

THE LONG-TERM EFFECTS OF CHILD SEXUAL ABUSE

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This views expressed in this webinar are those of the presenter, and do not necessarily reflect those of the Australian Institute of Family Studies or the Australian Government.

Aim to deal with both:

- **Research issues and findings**
- **Policy and practice implications**
- **Based on *CFCA Paper 11*:**
Cashmore & Shackel (2013). **The long-term effects of child sexual abuse.** <http://www.aifs.gov.au/cfca/pubs/papers/a143161/index.html>
and
- **Post-graduate course on Child Sexual Abuse at Sydney Law School**

- ❑ *Four Corners*: “Unholy Silence” 2 July 2012
<http://www.abc.net.au/4corners/stories/2012/06/28/3535079.htm>
- ❑ **VIC INQUIRY**: June 2012 Handling of Child Abuse in Religious Organisations (Family and Community Development Committee)
- ❑ **NSW**: Maitland-Hunter (Cunneen) Inquiry
- ❑ **NATIONAL ROYAL COMMISSION** into Institutional Responses to Child Sexual Abuse

□ **Being an intelligent reader of research requires:**

- An understanding of the basis research methods and issues in the field
- Critical evaluation of the findings
- Understanding the boundary between research and advocacy
- Room for an emotional response but not driven by it
- Understanding the implications for policy and practice

- Teasing out the ‘effects’ of child sexual abuse and other adverse experiences in childhood is not straightforward
- Estimating the prevalence is difficult – unknown ‘dark figure’ of those who never disclose, report
- Source of the accounts of abuse and outcomes
- Different definitions of child sexual abuse
- Different research methodologies

Teasing out the effects

- ❑ Establishing causation?
- ❑ Criteria for causal relationship
 - An association between abuse and later functioning
 - Abuse occurs before 'effects'
 - Association or 'effect' is not due to some other extraneous factors eg other adverse circumstances
 - Some mechanism that can explain the 'link'
- ❑ Conflation – source of reports and outcomes

Estimating the prevalence

- ❑ Different definitions of abuse / forms it takes →
? estimates of prevalence and outcomes across studies, countries
- ❑ Unknown 'dark figure' of those who never disclose, formally report
- ❑ So that will compromise any comparison between:
 - those classified as 'non-abused' and
 - those who are 'known' to have been abused and reported

Specialised and general populations

- ❑ Specialised and general populations:
 - ‘General population’ studies – age range?
 - Smaller and larger scale studies
 - eg retrospective survey reports of ‘unwanted’ sexual experiences before age 14, 16
 - College students esp US research
 - Referred to or seeking medical services, support, and counselling – not identified as reported abuse
 - “Reported” abuse
 - Child victim-witnesses
 - Survivors – using specialist services

Source of reports and outcomes

- Contemporaneous or retrospective account of abuse? and effects?
- Same source of account of abuse and impact?
- Has the abuse been disclosed/reported?
- Official or formal reporting to police and child protection?

Distinguishing disclosure and reporting

- ❑ **Responding to research questions**
- ❑ **Disclosure** – did they tell anyone? At any time?
- ❑ **Formal / official reporting**
 - Who did they tell?
 - When?
 - With what consequences?



Definitions and measures

**Christchurch
longitudinal study –
Retrospective 18+ yrs**

Whether **before the
age of 16 -**

- **anyone** had ever attempted to involve them in any of a series of 15 sexual activities
- **when they did not want this to happen...**

3 categories:

- **Non-contact**
- **Contact** – any form of physical contact
- Oral, vaginal or anal **penetration**

ACE study (Adverse Childhood Experiences)

Did an adult or person at least **5 years older** than you **ever**...

- Touch or fondle you or have you touch their body in a sexual way? or
- Attempt or actually have oral, anal, or vaginal intercourse with you? *Yes/ No : If yes, enter 1*
- Felitti & Anda (2009) The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders, and sexual behavior: Implications for healthcare. Book chapter:
<http://humanservices.ucdavis.edu/resource/uploadfiles/Keynote--Felitti.pdf>

Some instability in response

- ❑ Christchurch longitudinal study *
 - Repeated questions at age 18 and 21
 - **Instability in response – any child sexual abuse**
 - **86% - no CSA at both ages**
 - **4.7% - CSA at both ages**
 - 10% said CSA at age 18 but half did not “admit” at age 21
 - 3.8% said CSA at age 21 but not at 18
 - Not associated with psychiatric state at time of reporting
 - Wanting to forget / embarrassment
- ❑ D. M. Fergusson, L. J. Horwood & L. J. WOODWARD (2000). The stability of child abuse reports: a longitudinal study of the reporting behaviour of young adults. *Psychological Medicine*, 30, 529-544.


- ❑ Substantial under-reporting of child sexual abuse
 - More so for males
- ❑ Where child sexual abuse/assault known from official records but not reported in adulthood
- ❑ Fallibility of memory *and/or*
- ❑ Desire to forget *and/or*
- ❑ Unwillingness to 'volunteer' info
 - Abuse by a family member and abuse at an early age – under 5 yrs – both less likely to be reported

- **More rigorous studies** eg large-scale longitudinal designs, twin studies, and data linkage studies
 - Australia – Cutajar et al, 2010; Nelson et al, 2002
 - NZ – Christchurch cohort study: Fergusson et al, 2008
 - US – Nationally rep samples, and prospective and twin studies: Brown et al, 1999; Molnar, Berkman et al, 2001

- **Meta-analyses** – systematic cross-study measures eg Paolucci et al, 2001

See Cashmore & Shackel (2013) for references

Consequences of child sexual abuse

- ❑ Distortion and abuse of relationships – if known
 - ❑ Betrayal of trust
 - ❑ Sexualisation  sexualised behaviours
 - Often misunderstood in court proceedings
 - ❑ Trauma – stress response – brain development
- HPA axis = Hypothalamic – Pituitary - Adrenal**

Consequences of disclosure and reporting

- Being believed
- Powerlessness - getting it to stop
- Betrayal of trust
- Child protection
- Church / institution
- Police
- Criminal prosecution?

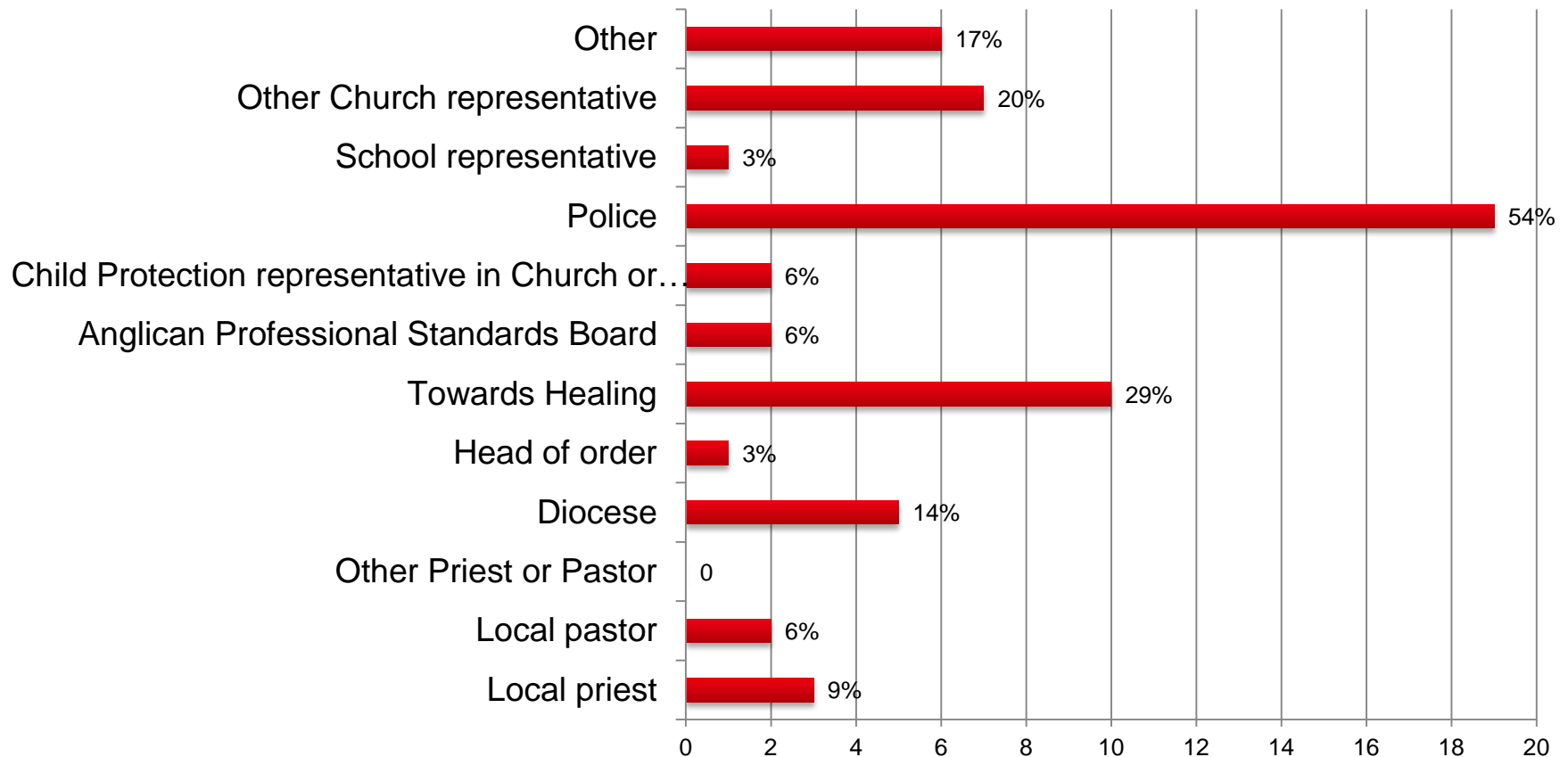


Why did you believe someone else knew

- ❑ Jodie Death (2013) *“They did not believe me”*: *Responding to Child Sexual Abuse by Church Personnel in Australia*
 - ❑ “Incidents took place in his bedroom in monastery with others knowing I was alone with him with the door shut. They never spoke to me..”
 - ❑ “Brother was removed to another school”
 - ❑ “They witnessed and masturbated while they watched “
 - ❑ “One adult witnessed it, another was told about it by several parents”
 - ❑ “Because the priest (abuser) told them”
 - ❑ “I quite obviously hated him, and would avoid him at our house “
-

Official Reporting (Death, 2013)

70% (n = 44) had made an official report



Main reasons for reporting: Death (2013)

1. To protect children
2. The Church to accept responsibility for the abuse
3. The individual to accept responsibility for the abuse
4. My story to be heard by the Church
5. To remove that individual from their position
6. Counseling for myself
7. Church investigation
8. Police Investigation
9. Criminal conviction

J Death (2013) *"They did not believe me"* : *Responding to Child Sexual Abuse by Church Personnel in Australia.*
http://citation.allacademic.com/meta/p_mla_apa_research_citation/5/7/6/7/5/p576757_index.html?phpsessid=36r73kfb79alcjkohh454caa0

- Being believed?
- An equal playing field?
- Being prepared ?
- Conviction/acquittal / aborted trial
- Betrayal of trust
- Treatment by police
- Treatment by prosecution lawyers
- Treatment by defence lawyers

Criminal justice prosecutions - difficulties

- ❑ Being able to tell ‘story’ – own voice
- ❑ Adversarial cross-examination
- ❑ Attack on credibility – twisted defence narrative in
Legal fictions – “peripheral becomes central”
- ❑ Misunderstandings and exploitation of myths re
delayed disclosure and continued relationship
- ❑ Problem of separate trials
- ❑ Multitude of warnings to jury

Main findings: LT “Effects”

- ❑ **Range of adverse outcomes** for sexually abused children during childhood, adolescence and adulthood
- ❑ **But** abuse is not destiny – not all experience adverse outcomes and timing of difficulties varies
- ❑ **Aspects of the abuse** – relationship between the abuser and the child, age and gender of the child, betrayal of trust and manipulation, form of abuse **as well as family and friends’ and other reactions to disclosure are key factors**

Behavioural and mental health functioning

- Anxiety, depression and suicidality
- Alcohol and substance abuse
- Risky behaviours including sexual behaviours
- Interpersonal difficulties
 - Trust and intimacy, parenting and risk of re-victimisation
- Involvement with criminal justice system

Range of physical health problems – stress-response related

Gender differences – greater problems? later disclosure and less support for males?

Diverse effects - child sexual abuse as “non-specific” risk factor

- Anxiety and depression
- Alcohol and substance dependence
- Eating disorders
- Post-traumatic stress disorder
- Suicidality
- Cumulative and additive/synergistic effects

Alcohol and substance dependence

❑ Life-time alcohol dependence rates

eg women 16% cf 8% for women (Molnar, Buka & Kessler (2001)


And higher for men – 39% cf 19% (non-abused)

❑ Explanatory mechanisms – self-medication

 dampening of hyper-arousal PTSD symptoms

❑ Interactive additive effects:

- With parental alcohol problems and other forms of maltreatment, adverse childhood events see Fenton et al (2013)
Psychological Medicine

- Childhood abuse and cannabis use  psychosis
“Greater than additive interaction” (Harley et al, 2010)

Harley et al. (2010)

Psychological Medicine (2010), 40, 1627–1634. © Cambridge University Press 2009
doi:10.1017/S0033291709991966

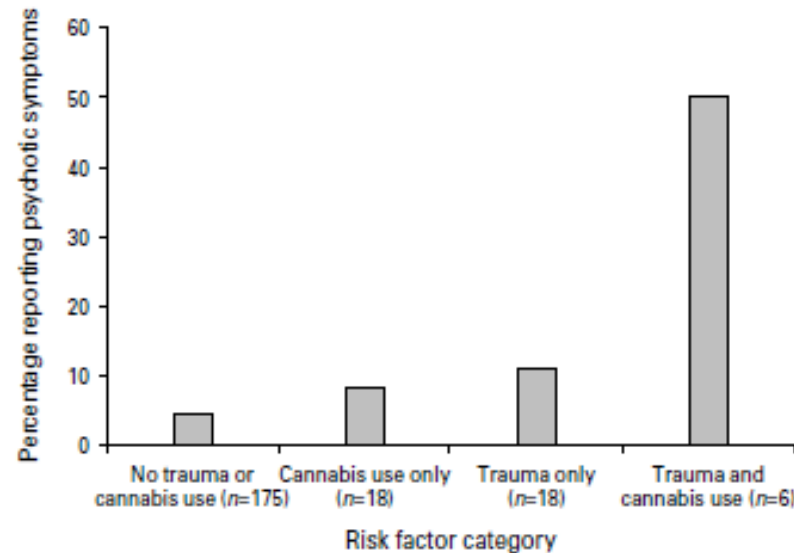



Fig. 1. Percentage of adolescents with psychotic symptoms (■) in each risk exposure category.

Cannabis use and childhood trauma interact additively to increase the risk of psychotic symptoms in adolescence

□ Increased likelihood of risky/harmful behaviours

- Especially in adolescence
- “Accidental” fatal overdoses
- Gambling
- Sexual behaviour/activity
 - Early onset consensual activity
 - Multiple partners
 - Unprotected intercourse  STDs, unwanted pregnancies


Explaining and accounting for association between CSA and risky sexual behaviours:



❑ Trust and intimacy

- Betrayal of trust and personal boundaries
- Secrecy - confusion, guilt, shame, isolation

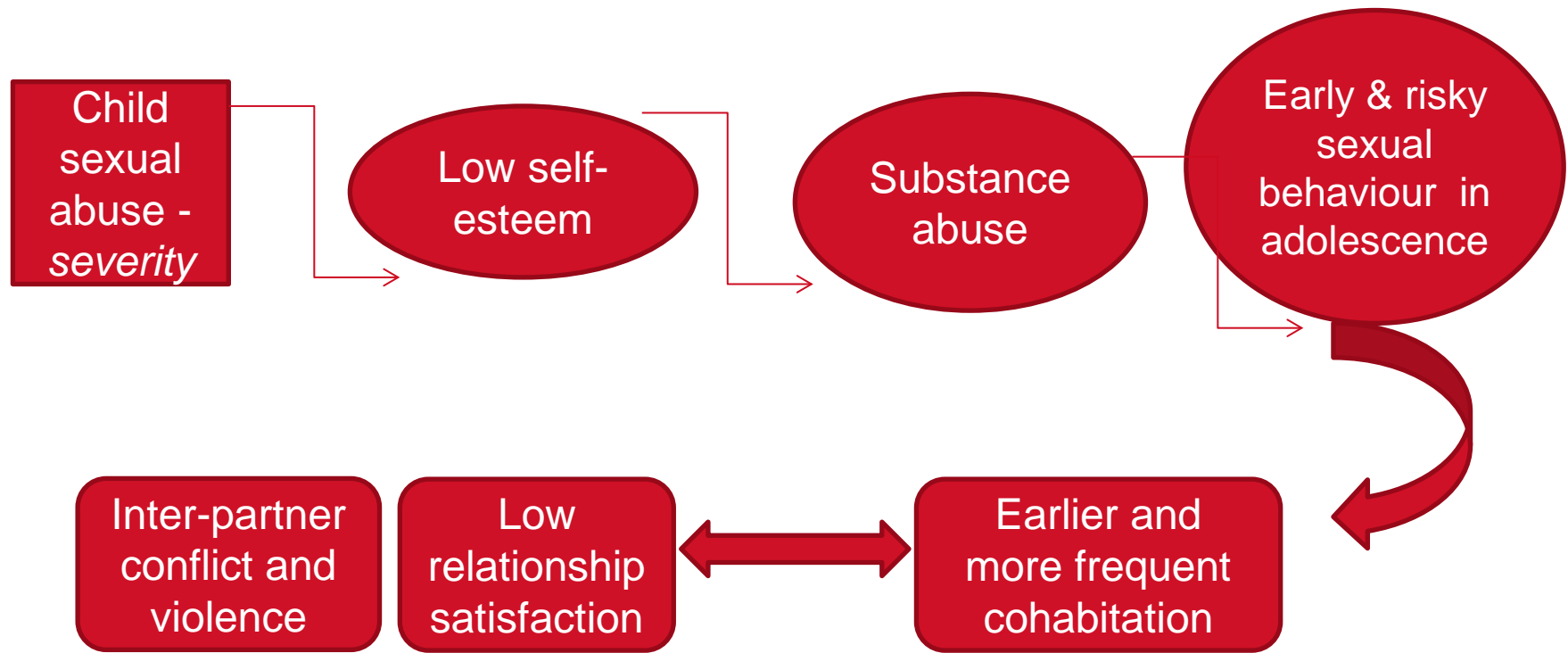
❑ Parenting – different for males and females

- Anxiety and lack of confidence  parental stress
- Other adverse circumstances – isolation, violence

❑ Fathering

- Anxiety and over-protectiveness
- Concerns about own possible victim-to-offender pathway
- As a healing experience


□ Christchurch longitudinal study – Friesen *et al* (2010)



- ❑ Sexually abused children and adolescents more likely to be sexually assaulted as adults
 - Teasing out the effects – proximal as well as indirect
- ❑ Not just sexual victimisation
- ❑ Likely mechanisms / mediators
 - Self-esteem
 - Discrimination and trust
 - Hyper-arousal – distinguishing actual/false alarms

- ❑ **Victim-to-offender cycle – stigma and fear**
 - An increased risk but vast majority of sexually abused children do not go on to offend
 - Different types of studies and population base
 - Depends on starting point
- ❑ Starting with CSA children ...
- ❑ Starting with offenders / prison / JJ detention ...

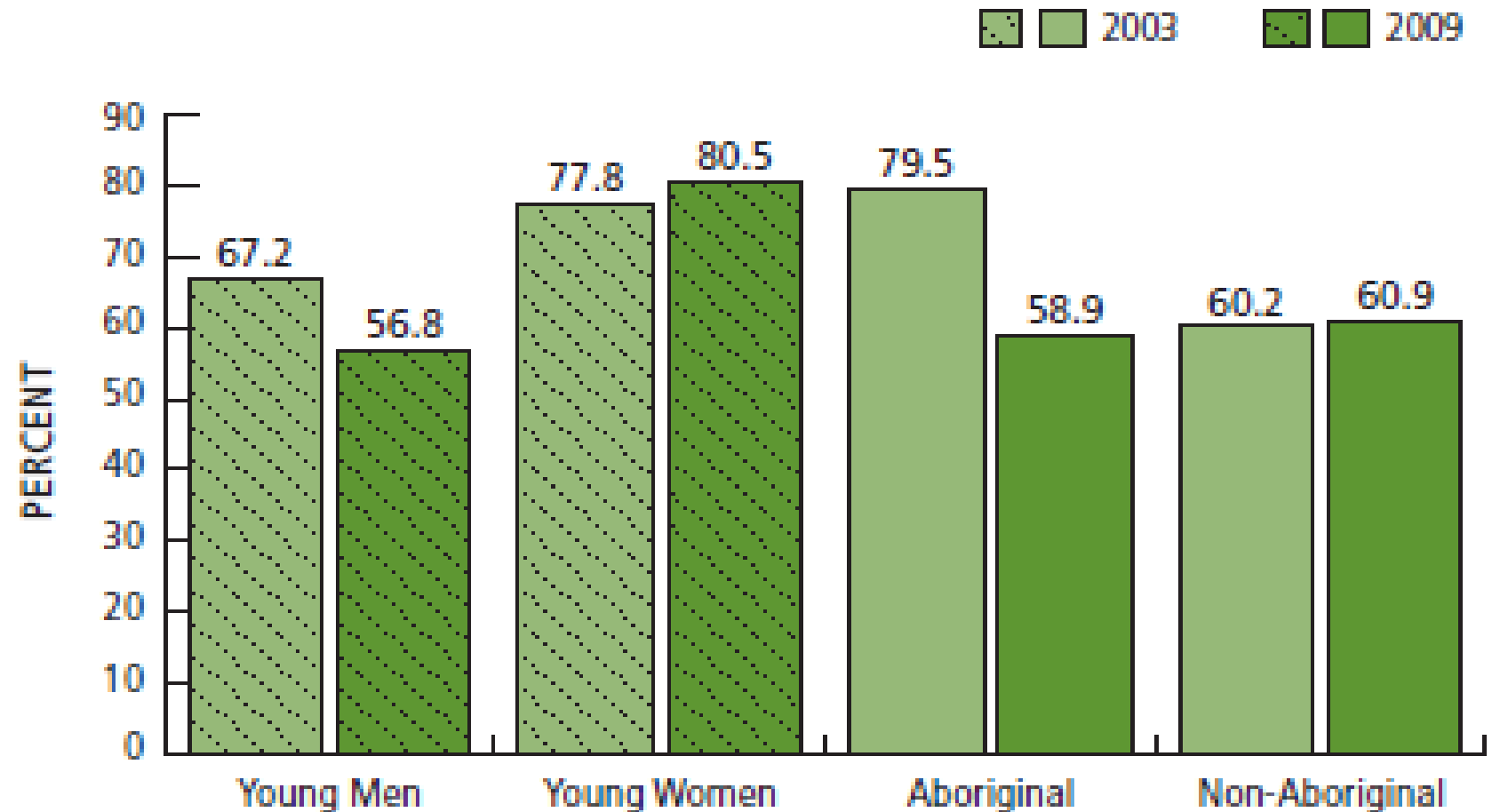
□ Starting with children who have been sexually abused

- Greater likelihood of
 - Behaviour problems
 - Running away  survival crimes eg prostitution, stealing, drug offences
 - Juvenile offending
- Sexual offending - mixed results but more likely if abuse as adolescent ie 12 yrs plus
- Type of study important – follow-up
 - Ogloff et al (2012) – 31 yr follow up using Vic records
 - Sexual offending by males – 9% if 12+ yrs cf 3% (under 12) cf comparison group 1% overall

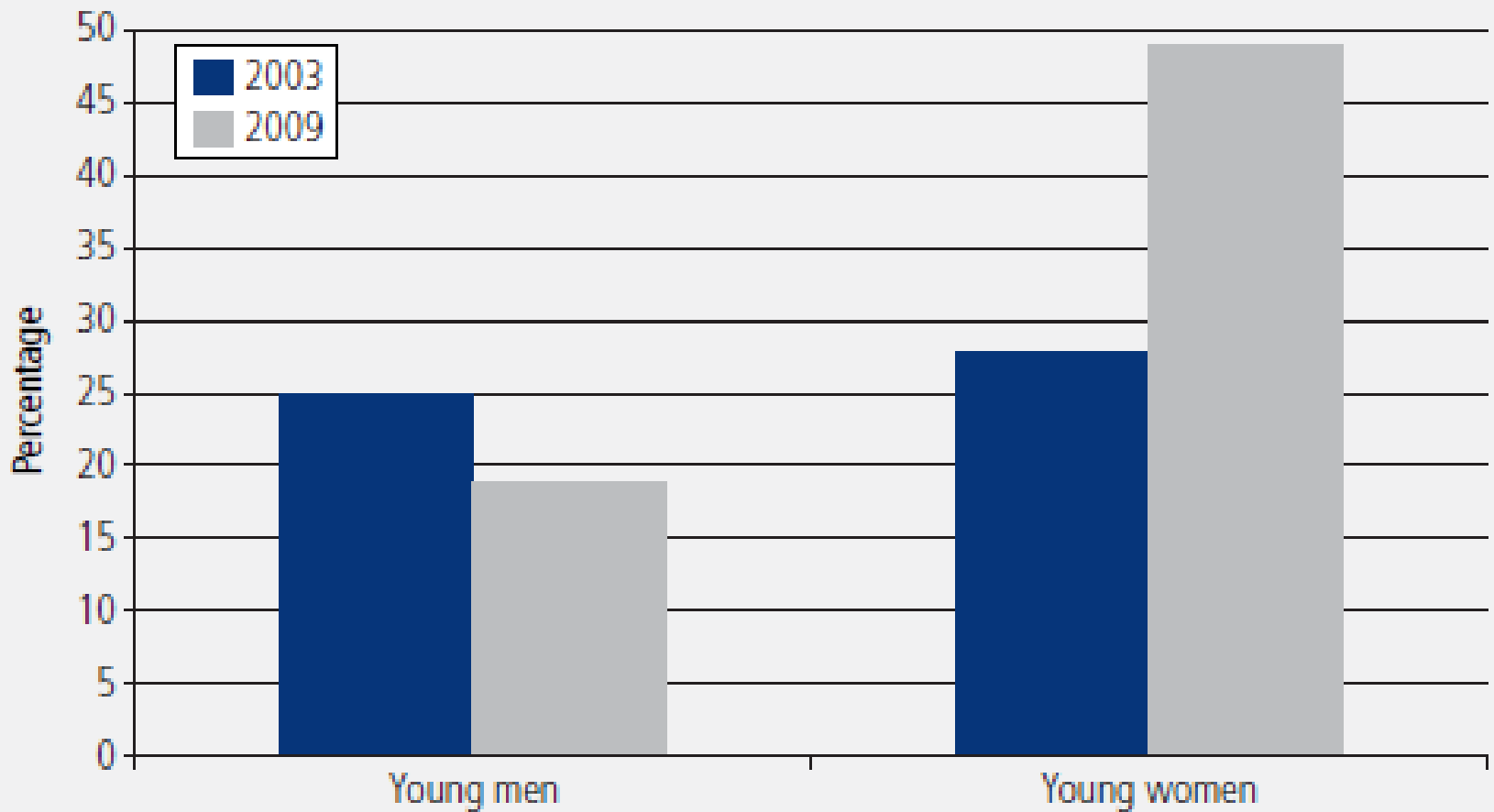
□ Starting with adults, adolescents in detention

- High proportion with history of maltreatment and social disadvantages and adverse childhood experiences
- Overall average – studies 41-43%
- Indig et al (2011) – NSW Health survey of JJ detainees
 - 39% of females and 5% males -- self-report CSA
 - 55% of females and 24% males – high psychological distress
 - 45 males – committed sexual offence

Table/Fig 6.7.2 Any childhood abuse or neglect (scores above 'none to low')



Indig, D., Vecchiato, C., Haysom, L., Bellby, R., Carter, J., Champlon, U., Gaskin, C., Heller, E., Kumar, S., Mamone, N., Muir, P., van den Dolder, P. & Whittton, G. (2011) *2009 NSW Young People in Custody Health Survey: Full Report*. Justice Health and Juvenile Justice. Sydney.



Source: Adapted from Indig et al. (2011), Figure 6.7.3, p. 158

Figure 1 Proportion of young people in NSW juvenile justice detention reporting experiencing any serious childhood abuse or neglect, by gender

- ❑ **Range of physical health problems**
- ❑ Complex links involving behavioural, emotional, social and cognitive factors
 - Esp affecting health-promoting behaviours
 - Stress-response – HPA – hypothalamic-pituitary – adrenal stress response
 - Affecting neuro-endocrine and immunological systems
- ❑ Reduced life expectancy (Brown et al, *American Journal of Preventive Medicine*, 2009, 37(5), 389–396).

- ❑ **Mixed results** but under-reported sexual abuse *of* males and *by* males
- ❑ **Prevalence issues** – severity, frequency, duration, relationship to offender
- ❑ Boys and men less likely to disclose and report CSA


Dynamics of child sexual abuse

- ‘Real men’ – not ‘victims’ or vulnerable /sexual prowess
- Fear of homosexuality – label and self-label
- Fear of victim-to-offender cycle
- More likely to be seen as instigator?

□ Abuse by clergy

- Boys more likely than girls – 75-80% of victims
- Most common age – 11-14 years
- Long delay to disclosure – average 25 years
 - John Jay College US – 2004 large-scale study
 - Parkinson, Oates & Jayakody 2010 – Anglican church

Main messages – what do we know?

- ❑ Complex picture – multiply determined
‘multiple pathways’  multiple problems
- ❑ Interactive synergistic relationships – “more than additive”
- ❑ Increased risk of adverse long-term effects of child sexual abuse but ..

Abuse is not destiny

- What is the effect of criminal prosecutions on survivors?
 - Do those who decide to report and engage in criminal proceedings fare better or worse? Depending on?
- What is the impact of media coverage?
- What is/will be the effect of the Royal Commission on survivors?
 - Do those who decide to engage with the Commission fare better or worse as a result? Depending on?
- The evidence base for what works in treatment?

- ❑ **Critical evaluation of research findings is ‘critical’**
 - Research rigour
 - Consistent patterns – not just single studies, outliers
 - Both quantitative and qualitative studies and ‘stories’
 - Peer review and journal quality – though not foolproof
- ❑ Systematic reviews and meta-analyses
- ❑ **Keeping in mind:**
 - Historical context
 - Cultural context
 - Other confounding factors – ‘multiple pathways’



Intelligent application of research

- ❑ Gap between what we know and what we don't know
- ❑ Gap between what we know and *what we do*
- ❑ Critical importance of properly evaluated treatments and interventions

- ❑ Providing appropriate support and treatment
 - Not alone!
 - Can re-evaluate self-blame, guilt and helplessness
- ❑ “No wrong door”
- ❑ Rural and regional access

Thank you for listening
and
Any questions?

sexual abuse of children and young people causes long-term mental health difficulties and disabled young people are not immune from these consequences. The effect of this is that children and young people with disabilities are deemed to be at more risk of sexual abuse than other children, but to receive less protection from both mainstream and specialist agencies. This places them in double jeopardy. Where is the evidence? Long-term effects. Studies show that severe emotional abuse can be as powerful as physical abuse. Over time, both can contribute to low self-esteem and depression. Most children who are abused don't grow up to abuse others. But some research suggests that they may be more likely than adults who weren't abused during childhood to engage in toxic behaviors. Adults who were abused or neglected as children may also be more likely to develop chronic health problems, including: eating disorders. headaches.