financial impacts.
- Chapter 7 contains a brief conclusion and a list of key evidence gaps relevant to the REA research questions which could form the focus of future primary research.

121 Such studies are those which focus on institutional CSA, that is CSA which occurs in institutions such as a religious or educational establishment.



Chapter 2: Method

2.1 REA methodology

A rapid evidence assessment (REA) method was selected to meet the aims of this study. REAs are a well-established form of desk-based research. They adopt the robust and defensible principles of a systematic literature review to identify, sift and assess the quality of existing research studies. However, they employ tighter parameters (for example, in relation to the type or publication date of studies) to ensure that the review can be achieved within a shorter timeframe or with fewer resources than a traditional systematic review requires. In other words, REAs aim to be “rigorous and explicit in method and thus systematic, but make concessions to the breadth or depth of the process by limiting particular aspects of the systematic review process”.¹²²

The method adopted is summarised below. Further details are set out in Appendices B and C. Approval was secured from IICSA’s Research Ethics Board before the study commenced.

2.2 Literature search strategy

A set of specific search terms was developed that was relevant to the REA aims and research questions (see section 1.3). These terms were combined and used to search a number of academic databases (including – among others – Web of Science, ScienceDirect, PsycARTICLES, Access to Research and Criminal Justice Abstracts). Simplified combinations of these terms were used to search specific websites for grey literature.¹²³ Appendix B contains a full list of search terms, as well as the databases and websites searched.

Before the terms were finalised, they were piloted, along with the search parameters and inclusion/exclusion criteria, to ensure that they identified pertinent material and generated a manageable number of articles and reports. Following the pilot, several revisions were made to the search terms and inclusion criteria, to reduce the volume of literature identified and minimise irrelevant sources. The final criteria reflected a focus on articles in peer-reviewed journals and grey literature published between 2006 and 2016 which explore the impacts of CSA in the UK or other high-income/economically developed countries. A full list of these criteria can be found in Appendix B.

The main phase of the searches were conducted in December 2016. The literature identified was first screened for relevance to the research questions on the basis of title and abstract. A further sift was undertaken to identify the highest-priority studies and reduce the volume of literature to a manageable size.¹²⁴ Appendix B details the prioritisation criteria used. A full text screen of the high-priority studies was then conducted to confirm their relevance. Studies were excluded if the full text could not be accessed, or if they were of limited relevance to the research questions. Literature that met the thresholds for inclusion was taken forward to the data-extraction stage. Appendix B contains a PRISMA flow chart showing the number of documents sourced, screened and included at each stage.

122 Government Social Research Unit (2008) *Government Social Research Rapid Evidence Assessment Toolkit*. Accessed on 6th April 2017: <http://webarchive.nationalarchives.gov.uk/20140305122816/http://www.civilservice.gov.uk/networks/gsr/resources-and-guidance/rapid-evidence-assessment/what-is>

123 The term ‘grey literature’ refers to literature which is not published in the formal sense of the word. This includes among other things organisational reports, government documents and policy papers.

124 Priority was determined by 1) how directly the study answered the research question and 2) the research method (with systematic reviews and meta-analyses being deemed highest priority).

2.3 Data extraction, analysis and quality assessment

Each piece of literature included was reviewed by a member of the research team and coded using NVivo software to highlight the key themes and research findings. The study type and design, publication date and country of origin (among other pieces of information) were also recorded in NVivo. The literature was then assessed for quality with the aid of a bespoke tool produced by the IICSA research team. The tool is based on widely used research quality-assessment (QA) instruments. It involves multiple sets of evaluation criteria, each tailored to a specific type of research method but harmonised across sets as far as possible. This feature enabled the tool to be used with the majority of studies reviewed in this REA.¹²⁵ Appendix C contains full details of the QA tool. Ten per cent of the studies were quality assessed by more than one member of the team. Scores were discussed and, where there was disagreement between team members, were debated until consensus was reached.

During the data analysis, synthesis and report-writing process, a 'weight of evidence' approach was adopted, taking into account both the relevance and the rigour of each study (the latter measured by the QA tool). Greatest weight was given to the more relevant and more robust studies. Where significant gaps in the evidence were identified, the research team went back to the lower-priority studies to identify any sources which could fill the gap. Where these were found, they were coded and quality assessed, as for the other studies. Some additional literature that was deemed to provide valuable context but did not directly answer the research questions has also been included in the report. The report was reviewed by two anonymous peer reviewers prior to publication.

2.4 Limitations

All research has its limitations, and transparency on this matter is a hallmark of high-quality studies. The following key limitations should be noted when considering the REA findings:

- An REA is not a full systematic review, and the resulting report will therefore not provide a fully comprehensive summary of the evidence base on the impacts of CSA. The review should, however, constitute a rigorous synthesis of the most relevant and robust research.
- Due to time and resource constraints, the research team did not routinely locate and review primary studies referenced in the systematic reviews and meta-analyses considered. The secondary studies included in the REA were deemed to have used sufficiently robust methods to render this unnecessary. However, inherent in this approach is the risk that any reporting inaccuracies in the secondary literature that relate to the research findings or methods of the primary studies will have been replicated in this report.

¹²⁵ The exception to this is the evidence on neurobiological changes following CSA generated by biomedical research methods. Due to the nature of the emerging evidence in this area, the rigour of these studies was assessed in a less formal way.



Chapter 3: The evidence base

This chapter contains a summary of the nature and extent of the evidence reviewed as part of this REA. It also contains an overview of the main approaches (including theories and models) which have informed and shaped research in this area, as well as a discussion of the challenges involved in drawing robust conclusions about the impacts of CSA on the lives of victims, survivors and their families. This information provides critical context for the research findings summarised in the subsequent sections.

3.1 Summary of the evidence reviewed

This section provides an overview of the type and nature of literature included in this review. The profile of this literature should not be used to make generalisations about the nature of the wider evidence base on the impacts of CSA; however, it does provide an overview of the kinds of study that exist, and an indication of their relative volumes. Charts illustrating the following points can be found in Appendix D.

In total, 205 research papers/reports were coded and quality assessed as part of this review. This breaks down into:

- **Publication type:** 180 journal articles and 25 grey literature reports.
- **Publication date:** Most of the literature reviewed (156 papers) was published in 2010 or later (Figure D.1).
- **Country:** Most of the papers reviewed relate to research from the United States (78 papers); 27 relate to research conducted in the United Kingdom; and 14 cover other European countries. In all, 58 papers synthesised research relating to multiple countries (see Figure D.2).
- **Method:** Most of the papers involved primary or secondary quantitative¹²⁶ research methods (64 and 46 studies, respectively) although 24 used qualitative approaches and 7 used mixed methods. Of the papers, 45 were literature reviews, including 23 systematic reviews (Figure D.3). Of those papers that used empirical methods, 35 involved longitudinal approaches.
- **Participant life stage:** In all, 63 papers focused on CSA victims and survivors during childhood and early adulthood specifically. Slightly more (74 papers) were focused on victims and survivors during adulthood generally and 63 spanned multiple life stages (Figure D.4).
- **Participant gender:** The majority of the papers explored impacts on victims and survivors of all genders (136). In all, 56 papers explored impacts on female victims and survivors (or their female family members) only, and 11 focused on male victims and survivors (or their male family members) only.
- **Type of CSA:** Most of the papers covered a range of types of CSA (160 papers). Of those that focused on a specific kind of abuse: 17 concentrated on intra-familial abuse; 11 on institutional abuse; 5 on CSE; 5 on online abuse; 1 on extra-familial abuse; and 1 on female-perpetrated abuse.

Some additional literature that provided valuable context for the report findings but that did not directly answer the research questions or meet the criteria for inclusion is also referenced in the report. This literature was not coded or quality assessed in the same way as the core papers.

126 Primary quantitative methods include primarily surveys; secondary quantitative methods include statistical analysis of existing quantitative datasets, and meta-analyses (analyses of data aggregated from multiple primary studies).

3.2 How have the impacts of CSA been explored?

3.2.1 Academic disciplines and sectors

Before presenting the key research findings from this review in depth, it is important to consider the way in which the impacts of CSA have been explored by those academic disciplines which have produced the most research on this issue. Such disciplines include medicine, psychology and criminology, among others. The focus, theoretical foundations and assumptions of these disciplines have shaped how researchers have approached the question of CSA impacts in three main ways:

- They have influenced the kinds of outcomes that are focused on (for example, health conditions, or convictions for criminal offences).
- They have influenced the methods used to measure these outcomes (for example, self-report data, administrative data or clinical diagnoses).
- They have influenced the population groups within which these outcomes have most commonly been measured (for example, the focus on female rather than male victims and survivors that can be observed in the literature; and the neglect of black and minority ethnic (BME) and lesbian, gay, bisexual and transgender (LGBT) individuals, for reasons of representation and access).

In this way, the approach of these disciplines and their assumptions have fundamentally shaped the nature of the evidence base on the impacts of CSA, and thereby also limited the extent of society's knowledge and understanding of the issue.

Table 3.1 contains a summary of the main academic disciplines which have explored the impacts of CSA; the types of outcomes they have tended to focus on; and the methods they have most frequently used to generate their evidence. The information in this table is necessarily a simplification. In reality, interdisciplinary teams which bring together representatives from a range of disciplines and combine different approaches and perspectives are not uncommon, although still in the minority. Equally, some schools of thought – for example, feminism, with its focus on gendered power dynamics and patriarchal social structures – have influenced a number of different disciplines and are reflected in aspects of the evidence produced by those disciplines.

Table 3.1: Outcomes and methods of key academic disciplines in relation to CSA

Discipline	Outcomes of particular focus	Methods
Criminology	'Deviant' and offending behaviour, particularly 'cycles of abuse' (intergenerational transmission of abusive behaviours); revictimisation	Quantitative, qualitative and mixed-method studies
Medicine/biology (and other natural sciences)	Physical or mental health conditions; behavioural issues or disorders; neurobiological changes	Mainly quantitative studies, often focusing on estimating the prevalence of certain conditions or issues in the population; biomedical research
Psychoanalysis	Mental and emotional wellbeing; interpersonal relationships; resilience, recovery and coping strategies; subjective meaning-making in relation to the experience of CSA	Mainly qualitative studies exploring study participants' internal processes and personal experiences in depth
Psychology	Abnormal psychology, including mental health conditions and behavioural disorders; interpersonal relationships (including attachment); resilience, recovery and coping strategies	Predominantly quantitative studies, with qualitative approaches favoured by specific branches of psychology
Social work	Intergenerational transmission of victimisation; impacts on family dynamics and parenting practices; impacts on family members	Mainly qualitative studies
Sociology	Includes many of the above, as well as socioeconomic outcomes; societal responses to disclosure of abuse; impacts on wider society	Qualitative, quantitative and mixed-method studies

There are also differences in the type of insight produced, according to the sector generating the evidence. For example, while the above table focuses primarily on academic research (which makes up the bulk of the studies reviewed as part of this REA), third-sector organisations, including charities and support groups, are increasingly producing studies on the impacts of CSA.¹²⁷ These organisations – often led by victims and survivors – have tended to produce research which eschews a more medicalised/natural sciences approach in favour of privileging victim and survivor voices and experiences. There are some similarities between these types of studies and certain psychology and psychoanalytical literature, but unlike much of the academic literature, they usually position the victims and survivors, rather than the researchers, as the experts (or 'experts by experience') on the impacts of CSA.

3.2.2 Specific theories and models

Theories or 'models' seek to provide explanations for the ways in which the experience of CSA affects victims and survivors. They are simply sets of ideas which have been used to explain or account for something that has been observed in the world. They are used within – and sometimes across – disciplines to help inform study designs and make sense of research findings. Some are strongly supported by evidence; others less so. This may be because they are more effective at providing an accurate explanation of the impacts of CSA on victims and survivors, or because they are easier to test empirically. Theories which have the greatest explanatory value often evolve over time, as successive generations of researchers produce evidence which enables them to be further developed and refined.

¹²⁷ Third-sector organisations tend to have more limited resources for conducting research and therefore have produced fewer reports on this issue. All studies produced by UK-based third-sector organisations located during the REA search phase which explicitly address the question of the impact of CSA were included in the review.

There are many theories which either originate in, or have been applied to, the study of CSA and its outcomes. Key theories in this field (several of which are referenced later in the report) are:

- **Finkelhor and Browne's traumagenic model (1985)**¹²⁸ – a framework for understanding the unique psychological impacts of CSA based around four 'traumagenic dynamics' involved in the experience of CSA victimisation: traumatic sexualisation, betrayal, stigmatisation and powerlessness.
- **Bowlby's attachment theory (1958)**¹²⁹ – a way of explaining people's long-term approach to interpersonal relationships that focuses on the strength and security of the attachment between an infant and the caregiver (usually the mother) and the life-long blueprint which that relationship can create.
- **Risk and resilience (for example, Rutter and Garmezy, 1983)**¹³⁰ – a theory which attempts to explain why some individuals appear to be 'resilient' (that is, show no significant or enduring negative outcomes and demonstrate positive adaptation) in the face of adverse experiences such as CSA, through reference to risk and protective factors. Resilience has most recently been positioned as a dynamic process.¹³¹
- **Bronfenbrenner's social-ecological model (1979)**¹³² – a framework which situates human development in the context of the social environment in which it takes place, and seeks to explain how different elements of a person's environment influence that person's development, both directly and through interaction with each other.
- **Gender-based theories (for example, Kelly, 1988)**¹³³ – a group of theories which seek to explore and understand CSA (and other crimes) in a way that is sensitive to and brings out the role of gender. Many, but not all, gender-based theories draw on feminist approaches. Feminist approaches often position CSA – which is most commonly perpetrated by males against females – within the context of broader patriarchal structures which oppress and silence women through the use of violence, abuse and strict gender norms, among other means.

3.3 Challenges in identifying the impacts of CSA

The purpose of this review is to draw together current evidence on the impacts of CSA on victims and survivors, their families and wider society. In practice, however, it is often 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 how some of the current evidence was generated, which means that the 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** between CSA and a specific life outcome or medical condition; it cannot indicate that CSA **caused** the outcome under consideration.

128 Finkelhor, D., and Browne, A. (1985) The Traumatic Impact of Child Sexual Abuse: A Conceptualization. *American Journal of Orthopsychiatry*, 55(4)

129 Bowlby, J. (1958), *op. cit.*

130 Rutter, M., and Garmezy, N. (1983). Developmental psychopathology. In E.M. Hetherington (Ed.), *Mussen's handbook of child psychology: Vol. 4. Socialization, personality, and social development* (4th ed., pp.775–911). New York: Wiley

131 Rutter, M. (2012) Resilience as a dynamic concept. *Development and Psychopathology*, 24, pp.335–344

132 Bronfenbrenner, U. (1979) *The ecology of human development: Experiments by nature and design*. Harvard University Press, Cambridge, MA

133 Kelly, L. (1988) *Surviving sexual violence, Feminist Perspectives Series*. Minneapolis: University of Minnesota Press

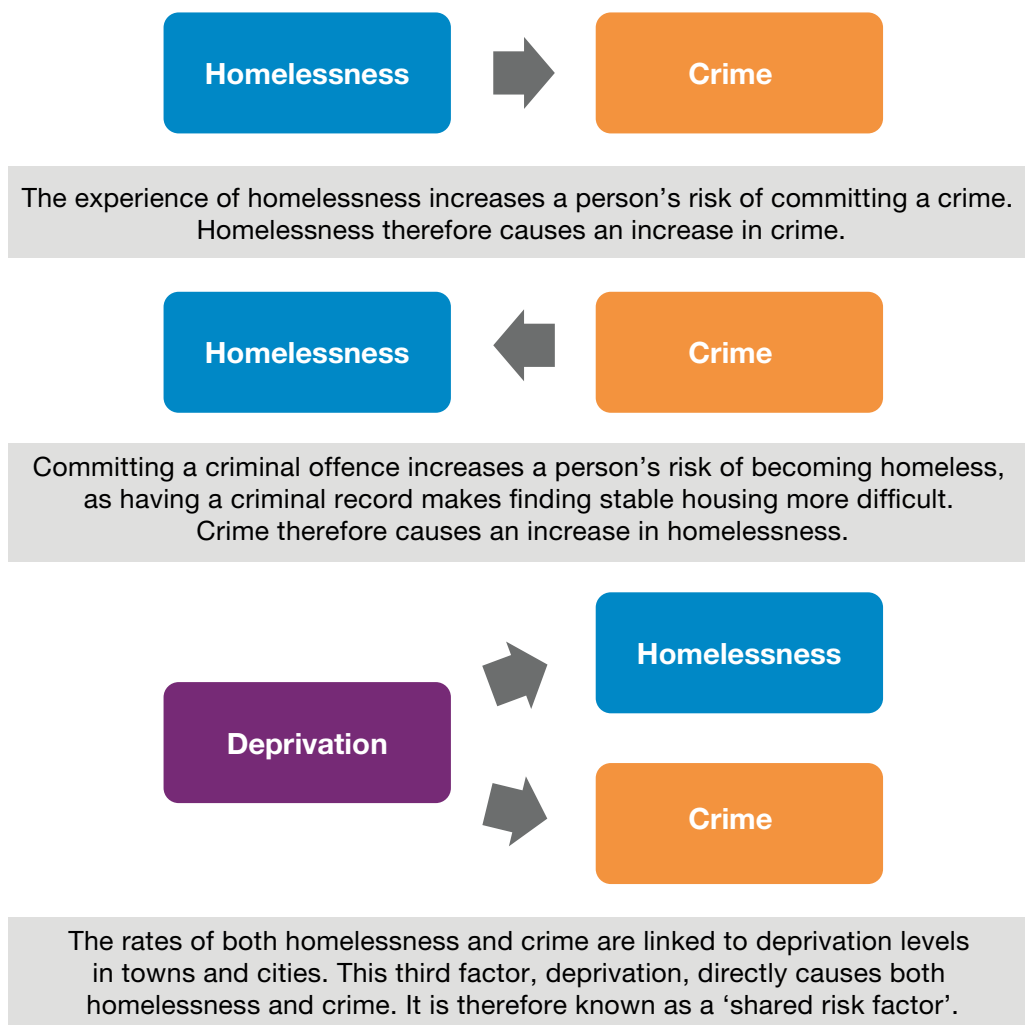
The four main reasons why identifying the impacts of CSA is so challenging are explored below.

3.3.1 Relationships between factors: causality or 'just' correlation?

Many quantitative studies attempt to identify correlations – in other words associations, relationships or links – between two factors. This report focuses on exploring the relationship between CSA and life outcomes. As mentioned above, it is important to remember that just because a study has found a relationship between CSA and life outcomes, this does not mean that CSA caused the life outcomes. In other words, it cannot be assumed that a causal relationship exists just because a correlation has been identified.

To illustrate this point using an example not directly related to CSA, a study might have found that crime rates and levels of homelessness in UK towns and cities are correlated or linked. There are three main explanations which might account for this link.

Figure 3.1: Possible associations between homelessness and crime



In some cases, the timing of the outcome being explored narrows down the number of possible explanations for the observed relationship. For example, in the case of juvenile offending and homelessness in adulthood, the relative timing of these events means it is impossible for a person's later housing status to have caused the earlier offending. In most cases, however, the links between different elements of people's lives are highly complex. It may well be that all three of the above explanations play some role in accounting for the relationship between homelessness and crime rates.

Some research methods are better than others for identifying whether or not a relationship between CSA and a life outcome is causal, and if so what the main ‘direction of causality’¹³⁴ might be. The best studies for this purpose are longitudinal (that is, they revisit the same set of people several times over a number of years); involve both people with and without experience of CSA who are otherwise similar and can be reliably compared (that is, the use of comparison groups); and use statistical techniques to ‘account’ for important influencing factors like age, gender and family background. Studies which explore the mechanisms or pathways linking CSA and outcomes – including those that use qualitative methods, such as focus groups and interviews – can also help to clarify the nature of the relationship between them. Unfortunately, many studies do not adopt these approaches;¹³⁵ and even when they do, the real-world complexity means that clear-cut conclusions can be hard to draw.

3.3.2 Isolating the role of CSA

CSA frequently occurs in conjunction with other types of abuse or maltreatment,¹³⁶ as well as with other life circumstances (such as an unstable family life) which might result in longer-term adverse consequences. These factors are sometimes referred to as ‘confounding variables’, because they make it challenging to tease out the role of CSA from the role of these other factors in creating life outcomes. Statistical techniques (for example, regression analysis) are often used to try and isolate the impacts of CSA, but it remains a difficult task.

Similarly, in studies of medium- and long-term outcomes that are measured years – or even decades – after the CSA first occurred, it is difficult to be confident in attributing the outcomes to CSA, rather than to the multiple and complex life experiences that a person may have had in between those two points in time.

3.3.3 Hidden nature of CSA

CSA is a hidden crime which suffers from significant underreporting. The Office of the Children’s Commissioner has estimated that only one victim in eight ever comes to the attention of the statutory authorities in the UK and therefore appears in their datasets.¹³⁷ Many victims and survivors wait for decades to disclose the abuse – and some never do.¹³⁸ Self-report surveys are generally considered to provide the most accurate estimates of prevalence,¹³⁹ although the rate of false negatives (that is, non-reporting by victims and survivors of CSA) is still thought to be high.¹⁴⁰

134 This means whether y causes x, or x causes y. In other words, in this example, whether CSA causes homelessness or homelessness causes CSA (assuming that one of them definitely ‘caused’ the other).

135 This may be for a variety of reasons. Longitudinal studies, for example, are by nature time consuming and expensive, and are not suitable or practical in all cases.

136 The Crime Survey for England and Wales 2015/16 found that around three quarters (about 74 per cent) of female victims and survivors of CSA and nine in ten (about 91 per cent) of male victims and survivors in England and Wales experienced at least one other form of abuse during childhood. This is known as ‘polyvictimisation’. Office for National Statistics (2016), *op. cit.*

137 Office of the Children’s Commissioner (2015) *Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action.*

138 Office for National Statistics (2016), *op.cit.*

139 Although the nature of self-report surveys means that the reports of abuse may not have been substantiated, studies have found that the number of false negatives in such surveys is higher than the number of people reporting false allegations. Brown et al, 2001 and Fergusson et al, 2000 cited in Pereda, N., Guilera, G., Forns, M. & Gomez-Benito (2009) The international epidemiology of child sexual abuse: A continuation of Finkelhor (1994) in *Child Abuse and Neglect* (33):331-342.

140 Fergusson et al found the probability of a false negative report by abuse victims to be in the region of 50 per cent when interviewing a cohort of young people at age 18 and again at age 21 about their experiences of child sexual abuse and physical punishment. Fergusson D. M., Horwood, L. J. and Woodward, L. (2000) The stability of child abuse reports: A longitudinal study of the reporting behaviour of young adults in *Psychological Medicine* 30(3):529-44.

This has three main implications for the evidence on the impacts of CSA:

1. Understanding the short-term impacts is challenging when only a minority of cases are identified in the weeks and months following the onset of abuse.
2. Groups of 'non-victims and survivors' will inevitably contain people who have experienced CSA, but who have not disclosed it. This can make identifying clear differences between victims and survivors and others more difficult.
3. It makes it more challenging for researchers to locate victims and survivors. As a result, studies often use 'convenience' samples of victims and survivors, recruited through support services or other channels, rather than randomly selected from the larger population. Such convenience samples are unlikely to be representative of the wider victim and survivor population. The findings produced by such studies should not, therefore, be generalised to the wider group.

3.3.4 Inconsistency in definitions and measurement

A final challenge relates to the fact that there is no single agreed definition of CSA, or any universally accepted way of measuring it. Different studies have adopted different definitions, as well as different measurement tools and approaches. Additionally, many have defined and measured the same life outcomes in varying ways. This inconsistency limits the ability to compare research findings across studies and to draw robust conclusions from the wider evidence base.

3.3.5 Summary

When reviewing the research findings in the following chapters on the 'impacts' of CSA, it is important to be mindful of the complexity of both human lives and the social world, and therefore the imperfectness of the evidence base in this area. These factors make it extremely difficult to reach robust and well-supported conclusions about the impacts of CSA. The evidence does, however, provide a clear indication of the kinds of support needs that victims and survivors have, and the areas in which they require support and assistance in order to maximise their chances of experiencing resilience or recovery following CSA. This insight is arguably the most valuable aspect of the evidence in this area.



Chapter 4: Impacts of CSA on victims and survivors

4.1 Introduction and overview

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 term¹⁴¹ following abuse, but instead can endure over a victim and survivor's lifetime.

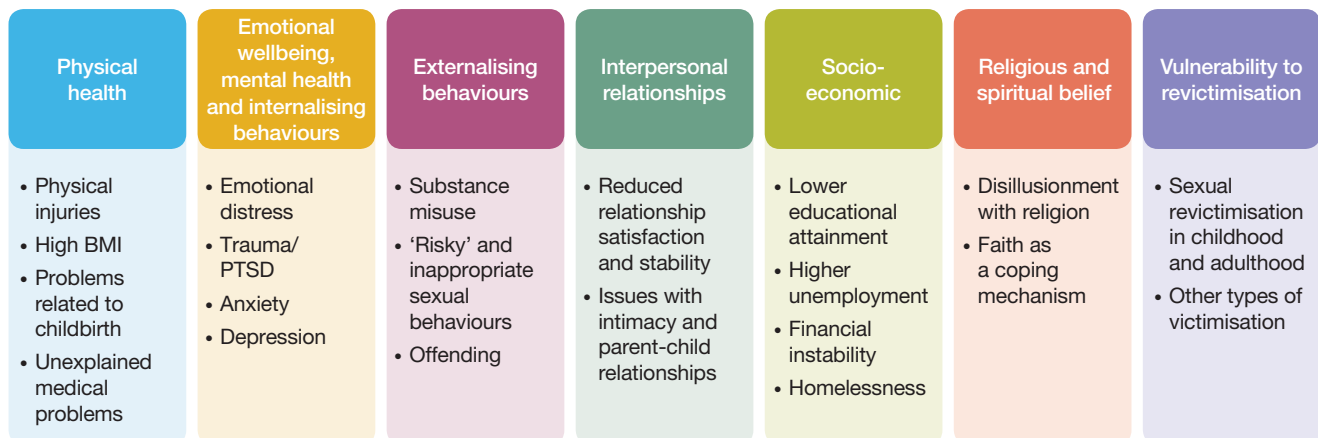
In the words of victims and survivors themselves, taken from one of the qualitative studies included in this review:

*"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."*¹⁴²

*"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."*¹⁴³

The outcomes that emerged from the reviewed studies can be grouped into seven areas, as shown in Figure 4.1.1. There is significant overlap between these outcome areas and the domains covered by quality of life/wellbeing measures (for example, the World Health Organization's quality of life assessment).¹⁴⁴ This further reinforces how pervasive and all-encompassing the effects of CSA can be in the lives of victims and survivors.

Figure 4.1: CSA victim and survivor outcome areas with example outcomes



141 Short to medium terms refers to the initial months and years following the onset of abuse.

142 One In Four (2015) *op. cit.*, p.16

143 *Ibid.*, p.24

144 For more information see: World Health Organization (1995) The World Health Organization Quality of Life assessment (WHOQOL): position paper from the World Health Organization. *Soc Sci Med*, 41(10), p.1403-1409

The ways 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.

The research findings summarised in the following sections demonstrate clearly that victims and survivors are not a homogeneous group. They constitute a diverse set of individuals with very different experiences of CSA as well as a wide variety of different backgrounds, demographic profiles and broader life experiences. 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 – as a result. The risk and protective factors which might serve to increase or reduce an individual's risk of experiencing a certain outcome are highlighted in boxes in the following sections wherever the evidence enables this to be done. These factors are important as they could help practitioners to identify those victims and survivors most at risk of adverse outcomes and therefore who would realise most benefit from preventative services.

Linked to this, the evidence suggests that it is not inevitable that victims and survivors 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. This happens if they either appear to experience no major adverse consequences, or find their way back to 'adaptive' or 'positive' functioning after a period of difficulty that might have lasted several years or several decades. Research in this area has focused on identifying the protective factors that increase the chance of a victim and survivor achieving 'good' life outcomes despite the experience of abuse. Some studies suggest that a small number of victims and survivors even appear to display post-traumatic growth or positive adaptation following CSA victimisation.

Resilience and recovery are dynamic states; an individual might be resilient at one point in time but not at another. Adverse outcomes can occur, or recur, at any stage of a victim and survivor's life course. Sometimes this happens in response to specific triggers such as life events – the experience of pregnancy and becoming a parent appear to be key – sometimes as a result of natural fluctuations.¹⁴⁵ Simply because a victim and survivor is not experiencing a particular outcome at one point in their lives does not mean they will not experience it at a later stage.

Section A presents the evidence on the impacts of CSA on victims and survivors structured according to the seven outcome areas in Figure 4.1. Section A also includes a discussion of the differences in observed outcomes according to victims and survivors' life stage and gender (section 4.9). It should be noted that there is significant variability in the quality of the research evidence across these broad outcome areas. Some areas (for example, mental health) have been studied substantially in more depth, using higher-quality methods, than other areas. This affects the level of confidence with which links can be drawn between CSA and the outcomes in question.

Section B summarises the evidence on resilience and recovery, including the factors that have been shown to play a role in increasing or decreasing the risk of victims and survivors experiencing significant adverse impacts following CSA. It also outlines some examples of the way society's response to CSA can work to compound or mitigate adverse impacts for victims and survivors.

Throughout the report, direct quotes from victims and survivors who participated in the qualitative studies reviewed are used to illustrate the research findings wherever possible.

¹⁴⁵ For example, it is not uncommon for symptoms of chronic illness or mental health problems to fluctuate over time.

● Section A: Outcome areas

4.2 Physical health

This section summarises the evidence on the impacts of CSA on victims and survivors' physical health.

Summary of key themes

- 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.¹⁴⁶
- In the longer term, CSA has been linked to a range of illnesses and disabilities; in one study, one in four CSA victims and survivors reported a long-standing illness or disability compared with one in five of the general population.¹⁴⁷
- Physical health outcomes include increased BMI,¹⁴⁸ heart problems¹⁴⁹ and issues around childbirth.¹⁵⁰
- 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 CSA¹⁵¹ – which can be an indicator of poor physical health.
- Some victims and survivors report “medically unexplained” symptoms, which can include non-epileptic seizures¹⁵² and chronic pain.¹⁵³

Experiencing CSA has been associated with an increased risk of experiencing a wide range of adverse physical health conditions. Given the low number of studies designed to reliably establish causation, the majority of the research findings presented here should be understood as providing evidence of a link or relationship between CSA and physical health problems, rather than evidence that CSA leads to those problems.

4.2.1 General physical health

Physical health problems can reduce quality of life and affect areas of wellbeing such as work, family and hobbies. A number of studies point to general reports of poor physical health among victims and survivors of CSA.¹⁵⁴ The increased risk of developing physical health problems following CSA has been suggested as

146 Heger et al. (2002), *op. cit.*

147 Allnock et al. (2015), *op. cit.*

148 Trickett et al. (2011), *op. cit.*; McCarthy-Jones and McCarthy-Jones (2014), *op. cit.*; Havig (2008), *op. cit.*; Mamun et al. (2007), *op. cit.*; Richardson et al. (2014), *op. cit.*

149 Kamiya et al. (2016), *op. cit.*; Allnock et al. (2015), *op. cit.*; McCarthy-Jones and McCarthy-Jones (2014), *op. cit.*

150 Trickett et al. (2011), *op. cit.*; Wosu et al. (2015c), *op. cit.*; Hooper and Warwick (2006), *op. cit.*; Leeners et al. (2016), *op. cit.*

151 Kamiya et al. (2016), *op. cit.*

152 Nelson et al. (2012), *op. cit.*; Chen et al. (2010), *op. cit.*; Maniglio (2009), *op. cit.*; Sharpe and Faye (2006), *op. cit.*

153 Kamiya et al. (2016), *op. cit.*; Chen et al. (2010), *op. cit.*

154 Kamiya et al. (2016), *op. cit.*; Quadara et al. (2016), *op. cit.*; Allnock et al. (2015), *op. cit.*; Coles et al. (2015), *op. cit.*; Zeglin et al. (2015), *op. cit.*; Irish, L., Kobayashi, I., and Delahanty, D. L. (2010) Long-term Physical Health Consequences of Childhood Sexual Abuse: A Meta-Analytic Review. *Journal of Pediatric Psychology*, 35(5), pp.450-461

being “small to moderate”.¹⁵⁵ For example, a longitudinal study found that women who had experienced both CSA and adult violence were 1.3 times more likely to report poor general health than women who had experienced no abuse.¹⁵⁶

CSA has also been linked to long-term illnesses and disabilities; in one study, one in four CSA victims and survivors reported a long-standing illness or disability compared with one in five of the general population.¹⁵⁷ In addition, 19 per cent of CSA victims and survivors have been classified as disabled/sick, compared with eight per cent who had not experienced CSA.¹⁵⁸ The Adult Psychiatric Morbidity Survey in England and Wales found that 16 per cent of people with a history of CSA reported difficulty with one or more “activities of daily living”.¹⁵⁹ Activities of daily living include things like personal care, household activities and using public transport. The impact of physical health problems can be devastating; in a study with older patients, a history of CSA was found to be associated with a higher burden of medical illness, roughly comparable to adding eight years to a person’s age. CSA history was also associated with poorer activities of daily living and greater bodily pain, roughly comparable to adding 20 years to someone’s age.¹⁶⁰ Physical health problems and disability can also help to explain the relationship between CSA and other outcomes, such as lower levels of employment¹⁶¹ (see section 4.6 on socioeconomic outcomes).

Research suggests that people with a history of CSA have a greater average number of doctor and hospital contacts¹⁶² which can be an indicator of poor physical health. In one study, the average number of appointments was 20 per cent higher than comparisons.¹⁶³ However, it should be noted that other evidence has shown that some victims and survivors avoid medical appointments altogether for reasons linked to the experience of CSA.¹⁶⁴ This places their health at greater risk.

4.2.2 Specific physical health conditions

In addition to the research findings on the links between CSA and general physical health, there is a notable body of research exploring the links between CSA and particular physical health conditions. Many of the reviewed studies focused on the adult population; consequently, most of the findings relate to health problems that either only emerge in later life, or emerge earlier but endure into adulthood.

155 Fergusson et al. (2013), *op. cit.*

156 Coles, J., Lee, A., Taft, A., Mazza, D., and Loxton, D. (2015) Childhood sexual abuse and its association with adult physical and mental health: results from a National cohort of young Australian women. *Journal of Interpersonal Violence*, 30(11), pp.1929-1944

157 Allnock et al. (2015), *op. cit.*

158 Barrett et al. (2014), *op. cit.*

159 Scott, S., Williams, J., McNaughton Nicholls, C., McManus, S., Brown, A., Harvey, S., Kelly, L., and Lovett, J. (2015) *Violence, abuse and mental health in England: Population patterns (Responding effectively to violence and abuse (REVA) study)*

160 Talbot, N., Chapman, B., Conwell, Y., McCollum, K., Franus, N., Cotesco, S., and Duberstein, P. R. (2009) Childhood sexual abuse is associated with physical illness burden and functioning in psychiatric patients 50 years of age and older. *Psychosomatic Medicine*, 71(4), pp.417-422

161 Lee and Tolman (2006), *op. cit.*; Barrett et al. (2014), *op. cit.*

162 Kamiya et al. (2016), *op. cit.*; Fergusson et al. (2013), *op. cit.*; Trickett et al. (2011), *op. cit.*

163 Kamiya et al. (2016), *op. cit.*

164 Sneddon et al. (2016), *op. cit.*

Some of the specific health conditions that have been linked with CSA are outlined below.

- **injuries associated with penetrative CSA**¹⁶⁵
 - acute trauma
 - transections of the hymen that extend to the base of the hymen
 - anal or genital scarring
- **sexually transmitted infections, including HIV**¹⁶⁶
- **migraine/headaches**¹⁶⁷
- **lung problems**
 - lung disease¹⁶⁸
 - bronchitis/emphysema¹⁶⁹
 - asthma¹⁷⁰
- **heart problems**
 - cardiovascular disease risk factors¹⁷¹
 - cardiopulmonary symptoms¹⁷²
 - cardiovascular disease¹⁷³
- **liver disease**¹⁷⁴
- **digestive system problems**
 - gastrointestinal¹⁷⁵
 - stomach ulcer/digestive¹⁷⁶
 - diarrhoea¹⁷⁷
- **reproductive system problems**
 - gynaecological¹⁷⁸

165 Heger et al. (2002), *op. cit.*

166 Trickett et al. (2011), *op. cit.*; Maniglio (2009), *op. cit.*; Sutherland, M. A. (2011) Examining Mediators of Child Sexual Abuse and Sexually Transmitted Infections. *Nursing Research*, 60 (2), pp.139-147

167 McCarthy-Jones and McCarthy-Jones (2014), *op. cit.*, O’Riordan and Arensman (2007), *op. cit.*, Havig (2008), *op. cit.*, Nelson et al. (2012), *op. cit.*

168 Kamiya et al. (2016), *op. cit.*,

169 McCarthy-Jones and McCarthy-Jones (2014), *op. cit.*

170 *Ibid.*

171 Kamiya et al. (2016), *op. cit.*

172 Allnock et al. (2015), *op. cit.*

173 McCarthy-Jones and McCarthy-Jones (2014), *op. cit.*

174 Havig (2008), *op. cit.*

175 Havig (2008), *op. cit.*; Nelson et al. (2012), *op. cit.*; Allnock et al. (2015), *op. cit.*; Chen et al. (2010), *op. cit.*

176 Kamiya et al. (2016), *op. cit.*; McCarthy-Jones and McCarthy-Jones (2014), *op. cit.*

177 O’Riordan and Arensman (2007), *op. cit.*

178 Havig (2008), *op. cit.*; Nelson et al. (2012), *op. cit.*; Allnock et al. (2015), *op. cit.*

- early onset of puberty¹⁷⁹
- chronic pelvic pain¹⁸⁰
- sexual pain disorder (vaginismus and/or dyspareunia)¹⁸¹
- **perinatal problems**
 - premature delivery¹⁸²
 - childbirth complications¹⁸³
- **bladder/urinary problems**¹⁸⁴
- **musculo-skeletal problems**¹⁸⁵
- **obesity/high body mass index (BMI)**¹⁸⁶
- **diabetes**¹⁸⁷
- **arthritis**¹⁸⁸
- **immune system problems**
 - allergies¹⁸⁹
 - compromised immune system functioning¹⁹⁰
- **non-epileptic seizures**¹⁹¹
- **cancer**¹⁹²
- **pain**
 - chronic¹⁹³
 - bone/back/muscle/joint pain¹⁹⁴
 - generalised pain¹⁹⁵
 - chronic fatigue¹⁹⁶

179 Trickett et al. (2011), *op. cit.*

180 Chen et al. (2010), *op. cit.*; Nelson et al. (2012), *op. cit.*; Maniglio (2009), *op. cit.*

181 Kristensen and Lau (2011), *op. cit.*

182 Trickett et al. (2011), *op. cit.*; Wosu et al. (2015c), *op. cit.*

183 Hooper and Warwick (2006), *op. cit.*; Leeners et al. (2016), *op. cit.*

184 McCarthy-Jones and McCarthy-Jones (2014), *op. cit.*; Havig (2008), *op. cit.*

185 Havig (2008), *op. cit.*

186 Trickett et al. (2011), *op. cit.*; McCarthy-Jones and McCarthy-Jones (2014), *op. cit.*; Havig (2008), *op. cit.*; Mamun et al. (2007), *op. cit.*; Richardson et al. (2014), *op. cit.*

187 McCarthy-Jones and McCarthy-Jones (2014), *op. cit.*

188 Kamiya et al. (2016), *op. cit.*; McCarthy-Jones and McCarthy-Jones (2014), *op. cit.*

189 McCarthy-Jones and McCarthy-Jones (2014), *op. cit.*

190 Trickett et al. (2011), *op. cit.*, Havig (2008), *op. cit.*

191 Nelson et al. (2012), *op. cit.*, Chen et al. (2010), *op. cit.*, Maniglio (2009), *op. cit.*, Sharpe and Faye (2006), *op. cit.*

192 Havig (2008), *op. cit.*

193 Kamiya et al. (2016), *op. cit.*, Chen et al. (2010), *op. cit.*

194 McCarthy-Jones and McCarthy-Jones (2014), *op. cit.*

195 Havig (2008), *op. cit.*, Coles et al. (2015), *op. cit.*

196 Nelson et al. (2012), *op. cit.*

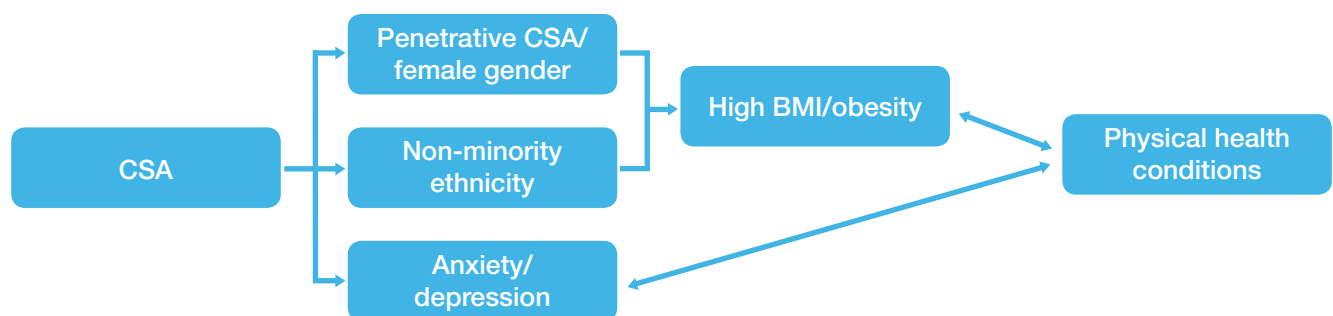
4.2.3 Causes of and risk factors for physical health conditions

Immediate physical injuries aside, the relationships between CSA and physical health may not be directly causal but may occur as a result of other factors linked to the abuse. For example, CSA has been associated with an increased risk of experiencing both mental health problems (see section 4.3) and substance misuse (see section 4.4), and these issues can lead to physical health problems. In particular, research suggests that the risk factors for obesity can vary by group, with increased risk among female, but not male, victims and survivors¹⁹⁷ and among non-minority, but not minority, victims and survivors.¹⁹⁸

Table 4.1: Risk factors for physical health problems

Physical health problems	<p>Risk factors:</p> <ul style="list-style-type: none"> • Demographic characteristics and other background variables: <ul style="list-style-type: none"> – Female gender, younger age, substance misuse, parent–child conflict and maternal disengagement are shared risk factors for both CSA and adolescent pregnancy.¹⁹⁹ – For women but not men, penetrative CSA was associated with increased odds of being overweight later in life (see Figure 4.2).²⁰⁰ – Among victims and survivors from non-minority ethnic groups only, combined exposure to CSA and child physical abuse (CPA) increased the risk of developing severe obesity in later life.²⁰¹ • High BMI and mental health problems: BMI, along with anxiety/depression, helped to explain the association between CSA and the majority of physical health conditions in one study, although the relationship can work in both directions (see Figure 4.2).²⁰²
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Figure 4.2: Example of associations between CSA and physical and mental health conditions



197 Mamun et al. (2007), *op. cit.*

198 Richardson et al. (2014), *op. cit.*

199 Francisco et al. (2008), *op. cit.*

200 Mamun et al. (2007), *op. cit.*

201 Richardson et al. (2014), *op. cit.*

202 McCarthy-Jones and McCarthy-Jones (2014), *op. cit.*

In recent years, evidence has started to emerge about the impacts of CSA on the structure and functioning of victim and survivors' brains and bodies. An overview of how neurobiological changes might operate as a risk factor is provided below. It should be borne in mind that research into CSA and neurobiology is at an early stage.

Box 4.1: Emerging evidence about the effects of CSA on the developing brain

Research in this field has the potential to shed significant light on the biological mechanisms through which CSA increases the risk of experiencing certain outcomes, particularly mental and physical health conditions. Differences in neurobiological changes among CSA victims and survivors could, in the future, help to explain as well as predict differences in later life outcomes. This would also enable the development of more targeted and tailored support.

For example:

- Experiencing extreme stress, such as that involved in being a victim of CSA, can lead to changes in how the body regulates itself in terms of the nervous system, hormones and immune system. Research suggests such changes can lead to further changes in the brain, which in turn might make some individuals more sensitive to future stress and increase their risk of a range of negative outcomes.²⁰³
- The above-mentioned changes in body regulation in response to stress might, at least in part, be a result of an individual's genetic make-up and the way the expression of their genes is affected by their experiences. Differences in victims and survivors' genes might therefore have a bearing on whether or not they exhibit resilience following CSA.²⁰⁴
- 'Sensitive periods' are times during childhood and adolescence when the brain is at its most 'plastic'. In other words, times when it is most sensitive to being influenced by external experiences. Different parts of the brain go through sensitive periods at different times. If adversity is experienced during a sensitive period, the research suggests it will have a larger impact on the brain's structure and function than if it occurred at other times. The timing and duration of CSA might therefore lead to differences in outcomes for victims and survivors as a result.²⁰⁵
- Timely interventions can mitigate the effects of adverse experiences.²⁰⁶

It should be noted that this research is at an early stage, however, and therefore these findings should be interpreted with caution.

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- 203 De Bellis, M. D., Spratt, E. G., and Hooper, S. R. (2011) Neurodevelopmental Biology Associated with Childhood Sexual Abuse. *Journal of Child Sexual Abuse*, 20(5), pp.548-587; Blanco, L., Nydegger, L. A., Camarillo, G., Trinidad, D. R., Schramm, E., and Ames, S. L. (2015) Neurological changes in brain structure and functions among individuals with a history of childhood sexual abuse: A review. *Neuroscience and Biobehavioral Reviews*, 57, pp.63-69; Hulme, P. A. (2011) Childhood Sexual Abuse, HPA Axis Regulation, and Mental Health: An Integrative Review. *Western Journal of Nursing Research*, 33(8), pp.1069-1097
- 204 Beach, S. R. H., Brody, G. H., Lei, M. K., Gibbons, F. X., Gerrard, M., Simons, R. L., Cutrona, C. E., and Philibert, R. A. (2013) 'Impact of child sex abuse on adult psychopathology: A genetically and epigenetically informed investigation': Correction to Beach et al. (2013). *Journal of Family Psychology*, 27(2), pp.329-329
- 205 Andersen, S. L., Tomada, A., Vincow, E. S., Valente, E., Polcari, A., and Teicher, M. H. (2008) Preliminary evidence for sensitive periods in the effect of childhood sexual abuse on regional brain development. *Journal of Neuropsychiatry and Clinical Neurosciences*, 20(3), pp.292-301; Cicchetti, D., Rogosch, F. A., Gunnar, M. R., and Toth, S. L. (2010) The differential impacts of early physical and sexual abuse and internalizing problems on daytime cortisol rhythm in school-aged children. *Child Development*, 81(1), pp.252-269
- 206 Brotman, L. M., Gouley, K. K., Huang, K., Kamboukos, D., Fratto C., and Pine, D.S. (2007) Effects of a Psychosocial Family-Based Preventive Intervention on Cortisol Response to a Social Challenge in Preschoolers at High Risk for Antisocial Behavior. *Archives of General Psychiatry*, 64(10), pp.1172-1179; Heger et al. (2002), *op. cit.*

4.2.4 Medically unexplained symptoms

Studies have found that some victims and survivors report physical health symptoms for which no known physical cause has been established. These symptoms are sometimes referred to as “psychosomatic” – meaning they are linked to psychological causes or triggers – or simply as “medically unexplained”.²⁰⁷

The extent to which the causes of physical health problems are believed to be psychosomatic is disputed. A review of the literature noted studies that offered evidence of direct physical harm caused by the abuse, as well as studies which found that CSA had an independent effect on physical conditions and disorders, even after controlling for any psychiatric diagnoses.²⁰⁸ Among studies that have found a link, a wide range of medically unexplained symptoms have been reported by victims and survivors, including gastrointestinal, gynaecological, neurological and upper respiratory issues;²⁰⁹ chronic fatigue;²¹⁰ pelvic and genital pain; irritable bowel syndrome; recurring allergies and skin conditions;²¹¹ and migraines.²¹² Chronic pain and non-epileptic seizures in particular frequently fall into this category. Several studies point to an association between non-epileptic seizures and CSA.²¹³ One study compared people who experienced non-epileptic seizures to a comparison group, and found that those suffering with the seizures were three times more likely to have been a victim of CSA than the comparison group. However, the authors of this paper caution against drawing any inferences regarding causality.²¹⁴

The association between “psychosomatic disorders” and CSA further illustrates the importance of mental health as a factor that can help to explain physical health problems, as well as an outcome in its own right. A range of mental health problems have been linked to experiences of CSA; these form the focus of the following section.

207 Havig (2008), *op. cit.*

208 Nelson et al. (2012), *op. cit.*

209 *Ibid.*

210 *Ibid.*

211 One in Four (2015), *op. cit.*

212 O’Riordan and Arensman (2007), *op. cit.*

213 Chen et al. (2010), *op. cit.*; Maniglio (2009), *op. cit.*; Nelson et al. (2012), *op. cit.*; Sharpe and Faye (2006), *op. cit.*

214 Sharpe and Faye (2006), *op. cit.*

4.3 Emotional wellbeing, mental health and internalising behaviours

This section summarises the evidence on the impacts of CSA on victims and survivors' emotional wellbeing, mental health and internalising behaviours.

Summary of key themes

- The experience of CSA can have a detrimental effect on general emotional wellbeing, leading to low self-esteem and loss of confidence.²¹⁵ 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.²¹⁶
- Depression has been found in 57 per cent of young people who have experienced CSE.²¹⁷ The increased likelihood of major depression following a history of CSA has been shown to be 2.05²¹⁸ in young adults and 1.83²¹⁹ 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.²²⁰
- Rates of self-harm have been shown to be as high as 49 per cent among adult survivors in treatment²²¹ and 32 per cent among CSE victims and survivors.²²² The risk of CSA victims and survivors attempting suicide can be as much as six times higher than the general population.²²³
- 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.²²⁴
- The quality of interpersonal relationships has been shown to be instrumental in mitigating or compounding the impacts of CSA on mental health conditions.²²⁵

There is a large body of literature exploring the links between CSA and the emotional wellbeing, mental health and internalising behaviours of victims and survivors. The research has shown the impacts to be wide-ranging and diverse, although there is considerable variation in the strength of the relationships found between specific conditions and CSA. In particular, general emotional distress and trauma, depression, anxiety, PTSD, dissociation, and self-harm/suicidal behaviours have all been linked with CSA victimisation (see Table 4.3 for explanations of these terms).

215 One in Four (2015), *op. cit.*; Nelson (2009), *op. cit.*

216 Maniglio (2009), *op. cit.*

217 Health Working Group on Child Sexual Exploitation (2014), *op. cit.*

218 Mills et al. (2016), *op. cit.*

219 Kendler and Aggen (2014), *op. cit.*

220 Health Working Group on Child Sexual Exploitation (2014), *op. cit.*

221 Bolen et al. (2013), *op. cit.*

222 Health Working Group on Child Sexual Exploitation (2014), *op. cit.*

223 McCarthy-Jones and McCarthy-Jones (2014), *op. cit.*; Tomasula et al. (2012), *op. cit.*

224 Hooper and Warwick (2006), *op. cit.* citing Lisak (1995); Finkelhor et al. (1990); Durham (2003); van Toledo et al. (2013), *op. cit.* citing Baker & Duncan (1985); Fergusson et al. (2000)

225 Knott (2014), *op. cit.*; Parent-Boursier and Herbert (2015), *op. cit.*; Canton-Cortes et al. (2015), *op. cit.*

It is worth noting that, in recent years, there has been a shift in how the links between mental health outcomes and CSA are understood, in part due to emerging evidence from neurobiology (see section 4.2). Rather than being perceived purely as problematic, certain conditions and behaviours are now acknowledged to be adaptations to an abusive environment. Such adaptations include withdrawal, dissociation and hyper-vigilance to possible threats. These serve a protective purpose while victims and survivors are in that environment but, in the longer term, these adaptations can increase the risk of victims and survivors experiencing a number of emotional and mental health problems.²²⁶

The following sections outline the evidence on CSA, emotional wellbeing and mental health conditions.

4.3.1 General emotional wellbeing and mental health

Some of the psychological impacts of CSA victimisation do not constitute clinical mental health diagnoses, but can nonetheless have significant detrimental impacts on victims and survivors' quality of life. They can also increase the likelihood of diagnosable mental health conditions emerging. Around the time of the abuse, children can experience a range of emotions, including fear, sadness, anger, guilt, self-blame and confusion.²²⁷ In particular, familiarity with the perpetrator and use of force have been related to the negative emotions of humiliation, fear and self-consciousness, as well as a reduced ability to disclose the abuse.²²⁸ Such negative feelings may persist into adult life, with adult victims and survivors describing emotions such as worthlessness, powerlessness, low self-esteem, self-loathing and a lack of self-respect.²²⁹

In particular, many studies have highlighted a link between CSA, self-blame and low self-esteem.²³⁰ Self-blame appears to be particularly common among younger victims and survivors,²³¹ and self-esteem can improve over time.²³² Qualitative research has shown that increased understanding about the nature of abuse and how it can happen may reduce the tendency to self-blame.

*"I think understanding that it wasn't my fault was the key to getting confident and being able to deal with the trauma. Understanding that I was only a child, and an adult should never have taken advantage of a child who was starving for affection and love."*²³³

Similarly, a study with male survivors of abuse found that some of them had spent years in therapy learning to not blame themselves. Others had developed sophisticated methods of dealing with their feelings of self-blame.²³⁴

226 McCrory, E. J., Gerin, M. I., and Viding, E. (2017) Annual Research Review: Childhood maltreatment, latent vulnerability and the shift to preventative psychiatry – the contribution of functional brain imaging. *Journal of Child Psychology and Psychiatry*, 58, pp.338-357

227 Foster and Hagedorn (2014), *op. cit.*, Warrington et al. (2017), *op. cit.*

228 Young, T. L., Riggs, M., and Robinson, J. L. (2011) Childhood Sexual Abuse Severity Reconsidered: A Factor Structure of CSA Characteristics. *Journal of Child Sexual Abuse*, 20(4), pp.373-395

229 One in Four (2015), *op. cit.*, Nelson (2009), *op. cit.*

230 Perez-Gonzalez, A., and Pereda, N. (2015) Systematic review of the prevalence of suicidal ideation and behavior in minors who have been sexually abused. *Actas Espanolas De Psiquiatria*, 43(4), pp.149-158; Fergusson et al. (2013), *op. cit.*; O'Riordan and Arensman (2007), *op. cit.*

231 Marriott et al. (2014), *op. cit.*, citing Moran and Eckenrode (1992)

232 Daigneault et al. (2007), *op. cit.*

233 One in Four (2015), *op. cit.*, p.13

234 Grossman et al. (2006), *op. cit.*

Table 4.2: Protective and risk factors for self-esteem

Self-esteem and emotional wellbeing	Protective factors:
	<ul style="list-style-type: none"> • Supportive relationships with the mother.²³⁵ • Achievements in sport, the visual arts, drama or music.²³⁶ • Understanding more about how CSA can happen and recognising that the perpetrator is at fault.²³⁷
	Risk factors: <ul style="list-style-type: none"> • Feelings of hopelessness and powerlessness.²³⁸ • Perceived failure and underachievement.²³⁹ • Shame and guilt arising from an unsupportive or stigmatising response from other people following disclosure (see sections 4.10 and 4.11). • Feeling responsible for the abuse.²⁴⁰ • Familiarity with the perpetrator and use of force leading to humiliation, fear and self-consciousness, as well as a reduced ability to disclose the abuse.²⁴¹

4.3.2 Specific mental health conditions/internalising behaviours

The literature shows that the most common mental health condition associated with CSA is depression, followed by anxiety disorders, particularly PTSD.²⁴² However, as mentioned, CSA has been linked to a range of mental health problems.

As different studies use a variety of tools for measuring mental health conditions, definitions vary in the literature. Different measurement approaches may partly account for variation in research findings. For full definitions of mental health conditions, please see the glossary in Appendix A. Some of the mental health problems associated with CSA are outlined below.

235 Knott (2014), *op. cit.* citing Morrison and Clavenna-Valleroy (1998)

236 Nelson (2009), *op. cit.*

237 Grossman et al. (2006), *op. cit.*

238 Senn et al. (2012), *op. cit.*

239 Nelson (2009), *op. cit.*

240 Quadara et al. (2016), *op. cit.*; Montgomery et al. (2015), *op. cit.*; Allnock et al. (2015), *op. cit.*; Chouliara et al. (2014), *op. cit.*; Foster and Hagedorn (2014), *op. cit.*; Katz, C. (2013) Internet-related child sexual abuse: What children tell us in their testimonies. *Children and Youth Services Review*, 35(9), pp.1536-1542; Davidson et al. (2006), *op. cit.*

241 Young et al. (2011), *op. cit.*

242 Maniglio (2013b), *op. cit.*

Table 4.3: Mental health conditions linked with CSA

Internalising behaviours ²⁴³	General term for inward-focused harmful behaviours linked to mental health conditions, such as withdrawal and self-harm.
Depression ²⁴⁴	Persistent low mood that affects a person's daily life.
Anxiety ²⁴⁵	Feelings of unease, worry and fear.
Post-traumatic stress disorder ²⁴⁶	A form of anxiety that can emerge after experiencing or witnessing traumatic events.
Dissociation ²⁴⁷	Feeling disconnected in some way from the world around you. Can include memory loss and an altered sense of identity.
Self-harm ²⁴⁸	Causing direct and deliberate harm to oneself, such as by cutting or hitting oneself.
Suicide attempts or suicidal ideation ²⁴⁹	Intentionally killing oneself, attempting to do so, or having thoughts of doing so.
Eating disorders ²⁵⁰	Issues with eating and a problematic relationship with food.
Personality disorders ²⁵¹	Particular groups of attitudes, beliefs and behaviours that cause long-standing problems.
Perinatal problems ²⁵²	Emotional and psychological problems associated with pregnancy and childbirth. Includes postnatal depression and postnatal psychosis.
Psychosis ²⁵³	A loss of connection with reality. Can include hallucinations and delusions.
Schizophrenia ²⁵⁴	Changes in behaviour, thoughts and functioning which can include psychotic episodes (hallucinations, delusions, etc) and disorganised thinking and speech.
Bipolar disorder ²⁵⁵	Episodic mood states including feeling high (manic) or low (depressed).

The remainder of this section explores some of the most evidenced mental health conditions in more detail.

243 van Toledo et al. (2013), *op. cit.*; Aaron (2012), *op. cit.*; Hooper and Warwick (2006), *op. cit.*; van Delft, I., Finkenauer, C., Clasiën De Schipper, J., Lamers-Winkelmann, F., and Visser, M. M. (2015) The mediating role of secrecy in the development of psychopathology in sexually abused children. *Child Abuse & Neglect*, 46, 27-36; Parent-Boursier and Herbert (2015), *op. cit.*; Baril et al. (2016), *op. cit.*; Taylor, J. E., and Harvey, S. T. (2010) A meta-analysis of the effects of psychotherapy with adults sexually abused in childhood. *Clinical Psychology Review*, 30 (6), pp.749-767

244 Cooper, K., Quayle, E., Jonsson, L., and Svedin, C. G. (2016) Adolescents and self-taken sexual images: A review of the literature. *Computers in Human Behavior*, 55, pp.706-716; Easton, S. D., and Kong, J. (2017) Mental health indicators fifty years later: A population-based study of men with histories of child sexual abuse. *Child Abuse and Neglect*, 63, pp.273-283; Kamiya et al. (2016), *op. cit.*; Mills et al. (2016), *op. cit.*; NSPCC (2016) *It's time campaign report*; Coles et al. (2015), *op. cit.*; Perez-Gonzalez and Pereda (2015), *op. cit.*; Health Working Group on Child Sexual Exploitation (2014), *op. cit.*; Lindert, J., von Ehrenstein, O. S., Grashow, R., Gal, G., Braehler, E., and Weiskopf, M. G. (2014) Sexual and physical abuse in childhood is associated with depression and anxiety over the life course: systematic review and meta-analysis. *International Journal of Public Health*, 59, pp.359-372; Maniglio, R. (2010) Child sexual abuse in the etiology of depression: A systematic review of reviews. *Depression and Anxiety*, 27(7), pp.631-642; Sprober et al. (2014), *op. cit.*; Trickett et al. (2011), *op. cit.*; Chen et al. (2010), *op. cit.*; O'Riordan and Arensman (2007), *op. cit.*; Coles et al. (2015), *op. cit.*; Hetzel-Riggin, M. D., Brausch, A. M., and Montgomery, B. S. (2007) A meta-analytic investigation of therapy modality outcomes for sexually abused children and adolescents: An exploratory study. *Child Abuse and Neglect*, 31(2), pp.125-141; Kendler and Aggen (2014), *op. cit.*; Nelson et al. (2012), *op. cit.*; van Toledo et al. (2013), *op. cit.*; Wosu, A. C., Gelaye, B., and Williams, M. A. (2015) History of childhood sexual abuse and risk of prenatal and postpartum depression or depressive symptoms: an epidemiologic review. *Archives of Women's Mental Health*, 18(5), pp.659-671; Zeglin et al. (2015), *op. cit.*; Chen et al. (2010), *op. cit.*; Asgeirsdottir et al. (2010), *op. cit.*; Hunter (2009), *op. cit.*; McCarthy-Jones and McCarthy-Jones (2014), *op. cit.*; Parent-Boursier and Herbert (2015), *op. cit.*; Canton-Cortes et al. (2015), *op. cit.*; O'Riordan and Arensman (2007), *op. cit.*

- 245 Kamiya et al. (2016), *op. cit.*; Mills et al. (2016), *op. cit.*; NSPCC (2016), *op. cit.*; Lindert et al. (2014), *op. cit.*; Sprober et al. (2014), *op. cit.*; Trickett et al. (2011), *op. cit.*; Chen et al. (2010), *op. cit.*; O’Riordan and Arensman (2007), *op. cit.*; Danielson, C.K., Macdonald, A., Amstadter, A.B., Hanson, R., de Arellano, M.A., Saunders, B.E., and Kilpatrick, D. G. (2010) Risky behaviors and depression in conjunction with - or in the absence of - lifetime history of PTSD among sexually abused adolescents. *Child Maltreatment*, 15(1), pp.101-107; Fitzpatrick et al. (2010), *op. cit.*; Maniglio (2013), *op. cit.*; O’Riordan and Arensman (2007), *op. cit.*; Roffman et al. (2014), *op. cit.*; Health Working Group on Child Sexual Exploitation (2014), *op. cit.*; Canton-Cortes, D., and Canton, J. (2010) Coping with child sexual abuse among college students and post-traumatic stress disorder: the role of continuity of abuse and relationship with the perpetrator. *Child Abuse and Neglect*, 34(7), pp.496-506; Aaron (2012), *op. cit.*; Cooper et al. (2016), *op. cit.*; Havig (2008), *op. cit.*; Maniglio (2009), *op. cit.*; McCarthy-Jones and McCarthy-Jones (2014), *op. cit.*; 4; Parent-Boursier and Herbert (2015), *op. cit.*; van Toledo et al. (2013), *op. cit.*; Bick et al. (2014), *op. cit.*; Cashmore and Shackel (2014), *op. cit.*; Maniglio (2013b), *op. cit.*
- 246 Easton, S. D., Rennerb, L. M., and O’Leary, P. (2013) Posttraumatic growth among men with histories of child sexual abuse. *Child Maltreatment*, 18(4), pp.211-220; Canton-Cortes et al. (2011), *op. cit.*; Canton-Cortes and Canton (2010), *op. cit.*; Mills et al. (2016), *op. cit.*; Knott (2014), *op. cit.*; Harding, H. G., Burns, E. E., and Jackson, J. L. (2012) Identification of Child Sexual Abuse Survivor Subgroups Based on Early Maladaptive Schemas: Implications for Understanding Differences in Posttraumatic Stress Disorder Symptom Severity. *Cognitive Therapy and Research*, 36(5), pp.560-575; Maniglio (2013b), *op. cit.*; Breckenridge and Flax (2016), *op. cit.*; Hebert, M., Lavoie, F., and Blais, M. (2014) Post Traumatic Stress Disorder/PTSD in adolescent victims of sexual abuse: resilience and social support as protection factors. *Ciencia & Saude Coletiva*, 19(3), pp.685-694; Wosu, A. C., Gelaye, B., and Williams, M. A. (2015) Childhood sexual abuse and posttraumatic stress disorder among pregnant and postpartum women: review of the literature. *Archives of Women’s Mental Health*, 18(1), 61-72; McClean, L. M., Toner, B., Jackson, J., Desrocher, M., and Stuckless, N. (2006) The relationship between child sexual abuse, complex post-traumatic stress disorder and alexithymia in two outpatient samples: Examination of women treated in community and institutional clinics. *Journal of Child Sexual Abuse*, 15(3)
- 247 Sutherland et al. (2011), *op. cit.*; Trickett et al. (2011), *op. cit.*; Maniglio (2009), *op. cit.*; Havig (2008), *op. cit.*; Hunter (2009), *op. cit.*; Bick et al. (2014), *op. cit.*; Breckenridge and Flax (2016), *op. cit.*
- 248 NSPCC (2016), *op. cit.*; Health Working Group on Child Sexual Exploitation (2014), *op. cit.*; Maniglio (2009), *op. cit.*; Klonsky, E. D., and Moyer, A. (2008) Childhood sexual abuse and non-suicidal self-injury: meta-analysis. *British Journal of Psychiatry*, 192(3), pp.166-170; Trickett et al. (2011), *op. cit.*; Bolen et al. (2013), *op. cit.*; Breckenridge and Flax (2016), *op. cit.*; Scott et al. (2015), *op. cit.*; McNaughton Nicholls, C., Cockbain, E., Brayley, H., Harvey, S., Fox, C., Paskell, C., Ashby, M., Gibson, K. and Jago, N. (2014) *Research on the sexual exploitation of boys and young men: A UK scoping study*. Barnado’s; McPherson, P., Scribano, P., and Stevens, J. (2012) Barriers to Successful Treatment Completion in Child Sexual Abuse Survivors. *Journal of Interpersonal Violence*, 27(1), pp.23-39
- 249 NSPCC (2016), *op. cit.*; Perez-Gonzalez and Pereda (2015), *op. cit.*; Devries, K. M., Mak, J. Y. T., Child, J. C., Falder, G., Bacchus, L. J., Astbury, J., and Watts, C. H. (2014) Childhood Sexual Abuse and Suicidal Behavior: A Meta-analysis. *Pediatrics*, 133(5), pp.1331-1344; Chen et al. (2010), *op. cit.*; O’Riordan and Arensman (2007), *op. cit.*
- 250 Perez-Gonzalez and Pereda (2015), *op. cit.*; Chen et al. (2010), *op. cit.*; Maniglio (2009), *op. cit.*; Havig (2008), *op. cit.*; Hetzel-Riggin et al. (2007) *op. cit.* citing Kendler et al. (2000)
- 251 Breckenridge and Flax (2016), *op. cit.*; Health Working Group on Child Sexual Exploitation (2014), *op. cit.*; Cutajar, M. C., Mullen, P. E., Ogloff, J. R. P., Thomas, S. D., Wells, D. L., and Spataro, J. (2010) Psychopathology in a large cohort of sexually abused children followed up to 43 years. *Child Abuse & Neglect*, 34(11), pp.813-822; Fitzpatrick et al. (2010), *op. cit.*; Maniglio (2009), *op. cit.*
- 252 Leeners et al. (2016), *op. cit.*
- 253 Health Working Group on Child Sexual Exploitation (2014), *op. cit.*; Bebbington et al. (2011), *op. cit.*; Cutajar, M. C., Mullen, P. E., Ogloff, J. R. P., Thomas, S. D., Wells, D. L., and Spataro, J. (2010) Schizophrenia and Other Psychotic Disorders in a Cohort of Sexually Abused Children. *Archives of General Psychiatry*, 67(11), pp.1114-1119; Varese, F., Smeets, F., Drukker, M., Lieveise, R., Lataster, T., Viechtbauer, W., Read, J., van Os, J., and Bentall, R. P. (2012) Childhood adversities increase the risk of psychosis: A meta-analysis of patient-control, prospective and cross-sectional cohort studies. *Schizophrenia Bulletin*, 38(4), pp.661-671; Read, J., van Os, J., Morrison, A. P., and Ross, C. A. (2005) Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatr Scand*, 112, pp.330-350
- 254 Cutajar et al. (2010), *op. cit.*; Read et al. (2005), *op. cit.*
- 255 Maniglio (2013), *op. cit.*; O’Riordan and Arensman (2007), *op. cit.*

4.3.3 Internalising behaviours

People deal with stress in different ways; some people have a tendency to internalise and others to externalise their stress. 'Internalising behaviours' are mental health related conditions and/or behaviours that include anxiety, depression, decreased self-efficacy and self-confidence, and withdrawal. Externalising behaviours on the other hand, include anti-social behaviours and offending (see section 4.4). Some studies group outcomes into 'internalising and externalising behaviours'. However, the categorisation of certain behaviours is not always consistent, with self-harm described as an internalising behaviour in some research²⁵⁶ and an externalising behaviour in other research.²⁵⁷ For the purposes of this report, self-harm is treated as a mental health issue.

In terms of prevalence, one study with children who had experienced CSA showed that they were more likely to score highly (in the clinical or just below the clinical range²⁵⁸) on internalising behaviours, and experience significantly more internalising behaviour problems. Fifty-four per cent scored in the clinical range compared with only four per cent of the non-abused comparison group.²⁵⁹ Another study found that withdrawn behaviours were identified in ten per cent of pre-schoolers, 36 per cent of children aged 6–12, and 45 per cent of adolescents who had experienced sexual abuse,²⁶⁰ demonstrating how the likelihood increases with age. Such behaviours can be driven by the following: perpetrator manipulation; loss of trust in people; feelings of shame, guilt, fear, inadequacy; or physical separation from family members.²⁶¹ Victims and survivors may also isolate themselves and suppress their feelings in an attempt to appear 'normal'.²⁶²

Some research has argued that female victims and survivors have a higher propensity to internalise distress, while male victims and survivors are more likely to externalise distress.²⁶³ However, other studies have found no gender differences.²⁶⁴ A qualitative study with male prisoners with a history of CSA found that, while all reported feeling anger after the abuse – usually for many years – they dealt with it in different ways. Some internalised it, some tried to suppress it, while others turned to aggression and offending in their childhood and adolescence.²⁶⁵ Authors have noted that differences between the genders in how they express their distress may change as societal expectations around men and women's behaviour changes.²⁶⁶

A number of factors have been shown to influence the likelihood of exhibiting problematic internalising behaviours following CSA.

256 Hooper and Warwick (2006), *op. cit.*

257 van Toledo et al. (2013), *op. cit.*

258 Based on the Dutch translation of the Child Behaviour Checklist consisting of 113 items. Scores greater than 63 fell in the clinical range, scores of 60–63 were classified as subclinical.

259 van Delft et al. (2015), *op. cit.*

260 Aaron (2012), *op. cit.* citing Kendall-Tackett et al. (1993)

261 Nelson (2009), *op. cit.*; Maniglio (2009), *op. cit.*; Montgomery et al. (2015), *op. cit.*; Walsh, K., Fortier, M. A., and DeLillo, D. (2010) Adult coping with childhood sexual abuse: A theoretical and empirical review. *Aggression and Violent Behaviour*, 15(1), pp.1-13; Warrington et al. (2017), *op. cit.*

262 Montgomery et al. (2015), *op. cit.*

263 Hooper and Warwick (2006), *op. cit.* citing Lisak (1995); Finkelhor et al. (1990); Lisak (1994); Durham (2003); van Toledo et al. (2013), *op. cit.* citing Baker & Duncan, (1985); Fergusson et al. (2000)

264 van Toledo et al. (2013), *op. cit.* citing Maikovich-Fong and Jaffee (2010)

265 Nelson (2009), *op. cit.*

266 Hooper and Warwick (2006), *op. cit.*

Table 4.4: Protective and risk factors for internalising behaviours

Internalising behaviours	Protective factors:
	<ul style="list-style-type: none"> • Perception of a secure attachment between victims and survivors and their fathers.²⁶⁷
	Risk factors:
	<ul style="list-style-type: none"> • Having a mother who also has a history of CSA.²⁶⁸ • Higher levels of maternal distress, as measured in the last seven days.²⁶⁹ • A larger number of abuse events.²⁷⁰ • Older age at the time of the abuse.²⁷¹ • A tendency for the child to be generally secretive, as perceived by the mother.²⁷²

4.3.4 Depression

Depression is characterised by a persistently low mood that affects daily life. From the review of literature, a recurrent theme was an association between depression and CSA. Depression has been found in more than half (57 per cent) of young people who have experienced CSE.²⁷³ The increased likelihood of major depression following a history of CSA has been shown to be 2.05 in young adults²⁷⁴ and 1.83 in women victims and survivors²⁷⁵ relative to comparison groups. Additionally, studies focusing on people with depression have found higher rates of CSA relative to the rates in comparison groups or the general population.²⁷⁶ CSA has been associated with depression in the short term²⁷⁷ and with an increased risk of lifetime major depression.²⁷⁸ The symptoms may not be evident immediately, but can emerge or deepen at any time, as one victim and survivor described:

“You just slog on... really was only in last 6 to 7 years that I actually sought help – really when things just crashed, depression-wise that is... Now I’m at rock bottom financially...”²⁷⁹

The strength of the relationship between CSA and adult depression tends to be small to medium in statistical terms,²⁸⁰ and the relationship remains even after taking other factors associated with depression into account, such as sociodemographic characteristics.²⁸¹ Some studies have suggested that the experience of CSA directly causes depression.²⁸²

267 Parent-Boursier and Herbert (2015), *op. cit.*

268 Baril et al. (2016), *op. cit.*

269 Parent-Boursier and Herbert (2015), *op. cit.* Distress may or may not be related to the impact of parenting a child who had experienced CSA.

270 Taylor et al. (2010), *op. cit.*

271 Aaron (2012), *op. cit.* citing Kendall-Tackett et al. (1993)

272 van Delft et al. (2015), *op. cit.*

273 Health Working Group on Child Sexual Exploitation (2014), *op. cit.*

274 Mills et al. (2016), *op. cit.*

275 Kendler and Aggen (2014), *op. cit.*

276 O’Riordan and Arensman (2007), *op. cit.* citing Zlotnick et al (2001) and Tanskanen et al (2004)

277 van Toledo et al. (2013), *op. cit.*

278 Easton and Kong (2017), *op. cit.*; Mills et al. (2016), *op. cit.*; Kendler and Aggen (2014), *op. cit.*

279 Nelson (2009), *op. cit.*, p.111

280 Maniglio (2010), *op. cit.*

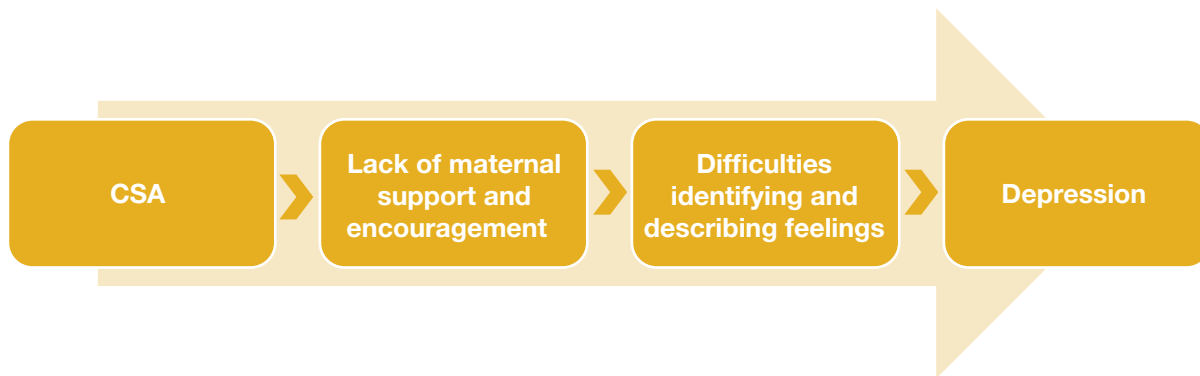
281 Coles et al. (2015), *op. cit.*

282 Perez-Gonzalez and Pereda (2015), *op. cit.*

Research findings are inconclusive regarding whether males or females are more at risk for depression following CSA. Some studies point to higher levels of depression among female compared with male victims and survivors²⁸³ or suggest that CSA is a risk factor for depression in female victims and survivors only.²⁸⁴ Other research found no significant differences in depression severity between male and female victims and survivors.²⁸⁵

While some studies have suggested that the relationship between CSA and depression is causal, there are many studies that have found that some protective and risk factors help to explain the relationship between the two. An example pathway of CSA leading to depression is in a study with female veterans. Using standardised instruments, the study measured the nature of the abuse, depression, difficulties identifying and describing feelings (alexithymia), and parents' responses to children's display of negative emotions. The results showed that 'positive maternal practices' such as problem solving, support, or expressive encouragement (or a lack of them) helped to explain the association between CSA and difficulties identifying and describing feelings, which can lead to depression.²⁸⁶

Figure 4.3: Example pathway between CSA and depression



283 Goldberg Edelson and Joa (2010), *op. cit.* citing Banyard, Williams, and Siegel (2004)

284 Zeglin et al. (2015), *op. cit.*

285 Schlachter, L., Weiner, S., and Nash, M. R. (2009) Family Functioning Moderating the Effects of Childhood Sexual Abuse on Memory Specificity. *Journal of Aggression, Maltreatment and Trauma*, 18(8), pp.859-871

286 Thomas, R., DiLillo, D., Walsh, K., and Polusny, M. A. (2011) Pathways from child sexual abuse to adult depression: The role of parental socialization of emotions and alexithymia. *Psychology of Violence*, 1(2), pp.121-135

Table 4.5: Protective and risk factors for depression

Depression	<p>Protective factors:</p> <ul style="list-style-type: none"> • Good quality, supportive relationships: <ul style="list-style-type: none"> – Perceiving the mother as supportive (for adolescent girls undergoing treatment for CSA).²⁸⁷ – A secure attachment style. The nature of CSA affected the relationship between attachment style and depression.²⁸⁸ – Having children (for women only).²⁸⁹ • High self-esteem, positive attitudes towards school, parental support, and sport participation, in a sample of sexually abused adolescents. Self-esteem helped to explain the links between parental support, attitudes towards school and sport participation, and the affect on depressed mood and anger.²⁹⁰
	<p>Risk factors:</p> <ul style="list-style-type: none"> • Polyvictimisation: experiencing other childhood adversities.²⁹¹ • Being revictimised through adult violence.²⁹² • Maladaptive schemas in a sample of women.²⁹³ • Alexithymia (difficulties in identifying and describing feelings).²⁹⁴

4.3.5 Anxiety

Anxiety is an umbrella term for a range of disorders, but can generally be characterised by feelings of nervousness, tension and unease related to what is happening or what may happen in the future. A person may suffer from a range of anxiety disorders. After depression, anxiety has been argued to be the most common mental health problem associated with CSA. In research conducted with 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.²⁹⁵ In a review of studies looking at the relationship between CSA and health outcomes, CSA was linked to the following kinds of anxiety disorders: generic anxiety; obsessive-compulsive disorder; phobic symptomatology;²⁹⁶ and PTSD.²⁹⁷

287 Knott (2014), *op. cit.* citing Morrison and Clavenna-Valleroy (1998)

288 Canton-Cortes et al. (2015), *op. cit.* The nature of CSA was measured by severe abuse, abuse committed by a non-family member, and abuse consisting of an isolated incident. These types of abuse strengthened the relationship.

289 Zeglin et al. (2015), *op. cit.*

290 Asgeirsdottir et al. (2010), *op. cit.*

291 Easton and Kong (2017), *op. cit.*

292 Coles et al. (2015), *op. cit.*

293 Harding et al. (2012), *op. cit.* A schema is a “broad pervasive theme or pattern” that is “comprised of memories, emotions, cognitions, and bodily sensations” (Young et al. 2003, p. 7 in Harding et al. (2012), *op. cit.*). Maladaptive schemas are dysfunctional, self-defeating and impairing schemas.

294 Thomas et al. (2011), *op. cit.*

295 Health Working Group on Child Sexual Exploitation (2014), *op. cit.*

296 Defined as a persistent fear response of an irrational and disproportionate nature to a specific person, place, object, or situation.

297 Maniglio (2013b), *op. cit.*

There is inconclusive evidence about whether males or females are more likely to suffer from anxiety following CSA. Some studies point to women and girls being at higher risk,²⁹⁸ whereas others have found a higher prevalence among men.²⁹⁹ One review of the literature concludes that male victims and survivors have the same risk of developing anxiety disorders as female victims and survivors.³⁰⁰

Although some authors have regarded the link between anxiety and CSA as causal, others have adopted a more cautious approach. Some authors recognise that anxiety may be influenced by other risk factors, such as parental mental illness and/or substance abuse, family conflict or dysfunction, and other forms of child maltreatment.³⁰¹ The evidence is mixed regarding the link between the nature of CSA and increased anxiety: some studies suggest an association between what is categorised as CSA ‘severity’ and increased anxiety/PTSD;³⁰² other studies have found no association.³⁰³ As there is little agreement in the literature regarding what constitutes ‘severity’, it has been inferred that there is insufficient evidence to claim that CSA ‘severity’ leads to an increased risk of anxiety symptoms or disorders. The same point is argued to apply to other aspects of sexual abuse, such as younger age, longer duration or higher frequency.³⁰⁴

Table 4.6: Risk factors for anxiety

Anxiety	<p>Risk factors:</p> <ul style="list-style-type: none"> • People with self-reported abuse had higher rates of anxiety and PTSD in adulthood than substantiated cases of CSA, although both were significantly associated.³⁰⁵ • Mothers not believing the child after disclosure was associated with greater levels of anxiety and trauma symptoms and dissociation.³⁰⁶ • When both friendship quality and the quality of the mother–child relationship were rated as low, there was a stronger link between CSA and the number of diagnosed anxiety disorders compared with when both were rated as high quality.³⁰⁷
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4.3.6 Post-traumatic stress disorder and complex trauma

PTSD has been found to be more related to CSA than other anxiety disorders.³⁰⁸ PTSD can be characterised by intrusive and recurrent thoughts and images of the traumatic event, hyper-arousal, and avoidance of trauma-related cues.³⁰⁹ The relationship between CSA and PTSD tends to persist after controlling for other forms of child maltreatment and several clinical and/or sociodemographic variables.³¹⁰ The strength of the relationship tends to be small to medium in statistical terms.³¹¹

298 Aaron (2012), *op. cit.*; Goldberg Edelson and Joa (2010), *op. cit.*

299 Cashmore and Shackel (2014), *op. cit.*

300 Maniglio (2013b), *op. cit.*

301 *Ibid.*

302 Canton-Cortes and Canton (2010), *op. cit.*; O’Riordan and Arensman (2007), *op. cit.*; Gall et al. (2007), *op. cit.*; Filipas (2006), *op. cit.*

303 Mills et al. (2016), *op. cit.*

304 Maniglio (2013b), *op. cit.*

305 Mills et al. (2016), *op. cit.*

306 Bick et al. (2014), *op. cit.*

307 Adams, R. E., and Bukowski, W. M. (2007) Relationships with mothers and peers moderate the association between childhood sexual abuse and anxiety disorders. *Child Abuse and Neglect*, 31(6), pp.645-656

308 Maniglio (2013b), *op. cit.*

309 Harding et al. (2012), *op. cit.*

310 Maniglio (2013b), *op. cit.*

311 *Ibid.*

PTSD is argued to be the diagnosis that best fits the syndrome commonly seen in victims and survivors of CSA.³¹² However, it may not be immediately obvious what the cause of trauma is. Failure to recognise this can lead to further trauma, as described in one qualitative study:

“...post-traumatic stress was not recognised. I was having flashbacks, having seizures, total comatose state... ranting and raving at times... when I was getting a morphine injection for pain, they didn't connect that the really heavy deep sleep puts you into subconscious flashbacks, and I would re-enact whatever state was going through my head... flashbacks to the rape and my childhood.”³¹³

In one sample, 26 per cent of adolescent victims of sexual abuse showed PTSD symptoms.³¹⁴ The likelihood of experiencing PTSD has also been shown to increase with the degree of abuse experienced. In particular, experiencing physical and sexual abuse in both childhood and adulthood was related to a much higher risk of PTSD than abuse in childhood only, or adulthood only.³¹⁵ It has also been argued that sexual assault and rape are higher risk stressors for PTSD than other forms of trauma, such as being a victim of physical assault, witnessing violence or experiencing a natural disaster.³¹⁶

For some victims and survivors, the symptoms they experience as a consequence of their trauma are not captured by a diagnosis of PTSD. The terms ‘complex trauma’ or ‘complex PTSD’ have been used to describe exposure to multiple and/or chronic, interpersonal traumatic experiences, which often begin in early childhood and occur within the caregiving system. The terms also relate to the immediate and ongoing impacts of this exposure on a person’s development and functioning.³¹⁷ These include disorders of affect regulation, dissociation, chronic difficulties in self-concept, and alterations in negotiating interpersonal relationships, physical symptoms, and somatization.³¹⁸ In one study, women who experienced early onset (before the age of 12) CSA were highly likely to report current or lifetime complex PTSD. Women with later onset CSA were highly likely to report complex PTSD that spanned multiple life stages, but not highly likely to report complex PTSD at the time of the study. The authors of the paper suggest that this decline of symptoms could be a result of recovery amongst these women.³¹⁹

312 Maniglio (2013b), *op. cit.*

313 Nelson (2009), *op. cit.*, p.155

314 Hebert et al. (2014), *op. cit.*

315 Wosu et al. (2015), *op. cit.* citing Seng et al. (2008)

316 Health Working Group on Child Sexual Exploitation (2014), *op. cit.* citing Seedat et al. (2004)

317 Kisiel, C., Fehrenbach, T., Liang, L., Stolbach, B., McClelland, G., Griffin, G., Maj, N., Briggs, E. C., Vivrette, R. L., Layne, C. M., and Spinazzola, J. (2014) Examining child sexual abuse in relation to complex patterns of trauma exposure: Findings from the national child traumatic stress network. *Psychological Trauma: Theory, Research, Practice and Policy*, 6(1), pp.29-39

318 McClean et al. (2006), *op. cit.* citing van der Kolk (2003)

319 McClean et al. (2006), *op. cit.*

Table 4.7: Protective and risk factors for PTSD

Post-traumatic stress disorder	Protective factors:
	<ul style="list-style-type: none"> • Placing responsibility for the abuse onto the perpetrator.³²⁰
	Risk factors:
	<ul style="list-style-type: none"> • Feelings of stigma, betrayal and powerlessness were associated with more PTSD symptoms among female students.³²¹ • Self-destructive and evasion coping strategies had a stronger link with PTSD than other coping strategies.³²² • People with self-reported abuse had higher rates of anxiety and PTSD in adulthood than substantiated cases of CSA, although both were significantly associated.³²³ • Non-offending mothers' depression was associated with PTSD.³²⁴ • Maladaptive schemas predicted PTSD.³²⁵

One study demonstrated how post-traumatic growth (positive adaptation) can occur following CSA, through lower levels of self-blame and an increased understanding of the emotions that can follow CSA, in oneself and in others.³²⁶

Figure 4.4: Example of protective factors leading to post-traumatic growth

320 Easton et al. (2013), *op. cit.*

321 Canton-Cortes et al. (2011), *op. cit.*

322 Canton-Cortes and Canton (2010), *op. cit.* Self-destructive: "Getting yourself into risky situations more than you usually would". Evasion: "Sleeping a lot and trying to not think about what happened".

323 Mills et al. (2016), *op. cit.*

324 Knott (2014), *op. cit.* citing Deblinger et al. (1999)

325 Harding et al. (2012), *op. cit.* A schema is a "broad pervasive theme or pattern" that is "comprised of memories, emotions, cognitions, and bodily sensations" (Young et al. 2003, p. 7 in Harding et al. (2012), *op. cit.*). Maladaptive schemas are dysfunctional, self-defeating and impairing schemas. For PTSD, maladaptive schemas related to themes of vulnerability to harm and mistrust/abuse.

326 Easton et al. (2013), *op. cit.*

4.3.7 Dissociation

Dissociation is a common reaction to trauma, and has been described as disruptions in the connections between consciousness, memory, identity, or perception of the environment, which interferes with the integration of information.³²⁷ Victims and survivors have described feelings such as numbness, confusion, feeling unreal or living in a fog.³²⁸ The most severe form of dissociation is dissociative identity disorder. Dissociation can also include the repression of memories which, when uncovered can be very painful for the victim and survivor.³²⁹ A number of studies have found links between CSA and dissociation.³³⁰

Dissociation can lead to further challenges. One study with children who were sexually abused by someone within their family, and/or reported symptoms of dissociation on disclosure of abuse, were at increased risk of developing attention problems eight to 36 months after disclosure.³³¹ Another study found that dissociation, more than depression or anxiety, was broadly associated with trauma. Conducted over a number of time periods, the research showed that dissociation occurred as a consequence of past sexual trauma and was associated with the future perpetuation of trauma such as revictimisation, self-harm, and harsh parental discipline.³³²

Some studies suggest that dissociation can be used as a way of coping in the context of abuse, which is then repeated in other contexts. Victims and survivors have reported that severe numbness and detachment from feelings are a form of adaptation and a way of surviving.³³³ As one woman, a victim of sex trafficking, explained in a qualitative study:

“It’s a process, and then if a person hasn’t had counselling in that area, like a lot of us didn’t, we learned to suppress [our feelings]. It creates a problem. I had to mentally separate, you really just become like a machine. It’s business. You just learn how to shut it off... A lot of numbing. Even if you come out alive it’s a lot of numbing.”³³⁴

Although sometimes used as a coping mechanism, dissociation can be very detrimental, leading to confusion, lack of focus, fragmented memories and an increased sense of unreality.³³⁵

“Dissociation with much lost time, which is a subconscious way of keeping away from this inner reality. This was useful as a child so as to disconnect from unbearable inescapable situations, but can be a huge hindrance as an adult.”³³⁶

327 Kaplow, J. B., Hall, E., Koenen, K. C., Dodged, K. A., and Amaya-Jackson, L. (2008) Dissociation predicts later attention problems in sexually abused children. *Child Abuse and Neglect*, 32(2), pp.261-275 citing Putnam (1997)

328 One in Four (2015), *op. cit.*

329 Hunter (2009), *op. cit.*

330 Sutherland et al. (2011), *op. cit.*; Trickett et al. (2011), *op. cit.*; Maniglio (2009), *op. cit.*; Havig (2008), *op. cit.*; Hunter (2009), *op. cit.*; Bick et al. (2014), *op. cit.*; Breckenridge and Flax (2016), *op. cit.*

331 Kaplow et al. (2008), *op. cit.*

332 Trickett et al. (2011), *op. cit.*

333 Leeners et al. (2016), *op. cit.*; Montgomery (2013), *op. cit.*; Montgomery et al. (2015), *op. cit.*

334 Cecchet and Thoburn (2014), *op. cit.*, p.489

335 One in Four (2015), *op. cit.*

336 *Ibid.* p.29

Table 4.8: Risk factors for dissociation

Dissociation	<p>Risk factors:</p> <ul style="list-style-type: none"> • Early onset of abuse and multiple perpetrators associated with dissociation among sexually abused females.³³⁷ • Mothers not believing the child after disclosure was associated with greater levels of dissociation.³³⁸ • Difficult events that may remind survivors of the abuse, such as medical examinations, pain and childbirth can trigger dissociation³³⁹ (see section 4.10).
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4.3.8 Self-harm

Self-harm can take many forms, such as self-cutting, burning and scarring, and has broadly been described as a turning inwards on the self through injurious behaviour.³⁴⁰ However, there are other types of behaviours that can also be expressions of self-harm, such as addictions, 'risky' behaviours and substance misuse. For the purposes of this review, self-harm is defined as inflicting direct and deliberate injuries on oneself. Other outcomes, including addictions and substance misuse are considered in section 4.4, which covers behavioural impacts.

Rates of self-harm vary depending on the methodology and sample used, but have been shown to be as high as 49 per cent among adult survivors in treatment³⁴¹ and 32 per cent among victims and survivors of CSE.³⁴² Self-harm is more common among those who have experienced CSA relative to comparison groups; one study found that females who had experienced CSA reported almost four times as many incidences of self-inflicted harm and suicidality compared with those who had not experienced CSA.³⁴³

Regarding different kinds of self-harm, a sample of adult victims and survivors receiving or entering treatment found that the most common form of severe self-injury was cutting and hitting oneself with fists. Other less common forms of self-harm included scratching one's skin, head banging, interfering with wounds and bone breaking. Respondents who had engaged in self-harm reported an average of three types of harm over their lifetime and one type in the past year.³⁴⁴

337 Trickett et al. (2011), *op. cit.*

338 Bick et al. (2014), *op. cit.*

339 Leeners et al. (2016), *op. cit.*; Montgomery (2013), *op. cit.*; Montgomery et al. (2015), *op. cit.*

340 Nelson (2009), *op. cit.*

341 Bolen et al. (2013), *op. cit.*

342 Health Working Group on Child Sexual Exploitation (2014), *op. cit.*

343 Trickett et al. (2011), *op. cit.*

344 Bolen et al. (2013), *op. cit.*

The definition of self-harm as a turning inwards has implications in terms of the gender differences noted in the prevalence of self-harm. There is some suggestion from research findings that male victims and survivors of CSA in general tend to report fewer negative impacts than do their female counterparts. This includes impacts relating to self-harm.³⁴⁵ However, one study found that professionals³⁴⁶ interviewed about CSE reported that males may express their anger externally and self-harm in different ways to females as a response to CSE. For example, males may intentionally provoke a fight as a means of sustaining an injury, which may not be recognised by others as a method of self-harm.³⁴⁷ Consequently, gender differences may relate to variation in the forms of self-harm rather than differences in the prevalence of self-harm.

Table 4.9: Risk factors for self-harm

Self-harm	<p>Risk factors:</p> <ul style="list-style-type: none"> • Authors have argued that CSA appears to be a risk factor for self-harm because both CSA and self-harm are related to the same mental health risk factors, such as depression, anxiety and poor self-esteem.³⁴⁸ • Dissociation and PTSD increase the likelihood of non-suicidal self-injury.³⁴⁹
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4.3.9 Suicide attempts and suicidal ideation

Deliberately taking one's own life, or attempting to, is the most serious form of self-harm. People may also experience suicidal thoughts (ideation), including planning suicide attempts. Suicidal ideation and attempted suicide have been associated with CSA in a number of studies.³⁵⁰ The Adult Psychiatric Morbidity Survey found that ten per cent of adults with a history of CSA had attempted suicide.³⁵¹ The risk of CSA victims and survivors attempting suicide can be as much as six times higher than their non-abused counterparts.³⁵² In a qualitative study with 24 male survivors of CSA involving contact, more than two-thirds had attempted suicide and almost all had thought seriously about it.³⁵³ A US study with victims and survivors found that 55 per cent of adults had symptoms of suicidality.³⁵⁴

Studies also show a higher incidence of history of CSA among those who have attempted suicide compared with those who have not. In one study with people admitted to hospital for suicide attempts, 35 per cent had experienced CSA. The rates of CSA and child physical abuse (CPA) were highest among those with repeated suicide attempts and self-cutting.³⁵⁵ Among adolescents presenting to a medical emergency department following a suicide attempt, CSA was a major risk factor for re-attempting suicide within 12 months.³⁵⁶

345 McNaughton Nicholls et al. (2014), *op. cit.* citing Brayley et al (2014)

346 'Professionals' refers to representatives from specialist CSE services, police and social services, men's sexual violence support services, black and minority ethnic youth services, young people's substance misuse services, and services for lesbian, gay, bisexual and transgender young people.

347 McNaughton Nicholls et al. (2014), *op. cit.*

348 Klonsky and Moyer (2008), *op. cit.*

349 Bolen et al. (2013), *op. cit.*

350 Perez-Gonzalez and Pereda (2015), *op. cit.*

351 Scott et al. (2015), *op. cit.*

352 McCarthy-Jones and McCarthy-Jones (2014), *op. cit.*; Tomasula et al. (2012), *op. cit.*

353 Nelson (2009), *op. cit.*

354 O'Riordan and Arensman (2007), *op. cit.* citing Ponton and Goldstein (2004)

355 *Ibid.* citing Ystgaard et al. (2004)

356 *Ibid.* citing Vajda & Steinbeck (1999)

The strength of the relationship between CSA exposure and attempted or completed suicides has been shown to vary a great deal between studies.³⁵⁷ However, there is some indication from research with young people that CSA can directly predict suicidal behaviour.³⁵⁸ Among homeless young people living on the street, experiencing CSA and CPA prior to leaving home were independent predictors of suicide attempts for both males and females.³⁵⁹ For adolescents incarcerated in juvenile detention centres, CSA independently predicted suicidal ideation and non-fatal suicidal behaviour.³⁶⁰ However, it is not possible to draw conclusions about causality as these studies were carried out with sub-groups of victims and survivors with particular needs.

For gender differences in suicidal behaviour, many studies have found stronger associations between suicide attempts for male survivors of CSA than for female survivors.³⁶¹ In one study with adolescent victims and survivors of sexual assault, the prevalence of suicide attempts for males and females was 26 per cent for both groups. Victims and survivors of both genders were more likely to have attempted suicide than their non-abused counterparts. However, the increased likelihood was nearly ten times more likely for boys, compared with nearly five times more likely for girls. The gender difference was even more pronounced when looking at medically serious suicide attempts – attempts that required treatment by a doctor or a nurse.³⁶² However, the evidence is not conclusive, with some studies reporting females to be more at risk³⁶³ and others finding equal risk.³⁶⁴ It has been suggested that females have different coping mechanisms to males and this may be a protective factor.³⁶⁵

Table 4.10: Risk factors for suicide attempts

Suicide	<p>Risk factors:</p> <ul style="list-style-type: none"> Some evidence to suggest that males are more at risk than females of attempting suicide following CSA, however, research findings are mixed.³⁶⁶
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As discussed, many mental health conditions such as self-harm and suicidal behaviours are examples of internalising behaviours. The following section explores some of the externalising behaviours associated with CSA.

357 Devries et al. (2014), *op. cit.*

358 Maniglio (2013), *op. cit.*

359 O’Riordan and Arensman (2007), *op. cit.*, citing Molnar et al. (1998)

360 *Ibid.* citing Esposito & Clum (2002)

361 Cashmore and Shackel (2014), *op. cit.* citing Rhodes et al. (2011); Garnefski and Arends (1998); Garnefski and Diekstra (1997); Martin et al. (2004); Molnar, Berkman and Buka (2001); Spataro et al (2004); van Roode et al. (2009)

362 Tomasula et al. (2012), *op. cit.*

363 Cashmore and Shackel (2014), *op. cit.*, citing Cutajar et al. (2010)

364 *Ibid.* citing Dube et al. (2005); Fergusson et al. (1996, 2003, 2008, 2013); Nelson (2002)

365 O’Riordan and Arensman (2007), *op. cit.*

366 Tomasula et al. (2012), *op. cit.*; Cashmore and Shackel (2014), *op. cit.*

4.4 Externalising behaviours

This section summarises the evidence on the impacts of CSA on victims and survivors.

Summary of key themes

- 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).³⁶⁷
- Behaviours exhibited following CSA can vary depending on the age and gender of the victim and survivor.³⁶⁸ 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.³⁶⁹
- 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.³⁷⁰ Additionally, one study found that young victims and survivors are up to 12 times more likely than comparison groups to report conduct disorder.³⁷¹
- 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.³⁷²
- 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.³⁷³ Supportive family relationships and increased levels of education among victims and survivors have been found to reduce the risk of these maladaptive behaviours.³⁷⁴

Victims and survivors of CSA may display a range of externalising behaviours during and after the experience of sexual abuse, and into adulthood. A strong theme in the literature is that behavioural responses to CSA are very often forms of coping strategy. That is, victims and survivors may adopt certain behaviours in an effort to manage, suppress or gain temporary relief from the trauma and distress of the abuse.³⁷⁵ Broader research also draws links between complex trauma and certain types of behaviour³⁷⁶ (see section 4.3 for further details on complex trauma).

367 Nelson (2009), *op. cit.*; O'Riordan and Arensman (2007), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Chouliara et al. (2014), *op. cit.*

368 See for example, Nelson (2009), *op. cit.*

369 See for example Lown et al. (2011), *op. cit.*; Nelson (2009), *op. cit.*; One in Four (2015), *op. cit.*

370 Nelson (2009), *op. cit.*; One in Four (2015), *op. cit.*; Beckett, H., Holmes, D., and Walker, J. (2017) *Child sexual exploitation: Definition & Guide for Professionals (Extended text)*. University of Bedfordshire: Luton; Maniglio (2009), *op. cit.*

371 Maniglio (2015), *op. cit.*

372 Ogloff et al. (2012), *op. cit.*

373 See for example, Nelson (2009), *op. cit.*; One in Four (2015), *op. cit.*; Warrington et al. (2017), *op. cit.*

374 Bick et al. (2014), *op. cit.*; Draucker and Mazurczyk (2013), *op. cit.*; Young et al. (2011b), *op. cit.*

375 Nelson (2009), *op. cit.*; O'Riordan and Arensman (2007), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Chouliara et al. (2014), *op. cit.*

376 See for example, Kiesel et al. (2014), *op. cit.*

This body of literature also reminds us that, as with the other outcome areas, adverse behavioural outcomes can affect any victims and survivors across different life stages. This includes those who have disclosed CSA (or had it identified) and those who have not. Behavioural outcomes of CSA must be considered in these different contexts. Among those victims and survivors who have not disclosed abuse, behavioural impacts can serve as indicators of CSA – a means of communicating that something is wrong and signalling a need for help.³⁷⁷ In a recent study with child victims of CSA, most viewed direct disclosure as unlikely or impossible, despite desires for the abuse to be recognised.³⁷⁸ This viewpoint emphasises the importance of professionals, as well as the wider public, having the necessary knowledge, awareness and skills to respond sensitively if individuals exhibit behaviours which might indicate that some form of abuse has occurred (see sections 4.10 and 4.11 for further information). As victims and survivors recount:

“[the victim and survivor’s] conspicuous behaviour of hair pulling, eyebrow pulling and prolonged bouts of crying in the school cloakroom were simply interpreted as some kind of baffling general anxiety by both parents and teachers.”³⁷⁹

“Heavy drinking was not recognised early and picked up, because young men are assumed to drink heavily in this [Scottish] culture.”³⁸⁰

“I was a tortured soul so took drugs and went into school hoping someone would figure it out, but I was expelled. I ran away from home, which only led to being taken into care.”³⁸¹

“[Before telling someone] you want to lock your mouth up... you feel like you have a dead end, you’ve hit a dead end and you don’t know what to do and you’re trapped... and your feelings are trapped inside... you’re worried and you’re scared... and you might feel angry, confused and also you might feel like you’ve locked yourself in like a prison that is keeping your worries from coming out.”³⁸²

Other studies further emphasise that identifying signs of sexual abuse can be particularly difficult when individuals also have a disability (for example, autism).³⁸³ One child victim participating in a qualitative study with children and young people describes:

“They [adults] could just think it was part of autism because children with autism can get angry and throw things.”³⁸⁴

377 See for example, Nelson (2009), *op. cit.*; One in Four (2015), *op. cit.*; Warrington et al. (2017), *op. cit.*

378 Heger et al. (2002), *op. cit.*

379 Nelson (2009), *op. cit.*, p.80

380 *Ibid.*, p.7

381 One in Four (2015), *op. cit.*, p.16

382 Warrington et al. (2017), *op. cit.*, p.41

383 Warrington et al. (2017), *op. cit.*; Sobsey and Mansell (1994) cited in Breckenridge and Flax (2016), *op. cit.*

384 Warrington et al. (2017), *op. cit.*, p.61

4.4.1 Defining externalising behaviours

Overall, two broad categories of behaviours emerge from the literature:

- internalised behaviours
- externalised behaviours

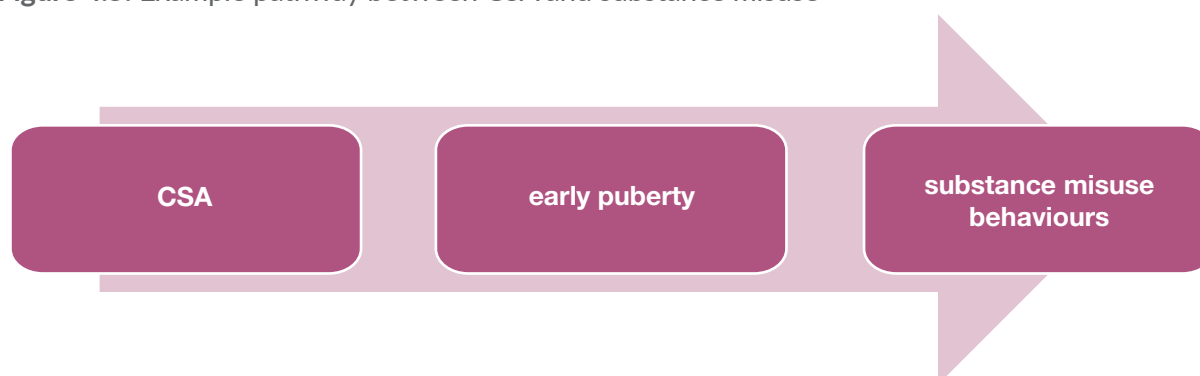
The overlap between behaviours and mental health is acknowledged. Some research recognises that certain behaviours have psychological or psychiatric origins and they are often discussed in this context. However, as described in section 4.3, the categorisation of certain behaviours is not always clear or consistent. Table 4.11 details how internalised and externalised behaviours have been grouped for the purpose of this report and the relevant sections where they are discussed.

Table 4.11: Definitions of internalised and externalised behaviours

Internalised behaviours	Victims and survivors may internalise their distress and this is often associated with a range of different behaviours including anxiety, depression, decreased self-efficacy and self-confidence, and withdrawal.
Research findings relating to this group of behaviours are discussed in more detail in section 4.3.3 in the context of mental health.	
Externalised behaviours	Victims and survivors may externalise their distress and exhibit a range of outward-facing behaviours such as anger, aggression, hostility, substance misuse, addictive behaviours, sexual behaviours which are inappropriate or 'risky', anti-social behaviour and offending. ³⁸⁵ Studies have also revealed an association between CSA and conduct disorder. ³⁸⁶
Research findings relating to this group of behaviours form the focus of the current section 4.4. 'Running away' is discussed in section 4.6 in the context of youth homelessness.	

It is evident from literature that behavioural impacts of CSA are best understood as dynamic over time, rather than static or fixed.³⁸⁷ Certain behaviours may also occur in response to, or are linked to, other outcomes of CSA. One study highlights this, drawing a link between early physical development and substance misuse (Figure 4.5).³⁸⁸

Figure 4.5: Example pathway between CSA and substance misuse



The remainder of this section concentrates on the evidence around externalised behaviours, looking specifically at the behaviours explored more fully in the reviewed studies.

³⁸⁵ Nelson (2009), *op. cit.*; One in Four (2015), *op. cit.*; Maniglio (2009), *op. cit.*

³⁸⁶ Maniglio (2013), *op. cit.*; Maniglio (2015), *op. cit.*

³⁸⁷ See Nelson (2009), *op. cit.*; Warrington et al. (2017), *op. cit.*; Trickett et al. (2011), *op. cit.*; O'Riordan and Arensman (2007), *op. cit.*; One in Four (2015), *op. cit.*

³⁸⁸ Trickett et al. (2011), *op. cit.*

4.4.2 Conduct disorder

Conduct disorder is a condition typically diagnosed in childhood and adolescence where individuals persistently display disruptive and socially inappropriate behaviour. This condition is sometimes described as a mental health issue but, given its nature, it is included in this REA as a behavioural outcome.

In a systematic review of (mostly American) studies, CSA was found to be associated with conduct disorder after testing for a number of other factors.³⁸⁹ While some studies found that conduct disorder could result from CSA, others identified it as a pre-existing risk factor for CSA victimisation. It is therefore not possible to fully establish the nature of the relationship between the two issues. It is suggested that those who have experienced CSA can be up to 12 times more likely than comparison groups to report conduct disorder.³⁹⁰

A number of negative outcomes were associated with conduct disorder:³⁹¹

- poorer psychological and social functioning
- poorer educational achievement
- increased vulnerability for revictimisation
- substance misuse
- suicidal behaviours

Most of the papers included in this study found no significant gender differences in relation to the experience of conduct disorder following CSA.³⁹²

Table 4.12: Risk factors for conduct disorder

Conduct disorder	<p>Risk factors:</p> <ul style="list-style-type: none"> • Nature of abuse: abuse involving penetration or force; causing injury; or consisting of multiple or prolonged incidents.³⁹³ • Polyvictimisation: physical abuse co-occurring with CSA.³⁹⁴ • Depression: depression has been identified as a strong predictor of lifetime conduct disorder among victims and survivors of CSA.³⁹⁵ • Disability: one study suggests that conduct disorder is more prevalent among child victims of CSA who have a disability.³⁹⁶
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389 Maniglio (2015), *op. cit.*

390 *Ibid.*

391 Frick (1998); Keenan, Loeber, & Green (1999); Lahey & Waldman (2012); Loeber et al. (2000) cited in Maniglio (2015), *op. cit.*

392 Maniglio (2015), *op. cit.*

393 *Ibid.*

394 Burke et al. (2002); Murray & Farrington (2010) cited in Maniglio (2015), *op. cit.*

395 Romano et al. (2006) cited in Maniglio (2015), *op. cit.*

396 Soyulu et al. (2013); Sullivan (1993), cited in Breckenridge and Flax (2016), *op. cit.*

4.4.3 Substance misuse and compulsivity

Multiple studies reviewed as part of this REA found an association between CSA and substance misuse.³⁹⁷ Addictive behaviours relating to gambling, food and sex were also identified³⁹⁸ (see section 4.4.4 for further information on sexual behaviours). ‘Overworking’ (or ‘workaholism’) emerges as another compulsive behaviour used by some victims and survivors to manage the impacts of the abuse³⁹⁹ (see section 4.6).

This section concentrates on research findings relating to substance misuse. It is important to note that definitions of substance use, misuse and dependency are not always clear or consistent across studies. Substance misuse is therefore used here as an umbrella term for this range of outcomes.

Research has found CSA to be significantly associated with increased use of nicotine, alcohol and illegal drugs.⁴⁰⁰ Using substance misuse behaviours as coping mechanisms seems to be relevant to both adolescent and adult victims and survivors, with polysubstance misuse also cited in some of the literature. In a qualitative study with male victims and survivors of CSA, a number of males described how they had become addicted to drugs or alcohol in their adolescent years or later in life. Some used multiple substances simultaneously, and some became addicted before reaching their teens.⁴⁰¹ Similarly, One female victim and survivor from another study explains:

“Drug abuse: the only thing that would make me feel good temporarily. I started smoking and drinking at 13 and continued to smoke cannabis daily since age 14. By the time I was 15 I was taking amphetamines, ecstasy, LSD and then moved on to ketamine and cocaine as well until I finally stopped at age 21. I saw many of my friends have psychotic episodes and some of them being hospitalised. The turning point for me was when I gained insight about how I was using drugs to numb the pain.”⁴⁰²

In the context of CSE, it is also important to point out that substance misuse can also form part of the abuse. This is specifically in relation to the grooming process where perpetrators may supply children with free alcohol or drugs over a period of time before forcing them to engage in sexual activity.⁴⁰³

397 See for example Breckenridge and Flax (2016), *op. cit.*; Draucker and Mazurczyk (2013), *op. cit.*; Lown et al. (2011), *op. cit.*; Maniglio (2013), *op. cit.*; Cashmore and Shackel (2014), *op. cit.*; One in Four (2015), *op. cit.*; Duncan, A. E., Sartor, C. E., Scherrer, J. F., Grant, J. D., Heath, A. C., Nelson, E. C., Jacob, T., and Bucholz, K. K. (2008) The association between cannabis abuse and dependence and childhood physical and sexual abuse: evidence from an offspring of twins design. *Addiction*, 103 (6), pp.990-997; Hayatbakhsh, M. R., Najman, J. M., Jamrozik, K., Mamun, A. A., O’Callaghan, M. J., and Williams, G. M. (2009) Childhood Sexual Abuse and Cannabis Use in Early Adulthood: Findings from an Australian Birth Cohort Study. *Archives of Sexual Behavior*, 38(1), pp.135-142

398 Nelson (2009), *op. cit.*; One in Four (2015), *op. cit.*; Aaron (2012), *op. cit.*

399 Nelson (2009), *op. cit.*; Chouliara et al. (2014), *op. cit.*

400 Fergusson et al. (2013), *op. cit.*; Draucker and Mazurczyk (2013), *op. cit.*; Danielson et al. (2010), *op. cit.*; Maniglio (2013), *op. cit.*; Lown et al. (2011), *op. cit.*; Chouliara et al. (2014), *op. cit.*; Beckett et al. (2017), *op. cit.*; Duncan et al. (2008), *op. cit.*; Hadland et al. (2012), *op. cit.*; Hayatbakhsh et al. (2009), *op. cit.*; Butt, S., Chou, S., and Browne, K. (2011) A rapid systematic review on the association between childhood physical and sexual abuse and illicit drug use among males. *Child Abuse Review*, 20 (1), pp.6-38

401 Nelson (2009), *op. cit.*

402 One in Four (2015), *op. cit.*, p.13

403 Jay, A. (2014) *Report from the Independent Inquiry into Child Sexual exploitation in Rotherham: 1997 - 2013*

Research highlights that substance misuse can:⁴⁰⁴

- lead to physical health problems (see section 4.2)
- have damaging consequences for victims and survivors' relationships
- negatively affect educational and employment and career outcomes throughout adult lives
- create vulnerabilities for particular sexual behaviours
- create vulnerabilities for revictimisation

Further details on specific substances most prominent in the literature are discussed below.

Cannabis

Studies have found that the experience of CSA presents a significant risk of developing cannabis misuse compared with those who have not experienced sexual abuse. This association was found to remain, even after a number of individual and family factors (including having a drug-dependent parent) were taken into account.⁴⁰⁵

The research focuses some attention on gender differences and cannabis misuse. However, the research findings are inconsistent and it is therefore difficult to draw any firm conclusions. For example, in a review of studies exploring the associations between CSA and substance misuse during adolescence, one study refers to CSA predicting cannabis misuse in female adolescents more than males.⁴⁰⁶ Another Australian study (which looks at a slightly older victim and survivor population) suggests that, at age 21, cannabis misuse was prevalent among both genders.⁴⁰⁷

Amphetamines

The misuse of amphetamines also emerges from the literature.⁴⁰⁸ For example, one study found that CSA was associated with more amphetamine use in the 'past year' (at the time of the study) and a higher prevalence of 'lifetime' amphetamine use disorder.⁴⁰⁹

Alcohol

Several studies draw links between CSA and alcohol misuse.⁴¹⁰ A US study which specifically explored the relationship between CSA and alcohol consumption among females found that those who had experienced CSA were significantly more likely than those who had not to have higher levels of both 'past year' and 'lifetime' alcohol misuse.⁴¹¹ Researchers in this study tested for a number of factors in the data analysis. They also found that the same was true of women who had experienced child physical abuse (CPA). However, the prevalence of alcohol misuse was significantly higher among CSA compared with CPA victims and survivors. Similar messages emerge in another study reporting that 'drinking alcohol to intoxication' was the most frequently reported behaviour among adolescents with a history of CSA.⁴¹²

404 Nelson (2009), *op. cit.*; Lown et al. (2011), *op. cit.*; Pittenger et al. (2016), *op. cit.*; One in Four (2015), *op. cit.*

405 Duncan et al. (2008), *op. cit.*; Hayatbakhsh et al. (2009), *op. cit.*

406 Hayatbakhsh et al. (2009)

407 *Ibid.*

408 Draucker and Mazurczyk (2013), *op. cit.*; One in Four (2015), *op. cit.*

409 Hayatbakhsh et al. (2009) and Holmberg and Hellberg (2010) both cited in Draucker and Mazurczyk (2013), *op. cit.*

410 See for example Danielson et al. (2010), *op. cit.*; Draucker and Mazurczyk (2013), *op. cit.*; Maniglio (2013), *op. cit.*; Lown et al. (2011), *op. cit.*; Chouliara et al. (2014), *op. cit.*; Beckett et al. (2017), *op. cit.*

411 Lown et al. (2011), *op. cit.*

412 Danielson et al. (2010), *op. cit.*

Research in this area again emphasises the importance of understanding these behaviours as coping mechanisms and/or as an indicator of abuse:

“I was throwing hints to people an’ all. I was throwing hints ‘cause I didn’t want it comin’ out of my own mouth. I wanted people to work it out... I was getting myself drunk so I could come out with it, ‘cause I couldn’t say it when I was like sober. I was like ‘I can’t say it.’”⁴¹³

“I think it helped me cope, you know, you didn’t have the vivid memories, you didn’t have these dreams, because the alcohol when you did sleep, it made you sleep... I was getting abused by my husband as well, so I also closed down because of that as well.”⁴¹⁴

Nicotine and smoking

CSA has been found to be associated with earlier smoking initiation as well as frequent smoking or nicotine dependency.⁴¹⁵ Particular attention has also been given to rates of smoking during pregnancy among female victims and survivors. A systematic review of studies exploring CSA and pre-term birth highlights an association, identifying smoking as one of the key risk factors for pre-term birth.⁴¹⁶

Table 4.13: Protective and risk factors for substance misuse

Substance misuse	Protective factors:
	<ul style="list-style-type: none"> • Family support and positive parental response at the point of disclosure.⁴¹⁷ • Faith/spirituality: one study found that, for some females, having a sense of ‘God’s love’ protected against nicotine misuse.⁴¹⁸
	Risk factors: <ul style="list-style-type: none"> • Early pubertal development.⁴¹⁹ • Nature of abuse: abuse involving penetration, multiple episodes, occurring more frequently, causing injury are all cited as negatively influencing cannabis, amphetamine and nicotine related behaviours across the lifetime.⁴²⁰ • Polyvictimisation: those experiencing both CSA and CPA have been identified as being at particular risk of illicit drug use and nicotine-related outcomes.⁴²¹

413 Beckett et al. (2017), *op. cit.*, p.15

414 Chouliara et al. (2014), *op. cit.*, p.73

415 Draucker and Mazurczyk (2013), *op. cit.*

416 Wosu et al. (2015c), *op. cit.*

417 Bick et al. (2014), *op. cit.*; Draucker and Mazurczyk (2013), *op. cit.*

418 Kim and Williams (2009) cited in Draucker and Mazurczyk (2013), *op. cit.*

419 Trickett et al. (2011), *op. cit.*

420 Draucker and Mazurczyk (2013), *op. cit.*; Hayatbakhsh et al. (2009), *op. cit.*; Lown et al. (2011), *op. cit.*; Hayatbakhsh et al. (2009) cited by Draucker and Mazurczyk (2013), *op. cit.*; Al Mamun et al. (2007), Chen et al. (2006), and Roberts et al. (2008) cited in Draucker and Mazurczyk (2013), *op. cit.*

421 Jun et al. (2008) and Moran et al. (2004) cited in Draucker and Mazurczyk (2013), *op. cit.*

4.4.4 Sexual behaviours

In both childhood and adulthood, victims and survivors of CSA may exhibit a range of sexual behaviours in response to the abuse. The literature reviewed provides examples of how sexual behaviours can manifest over different life stages – and how the ages at which the abuse is experienced may influence this. However, it is acknowledged that this is a complex area. There are inconsistencies in the way research categorises and/or describes sexual behaviours. Overall, there appears to be a gap in longitudinal research looking at patterns of sexual behaviour after experiencing CSA across the lifespan.

Hackett⁴²² provides a framework for understanding a range of sexual behaviours (Figure 4.6). While this framework has been developed specifically in relation to children and young people (and not exclusively in relation to sexual behaviours as a response to CSA), it provides a useful framework for understanding sexual behaviour outcomes following CSA.

Figure 4.6: Hackett's continuum of children and young people's sexual behaviours



Source: Hackett (2010) in Hackett (2014), *op. cit.*, p.2

422 Hackett (2010) cited in Hackett, S. (2014) *Children and young people with harmful sexual behaviours*

This section of the report concentrates on ‘inappropriate’ or ‘problematic’ sexual behaviours as well as ‘risky sexual behaviours’ – a key theme emerging from this REA. Sexual behaviours falling in to ‘abusive’ or ‘violent’ categories are discussed in section 4.4.5 on anti-social behaviour and offending. Further issues of sex avoidance and sexual dysfunction are discussed in the context of interpersonal relationships in section 4.5.

Sexual behaviours in early childhood

Few studies reviewed for this REA specifically explore sexual behaviours in early childhood as a response to sexual abuse. However, some research highlights that the exhibition of inappropriate or problematic sexual behaviours can be most pronounced among this group.⁴²³ A literature review exploring factors affecting problematic sexual behaviour in victims and survivors of CSA, suggests that children aged six and younger are most likely to exhibit, for example, sexualised play with dolls, public masturbation, or other displays of sexuality in response to the abuse.⁴²⁴ Indeed, one victim and survivor in a qualitative study with males describes an account of being excluded from nursery for his sexualised behaviours.⁴²⁵ Where children are sexually abused at age six and below, it has been suggested that 35 per cent of them will exhibit inappropriate or problematic sexual behaviours during this childhood period, compared with six per cent among children sexually abused at age 6 to 12.⁴²⁶

Sexual behaviours in adolescence

Some research suggests that children who experience sexual abuse at age 12 and over are more likely to become withdrawn and internalise their distress (compared with younger age groups).⁴²⁷ However, other research presents a complex picture of the sexual behaviours adolescent victims and survivors may exhibit. A consistent thread running through this literature is that of ‘risky sexual behaviours’. While this may be a rather subjective term, it is explored in the literature through specific examples of negative sexual conduct and themes of early pregnancy, sexually transmitted infections, having multiple sexual partners, and online-specific behaviours. Attention is also given to the role of drugs and/or alcohol within these behavioural contexts.

Several studies⁴²⁸ suggest that adolescents who have experienced CSA are more likely than comparison groups to:

- have consensual sexual intercourse at a younger age
- have unprotected intercourse
- have multiple sexual partners
- become pregnant or impregnate female peers

423 Aaron (2012), *op. cit.*; Chromy (2007), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Nelson (2009), *op. cit.*

424 Kendall-Tackett et al. (1993) cited in Aaron (2012), *op. cit.*

425 Nelson (2009), *op. cit.*

426 Kendall-Tackett et al. (1993) cited in Aaron (2012), *op. cit.*

427 *Ibid.*

428 Homma et al. (2012), *op. cit.*; Draucker and Mazurczyk (2013), *op. cit.*; Francisco et al. (2008), *op. cit.*; Maniglio (2009), *op. cit.*; Young et al. (2011b), *op. cit.*

The association between CSA and adolescent pregnancy was a particularly striking theme within the studies reviewed.⁴²⁹ One study that explored this specific association asserts that the risk of adolescent pregnancy among victims and survivors (as compared with those who had not experienced CSA) varied depending on the age at which the abuse took place. The study identified that the greatest increase in risk was among those abused both in younger childhood and adolescence.⁴³⁰ The risk of adolescent pregnancy was found to be 80 per cent greater in this group. This compared with a 30 per cent increase where abuse took place in adolescence only, and a 20 per cent increase where abuse took place in younger childhood only. However, caution should be exercised with these research findings given that the behaviours and connections between CSA and pregnancy were not fully explored. Also, the literature reviewed in this area does not differentiate between pregnancies that are planned or unplanned.

Some studies also draw attention to the role of gender constructs in the exhibition of sexual behaviours.⁴³¹ A meta-analysis looking at the relationship between CSA and 'risky sexual behaviours' among adolescent boys, for example, suggests that males (particularly those abused by other males) may exert their sexuality as a way of managing confusion about their masculinity and/or sexuality, and to deal with the stigma associated with the abuse.⁴³²

The relatively new phenomenon of 'sexting' and adolescents self-generating sexual images adds complexity to the discourse of adolescent sexual behaviours.⁴³³ For example, emerging evidence suggests a link between 'sexting' and having multiple sexual partners and/or unprotected sex.⁴³⁴ However, the extent to which these behaviours are linked to CSA is not known and more research is needed in this area.

Sexual behaviours in adulthood

Findings from a longitudinal study⁴³⁵ looking at CSA and adult developmental outcomes found that CSA was a risk factor for higher rates of 'risky' sexual behaviour extending into adulthood.⁴³⁶ Many of these 'risky' behaviours were similar to those found among adolescents, such as having unprotected sex or multiple sexual partners, and (unplanned) pregnancies.⁴³⁷ The role of substance misuse in this behaviour is again notable.

429 See for example, Draucker and Mazurczyk (2013), *op. cit.*; Francisco et al. (2008), *op. cit.*; Homma et al. (2012), *op. cit.*; Noll, J. G., Shenk, C. E., Putnam, K. T. (2009) Childhood Sexual Abuse and Adolescent Pregnancy: A Meta-analytic Update. *Journal of Pediatric Psychology*, 34(4), pp.366-378; Young et al. (2011b), *op. cit.*

430 Young et al. (2011b), *op. cit.*

431 See for example Hooper and Warwick (2006), *op. cit.*; Hunter (2009), *op. cit.*; Homma et al. (2012), *op. cit.*

432 Homma et al. (2012), *op. cit.*

433 Cooper et al. (2016), *op. cit.*; Gómez, L. C., and Ayala, E. S. (2014) Psychological Aspects, Attitudes and Behaviour Related to the Practice of Sexting: A Systematic Review of the Existent Literature. *Procedia - Social and Behavioral Sciences*, 132, pp.114-120

434 Benotsch et al (2013); Dake et al. (2012); Englander (2012); Rice et al. (2012); Ferguson (2011); Perkins et al. (2014); Crimmins and Seigfried-Spellar (2014) cited in Cooper et al. (2016), *op. cit.*

435 Fergusson et al. (2013), *op. cit.*

436 Outcomes were explored up to age 30.

437 Aaron (2012), *op. cit.*; Senn et al. (2012), *op. cit.*; Hunter (2009), *op. cit.*

Narratives of sexually compulsive behaviours, sex addictions, seeking anonymous sex, sexual aggression, and traumatic sexual re-enactment⁴³⁸ were more pronounced in adult-based studies. They appear to be particularly pertinent issues for males.⁴³⁹ In this context, CSA interventions focused on reducing risky sexual behaviours are encouraged to consider the impacts of sexual trauma as well as broader sexual health issues.⁴⁴⁰ One report highlights CSE as a risk factor for adult sex-work outcomes,⁴⁴¹ although research exploring this association more fully was limited within this REA.

Table 4.14: Protective and risk factors for sexual behaviours

Sexual behaviours	Protective factors:
	<ul style="list-style-type: none"> • Higher levels of education: females with higher levels of educational attainment have been found to be less likely to experience early pregnancy following CSA.⁴⁴²
	Risk factors: <ul style="list-style-type: none"> • Nature of abuse: abuse involving penetration, occurring more frequently, involving multiple perpetrators were identified as risk factors influencing sexual behaviour outcomes across all life stages.⁴⁴³ <ul style="list-style-type: none"> – Frequency of abuse was noted as a particular risk factor for the exhibition of sexual behaviours in younger children.⁴⁴⁴ – CSA in both young childhood and adolescence poses the greatest risk for adolescent pregnancy.⁴⁴⁵ • Abuse occurring at a younger age.⁴⁴⁶ • Early onset of puberty and (younger) age of first consensual sexual encounter: have been identified as risk factors for early pregnancy among female victims of CSA.⁴⁴⁷ • Polyvictimisation.⁴⁴⁸

438 In other words, engaging in sexual practices reminiscent of the abuse.

439 Paul et al. (2001); Senn et al. (2007); Holmes and Slap (1998); Guigliano (2006) cited in Aaron (2012), *op. cit.*; Nelson (2009), *op. cit.*

440 Senn et al. (2012), *op. cit.*

441 Beckett et al. (2017), *op. cit.*

442 Young et al. (2011b), *op. cit.*

443 Aaron (2012), *op. cit.*; Draucker and Mazurczyk (2013), *op. cit.*

444 Aaron (2012), *op. cit.*

445 Young et al. (2011b), *op. cit.*

446 Chromy (2007), *op. cit.*; Draucker and Mazurczyk (2013), *op. cit.*; Homma et al. (2012), *op. cit.*; Aaron (2012), *op. cit.*

447 Young et al. (2011b), *op. cit.*; Trickett et al. (2011), *op. cit.*

448 Beckett et al. (2017), *op. cit.*

4.4.5 Anti-social behaviour and offending

Multiple studies refer to associations between CSA and offending behaviour among both adolescent and/or adult victims and survivors.⁴⁴⁹ Offending behaviours are diverse and include general aggression towards others, fighting, vandalism, stealing, shoplifting, arson, online harassment and other violent offences.

A study carried out by the Australian Institute of Criminology explores the association between CSA and offending in more depth. The study offers more insight into the prevalence of offending among victims and survivors and the types of offences committed. The 45-year longitudinal study found that those who had experienced CSA were 1.4 times more likely to have contact with the police (including for being a victim of crime) and almost five times more likely than comparison groups to be charged with a criminal offence.⁴⁵⁰ However, the research does highlight that most victims and survivors – over three-quarters (77 per cent) – did not have a criminal record. Other research suggests that the propensity to commit serious violent crime is greater among those who have experienced CPA compared with those who have experienced CSA.⁴⁵¹

Research literature draws links between offending and other outcomes linked to CSA, such as substance misuse. For example, victims and survivors may commit certain crimes to pay for drugs⁴⁵² (indeed, the use of illegal drugs is in itself a criminal offence). Research again highlights how some offending behaviours can be adopted (often indirectly) as a mechanism to cope with abuse, and even to escape it. For example, one qualitative study describes an account of a victim and survivor who began shoplifting in an attempt to get arrested to escape the person who was abusing him.⁴⁵³

Rates of offending (across offences) were greater for both males and females, compared with their respective comparison groups. However, a number of differences were observed between the genders. Most notably, a broader range of offences were committed by male victims and survivors, compared with females.⁴⁵⁴ Another study found that female victims and survivors of CSA were significantly more likely than comparison groups to be charged with a sex-work offence.⁴⁵⁵ However, there is a paucity of literature relating to adult sex-work as an outcome of CSA, and no equivalent data was found for males to be able to make gender comparisons.

Interest in the links between CSA and behaviour that is sexually abusive or violent is evident from the literature. However, it should be noted that the vast majority of victims and survivors do not go on to perpetrate a sexual offence. Where such offences do take place, these are most strongly associated with male victims and survivors, with five per cent of male victims and survivors convicted of a sexual offence compared with less than one per cent (0.6 per cent) in the comparison group.⁴⁵⁶

449 Ogloff et al. (2012), *op. cit.*; McGrath et al. (2011), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Hatton and Duff (2016), *op. cit.*; Roffman et al. (2014), *op. cit.*; NSPCC (2016), *op. cit.*; Nelson (2009), *op. cit.*; Radford et al. (2011), *op. cit.*; Cooper et al. (2016), *op. cit.*; Price-Robertson (2012), *op. cit.*

450 Ogloff et al. (2012), *op. cit.*

451 Widom and Maxfield (2000); Widom (1995, 1996) cited in McGrath et al. (2011), *op. cit.*

452 Nelson (2009), *op. cit.*

453 *Ibid.*

454 Ogloff et al. (2012), *op. cit.*

455 Widom (1995) cited in McGrath et al. (2011), *op. cit.*

456 Ogloff et al. (2012), *op. cit.*; Glasser et al. (2001); Salter et al. (2003) cited in Price-Robertson (2012), *op. cit.*

Some research suggests that a higher propensity for sexually abusive behaviour and offending is relevant to male victims and survivors in both adolescence and adulthood.⁴⁵⁷ For example, an (adult) male victim and survivor describes sexually assaulting his sister when he was 11 or 12, acting out the abuse he had experienced. Broader research which has explored the characteristics of children and young people referred to UK services for sexually abusive behaviours suggests that the most common age for referral was 15 years old.⁴⁵⁸ Behaviours identified included: non-contact sexual behaviours; inappropriate touching of others' genitals; penetration or attempted penetration; and sexual violence or use of physical force.⁴⁵⁹ That being said, other research highlights that, for young people exhibiting abusive or violent sexual behaviours, only a small proportion are likely to persist with sexual offending behaviour as adults.⁴⁶⁰

Table 4.15: Protective and risk factors for offending

Offending	Protective factors:
	<ul style="list-style-type: none"> • Secure attachment to fathers:⁴⁶¹ has been found to protect against aggressive and 'delinquent behaviours'.
	Risk factors:
	<ul style="list-style-type: none"> • PTSD.⁴⁶² • Substance misuse.⁴⁶³ • Age and gender: it has been suggested that males sexually abused when aged 12 or over are most at risk of committing a sexual offence.⁴⁶⁴

457 Nelson (2009), *op. cit.*; Burton et al. (2002); Smith (1998); Widom (1995) cited in McGrath et al. (2011), *op. cit.*; Hackett, S., Phillips, J., Masson, H., and Balfe, M. (2013) Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers. *Child Abuse Review*, 22(4), pp.232-245

458 Hackett et al. (2013), *op. cit.*

459 The study was not focused on children and young people who had experienced CSA specifically. However, 66 per cent of the children and young people referred were known to have experienced at least one form of abuse or trauma including sexual abuse.

460 Radford et al. (2017), *op. cit.*

461 Parent-Boursier and Herbert (2015), *op. cit.*

462 Danielson et al. (2010), *op. cit.*

463 Nelson (2009), *op. cit.*

464 Ogloff et al. (2012), *op. cit.*

4.5 Interpersonal relationships

This section summarises the evidence on the impacts of CSA on victims and survivors' interpersonal relationships.

Summary of key themes

- CSA can have a profound effect on victims and survivors' ability to form and/or maintain positive relationships. Only 17 per cent of CSA victims and survivors are said to have a secure attachment style,⁴⁶⁵ 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.⁴⁶⁶ Health and behavioural impacts can also negatively affect intimate relationships.⁴⁶⁷
- In relation to parent-child relationships, the evidence suggests that having children can have a positive influence on victims and survivors and even help to aid recovery.⁴⁶⁸ However, the role of parenthood can also activate a range of emotions and initiate particular parenting practices that 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.⁴⁶⁹ These negative outcomes can be compounded where individuals are also suffering from depression.⁴⁷⁰
- 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.⁴⁷¹

Several studies observe that CSA can have negative impacts on interpersonal relationships, and that this can carry through from childhood into adulthood.⁴⁷² Only 17 per cent of CSA victims and survivors are said to have a secure attachment style, important for forming strong emotional connections, behaviours and interactions between people.⁴⁷³

465 Fitzpatrick et al. (2010), *op. cit.*; Sprober et al. (2014), *op. cit.* See also Bowlby (1958), *op. cit.*

466 Cashmore and Shackel (2014), *op. cit.*; Friesen et al. (2010), *op. cit.*; Grossman et al. (2006), *op. cit.*; Havig (2008), *op. cit.*; Hunter (2009), *op. cit.*; Kia-Keating et al. (2010), *op. cit.*; Kristensen and Lau (2011), *op. cit.*; Liang et al. (2006), *op. cit.*; Nelson (2009), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Wilson et al. (2010), *op. cit.*; Senn et al. (2012), *op. cit.*; One in Four (2015), *op. cit.*

467 See for example, Friesen et al. (2010), *op. cit.*; Liang et al. (2006), *op. cit.*; Nelson (2009), *op. cit.*; Hunter (2009), *op. cit.*; Kia-Keating et al. (2010), *op. cit.*; Senn et al. (2012), *op. cit.*; One in Four (2015), *op. cit.*; Aaron (2012), *op. cit.*; Kristensen and Lau (2011), *op. cit.*

468 Sneddon et al. (2016), *op. cit.*; Nelson (2009), *op. cit.*; Price-Robertson (2012), *op. cit.*; Selmann and Wright (2013), *op. cit.*

469 One in Four (2015), *op. cit.*; Allbaugh et al. (2014), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Pazdera et al. (2013), *op. cit.*; Quadara et al. (2016), *op. cit.*

470 Allbaugh et al. (2014), *op. cit.*; Baril et al. (2016), *op. cit.*; Pazdera et al. (2013), *op. cit.*; Cross et al. (2016), *op. cit.*; Selmann and Wright (2013), *op. cit.*; Mapp (2006), *op. cit.*

471 Testa et al. (2011), *op. cit.*; Cross et al. (2016), *op. cit.*; Kim et al. (2010), *op. cit.*; Pazdera et al. (2013), *op. cit.*; Mapp (2006), *op. cit.*

472 See for example Hatton and Duff (2016), *op. cit.*; Havig (2008), *op. cit.*; NSPCC (2016), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Beckett et al. (2017), *op. cit.*; Breckenridge and Flax (2016), *op. cit.*; One in Four (2015), *op. cit.*; Fitzpatrick et al. (2010), *op. cit.*; Sprober et al. (2014), *op. cit.*

473 Fitzpatrick et al. (2010), *op. cit.*; Sprober et al. (2014), *op. cit.* See also Bowlby (1958), *op. cit.*

In terms of the impacts on interpersonal relationships in childhood, a study with child victims of sexual abuse, describes the challenges young children and adolescents can face – or fear – regarding their relationships with family members and friends. This includes the responsibility they can feel for changes to family dynamics and wellbeing of family members as well as disruptions to friendship groups and being bullied or ‘gossiped about’ by peers.⁴⁷⁴ This study also sheds light on the distinct and positive ways that friendships can support victims of CSA and how familial bonds can even be strengthened following the identification of abuse.⁴⁷⁵ Beyond this, relatively little research was found in this REA that explored the impacts of CSA on interpersonal relationships in childhood. The remainder of this section is therefore adult focused.

Two main strands of research emerged from the literature on CSA and adult interpersonal relationships; they form the basis of this section:

- The impacts of CSA on intimate and sexual relationships, including issues relating to sexual identity and orientation. Research findings relating to sex avoidance and sexual dysfunction are also discussed.
- The impacts of CSA on victims and survivors’ parenting skills, including parenting approach as a potential pathway for intergenerational abuse.

Within these strands of literature, clear links are made between the health and behavioural outcomes following CSA (as described earlier in this report) and the challenges victims and survivors can face in forming and maintaining relationships. Where relevant, these are highlighted in the research findings presented below.

Little evidence was found relating to the impacts on relationships more broadly (for example, relationships with siblings, wider family members, and even perpetrators in the instance of a known person or family member).

4.5.1 Intimate and sexual relationships

Research has found that both male and female victims of CSA can struggle with a range of complex emotions that can impede the formation of happy and stable intimate relationships in adulthood.⁴⁷⁶ Evident in the research literature are recurring themes of sexual trauma, sex avoidance, confused sexual identity, and loss of trust. Also discussed are early entry into marriage or cohabitation, early parenthood, interpersonal violence, having multiple sexual partners and ‘risky sexual behaviours’.

Relationship satisfaction and stability

Longitudinal studies exploring the association between CSA and intimate relationship outcomes have found CSA to be associated with lower levels of relationship satisfaction, stability and investment.⁴⁷⁷ A range of specific partnership outcomes were revealed including:

- early entry into marital or co-habiting relationships
- frequent co-habiting relationships
- becoming a parent by the age of 21
- interpersonal violence and conflict within relationships – as victim and/or perpetrator

474 Warrington et al. (2017), *op. cit.*

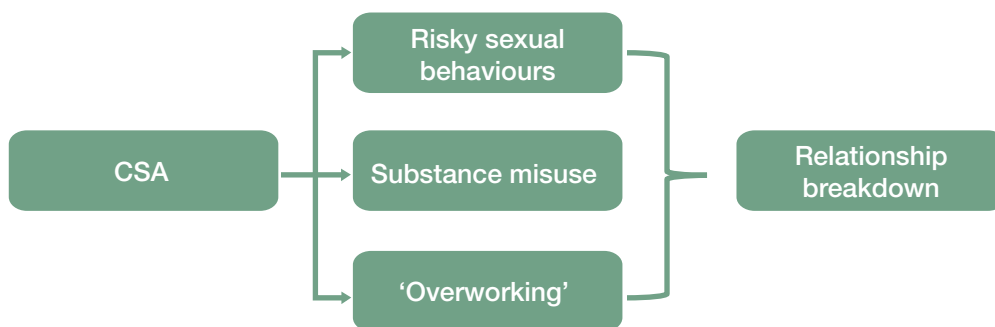
475 *Ibid.*

476 Friesen et al. (2010), *op. cit.*; Havig (2008), *op. cit.*; Liang et al. (2006), *op. cit.*; Wilson et al. (2010), *op. cit.*; Kristensen and Lau (2011), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Nelson (2009), *op. cit.*

477 Friesen et al. (2010), *op. cit.*; Liang et al. (2006), *op. cit.*

Substance misuse and risky sexual behaviours have been linked to lower relationship satisfaction and stability among victims and survivors (see section 4.4). Substance misuse in adolescence can extend into adulthood, and CSA is a risk factor for higher rates of risky sexual behaviours extending into adulthood.⁴⁷⁸ Therefore, it is perhaps unsurprising that both of these impacts are associated with negative partnership outcomes at age 30.⁴⁷⁹ An account given by one male survivor in a qualitative study identified substance misuse as a contributing factor in the breakdown of his long-term partnership.⁴⁸⁰ Other coping mechanisms such as ‘overworking’ also emerge as factors contributing to the breakdown of intimate relationships⁴⁸¹ (see section 4.6 for more information on overworking). Figure 4.7 shows how these outcomes can be interrelated.

Figure 4.7: Example pathway between CSA and relationship breakdown



Emotional and sexual intimacy

Inextricably linked to relationship satisfaction and stability are the complexities faced by victims and survivors of CSA in relation to intimacy and sexual intimacy in adult relationships.⁴⁸² Studies reveal how victims and survivors may have a desire to establish relationships that are emotionally and sexually intimate, but can be burdened by an array of emotional barriers. These barriers are illustrated in Figure 4.8.⁴⁸³ Such emotions have been found to be problematic for both male and female victims and survivors and are linked to internalised behaviour responses (see section 4.3). In a qualitative study, one female victim and survivor describes:

“The long-term impact is that I am now in my forties and even though I have had extensive therapy and various other kinds of help, I am still struggling to form a well-functioning intimate relationship with a man.”⁴⁸⁴

478 Lown et al. (2011), *op. cit.*; Fergusson et al. (2013), *op. cit.*

479 Friesen et al. (2010), *op. cit.*

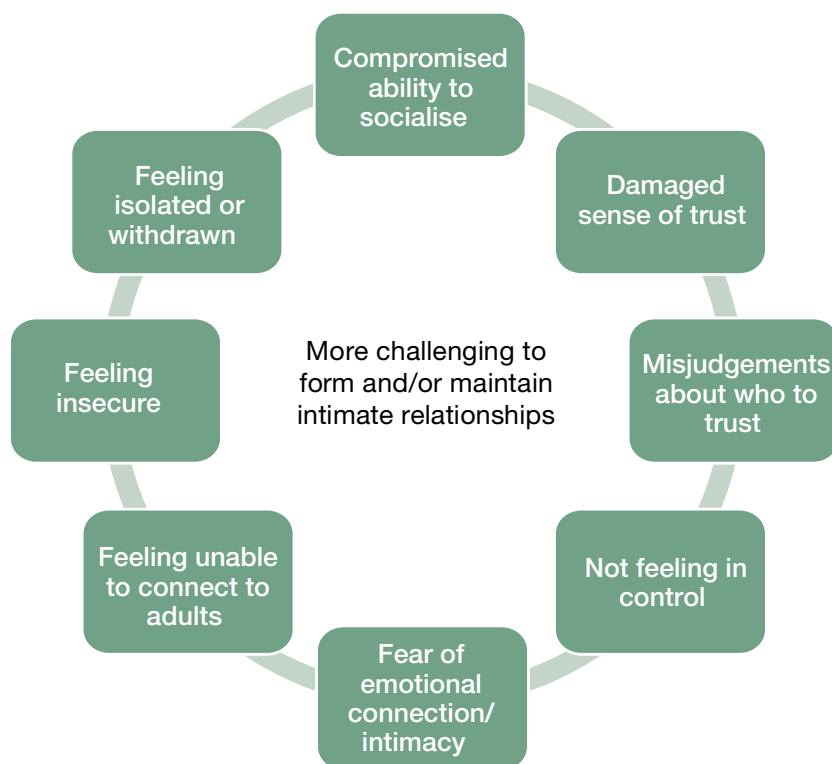
480 Nelson (2009), *op. cit.*

481 *Ibid.*

482 See for example Liang et al. (2006), *op. cit.*; Nelson (2009), *op. cit.*; Hunter (2009), *op. cit.*; Kia-Keating et al. (2010), *op. cit.*; Senn et al. (2012), *op. cit.*

483 Nelson (2009), *op. cit.*; Kia-Keating et al. (2010), *op. cit.*; One in Four (2015), *op. cit.*; Senn et al. (2012), *op. cit.*

484 One in Four (2015), *op. cit.*, p.20

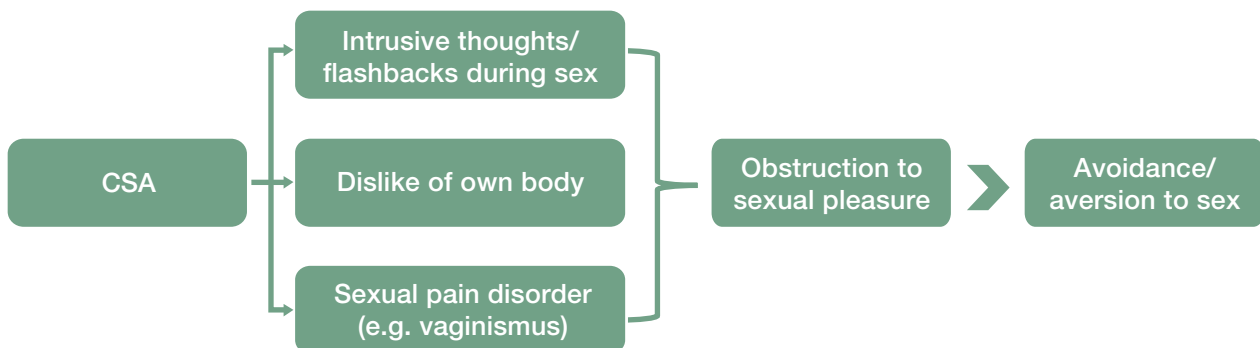
Figure 4.8: Emotional barriers to forming partner relationships

Linked to this, research suggests that satisfaction with sex life can also be an issue for victims and survivors of CSA. This can manifest in an avoidance of or aversion to sex or, on the contrary, having multiple sexual partners (see section 4.4). In terms of gender differences, some literature suggests that avoidance of or aversion to sex may be more prevalent among females and that having multiple sexual partners may be more prevalent among males.⁴⁸⁵ Table 4.16 contains further information on these issues.

485 Goldberg Edelson and Joa (2010), *op. cit.*

Table 4.16: Issues impacting on satisfaction with sex life

<p>Sex avoidance/aversion</p>	<p>A longitudinal study (with African-American females) emphasises the way memories of abuse can interfere with intercourse in adulthood,⁴⁸⁶ highlighting how sexual trauma and intrusive thoughts and flashbacks relating to the abuse can obstruct arousal and orgasm. Symptoms of the sexual pain disorder, vaginismus are also cited. This can cause avoidance of, aversion to or lack of enjoyment of sex. Women can also feel dislike towards their own bodies as a result of CSA, compounding the issue further.</p> <p>Other research exploring sexual function in women following intrafamilial CSA suggests that 63 per cent were dissatisfied with their current sex life and 71 per cent were not satisfied with their bodies.⁴⁸⁷ It found that 75 per cent reported problems with sexual functioning.</p> <p>Based on these research findings, Figure 4.9 provides an illustration of a sex avoidance pathway.</p>
<p>Having multiple sexual partners</p>	<p>The dominant discourse in relation to male victims and survivors is the challenge they can face negotiating intimacy and sex simultaneously.⁴⁸⁸ As a result, some men can find themselves having numerous brief (sometimes anonymous) sexual encounters to keep sex as something devoid of emotion and intimacy. This links back to the broader discourse of 'risky sexual behaviours' – a mechanism through which relationship breakdown can occur.⁴⁸⁹</p>

Figure 4.9: Example pathway between CSA and sex avoidance/aversion486 Liang et al. (2006), *op. cit.*487 Kristensen and Lau (2011), *op. cit.*488 Nelson (2009), *op. cit.*; Hunter (2009), *op. cit.*489 Nelson (2009), *op. cit.*; One in Four (2015), *op. cit.*

Sexuality and sexual orientation

CSA can cause some victims and survivors to feel confused about their sexuality. This appears to be a particularly pertinent issue for males who, following the abuse, can begin to question whether they might be gay – particularly where the perpetrator is also male.⁴⁹⁰ Qualitative accounts suggest that questioning one's sexuality and anxiety in relation to it can be triggered in the immediate period following (or during) the abuse, extending into adolescence and sometimes in to adulthood.⁴⁹¹ One study suggests that anxiety related to sexuality is a particular issue for heterosexual males, with confused feelings about their sexuality compounded by uncertainties about their identity and masculinity more broadly.⁴⁹² This study suggests that gay males tended to feel more secure in their sexuality and identity more broadly. However, this is not to say that these individuals did not go through a 'questioning' phase. It is also unknown how many gay men were represented in this particular sample. However, the issue of questioning sexual orientation – or gender identity – following the experience of CSA is one of the themes emerging from a forthcoming study with LGBT young people more broadly.⁴⁹³

Literature specifically pertaining to sexual orientation as an impact of CSA was limited within this REA. One study which prospectively examined the association between childhood abuse and/or neglect and likelihood of consensual same-sex partnerships in adulthood, did find that men who had experienced CSA were significantly more likely to have had same-sex sexual partners.⁴⁹⁴ However, caution should be taken when interpreting these findings as the nature of the relationship between sexual behaviour and CSA is complex and underexplored. Furthermore, males who had had same-sex sexual partners may not necessarily identify as gay or bisexual. In the forthcoming study, victims and survivors concluded that, despite going through a questioning phase, their LGBT identity was not due to the sexual abuse they had experienced.⁴⁹⁵

Table 4.17 outlines the protective and risk factors for intimate relationships.

490 Nelson (2009), *op. cit.*; Wilson et al. (2010), *op. cit.*; Grossman et al. (2006), *op. cit.*; Cashmore and Shackel (2014), *op. cit.*

491 Nelson (2009), *op. cit.*

492 *Ibid.*

493 Cossar, J., Schofield, G., Ward, E., Belderson, P., Larsson, B., Cocker, C. and Dodsworth, J. (forthcoming) *A study of the experiences and identity development of lesbian, gay, bisexual and transgender young people in care and the support they receive.* University of East Anglia

494 Wilson et al. (2010), *op. cit.*

495 Cossar et al. (forthcoming), *op. cit.*

Table 4.17: Protective and risk factors for intimate relationships

Intimate relationships	Protective factors:
	<ul style="list-style-type: none"> • Strong maternal/adult attachments and positive parental response to the disclosure of CSA: have been found to positively affect interpersonal relationship outcomes (in general) in adulthood and protect against sexual dysfunction outcomes.⁴⁹⁶
	Risk factors:
	<ul style="list-style-type: none"> • Polyvictimisation: CPA experienced in addition to CSA is identified as increasing the likelihood of frequent co-habiting relationships, becoming a parent by the age of 21, and interpersonal violence within relationships.⁴⁹⁷ • Nature of abuse: where CSA is understood by the research to be more ‘severe’, this may increase the likelihood of increased marital dissatisfaction/intimate relationship problems.⁴⁹⁸ • Perpetrator characteristics: the issue of distrust as having negative implications for sex and relationship outcomes seems particularly pertinent where CSA has been perpetrated by a family member or trusted person.⁴⁹⁹ • Internalised and externalised behaviours: e.g. withdrawal, isolation, substance misuse, ‘risky sexual behaviours’. • Emotional barriers. • Physical health problems.

4.5.2 Parent–child relationships

Several studies draw attention to the impacts of CSA on parent–child relationships and the parenting experience. Some research highlights the positive and happy relationships that victims and survivors can go on to have with their children. For example, one study found that, even where CSA was understood by the research to be more ‘severe’, this did not have a direct impact on a mother’s:

- emotional attachment to her child
- ability to set appropriate parent–child boundaries
- ability to effectively communicate with her child
- general involvement in her child’s life⁵⁰⁰

It has been suggested that, for some victims and survivors, children can aid the recovery process⁵⁰¹ (see section 4.10 for further details on recovery) and (for female victims and survivors) having children can be a protective factor against depression (see section 4.3).

496 Bick et al. (2014), *op. cit.*; Doyle (2009), *op. cit.*; Hooper and Warwick (2006), *op. cit.*; Knott (2014), *op. cit.*; Quadara et al. (2016), *op. cit.*; One in Four (2015), *op. cit.*; Liang et al. (2006), *op. cit.*; Kristensen and Lau (2011), *op. cit.*

497 Friesen et al. (2010), *op. cit.*

498 Liang et al. (2006), *op. cit.*

499 Foster and Hagedorn (2014), *op. cit.*; Sprober et al. (2014), *op. cit.*; Kia-Keating et al. (2010), *op. cit.*

500 Seltmann and Wright (2013), *op. cit.*

501 Sneddon et al. (2016), *op. cit.*; Nelson (2009), *op. cit.*; Price-Robertson (2012), *op. cit.*

It is clear from the papers reviewed that parenthood – or the prospect of it – can be highly challenging for CSA victims and survivors, for a number of different reasons. One female victim and survivor, for example, describes the challenges of parenthood as compounded by the mental health and behavioural impacts of CSA:

*“My mental state was mostly somewhere between severely depressed and even catatonic, with an almost constant undercurrent of suicidality. By the time I married and had my first child in my mid-20s, I suffered from constant anxiety, panic attacks, migraines, agoraphobia, insomnia and anger issues. This quite obviously impacted greatly on my marriage and the way I cared for my children.”*⁵⁰²

Another victim and survivor felt that the experience of CSA had played a key role in their decision not to have children:⁵⁰³

*“I was horrified by the risk of fatherhood, firmly believing the world needed no more like me, and I would not wish that on a child... avoidance of fatherhood being avoidance of being near to powerless precious creatures, a nearness which would have illuminated the wrongness of my abuse too strongly to bear.”*⁵⁰⁴

Pregnancy and the perinatal period has also been found to be a particularly vulnerable time, especially for female CSA victims and survivors. There is a risk of having traumatic experiences triggered and experiencing post-natal depression and other mental health problems.⁵⁰⁵ The evidence on this issue is explored in more depth in section 4.10.

Research in the area of parent–child relationships is complex and multifaceted. It highlights a number of variables that can influence the parenting experience and victim and survivors’ relationships with their children. These can be grouped under five key themes:

- parenting styles
- managing sexual development of children
- fear of inflicting harm
- lack of energy
- lack of confidence

Research findings are presented under these themes below. It should be noted that the papers reviewed in this REA have tended to concentrate on maternal relationships. Much less is known about the impacts of the relationships that male victims and survivors have with their children. It also remains largely unknown to what extent parent–child relationships might vary over time in accordance with the age of the child, and of the victim and survivor.

502 One in Four (2015), *op. cit.*, p.20

503 *Ibid.*

504 *Ibid.*, p.19

505 Hooper and Warwick (2006), *op. cit.*; Montgomery (2013), *op. cit.*; Montgomery et al. (2015), *op. cit.*; Leeners et al. (2016), *op. cit.*; Wosu et al. (2015b), *op. cit.*; Seltmann and Wright (2013), *op. cit.*

Parenting styles

Several papers detail how the experience of CSA can influence the particular parenting styles adopted by victims and survivors. Emerging from the literature is evidence of an increased risk of overprotective or controlling parenting styles, as well as more detached or disengaged styles. Both styles can disrupt positive parent–child interactions.⁵⁰⁶ It has been suggested that these seemingly divergent practices might both be driven by victims and survivors' heightened sense of needing to protect their child (and/or themselves) compared with other parents. These two main types of parenting style are explored further in Table 4.18.

Table 4.18: Victim and survivor parenting styles linked to CSA

Overprotective	<p>Research describes how victims and survivors of CSA may be more likely to over-monitor their children's behaviour and restrict their independence.⁵⁰⁷ In the words of one male victim and survivor:</p> <p><i>"... I think that was always in your head, oh you can't let her go here you can't let her do this, I ruined my kid's life to be honest."</i>⁵⁰⁸</p>
Overpermissive	<p>In contrast to restrictive parenting behaviours, research also highlights that victims and survivors of CSA can find themselves being too permissive in their parenting approach and overpromote the independence of their child.⁵⁰⁹</p> <p>It is theorised that this style of parenting might be driven by:</p> <ul style="list-style-type: none"> • an attempt to protect their child (i.e. a belief that their child will be better able to protect themselves from victimisation if they are more independent)⁵¹⁰ • self-preservation (i.e. victims and survivors keeping an emotional distance from their child to help prevent their own trauma from re-surfacing)⁵¹¹ <p>The latter theory chimes with other research which has found that, for victims and survivors of CSA, becoming a parent can trigger (or re-trigger) the trauma associated with the sexual abuse they themselves experienced.⁵¹² In terms of the influence of the child's gender, there is some evidence that CSA is a risk factor for 'decreased maternal warmth' towards daughters specifically.⁵¹³</p>

506 Allbaugh et al. (2014), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Testa et al. (2011), *op. cit.*; Chouliara et al. (2014), *op. cit.*; Kim et al. (2010), *op. cit.*; Mapp (2006), *op. cit.*; Nelson (2009), *op. cit.*

507 Sneddon et al. (2016), *op. cit.*; Chouliara et al. (2014), *op. cit.*

508 Chouliara et al. (2014), *op. cit.*, p. 73

509 Sneddon et al. (2016), *op. cit.*; Testa et al. (2011), *op. cit.*; Cross et al. (2016), *op. cit.*

510 Cross et al. (2016), *op. cit.*

511 *Ibid.*

512 Sneddon et al. (2016), *op. cit.*; Price-Robertson (2012), *op. cit.*

513 Cross et al. (2016), *op. cit.*

Managing sexual development of children

Victims and survivors may find it especially difficult to deal with the sexual development and sexuality of their children. They may exert more parental control due to a lack of trust of others with their child.⁵¹⁴ In an exploratory study of parenting concerns among a sample of American mothers who had experienced intrafamilial sexual abuse in childhood, the sexual safety of their children was cited as a key concern. This included feeling uncomfortable about their child becoming sexually desirable.⁵¹⁵ Such feelings were found to be predictors of:

- mothers perceiving their child as more difficult to parent
- issues setting appropriate parent–child boundaries
- issues balancing child safety and autonomy
- overall lower parenting satisfaction

Fear of inflicting harm

Linked to parenting styles that are more permissive, several studies highlight that, for some victims and survivors of CSA (particularly males), maintaining an emotional and physical distance can be driven by the fear that they may perpetrate CSA against their own child. Victims and survivors have reported feeling discomfort with touching their own children and displaying affection,⁵¹⁶ and this has a negative impact on their parenting experience. It is suggested that this fear can be influential in males' decision to not have children.⁵¹⁷ It is unclear from the studies reviewed whether these fears were based on particular sexual feelings or driven by societal discourses concerning the victim–perpetrator 'cycle of abuse' – despite the fact that the vast majority of victims and survivors do not go on to perpetrate sexual offences (see section 4.4).

Lack of energy

Adding context to different parenting behaviours, research suggests that victims and survivors of CSA can feel that they lack the energy to parent their children. This has been attributed to having to invest their energy in navigating their own recovery and treatment following the abuse.⁵¹⁸ One study found that this lack of energy is a significant predictor of several maternal outcomes:⁵¹⁹

- not being able to effectively bond with their child
- having negative feelings towards their child
- finding it challenging to communicate with their child
- finding it challenging to set appropriate parent–child boundaries

Lack of energy emerged as another factor associated with low overall parenting satisfaction. This association remained after testing for depression.

514 Sneddon et al. (2016), *op. cit.*; Allbaugh et al. (2014), *op. cit.*

515 Allbaugh et al. (2014), *op. cit.*

516 Price-Robertson (2012), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Nelson (2009), *op. cit.*

517 Denov (2004) and Etherington (1995a) cited in Price-Robertson (2012), *op. cit.*

518 Allbaugh et al. (2014), *op. cit.*; Sneddon et al. (2016), *op. cit.*

519 Allbaugh et al. (2014), *op. cit.*

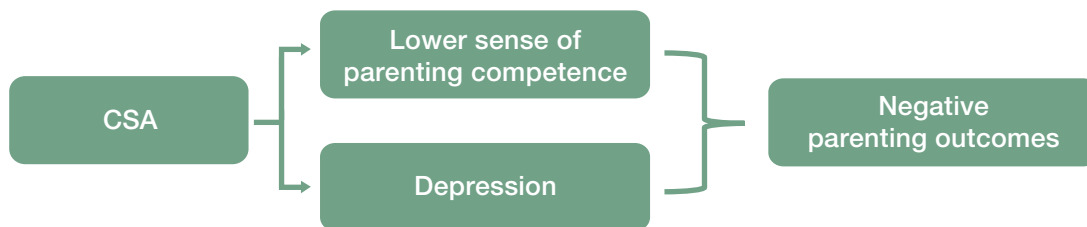
Lack of confidence

Victims and survivors can also believe that they lack the competency to parent, which has a negative impact on relationships with their children.⁵²⁰ In an Australian study, one male victim and survivor explained:

“I’ve got extreme limitations in my ability to cope with some of the parenting issues. It doesn’t come easily to me and I don’t know how to deal with a lot of it.”⁵²¹

One longitudinal study specifically examined the relationship between CSA and ‘high-risk’⁵²² maternal parenting, and the extent to which self-perceived parenting incompetence (and depression) influenced that relationship.⁵²³ CSA was not found to be directly associated with parenting stress or child maltreatment, but it was found to be associated with a lower sense of parenting competence and higher maternal depression. These factors were associated with negative parenting outcomes. Figure 4.10 shows the link between these outcomes.

Figure 4.10: Example pathway between CSA and negative parenting outcomes



Given the self-reporting nature of evidence in this area, research hypothesises that negative parent–child relationships are often manifested in victims and survivors’ beliefs about their own parenting abilities. That is, negative parenting outcomes may be real or perceived. For example, one study describes that victims and survivors of CSA may judge their parenting skills more harshly than other parents might.⁵²⁴

Table 4.19 summarises the risk and protective factors linked to parent–child relationships.

520 Pazdera et al. (2013), *op. cit.*; Quadara et al. (2016), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Allbaugh et al. (2014), *op. cit.*

521 Quadara et al. (2016), *op. cit.*, p.49

522 The study specifically explores high-risk as ‘parenting stress’ and ‘maltreatment behaviours’.

523 Pazdera et al. (2013), *op. cit.*

524 Sneddon et al. (2016), *op. cit.*

Table 4.19: Protective and risk factors for parent–child relationships

Parent–child relationships	Protective factors:
	<ul style="list-style-type: none"> • Strong maternal/adult attachments and positive parental response to the disclosure: have been found to positively affect interpersonal relationship adjustment and outcomes (in general) in adulthood.⁵²⁵ • Partner support: research suggests that having a supportive partner can help to protect against compromised parenting outcomes.⁵²⁶
	Risk factors: <ul style="list-style-type: none"> • Lack of confidence and energy.⁵²⁷ • Fear of harm being inflicted on the child.⁵²⁸ • Mental health and behavioural impacts of CSA:⁵²⁹ e.g. suicide ideation, anxiety, panic attacks, migraines, agoraphobia, insomnia and anger. • Depression (including post-natal depression): there is a body of research emphasising depression as a key pathway for negative parenting outcomes⁵³⁰ to occur or be compounded.⁵³¹ Where depressive symptoms are high, partner support may also be less effective as a protective factor.⁵³²

As well as looking at the impacts of CSA on parenting, some studies have also examined the risks that certain parenting behaviours may pose for the child. It is worth pointing out the gender bias evident in this area of research. That is, studies have focused on the parenting practices of mothers specifically. While this signifies a clear gap in research, it also suggests particular values that underpin research in this area. The risks of parenting practices among fathers who have experienced CSA have not been explored in the same way.

525 Bick et al. (2014), *op. cit.*; Doyle (2009), *op. cit.*; Hooper and Warwick (2006), *op. cit.*; Knott (2014), *op. cit.*; Quadara et al. (2016), *op. cit.*; One in Four (2015), *op. cit.*; Liang et al. (2006), *op. cit.*; Kristensen and Lau (2011), *op. cit.*

526 Wright et al. (2005) cited in Marriott et al. (2014), *op. cit.*; Selmann and Wright (2013), *op. cit.*

527 Allbaugh et al. (2014), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Pazdera et al. (2013), *op. cit.*; Quadara et al. (2016), *op. cit.*

528 Price-Robertson (2012), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Nelson (2009), *op. cit.*; Denov (2004) and Etherington (1995a) cited in Price-Robertson (2012), *op. cit.*

529 One in Four (2015), *op. cit.*

530 Parenting outcomes include: lower maternal warmth (towards both sons and daughters); increased lack of energy for parenting; heightened concerns around the sexuality or safety of children; increased poor parent–child boundary-setting practices; increased likelihood of exhibiting maltreatment or physical abuse behaviours towards their children.

531 Allbaugh et al. (2014), *op. cit.*; Baril et al. (2016), *op. cit.*; Pazdera et al. (2013), *op. cit.*; Cross et al. (2016), *op. cit.*; Selmann and Wright (2013), *op. cit.*; Mapp (2006), *op. cit.*

532 Selmann and Wright (2013), *op. cit.*

It is not the intention of this review to fully address the complexities of intergenerational pathways of abuse outcomes. However, a number of findings emerged from this REA which are useful to consider. For example, research suggests that:

- Where mothers have experienced CSA (particularly where it occurred when they were aged 14 or over), there is an increased likelihood of their daughters also experiencing CSA. (Tenuous links are made between this and overpermissive parenting styles.)⁵³³
- CSA can lead to victims and survivors showing a lack of maternal warmth towards their children (particularly daughters). Should that child also experience CSA, this may reduce their likelihood of disclosing the abuse to their mothers. The child may also feel inadequately supported by their mother if they do disclose the abuse.⁵³⁴ This is a risk factor for negative CSA outcomes.
- Where mothers have experienced CSA, this is linked to the subsequent use of punitive discipline against offspring who have also experienced CSA. This is a response to feelings of revictimisation (that is, feeling revictimised by the abuse of their own child).⁵³⁵
- Where mothers who have experienced CSA suffer depression, they are more likely to exhibit maltreatment behaviours or physically abuse their child.⁵³⁶

533 Testa et al. (2011), *op. cit.*

534 Cross et al. (2016), *op. cit.*

535 Kim et al. (2010), *op. cit.*

536 Pazdera et al. (2013), *op. cit.*; Mapp (2006), *op. cit.*

4.6 Socioeconomic outcomes

This section summarises the evidence on the impacts of CSA on victims and survivors' socioeconomic outcomes.

Summary of key themes

- 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 or further education.⁵³⁷ In some individual cases, however, it has also been linked to increased attainment.⁵³⁸ 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 and time out of the labour market,⁵³⁹ increased receipt of welfare benefits,⁵⁴⁰ reduced incomes⁵⁴¹ and greater financial instability.⁵⁴² The evidence suggests that poor physical or mental health could be the link between CSA and lower socioeconomic outcomes in many cases.⁵⁴³
- 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 the psychological impacts such as low self-esteem.⁵⁴⁴
- Recent studies which have explored the links between CSA and homelessness are limited in quantity and quality. Studies that do exist point to possible links between CSA victimisation and homelessness or housing issues during both youth⁵⁴⁵ and adulthood.⁵⁴⁶ This issue warrants further research.

A small number of studies in this REA explore the issue of socioeconomic outcomes for CSA victims and survivors. As with the evidence found in other areas, they are of variable quality. However, some higher-quality research was located which provides evidence of an enduring association between CSA and reduced life chances. Beginning in school years and extending well into adulthood, this affects victims and survivors' educational attainment, employment rates and income levels.

The following sections set out the key evidence on the links between CSA and educational attainment; employment, welfare benefit receipt and income; and homelessness and housing.

537 Zeglin et al. (2015), *op. cit.*; Trickett et al. (2011), *op. cit.*; Boden et al. (2007), *op. cit.*; Fergusson et al. (2013), *op. cit.*; Pereira et al. (2017), *op. cit.*

538 Nelson (2009), *op. cit.*

539 Zeglin et al. (2015), *op. cit.*; Senn et al. (2012), *op. cit.*; Barrett et al. (2014), *op. cit.*; Lee and Tolman (2006), *op. cit.*

540 Fergusson et al. (2013), *op. cit.*; Pereira et al. (2017), *op. cit.*

541 Fergusson et al. (2013), *op. cit.*; Barrett et al. (2014), *op. cit.*; Senn et al. (2012), *op. cit.*

542 Pereira et al. (2017), *op. cit.*

543 Barrett et al. (2014), *op. cit.*; Lee and Tolman (2006), *op. cit.*; Nelson (2009), *op. cit.*; One in Four (2015), *op. cit.*

544 Nelson (2009), *op. cit.*; Chouliara et al. (2014), *op. cit.*

545 Heerde et al. (2015), *op. cit.*; Rosario et al. (2012), *op. cit.*; Thrane et al. (2006), *op. cit.*; Petering, R. (2016) Sexual risk, substance use, mental health, and trauma experiences of gang-involved homeless youth. *Journal of Adolescence*, 48, pp.73-81

546 Henny et al. (2007), *op. cit.*; Rattelade et al. (2014), *op. cit.*; Nelson (2009), *op. cit.*; Fuller (2016), *op. cit.*

4.6.1 Educational attainment

The evidence reviewed suggests that CSA is associated with an overall reduction in educational engagement and attainment at school and in higher and further education among victims and survivors as a whole. However, in some cases it has also been linked to increased attainment. In these cases educational engagement appears to function as a coping strategy for dealing with – or escaping mentally and physically from – the abuse. Indeed, educational engagement has been found to be one of the key factors linked to resilience among victims and survivors during childhood (see section 4.10). The research findings on educational attainment are explored in more detail below.

Reduced attainment

Research has consistently found an association between CSA and lower-than-average educational outcomes among both male and female victims and survivors.⁵⁴⁷ A New Zealand study found that severity of abuse – as classified by the researchers – was associated with an increased likelihood of leaving secondary school without any qualifications and a decreased likelihood of gaining a university degree.⁵⁴⁸ However, once researchers took into account the study participants' socioeconomic background,⁵⁴⁹ family functioning,⁵⁵⁰ and other factors,⁵⁵¹ the differences between the groups in terms of school outcomes largely disappeared. This suggests that, in this example, the disparities in educational outcomes were largely a result of the family and wider social context in which the CSA took place, rather than the experience of CSA itself.

Other research has claimed a more direct, causal link between CSA and educational outcomes, describing CSA as “a substantial risk factor for cognitive maldevelopment and academic achievement”.⁵⁵² The study in question suggested that observed reductions in cognitive development such as language ability, changes in brain maturation processes and changes in classroom attitudes and behaviours among victims and survivors following abuse explained their lower educational engagement and attainment. This argument is supported by the emerging evidence on changes in the structure and functioning of children's developing brains following CSA (see box 4.1 for further information).

547 Zeglin et al. (2015), *op. cit.*; Trickett et al. (2011), *op. cit.*; Boden et al. (2007), *op. cit.*; Fergusson et al. (2013), *op. cit.*; Pereira et al. (2017), *op. cit.*

548 Fergusson et al. (2013), *op. cit.*

549 Proxies for socioeconomic disadvantage included: younger maternal age; lower maternal education; poorer family living standards; and lower family income.

550 Proxies for family functioning included: parental history of alcohol problems; criminality; illicit drug use; interparental violence; and changes of parents.

551 Those exposed to CSA were more likely to be female, have a lower IQ and more frequently experience regular or severe physical punishment or maltreatment. These dimensions were therefore controlled for in the analysis.

552 Trickett et al. (2011), *op. cit.*, p. 14

Qualitative research sheds further light on the ways in which the experience of CSA victimisation might be linked to reduced educational outcomes.⁵⁵³ Victims and survivors described difficulties concentrating at school, problems with learning – described by one as “*learning blocks*” – and low self-esteem following CSA. These difficulties were often mentioned in the context of the effects of trauma,⁵⁵⁴ as well as problems relating to their school peers.⁵⁵⁵ As one study participant put it:

*“I wasn’t able to concentrate at school. Teachers said: ‘She gets distracted easily’, but I was disassociating in order to manage my thoughts and the images of the abuse... Distancing was my only defence, in the moment and thereafter. My behaviour as a child was considered as being ‘bad’, so I was told I was bad, which was easy for me to accept...”*⁵⁵⁶

Some victims and survivors in the studies also discussed missing school. Absences were due to truanting, illness and exclusions for challenging behaviour, as well as disruptions caused by frequent family moves or transitions between care homes.⁵⁵⁷ Such experiences left them with significant gaps in their knowledge, including – in some cases – low literacy levels. While not all these outcomes were a direct result of CSA, victims and survivors felt they were linked in some way. Adult education opportunities to help address these gaps were therefore seen to be of critical importance.

Increased attainment

In contrast, several participants in a qualitative study with male victims cited their experiences of CSA as a turning point in their education which drove them to achieve the qualifications they felt they needed in order to escape the abuse:

*“You’re either a very low or very high achiever if you’re a survivor. You have this great drive in you to escape the situation... and to distract yourself: to plunge your mind into a different world.”*⁵⁵⁸

This finding should not be taken to mean that CSA had a positive overall impact on the lives of these particular victim and survivors. Educational engagement is viewed as a key protective factor and determinant of resilience (see section 4.10). The finding suggests that immersing oneself in schoolwork (and later careers – see section 4.6.2) is a coping strategy which some victims and survivors use to help manage the emotional and psychological distress caused by the CSA.⁵⁵⁹ More research is needed around how best to support victims and survivors to have a good educational experience and achieve their academic potential following CSA.

553 Nelson (2009), *op. cit.*; Quadara et al. (2016), *op. cit.*; One in Four (2015), *op. cit.*

554 Nelson (2009), *op. cit.*

555 Quadara et al. (2016), *op. cit.*

556 One in Four (2015), *op. cit.*, p.16

557 Nelson (2009), *op. cit.*

558 *Ibid.*, p.66

559 *Ibid.*

Table 4.20: Protective and risk factors for educational attainment

Low educational attainment	Protective factors:
	<ul style="list-style-type: none"> • Using educational engagement as a coping strategy.⁵⁶⁰
	Risk factors: <ul style="list-style-type: none"> • Severity of abuse.⁵⁶¹ • Demographic and background characteristics: socioeconomic background, family functioning.⁵⁶² • Delays/reductions in cognitive development.⁵⁶³ • Trauma and other mental health problems; truanting; unstable home circumstances.⁵⁶⁴

4.6.2 Employment, welfare benefit receipt and income

The links between CSA and socioeconomic outcomes have been shown to continue into mid-adulthood, with CSA being associated with: increased unemployment and time out of the labour market; increased receipt of welfare benefits; income and financial instability; and reduced incomes. The evidence suggests that poor physical or mental health could be the link between CSA and lower socioeconomic outcomes in many cases. As with education, however, it is important to recognise that some victims and survivors use work and career achievement, or ‘overwork’,⁵⁶⁵ as a means of coping with the after-effects of abuse, including psychological impacts such as low self-esteem. These themes are explored in more detail below.

Unemployment and time out of the labour market

Both male and female CSA victims and survivors have been found more likely to be unemployed or out of the labour market than others.⁵⁶⁶ A US study found that female victims and survivors spent significantly less time in employment over a 33-month period than their non-victim and survivor counterparts.⁵⁶⁷ This difference remained, even when the women’s demographic characteristics, education levels, work experience and literacy levels (among other factors) were taken into account.

In a similar vein, an Irish study with male CSA victims and survivors aged 50 or over found they were almost four times more likely to be out of the labour market as a result of sickness or disability than other men. They were also more likely to spend a higher proportion of their working lives out of the labour market due to these reasons.⁵⁶⁸ These differences remained after mental health problems and negative health behaviours were taken into account.

560 Nelson (2009), *op. cit.*

561 Fergusson et al. (2013), *op. cit.*

562 *Ibid.*

563 Trickett et al. (2011), *op. cit.*

564 Nelson (2009), *op. cit.*

565 *Ibid.*

566 Zeglin et al. (2015), *op. cit.*; Senn et al. (2012), *op. cit.*; Barrett et al. (2014), *op. cit.*; Lee and Tolman (2006), *op. cit.*

567 Lee and Tolman (2006), *op. cit.*

568 Barrett et al. (2014), *op. cit.*

Receipt of welfare benefits

Research from New Zealand and the UK respectively found that both male and female victims and survivors are more likely to be in receipt of welfare benefits than others at the age of 25 and 30⁵⁶⁹ and 45 and 50.⁵⁷⁰ The New Zealand study found that rates of welfare dependence increased as the severity of CSA increased.⁵⁷¹ The difference between groups in this study was small, but remained after other factors⁵⁷² had been taken into account.

Income and financial instability

CSA victimisation has also been associated with lower incomes⁵⁷³ as well as lower self-reported financial stability⁵⁷⁴ in adulthood. One study of men aged 50 or over found that the average household income of victims and survivors was 40 per cent lower than for other comparable households.⁵⁷⁵ However, in another study the association between CSA and income disappeared once other factors⁵⁷⁶ were taken into account.⁵⁷⁷

Pathways between CSA and unemployment

As discussed briefly in section 4.2 on physical health outcomes, several studies cite poor mental and physical health as a key pathway through which CSA affects the later life employment status and income of victims and survivors.⁵⁷⁸ The study of Irish men found that sickness or disability was the reason for the substantially lower employment rate among male victims and survivors compared with other men.⁵⁷⁹ Similarly, the research with US female welfare benefit recipients found that being a CSA victim or survivor was “strongly associated with the presence of a mental or physical health barrier”, and concluded that these barriers helped to explain the link between CSA and unemployment.⁵⁸⁰

Evidence from qualitative research with victims and survivors provides further support for the association between CSA, health problems and employment rates.⁵⁸¹ Participants in one study discussed needing to take time out of work due to mental or physical health issues. They explained some of the challenges they faced: managing detrimental side-effects of psychiatric medications on memory and concentration; and stress-related outbursts at work.⁵⁸² In another study, a victim and survivor spoke about the impact of illness on her career:

569 Fergusson et al. (2013), *op. cit.*

570 Pereira et al. (2017), *op. cit.*

571 Fergusson et al. (2013), *op. cit.*

572 Socioeconomic, family functioning and individual factors.

573 Fergusson et al. (2013), *op. cit.*; Barrett et al. (2014), *op. cit.*; Senn et al. (2012), *op. cit.*

574 Pereira et al. (2017), *op. cit.*

575 Barrett et al. (2014), *op. cit.*

576 *Ibid.*

577 Fergusson et al. (2013), *op. cit.*

578 Barrett et al. (2014), *op. cit.*; Lee and Tolman (2006), *op. cit.*

579 Barrett et al. (2014), *op. cit.*

580 Lee and Tolman (2006), *op. cit.*, p. 83

581 Nelson (2009), *op. cit.*; One in Four (2015), *op. cit.*

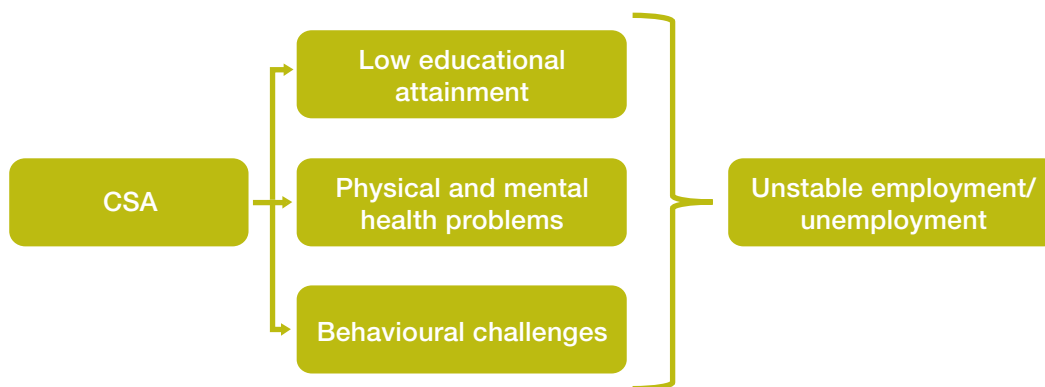
582 Nelson (2009), *op. cit.*

“ME⁵⁸³ caused me to suffer from extreme symptoms of fatigue and physical paralysis... I had to give up my work, my career and the life I had created for myself... I was told by medical professionals that the ME and PTSD were the long-term consequences of the childhood abuse and my suppression of the traumas. Eventually, with no life, constant physical pain and the uncontrollable flashbacks, I had to accept that childhood sexual abuse had... caused me to be very ill.”⁵⁸⁴

Victims and survivors have also mentioned the barriers to employment posed by: education gaps; employers’ lack of understanding of their needs and symptoms; and experiences of workplace bullying. The importance of having access to support services specifically tailored to help them secure long-term employment was emphasised by both male and female survivors across several studies.⁵⁸⁵

Figure 4.11 illustrates these potential pathways between CSA and unemployment.

Figure 4.11: Example pathway between CSA and unstable employment/unemployment



‘Overwork’ and ‘workaholism’ as a coping mechanism

As with education, qualitative research has highlighted accounts of victims and survivors immersing themselves in their work. This is an attempt to distract themselves from the flashbacks and other emotional and psychological problems associated with CSA, including low self-esteem.⁵⁸⁶ These survivors talked of a “*compulsive spiral of overwork*” which ultimately had a detrimental impact on their health and personal relationships.⁵⁸⁷ One reported becoming “*a workaholic; so as to avoid even thinking about the issues or anything else, I threw myself into work night and day*”.⁵⁸⁸

As with high educational attainment, this behaviour should be understood as a – potentially harmful – coping strategy (as referred to in section 4.4 on behavioural impacts) rather than automatically viewed as a positive outcome. Although, both such outcomes could be considered to denote resilience in some form (see section 4.10).

583 Myalgic Encephalomyelitis, now commonly known as Chronic Fatigue Syndrome.

584 One in Four (2015), *op. cit.*, p.31

585 Nelson (2009), *op. cit.*; Quadara et al. (2016), *op. cit.*

586 Nelson (2009), *op. cit.*; Chouliara et al. (2014), *op. cit.*

587 Nelson (2009), *op. cit.*

588 Chouliara et al. (2014), *op. cit.*, p.73

Table 4.21: Protective and risk factors for employment outcomes

Employment outcomes	Protective factors:
	<ul style="list-style-type: none"> Using work and career achievement as a coping strategy.⁵⁸⁹
	Risk factors:
	<ul style="list-style-type: none"> Severity of abuse.⁵⁹⁰ Disability/physical and mental health issues.⁵⁹¹ Education and skills gaps, e.g. low literacy levels.⁵⁹²

4.6.3 Homelessness and housing

The studies located and reviewed in relation to CSA and homelessness or housing instability were limited in quantity. Also, they did not use the kinds of methods that would enable associations between the two to be clearly identified. However, the studies which do exist point to possible links between CSA victimisation and homelessness or housing issues during both youth and adulthood, suggesting that this issue warrants further research.

Youth homelessness

A systematic review of literature exploring the associations between homelessness, sexual victimisation and sexual risk behaviours among young people suggests that the rate of CSA victimisation among homeless young people appears to be higher than the rate among youth in the general population.⁵⁹³ This finding is echoed by a US study of lesbian, gay and bisexual (LGB) young people which found that 61 per cent of homeless LGB youths had experienced CSA compared with 47 per cent of non-homeless LBG youths. In the majority of cases, the first instance of CSA reportedly occurred before the young people became homeless.⁵⁹⁴ The authors of the study hypothesise that CSA can act as a direct pathway to homelessness for LGB youth. However, the ultimate conclusion of the systematic review was that “it is unclear how homelessness and sexual victimisation... are related” as a result of the paucity of robust evidence on this issue.⁵⁹⁵

Two additional US studies explored the issues of homelessness and CSA among young people by focusing exclusively on the homeless population. One found that homeless young people who had been victims of sexual abuse (as well as those who had been victims of neglect) ran away from home for the first time at a younger average age than homeless young people who had not been exposed to those types of maltreatment.⁵⁹⁶ The study also found that these young people were more likely than the others to be revictimised while on the street. The authors of the study concluded that “destructive familial relations” (including those involving sexual abuse) were likely to be an important predictor of running away.⁵⁹⁷

589 Nelson (2009), *op. cit.*; Chouliara et al. (2014), *op. cit.*

590 Fergusson et al. (2013), *op. cit.*

591 Barrett et al. (2014), *op. cit.*; Lee and Tolman (2006), *op. cit.*; Nelson (2009), *op. cit.*

592 Nelson (2009), *op. cit.*

593 Heerde et al. (2015), *op. cit.*

594 Rosario et al. (2012), *op. cit.*

595 Heerde et al. (2015), *op. cit.*

596 Thrane et al. (2006), *op. cit.*

597 *Ibid.*

The second study found that homeless youth who were involved in gangs were more likely to have experienced CSA than those not involved in gangs.⁵⁹⁸ Although neither of these studies can demonstrate a categorical link between CSA and youth homelessness, they both suggest that CSA victims who run away from home might be at increased risk of further victimisation.

Homelessness and housing instability in adulthood

Evidence on the links between CSA and homelessness or housing instability during adulthood was even more limited. A US survey found a 'striking difference' between the levels of CSA victimisation in their sample of HIV-positive homeless or unstably housed adults (33 per cent of men and 52 per cent of women) when compared with rates among the general population.⁵⁹⁹ However, as these figures were taken from very different studies, other factors may have accounted for the apparent disparity.⁶⁰⁰ A study involving a representative sample of the Canadian homeless population also concluded that the rate of CSA victimisation seemed high compared with national figures.⁶⁰¹ However, again, this did not constitute a robust comparison and requires further research.

Qualitative research sheds some light on the ways CSA and homelessness or housing instability might be linked. A study with Scottish men found that the problems they experienced trying to achieve stable employment (which they attributed to the mental, physical and emotional impacts of CSA) had led to problems with housing and other welfare benefits. The study referred to resulting "yo-yo instability" in the lives of the victims and survivors.⁶⁰² Additionally, an Australian study involved an account from a CSA victim and survivor and her mother who both felt so unsafe as a result of the abuse that they found themselves in a "continual pattern of relocation" across countries which made it impossible for the family to put down roots and achieve stability.⁶⁰³ Although this last example might not be what is usually thought of as 'housing instability', it provides a powerful insight into the myriad ways that CSA can shape the lives of victims, survivors and their families.

598 Petering (2016), *op. cit.*

599 Henny et al. (2007), *op. cit.*

600 For example, different ways of defining and measuring CSA across the two studies, and/or differences in the background and profile of the two populations.

601 Rattelade et al. (2014), *op. cit.*

602 Nelson (2009), *op. cit.*

603 Fuller (2016), *op. cit.*

4.7 Religious and spiritual beliefs

This section summarises the evidence on the impacts of CSA on victims and survivors' religious and spiritual beliefs.

Summary of key themes

- 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.⁶⁰⁴
- 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.⁶⁰⁵ 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.⁶⁰⁶
- 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.⁶⁰⁷

For many people, spiritual belief or faith of some kind constitutes an important part of the way they understand, experience and find meaning in their lives. In some cases that belief involves an organised religion; in others it involves a more individual relationship with a perceived god or ‘higher power’. A small but significant body of literature explores the impact of CSA on religiosity and spirituality. A substantial component of this focuses specifically on the effects of ‘clergy abuse’, in other words abuse perpetrated by Church officials such as priests.⁶⁰⁸ An evidence gap was found on the effects of CSA in relation to religions other than Christianity.

Two main themes emerged from the reviewed papers: disillusionment with religion and spiritual belief following CSA; and to a lesser extent, faith as a coping mechanism and protective factor for resilience and recovery.

4.7.1 Disillusionment with religion and spirituality

Several papers reported finding a relationship between the experience of CSA and lower subsequent spiritual wellbeing. A Canadian survey of victims and survivors found that the more severe the abuse, the lower survivors' self-reported levels of hope and quality of relationship with God.⁶⁰⁹ A literature review similarly found that CSA victims and survivors reported: lower levels of spiritual wellbeing and a reduced involvement in religious practice;⁶¹⁰ a lower likelihood of trust in, and feeling loved and accepted by a God;⁶¹¹ and an increased propensity to view God as “cruel, uncaring and punishing”.⁶¹²

604 Gall et al. (2007), *op. cit.*

605 Doyle (2009), *op. cit.*; Benkert and Doyle (2009), *op. cit.*; Breckenridge and Flax (2016), *op. cit.*

606 Doyle (2009), *op. cit.*; Breckenridge and Flax (2016), *op. cit.*

607 Domhardt et al. (2015), *op. cit.*; Gall et al. (2007), *op. cit.*

608 Two of IICSA's investigations focus on CSA within Churches: one on the Catholic and the other on the Anglican Church. IICSA's research team are undertaking an REA on CSA in relation to both Churches.

609 Gall et al. (2007), *op. cit.*

610 Hall (1995); Rossetti (1995); Russell (1986) cited in Gall et al. (2007), *op. cit.*

611 Hall (1995) cited in Gall et al. (2007), *op. cit.*

612 Imbens and Jonkers (1992) cited in Gall et al. (2007), *op. cit.*, p.102

Research focusing on the impacts of abuse perpetrated by religious officials talked in particularly strong terms about the “spiritual trauma”⁶¹³ or “spiritual devastation”⁶¹⁴ which can result from it. One study on abuse by members of the Catholic clergy suggested that the combination of victims and survivors being deeply religious and very involved in the Church prior to the abuse, and the perpetrator being (in their eyes) a representative of God, often leads to a “deep spiritual confusion”. In these cases, victims question the morality of what has happened to them while also experiencing a shattering of their previously held belief systems.⁶¹⁵ The author of the study suggested that, in many cases, such impacts have been compounded by the response of the Church⁶¹⁶ and the wider community⁶¹⁷ when disclosures of clergy abuse have been met with disbelief, denial or requests to show the abuser forgiveness. Some studies highlighted attempts by victims and survivors to regain their spirituality by forging new belief systems in adulthood while distancing themselves from the specific institution or religion related to the abuse.⁶¹⁸ However, others talked of a “lifetime of painful spiritual loss and acute emptiness”⁶¹⁹ as well as “radical disillusionment... not only with the institutional Church but also the concept of a loving God”.⁶²⁰

4.7.2 Faith as a coping mechanism

A few of the review studies reported finding that religious and spiritual faith could be a positive force in victims and survivors’ lives which helped them cope with their experiences of abuse. This suggests that some people do find ways of reconciling themselves with religious beliefs following CSA.⁶²¹ The survey of victims and survivors in Canada found that there was a direct association between reporting a relationship with a benevolent God or higher power and a greater sense of personal growth and resolution in relation to surviving the experience of CSA.⁶²² A systematic review highlighted research which found that reported levels of faith and spirituality were higher among religiously-involved lay women who had experienced CSA than those who had not.⁶²³ The authors of this study suggested that this meant that faith and spirituality could provide victims and survivors’ with the emotional and psychological comfort they might otherwise find difficult to experience as a result of their abusive experiences.⁶²⁴ However, this explanation should be viewed with caution as the study design did not allow researchers to explore the nature of the relationship between the victims and survivors’ faith and their experiences of CSA.

Table 4.22: Risk factors for religious belief and spirituality

Religious belief and spirituality	<p>Risk factors:</p> <ul style="list-style-type: none"> Sexual abuse by a member of the clergy (or other religious institution).⁶²⁵
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613 Doyle (2009), *op. cit.*, p.1

614 Benkert and Doyle (2009), *op. cit.*, p.233

615 Doyle (2009), *op. cit.*

616 *Ibid.*

617 Breckenridge and Flax (2016), *op. cit.*

618 Grossman et al. (2006), *op. cit.*; Quadara et al. (2016), *op. cit.*

619 Benkert and Doyle (2009), *op. cit.*, p.233

620 Doyle (2009), *op. cit.*, p.253

621 Domhardt et al. (2015), *op. cit.*; Gall et al. (2007), *op. cit.*

622 Gall et al. (2007), *op. cit.*

623 Reinert and Smith (1997) cited in Gall et al. (2007), *op. cit.*

624 Gall et al. (2007), *op. cit.*

625 Benkert and Doyle (2009), *op. cit.*; Doyle (2009), *op. cit.*

4.8 Vulnerability to revictimisation

This section summarises the evidence on the impacts of CSA on victims and survivors' vulnerability to revictimisation.

Summary of key themes

- 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.⁶²⁶
- 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).⁶²⁷
- 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.⁶²⁸
- 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.⁶²⁹

A body of literature exploring the link between CSA and subsequent revictimisation suggests that those who have experienced CSA are more likely to experience victimisation again – in childhood and/or adulthood.⁶³⁰ More specifically, some studies suggest that CSA victims and survivors 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.⁶³¹ Sexual revictimisation is a particularly dominant theme. However, it is evident that revictimisation can also manifest in other forms. Furthermore, victims and survivors of CSA may experience multiple kinds of revictimisation at different stages of their lives. With this in mind, research looking at gender differences in relation to revictimisation has been largely inconclusive. It should also be noted that the majority of literature reviewed on this issue tended to focus on females.

⁶²⁶ Filipas (2006), *op. cit.*; Barnes et al. (2009), *op. cit.*; Sneddon et al. (2016), *op. cit.*

⁶²⁷ Filipas (2006), *op. cit.*; Trickett et al. (2011), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Friesen et al. (2010), *op. cit.*

⁶²⁸ Trickett et al. (2011), *op. cit.*

⁶²⁹ Finkelhor et al. (2007), *op. cit.*; Pittenger et al. (2016), *op. cit.*; Swartout et al. (2011), *op. cit.*

⁶³⁰ Barnes et al. (2009), *op. cit.*; Lutz-Zois, C. J., Phelps, C. E. R., and Reichle, A. C. (2011) Affective, Behavioral, and Social-Cognitive Dysregulation as Mechanisms for Sexual Abuse Revictimization. *Violence and Victims*, 26(2), pp.159-176; Sneddon et al. (2016), *op. cit.*; Trickett et al. (2011), *op. cit.*; Filipas (2006), *op. cit.*; Walsh et al. (2010), *op. cit.*; Ogloff et al. (2012), *op. cit.*; Pittenger et al. (2016), *op. cit.*; NSPCC (2016), *op. cit.*

⁶³¹ Filipas (2006), *op. cit.*; Barnes et al. (2009), *op. cit.*; Sneddon et al. (2016), *op. cit.*

4.8.1 Forms of revictimisation

Four key forms of revictimisation emerged from the literature. These are summarised in Table 4.23 below.

Table 4.23: Key forms of revictimisation

Sexual	Studies exploring revictimisation in the form of sexual assault specifically, have found that victims and survivors of CSA may be more than four times more likely to experience sexual assault in adulthood compared with those who had not experienced CSA. ⁶³² Sexual revictimisation can, however, also occur in younger childhood and adolescence. One study also highlights CSA as a potential risk factor for also experiencing CSE. ⁶³³
Physical	<p>An American study exploring the impact of intrafamilial sexual abuse on female development, found that, in addition to sexual victimisation or revictimisation, victims and survivors of CSA were also twice as likely to be physically abused during adolescence or early adulthood.⁶³⁴ This longitudinal study found that more than 53 per cent of females sexually abused in childhood reported at least one incident of domestic violence. This was in contrast to 24 per cent for comparison females. More specifically, research findings revealed that survivors are more likely to experience severe domestic violence (as categorised by the study) perpetrated by a partner.⁶³⁵ These findings chime with research suggesting that CSA survivors are more likely to experience interpersonal violence in their intimate relationships (see section 4.5).</p> <p>A longitudinal study in Australia which looked at the relationship between CSA and subsequent offending and victimisation found that both male and female survivors of CSA were significantly more likely than comparison groups to experience threats of violence and violent offences (in addition to sexual offences).⁶³⁶</p>
Criminal	Broadening our understanding of revictimisation, some studies draw attention to CSA survivors being more likely to be the victims of other types of crime, such as property damage. ⁶³⁷
Online	Several studies illustrate the manifestation of revictimisation in the online space – an issue particularly pertinent to children and adolescents. A report by the National Society for the Prevention of Cruelty to Children (NSPCC) about tackling the supply and demand of online sexual abuse images emphasises the rate at which CSA images can be circulated. ⁶³⁸ Attention is drawn to self-generated sexual images of children (typically adolescents) remaining online where they can often be used by perpetrators to harass, exploit and blackmail children to share more images – children can be sexually victimised and revictimised in this way. One study suggests that males in particular are more likely to experience having sexual images of themselves circulated without their consent. ⁶³⁹ Furthermore, children who have experienced (offline) sexual abuse may be particularly vulnerable to subsequent online CSA. ⁶⁴⁰

632 Filipas (2006), *op. cit.*; Sneddon et al. (2016), *op. cit.*

633 Trickett et al. (2011), *op. cit.*; Pittenger et al. (2016), *op. cit.*, Sneddon et al. (2016), *op. cit.*

634 Trickett et al. (2011), *op. cit.*

635 Friesen et al. (2010), *op. cit.*; Havig (2008), *op. cit.*

636 Ogloff et al. (2012), *op. cit.*

637 Ogloff et al. (2012), *op. cit.*; Finkelhor et al. (2007), *op. cit.*

638 Jutte (2016), *op. cit.*

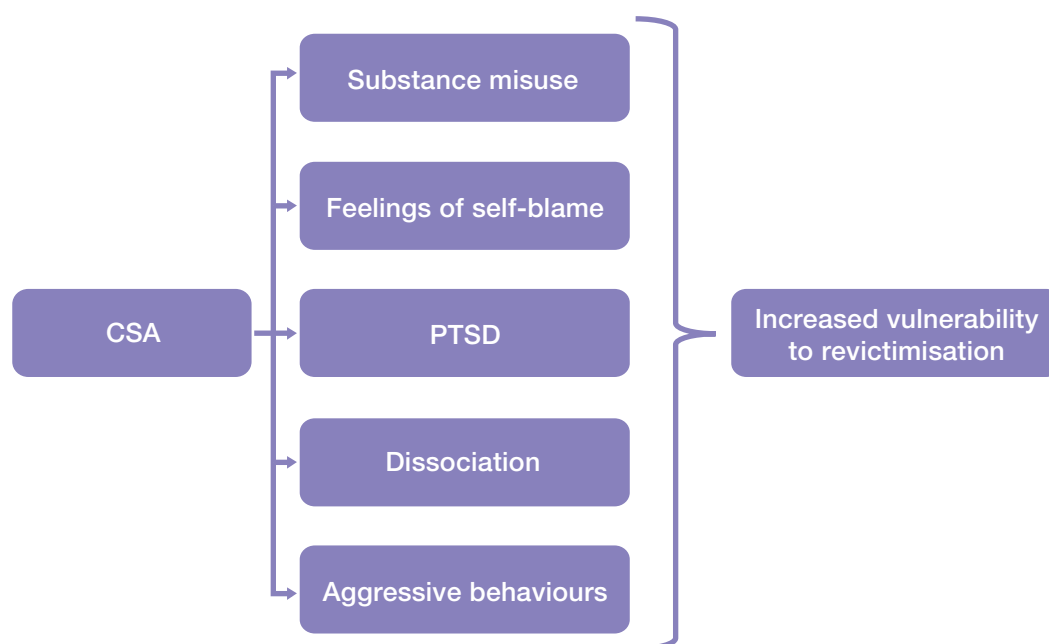
639 Jonsson et al. (2014) cited Cooper et al. (2016), *op. cit.*

640 Katz (2013), *op. cit.*

4.8.2 Pathways to revictimisation

It is important to frame revictimisation in the context of what is known about other outcomes following CSA. Several studies highlight how some of these outcomes increase victims and survivors' vulnerability to revictimisation.⁶⁴¹ For example, a number of other health and behavioural impacts have been identified as predictors of vulnerability to revictimisation (see Figure 4.12).

Figure 4.12: Example pathway between CSA and increased vulnerability to revictimisation



4.8.3 Perpetual/ongoing victimisation

It is important to acknowledge that the line between initial victimisation and subsequent revictimisation can be blurred.⁶⁴² For example, the relationship between the individual and the perpetrator may be such that the individual is more vulnerable to sustained sexual abuse by that person. This may be particularly likely where the perpetrator is a known or trusted person.

The literature highlights that victimisation/revictimisation should not be seen as an episodic occurrence.⁶⁴³ Rather this is a perpetual situation in which CSA victims and survivors can find themselves vulnerable to repeated victimisations of different forms across their lifespan. One form of victimisation often creates a vulnerability for another. As one female victim and survivor describes:

"I am nothing therefore I deserve nothing'. As I walked through life feeling like this, I had no way of protecting myself emotionally against people who would want to manipulate or hurt me for their own gains. Then if I was treated badly I would not stand up for myself and would try to get away from any conflict. Of course I was angry, but I did not know how to express or channel that anger in a healthy way to protect myself!"⁶⁴⁴

Table 4.24 details risk and protective factors for revictimisation.

641 Filipas (2006), *op. cit.*; Trickett et al. (2011), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Walsh et al. (2010), *op. cit.*; Lutz-Zois et al. (2011), *op. cit.*; Friesen et al. (2010), *op. cit.*

642 See for example, Doyle (2009), *op. cit.*

643 Finkelhor et al. (2007), *op. cit.*; Pittenger et al. (2016), *op. cit.*; Swartout et al. (2011), *op. cit.*

644 One in Four (2015), *op. cit.*, p.14

Table 4.24: Protective and risk factors for revictimisation

Revictimisation	Protective factors:
	<ul style="list-style-type: none"> • Supportive family and friend relationships.⁶⁴⁵ • Professional support.⁶⁴⁶
	Risk factors: <ul style="list-style-type: none"> • Nature of (initial) sexual abuse: some research suggests frequency of abuse, abuse involving penetration/force and enduring for longer periods increase likelihood of revictimisation.⁶⁴⁷ • Perpetrator characteristics: some research suggests that sexual abuse by a family member may increase the likelihood of (sexual) revictimisation, particularly for females.⁶⁴⁸ • Younger age of initial victimisation.⁶⁴⁹ • Mental health problems: e.g. PTSD, dissociation and psychological distress.⁶⁵⁰ • Internalised and externalised behaviours: e.g. withdrawal, self-isolation, feelings of self-blame, aggression, substance misuse, increased sexual activity or 'risky sexual behaviours', and conduct disorder.⁶⁵¹ • Dysfunctional intimate relationships.⁶⁵² • Unstable/chaotic family environments.⁶⁵³ • Housing and social factors: living in a neighbourhood with fewer economic and social resources and/or lower incomes, living in care, and homelessness.⁶⁵⁴

4.9 Outcomes by life stage and gender

This section summarises the evidence on how outcomes following CSA differ according to victims and survivors' life stage and gender.

⁶⁴⁵ Pittenger et al. (2016), *op. cit.*

⁶⁴⁶ *Ibid.*

⁶⁴⁷ *Ibid.*

⁶⁴⁸ Sneddon et al. (2016), *op. cit.*

⁶⁴⁹ Casey and Nurius (2005) cited in Pittenger et al. (2016), *op. cit.*

⁶⁵⁰ Pittenger et al. (2016), *op. cit.*; Trickett et al. (2011), *op. cit.*; Sneddon et al. (2016), *op. cit.*

⁶⁵¹ Sneddon et al. (2016), *op. cit.*; Filipas (2006), *op. cit.*; Pittenger et al. (2016), *op. cit.*; Friesen et al. (2010), *op. cit.*

⁶⁵² Pittenger et al. (2016), *op. cit.*; Friesen et al. (2010), *op. cit.*; Trickett et al. (2011), *op. cit.*

⁶⁵³ Pittenger et al. (2016), *op. cit.*

⁶⁵⁴ Drake and Pandey (1996), Ernst (2000) and Drake et al. (2003) cited in Pittenger et al. (2016), *op. cit.*; DePrince et al. (2015) cited in Pittenger et al. (2016), *op. cit.*; Thrane et al. (2006), *op. cit.*

Summary of key themes

- 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,⁶⁵⁵ early onset of puberty,⁶⁵⁶ conduct disorders,⁶⁵⁷ sexually inappropriate behaviours⁶⁵⁸ and low educational attainment⁶⁵⁹ are more salient for victims and survivors during childhood and adolescence, while longer-term chronic physical health conditions,⁶⁶⁰ challenges in relation to emotional and sexual intimacy and interpersonal relationships,⁶⁶¹ and employment issues⁶⁶² tend to affect victims and survivors in adulthood. Various outcomes, such as mental health conditions, including PTSD and anxiety⁶⁶³ and an increased vulnerability to sexual revictimisation,⁶⁶⁴ 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,⁶⁶⁵ internalising and externalising behaviours,⁶⁶⁶ offending,⁶⁶⁷ intimate relationships and sexuality,⁶⁶⁸ and pregnancy and childbirth.⁶⁶⁹

655 Heger et al. (2002), *op. cit.*

656 Trickett et al. (2011), *op. cit.*

657 Maniglio (2013), *op. cit.*; Maniglio (2015), *op. cit.*

658 Aaron (2012), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Nelson (2009), *op. cit.*; Homma et al. (2012), *op. cit.*; Draucker and Mazurczyk (2013), *op. cit.*; Francisco et al. (2008), *op. cit.*; Maniglio (2009), *op. cit.*; Young et al. (2011b), *op. cit.*; Chromy (2007), *op. cit.*

659 Zeglin et al. (2015), *op. cit.*; Trickett et al. (2011), *op. cit.*; Boden et al. (2007), *op. cit.*; Fergusson et al. (2013), *op. cit.*; Pereira et al. (2017), *op. cit.*

660 Allnock et al. (2015), *op. cit.*

661 Cashmore and Shackel (2014), *op. cit.*; Friesen et al. (2010), *op. cit.*; Grossman et al. (2006), *op. cit.*

662 Zeglin et al. (2015), *op. cit.*; Senn et al. (2012), *op. cit.*; Lee and Tolman (2006), *op. cit.*; Fergusson et al. (2013), *op. cit.*; Barrett et al. (2014), *op. cit.*; Senn et al. (2012), *op. cit.*; Pereira et al. (2017), *op. cit.*

663 Health Working Group on Child Sexual Exploitation (2014), *op. cit.*

664 Filipas (2006), *op. cit.*; Barnes et al. (2009), *op. cit.*; Sneddon et al. (2016), *op. cit.*

665 Goldberg Edelson and Joa (2010), *op. cit.* citing Banyard, Williams, and Siegel (2004); Zeglin et al. (2015), *op. cit.*

666 Hooper and Warwick (2006), *op. cit.* citing Lisak (1995); Finkelhor et al. (1990); Durham (2003); van Toledo et al. (2013), *op. cit.* citing Baker & Duncan (1985); Fergusson et al. (2000); Nelson (2009), *op. cit.*

667 Ogloff et al. (2012), *op. cit.*; Glasser et al. (2001); Salter et al. (2003) cited in Price-Robertson (2012), *op. cit.*; Widom (1995) cited in McGrath et al. (2011), *op. cit.*

668 Goldberg Edelson and Joa (2010), *op. cit.* citing Banyard, Williams, and Siegel (2004); Zeglin et al. (2015), *op. cit.*

669 Leeners et al. (2016), *op. cit.*; Montgomery (2013), *op. cit.*; Montgomery et al. (2015), *op. cit.*

As noted previously, victims and survivors are not a homogeneous group in terms of their characteristics, situations, or their experiences of any adverse outcomes following CSA. The studies reviewed suggest that there is significant variation in outcomes and impacts at both the sub-group and individual victim and survivor levels. Possible reasons for these differences are discussed in more depth in Section B.

Drawing conclusions from the current evidence base about how these outcomes differ by demographic and other characteristics is, nevertheless, challenging. For example, insufficient studies were located which explore differences in outcomes along the lines of ethnicity, sexuality or disability to enable us to distinguish any variation between the impacts of CSA for BME, LGBT or disabled victims and survivors compared with their counterparts. The studies reviewed do allow us to draw some conclusions – with varying degrees of confidence – about differences in outcomes according to the life stage and the gender of victims and survivors. These variations are explored in the following sections.

4.9.1 Life stage

Following a developmental approach, it is important to acknowledge that people experience ongoing internal and social and environmental change over the course of their lifetimes. Such changes include physical maturation and ageing, emotional and psychological growth, and changes in social and familial/interpersonal situations. The greatest developments occur during childhood, adolescence and the transition to adulthood.

Accordingly, different outcomes and impacts following CSA are likely to emerge or become apparent to victims and survivors at different life stages. Impacts can also be cumulative across the life course.⁶⁷⁰ Drawing on the studies summarised in the preceding sections, Table 4.25 presents the outcomes, differentiated where possible by overarching life stage (early childhood, adolescence and adulthood).

It is important to note a few points when reviewing this table:

- A lack of evidence linking an outcome to a particular life stage does not necessarily mean that victims and survivors are not at increased risk of that outcome during that life stage. This could just reflect a gap in the evidence. Some outcomes are obviously life-stage specific, for example, unemployment is not a relevant outcome for victims and survivors in early childhood.
- There is limited evidence generally about outcomes following CSA in early childhood and older adulthood, hence the information gaps and the decision to have one overarching category for adulthood.
- The studies reviewed were not always completely transparent about participants' ages, and used terms such as 'childhood' and 'adolescence' in different ways. Hence the decision not to ascribe age bands to the life stages used in the table.

⁶⁷⁰ For example, the way in which mental and physical health problems and low educational attainment can act as barriers to employment and financial stability.

Table 4.25: Outcomes that victims and survivors are at increased risk of experiencing by life stage

Outcome type	Life stage		
	Early childhood	Adolescence	Adulthood
Physical health ⁶⁷¹	Injuries to genitals and other parts of the body Early onset of puberty Differences in neurobiological development		General illness and disability A range of chronic and acute specific conditions, including heart disease, obesity, etc. Medically unexplained conditions Neurobiological differences
Emotional wellbeing, mental health and internalising behaviours ⁶⁷²	Emotions including fear, sadness, anger, guilt, blame and confusion, low self-esteem (which tend to reduce over time)		The emotions experienced during childhood/adolescence as well as worthlessness, powerlessness, self-loathing, and a lack of self-respect
	Trauma and PTSD Depression Suicidal ideation and self-harm Dissociation		
	Anxiety (including generalised anxiety disorder and separation anxiety disorder specifically)		Anxiety
	Generalised internalising behaviour problems including withdrawn behaviour		
			A range of less prevalent mental health conditions including psychosis, schizophrenia and bipolar disorder
Externalising behaviours ⁶⁷³	Conduct disorder Sexually inappropriate behaviours		
		Substance misuse Offending 'Risky' sexual behaviours	
Interpersonal relationships ⁶⁷⁴	Strained and/or challenging relationships with non-offending parents or carers, detrimental changes in family dynamics and wellbeing		Lower relationship satisfaction and stability Interpersonal violence and conflict within relationships Emotional and sexual intimacy challenges Parenting challenges
		Questioning sexual orientation	

671 See for example Heger et al. (2002), *op. cit.*; Trickett et al. (2011), *op. cit.*; Kamiya et al. (2016), *op. cit.*; Allnock et al. (2015), *op. cit.*; Havig (2008), *op. cit.*; De Bellis et al. (2011), *op. cit.* See section 4.2 for full references.

672 See for example One in Four (2015), *op. cit.*; Nelson (2009), *op. cit.*; Maniglio (2009), *op. cit.*; Health Working Group on Child Sexual Exploitation (2014), *op. cit.*; Mills et al. (2016), *op. cit.*; Kendler and Aggen (2014), *op. cit.* See section 4.3 for full references.

673 See for example Maniglio (2015), *op. cit.*; Breckenridge and Flax (2016), *op. cit.*; Draucker and Mazurczyk (2013), *op. cit.*; Nelson (2009), *op. cit.*; Ogloff et al. (2012), *op. cit.*; Aaron (2012), *op. cit.*; Chromy (2007), *op. cit.*; Sneddon et al. (2016), *op. cit.* See section 4.4 for full references.

674 See for example Fitzpatrick et al. (2010), *op. cit.*; Sprober et al. (2014), *op. cit.*; Cashmore and Shackel (2014), *op. cit.*; Friesen et al. (2010), *op. cit.*; Grossman et al. (2006), *op. cit.*; Havig (2008), *op. cit.*; Hunter (2009), *op. cit.*; Kia-Keating et al. (2010), *op. cit.*; Kristensen and Lau (2011), *op. cit.*; Liang et al. (2006), *op. cit.*; Nelson (2009), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Wilson et al. (2010), *op. cit.*; Senn et al. (2012), *op. cit.*; One in Four (2015), *op. cit.*; Aaron (2012), *op. cit.* See section 4.5 for full references.

Outcome type	Life stage		
	Early childhood	Adolescence	Adulthood
Socioeconomic outcomes ⁶⁷⁵	Lower average educational attainment (higher attainment in some cases)		Unemployment/time out of the labour market 'Workaholism' Lower financial stability Higher reliance on welfare benefits
		Homelessness	
Religion ⁶⁷⁶			Disengagement from/disillusionment with religion and spirituality Faith as a coping mechanism
Vulnerability to revictimisation ⁶⁷⁷	Sexual revictimisation (online CSA specifically)		Sexual revictimisation
		Physical revictimisation	
		Becoming a victim of other types of crime, such as property offences	

4.9.2 Gender

As highlighted throughout the report, much of the evidence located and reviewed on outcomes following CSA focuses on female victims and survivors. Male victims and survivors are either deliberately excluded from the scope of these studies, or their experiences are not represented because the vast majority of the study participants recruited were female. This makes it challenging to identify with any certainty if and how outcomes might differ for male and female (and transgender and non-binary) victims and survivors.

Differences were, however, suggested by some studies in relation to four main areas:

- **Mental health conditions/internalising behaviours and externalising behaviours**

As noted in sections 4.3 and 4.4, some studies have suggested that certain mental health conditions or internalising behaviours are more prevalent in female victims and survivors (for example, depression, anxiety and self-harm other than suicide) and that men might be more prone to expressing their distress through externalising behaviours such as outbursts of anger and aggression.⁶⁷⁸ It has been hypothesised that any such differences might be a reflection of social norms around what constitutes acceptable behaviours for men and women, rather than a result of any innate tendency to express distress differently.⁶⁷⁹ However, taken overall, the evidence is inconclusive, with some studies suggesting that the prevalence of certain mental health conditions such as anxiety are in fact higher in men, and others finding no differences along gender lines.

675 See for example Zeglin et al. (2015), *op. cit.*; Trickett et al. (2011), *op. cit.*; Boden et al. (2007), *op. cit.*; Fergusson et al. (2013), *op. cit.*; Pereira et al. (2017), *op. cit.*; Senn et al. (2012), *op. cit.*; Barrett et al. (2014), *op. cit.*; Lee and Tolman (2006), *op. cit.*; Nelson (2009), *op. cit.* See section 4.6 for full references.

676 See for example Doyle (2009), *op. cit.*; Benkert and Doyle (2009), *op. cit.*; Breckenridge and Flax (2016), *op. cit.*; Gall et al. (2007), *op. cit.* See section 4.7 for full references.

677 See for example Filipas (2006), *op. cit.*; Trickett et al. (2011), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Friesen et al. (2010), *op. cit.*; Barnes et al. (2009), *op. cit.* See section 4.8 for full references.

678 Hooper and Warwick (2006), *op. cit.* citing Lisak (1995); Finkelhor et al. (1990); Durham (2003); van Toledo et al. (2013), *op. cit.* citing Baker & Duncan (1985); Fergusson et al. (2000); Goldberg Edelson and Joa (2010), *op. cit.* citing Banyard, Williams, and Siegel (2004); Zeglin et al. (2015), *op. cit.*; Schlachter et al. (2009), *op. cit.*; Aaron (2012), *op. cit.*; Mills et al. (2016), *op. cit.*

679 Kendler and Aggen (2014), *op. cit.*

- **Offending**

While studies have shown that the risk of offending behaviour is elevated among both male and female victims and survivors compared with the general population, studies have suggested that men who offend tend to commit a broader range of offences, while women are more likely to commit offences related to sex work (see section 4.4 for further information).⁶⁸⁰ The very small minority of victims and survivors (less than one per cent) who go on to commit sexual offences have been found to be mostly male, in line with the profile of the wider sexual offending population.⁶⁸¹

- **Intimate relationships and sexuality**

There is evidence to suggest that issues with intimacy are more likely to manifest as avoidance of sexual contact among female victims and survivors, and having higher-than-average numbers of sexual partners among male victims and survivors (see section 4.5).⁶⁸² This could be a reflection of the gender norms prevalent within western culture. Other studies have shown that men who were abused by other men might be more likely to question their sexuality as a result of the CSA they experienced.⁶⁸³ Although, emerging research findings suggest that this might also be an outcome experienced by LGBT individuals of any gender following CSA.⁶⁸⁴

- **Pregnancy and childbirth**

Studies suggest that becoming a parent can be both highly challenging and transformative for both male and female victims and survivors.⁶⁸⁵ However, evidence has shown that the direct physical experience of pregnancy and childbirth can be a significant trigger of trauma, emotional distress and dissociation among female victims and survivors.⁶⁸⁶ The lack of control experienced during childbirth and certain medical examinations can act as a powerful reminder of the CSA experienced (see section 4.10 for further information).

680 Ogloff et al. (2012), *op. cit.*; Widom (1995) cited in McGrath et al. (2011), *op. cit.*

681 Nelson (2009), *op. cit.*; Burton et al. (2002); Smith (1998); Widom (1995) cited in McGrath et al. (2011), *op. cit.*; Hackett et al. (2013) *op. cit.*

682 Goldberg Edelson and Joa (2010), *op. cit.*

683 Nelson (2009), *op. cit.*; Wilson et al. (2010), *op. cit.*; Grossman et al. (2006), *op. cit.*; Cashmore and Shackel (2014), *op. cit.*

684 Cossar et al. (forthcoming), *op. cit.*

685 Nelson (2009), *op. cit.*; Price-Robertson (2012), *op. cit.*; One in Four (2015), *op. cit.*

686 Hooper and Warwick (2006), *op. cit.*; Montgomery (2013), *op. cit.*; Montgomery et al. (2015), *op. cit.*; Leeners et al. (2016), *op. cit.*; Wosu et al. (2015b), *op. cit.*; Seltmann and Wright (2013), *op. cit.*

● Section B: Resilience, recovery and factors that affect victim and survivor outcomes

The previous section summarised evidence on the range of outcomes experienced by victims and survivors of CSA across different life domains and across their life course. Despite the broad consensus in the literature about the increased risk of adverse outcomes which victims and survivors face across every area of life it is clear that the extent and nature of these impacts varies from one group of victims and survivors – and indeed one individual victim and survivor – to another.

Section B explores the key factors which the evidence suggests influence the degree and nature of impacts experienced at an individual level. Section 4.10 introduces the concepts of resilience to, and recovery from, adverse impacts of CSA. It also outlines the risk and protective factors which have been found to increase or reduce the likelihood of victims and survivors achieving resilience and recovery, as well as the evidence on experiences which can (re)trigger the emotional distress and trauma linked to CSA. Finally, section 4.11 considers the role that wider society – including family members, support professionals and wider systems and structures – can play in supporting or hindering resilience and recovery among victims and survivors.

4.10 Resilience and recovery: risk and protective factors and triggers

This section defines and describes resilience and recovery in the context of CSA, and summarises the risk and protective factors and triggers that can affect victim and survivor outcomes.

Summary of key themes

- 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.⁶⁸⁷ 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 that 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 which are influenced by an individual's interaction with their social environment.⁶⁸⁸

⁶⁸⁷ Sneddon et al. (2016), *op. cit.*

⁶⁸⁸ *Ibid.*

Summary of key themes (continued)

- A number of risk/protective factors have been identified that 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 (e.g. emotions, beliefs and attitudes)⁶⁸⁹
 - circumstances of the abuse (e.g. identity of the perpetrator, age at onset)⁶⁹⁰
 - the victim and survivor's interpersonal relationships and immediate environment (eg attitudes of caregivers,⁶⁹¹ partners and peers;⁶⁹² experiences of parenthood⁶⁹³)
 - the victim and survivor's wider social and environmental context (e.g. experiences of disclosure to professionals,⁶⁹⁴ experiences of other services such as education⁶⁹⁵ and healthcare⁶⁹⁶)
- 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.⁶⁹⁷
- 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

689 Canton-Cortes et al. (2011), *op. cit.*; Domhardt et al. (2015), *op. cit.*; Filipas (2006), *op. cit.*

690 Sneddon et al. (2016), *op. cit.*

691 Asgeirsdottir et al. (2010), *op. cit.*; Bick et al. (2014), *op. cit.*

692 Marriott et al. (2014), *op. cit.*; Seltsmann and Wright (2013), *op. cit.*

693 Zeglin et al. (2015), *op. cit.*

694 Draucker and Mazurczyk (2013), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Montgomery et al. (2015), *op. cit.*; Cecchet and Thoburn (2014), *op. cit.*

695 Williams and Nelson-Gardell (2012), *op. cit.*; Domhardt et al. (2015), *op. cit.*

696 Havig (2008), *op. cit.*; Montgomery et al. (2015), *op. cit.*; Montgomery (2013), *op. cit.*

697 Montgomery (2013), *op. cit.*; Stewart (2012), *op. cit.*; Mitchell et al. (2007), *op. cit.*; Bolitho and Freeman (2016), *op. cit.*; Montgomery et al. (2015), *op. cit.*; Havig (2008), *op. cit.*; Price-Robertson (2012), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Chouliara et al. (2014), *op. cit.*; Kristensen and Lau (2011), *op. cit.*; Kim et al. (2007), *op. cit.*; Kilroy et al. (2014), *op. cit.*; Doyle (2009), *op. cit.*; Nelson (2009), *op. cit.*; Leeners et al. (2016), *op. cit.*; Allnock et al. (2015), *op. cit.*

Summary of key themes (continued)

- Specific triggering situations include medical and dental examinations⁶⁹⁸; childbirth⁶⁹⁹; coming into contact with the perpetrator following abuse⁷⁰⁰; therapy⁷⁰¹; sexual activity⁷⁰²; going through legal proceedings relating to the CSA⁷⁰³; their own child experiencing CSA⁷⁰⁴; and needing to seek emotional support.⁷⁰⁵
- In particular, the experience of childbirth has been found to be deeply traumatic for some female victims and survivors.⁷⁰⁶ 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.⁷⁰⁷

Many studies focus on describing the potentially detrimental impacts of CSA, and the previous sections of this report have mapped that body of evidence. However, there has been increasing recognition of the need to explore and explain why some people may not suffer adverse outcomes despite experiencing traumatic events.

Theories of resilience and recovery focus on why some people appear to be resilient in the face of adversity or demonstrate outcomes that indicate recovery and growth, compared with others who develop mental health or behavioural problems. An individual with a history of CSA who is deemed to be functioning well, or to not have any clinically diagnosable problems, may be categorised as being resilient or having achieved recovery. Although related, the two concepts are distinct. Specifically, resilience can be observed in victims and survivors who appear to be insulated against the harmful effects of trauma, whereas recovery indicates a process over time where initial adverse effects are gradually overcome.⁷⁰⁸ Figure 4.13 describes the different trajectories of psychological functioning that are associated with each concept, and Figure 4.14 provides illustrative examples.⁷⁰⁹

698 Robohm & Bутtenheim (1996); Schachter et al. (1999); Schachter et al. (2004); Stalker et al. (2005) cited in Havig (2008), *op. cit.*

699 Nelson (2009), *op. cit.*; Lainsbury, (1999) cited in Price-Robertson (2012), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Stewart (2012), *op. cit.*; Leeners et al. (2016), *op. cit.*; Montgomery (2013), *op. cit.*; Montgomery et al. (2015), *op. cit.*

700 Chouliara et al. (2014), *op. cit.*; Foster and Hagedorn (2014), *op. cit.*

701 Allnock et al. (2015), *op. cit.*

702 Kristensen and Lau (2011), *op. cit.*

703 Back et al. (2011), *op. cit.*; Mitchell et al. (2007), *op. cit.*; Davidson et al. (2006), *op. cit.*; Foster and Hagedorn (2014), *op. cit.*

704 Terr (1991) cited in Kim et al. (2007), *op. cit.*; Kilroy et al. (2014), *op. cit.*

705 Doyle (2009), *op. cit.*

706 Nelson (2009), *op. cit.*; Lainsbury, (1999) cited in Price-Robertson (2012), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Stewart (2012), *op. cit.*; Leeners et al. (2016), *op. cit.*; Montgomery (2013), *op. cit.*; Montgomery et al. (2015), *op. cit.*; Nelson (2009), *op. cit.*; Price-Robertson (2012), *op. cit.*

707 Montgomery et al. (2015), *op. cit.*

708 Chouliara et al. (2014), *op. cit.*

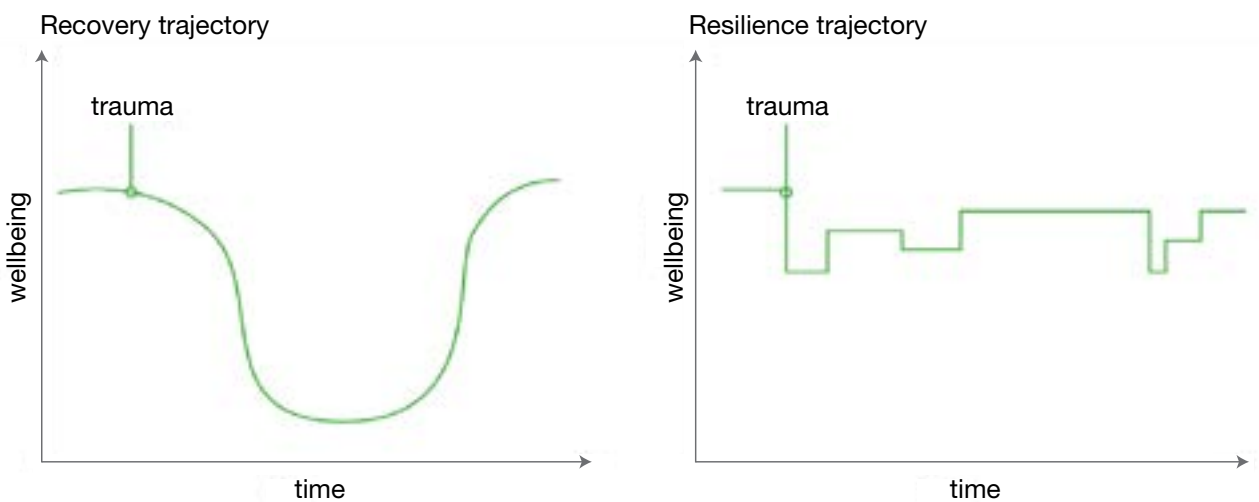
709 Sneddon et al. (2016), *op. cit.*

Figure 4.13: Resilience and recovery trajectories⁷¹⁰**Resilience:**

Resilient individuals are able to sustain relatively healthy levels of functioning after exposure to a potentially traumatic event. They show a more stable trajectory through the event and its aftermath. In the first few weeks after a stressor or trauma, they may experience disruptions to functioning such as problems with sleeping or intrusive thoughts, but these are not prolonged. Importantly, resilient individuals are still able to experience positive emotions and more likely to engage in caring behaviours even in extreme circumstances.

Recovery:

Recovery is characterised by a significant decline in wellbeing in the immediate aftermath of the traumatic event and a rise in symptoms of physical, mental and behavioural problems, which 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.

Figure 4.14: Examples of recovery and resilience trajectories⁷¹¹

Source: Sneddon et al. (2016), *op. cit.*, p.26

The two concepts are explored in more detail below.

⁷¹⁰ *Ibid.*

⁷¹¹ *Ibid.*

4.10.1 The concept of resilience

Resilience is inferred when people show signs of positive adaptation in the face of stressors that can disrupt positive functioning and development, such as CSA. Positive adaptation is deemed to arise as a consequence of protective factors or processes. However, there is a lack of consensus in the literature regarding how to define and measure the concept of resilience. The main contentions are outlined below:⁷¹²

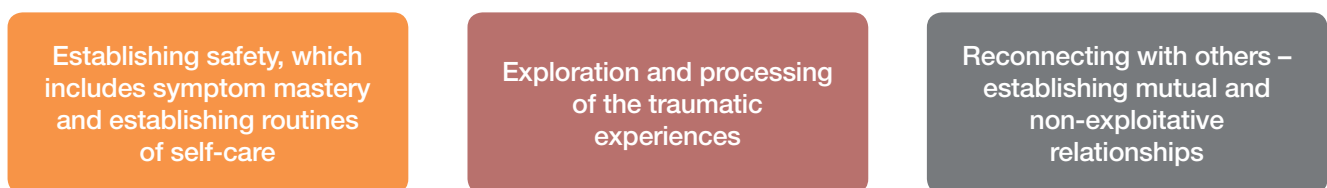
- There is disagreement over whether resilience is a personality trait or a dynamic process. Increasingly, it is being regarded as a dynamic process.⁷¹³
- There is disagreement over whether positive adaptation should be measured in terms of competence in certain areas of functioning (domains), or as an absence of negatives such as mental health problems. Much of the research emerged initially from the field of psychology and therefore focuses heavily on mental health and behavioural definitions of functioning.
- There is uncertainty over the level of functioning that is needed to define positive adaptation, and whether competence should be measured in only one, or more than one, domain.

In the recent literature, the emphasis on resilience as a multidimensional construct rather than a personality trait has led to resilience being considered in terms of resilient trajectories or profiles, rather than resilient individuals.⁷¹⁴

4.10.2 The concept of recovery

Recovery is often described as a lengthy and non-linear process, unique to each individual.⁷¹⁵ An essential part of recovery is the development of effective coping strategies. It is worth noting that some coping strategies, identified earlier in this report – such as dissociation and substance misuse – may not be helpful for recovery. Different models have been developed to describe the process of recovery following trauma. Herman's stage-based model is detailed below (Figure 4.15) to show the different types of coping strategies which may be used at different stages of recovery.⁷¹⁶ People may move back and forth through these stages as they recover.

Figure 4.15: Herman's three stages of recovery⁷¹⁷



712 Edmond et al. (2006), *op. cit.*; Domhardt et al. (2015), *op. cit.*; Grossman et al. (2006), *op. cit.*

713 Rutter (2012), *op. cit.*

714 Edmond et al. (2006), *op. cit.*

715 Sneddon et al. (2016), *op. cit.*

716 *Ibid.*

717 *Ibid.*

The process of recovery can take many years or even decades. People recover from trauma at different rates, and a greater number of risk factors may slow the rate of recovery. In the qualitative literature, victims and survivors have described their recovery as an ongoing process, with recognition that a 'full' recovery may not be possible:

*"I perceive myself as recovering. I don't know that I would say that I am recovered. I think that there would always be a slightly vulnerable part of me. A part of me that might be more easily wounded in a situation than maybe someone else. A part of me that would still get scared when... that does still get scared... I suppose I don't ever think well that's me done then. I suppose I say to me, look I do have a vulnerable part of me and it's important that I constantly be aware of that."*⁷¹⁸

4.10.3 Risk and protective factors

The resilience and recovery literature frequently focuses on risk and protective factors as a means of understanding why some individuals are thought to be resilient, or achieve recovery, while others are/do not. Risk and protective factors are defined in the following way:

Figure 4.16: Definition of risk and protective factors

Risk factor:

An attribute, characteristic or condition which **increases** an individual's risk of experiencing an adverse outcome

Protective factor:

An attribute, characteristic or condition which **reduces** an individual's likelihood of experiencing an adverse outcome

Some risk and protective factors are not amenable to change and are therefore seen to be fixed or 'static'. Static factors include individual characteristics such as age and gender, or a person's history, such as their victimisation or criminal convictions. Conversely, dynamic risk and protective factors are potentially amenable to change. They include things like family support, educational experience and substance misuse.

Many of the risk and protective factors identified in relation to CSA relate to the individual and factors from their environment, including the context and characteristics of the abuse, interpersonal factors, and wider social and environmental factors. In order to understand why people react in different ways to trauma, researchers often draw on theories of child development that highlight the different influences on the individual. While some theories focus on singular influences, such as biology or the social

718 Chouliara et al. (2014), *op. cit.*, p.75

environment, some theorists argue that development cannot be captured by single concepts, and adopt a multidimensional approach. One such approach is the ecological systems theory, formulated by Bronfenbrenner.⁷¹⁹ This theory perceives the individual as part of a wider system within which development occurs. The different parts of the system are interrelated and the child and environment interact with each other in a reciprocal way. The influence of different parts of the system is changing and dynamic. The parts of the system closest to the individual are likely to be most influential, but all parts of the model can interact and impact on the individual. This theory has been influential in considering the risk and protective factors for the prevalence of child abuse, and has shaped the presentation of information in this chapter.

Much of the literature sourced for this REA relates to the individual, context and characteristics of abuse, and interpersonal parts of the system. There is less information on the wider social and environmental factors. Similarly, authors of research on revictimisation argue that much of the evidence has focused on individual factors that promote revictimisation, and that there is limited evidence regarding societal values, public policy and law, preventing conclusions about how these systems may also impact on individual risk for experiencing multiple victimisations.⁷²⁰ However, the impact of these less proximal parts of the system is explored in this chapter where possible.

4.10.3.1 Factors affecting resilience and recovery following CSA

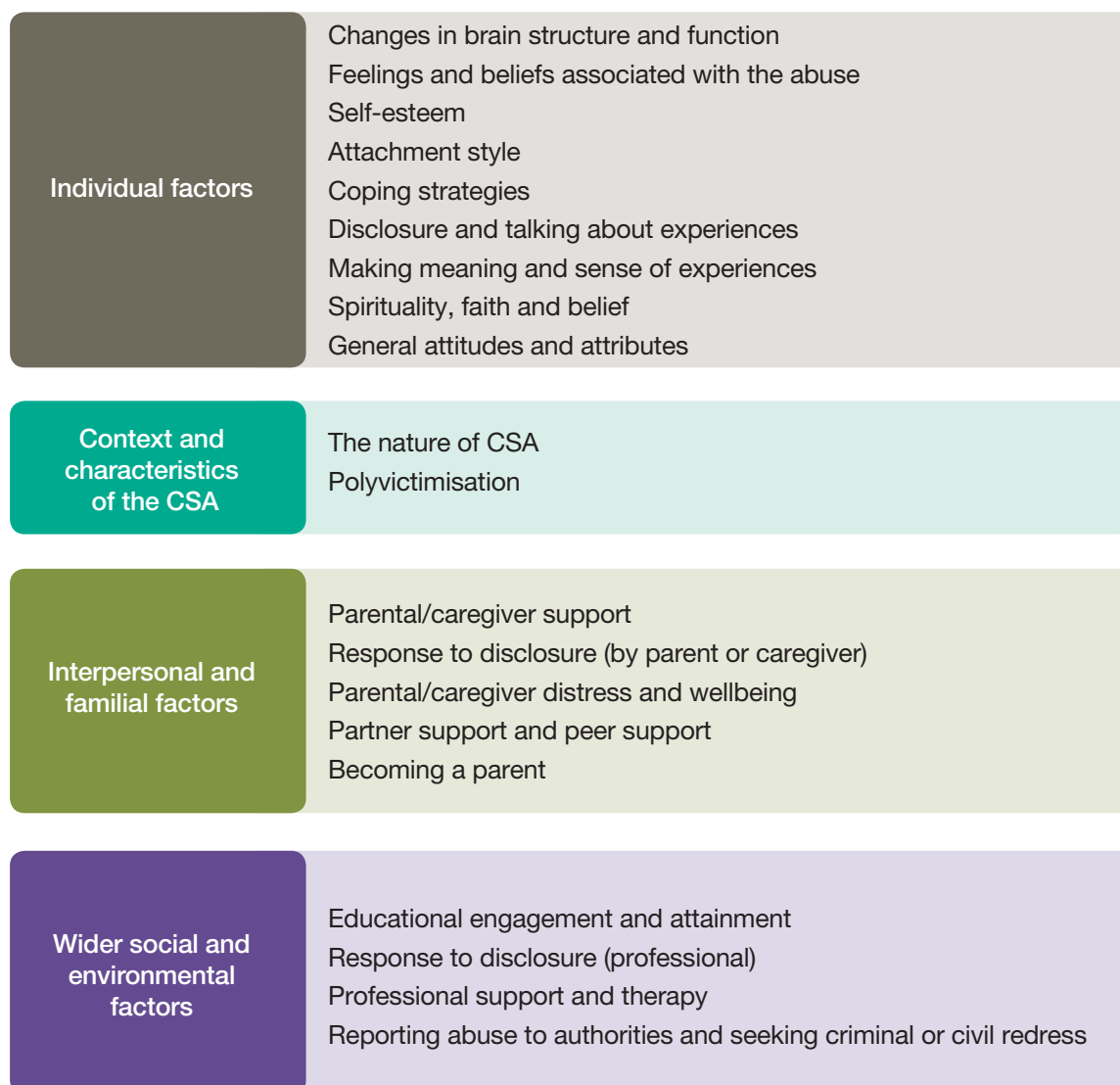
This section explores some of the key risk and protective factors that help to explain why some victims and survivors are deemed to be resilient while others are not. Many of these factors have been referenced during earlier sections of the report, but are drawn together here.⁷²¹

Some of the key protective factors at the individual level relate to feelings, attitudes and beliefs that help victims and survivors to avoid, or move beyond, the feelings of self-blame, stigma and betrayal that can follow CSA. In terms of environmental and interpersonal factors, education and supportive relationships have been shown to be highly influential in aiding resilience or recovery from CSA (Figure 4.17).

719 Bronfenbrenner (1979), *op. cit.*

720 Pittenger et al. (2016), *op. cit.*

721 For a systematic review of the evidence on the association between resilience and CSA, see Domhardt et al. (2015), *op. cit.*

Figure 4.17: Key factors related to resilience and recovery

Risk and protective factors related to social and environmental factors often affect individual-level factors, and vice versa. For example, cultural norms and attitudes that silence discussions around CSA can have a debilitating impact on recovery by inhibiting victims and survivors from disclosing and talking about the abuse they experienced, and thereby developing healthier beliefs about and attitudes towards it.⁷²²

The factors associated with resilience and recovery following CSA are explored in more detail in the next two sections.

722 Softestad, S., Toverud, R., and Jensen, T. K. (2013) Interactive Regulated Participation: Children's perspectives on child-parent interaction when suspicion of child sexual abuse is raised. *Qualitative Social Work*, 12(5), pp.603-619

4.10.3.2 Individual factors

At the individual level, improvements in self-perception underpinned by making positive choices are seen as important for the recovery process and development of resiliency. This often involves a process of improved understanding about the abuse that leads to lower levels of self-blame and a reduction in negative feelings. Coping strategies can help victims and survivors to deal with negative thoughts and feelings related to the abuse, and to effectively manage other challenges in their lives. These are often interrelated: for example, victims and survivors who place blame on the perpetrator are more likely to use adaptive coping strategies.⁷²³

For some victims and survivors, disclosing the abuse and talking about it with others can help with the healing process, particularly in terms of making meaning and sense out of what has happened. In some cases, certain beliefs, including religion and spirituality, can provide a framework that helps with this process. The improvements in self-esteem and self-concept that subsequently arise often lead to positive life choices, which further enhance self-esteem.

Related to self-perception is the language that victims and survivors of CSA use to describe themselves and their experiences. The terms 'victim' and 'survivor' mean different things to different people, and self-identification with these terms may change over time. What is most important is that people are able to describe and define their experiences using their own terms. The language that people use may reflect where they perceive themselves to be in the recovery process. For example, in one qualitative study, a woman described how she felt that she had progressed from victim to survivor to 'overcomer':

*"We're victims. We were victims should I say... But we are survivors, and we're overcomers. It's one thing to survive, it's another to overcome."*⁷²⁴

Table 4.26 draws out some of the research findings from the literature that highlight key individual factors. Quotations from victims and survivors illustrate the role of these factors in their lives.

Table 4.26: Individual-level risk and protective factors

Key factors	Examples and quotations from the literature
Changes in brain structure and function (see section 4.2 for more information)	<ul style="list-style-type: none"> CSA associated with early onset of puberty.⁷²⁵ Dysregulation of the stress hormone cortisol characterises survivors of CSA with major depression or PTSD, but not CSA survivors without depression, or individuals with depression without a history of CSA.⁷²⁶ Psychotherapy can increase hippocampal size for victims and survivors of CSA.⁷²⁷

723 Walsh et al. (2010), *op. cit.*

724 Cecchet and Thoburn (2014), *op. cit.*, p.489

725 Trickett et al. (2011), *op. cit.*

726 Heim et al. (2004, 2008); Feder et al.: (2004); Carrion et al. (2002); De Bellis et al. (1999), *op. cit.*; Hart et al. (1996); Kaufman (1991)

727 Heger et al. (2002), *op. cit.*

Key factors	Examples and quotations from the literature
Feelings and beliefs associated with the abuse	<ul style="list-style-type: none"> • Feelings of stigma, betrayal and powerlessness associated with PTSD.⁷²⁸ • Feeling empowered has been linked to resilience.⁷²⁹ • Self-blame linked with PTSD severity and revictimisation.⁷³⁰ • External attribution of blame linked with resilience.⁷³¹ <p><i>“The guilt is the worst because it’s mixed with shame too. I always felt guilty because I knew what they did to me was morally wrong so I carried their shame. Therefore, to set yourself free, you have to unpack these dense emotions. This is not easy as they have become embedded in your sense of self, so you have to feel that anger of injustice, in order to illuminate your needs and not stay in the fog.”⁷³²</i></p> <p><i>“I think understanding that it wasn’t my fault was the key to getting confident and being able to deal with the trauma.”⁷³³</i></p>
Self-esteem	<ul style="list-style-type: none"> • Low self-esteem predicts anger and depression in adolescents.⁷³⁴ • Robust sense of self-esteem (protective factor for children and adults – for the latter in relation to interpersonal problems and sexual risk taking).⁷³⁵ <p><i>“I have always felt not good enough. Not just self-esteem issues that the average person can also struggle with, but a real, bone-crushing devastation in feeling below everyone. Because of the way I was treated, I felt I did not deserve basic human rights. If the people that were supposed to nurture you as a child, sexually abused you, then surely you are unlovable, unworthy and deserve bad things to happen? I am nothing therefore I deserve nothing.”⁷³⁶</i></p>
Attachment style	<ul style="list-style-type: none"> • High emotional attachment, family social support, relationship satisfaction and quality all found to be protective factors. Sometimes found to be more of a protective factor for females.⁷³⁷ • A secure attachment style predicted lower depression after controlling for characteristics of abuse and occurrence of other maltreatments.⁷³⁸

728 Canton-Cortes et al. (2011), *op. cit.*

729 Domhardt et al. (2015), *op. cit.*

730 Filipas (2006), *op. cit.*

731 Domhardt et al. (2015), *op. cit.*

732 One in Four (2015), *op. cit.*, p.14

733 One in Four (2015), *op. cit.*, p.13

734 Asgeirsdottir et al. (2010), *op. cit.*

735 Domhardt et al. (2015), *op. cit.*

736 One in Four (2015), *op. cit.*, p.14

737 Domhardt et al. (2015), *op. cit.*

738 Canton-Cortes et al. (2015), *op. cit.*

Key factors	Examples and quotations from the literature
Coping strategies	<ul style="list-style-type: none"> • Problem-solving confidence affects relationship between CSA and suicidal ideation.⁷³⁹ • Resilient adolescents used more approach coping strategies and fewer avoidant coping strategies,⁷⁴⁰ with avoidant/maladaptive coping strategies being a risk factor for negative outcomes⁷⁴¹ (including PTSD).^{742 743} <p><i>"Splitting off or disassociating from my reality became a coping mechanism in a situation too awful to comprehend. Another way of coping was trying to forget. I have spent most of my life trying to forget what happened to me. Even when flashbacks arrived, I pushed them down so far that they were in the tips of my toes... But unfortunately, if you don't deal with these issues they find a way of seeping out, without you even being aware."</i>⁷⁴⁴</p> <p><i>"Looking back now, I realise in situations that we don't know how to deal with, our body and mind are smart, and they find ways to 'cope.'" ⁷⁴⁵</i></p>
Disclosure and talking about experiences	<ul style="list-style-type: none"> • Talking about experiences of CSA (general protective factor).⁷⁴⁶ • General secrecy, as reported by child's mother, related to higher levels of internalising.⁷⁴⁷ <p><i>"I feel proud, I told the story, and it was the right thing to do for me. I will not regret something... yes, only that I should have disclosed it earlier."</i>⁷⁴⁸</p> <p><i>"It took courage to tell my family, to disclose, to name the abuse and take ownership of my life, my sexuality, my body, my emotions. I felt used, abused, confused, and finally I became free. Free to be myself, without shame, guilt or secrets; secrets that I had been carrying all my life."</i>⁷⁴⁹</p>
Making meaning and sense of experiences	<ul style="list-style-type: none"> • In adulthood: ability to understand own trauma and the cause/consequence of it (protective factor against suicide for victims and survivors of institutional abuse – in the opinion of professionals only).⁷⁵⁰ • Personal growth and making meaning of experiences related to resilience among HIV+ adults.⁷⁵¹ <p><i>"I've done so much good and so much helpful for others. Even though I wish it [the abuse] didn't happen, I'm sort of glad because I've been able to help so many other people now."</i>⁷⁵²</p> <p><i>"As I heal myself, being able to start reaching out to other people, and helping people through this journey."</i>⁷⁵³</p>

739 O'Riordan and Arensman (2007), *op. cit.*

740 Daigneault, I., Hébert, M., and Tourigny, M. (2007) Personal and Interpersonal Characteristics Related to Resilient Developmental Pathways of Sexually Abused Adolescents. *Child and Adolescent Psychiatric Clinics of North America*, 16(2), pp.415-434

741 Domhardt et al. (2015), *op. cit.*

742 Canton-Cortes and Canton (2010), *op. cit.*

743 Filipas (2006), *op. cit.*

744 One in Four (2015), *op. cit.*, p.13

745 *Ibid.*, p.21

746 Sneddon et al. (2016), *op. cit.*

747 van Delft et al. (2015), *op. cit.*

748 Back et al. (2011), *op. cit.*, p.54

749 One in Four (2015), *op. cit.*, p.12

750 O'Riordan and Arensman (2007), *op. cit.*

751 Domhardt et al. (2015), *op. cit.*

752 Grossman et al. (2006), *op. cit.*, p.438

753 Hunter (2009), *op. cit.*, p.9

Key factors	Examples and quotations from the literature
Spirituality, faith and belief	<ul style="list-style-type: none"> Religiosity and spirituality (protective factor among women and among HIV+ adults).⁷⁵⁴ Faith and belief leading to a greater sense of personal growth and resolution in relation to experiencing CSA.⁷⁵⁵
General attitudes and attributes	<ul style="list-style-type: none"> Optimism, hope (general resilience factor among adolescents and adults).⁷⁵⁶ Self-control protective factor for mental health and self-esteem,⁷⁵⁷ and self-efficacy.⁷⁵⁸ protective factor against interpersonal problems and HIV/sexual risk taking behaviours.⁷⁵⁹ Emotional intelligence protective factor against adolescent suicide in one paper, non-sexual rumination in another and adult psychopathology in a third.⁷⁶⁰ <p><i>"My dream for my life is to move on and have a better life." (participant aged 11).⁷⁶¹</i></p> <p><i>"I always had a part of me that still had hope though, like an inner part of my soul that was burning bright and alive although hidden at times."⁷⁶²</i></p>

4.10.3.3 Context and characteristics of CSA

Some studies suggest a link between outcomes and the nature or 'severity' of CSA, such as duration, frequency, contact, and relationship with the perpetrator. Some of these possible links are illustrated in Table 4.27. However, as discussed in section 4.3 when looking at CSA and anxiety, research findings are often mixed and should be interpreted with caution.⁷⁶³ In a meta-analysis of the literature, it is argued that variations in methodology and categorisation of severity, and a tendency towards publication bias (whereby studies which find a link are more likely to be published than those which find no link), help to explain the mixed findings, making it very difficult to draw any robust conclusions.⁷⁶⁴

754 Domhardt et al. (2015), *op. cit.*; 194

755 Gall et al. (2007), *op. cit.*

756 Domhardt et al. (2015), *op. cit.*

757 *Ibid.*

758 This can be defined as the belief in one's own ability to succeed in a given situation.

759 Domhardt et al. (2015), *op. cit.*

760 *Ibid.*

761 Foster and Hagedorn (2014), *op. cit.*, p.550

762 One in Four (2015), *op. cit.*, p.29

763 Maniglio (2013b), *op. cit.*

764 Hillberg, T., Hamilton-Giachritsis, C., Dixon, L. (2011) Review of Meta-Analyses on the Association Between Child Sexual Abuse and Adult Mental Health Difficulties: A Systematic Approach. *Trauma, Violence & Abuse*, 12(1), pp.38-49

Table 4.27: CSA-related risk and protective factors

Key factors	Examples and quotations from the literature
The nature of CSA	<ul style="list-style-type: none"> Greater adverse outcomes linked to intra-familial abuse (where the perpetrator is related to the victim and survivor), the duration and severity of abuse (degree of force used and nature of the sexual acts), age at first abuse, multiple perpetrators – cumulative effects (general risk factors for negative outcomes).⁷⁶⁵ <p><i>“The abuse was disguised by love, affection and secrecy. It took many therapists, personal development workshops and finally a friend to help me realise that what happened to me was not right and that it never should have happened.”</i>⁷⁶⁶</p> <p><i>“Childhood sexual abuse is the ultimate betrayal, as the very people that are supposed to love, nurture and care for you are the ones who place you in a living nightmare.”</i>⁷⁶⁷</p>
Poly-victimisation	<ul style="list-style-type: none"> Children experiencing the greatest number of, and most serious, victimisations showed the most serious mental health problems.⁷⁶⁸ Women reporting both CSA and CPA were more likely to report alcohol consequences and dependence than women reporting one type of abuse.⁷⁶⁹ Being a victim and survivor of both CSA and CPA increased the odds of adult obesity by nearly 400 per cent. Those with more than one abuse experience were more likely to have physical health problems.⁷⁷⁰ <p><i>“The horror of the years of abuse, which was emotional and physical also, at times torturous on all levels, still haunts me.”</i>⁷⁷¹</p> <p><i>“It was one isolated incident but its impact on my life has been fundamental.”</i>⁷⁷²</p>

4.10.3.4 Interpersonal and familial factors

In terms of risk and protective factors in the victim and survivor’s immediate interpersonal environment (for example, in relation to their family and any other close relationships), supportive relationships emerged from the literature as a particularly important protective factor. Where self-esteem has been damaged by the experience of CSA, strong relationships can help victims and survivors to restore their faith in themselves. However, CSA can affect the ability to relate to other people and good quality, supportive relationships and therapy are often required by victims and survivors to restore this ability.⁷⁷³

The ability to form strong and enduring relationships is influenced by a person’s attachment style. Bowlby’s attachment theory⁷⁷⁴ states that the nature of a child’s attachment with their primary caregiver from infancy forms a blueprint for their attachment style which can persist into adolescence and adulthood. The response of the primary caregiver to the child’s needs influences the child’s expectations

765 Sneddon et al. (2016), *op. cit.*

766 One in Four (2015), *op. cit.*, p.12

767 *Ibid.*, p.14

768 Finkelhor et al., 2007

769 Lown et al. (2011), *op. cit.*

770 McCarthy-Jones and McCarthy-Jones (2014), *op. cit.*

771 One in Four (2015), *op. cit.*, p.29

772 *Ibid.*, p.39

773 Nelson (2009), *op. cit.*

774 Bowlby (1958), *op. cit.*

around the availability of support and protection. Secure attachments are characterised by stable, loving and supportive bonds between infant and caregiver. Avoidant, ambivalent or disorganised attachment styles, on the other hand, may result when the caregiver is less supportive and/or their behaviour is unpredictable.

In terms of the impacts of CSA, having a secure attachment may aid resiliency by enabling the child or young person to seek support and protection, and assist recovery by improving the chances of developing supportive relationships in later life. Attachment styles have been shown to play a role in the outcomes victims and survivors experience following CSA, with secure attachment style predictive of lower levels of depression⁷⁷⁵ and insecure levels of attachment increasing the risk of self-harm.⁷⁷⁶

It is important to note that, particularly in the case of intrafamilial abuse, the context and characteristics of CSA and the child's interpersonal environment may be strongly interrelated.

Table 4.28 draws out some of the research findings from the literature that highlight key risk and protective factors related to the individual victim and survivor's interpersonal and social relationships and immediate environment. Again, quotations from victims and survivors are used to give voice to how impacts are experienced.

775 Canton-Cortes et al. (2015), *op. cit.*

776 Bolen et al. (2013), *op. cit.*

Table 4.28: Interpersonal and familial risk and protective factors

Key factors	Examples and quotations from the literature
Parental/ caregiver support	<ul style="list-style-type: none"> Parental support predicted decreased likelihood of depression,⁷⁷⁷ smoking and drug use.⁷⁷⁸ Adolescent girls undergoing treatment showed better self-concept and less depression when mother perceived as supportive at the time of discharge.⁷⁷⁹ Lack of caregiver support, nurturing and affection increased stress and trauma symptomatology in the child.⁷⁸⁰ <p><i>"She's [her stepmother] a beautiful person, and if it had not been for her I probably [would have been] dead a long time ago."</i>⁷⁸¹</p>
Response to disclosure (by parent or caregiver)	<ul style="list-style-type: none"> More anxiety and other symptoms when both mother and child reported that the mother did not believe the child after disclosure.⁷⁸² Supportive response from non-offending caregiver was associated with improved mental health and social functioning.⁷⁸³ A positive parental response following CSA linked with interpersonal adjustment in adulthood.⁷⁸⁴ <p><i>"Once I told my mum something my abuser had said to me. She was giving me a bath at the time, I was probably around four or five. She responded with such anger, slapping my legs uncontrollably! Shouting: 'Don't you ever say anything like that ever again!' My legs were red and sore but what hurt the most was her reaction. Whatever her reasons were, I knew from that point on I really was on my own, so in order to survive I split off from my reality."</i>⁷⁸⁵</p> <p><i>"She started to be angry... started to cry... and told me why didn't I told her about what happened." (participant aged six).</i>⁷⁸⁶</p> <p><i>"My mother simply ended the conversation and resumed her Hoovering."</i>⁷⁸⁷</p> <p><i>"[My mother's] response was such a relief. She hadn't known. She was upset that I wasn't able to tell her sooner, and that others didn't consider she'd want to help us put things right. She's been so supportive. After years of anguish my family are finally breaking the silence."</i>⁷⁸⁸</p>
Parental/ caregiver distress and wellbeing	<ul style="list-style-type: none"> Non-offending mother's depression increased risk of PTSD.⁷⁸⁹ <p><i>"I protected my mum because she didn't keep well; she was very ill all her life and I suppose I protected her. Partly I protected my own children. I... I was just protecting folk round about."</i>⁷⁹⁰</p>

777 Asgeirsdottir et al. (2010), *op. cit.*778 Bick et al. (2014), *op. cit.*779 Knott (2014), *op. cit.*780 van Toledo et al. (2013), *op. cit.*781 Banyard, V., and Williams, L. M. (2007) Women's voices on recovery: a multi-method study of the complexity of recovery from child sexual abuse. *Child Abuse and Neglect*, 31(3), pp.275-290, p.286782 Bick et al. (2014), *op. cit.*783 Knott (2014), *op. cit.*784 Bick et al. (2014), *op. cit.*785 One in Four (2015), *op. cit.*, p.13786 Foster and Hagedorn (2014), *op. cit.*, p.547787 One in Four (2015), *op. cit.*, p.38788 *Ibid.*, p.27789 Knott (2014), *op. cit.*790 Chouliara et al. (2014), *op. cit.*, p.74

Key factors	Examples and quotations from the literature
Partner support and peer support	<ul style="list-style-type: none"> Partner support helped to protect against compromised parenting outcomes in reducing depressive symptoms, increasing parental sense of competency, promoting the survivor's ability to communicate with their child, setting appropriate boundaries, and enhancing emotional attachment to the child.⁷⁹¹ However, where depressive symptoms were high, partner support was less effective as a protective factor.⁷⁹² <p><i>"[My wife] and I talk about that, and our past, so we have a lot of that and we have a huge amount in common. So it's not just giving me support, it's being a true – she's been a partner in a deepest sense of that."</i>⁷⁹³</p> <p><i>"I finally found out that he was physically abused, not sexually abused, [but] we had something sort of in common. And we became best friends, and we sort of used each other to get on."</i>⁷⁹⁴</p>
Becoming a parent	<ul style="list-style-type: none"> Having children decreased the association between CSA and depression.⁷⁹⁵ Experience of childbirth acted as a trigger for memories of the abuse (see section 4.10 for more information on triggers).⁷⁹⁶ <p><i>"The first thing I felt when they put him on my stomach, I thought to myself, I feel clean, you know like all that bad stuff was washed away."</i>⁷⁹⁷</p> <p><i>"Because I'd never pleased anybody. I'd never really been good at anything. And that's what – this baby was gonna do it. This baby was going to be how I made my mark, in this world."</i>⁷⁹⁸</p> <p><i>"I thought that everyone would just hate me and think I was a terrible person and that I didn't deserve to have this baby."</i>⁷⁹⁹</p>

4.10.3.5 Wider social and environmental factors

Table 4.29 presents research findings from the literature that illustrate risk and protective factors associated with victims and survivors' wider environment and social context, including the services and support professionals they come into contact with. Relevant quotations from victims and survivors are again provided in the second column.

791 Wright et al. (2005) cited in Marriott et al. (2014), *op. cit.*

792 Seltmann and Wright (2013), *op. cit.*

793 Kia-Keating et al. (2010), *op. cit.*, p.675

794 *Ibid.*, p.675

795 Zeglin et al. (2015), *op. cit.*

796 Leeners et al. (2016), *op. cit.*; Montgomery (2013), *op. cit.*; Montgomery et al. (2015), *op. cit.*

797 Montgomery (2013), *op. cit.*, p.94

798 Montgomery et al. (2015), *op. cit.*, p.58

799 *Ibid.*, p.57

Table 4.29: Wider social and environmental risk and protective factors

Key factors	Examples and quotations from the literature
Educational engagement and attainment	<ul style="list-style-type: none"> • Good relationships with teachers, engagement with school, high academic achievement and the completion of education.⁸⁰⁰ • Being more certain about educational plans, stronger academic performance and having positive feelings towards school.⁸⁰¹ • Academic performance (protective factor for self-esteem) and school enjoyment (protective factor for self-esteem and mental health problems).⁸⁰² • Graduation from high school (among women).⁸⁰³ <p><i>“... after my university degree which was quite an important thing, I think achieving that and moving on with my life a wee bit, it’s something else to focus on, it wasn’t oh there is [name], poor case, been abused and all that kind of thing.”⁸⁰⁴</i></p> <p><i>“I had missed out on most of my school years and was absent for huge chunks of time. Finally, the truant officer came calling and my mother blamed me for not going to school... Despite all these professionals being involved, no one was able to work out why I was absent from school.”⁸⁰⁵</i></p>
Response to disclosure (professional)	<ul style="list-style-type: none"> • Positive response to disclosure reduced likelihood of smoking or drug use.⁸⁰⁶ • Receiving a negative response to disclosure “may be the most predictive factor of later negative outcomes”.⁸⁰⁷ • Victims and survivors who experienced an unsupportive response to their initial disclosure from a professional (e.g. disbelief, victim-blaming, dismissiveness or excessive displays of shock or emotion) reported feeling deterred from disclosing again.⁸⁰⁸ <p><i>“Even though I was very scared of my abusers and had been repeatedly threatened not to tell anyone, there was an occasion when I was even more scared of what my abusers would do to me next and I plucked up the courage to tell my primary school teacher. Sadly she didn’t quite believe me and informed my parents of my accusations; they obviously denied everything and I was later severely punished. By the time the social worker came to follow up on the concern raised by the school, nothing in the world could have made me speak up again.”⁸⁰⁹</i></p>

800 Williams and Nelson-Gardell (2012), *op. cit.*801 Domhardt et al. (2015), *op. cit.*802 *Ibid.*803 *Ibid.*804 Chouliara et al. (2014), *op. cit.*, p.74805 One in Four (2015), *op. cit.*, p.33806 Draucker and Mazurczyk (2013), *op. cit.*807 Jonzon et al (2004) cited in Sneddon et al. (2016), *op. cit.*808 Montgomery et al. (2015), *op. cit.*; Cecchet and Thoburn (2014), *op. cit.*809 One in Four (2015), *op. cit.*, p.20

Key factors	Examples and quotations from the literature
Professional support and therapy	<ul style="list-style-type: none"> • Effective support services and interventions including counselling, therapy, etc.⁸¹⁰ • Interactions with therapists or other healthcare providers often represented individuals' first experience of trusting another person since the abuse.⁸¹¹ <p><i>"Trust is a miracle. I've never trusted anybody. And it's the biggest single by-product of my therapy, just learning that I can sit in a room with another person and they don't have any desire to abuse me. It's a big deal."</i>⁸¹²</p>
Reporting abuse to authorities and seeking civil or criminal redress	<ul style="list-style-type: none"> • Formalising a complaint against the perpetrator is felt to be validating and empowering by some victims and survivors.⁸¹³ • Participating in interviews and giving evidence in court can be experienced as distressing⁸¹⁴ and may trigger trauma responses⁸¹⁵ (see section 4.10 for more information on triggers). • Involvement in criminal proceedings contributes to the lifetime incidence of depression.⁸¹⁶ • Giving evidence as a child is associated with negative attitudes towards the criminal justice system in the long term, although this is also true where the child does not testify and the perpetrator goes on to receive a more lenient sentence.⁸¹⁷ <p><i>"It was a lot to bear, to handle. Questions would be constantly pounding on me. I would have to recite my story countlessly."</i>⁸¹⁸</p>

4.10.4 Triggers

Over the course of their lifetime, victims and survivors of CSA may encounter certain situations, events or sensations which can (re)trigger the trauma associated with the abuse. These situations can cause distressing emotions and traumatic memories to resurface, and lead to victims and survivors feeling like they are back in the abusive situation, thereby disrupting resilience and recovery.⁸¹⁹

These 'triggers' can take multiple forms, including:

- physical or sexual contact
- seeing someone/something or being aware of a particular sight, sound or smell that reminds them of the abuse

810 Corcoran, J., and Pillai, P. (2008) A meta-analysis of parent-involved treatment for child sexual abuse. *Research on Social Work Practice*, 18(5), pp.453-464; Coren, E., Thomae, M., Hutchfield, J., and Iredale, W. (2013) Report on the implementation and results of an outcomes focused evaluation of child sexual abuse interventions in the UK. *Child Abuse Review*, 22(1), pp.44-59; Allnock et al. (2015), *op. cit.*; Domhardt et al. (2015), *op. cit.*; Benuto, L. T., and O'Donohue, W. (2015) Treatment of the Sexually Abused Child: Review and Synthesis of Recent Meta-Analyses. *Children and Youth Services Review*, 56, pp.52-60; Sneddon et al. (2016), *op. cit.*; One in Four (2015), *op. cit.*; van Toledo et al. (2013), *op. cit.*

811 Kia-Keating et al. (2010), *op. cit.*

812 *Ibid.*, p678

813 Sneddon et al. (2016), *op. cit.*; Davidson et al. (2006), *op. cit.*

814 Back et al. (2011), *op. cit.*, Foster and Hagedorn (2014), *op. cit.*

815 Davidson et al. (2006), *op. cit.*

816 Gutman et al. (2001) cited in Davidson et al. (2006), *op. cit.*

817 Mitchell et al. (2007), *op. cit.*

818 Foster and Hagedorn (2014), *op. cit.*, p.547

819 Montgomery (2013), *op. cit.*; Stewart (2012), *op. cit.*; Mitchell et al. (2007), *op. cit.*; Bolitho and Freeman (2016), *op. cit.*; Montgomery et al. (2015), *op. cit.*; Havig (2008), *op. cit.*; Price-Robertson (2012), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Chouliara et al. (2014), *op. cit.*; Kristensen and Lau (2011), *op. cit.*; Kim et al. (2007), *op. cit.*; Kilroy et al. (2014), *op. cit.*; Doyle (2009), *op. cit.*; Nelson (2009), *op. cit.*; Leeners et al. (2016), *op. cit.*; Allnock et al. (2015), *op. cit.*

- situations which cause them to feel out of control, powerless or vulnerable
- situations which require them to talk about or relive the abuse, such as criminal proceedings or some types of therapy

A victim and survivor in a qualitative study described their experience of triggers:

“I do still have moments when I’m caught unawares, smells I’m particularly sensitive to, if I smell something that reminds me of being back there.”⁸²⁰

A number of specific triggers are highlighted in the literature. These are summarised in Table 4.30. It should be noted that much of the literature in this area has been particularly female-focused. Three of the triggers in this table (childbirth, therapy and legal proceedings) are also touched on in the risk and protective factors tables above. This is because the evidence suggests they have the potential to bring about positive change for victims and survivors over the longer term, as well as to (re)trigger trauma.

Table 4.30: Potential triggers of CSA trauma

Trigger	Examples and quotations from the literature
Medical examinations	<p>Medical examinations – particularly gynaecological/genital ones – can feel invasive, reminiscent of unwanted touching, and trigger feelings of powerlessness. Victims and survivors may have uncontrollable and intrusive thoughts of danger or threat, can feel overwhelmed by emotions and can experience dissociation.⁸²¹</p> <p><i>“They [vaginal examinations] were really, really painful and I – the midwives on the ward just kept telling me to stop being so silly – everybody goes through it, everybody has it done.”⁸²²</i></p>
Childbirth ⁸²³	<p>Several studies have identified childbirth as a trigger for victims and survivors.⁸²⁴ Specific triggers related to the childbirth process include: being asked to take specific positions for vaginal examinations/labour (see also ‘Medical examinations’ above), difficulty with being able to do what the midwife is asking them, pain and duration of labour, and feeling a loss of control. Again, victims and survivors often report dissociation and ‘shutting down’ as a means of coping with the experience. See Box 4.2 below for more detail on pregnancy and childbirth as a trigger.</p> <p><i>“If she [the nurse] would have perhaps said... offered an opening, some little opening, like, ‘How is this on you? Sometimes this [childbirth] brings up a lot from people’s past’, or some little sense of awareness that it could be an issue, I think I would have right away given it... a teeny little opening would have taken it. But I never had the sense that there was one.”⁸²⁵</i></p> <p>Becoming a parent can also be a trigger for male victims and survivors.⁸²⁶</p>
Dental examinations	<p>Oral examinations, submissive body positioning (such as that involved when in the dentist’s chair) and the use of latex gloves can all be experienced as uncomfortable or traumatic.⁸²⁷</p>

820 Montgomery (2013), *op. cit.*, p.93

821 Robohm & Buttenheim (1996); Schachter et al. (1999); Schachter et al. (2004) cited in Havig (2008), *op. cit.*

822 Montgomery et al. (2015), *op. cit.*, p.57

823 Nelson (2009), *op. cit.*; Lainsbury, (1999) cited in Price-Robertson (2012), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Stewart (2012), *op. cit.*

824 Leeners et al. (2016), *op. cit.*; Montgomery (2013), *op. cit.*; Montgomery et al. (2015), *op. cit.*

825 Montgomery (2013), *op. cit.*, p.93

826 Nelson (2009), *op. cit.*; Price-Robertson (2012), *op. cit.*

827 Stalker et al. (2005) cited in Havig (2008), *op. cit.*

Trigger	Examples and quotations from the literature
Coming into contact with the perpetrator following the abuse ⁸²⁸	<p>Seeing the perpetrator in court can evoke fear and bring back memories of the abuse. One child victim described the following:</p> <p><i>"I went to court. I was nervous... I was mad when I saw [the perpetrator]."</i>⁸²⁹</p> <p>In another study, an adult victim and survivor explained:</p> <p><i>"At the time my abuser was still in contact with me at family gatherings and different things and he came and visited one day... and it felt just like I was back to eight years old."</i>⁸³⁰</p>
Therapy ⁸³¹	<p>Touch involved in the provision of physical therapy has been highlighted as a trigger for retraumatisation.⁸³²</p> <p>In another study, one victim and survivor described how art therapy triggered feelings associated with the abuse:</p> <p><i>"I did a bit of art therapy (I drew a bottle!), and that's how my feelings of shame about a particular rape at 16 emerged."</i>⁸³³</p>
Sexual activity ⁸³⁴	<p>As described in section 4.5, sexual interactions can trigger distress and flashbacks of the abuse – for females, this may be related to sexual pain disorders.</p>
Legal proceedings related to the CSA ⁸³⁵	<p>For child victims in particular, feelings of not being treated with respect, not being believed, and having to re-tell their story and revisit painful memories in the legal process, can be a traumatic experience.</p>
Own child experiencing CSA	<p>It is suggested that the disclosure of a child's sexual abuse may be more stressful for parents who were also sexually abused in childhood. The sexual abuse of a child can (re)trigger the trauma of the abuse they themselves experienced.⁸³⁶</p> <p><i>"I remember more about my own experiences since this happened... and it's like it's dug up the whole lot again that I had spent all them years hiding away."</i>⁸³⁷</p>
Requiring emotional or spiritual support (in cases of clergy CSA) ⁸³⁸	<p>Where victims and survivors may be in particular need of emotional support (for example, when experiencing a bereavement or illness), this may trigger negative feelings associated with the abuse. In the case of clergy abuse, for example, a person who they may once have turned to for support may now be a reminder of the abuse.</p>

828 Chouliara et al. (2014), *op. cit.*; Foster and Hagedorn (2014), *op. cit.*

829 Foster and Hagedorn (2014), *op. cit.*, p.548

830 Chouliara et al. (2014), *op. cit.*, p.73

831 Allnock et al. (2015), *op. cit.*

832 Robohm & Buttenheim (1996); Schachter et al. (1999); Teram et al. (1999) cited in Havig (2008), *op. cit.*

833 Allnock et al. (2015), *op. cit.*, p.123

834 Kristensen and Lau (2011), *op. cit.*

835 Back et al. (2011), *op. cit.*; Mitchell et al. (2007), *op. cit.*; Davidson et al. (2006), *op. cit.*; Foster and Hagedorn (2014), *op. cit.*

836 Terr (1991) cited in Kim et al. (2007), *op. cit.*; Kilroy et al. (2014), *op. cit.*

837 Kilroy et al. (2014), *op. cit.*, p.487

838 Doyle (2009), *op. cit.*

Triggers related to healthcare (including dental) experiences and childbirth were particularly prominent in the literature reviewed. Research in this area highlights how negative interactions with healthcare professionals can exacerbate certain triggers⁸³⁹ – which may in part be due to the abuse not having been previously disclosed or identified and examinations therefore not carried out in the most sensitive way.⁸⁴⁰ As described in section 4.2 on physical health, some victims and survivors may avoid medical appointments altogether for these very reasons, placing their health at greater risk.⁸⁴¹ The literature emphasises how the formation of trusting relationships with healthcare professionals can help to prevent negative feelings associated with the abuse from resurfacing and facilitate a more positive healthcare experience overall.⁸⁴² It is suggested that the formation of such relationships requires professionals to have a good understanding of trauma and potential triggers, and that there should be a greater emphasis placed on shared decision making in this healthcare context.⁸⁴³ See section 4.11 for further discussion of the role of healthcare professionals.

Triggers will be different for every victim and survivor and conclusions cannot be drawn about the victim and survivor population as a whole. Indeed, one study suggests that although the experience of childbirth may be deeply traumatic for some women who have experienced CSA, the majority will have relatively normal, uncomplicated births, indistinguishable from women who have not experienced CSA.⁸⁴⁴ Box 4.2 explores in more detail how pregnancy, childbirth and parenthood can be potentially triggering experiences following a history of CSA. Most research focuses on women victims and survivors, with few studies identified that considered parenthood from the point of view of male victims and survivors.

839 Back et al. (2011), *op. cit.*; Stewart (2012), *op. cit.*; Mitchell et al. (2007), *op. cit.*; Bolitho and Freeman (2016), *op. cit.*

840 Robohm & Buitenen (1996) cited in Havig (2008), *op. cit.*; Montgomery (2013), *op. cit.*

841 Sneddon et al. (2016), *op. cit.*; Havig (2008), *op. cit.*

842 Montgomery (2013), *op. cit.*; Montgomery et al. (2015), *op. cit.*; Stalker et al. (2005) cited in Havig (2008), *op. cit.*

843 Robohm and Buitenen (1996) and Teram et al. (1999) cited in Havig (2008), *op. cit.*; Havig (2008), *op. cit.*

844 Parratt (1994) and Garratt (2011) cited in Montgomery et al. (2015), *op. cit.*

Box 4.2: Pregnancy, childbirth and parenthood as potential triggers

Female victims and survivors of CSA who go on to have children may experience distinct physical and psychological impacts surrounding pregnancy and childbirth. A sense of guilt and shame about abuse can affect women's experiences of pregnancy, and their willingness to disclose past abuse to staff involved in their care.

Studies with pregnant victims and survivors have shown that anxiety and trauma can be re-triggered by situations that remind them of the abuse. As a consequence, they may feel powerless and a loss of control in the course of their childbearing experiences.⁸⁴⁵ An example is experiencing PTSD in the form of flashbacks during childbirth, where the woman is mentally transported back to the abusive situation.⁸⁴⁶ One woman talked in an interview about her first experience of labour:

*"... but – it was horrible and I – how it makes you feel... is how it made you feel when you were a child. It really does – although you know it's different circumstances, you know you're gonna have a baby and you know, you tell yourself this all the time... deep down you just turn yourself back into that seven-year-old that, that was treated so horribly and had things forced upon them that you just... was so unpleasant and that's what, what it reminds you of, it really is."*⁸⁴⁷

For some women, dissociation can occur as a response to this.⁸⁴⁸ Dissociation may be viewed positively as a coping mechanism, or it may be distressing for the individual. In one study, 58 per cent of pregnant women with a history of CSA experienced dissociation. Of these, 37 per cent considered this experience exclusively as helpful, in terms of reducing pain and fear and minimising the overwhelming aspects of the delivery, enabling them to feel they had gained control of the situation. However, a negative aspect was a sudden loss of contact with healthcare providers.⁸⁴⁹

Research has highlighted the need for maternity care staff to listen to and accommodate victims and survivors' distinct support needs and requirements.⁸⁵⁰ Victims and survivors may be acutely aware of the pressures on the health system, and this awareness may act as an additional disincentive to them 'open[ing] the can of worms' that they feel might result from a CSA disclosure.⁸⁵¹

845 Montgomery (2013), *op. cit.*; Montgomery et al. (2015), *op. cit.*

846 Montgomery (2013), *op. cit.*; Montgomery et al. (2015), *op. cit.*

847 Montgomery et al. (2015), *op. cit.*, p.57

848 Leeners et al. (2016), *op. cit.*; Montgomery (2013), *op. cit.*; Montgomery et al. (2015), *op. cit.*

849 Leeners et al. (2016), *op. cit.*

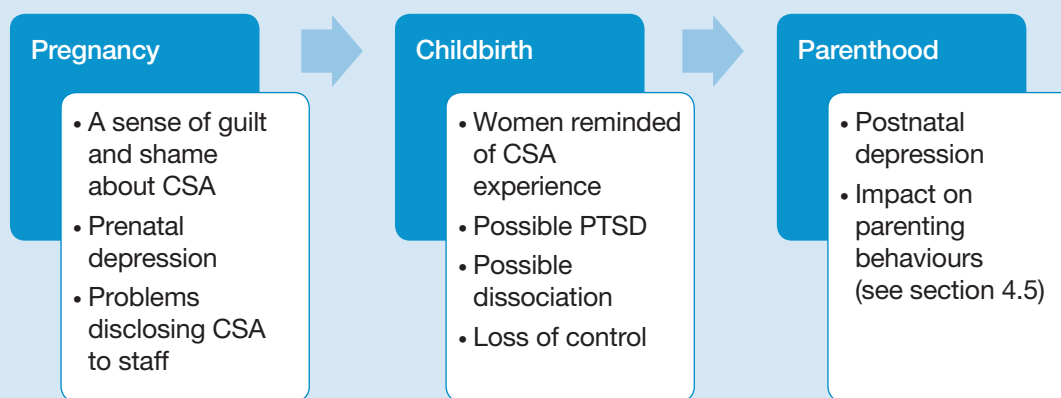
850 Montgomery et al. (2015), *op. cit.*

851 *Ibid.*, p.58

Box 4.2: Pregnancy, childbirth and parenthood as potential triggers (continued)

For some women with a history of CSA, there is a greater risk of depression during pregnancy and postnatal depression following childbirth,⁸⁵² although a meta-analysis found that CSA history may be more strongly associated with prenatal than postpartum depression or depressive symptoms.⁸⁵³ A study with mothers with a history of CSA found that 57 per cent reported levels of depression in the clinical range.⁸⁵⁴ Some of the adverse outcomes associated with pregnancy, childbirth and parenthood are shown in Figure 4.18.

Figure 4.18: Adverse outcomes associated with pregnancy, childbirth and parenthood for female CSA victims and survivors



852 Hooper and Warwick (2006), *op. cit.*

853 Wosu et al. (2015b), *op. cit.*

854 Seltmann and Wright (2013), *op. cit.*

4.11 The role of wider society

Building on the research findings set out in section 4.10, this section explores some of the ways in which wider society's response to victims and survivors can impact on their resilience and recovery following CSA.

Summary of key themes

- The response of wider 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 among 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.⁸⁵⁵ Supportive responses to disclosure,⁸⁵⁶ and supportive relationships,⁸⁵⁷ 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,⁸⁵⁸ and are based on an assessment of the individual's needs.⁸⁵⁹ Studies have found that there is a shortfall in the availability of specialist services for children and young people compared with demand.⁸⁶⁰ Inappropriate responses by services can compound the impacts of CSA and place victims and survivors at greater risk.⁸⁶¹
- Wider services – including health,⁸⁶² social services, the criminal justice system,⁸⁶³ and domestic violence and substance misuse services⁸⁶⁴ – 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,⁸⁶⁵ although sensitive practice by professionals can help to mitigate these impacts.⁸⁶⁶ Fear of blame and retraumatisation can discourage victims and survivors from seeking accountability and reparations for CSA.⁸⁶⁷ There has been a recent international trend towards legislative and policy changes that aim to improve victims and survivors' access to justice.⁸⁶⁸

855 Bick et al. (2014), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Montgomery et al. (2015), *op. cit.*; Cecchet and Thoburn (2014), *op. cit.*

856 Bick et al. (2014), *op. cit.*; Knott (2014), *op. cit.*

857 Knott (2014), *op. cit.*; Marriott et al. (2014), *op. cit.*; Seltsmann and Wright (2013), *op. cit.*

858 Breckenridge and Flax (2016), *op. cit.*; Allnock et al. (2015), *op. cit.*; Jay (2014), *op. cit.*

859 Edmond et al. (2006), *op. cit.*; Daigneault et al. (2007), *op. cit.*

860 Allnock et al. (2015), *op. cit.*

861 Edmond et al. (2006), *op. cit.*; Biehal et al. (2014), *op. cit.*; Jay (2014), *op. cit.*; Wolters (2008), *op. cit.*; Uliando and Mellor (2012), *op. cit.*

862 Hatton and Duff (2016), *op. cit.*

863 Bebbington et al. (2011), *op. cit.*

864 Friesen et al. (2010), *op. cit.*; Hadland et al. (2012), *op. cit.*; Nelson (2009), *op. cit.*

865 Foster and Hagedorn (2014), *op. cit.*; Davidson et al. (2006), *op. cit.*; Hovarth et al. (2014), *op. cit.*; Back et al. (2011), *op. cit.*

866 Radford et al. (2017), *op. cit.*; Hovarth et al. (2014), *op. cit.*; Davidson et al. (2006), *op. cit.*

867 One in Four (2015), *op. cit.*

868 Roffman et al. (2014), *op. cit.*; Bolitho and Freeman (2016), *op. cit.*

Society's response 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 built on the previous section to identify a number of ways in which society can help to bolster, or conversely undermine, resilience and recovery. The research findings have relevance for different parts of the social system surrounding the individual victim and survivor – from their family and immediate social environment to support services, and the wider influences of policy and culture.

4.11.1 Disclosure, identification and responses following them

Positive experiences of disclosure have been identified as a protective factor, with the potential to promote recovery.⁸⁶⁹ In practical terms, making a disclosure may result in the victim and survivor receiving more effective support and treatment – not only because they can be referred or signposted to specialist support, but also because knowledge of a patient or service user's history of CSA can inform professionals' decision making about the most appropriate intervention for the presenting problem.⁸⁷⁰ Independently of any practical consequences, talking about experiences of CSA with others is associated with psychological benefits. On the other hand, a poor experience of making an initial disclosure can deter victims and survivors from talking about an experience of abuse again,⁸⁷¹ and may influence their attitudes towards seeking support in future.⁸⁷² Research with male victims and survivors found that reactions to disclosures of CSA by this population are characterised by scepticism and minimisation, homophobia (influenced by stereotypes of male abuse victims and survivors), and assumptions that the victim or survivor poses a risk of perpetrating CSA.⁸⁷³

As outlined in the previous section, supportive relationships with both professionals and caregivers are a significant protective factor against experiencing harm following CSA. Such relationships can encourage victims and survivors to disclose abuse and ensure a supportive response, although they are also valuable even in the absence of any disclosure. Interactions with therapists or other healthcare providers may represent individuals' first experience of trusting another person since the abuse. One study found that “knowledge, empathy, skills and perception” on the part of staff – as opposed to therapeutic approach or formal qualifications – was what made the difference to victims and survivors' willingness to disclose.⁸⁷⁴

Fear of blame may be a particularly powerful deterrent to disclosure and reporting to the criminal justice system for some groups of victims and survivors – for example, victims and survivors of CSA involving sexting, in which current legislation can allow children and young people to be “both victims and criminals at the same time”.⁸⁷⁵ Furthermore, gang-involved girls and young women interviewed as part of a qualitative study into CSE reported reluctance to disclose abuse. They said this was partly because of a perception that police and other agencies would be more interested in their involvement in offending rather than their experience of victimisation, and partly because they lacked confidence that those agencies would be able to respond in a way that protected them from revictimisation.⁸⁷⁶

869 Draucker and Mazurczyk (2013), *op. cit.*; Sneddon et al. (2016), *op. cit.*

870 Aaron (2012), *op. cit.*; Coles et al. (2015), *op. cit.*; Francisco et al. (2008), *op. cit.*

871 Montgomery et al. (2015), *op. cit.*; Cecchet and Thoburn (2014), *op. cit.*

872 Teram et al. (2006), cited in Havig (2008), *op. cit.*

873 *Ibid.*

874 Kia-Keating et al. (2010), *op. cit.*; Nelson (2009), *op. cit.*, p.152

875 Gómez and Ayala (2014), *op. cit.*, p. 116

876 Race on the Agenda (rota) (2011) *Female voice in violence: Final report*

A recent review of public perceptions of CSA victims and survivors in England and Wales found significant differences in the attitudes of men and women, with male respondents tending to have more negative perceptions of victims and survivors (of any gender) – seeing them as more culpable, less reliable, less honest and less credible. The authors of that review point out the potential implications for access to justice in the context of an overwhelmingly male legal workforce, and the lack of a requirement for gender balance in juries.⁸⁷⁷ They also draw a parallel with findings from research into stalking, which has revealed specialist police officers to be less influenced by ‘stalking myths’ (e.g. that the stalking victim encouraged or provoked a perpetrator) compared with non-specialist police officers.⁸⁷⁸ This may be a positive finding, in that it suggests that attitudes are susceptible to change through the provision of information and education. Similarly, professionals tend to perceive sexual abuse perpetrated by females as less likely to merit a judicial response than where such abuse is perpetrated by males.⁸⁷⁹

Whether due to fear of blame or other reasons, such as believing an abusive relationship is consensual,⁸⁸⁰ many victims and survivors of CSA do not disclose the abuse they have experienced.⁸⁸¹ It is therefore important that systems and services are equipped to proactively detect CSA. Research findings suggest that schools, in common with other services, should be aware of the impacts of CSA on children and young people’s behaviour, in order to identify victims and provide them with appropriate support. Qualitative research shows that this awareness is often lacking. In a study in Scotland, men who recalled having behaved violently or disruptively at school following an experience of abuse reported that their behaviour had either been misinterpreted (as a sign of poverty, for example) or met with punishment.⁸⁸² Identifying behavioural signs and symptoms may be particularly difficult where the victim and survivor has pre-existing behavioural difficulties, for example related to a disability (see section 4.4).⁸⁸³

4.11.2 Support following identification/disclosure

It follows that policy and practice should aim to improve the capacity of families and practitioners to respond effectively and supportively following disclosure. To that end, research has considered support for non-offending parents/caregivers independently of their children. The literature suggests that their child’s disclosure of CSA may have ‘intertwined’ effects on caregivers’ mental and physical health, indicating potential benefits from joint service delivery.⁸⁸⁴ A number of studies have indicated that effective treatment following CSA should involve both the child and the (non-offending) parent or caregiver. Such treatment has been shown to have a small positive effect on children’s outcomes, and to be more effective compared with alternative treatment (e.g. for the child only).⁸⁸⁵

While proactive or preventative services may be desirable, research evidence cautions against making assumptions about the best form of support for children and young people on the basis of a history of CSA by itself, as opposed to an assessment of their actual psychological needs. This may result in inappropriate or disproportionate responses – such as placement in a high-needs setting (e.g. residential care), which itself has potential implications for the availability of social support and later life outcomes

877 Hatton and Duff (2016), *op. cit.*

878 Scott, Nixon and Sheridan (2013), cited in Hatton and Duff (2016), *op. cit.*

879 Cashmore and Shackel (2014), *op. cit.*

880 Dillane, J., Hill, M., Munro, C., (2005) *A study of sexual exploitation of looked after and accommodated young people*. Centre for the Child: University of Glasgow

881 Office for National Statistics (2016), *op. cit.*

882 Nelson (2009), *op. cit.*

883 Warrington et al. (2017), *op. cit.*

884 Cyr et al. (2016), *op. cit.*

885 Corcoran and Pillai (2008), *op. cit.*

as well as the risk of revictimisation.⁸⁸⁶ Likewise, the decision to end access to treatment should be governed by the individual's needs, rather than the child losing eligibility for services when they turn 18.⁸⁸⁷

Placement away from home has historically been a common response to identification or disclosure of CSA. However, the fact of being in residential care may itself put children at increased risk of victimisation. Accommodation in a residential home makes young people “an identifiable target” for sexual abuse and exploitation by adults external to the placement, as well as potentially exposing them to victimisation by peers.⁸⁸⁸ A review of open and less recent case files conducted as part of the Independent Inquiry into Child Sexual Exploitation in Rotherham found that girls who had been placed in residential care for their own safety continued to be targeted by perpetrators of CSE, with some being newly recruited into CSE by other victims who were their peers in care.⁸⁸⁹ Furthermore, institutionalisation may compound the impacts of abuse on victims and survivors.⁸⁹⁰ It has been suggested that the cumulative harm (i.e. the effect of abuse prior to admission to care, coupled with the effect of abuse while in care) is a more powerful predictor of adverse outcomes for victims and survivors than are specific risk factors in isolation.⁸⁹¹

It was outside the scope of this review to consider the effectiveness or otherwise of specialist treatments for child or adult victims and survivors of CSA. Considerations of ethics and study design make it difficult to quantify the overall effect of interventions following CSA, and more difficult still is establishing who benefits from what form of treatment, and which outcomes are amenable to change. Moreover, individual-level risk factors, such as high existing levels of need and unstable personal circumstances, may in themselves reduce victims and survivors' ability to engage in any form of intervention.⁸⁹²

Nevertheless, research indicates that services such as counselling and therapy can play a part in promoting resilience and recovery, with the strongest evidence base for child victims relating to trauma-focused cognitive behavioural therapy.⁸⁹³ However, a mapping exercise undertaken in the UK in 2009 identified a significant shortfall in the availability of services for children and young people following CSA compared with demand. The study indicated that waiting lists were generally long, and support was not offered proactively, but rather reactively in response to children and young people displaying symptoms of psychological or behavioural difficulties.⁸⁹⁴ Less than a quarter of all services had staff with specialist training, qualifications and/or experience.⁸⁹⁵

The nature of support following CSA, as well as its availability and accessibility, may vary according to the gender of the victim and survivor. Recent research suggests that women's disclosures of abuse are more likely to result in a referral to therapeutic support, but it is not clear whether this is a result of referrers' perceptions of need or the availability of services.⁸⁹⁶ In another study, male victims and survivors reported that they had found it difficult to locate support that was open to men; many services catered specifically

886 Edmond et al. (2006), *op. cit.*

887 Daigneault et al. (2007), *op. cit.*

888 Biehal et al. (2014), *op. cit.*, p.26

889 Jay (2014), *op. cit.*

890 Wolters (2008), *op. cit.*

891 Uliando and Mellor (2012), *op. cit.*

892 Allnock et al. (2015), *op. cit.*

893 Radford et al. (2017), *op. cit.*

894 Allnock et al. (2015), *op. cit.*

895 *Ibid.*

896 Agar and Read (2002) cited in Hooper and Warwick (2006), *op. cit.*

to women and, where this was not the case, it was not made sufficiently clear that they were open to all.⁸⁹⁷ A Scottish study found that referral routes into CSE support services tended to be different for male and female victims and survivors. This may relate to the different societal expectations of young men and women, which can mean that risk indicators such as going missing or friendships with older individuals are viewed with less concern for young men.⁸⁹⁸

A recent review found that there may be value in tailoring intervention according to whether CSA was experienced in a residential or a non-residential institutional setting.⁸⁹⁹ Doyle, focusing on the impacts of abuse within the Catholic Church, argues that traditional therapeutic responses may not provide relief from the spiritual dimension of trauma experienced by this group of victims and survivors.⁹⁰⁰ Similarly, academic studies suggest that specialist services should be better tailored to the specific needs of sub-groups of victims and survivors, including those with physical and learning disabilities, and those from BME backgrounds.⁹⁰¹ This applies both to the nature of the service provided and to how it is delivered. For example, concerning groups of children and young people who experience the most significant barriers to engaging with services – such as many of those at risk of CSE – outreach services may be an invaluable resource.⁹⁰²

4.11.3 Experiences of healthcare and other general services

In addition to the need for specialist services, a theme which emerged strongly from a number of studies was the need for mainstream services to be prepared to support service users with a history of CSA – whether or not this is ever disclosed. In a UK survey of victims and survivors, a quarter of respondents reported that they had used services for needs related to an experience of abuse before ever having made a disclosure.⁹⁰³ Much of the reviewed literature concentrated on primary health services in this regard – a point which is illustrated by the following quote from a victim and survivor surveyed about their experience of primary care:

“I think that providers should treat everyone as if they were a survivor.”⁹⁰⁴

This is particularly pertinent for those services which are known to be more likely to come into contact with victims and survivors. Various studies have suggested that relationship counselling and domestic violence services,⁹⁰⁵ alcohol and substance abuse treatment programmes,⁹⁰⁶ social services and the criminal justice system,⁹⁰⁷ and welfare-to-work programmes⁹⁰⁸ should take into account the possibility of service users having a history of CSA.

897 Nelson (2009), *op. cit.*

898 McNaughton Nicholls et al. (2014), *op. cit.*

899 Breckenridge and Flax (2016), *op. cit.*

900 Doyle (2009), *op. cit.*

901 Allnock et al. (2015), *op. cit.*; Breckenridge and Flax (2016), *op. cit.*

902 Jay (2014), *op. cit.*

903 Smith, N., Dogaru, C., and Ellis, F. (2015) *Hear me. Believe me. Respect me. Focus on survivors: a survey of adult survivors of child sexual abuse and their experiences of support services.* University Campus Suffolk: Ipswich

904 Roberts et al. (1999) cited in Hatton and Duff (2016), *op. cit.*, p.45

905 Friesen et al. (2010), *op. cit.*

906 Hadland et al. (2012), *op. cit.*; Nelson (2009), *op. cit.*

907 Bebbington et al. (2011), *op. cit.*

908 Lee and Tolman (2006), *op. cit.*

4.11.4 Seeking redress through the civil and criminal justice systems

For both children and adults who have experienced CSA and choose to seek redress through the civil and/or criminal justice systems, the experience of seeking justice and compensation can be a risk factor or trigger for retraumatisation. Research has identified a number of specific elements of the process which can have negative consequences for children's recovery from CSA, including investigative interviews,⁹⁰⁹ lengthy waits for court appearances,⁹¹⁰ cross-examination in criminal trials,⁹¹¹ and giving evidence in court.⁹¹² These effects can be exacerbated by particular actions (or omissions) on the part of services – for example, unsupportive behaviour by professionals (e.g. not being prepared to listen to or believe the child or young person),⁹¹³ aggressive cross-examination techniques,⁹¹⁴ or the child being required to give evidence with the (alleged) perpetrator present in the courtroom.⁹¹⁵ Conversely, sensitive practices such as the Barnahus or 'Children's House' model – which involve co-located services,⁹¹⁶ court familiarisation visits and the use of special measures to help children give best evidence – can mitigate these impacts.⁹¹⁷ Professional practice which "validate[s] the child's experience, [and offers] a respectful view of the child as informant" may even be a protective factor promoting psychological resilience.⁹¹⁸

A poor experience of giving evidence in a criminal trial as a child is associated with negative attitudes towards the criminal justice system that persist into later life,⁹¹⁹ while any involvement with the legal system has been found to contribute to lifetime incidence of depression among victims and survivors.⁹²⁰ Regarding adult victims and survivors, fear of retraumatisation through engagement with the criminal justice system was named in one study as a factor which deterred victims and survivors from reporting abuse.⁹²¹

This review was not able to identify any research evidence to indicate that achieving justice (i.e. the successful conviction of a perpetrator) and/or securing compensation played a part in promoting resilience or recovery. However, there was some evidence of the reverse. One study suggested that child victims whose cases had gone to court but not resulted in prosecution reported a strong sense of injustice,⁹²² while in another, not testifying in a case where the perpetrator went on to receive a more lenient sentence was predictive of poorer mental health and more negative attitudes towards the legal system in adulthood.⁹²³ A Swedish study examining child victims' priorities regarding adults who had perpetrated abuse against them found that they felt it was important for perpetrators to receive treatment to prevent them from reoffending, and to acknowledge that what they had done was wrong.⁹²⁴

909 Foster and Hagedorn (2014), *op. cit.*; Davidson et al. (2006), *op. cit.*

910 Hovarth et al. (2014), *op. cit.*

911 Back et al. (2011), *op. cit.*

912 Foster and Hagedorn (2014), *op. cit.*

913 Back et al. (2011), *op. cit.*

914 Hovarth et al. (2014), *op. cit.*

915 Foster and Hagedorn (2014), *op. cit.*

916 Radford et al. (2017), *op. cit.*

917 Hovarth et al. (2014), *op. cit.*

918 Davidson et al. (2006), *op. cit.*, p.252

919 Mitchell et al. (2007), *op. cit.*

920 Gutman, Tonge, King, Myerson and Wollner (2001) cited in Davidson et al. (2006), *op. cit.*

921 One in Four (2015), *op. cit.*

922 Foster and Hagedorn (2014), *op. cit.*

923 Mitchell et al. (2007), *op. cit.*

924 Back et al. (2011), *op. cit.*

The literature highlights a number of ways in which different jurisdictions have sought to improve victims and survivors' access to justice. In the US, a number of states have enacted measures to make it easier to pursue prosecutions for non-recent abuse – primarily by extending the statute of limitations.⁹²⁵ Likewise, in the US, victims and survivors of online-facilitated CSA can seek criminal compensation from perpetrators found guilty of possessing illegal images of them as children, although it has been suggested that it would be more appropriate and proportionate to address this via the mechanisms of civil law.⁹²⁶ Very little research was identified regarding the impacts on victims and survivors of civil redress schemes, and none that related specifically to England and Wales. One study, which focused exclusively on CSA within the Catholic Church, suggested that the high profile civil court cases in the US in the 1980s and 1990s were instrumental in raising awareness of the impacts of CSA on those who experienced it and exerting pressure on the Church to respond. This may be interpreted as an indirect benefit to victims and survivors.⁹²⁷

There is emerging interest in restorative justice as an additional or alternative means of seeking reparation for CSA. Restorative justice is a process in which both a perpetrator and a victim and survivor (or his/her representative, family member(s) or the wider community) participate, with the aim of addressing and offering reparation for harm. It is most often employed in the context of youth offending, and its application to CSA is in its infancy. An evaluation of restorative justice programmes in Australia found that restorative justice was more likely than the traditional court process to result in an earlier admission of guilt by the perpetrator, and a voluntary agreement by the perpetrator to stay away from the victim and survivor. It has been argued that this approach can provide 'validation' of the victim and survivor's experience. However, more research is needed to determine whether this approach improves access to justice and/or provides psychological benefits for victims and survivors, their families and communities.⁹²⁸

The following two chapters consider the impacts of CSA on the families of victims and survivors, and on wider society.

925 Roffman et al. (2014), *op. cit.*

926 Lollar, C. E. (2013) Child pornography and the restitution revolution. *Journal of Criminal Law and Criminology*, 103(2), pp.343-406

927 Doyle (2009), *op. cit.*

928 Bolitho and Freeman (2016), *op. cit.*



Chapter 5: Impacts of CSA on the families of victims and survivors

This chapter outlines the evidence around the impacts of CSA on the families of victims and survivors, including non-offending parents and carers, siblings, partners and children.

Summary of key themes

- Evidence shows that CSA does not just impact on the lives of victims and survivors, but can also have adverse effects on their families.⁹²⁹ 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.⁹³⁰ CSA can affect all aspects of parents’ lives, including areas like personal relationships, employment and financial stability, over the medium to long term.⁹³¹
- 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.⁹³²
- 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.⁹³³
- 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.⁹³⁴ 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.⁹³⁵

The previous chapter explored the breadth of outcomes for victims and survivors that the evidence suggests are associated with CSA. It is important to recognise that CSA not only adversely impacts on victims and survivors, but can also have profound ripple effects on the lives of those people close to them during both childhood and adulthood.⁹³⁶

929 Quadara et al. (2016), *op. cit.*; Clevenger (2016), *op. cit.*; Stewart (2012), *op. cit.*; van Toledo et al. (2013), *op. cit.*; Breckenridge and Flax (2016), *op. cit.*

930 Breckenridge and Flax (2016), *op. cit.*; Quadara et al. (2016), *op. cit.*; Stewart (2012), *op. cit.*

931 Quadara et al. (2016), *op. cit.*; Stewart (2012), *op. cit.*; Jobe-Shields et al. (2016), *op. cit.*; Kilroy et al. (2014), *op. cit.*; van Toledo et al. (2013), *op. cit.*; Fuller (2016), *op. cit.*; Knott (2014), *op. cit.*

932 Cyr et al. (2016), *op. cit.*; Kim et al. (2007), *op. cit.*; Knott (2014), *op. cit.*; Breckenridge and Flax (2016), *op. cit.*

933 Breckenridge and Flax (2016), *op. cit.*; Jobe-Sheilds et al. (2016), *op. cit.*

934 Schreier et al. (2016), *op. cit.*; Quadara et al. (2016), *op. cit.*

935 Schreier et al. (2016), *op. cit.*

936 CSA has also been found to adversely impact professionals working with victims and survivors, predominantly via ‘vicarious traumatisation’; that is, trauma induced by exposure to the distressing experiences of others. However, as noted in Chapter 1, literature on this issue is outside the scope of this review. See, for example, Nen, S., Astbury, J., Subhi, N., and Mohamad, M. S. (2011) The impact of vicarious trauma on professionals involved in child sexual abuse cases (CSA). *Pertanika Journal of Social Science and Humanities*, 19, pp.147-155

The evidence reviewed focused predominantly on the impacts of CSA on the non-abusing parents or caregivers of victims and survivors, and within this group it primarily focused on the impacts on mothers. This gender bias mirrors that seen in the studies on victims and survivors. Far fewer studies were identified which explore the impacts on victims and survivors' siblings, and later on their partners. The limited research findings relating to these groups are briefly summarised in this section. The consequences of CSA for the children of victims and survivors – including impacts on the parent-child attachment relationship and increases in the risk of CSA victimisation among those children – are discussed in detail in section 4.5, which examines interpersonal relationship outcomes for victims and survivors.

While some of the impacts outlined in this section necessarily require the disclosure or identification of CSA (for example, the emotional distress and guilt that family members can experience once they are aware of the abuse), not all of them do. Strain on family life or parental wellbeing resulting from the victim or survivor's mental health or behavioural issues will be felt regardless of whether the CSA has come to light.⁹³⁷

In cases where the CSA has been identified or disclosed, the evidence suggests that intra-familial abuse might have particularly pronounced impacts on non-abusing parents in terms of their levels of guilt and self-blame, as well as the potential for immediate family breakdown and resulting housing and financial instability. Although only two of the studies included in this section focused exclusively on intra-familial abuse, some others highlighted specific impacts for non-abusing mothers in cases where their partner was the perpetrator of the abuse.

As with the victim and survivor impacts detailed in the previous chapter, the nature of the evidence means that cause and effect are in many cases difficult to ascertain. Some impacts on family members that have been linked to CSA – for example, parental mental health conditions or strained parent-child relationships – may in some cases have pre-dated, or possibly even been a risk factor for, the CSA. What does emerge clearly from the evidence, however, is the importance of a sensitive and supportive societal response which avoids apportioning blame to or judging non-offending family members but instead engages the whole family in holistic support services.

5.1 Impacts on non-abusing parents and caregivers

Research shows that the impacts experienced by parents – and, in particular, mothers⁹³⁸ – as a result of their children's CSA victimisation in many ways mirror those outcomes experienced by victims and survivors detailed in the preceding chapter. Studies suggest that CSA can affect all aspects of non-abusing parents'/carers' lives, including personal relationships, employment and financial stability,⁹³⁹ and that impacts are not simply experienced over the short term and restricted to the period of disclosure or identification but instead can persist and exert a strain on family wellbeing for many years afterwards.⁹⁴⁰ Trauma (in this case in the form of 'secondary' or 'vicarious' trauma) and emotional distress were found to be highly prevalent among non-offending parents/carers.⁹⁴¹

937 Quadara et al. (2016), *op. cit.*

938 The studies located focused largely on the impact on mothers, suggesting that the impact on non-offending fathers and other caregivers, for example grandparents, is a less well researched area.

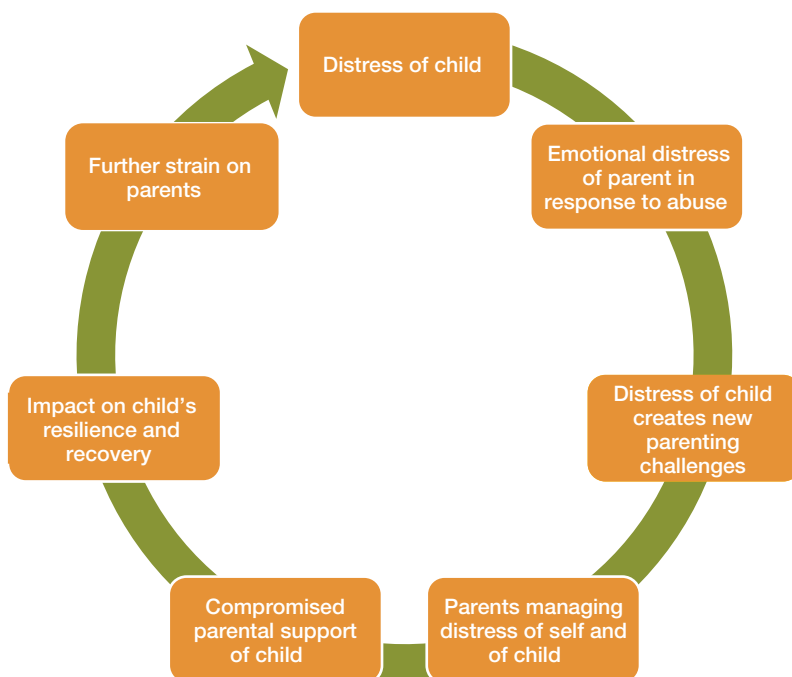
939 Quadara et al. (2016), *op. cit.*; Clevenger (2016), *op. cit.*; Stewart (2012), *op. cit.*; van Toledo et al. (2013), *op. cit.*

940 Breckenridge and Flax (2016), *op. cit.*; van Toledo et al. (2013), *op. cit.*

941 Cyr et al. (2016), *op. cit.*; Kim et al. (2007), *op. cit.*; Knott (2014), *op. cit.*; Breckenridge and Flax (2016), *op. cit.*

Some of the impacts experienced by this group are, however, more unique to them in their role as parents/carers. Research highlights the challenges involved in attempting to parent and support a victimised child who is likely to be experiencing extreme emotional distress, as well as potentially exhibiting new and challenging mental, physical and behavioural problems, at a time when the parent themselves might be struggling to cope with the emotional and practical strain caused by CSA. This can create a vicious circle in which the support that parents are able to provide to their victimised children can be compromised, thereby reducing the child's chances of experiencing resilience or recovery and in turn increasing the strain on the parents (see Figure 5.1). The literature has suggested that there is a 'strong link' between the functioning of victims of CSA and that of their parents and families.⁹⁴²

Figure 5.1: Challenges involved in parenting a distressed child following CSA victimisation



The following impacts are explored in more depth below: emotional distress, mental health problems and stress; strain on parent–child relationships; strain on other social relationships/ isolation; and employment, financial stability and housing.

5.1.1 Emotional distress, mental health problems and stress

The experience of emotional turmoil and psychological distress has been found to be common among non-abusing parents; this includes feelings of guilt, self-blame, shame, powerlessness and failure as a parent,⁹⁴³ anger, anxiety,⁹⁴⁴ confusion, shock, disbelief, despair⁹⁴⁵ and grief.⁹⁴⁶ The evidence suggests that these emotions might be particularly pronounced in cases of intra-familial abuse where the abuser was the non-abusing parent's partner.⁹⁴⁷ Words that parents themselves have used to describe their feelings about CSA include 'devastating', 'all-consuming', 'heartbreaking' and 'the end of the world'.⁹⁴⁸

⁹⁴² Breckenridge and Flax (2016), *op. cit.*

⁹⁴³ Stewart (2012), *op. cit.*; Kilroy et al. (2014), *op. cit.*; Knott (2014), *op. cit.*; Fuller (2016), *op. cit.*; van Toledo et al. (2013), *op. cit.*

⁹⁴⁴ Fuller (2016), *op. cit.*

⁹⁴⁵ Fuller (2016), *op. cit.*; van Toledo et al. (2013), *op. cit.*

⁹⁴⁶ Quadara et al. (2016), *op. cit.*

⁹⁴⁷ van Toledo et al. (2013), *op. cit.*; Clevenger (2016), *op. cit.*

⁹⁴⁸ Kilroy et al. (2014), *op. cit.*, p. 489

Multiple studies have reported an association between the disclosure of CSA by a child and mental health conditions among the parents, including PTSD and depression.⁹⁴⁹ PTSD has been found to persist among non-abusing parents for four years after their child's disclosure,⁹⁵⁰ and some evidence suggests that parental mental health difficulties can increase over time rather than peaking around the point of disclosure.⁹⁵¹ Several studies have found that mental health difficulties are more pronounced among mothers than fathers,⁹⁵² although one study has also shown increased health service and anti-depressant usage by both groups following the disclosure of CSA.⁹⁵³

Evidence shows that non-abusing parents' stress can be compounded by contact with the criminal justice system and social services in relation to the CSA. This stress has been attributed in part to the challenge of navigating complex, daunting and often unfamiliar systems, but also to the perceived criticism and judgement parents experience from the professionals working in these services for failing to keep their child safe from abuse.⁹⁵⁴ These research findings emphasise the importance of a sensitive, appropriate and effective social response to the parents of CSA victims (as well as their children) in order to maximise the resilience of the whole family.

5.1.2 Strain on parent–child relationships

Section 4.5 explores the effects of CSA on victims and survivors who later become parents in terms of their parent–child relationships and parenting style. This section explores the impacts of CSA on the relationship between child victims and their parents in the aftermath of abuse. It is important to note that there is overlap between these groups, and some parents of victimised children will have been abused in childhood themselves. The evidence suggests that this situation is particularly challenging for this group of parents.

Changes in parenting style following a child's CSA disclosure have been observed. These include an increase in overprotectiveness of, and a mistrust of others with, their child. Although a natural response, such a change can strain parent–child relationships and potentially damage or delay the child's development of social and emotional skills.⁹⁵⁵ Conversely, some parents have been found to cope with their guilt and distress by emotionally distancing themselves from their child and avoiding or limiting contact.⁹⁵⁶ The evidence suggests that such coping strategies might be particularly common among parents who are themselves victims and survivors of CSA and who therefore find that their child's abuse triggers painful memories of their own trauma (see section 4.10 for further information on triggers).⁹⁵⁷ As one parent put it:

*"I remember more about my own experiences since this happened... and it's like it's dug up the whole lot again that I had spent all them years hiding away."*⁹⁵⁸

949 Cyr et al. (2016), *op. cit.*; Kim et al. (2007), *op. cit.*; Knott (2014), *op. cit.*; Breckenridge and Flax (2016), *op. cit.*

950 Breckenridge and Flax (2016), *op. cit.*

951 van Toledo et al. (2013), *op. cit.*

952 Kim et al. (2007), *op. cit.*; Cyr et al. (2016), *op. cit.*; Breckenridge and Flax (2016), *op. cit.*; Adams and Bukowski (2007), *op. cit.*

953 Cyr et al. (2016), *op. cit.*

954 Breckenridge and Flax (2016), *op. cit.*; Clevenger (2016), *op. cit.*; Corcoran and Pillai (2008), *op. cit.*; Davidson et al. (2006), *op. cit.*; Jobe-Shields et al. (2016), *op. cit.*; Stewart (2012), *op. cit.*; van Toledo et al. (2013), *op. cit.*

955 Stewart (2012), *op. cit.*; Fuller (2016), *op. cit.*

956 Fuller (2016), *op. cit.*; Knott (2014), *op. cit.*; Jobe-Shields et al. (2016), *op. cit.*

957 Jobe-Shields et al. (2016), *op. cit.*

958 Kilroy et al. (2014), *op. cit.*, p.487

Inconsistent use of discipline and problems engaging in fun activities or talking about positive topics have also been reported by non-abusing parents of victims and survivors who experience mental health problems.⁹⁵⁹

As noted above, the challenges involved in parenting a child exhibiting emotional distress and problematic behaviours following CSA – such as inappropriate sexual behaviours, aggression, hostility and withdrawal, mental health and substance misuse issues, and suicide attempts – can cause parents much stress and distress, and again contribute to difficulties in the parent–child relationship.⁹⁶⁰

None of the studies reviewed mentioned parents losing custody of their child or having them taken into care following CSA.

5.1.3 Strain on other relationships/social isolation

Research has found that CSA can put pressure on – and ultimately lead to the break-up of – marriages and partnerships as a result of the general strain involved in dealing with the CSA. Differences in coping styles between partners have also been found to cause problems.⁹⁶¹ Relationship break-ups can be particularly sudden in cases where the abuse was perpetrated by the non-abusing parent's partner.⁹⁶²

Wider social isolation caused by withdrawal from social networks due to reduced trust in others, the pressure of the situation affecting social connections, and the decision to move area to escape the abuse has also been observed among parents.⁹⁶³

5.1.4 Employment, financial stability and housing

Evidence suggests that the pressures involved in dealing with the issues outlined above can increase the likelihood of parental unemployment and thereby increase financial problems and strain.⁹⁶⁴ Financial strain can also result from the need to pay for support services required by the child, as well as from family breakdown. Studies highlight the burden that can occur in cases of intra-familial abuse where the perpetrator's income is lost after the abuse is disclosed and the financial responsibility falls solely on the non-abusing parent/carer.⁹⁶⁵

Research has found that a non-abusing parent's housing situation might also be destabilised in cases where they and their child need to flee the family home to escape from the abuser.⁹⁶⁶

The table below summarises the risk and protective factors which the literature suggests might reduce or increase the chances of non-abusing parents experiencing adverse outcomes following their child's experience of CSA.

959 Jobe-Shields et al. (2016), *op. cit.*

960 Quadara et al. (2016), *op. cit.*; Stewart (2012), *op. cit.*

961 Quadara et al. (2016), *op. cit.*; Clevenger (2016), *op. cit.*; Fuller (2016), *op. cit.*

962 Jobe-Shields et al. (2016), *op. cit.*

963 Fuller (2016), *op. cit.*; Quadara et al. (2016), *op. cit.*; Stewart (2012), *op. cit.*

964 Quadara et al. (2016), *op. cit.*; Stewart (2012), *op. cit.*

965 Jobe-Shields et al. (2016), *op. cit.*; Kilroy et al. (2014), *op. cit.*; van Toledo et al. (2013), *op. cit.*

966 Jobe-Shields et al. (2016), *op. cit.*; Kilroy et al. (2014), *op. cit.*

Table 5.1: Protective and risk factors for adverse outcomes for non-abusing parents

Adverse outcomes for non-abusing parents	Protective factors:
	<ul style="list-style-type: none"> • Specialist support that involves the whole family.⁹⁶⁷
	Risk factors: <ul style="list-style-type: none"> • Being the mother as opposed to the father of a CSA victim and survivor might increase the risk of PTSD.⁹⁶⁸ • Intra-familial abuse can increase the risk of emotional distress for the non-offending parent, family break-up and resulting financial strain.⁹⁶⁹

5.2 Impacts on non-abusing siblings

A recent review of the literature has highlighted the relative paucity of research on the impacts of CSA on non-abusing⁹⁷⁰ and non-abused siblings of CSA victims in childhood.⁹⁷¹ The evidence that does exist suggests that siblings have an increased likelihood of exhibiting a range of mental health/internalising behaviours and externalising behaviours following the disclosure of identification of CSA. These include anxiety and depression, as well as emotions of guilt, confusion and anger, all of which can increase family distress. Studies also highlight the fact that siblings are affected by any increased pressure and strain experienced by the wider family following CSA, including pressure resulting from family breakdown and involvement with the justice system.⁹⁷² Sibling responses and outcomes, like those for victims and survivors, are varied and the evidence suggests that whole-family approaches can help to reduce distress and adverse outcomes for both victims and survivors and their siblings.⁹⁷³ Ultimately, however, further research is needed in this area in order to fully understand the impacts of CSA on siblings of victims and survivors.

967 Kilroy et al. (2014), *op. cit.*; Fuller (2016), *op. cit.*

968 Kim et al. (2007), *op. cit.*; Cyr et al. (2016), *op. cit.*; Breckenridge and Flax (2016), *op. cit.*; Baum, N., Rahav, G., and Sharon, M. (2014) Heightened susceptibility to secondary traumatization: A meta-analysis of gender differences. *American Journal of Orthopsychiatry*, 84(2), pp.111-122

969 van Toledo et al. (2013), *op. cit.*; Clevenger (2016), *op. cit.*; Jobe-Shields et al. (2016), *op. cit.*

970 There is a growing recognition of the prevalence of intra-familial CSA perpetrated by siblings of the victim.

971 Schreier et al. (2016), *op. cit.*

972 Schreier et al. (2016), *op. cit.*; Quadara et al. (2016), *op. cit.*

973 Schreier et al. (2016), *op. cit.*

5.3 Impacts on partners

As mentioned previously, only one study included in this review directly explored the impacts of CSA victimisation from the perspective of the partners of adult victims and survivors.⁹⁷⁴ This research specifically explored the impacts of disclosure. It found that some partners felt betrayed by the fact that they had not known about the CSA from the start of the relationship, while others reported feeling anxious about their partner's mental and emotional wellbeing as a result of the abuse and concerned about their ability to provide their partner with the required support. Others responded more positively, reporting that the disclosure had led to an increased empathy towards and understanding of their partner. The studies summarised in section 4.5.1 on the impacts of CSA on victims and survivors' intimate and sexual relationships shed some further light on the ways in which CSA might affect the partners of victims and survivors. Research with partners themselves appears to be a significant gap in the literature, however.

5.4 Impacts on children

The evidence suggests that children of victims and survivors can be impacted by their parent's experience of CSA in a range of ways. Most frequently, this question has been explored in terms of the parenting style of the victim and survivor, and the repercussions of this for their children. The evidence on these issues is discussed in section 4.5.2 on parent-child relationship outcomes.

974 Quadara et al. (2016), *op. cit.*



Chapter 6: Impacts of CSA on wider society

This chapter outlines the evidence about the impacts of CSA on wider society, including the impact on the uptake of public services and financial impacts.

Summary of key themes

- 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.⁹⁷⁵
- 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).⁹⁷⁶ 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.⁹⁷⁷ 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,⁹⁷⁸ and emotional distress experienced by children who accidentally view indecent images of other children online.⁹⁷⁹

As mentioned above, this chapter brings together the main themes from the studies reviewed which explicitly – or implicitly – explore the impacts of CSA on wider society. In this report, impacts on wider society refers to any consequences of CSA for victims and survivors, their families and others which have identifiable knock-on effects for the wider population, including on public services and the economy,⁹⁸⁰ as well as any impacts on the general population resulting from their awareness of (or some form of indirect exposure to⁹⁸¹) the issue of CSA.⁹⁸² In some cases, it also refers to the aggregated impacts of CSA across all victims and survivors.⁹⁸³

975 One in Four (2015), *op. cit.*; Beckett et al. (2017), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Maniglio (2009), *op. cit.*; Price-Robertson (2012), *op. cit.*; McGrath et al. (2011), *op. cit.*; Oglloff et al. (2012), *op. cit.*; Kamiya et al. (2016), *op. cit.*; Cyr et al. (2016), *op. cit.*; Fergusson et al. (2013), *op. cit.*; Pereira et al. (2017), *op. cit.*; Nelson (2009), *op. cit.*; Saied-Tessier (2014), *op. cit.*; Biehal et al. (2014), *op. cit.*; Jay (2014), *op. cit.*

976 Saied-Tessier (2014), *op. cit.*

977 *Ibid.*

978 Mancini, C., and Shields, R. T. (2014) Notes on a (sex crime) scandal: The impact of media coverage of sexual abuse in the Catholic Church on public opinion. *Journal of Criminal Justice*, 42(2), pp.221-232

979 Jutte (2016), *op. cit.*

980 See for example Saied-Tessier (2014), *op. cit.*

981 For example, hearing about cases of CSA in the media.

982 See for example Jutte (2016), *op. cit.*

983 See for example Saied-Tessier (2014), *op. cit.*

The following sections summarise the evidence about: the impacts of CSA on the use of public services; the financial impacts of CSA; and other social impacts of CSA.

6.1 Impacts on the uptake of public services

Most of the impacts with implications for wider society, as identified by the studies reviewed, relate to the use of public services or systems by victims and survivors of CSA, as well as by their families and – in some cases – by the perpetrators. However, the literature reviewed does not make explicit the consequences of this service usage in terms of public funding requirements or the impacts on waiting lists and access to services.

Many of the studies already discussed in previous chapters, and some additional ones, show that CSA has implications for the following public services and systems:

- the criminal justice system⁹⁸⁴
 - CSA detection activities including policing
 - conviction, punishment and treatment of CSA perpetrators
 - dealing with offending behaviour by victims and survivors following their experience of CSA⁹⁸⁵
- the healthcare system
 - increased use of physical and mental health services by victims and survivors throughout their life⁹⁸⁶
 - increased use of physical and mental health services by the families and friends of victims and survivors⁹⁸⁷
- social services⁹⁸⁸
 - delivery of child protection services
 - fostering, adoption and residential care
- the welfare benefits system⁹⁸⁹
 - increased rates of welfare benefit receipt
- special education provision⁹⁹⁰
 - use of adult education to address gaps in schooling and skills (e.g. low literacy levels)

984 One in Four (2015), *op. cit.*

985 Beckett et al. (2017), *op. cit.*; Sneddon et al. (2016), *op. cit.*; Maniglio (2009), *op. cit.*; Price-Robertson (2012), *op. cit.*; McGrath et al. (2011), *op. cit.*; Ogloff et al. (2012), *op. cit.*

986 Fergusson et al. (2013), *op. cit.*; Kamiya et al. (2016), *op. cit.*; Sneddon et al. (2016), *op. cit.*

987 Cyr et al. (2016), *op. cit.*

988 Saied-Tessier (2014), *op. cit.*; Biehal et al. (2014), *op. cit.*; Jay (2014), *op. cit.*

989 Fergusson et al. (2013), *op. cit.*; Pereira et al. (2017), *op. cit.*

990 Nelson (2009), *op. cit.*

6.2 Financial impacts

Certain studies have drawn on the kind of research findings identified above to try and quantify the socioeconomic costs of child abuse within specific countries or regions. Most of these have attempted to calculate the costs of child maltreatment more broadly, in high income countries such as the US and Australia, and do not disaggregate their findings by type of abuse or neglect.⁹⁹¹ This review only identified one study, produced by the NSPCC, that explores the costs of CSA specifically. The research aimed to develop a 'ballpark figure' for the annual cost of CSA both to victims and survivors and to the wider UK society.⁹⁹²

The study analysed the best available data on: the increased likelihood of adverse outcomes amongst victims and survivors and/or increased service usage as a result of those adverse outcomes following CSA; the prevalence of CSA in the UK; and the unit costs of various different types of service provision. On the basis of this data, it estimated that CSA costs the UK around £3 billion a year (2012/13 prices). 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 healthcare, the criminal justice system and child social services.

Table 6.1 sets out the detailed cost estimates calculated by this study, broken down by type of service and/or adverse outcome.

Table 6.1: NSPCC estimates of the annual costs of CSA in the UK (2012/13 prices)

(2012/13 prices)		£ million Central
Health	Child mental health – depression	£1.6
	Child suicide and self-harm	£1.9
	Adult mental health – depression and PTSD	£162.7
	Adult physical health – alcohol and drug misuse	£15.4
	Total health	£182
Criminal Justice System	Perpetrator	£89.9
	Adult victim of CSA	£58.8
	Total CJS	£149
Services for children	Children social care	£93.9
	NSPCC	£7.7
	Total services for children	£124
Labour market	Lost productivity	£2,700
Total costs to Exchequer		£424 million
Total costs		£3.2 billion

Source: Saied-Tessier (2014), *op. cit.*, p.19

991 See for example Fang, X. M., Brown, D. S., Florence, C. S., and Mercy, J. A. (2012) The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse and Neglect*, 36(2), pp.156-165; Ferrara, P., Corsello, G., Basile, M. C., Nigri, L., Campanozzi, A., Ehrich, J., and Pettoello-Mantovani, M. (2015) The Economic Burden of Child Maltreatment in High Income Countries. *The Journal of Pediatrics*, 167(6), pp.1457-1459; Roffman et al. (2014), *op. cit.*

992 Saied-Tessier (2014), *op. cit.*, p. 9

These cost estimates, although valuable in highlighting the potential scale of the financial impacts of CSA, should be treated with caution. As the NSPCC itself acknowledges, although the study was underpinned by the best evidence available at the time, it nonetheless relied heavily on a number of assumptions about the scale and impact of CSA. The NSPCC also assumed that all victims and survivors who have a need for services as a result of problems linked to their experience of CSA (such as mental health conditions) are actually receiving them. In reality this is unlikely to be the case. However, given the fact that the study uses fairly conservative estimates and only takes into account a limited number of outcomes⁹⁹³ linked to CSA on which the NSPCC felt that there was reasonably robust evidence, the figures generated may well substantially underestimate the true financial costs of CSA in the UK.

In addition to the estimates detailed above, the NSPCC also attempted to monetise the human and emotional costs of CSA to victims and survivors. Although this approach is contested, the NSPCC's rationale for undertaking this calculation was to enable the pain and suffering caused by CSA to be factored into estimates of its economic cost. The calculation was made using CSA prevalence estimates, in combination with monetisation figures previously calculated for a study on the impact of domestic violence.⁹⁹⁴ In total, the NSPCC estimated that the human and emotional costs experienced by victims and survivors in the UK amount 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, on both a personal and societal level.

6.3 Other impacts on wider society

In addition to the impacts on public services and the economy, it could be speculated that the existence of CSA – and the general public's awareness of it – could have a range of impacts on the wider population or on certain groups within it, such as reduced trust in authority or increased anxiety among parents. In fact, very few studies in the literature search explored these sorts of issues in any depth. Of the studies reviewed as part of this REA, one looked at the effect of people's exposure to media coverage of CSA within the Catholic Church in America on levels of public confidence in the Church's ability to protect children from abuse in the future.⁹⁹⁵ The researchers found that the media coverage had no significant effect on non-Catholics' confidence in the Church, but that Catholics who consumed more of the reporting were (unexpectedly) more confident in the Church's ability to prevent CSA than Catholics who consumed less reporting. Further research would be valuable to explore the mechanisms underpinning this association, as well as whether these research findings are transferable to other institutions that have been in the media as a result of CSA cases. Linked to this, IICSA is undertaking research to explore the impact of discourses around CSA – including those found in the media – on the child protection and safeguarding practice of specific institutions and professions.

993 These outcomes include health (child mental health – depression, suicide and self-harm; adult mental health – depression and PTSD; adult physical health – drug and alcohol misuse); involvement in the criminal justice system by perpetrators of CSA, and juvenile and adult victims and survivors; the involvement of children's services (social care and the NSPCC); and lost productivity in the labour market (increased unemployment and reduced earnings among victims and survivors).

994 Walby (2004) (cited in Saied-Tessier (2014), *op. cit.*) used an economic technique known as 'willingness to pay' to assign a monetary cost to the experience of penetrative and non-penetrative sexual assault. This methodology involves quantifying the impact of experiencing certain crimes by estimating how much individuals would be willing to pay to decrease their risk of experiencing that crime by a specified amount.

995 Mancini and Shields (2014), *op. cit.*

Finally, one reviewed paper explored the experiences of children who had viewed CSA images online.⁹⁹⁶ The study found that children who had viewed these images were often left extremely anxious and upset by what they had seen, and concerned that they would get into trouble with the police as a result. In the words of one of the young people who spoke to the NSPCC's Childline service:

*"I can't get the images I saw on the internet out of my head because they were of children. I don't know what to do or who to talk to. I don't want people thinking I viewed them intentionally because I didn't. I feel so depressed – I wish I'd never seen them."*⁹⁹⁷

Although this issue was only explored by one study included in this REA, this quote powerfully demonstrates just one of the ways in which CSA can adversely affect children other than victims and their family members.

996 Jutte (2016), *op. cit.*

997 *Ibid.*, p.13



Chapter 7: Conclusion 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. CSA also impacts on family members of the victims and survivors, and wider society in both financial and less tangible ways. However, it is apparent from the evidence reviewed 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. These gaps are 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 BME, 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
- victims 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

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 that 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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Appendices

● Appendix A: Acronyms and glossary

Key acronyms

BMI	body mass index
BME	black and minority ethnic
CPA	child physical abuse
CSA	child sexual abuse
CSE	child sexual exploitation
LGBT	lesbian, gay, bisexual and transgender
PTSD	post-traumatic stress disorder
REA	rapid evidence assessment
STI	sexually transmitted infection

Glossary

Child abuse terms

Child	A person under the age of 18.
Child maltreatment	A term used to group the range of different types of abuse which result in actual or potential harm to a child. Types of abuse include sexual abuse, physical abuse, emotional abuse, neglect and negligent treatment, and exploitation.
Child physical abuse	Physical abuse of children involves someone deliberately hurting a child, causing injuries such as bruises, broken bones, burns or cuts. Children may suffer violence such as being hit, kicked, poisoned, burned, slapped, having objects thrown at them or intentionally being made unwell.
Child protection	Activity that is undertaken to protect children who are suffering, or are likely to suffer, significant harm.
Child sexual abuse	Sexual abuse of children involves forcing or enticing a child or young person to take part in sexual activities. The activities may involve physical contact, and non-contact activities such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse including via the internet. Child sexual abuse includes child sexual exploitation.
Child sexual exploitation	Sexual exploitation of children is a form of child sexual abuse. It involves exploitative situations, contexts and relationships where a child receives something, as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology.

Extra-familial sexual abuse	Sexual abuse perpetrated by someone outside of the family unit. For example, abuse perpetrated by a stranger, organised groups/networks or a trusted person within an institution. See also: institutional sexual abuse.
Grooming	The criminal offence of solicitation whereby a relationship with a child is formed in order to gain their trust for the purposes of sexual abuse or exploitation.
Institution	Means the same as 'organisation'. That is, a group of people who work together in an organised way for a particular shared purpose. For example, a business, a government department, a school or a church.
Institutional sexual abuse	Sexual abuse perpetrated by someone within a particular setting or service. For example, a teacher in a school or a priest within a church. See also: institution.
Intergenerational transmission of abuse	The increased risk that abuse may be repeated across generations of the same family.
Intra-familial sexual abuse	Sexual abuse perpetrated by a family member or that takes place within a family context or environment, whether or not by a family member. These offences reflect modern family units and take account of situations where someone is living within the same household as a child and assuming a position of trust or authority over that child, as well as relationships defined by blood ties, adoption, fostering, marriage or living together as partners.
Online sexual abuse	Child sexual abuse/exploitation facilitated by the online environment. For example, via social networks, online games or mobile phones.
Polyvictimisation	Exposure to multiple forms of violence, crime and abuse rather than a single form of abuse. For example, experiencing physical abuse as well as sexual abuse. See also: child physical abuse; child maltreatment.
Severity of child sexual abuse	A subjective term, defined differently across research, but used for describing child sexual abuse involving, for example, multiple incidents, force/penetration, higher frequency, multiple perpetrators, and/or co-occurrence with other forms of maltreatment.
Sexting	Someone creating or sharing sexually explicit digital images or videos of themselves or of other people or sending sexually explicit messages. Sexting is typically via mobile phones, tablets or laptops.
Trauma-bond	A strong emotional attachment between an abused person and his or her abuser.
Victims and survivors	Defined in this report as individuals who have been sexually abused as children.

Research terms

Association	A relationship or link between two factors. For example, child sexual abuse may be linked or associated with a particular life outcome. See also: correlation.
Causality	A term used to describe cause and effect relationships, where one thing causes another thing to happen or exist. For example, a particular life outcome that has been directly caused by child sexual abuse.
Confounding variable (or factor)	An 'extra' variable which can influence the relationship between an independent variable and dependent variable. Not testing for confounding variables can suggest that there is a particular relationship between two things when that may not necessarily be true. For example, the suggestion that a particular life outcome is linked to child sexual abuse when it may actually be linked to child physical abuse.
Convenience sample	A technique for sampling individuals to participate in research where participants are selected because of their accessibility to the researcher, rather than in a randomised way. For example, participants may be recruited through a support service. In this case the study findings may only be generalisable to victims and survivors who have accessed that service, rather than to victims and survivors as a whole.
Correlation	An association, relationship or link between two things. For example, a correlation between child sexual abuse and a particular life outcome.
Cross-sectional study	A type of research study whereby data is collected from a specific population at a single specific point in time. Cross-sectional data provides a 'snapshot' of a particular subject at a specific point in time only.
Grey literature	Refers to literature which is not published in the formal sense of the word, such as public and third-sector reports, government documents, policy papers, and websites of academic institutes.
Incidence	The occurrence, rate or frequency of an event, condition, disease or case.
Longitudinal study	A type of research study whereby data is collected from a specific population about a particular subject at different points in time. Longitudinal data provides information on a particular subject, identifying patterns over time.
Peer reviewed journal	Periodical academic publications published to advance knowledge in a particular field. Journals contain articles written by academics or professionals who are experts in the specific discipline to which the journal relates. Most articles contain research results and are peer-reviewed, which means they are reviewed by a number of other experts before they are published to ensure the article's quality.
Prevalence	The proportion of a population who has a particular condition or disease, or has experienced a particular event.

Rapid evidence assessment	A research methodology used in the identification, quality assessment and synthesis of existing literature on a particular topic. More structured and rigorous than a standard literature review, it is not as exhaustive as a systematic review.
Variable	Anything that has a quantity or quality that can be measured or take on different values. Variables can be independent (fixed and not changeable) or dependent (not fixed and can change depending on other factors).

Impact terms

Impact	A marked effect or influence on someone or something.
Outcome	A result, effect or consequence of an experience, action or situation.
Protective factor	A factor, attribute, characteristic or exposure of an individual to something that reduces the likelihood of a particular outcome or severity of a particular outcome.
Psychosocial	Relates to the interaction between social factors and individual thought and behaviour.
Recovery	The act or process of returning to a positive, former or improved level of functioning following a traumatic experience that caused a decline in levels of functioning and wellbeing.
Resilience	The ability to sustain adaptive levels of healthy functioning following a traumatic experience and/or the capacity to recover quickly from an adverse/traumatic experience.
Retraumatization	A conscious or unconscious reminder of past trauma that results in a re-experiencing of the original trauma or relapsing into a state of trauma. This can be triggered by a situation or attitude, or by certain environments that may replicate dynamics of the original trauma.
Revictimisation	Becoming a victim of violence, crime and abuse, having already been victimised previously.
Risk factor	A factor, attribute or characteristic, or exposure of an individual to something, that increases the likelihood of a particular outcome or severity of a particular outcome. Risk factors can be 'static' (generally unchangeable, such as age) or 'dynamic' (potentially changeable, such as substance use).
Secondary or vicarious trauma	The experience of trauma that is not direct but induced by exposure to the adverse/traumatic experience of others.

Health and behaviour terms

Anxiety	An uncomfortable feeling of nervousness, tension or unease about something happening or that might happen in the future. Levels of anxiety can vary and there are a number of specific anxiety disorders a person may suffer from.
Attachment style	Based on attachment theory, this term is used to describe the formation of an emotional bond that connects one person to another. A person may develop one of several attachment styles which influences the way in which they behave and interact with the other person. It is typically used in the context of close relationships. For example, parent-child relationships or intimate partner relationships.
Bipolar	A mental health condition linked to depression affecting a person's mood, which often alternates between extreme highs and extreme lows, in extended periods.
Conduct disorder	A disorder typically diagnosed in childhood and adolescence whereby individuals persistently present with patterns of disruptive and socially inappropriate behaviour, and often have problems following rules. Symptoms of the disorder may be different at different ages.
Depression	A mental health condition often characterised by feelings of emotional sadness, unhappiness, anxiety, loss of hope, and loss of interest in usual activities. This condition can vary in severity. It is sometimes clinically diagnosed and sometimes not. See also: anxiety.
Dissociation	A term used to describe a reaction to trauma or a way of coping with trauma where individuals may feel or become disconnected or detached from the world around them. A dissociative disorder impairs the normal state of awareness and limits or alters one's sense of identity, memory or consciousness. There are a number of dissociative disorders a person may suffer from.
Externalising behaviours	A term used to group behaviours which are outward facing, such as aggression, anger, hostility, substance (mis)use, addictive behaviours, anti-social behaviour, 'risky' sexual behaviours, and offending.
Internalising behaviours	A term used to group behaviours which are inward facing, such as anxiety, depression, decreased self-efficacy and self-confidence, and withdrawal and isolation.
Neurobiology or neurodevelopment	Refers to the branch of biology concerned with the structure and functioning of the brain and central nervous system.
Perinatal problems	Physical problems with pregnancy and childbirth.
Personality disorders	A term used to group conditions where an individual may significantly differ from an average person in how they think, perceive, feel, behave, manage relationships and cope with life. There are a range of personality disorders a person may suffer from.

Psychosis	A mental health condition often characterised by symptoms of delusions, hallucinations and impaired contact with reality. There are a range of specific conditions where psychosis may be a symptom, including schizophrenia.
Psychosomatic symptoms	Used to describe psychological symptoms which are interpreted or converted into physical symptoms or illness, even if there is no underlying physical cause.
Risky sexual behaviours	Used to describe the engagement of individuals in sexual practices or activities that may place them at risk of negative or unintended outcomes.
Schizophrenia	A mental health condition where individuals experience symptoms that may include delusions and hallucinations, disorganised thinking and speech.
Self-harm	A term used to describe deliberate cutting or other injury to oneself usually due to emotional or psychological disturbance.
Sexual behaviours	Sexual behaviours refers to a broad spectrum of behaviours through which a people exhibit their sexuality. This includes the gender of sexual partners, numbers of sexual partners and the types of sexual activities engaged in.
Stressor	An agent, condition, activity, stimulus or event that causes stress and results in the release of stress hormones.
Substance misuse	The continued use of a substance which severely affects a person's health, behaviour, social situation and/or responsibility. Typically characterised by the use of drugs and/or alcohol which exceeds legal and medical guidelines. It may take the form of a drug or alcohol dependency or addiction.
Vaginismus	A medical term used to describe recurrent or persistent involuntary tightening of muscles around the vagina whenever penetration is attempted.

● Appendix B: Method – technical details

This appendix supplements the information provided in Chapter 2 of this report, on the method adopted for this REA.

Table B.1: Primary search terms

(To be used in combination with other primary or secondary terms)

Simple child sexual abuse terms	Complex child sexual abuse terms (to be used with simple terms joined by an 'OR')	Impact terms	Systemic response terms	Resilience terms	Mechanism/pathway terms
child* AND "sex* abuse*" "sex* assault*" "sex* exploit*"	child* AND sext* incest* "indecent image*" molest* porn* prostitut* rape* "sex* work*" "sex* violence"	adverse consequence* correlat* effect* impact* indicator* outcome* poly*victimi* re*victimi* sequel*	agency authorit* "betrayal abuse" "betrayal trauma" bureau* "child protection" "children's service*" "civil justice" compensat* courts "criminal justice" disclos* federal "health service*" identif* institution* investigat* "justice system" "law enforcement" "medical response" "medical service*" notif* police redress reparation report* respon* safeguard* "secondary trauma*" "secondary victimi*" "vicarious trauma*" "social service*" "statutory service*" "support service*" system*	mitigat* recover* resilien*	epigenetic* "health* behavior*" "intergenerational transmi*" neurobiolog* "risk* behavior*"

Table B.2: Secondary search terms*(To be used in combination with key primary search terms only if primary search terms bring up too many results)*

Disadvantage terms	Societal impact terms	Family and friends terms	Institutional terms	Factor terms	Risk terms
depriv* disadvantage* discriminat* inequalit*	communit* cost* societ*	"care*giver*" carer* child* family friend* guardian parent* partner* peer* sibling*	"care home*" "children's home*" residential church* club* custod* institut* organisation* "position of authority" religio* school*	group* differen* categor* profil* demog* socio*economic "type of abuse" internet online *contact penetrat* race* raci* "black and minority ethnic" B*ME "ethnic* minorit*" "minorit* ethnic*" homosexual* gay lesbian bi*sexual trans*gender LGBT* gender* female male homeless* intra*familial extra*familial	risk* chance* probabilit* likelihood heighten* increase* reduce* diminish*

Table B.3: Databases and websites searched

Database	Organisation/website
EBSCO	Gov.uk
PsychINFO	The Children's Society
PsychARTICLES	Victim Support
Web of Science	Barnardo's
Medline	NSPCC
Criminal Justice Abstracts	Rape Crisis England and Wales
Cochrane Library	Women's Aid
ScienceDirect	Welsh Women's Aid
OpenGrey	Women's Resource Centre
SCIE	Women's National Commission
HeinOnline	End Violence Against Women and Girls
Lexis	The Survivors Trust
	NAPAC
	SurvivorsUK
	Anna Freud National Centre for Children and Families
	Survivors in Transition
	Stepping Stones
	MOSAC
	All-party Parliamentary Group on Domestic and Sexual Violence
	Early Intervention Foundation
	World Health Organization
	Children's Commissioner
	Australian Royal Commission into Institutional Responses to Child Sexual Abuse
	House of Commons parliamentary papers
	CSE & Policing Knowledge Hub
	Range of UK-based university and academic institute websites

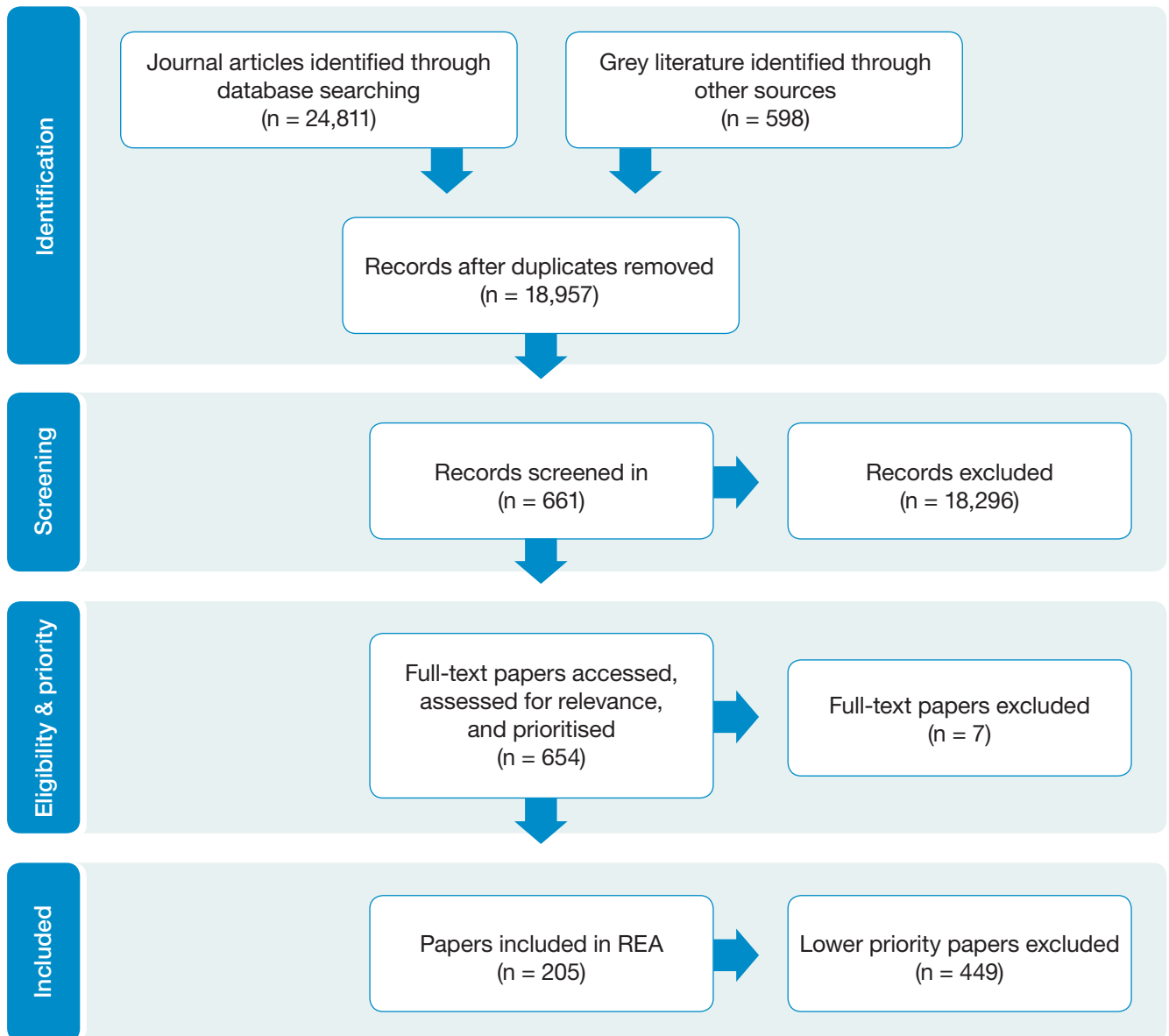
Table B.4: Search parameters and inclusion/exclusion criteria

Criteria / parameter	Include	Exclude
Language	English	All other languages
Country of origin	Research from or about England & Wales/the UK or an economically developed country (e.g. a western European country, US, Australia, Canada etc)	Research from or about economically developing countries (e.g. countries in South America, Africa etc)
Evidence type	<ul style="list-style-type: none"> • High-quality empirical primary and secondary research studies, including systematic literature reviews and meta-analyses • Papers setting out key evidence-based theories or frameworks in this field 	<ul style="list-style-type: none"> • Low-quality studies • Non-empirical, theoretical studies (other than those setting out key theories and frameworks)
Publication type	<ul style="list-style-type: none"> • Peer-reviewed journals • Grey literature from the websites of academic institutes, and public and third-sector organisations 	<ul style="list-style-type: none"> • Non-peer-reviewed journals • Media features and articles • Books
Year of publication	2006–2016	Pre-2006, unless study is a high-quality systematic review or meta-analysis that fills an otherwise existing evidence gap, or sets out a theoretical model or framework that has been influential in the field of CSA impacts
Access	Full text access by the IICSA research team	Only title and abstract (and/or a portion of the main text) are accessible to the IICSA research team
Relevance	Directly relates to the research aims/questions and provides evidence on CSA specifically (rather than on abuse or maltreatment more generally)	Does not directly relate to the research aims/questions and does not disaggregate findings by type of child abuse, or contain specific findings on CSA

Table B.5: Prioritisation criteria

Priority 1 criteria		
Study is explicitly about the impact of CSA <i>on victims and survivors</i>	AND	Is a:
		Meta-analysis
		Systematic review
		Other literature review
		Longitudinal study/birth cohort study
		Qualitative study with survivor voices at the forefront
OR		
Study is explicitly about the impact of CSA	AND	Explores the impact on family, friends, peers or wider society
		Focuses on neurobiology or epigenetics
		Explores resilience/recovery (including moderators) or risk factors for impact
		Focuses on a specific institution
		Focuses on systemic response or works in a general way (i.e. reviews of effective approaches rather than evaluations of specific interventions)

Figure B.1: PRISMA flow diagram



● Appendix C: Quality assessment tools

Identified literature was categorised into eleven study types, as follows: primary quantitative, primary qualitative, primary mixed-methods, secondary quantitative, secondary qualitative, secondary (critical) review, theoretical, quantitative evaluation, qualitative evaluation, economic evaluation and mixed-methods evaluation.

Studies were scored against different sets of criteria according to the study type. Table C.1 presents the criteria for each study type.

The only possible scores for each criterion were 'Yes' (corresponding to a score of 1), 'No' (corresponding to 0) and 'Not applicable'. Where a given criterion was scored as 'Not applicable' to a particular study, that criterion was excluded from the potential total score for that study. Scores were entered into a spreadsheet, and the total score for each study was calculated as a percentage score relative to the maximum possible score against the relevant criteria. The percentage score was used to guide decisions about the relative weight given to different studies in the written report.

Table C.1: Quality assessment tool evaluation criteria

Study type	Criterion	Primary quantitative	Primary qualitative	Primary mixed-methods	Secondary quantitative	Secondary qualitative study	Secondary (critical) review	Theoretical	Quantitative evaluation	Qualitative evaluation	Economic evaluation	Mixed-methods evaluation
Design	Clearly defined research question or objective	X	X	X	X	X	X	X	X	X	X	X
	Appropriate research design that addresses research question or objective (including appropriate integration of quantitative and qualitative data / results)	X	X	X	X	X	X		X	X	X	X
	Appropriate sampling strategy	X	X	X	X	X			X	X		X
	Adequate attention paid to ethical considerations	X	X	X	X	X	X	X	X	X	X	X
	Source of opinion is clearly identified							X				
	Source of opinion has standing in the field of expertise							X				
	Maryland Scale of Scientific Methods (MSSM) score (1-5)								X			X
	Comprehensive description of alternatives										X	
	All relevant costs and outcomes are specified for each alternative										X	
	(Where relevant) effectiveness of any interventions previously established										X	
Well-defined outcome measures								X			X	

Study type	Criterion	Primary quantitative	Primary qualitative	Primary mixed-methods	Secondary quantitative	Secondary qualitative study	Secondary (critical) review	Theoretical	Quantitative evaluation	Qualitative evaluation	Economic evaluation	Mixed-methods evaluation
Data collection	Validity and robustness of data collection methods	X	X	X	X	X			X	X		X
	Appropriate sample achieved	X	X	X	X	X			X	X		X
	Appropriate search strategy						X					
	Sources and resources used to search for studies are adequate						X					
	Appropriate inclusion/exclusion criteria applied						X					
	Validity and robustness of data extraction and recording methods						X					
	Costs and outcomes measured accurately										X	
Analysis	Appropriate analytical methods	X	X	X	X	X			X	X	X	X
	Appropriate criteria applied to appraise studies						X					
	Critical appraisal conducted by two or more reviewers independently						X					
	Appropriate methods used to combine studies or to analyse data extracted						X					
	Costs and outcomes valued credibly										X	

Study type	Criterion	Primary quantitative	Primary qualitative	Primary mixed-methods	Secondary quantitative	Secondary qualitative study	Secondary (critical) review	Theoretical	Quantitative evaluation	Qualitative evaluation	Economic evaluation	Mixed-methods evaluation
Reporting	Reporting is accessible, clear and coherent	X	X	X	X	X	X	X	X	X	X	X
	Conclusion supported by results	X	X	X	X	X	X	X	X	X	X	X
	Reference is made to existing literature	X	X	X	X	X	X	X	X	X	X	X
	Research advances knowledge or understanding, or fills evidence gap	X	X	X	X	X	X	X	X	X	X	X
	Limitations of research are discussed	X	X	X	X	X	X	X	X	X	X	X
	Any theoretical perspectives, values or assumptions/presuppositions that have shaped the form and output of the research are clearly addressed	X	X	X	X	X	X	X	X	X	X	X
	Any obvious sources of potential bias (e.g. interests of funder and commissioner) acknowledged	X	X	X	X	X	X	X	X	X	X	X

● Appendix D: Charts illustrating the profile of the reviewed literature

Figure D.1: Number of reviewed studies by publication date

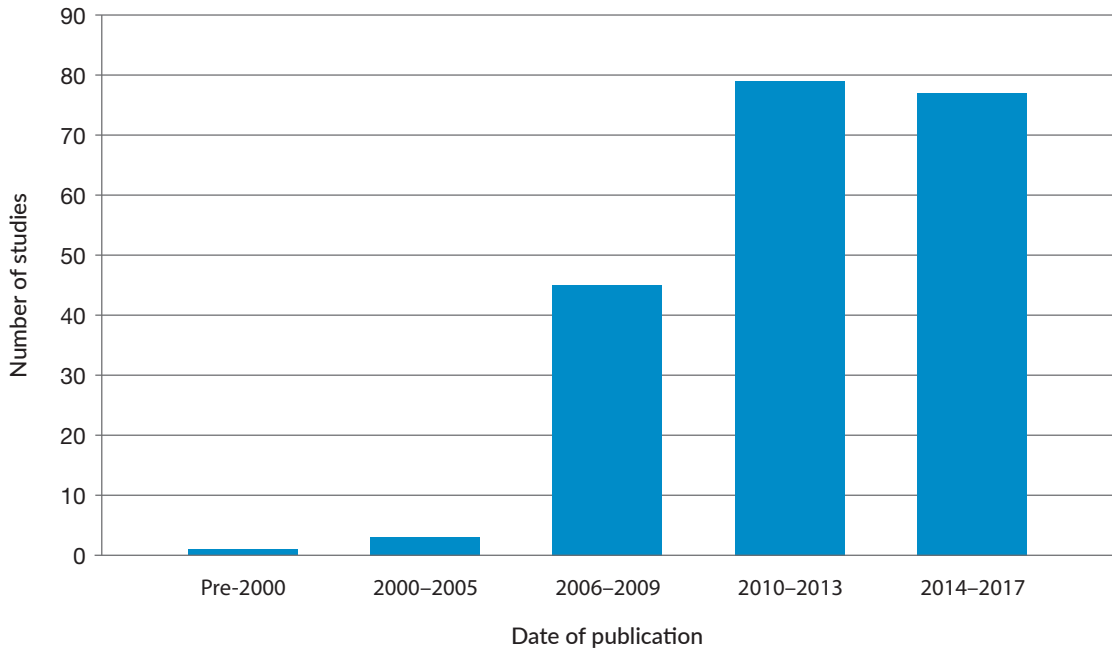


Figure D.2: Number of reviewed studies by country of study

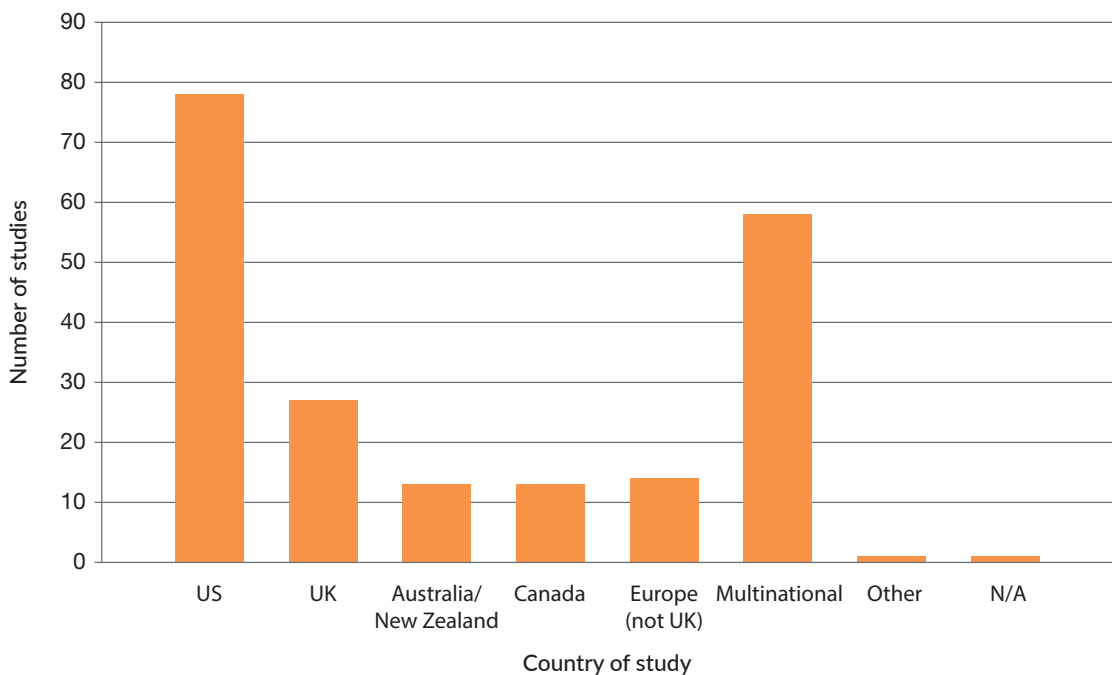
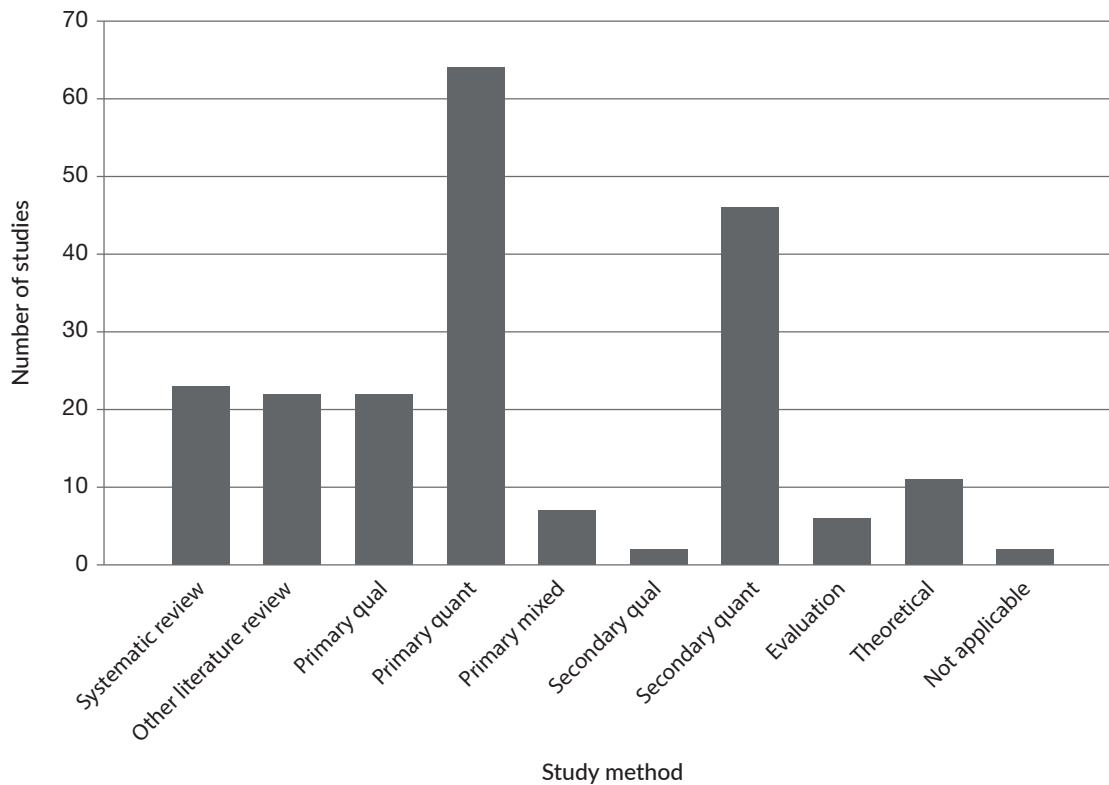


Figure D.3: Number of reviewed studies by method**Figure D.4:** Number of reviewed studies by life stage of participants