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Child Sexual Abuse

LEARNING OBJECTIVES

1. Describe the definition and scope of child sexual abuse, including problems inherent in measuring this form of abuse.
2. Identify the various risk factors associated with child sexual abuse.
3. Summarize the consequences of child sexual abuse including both short- and long-term outcomes.
4. Discuss the various intervention and prevention efforts that have been developed to address child sexual abuse, including evidence of their effectiveness.

Case History: Sashim's Secret

Sashim, an only child, was 9 years old when her parents divorced. Her father had been physically violent toward both Sashim and her mother, and they broke off all ties with him after the divorce. The next three years were difficult for Sashim and she was frequently lonely, because she rarely saw her mother, who had to work two jobs to make ends meet. When Sashim was 12 years old, her mother became romantically involved with Bhagwan, a 39-year-old construction foreman. Shortly after Sashim's mother met Bhagwan, he moved in with the family and took a serious interest in Sashim. He showered her with attention by taking her to movies, buying her new clothes, and listening to her when she complained about difficulties at school. He seemed to provide her with the parental attention and affection that she had missed for so many years.

During the course of several months, Bhagwan's behavior toward Sashim gradually changed. He became much more physical with her, putting his arm around her when they were at the movies, stroking her hair, and kissing her on the lips when he said good night. He began to go into her bedroom and the bathroom without knocking when she was changing her clothes or bathing. He also began checking on her in the middle of the night. During these visits, he would stroke and caress her body. In the beginning, he touched only her nonprivate areas (e.g., shoulders, arms, and legs), but after several visits, he began to touch her breasts and genitals. Eventually, he began to kiss her sexually during his touching, all the while telling her how much he loved her and enjoyed being her father. He warned her that she should not tell anyone about their time together because others would not understand their special relationship.

One night, Bhagwan forced Sashim to have sexual intercourse with him. A few days later, one of Sashim's favorite teachers noticed that Sashim seemed very quiet and asked if something was bothering her. Sashim began crying and told her teacher everything that had happened. Sashim's teacher reassured her that she believed her and would help her. The teacher called Child Protective Services (CPS) and Bhagwan was arrested. Sashim's mother could not believe that Bhagwan would do such things or that the things Sashim described could occur without her knowledge. She refused to believe Sashim, calling her a liar and a home wrecker.

As a result, Sashim was placed in a foster home. Shortly thereafter, she was diagnosed with leukemia; the doctors estimated that she had only six months to live. Her only request was that she be able to die at home with her foster parents, to whom she had become quite attached. The hospital, however, was unable to grant Sashim's request without the consent of her biological mother, who still had legal custody of Sashim. Her mother refused to consent unless Sashim agreed to recant her story about Bhagwan. After much discussion and deliberation, Sashim recanted her story and was able to return to her foster parents' home, where she died several months later.

As this case history demonstrates, child sexual abuse (CSA) is a multifaceted problem, extraordinarily complex in its characteristics, dynamics, causes, and consequences.

This chapter examines the major issues that contribute to this complexity. We begin by addressing issues related to defining the scope of CSA, including definitions and estimates of the rates of CSA in the United States. We then focus on risk factors associated with this form of abuse including characteristics of victims and perpetrators as well as family and cultural factors that help us to understand why it occurs. We also address the myriad consequences of this form of maltreatment for victims. We conclude the chapter with a description of various responses to the problem, including both intervention and prevention approaches.

Scope of the Problem

What Is Child Sexual Abuse?

What sexual interactions should be defined as *abusive*? To illustrate the complexities inherent in answering this question, consider the following scenarios:

- Jamie, a 15-year-old, frequently served as babysitter for his neighbor, 4-year-old Naomi. Each time Jamie was left alone with Naomi, he had her stroke his exposed penis while they watched her favorite movie.
- Manuel and Maria frequently walked around nude at home in front of their 5-year-old son, Ernesto.
- Richard, an adult, repeatedly forced his nephew Matt to have anal intercourse with him when Matt was between the ages of 5 and 9 years. After the abuse stopped when he was 10, Matt frequently sneaked into his 6-year-old sister's room and had anal intercourse with her.
- Sally, at 16 years old, was a self-proclaimed nymphomaniac. She had physical relationships (e.g., kissing, fondling, and sexual intercourse) with numerous boyfriends from school. One evening when Sally was home alone with her 45-year-old stepfather, he asked her if she wanted to "mess around." Sally willingly agreed to have sexual intercourse with him.
- Dexter, a 30-year-old man, invited 7-year-old Jimmy to his house frequently for after-school snacks. After their snacks, Dexter asked Jimmy to undress and instructed him to assume various sexual poses while Dexter photographed him. Dexter sold the photos for profit.

The above vignettes illustrate a number of important issues to consider when defining CSA. In the following sections we discuss the importance of conceptual issues, culture and development, and legal perspectives in determining what constitutes CSA before providing an operational definition of CSA.

Conceptual Issues in Defining CSA

There are a number of key components that are generally regarded as essential in defining CSA, and these are illustrated in the vignettes included at the beginning of

this section of the chapter. First, definitions of CSA should include sexual experiences with children that involve both physical contact and noncontact activities. For example, CSA may include physical contact such as fondling or intercourse as described in the vignettes above about Jamie, Matt, and Sally, but it can also include noncontact forms, such as taking photographs, as in the scenario involving Dexter and Jimmy. Furthermore, sexual activities include sexual contact performed by the perpetrator on the child but also by the child on the perpetrator, as in the vignette involving Jamie and Naomi. Controversy continues to exist, however, regarding what specific behaviors should be deemed abusive, regardless of whether those behaviors are classified as contact or noncontact experiences. The range of sexual activities we might call CSA extends from exhibitionism to intercourse. Although certain sexual acts are generally universally recognized as abusive (e.g., vaginal and anal penetration), other activities are less obviously abusive, such as the vignette depicting the parental nudity (a noncontact behavior) of Manuel or Maria or when an adult kisses a child on the mouth (a contact behavior).

One way to distinguish between abusive and nonabusive behaviors is to evaluate the intent of the perpetrator. Many definitions of CSA, for example, include the requirement that the activities are intended for the sexual stimulation of the perpetrator, thus excluding normal family and caregiving interactions (e.g., nudity, bathing, displays of affection). In practice, of course, determining whether a behavioral intention is sexual or nonsexual can be difficult. How can one determine whether a grandfather kisses his granddaughter out of innocent affection or for his sexual gratification?

A second important component of CSA definitions emphasizes the adult's exploitation of his or her authority, knowledge, and power to achieve sexual ends. Implicit in this component is the assumption that children are incapable of providing informed consent to sexual interactions with adults for two reasons: (1) because of their developmental status, children are not capable of fully understanding what they are consenting to and what the consequences of their consent might be, and (2) children might not be in a position to decline involvement because of the adult's authority status. The vignette above about Sally and her stepfather illustrates a case of abuse because, despite Sally's sexual experience and consent in this situation, she is not mature enough to understand the ramifications of having sexual intercourse with her stepfather. As Haugaard and Reppucci (1988) point out, "The total legal and moral responsibility for any sexual behavior between an adult and a child is the adult's; it is the responsibility of the adult not to respond to the child" (p. 193).

The third and final component of CSA definitions addresses the age or maturational advantage of the perpetrator over the victim. Although many definitions limit abuse to situations involving an age discrepancy of five years or more between perpetrator and victim, others include children and adolescents as potential perpetrators if a situation involves the exploitation of a child by virtue of the perpetrator's size, age, sex, or status. Broader definitions of CSA include circumstances such as those described above in the second scenario of anal intercourse between 10-year-old Matt

and his 6-year-old sister. An increasing number of reports involving both adolescent offenders and children victimizing children younger than themselves are beginning to appear (e.g., Grossi, Lee, Schuler, Ryan, & Prentky, 2016).

Culturally and Developmentally Normative Sexual Behavior

As noted in Chapter 1, sexual interactions between children and adults have occurred throughout history and only relatively recently have come to be recognized as a social problem. Recall from the discussion in Chapter 1 that the appropriateness or inappropriateness of various sexual behaviors has not only varied across time but across societies and cultures. In some cultures, for example, young boys performing fellatio on older boys is a developmental right-of-passage (Herdt, 1987). In the United States, circumcision is defined as a voluntary medical procedure, whereas in Europe it is recognized as a violation of children's rights (Kulish, 2012). It is thus apparent that any definition of CSA depends on the historical period in question, the cultural context of the behavior, and the values and orientations of specific social groups.

To define CSA today in the United States, it is also essential to know something about what types of behaviors are generally regarded as developmentally appropriate as well as acceptable within American families. Would most people consider Manuel and Maria abusive for walking around nude in front of their 5-year-old son? What if their son were 13 years old? How much variation in nudity, touching various body parts, and kissing on the lips is socially acceptable between adults and children?

One way to approach the question of acceptability is to examine what kinds of sexual behaviors are common in children. Poole and Wolfe (2009), in a review of the research on normative sexual behaviors in early, middle, and late childhood, conclude that children are curious about sex and engage in sexual behaviors throughout childhood. Some of the most common behaviors in children aged 2–6 years include kissing nonfamily members, trying to look at others undressing, undressing in front of others, showing sex parts to others, touching women's breasts, and touching sex parts or masturbating. The most common sexual behaviors during middle and late childhood (for children aged 7 to 10 years and 11 to 12 years, respectively) are similar to those described for early childhood, but by middle school, sex play with friends is not uncommon, and this play sometimes involves some form of manipulation or persuasion. Several unique behaviors also increase from middle to late childhood, including talking about sex, kissing and hugging, looking at pornographic pictures, sexual teasing, and interest in the opposite sex (Friedrich, Fisher, Broughton, Houston, & Shafran, 1998; Larsson & Svedin, 2002). An estimated 15 percent of middle schoolers and 50 percent of high school seniors have had sexual intercourse (Martinez & Abma, 2015).

Of course, there will be disagreement as to whether these activities are "good" or "bad," but that is not our point. We want to emphasize that sexualized behavior in children is not uncommon. It is, in fact, a developmentally normal curiosity of childhood. Although a comprehensive review of cultural and developmental

factors impacting CSA is beyond the scope of this chapter, we recommend Lisa Aronson Fontes's (2008) *Child Abuse and Culture: Working With Diverse Families* and John Bancroft's (2003) *Sexual Development in Childhood* for those interested in further reading.

Legal Perspectives in Defining CSA

All U.S. states have laws prohibiting the sexual abuse of children, but the specifics of criminal statutes vary from state to state. CSA laws typically identify an age of consent—that is, the age at which an individual is considered to be capable of consenting to sexual contact. In most states, the age of consent falls somewhere in the range of 14 to 18 years. Sexual contact between an adult and a minor who has not reached the age of consent is illegal. Most states, however, define incest as illegal regardless of the victim's age or consent (Berliner & Elliott, 2002).

Criminal statutes also vary in how they define sexual contact between an adult and a minor. Some states define CSA in relatively broad terms. In the state of Maryland, for example, *sexual abuse* is defined as "any act that involves sexual molestation or exploitation of a child" including "incest, rape, sexual offense in any degree, sodomy, and unnatural or perverted sexual practices" (Maryland Family Law 5-701). In contrast, California law defines CSA very specifically: *sexual abuse* includes **child sexual assault** and **child sexual exploitation**, and both of these terms are explicitly defined. In the California statute, *sexual assault* includes anal or vaginal penetration by the penis or another object, oral–genital and oral–anal contact, touching of the genitals or other intimate body parts whether clothed or unclothed, and genital masturbation of the perpetrator in the presence of a child (California Penal Code 11165.1). California law also defines *sexual exploitation*, which primarily refers to noncontact activities involving pornography (preparing, accessing, or distributing obscene matter depicting a child) and activities that include the sexual exploitation of children for financial gain such as selling child pornography or encouraging and/or coercing child prostitution. The California Penal Code also defines **commercial sexual exploitation of children (CSEC)** and includes **child sex trafficking** as a form of CSA. Although outside the scope of the current chapter, which focuses primarily on noncommercial forms of CSA, sexual exploitation for commercial gain is an important topic that has recently gained considerable research and legislative attention (see Box 4.1).

An Operational Definition of CSA

At this point we have considered the complicating factors, but have not yet offered an operational definition of CSA. This oft-cited definition from the Centers for Disease Control and Prevention (CDC) will serve as our definition: "any completed or attempted (non-completed) sexual act, sexual contact with, or exploitation of (i.e., noncontact sexual interaction) a child . . . " (Leeb, Paulozzi, Melanson, Simon, & Arias, 2008, p. 11). According to this definition, *sexual acts* include contact that involves some form of penetration "between the mouth, penis, vulva, or anus of the child and

another individual" (p. 14). *Sexual contact* refers to intentional touching, by the caregiver on the child or by the child on the caregiver, of the genitalia, anus, groin, breast, inner thigh, or buttocks. *Exploitation*, or noncontact sexual abuse, includes exposing a child to activities such as pornography, voyeurism, or exhibitionism; depicting a child in a sexual act either through photographs or film; sexual harassment of a child; and prostitution of a child.

Readers who are familiar with the CDC definition of CSA may well notice that we have deleted the final three words: "by a caregiver." Although in this chapter we will focus our attention on maltreatment in intimate relationships, it is important to recognize at the outset that CSA is frequently *not* committed by parents or caregivers (Finkelhor, Ormrod, & Turner, 2009). CSA can be committed by family members other than parents and caregivers, acquaintances, strangers, older children and adolescents, and other individuals in positions of authority over children. Indeed, news media and research publications are replete with stories of nonfamilial CSA occurring in religious organizations, day care settings and preschools, schools, and other youth-serving organizations such as organized clubs and sports (e.g., Miller-Perrin & Wurtele, 2017(b); Speckhardt, 2011; Sturtz, 2014; Yardley, 2010).

Box 4.1 Commercial Sexual Exploitation of Children

The First World Congress Against the Commercial Sexual Exploitation of Children, held in 1996, provided the first working definition of *commercial sexual exploitation of children (CSEC)* as comprising "sexual abuse by the adult and remuneration in cash or kind to the child or a third person or persons. The child is treated as a sexual and commercial object. The commercial sexual exploitation of children constitutes a form of coercion and violence against children, and amounts to forced labor and a contemporary form of slavery." Of all the major forms of child maltreatment discussed in this book, CSA is the one that is most likely to occur between a child and an adult who is not a family member. CSEC is one form of CSA that is typically extrafamilial, although reports also suggest that some elements of CSEC may also occur within the family (e.g., Miller-Perrin & Wurtele, 2017a). CSEC includes pornography, prostitution, and sex trafficking—activities that are often interrelated—and they are important to study not only because they are a violation of children's human rights but because of their negative impact on children's development (Miller-Perrin & Wurtele, 2017a; Oram, Khondoker, Abas, Broadbent, & Howard, 2015).

Child pornography is defined by federal law under 18 U.S.C. § 2256(8) as any "visual depiction" of an actual minor (under age 18) or a computer-generated image that "is indistinguishable from that of a minor" who is "engaging in sexually explicit conduct," "including any photograph, film, video, picture, or computer-generated image or picture, whether made or produced by electronic, mechanical, or other means" (U.S. Sentencing Commission, 2012). In 1978, the U.S. Congress passed the Protection of Children Against Sexual Exploitation Act in an attempt to halt the production and dissemination of

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pornographic materials involving children. In addition, the **Child Sexual Abuse and Pornography Act** of 1986 provides for federal prosecution of individuals engaged in child pornography, including parents who permit their children to engage in such activities (Otto & Melton, 1990).

According to a 2012 U.S. Congress report, there are at least 5 million child pornographic images available on the Internet at any given time (U.S. Sentencing Commission, 2012). Studies of the number of images in offenders' collections included an average of 15,099 in one study (Long, Alison, & McManus, 2013). In recent years, the advent of the Internet has revolutionized the viewing, distribution, and production of pornographic images of children, exacerbating the problem on a global scale (Wolak, Liberatore, & Levine, 2014). According to the Internet Watch Foundation (www.iwf.org.uk), there were 13,182 Web pages containing child pornography being hosted on 1,660 domains worldwide in 2013.

Some have objected to the use of the term *child pornography*, arguing that the term trivializes its inherently abusive content, implies consensual activity, and fails to recognize that such materials are not the same as adult pornography or erotica (Holmes & Holmes, 2009). Indeed, the Internet Watch Foundation (IWF) argues that "The use of such language acts to legitimize images which are not pornography, rather, they are permanent records of children being sexually exploited and as such should be referred to as ***child sexual abuse images"*** (www.iwf.org.uk; emphasis theirs). Child pornography, then, is clearly abusive in and of itself, but it also likely contributes to the problem of CSA by stimulating adult sexual interest in children (Merdian et al., 2013). In addition, child pornography contributes to the exploitation of children by creating a market for the victimization of children and by serving as a tool that perpetrators use to groom victims for contact abuse or to blackmail victims into maintaining secrecy about abusive activities (A. Burgess & Hartman, 1987; P. Hunt & Baird, 1990; Seto, Hanson, & Babchishin, 2011; R. Tyler & Stone, 1985; Wolak, Finkelhor, & Mitchell, 2011).

Child prostitution is another form of CSEC and is defined by the United Nations Optional Protocol as "the use of a child in sexual activities for remuneration or any other form of consideration" (United Nations Optional Protocol, 2000, article 2[b]). The commercial element in child prostitution can include any form of compensation, financial or otherwise, where the child or youth is treated as a commodity. Closely related to child prostitution is *child sex trafficking*, defined by the U.S. Trafficking Victims Protection Act (TVPA) of 2000 (P.L. 106-386) and its reauthorizations in 2003, 2005, 2008, and 2013, as "the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act." The use of the term *trafficking* is somewhat misleading because it implies physical movement of the child, which is not a requirement of most definitions (Miller-Perrin & Wurtele, 2017a). That transportation is not a requirement reflects current recognition that child sex trafficking is defined by exploitation, rather than by movement (Rafferty, 2013). Thus, prostitution of minors is essentially equivalent to child sex trafficking (see Reid & Jones, 2011).

Although child victims of prostitution and sex trafficking have historically been characterized as "child prostitutes" or "juvenile delinquents," most experts now argue that these minors should be viewed as victims of CSEC, regardless of whether or not they seem to be engaging in sexual acts willingly (IOM & NRC, 2013). Traditional views of prostituted children as voluntarily engaging in sex acts in exchange for something of value, for example, imply that children possess the maturity and

cognitive ability to fully understand and consent to such acts (APSAC, 2013). In addition, with sex trafficking victims, there is often an element of force or coercion when victims are recruited through kidnapping/physical coercion, false promises such as a paying job, or through the guise of legitimate organizations such as modeling or tourist agencies (e.g., Hodge & Lietz, 2007; Jones, Engstrom, Hilliard, & Diaz, 2007).

"Guesstimates" of the problem of sex trafficking and child prostitution, such as "millions of victims of trafficking," are commonly referenced in international publications attempting to draw attention to a largely undocumented crime (Goodey, 2008). One source, for example, claimed that 9 million girls and 1 million boys are prostituted globally each year (Willis & Levy, 2002). According to the International Labour Organization (ILO, 2012), an estimated 945,000 minors were victims of forced sexual exploitation worldwide. Within the United States, estimates of child prostitution have ranged from 1,400 to 326,000 children (Sedlak, Finkelhor, Hammer, & Schultz, 2002; Shared Hope International, 2009). The covert nature of sex trafficking and child prostitution, as well as the lack of a uniform reporting system, contributes to the difficulty in determining the extent of the problem. In the United States, new legislation is attempting to improve documentation of CSEC. The Justice for Victims of Trafficking Act of 2015, for example, requires each state to report child victims of CSEC and will be added to NCANDS data over the next several years (U.S. DHHS, 2016). Although there is reason to question the validity of estimates, what is not debatable is the fact that the purchase of youth for sexual purposes does occur and is a serious violation of their human rights (Miller-Perrin & Wurtele, 2017a).

Miller-Perrin and Wurtele (2017a) described a number of characteristics of child prostitutes and sex trafficking victims that have been documented repeatedly in the literature. This literature suggests that children who are vulnerable in some way are the ones typically targeted and recruited. Children who have drug and alcohol problems, physical and/or intellectual difficulties, and troubled family lives (e.g., parental substance abuse) are much more likely to become involved in CSEC (Clawson, Dutch, Solomon, & Grace, 2009; Cobbina & Oselin, 2011; IOM & NRC, 2013). Being female and pubescent (ages 15–19 years) are also risk factors (Clawson et al., 2009; UNICEF, 2014). Another common vulnerability is the presence of violence in the home, including child physical and sexual abuse and neglect, which often result in youth running away to escape the abusive home (Wilson & Widom, 2010). Social and economic factors are also likely to contribute to sex trafficking, such as poverty and few employment or educational opportunities (United Nations Office on Drugs and Crime, 2009; U.S. Department of State, 2005).

In response to the problem of CSEC, guidelines and standards have been set in various U.S. and international laws, treaties, and protocols to protect victims, prosecute offenders, provide services to victims, and prevent future CSEC (e.g., United Nations, 2000; U.S. Trafficking Victims Protection Act [TVPA], 2000). For example, in an effort both to protect victims and prosecute offenders, 116 countries have enacted legislation prohibiting all forms of human trafficking (U.S. Department of State, 2010). With regard to providing services for victims, the **Administration for Children and Families** has a website with resources to Rescue and Restore Victims of Human Trafficking (http://www.acf.hhs.gov/programs/orr/programs/anti-trafficking). Ideally, victim services should include temporary and safe shelter, physical and mental health services, public benefits, legal and immigration assistance, substance abuse treatment, support groups, employment and training services,

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language education, and long-term housing or relocation assistance (Miller-Perrin & Wurtele, 2017a). The National Human Trafficking Resource Center, funded by the U.S. Department of Health and Human Services, operates a hotline where one can report CSEC and also obtain services (https://traffickingresourcecenter.org/). A number of efforts to prevent CSEC, including public awareness campaigns and interventions for at-risk youth, are currently underway and hold promise (Wurtele & Miller-Perrin, 2012).

How Common Is Child Sexual Abuse?

Of the approximately 3.2 million children reported to CPS during 2014, 8.3 percent were victims of CSA. Approximately 60,000 total cases of CSA were substantiated, a number that is less than one-half what it was in the early 1990s, according to the National Child Abuse and Neglect Data System (NCANDS) (U.S. DHHS, 2016). The most up-to-date examination of NCANDS data suggests a 64 percent decline in CSA between 1990 and 2014 (Finkelhor, Saito, & Jones, 2016). The four National Incidence Studies (NIS-1, NIS-2, NIS-3, NIS-4), which survey mandated professionals, similarly suggest that CSA has declined since the early 1990s. For example, NIS-3 estimated a 1993 rate of 4.5 per 1,000 children. NIS-4, which is the most recent study, estimated a rate of 2.4 per 1,000 children (Sedlak et al., 2010). These trends are discussed further in Chapter 11.

As noted previously, official statistics, such as those published by NCANDS, are difficult to interpret because most child maltreatment never comes to the attention of CPS. Underreporting of CSA, in particular, is problematic given that many incidents are not disclosed to professionals, friends, or family members (London, Bruck, Wright, & Ceci, 2008). Indeed, surveys asking adults about childhood histories of CSA reveal that a large percentage of adults report never having disclosed their abuse (Lyon & Ahern, 2011). In one study as many as 74 percent of women and 78 percent of men did not disclose the abuse during childhood (Laumann, Gagnon, Michael, & Michaels, 1994). Another limitation of the NCANDS data is that only cases of CSA perpetrated by parents or caregivers are included. It seems clear that whatever estimates are used, they are likely underestimates of the true incidence and prevalence of CSA (Berliner, 2011).

Compared with official statistics, self-report surveys have the potential to present a clearer picture of the true rate of victimization. As discussed in Chapter 2, however, such surveys are not without their problems. Some men and women who were victimized as children may be reluctant to report their childhood experiences as adults. Adult reports might also be biased by retrospective recall. Retrospective studies of adults are also limited because they provide rates of CSA that apply to the past and do not reflect current trends (Jud, Fegert, & Finkelhor, 2016). Even more important, measurement requires definition and operationalization of the ambiguous term *sexual abuse* and definitions of this term vary widely across studies.

Despite these difficult hurdles, after nearly three decades of research examining the occurrence of CSA in the general population, consistent prevalence estimates have emerged in studies examining populations in both the United States and worldwide. In a national random sample of 1,000 U.S. adults who participated in a telephone survey sponsored by the Gallup Organization, Finkelhor, Moore, Hamby, and Straus (1997) asked respondents two questions about their own childhood experiences of sexual abuse. Overall, 23 percent of the respondents reported having been touched in a sexual way or forced to have sex before the age of 18 by a family member or by someone outside the family. The women in this survey sample were nearly 3 times as likely as the men to self-report CSA. These results are similar to those found in the most representative and methodologically sound self-report surveys in the literature, which indicate that at least 20 percent of women and between 5 percent and 10 percent of men in North America experienced some form of sexual abuse as children (Finkelhor, 1994). Studies examining the amount of CSA abuse in countries outside the United States have corroborated these findings by finding similar rates (e.g., Barth, Bermetz, Heim, Trelle, & Tonia, 2013; Gilbert, Widom et al., 2009). In a meta-analysis of the prevalence of child sexual abuse in 22 countries, approximately 8 percent of men and 20 percent of women suffered some form of sexual abuse prior to the age of 18 (Pereda, Guilera, Forns, & Gómez-Benito, 2009). Using a more narrow definition of CSA, Barth and colleagues (2013) conducted a meta-analysis of 55 studies from 24 countries examining children and adolescents and found that about 9 percent of girls and 3 percent of boys were victims of forced intercourse.

Risk Factors Associated With Child Sexual Abuse

In attempting to understand why CSA occurs, many experts in the field adhere to an ecological perspective that attempts to explain CSA using a framework that considers the person and his or her environment and focuses on multiple levels of the ecology including the individual, family, community, and society (Lanier, Maguire-Jack, Mienko, & Panlilio, 2015; Miller-Perrin & Wurtele, 2017b). Using this approach, various risk factors associated with CSA can be identified including those that are characteristic of victims, perpetrators, and the social environments, including families and society, in which they reside. Table 4.1 displays the risk factors associated with each of these systems, and this section of the chapter concludes by describing contemporary theories that attempt to integrate these various risk factors to help explain why CSA occurs. Keep in mind, however, that CSA victims and perpetrators are a homogeneous group and therefore no one risk factor, or group of risk factors, applies to all.

Characteristics of Children Who Are Sexually Abused

Accurately identifying risk factors for CSA victimization is difficult, because as noted above, much of the victim population is unidentified due to nondisclosure of abuse.

Table 4.1 Risk Factors Associated With Child Sexual Abuse

System Level	Risk Factor
Child	Demographic characteristics such as female sex, early adolescent age, sexual minority status
	Disability status including cognitive, physical, and mental health
	Psychological characteristics such as low self-esteem, susceptibility to persuasion/easily manipulated, emotional immaturity, behavioral difficulties, lonely, few close friends, passivity, quietness, trustingness, emotional neediness
Perpetrator	Demographic characteristics such as male sex, adolescent or early adulthood age, someone with a relationship with the child
	Childhood history variables such as a history of child maltreatment (sexual, physical, psychological, neglect), witnessing violence, poor parent–child attachment, early sexual experience including viewing pornography
	Sexual deviances, including sexual attraction to children and/or adolescents, fantasies about sexual activity with children, high sex drive
	Presence of disinhibitors, such as alcohol and drug use/abuse and cognitive distortions
	Social deficits, including low social skills/competence, empathy deficiencies, loneliness, difficulties with intimate relationships, emotional congruence with children
	Behavioral problems/disorders including externalizing (aggression/violence, criminal behavioral, anger/hostility, paranoia/mistrust, and antisocial personality) and internalizing (anxiety, depression, low self-esteem)
	Neurobiological/psychological markers such as deficits in IQ, increased frequency of childhood head injury, abnormalities in brain anatomy
Family	Family structural characteristics such as a female child living with a nonbiological father or single parent, absence of both parents
	Conflicted family relationships such as marital discord, divorce, intimate partner violence, absent and emotionally detached parenting, poor parent–child relationships, and absence of family cohesion, warm parenting, and family support
	Parent characteristics such as maternal lack of education, maternal unemployment, substance abuse, parental history of CSA, mental health problems
Society	Social attitudes that fail to recognize or understand CSA, sanctioning male/female power and status differentials
	Sexualization of children
	Sanctioning sexual relations between adults and children through media portrayals of children

SOURCES: References are representative rather than exhaustive: American Psychological Association (APA), 2007; Averdijk, Mueller-Johnson, & Eisner, 2011; Bebbington et al., 2011; Butler, 2013; L. Cohen & Galynker, 2009; Davies & Jones, 2013; Finkelhor, Turner et al., 2013; Friedenberg et al., 2013; Friedman, Marshal, Guadamuz et al., 2011; Houtepen, Sijtsema & Bogaerts, 2016; Jack, Munn, Cheng, & Macmillan, 2006; A. Jones & Trotman Jemmott, 2009; Laaksonen et al., 2011; Lund & Vaughn-Jensen, 2012; Pérez-Fuentes et al., 2013; F. Putnam, 2003; Sedlak et al., 2010; N. Smith & Harrell, 2013; Whitaker et al., 2008; Whittle, Hamilton-Giachritsis, Beech, & Collings, 2013; Widom & Massey, 2015.

One consistent risk factor, noted in both official sources and self-report surveys, is female sex. Girls are nearly 4 times more likely than boys to be sexually abused, according to NIS-4 findings (Sedlak et al., 2010). Data from national community surveys show that sexual victimization is more common for girls, although the sex differences are less pronounced (Finkelhor, Turner et al., 2009). New research also suggests that sexual orientation is a risk factor for CSA. A recent meta-analysis conducted on 26 school-based studies in North America indicated that sexual minority adolescents were 3.8 times more likely to experience CSA than heterosexual youth, especially male sexual minority youth (Friedman, Marshal, Guadamuz et al., 2011).

Children of all ages, from infants to adolescents, are at risk of being sexually exploited. Like Sashim in the case history that opened this chapter, older children and adolescents tend to be at greater risk. The second National Survey of Children's Exposure to Violence (NatSCEV), for example, found that rates of contact sexual abuse were highest for girls aged 14 to 17 years, 23 percent of whom experienced a sexual victimization in their lifetime (Finkelhor, Turner, Shattuck, & Hamby, 2013). Many have argued that risk for sexual abuse peaks in early adolescence (Bebbington et al., 2011; Davies & Jones, 2013; Finkelhor, Turner et al., 2013).

No clear differences in rates of sexual abuse between race and ethnic groups have been identified, although Asian American children tend to have the lowest CSA rates (F. Putnam, 2003; Sedlak et al., 2010). Low SES does not appear to be an important risk factor for CSA (Sedlak et al., 2010). In contrast, there is some evidence that children with cognitive or physical vulnerabilities are at increased risk for CSA. Children with disabilities are 2 to 3 times more likely to be sexually abused as children without disabilities (Reiter, Bryen, & Shachar, 2007; N. Smith & Harrell, 2013), and the risk is higher for children with certain types of disabilities such as cognitive and mental health disabilities rather than physical disabilities (Friedenberg et al., 2013; Lund & Vaughn-Jensen, 2012). (See Chapter 10 for a discussion of abuse in adults with disabilities.)

Some researchers have also examined various socioemotional characteristics of victims that increase their vulnerability to CSA. Low self-esteem, susceptibility to persuasion, behavior difficulties, and emotional immaturity are all victim characteristics associated with CSA (Dombrowski, LeMasney, Ahia, & Dickson, 2004; Olson, Daggs, Ellevold, & Rogers, 2007; Whittle, Hamilton-Giachritsis, Beech, & Collings, 2013). Studies with CSA offenders reveal other characteristics of victims for which offenders report a preference such as quiet, withdrawn, lonely, passive, easily manipulated children and those with low self-esteem, few close friends, and who are emotionally needy (Budin & Johnson, 1989; Conte, Wolf, & Smith, 1989; M. Elliott, Browne, & Kilcoyne, 1995; C. Johnson, 2004).

Characteristics of Individuals Who Sexually Abuse Children

Many people have the impression that CSA perpetrators are frightening strangers or "dirty old men." Research findings concerning the demographic and psychological characteristics of CSA perpetrators, however, suggest that these stereotypes are rarely accurate.

Demographic Characteristics

Data from NIS-4 suggest a relatively equal distribution of offenders across age groups for offenders 26 years old or older (Sedlak et al., 2010). Although official statistics show that CSA offenders vary widely in age, clinical and community studies suggest that there seem to be two distinct age periods for the onset of CSA offending: one during adolescence and one during early adulthood. Studies show, for example, that most male offenders come to the attention of authorities when they are in their mid-thirties (Smallbone, Marshall, & Wortley, 2008) and the average age of female sex offenders is between 26 and 36 years (Strickland, 2008; Wijkman, Bijleveld, & Hendriks, 2010). In McLeod's (2015) large sample of sexual offenders reported to child protective services, the mean ages of both male and female perpetrators were quite similar (33 years of age), although male offenders began at earlier ages and continued for a longer duration. Indeed, many sex offenders report that their sexual offending actually began while they were teenagers (Seto, 2008). Consistent estimates suggest that adolescents are responsible for approximately 40 percent of all sex offenses against children, with most of those adolescents being boys around 14 years of age (Saunders, Kilpatrick, Hanson, Resnick, & Walker, 1999; Veneziano & Veneziano, 2002). Children are also sometimes sexually abusive toward younger children, as is sometimes the case in sibling abuse (Jones, Bellis et al., 2012).

The overwhelming majority of CSA perpetrators are male. This sex discrepancy has been noted across multiple studies using a variety of samples and methodologies. Data from the 2000 National Incident-Based Reporting System indicate that of those sex offenses reported, approximately 96 percent included male offenders and 4 percent female offenders (McCloskey & Raphael, 2005). Perpetrator–victim sex differences varied depending on whether the offense was **pedophilia** (adult-to-child) or **hebephilia** (adult-to-adolescent). Male perpetrators offended against child victims nearly one-fourth of the time and chose female victims in approximately 90 percent of cases. Male perpetrators offended against adolescent victims in approximately 40 percent of cases and likewise chose female victims. In contrast, females offended against child victims in about 40 percent of cases and adolescent victims in 45 percent of cases, choosing male victims as often as female victims.

It may be that sexual abuse committed by females is more common than once believed. Kestin and Williams (2010), for example, reported that 20 percent of the student–teacher sexual misconduct cases in south Florida were women. In juvenile correctional facilities, approximately 95 percent of youth who reported being sexually abused by staff identified female correctional staff as the perpetrators, despite the fact that females made up only 42 percent of facility staff (Beck, Harrison, & Guerino, 2010). Indeed, a recent study conducted by McLeod (2015) reported that 21 percent of all substantiated child sexual abuse cases reported to U.S. child protective services in 2010 were perpetrated by females, particularly parents and adoptive parents. These findings suggest that perpetrator sex may vary depending on the relationship the perpetrator has to the victim and also support the assertion that women in caregiving roles do commit sexual offenses involving young children.

There are a variety of reasons to explain why female perpetration of CSA may be underreported. Because of culturally prescribed definitions of CSA, many Americans may fail to recognize women as potential offenders. As Boroughs (2004) aptly puts it, "it is difficult to understand how a woman is physically capable of sexually abusing a child in the traditional concept of rape without a genital organ for penetration" (p. 484). Abuse by females may also go unnoticed because inappropriate sexual contact may occur in the context of culturally approved routine child care (e.g., bathing, dressing, sleeping with children). In addition, some have suggested that there may be more shame associated with disclosing CSA by a female, especially a mother figure (Tsopelas, Spyridoula, & Athanasios, 2011). Even when such contact comes to light, there may be a tendency to minimize the behavior and label it as *inappropriate affection* (Turton, 2010). This minimization is illustrated in one of the most well-publicized cases of female-perpetrated sexual abuse in which Mary Kay LeTourneau began having sex with one of her sixth-grade male students. The relationship was discovered when LeTourneau discovered she was pregnant with the boy's child. LeTourneau pled guilty to second-degree child rape but the judge suspended all but 6 months of her 7.5-year sentence and not even the boy's mother was pushing for prison time. Indeed, the general public views sexual abuse by women as both less harmful and less serious (Tsopelas, Tsetsou, Ntounas, & Douzenis, 2012).

Relationship to the Abused Child

There is some debate in the literature as to whether CSA is more common within or outside the family. Approximately 60 percent of sexual abuse reported to authorities is committed by either a biological or nonbiological parent/partner (Sedlak et al., 2010). However, self-report victimization surveys generally find that sexual victimization is more likely to occur outside the family (Finkelhor, Ormrod, & Turner, 2009). Although growing evidence suggests that extrafamilial CSA is more common than intrafamilial abuse, it is important to remember that the perpetrator of either form of abuse is a person familiar to the child in the majority of cases. Indeed, only about 10 percent of CSA victims do not know their offender (Finkelhor & Ormrod, 2001; Richards, 2011).

Mental Health and Psychological Deficits

Researchers have identified various mental health problems and psychological deficits that characterize some CSA offenders and increase risk of offending. Some evidence suggests that CSA perpetrators seek out sexual encounters with children primarily because they are sexually attracted to children (Houtepen, Sijtsema, & Bogaerts, 2016; Ward & Beech, 2006). Psychologists define such sexual attraction as a mental disorder called pedophilia, where the individual has "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children" (American Psychiatric Association, 2013, p. 697). Some evidence suggests that CSA offenders are not only sexually attracted to children

but also have an emotional attachment with children, sometimes called emotional congruence, who meet their needs for intimacy (Houtepen et al., 2016). The origins of such deviant sexual arousal or emotional congruence with children, however, are undetermined. Some researchers have suggested that biological factors may be a cause of deviate sexual arousal, such as abnormally high levels of male hormones such as testosterone (Ward & Beech, 2006). We know, for example, that measures of sex drive and hypersexuality predict deviant sexual interests in general (Dawson, Bannerman, & Lalumière, 2016) and that many CSA offenders, in particular, have higher sex drives, which might lead to their acting on their sexual attraction toward children (Whitaker et al., 2008). Others suggest that deviant sexual arousal is learned, when offenders have early sexual experiences (e.g., masturbation, playing "doctor" with other children, viewing pornography) that later become sexual fantasies and therefore deviant sexual arousal becomes conditioned through the pairing of deviate sexual fantasies with masturbation and orgasm (e.g., Houtepen et al., 2016).

Because not all individuals who are sexually aroused by children act on their feelings, researchers have hypothesized that other factors, usually referred to as **disinhibitors**, must be operating. Alcohol, for example, is a disinhibitor. **Cognitive distortions** may also be disinhibitors. For example, perpetrators may rationalize and defend their behavior through distorted ideas or thoughts, such as "Having sex with children is a good way to teach them about sex" or "Children need to be liberated from the sexually repressive bonds of society." Indeed, the infamous Penn State football coach convicted of sexually abusing dozens of children, Jerry Sandusky, described his behavior as "horsing around" with the boys in the shower (NBC's Rock Center with Bob Costas, 2011). Research evidence indicates the presence of both substance abuse and cognitive distortions in CSA perpetrators (L. Cohen & Galynker, 2009; Whitaker et al., 2008).

CSA offenders also exhibit other psychological characteristics such as externalizing (e.g., aggression and violence, criminal behavior, anger/hostility, substance abuse, paranoia/mistrust, and antisocial personality disorder) as well as internalizing behaviors (e.g., anxiety, depression, low self-esteem, and external locus of control) (Whitaker et al., 2008). They are also more likely to exhibit various social deficits such as low social skills/competence, empathy deficits, loneliness, and difficulties in intimate relationships (Whitaker et al., 2008). Other research has identified various neuropsychological and neurobiological deficits associated with CSA perpetration such as lower mean IQ, increased frequency of childhood head injury, and abnormalities in brain anatomy (Blanchard et al., 2003; Cantor, Blanchard, Robichaud, & Christensen, 2005; Schiffer et al., 2007).

Modus Operandi of Offenders

There have been several studies, predominantly with CSA perpetrators, that attempt to understand the **modus operandi**, or method of operation, of offenders (for a review, see Clemente, 2013). We know that CSA offenders use specific tactics both to recruit victims as well as to maintain their compliance. Although only a handful of studies

have been undertaken in this area, their credibility is increased by the fact that some child victims' accounts closely resemble those provided by perpetrators (see Berliner & Conte, 1990).

As noted above, perpetrators typically select children who are vulnerable or needy in some way. Once a perpetrator has identified a target child, he or she typically engages in a process referred to as **grooming**, whereby the offender employs a series of strategies aimed at gaining the child's trust and compliance, developing a "special" relationship with the child, and gradually crossing sexual boundaries by progressing from nonsexual to sexual touch (Lanning, 2010; Leclerc, Proulx, & McKibben, 2005). As noted in the opening case study, Bhagwan showered Sashim with the attention she had been longing for by taking her to movies, buying her new clothes, and listening to her when she complained about difficulties at school. Their interactions then moved to increasingly more physical contact.

In order to build trust and establish a relationship with their victims, perpetrators attempt to provide both emotional and tangible things to their victims in an attempt to fulfill their unmet needs. They do this by providing attention, recognition, affection, kindness, romance, gifts, money, trips, jewelry, clothing, drugs, alcohol, tobacco, or special privileges (e.g., getting to drive a vehicle without a license). A consistent tactic is to make the victim feel exceptionally special. Victims comply with the demands of the offender because "they have finally found someone . . . who treats them well or tells them they are special" (Clemente, 2013, p. 7). Offenders also break down sexual boundaries that usually exist between adults and children by lowering inhibitions, being overly physical and playful, talking about or encouraging masturbation and/or sex, giving sexual instructions, or supplying pornography.

The grooming process not only involves victims but also their parents or other adults in the community. According to McAlinden (2006), grooming of the parents or organization has a dual purpose—first, to secure the trust and thus cooperation of adults in gaining access to the child; and second, to reduce the likelihood of discovery by appearing to be "above reproach." Jerry Sandusky successfully groomed "child care experts, psychologists, professionals, celebrities, athletes, coaches, friends and family," all of whom believed him to be "a pillar of the community" (Clemente, 2013, pp. 3–4).

Youth may also be vulnerable to **online grooming**, when children are sexually exploited over the Internet (see Box 4.2), where the presumed anonymity of the perpetrator and victim contributes to abuse. Online grooming is similar to offline strategies in that the goal is to establish a relationship by making the youth feel "special." Offenders are often successful at this by promising love or romance, or by offering a sympathetic "ear" to the teen's concerns (e.g., sexual orientation) or frustrations (e.g., school problems, parent conflict) (Katz, 2013). Once rapport is established, the offender might escalate the sexualization process just as he or she would in face-to-face situations. Another potential way to form a relationship with a child or adolescent is through **sexting**, discussed further in Chapter 7, which involves sending sexually explicit messages and/or photographs electronically either via text messaging or by posting photographs on the Internet (Hasinoff, 2016).

Studies also shed light on the strategies that perpetrators use to keep children engaged in sexual activities for prolonged periods. Central to a perpetrator's ability to continue sexual activities with a child is the perpetrator's ability to convince the child that the activities should be kept secret so that other adults cannot intervene to terminate the abuse. The victim might be just as motivated to keep the relationship a secret as the perpetrator, if the victim perceives that he or she has done something "wrong." As noted previously, the majority of CSA victims do not disclose their abuse immediately, and a significant number of victims do not disclose their abuse for years (Goodyear-Brown, Fath, & Myers, 2012; London, Bruck, Wright, & Ceci, 2008).

Box 4.2 Exploitation Over the Internet

Sexual exploitation of children can also occur as a result of Internet interactions, a form of exploitation described in the research literature in recent years as **cyberexploitation** or online crimes against children. Researchers examining this issue have described the variety of ways in which children who use the Internet may be at risk (Kreston, 2002; Malesky, 2005; Mitchell, Finkelhor, & Wolak, 2003; Wurtele & Miller-Perrin, 2014). First, children and adolescents may be propositioned online for sexual activity. Such propositions may be explicit proposals, or perpetrators may take a more indirect approach, using an online version of the grooming process just described to establish and maintain contact with children. Some children may provide their names, addresses, and telephone numbers to individuals they correspond with online and may even agree to meet with them. Second, children may be exposed to various forms of sexually explicit material on the Internet via links that come up when they use search engines, through their own misspelling of web addresses, or through unsolicited e-mails and pop-up ads. Third, children may experience online **sexual harassment**. This can include a variety of behaviors, such as "threatening or offensive behavior targeting the child or sharing information or pictures online about the targeted child" (Kreston, 2002, p. 13). The risks of these activities are promulgated by a number of different Internet facets including newsgroups, e-mail, websites, and chat rooms.

Researchers at the Crimes Against Children Research Center conducted three administrations of the **Youth Internet Safety Survey (YISS)** in an attempt to determine the magnitude of online exploitation of children (Finkelhor, Mitchell, & Wolak, 2000, 2005; Priebe, Mitchell, & Finkelhor, 2013). The YIIS-1 was administered to a national U.S. sample of 1,501 children and adolescents aged 10 to 17 years in the year 2000 (Finkelhor et al., 2000). The respondents were asked about their experiences online with unwanted sexual solicitation, exposure to pornography, and harassment within the past year. Of the children in this sample, 1 in 5 reported having experienced an unwanted sexual solicitation (e.g., received an online request to engage in sexual activities or sexual talk or to give personal sexual information to an adult), 1 in 4 had experienced unwanted exposure to sexual material, and 1 in 17 had been threatened or harassed. Adolescents in the sample (aged 14 to 17 years) were more likely than younger children to have had these experiences online. Subsequent administrations of the survey in 2005 and 2010 showed decreases in both online sexual solicitation and pornography viewing, but slight increases in harassment (Priebe et al., 2013; Wolak, Mitchell, & Finkelhor, 2006).

Even fewer youth have face-to-face meetings with unknown online "friends." According to a survey of adolescents conducted by the Adolescent Risk Communication Institute of the Annenberg Public Policy Center, few social network users (3%) reported actually meeting strangers offline. Only 2 percent of teens in YISS-1 reported online "romances" (defined as someone met online who the youth believed to be a boyfriend or girlfriend [Wolak, Mitchell, & Finkelhor, 2003]. Although the findings from these surveys suggest that children are at risk for this form of exploitation, such victimization constitutes a small proportion of the sexual abuse, exploitation, and other crimes to which children are vulnerable. In addition, the results of these surveys suggest that most of the solicitations made online by potential CSA perpetrators fail; they do not result in offline sexual assault or illegal sexual contact.

Scholars have proposed several approaches to combating the problem of Internet exploitation of youth. A first step is to educate youth, parents, and professionals who work with youth and families about the potential dangers of the Internet and how they can protect against this form of exploitation. Parents need to be educated, for example, about ways in which they can limit their child's Internet access (e.g., browser access controls, software filters). An additional approach is for families to place any computers with Internet access in family living areas rather than in private rooms and for parents to instruct their children not to enter Internet chat rooms without parental permission (Kreston, 2002; Wurtele & Miller-Perrin, 2014). Legislation has also been enacted to address this form of exploitation. The United States has established an $11 million federal program that includes Internet Crimes Against Children task forces, which were developed to assist state and local law enforcement agencies in conducting undercover investigations, provide technical assistance and training, and develop prevention and education materials (Wortley & Smallbone, 2012). Additional efforts are necessary to ensure that federal and state child abuse statutes, most of which were written prior to the development of the Internet, apply to illegal behaviors carried out online.

Family and Cultural Risk Factors

It is not only important to examine individual victim and perpetrator characteristics in identifying CSA risk factors, but it is also important to examine other systems and contexts in which the individuals reside. Some of this research has focused on family characteristics while other research has focused on the broad context of societal and community forces, such as societal attitudes, that may play roles in the etiology of CSA.

Family Characteristics

Family life that is characterized by violence, dysfunction, and instability serves as a risk factor for CSA, and this is true for both the families of victims as well as perpetrators. The families of CSA victims, for example, are often characterized by marital discord and divorce, intimate partner violence, and absence of family cohesion and support, as we saw in the case study of Sashim's family (e.g., Butler, 2013; Laaksonen et al., 2011; Pérez-Fuentes et al., 2013; Stith et al., 2009). Parental substance abuse, maternal unemployment and educational deficits, parental history of sexual abuse, and parental

mental health problems are also risk factors (e.g., L. Berger, Slack, Waldfogel, & Bruch, 2010; Butler, 2013; Perez-Fuentes et al., 2013). Finally, the fact that CSA victims are more likely to live with a stepfather, foster father, adoptive father, or single parent are also risk factors (Butler, 2013; Olafson, 2011; F. Putnam, 2003). The exact mechanisms through which these risk factors operate are unknown but appear to contribute to a chaotic, violent, unsupportive environment that might make it difficult to protect a child from CSA.

There is considerable research on the specific role of parenting in predicting CSA. Parent–child bonds that are strong and secure are more likely to produce healthy relationships in adult life. When the bond is insecure, on the other hand, children expect to be ignored or rejected in their relationships and this expectation extends into adulthood (Sawle & Kear-Colwell, 2001; Waters, Hamilton, & Weinfield, 2000). As discussed in Chapter 2, we also know that a weak bond with family reduces the potential cost of deviant behavior. Anything that weakens the bond between parent and child, therefore, is a risk factor. Parenting in the families of child victims, for example, is characterized by absent and emotionally detached parenting, poor parent–child relationships, and the absence of warm parenting (Averdijk et al., 2011; Butler, 2013; Jack, Munn, Cheng, & MacMillan, 2006).

Parenting within the families of individuals who become perpetrators of CSA has also been examined as a risk factor. Several studies have reported a greater likelihood of insecure childhood and adult **attachment styles** in CSA perpetrators (e.g., Marshall & Marshall, 2010; W. Marshall, 2010). Theories about why disrupted parent–child attachments might lead to CSA perpetration focus on the deficits in empathy and difficulties with intimacy that we noted above. These theories suggest that insecurely attached individuals have deficits in empathy that limit their ability to see the negative consequences of their actions for others and are also more likely to fulfill their intimacy needs through inappropriate relationships (Seto & Lalumiere, 2010; Simons, Wurtele, & Durham, 2008).

Perhaps the most widely researched family risk factor for perpetration of CSA is a childhood history of abuse. As discussed in Chapter 2, the research on intergenerational transmission is not always definitive. Certainly, there is research that suggests that sexual offenders are indeed more likely to have been sexually victimized as children when compared either to the general population (Babchishin, Hanson, & Hermann, 2011) or other types of offenders (Jesperson, Lalumiere, & Seto, 2009; Nunes, Hermann, Malcolm, & Lavoie, 2013). In addition, the other forms of child maltreatment discussed in this book are also risk factors (e.g., Laaksonen et al., 2011). One problem with this research, especially the research on sexual victimization as a child, is that most of these studies have been conducted with special populations of male offenders who are either incarcerated or in treatment and may be motivated to exaggerate claims of childhood victimization (Richards, 2011). Indeed, data from the ongoing prospective longitudinal study conducted by Widom and Massey (2015) suggested that a history of childhood physical abuse and neglect increased the risk for being arrested for a sex crime but, interestingly, a history of CSA did not predict arrest for sex crimes.

Societal Attitudes

Societal attitudes, such as a lack of understanding and acknowledgment of CSA, represent another risk factor that contributes to a climate where CSA can occur. A study by the organization Stop It Now! (2010) found that fewer than half of adults (44%) from a large U.S. sample (N = 5,241) reported that CSA was a major problem in their community. The authors of the report suggest, "We either do not recognize behaviors that should raise concerns about abuse or choose not to see them" (p. 8).

Attitudes toward sexuality and the appropriateness of sexual behaviors between adults and children have also been implicated as potential risk factors for CSA (Swenson & Chaffin, 2006). Some would argue that too often children are sexualized. According to the American Psychological Association (APA, 2007), sexualization occurs when a person is sexually objectified—made into a thing for others' sexual use, a person's value comes only from his or her sexual appeal or behavior, and a standard is applied that equates physical attractiveness with being sexy. According to its 2007 report, the APA found a growing trend of sexualizing young children through video games, television shows, movies, music videos, song lyrics, magazines, clothing styles, and toys. A 2011 study, for example, analyzed the presence of sexualizing characteristics in girls' clothing (sizes 6–14) on the websites of 15 popular stores in the United States (Goodin, Van Denburg, Murnen, & Smolak, 2011). Findings indicated that approximately 30 percent of clothing items, such as those sold by Abercrombie Kids, had sexualizing characteristics (e.g., revealing or emphasizing a sexualized body part). By the time a child reaches puberty, she or he has likely been exposed to thousands if not tens of thousands of sexualized messages, leading to the creation of what Kaeser (2011) calls "a generation of super-sexualized children." Sexualized images are sending clear messages to people who have sexual interests in children "that contrary to laws and ethical norms, children are sexually available" (Egan & Hawkes, 2008, p. 295). To sexualize children also implicitly suggests to adults that children are interested in and ready for sex, and may lead children and adults to believe that sexual activity with children is acceptable.

Integrative Theories Explaining CSA

Until relatively recently, most models and theories attempting to explain the behavior of CSA perpetrators focused on only one possible characteristic (e.g., deviant sexual arousal or a childhood history of abuse). Contemporary theories, however, attempt to explain sexually abusive behavior by focusing on the integration of multiple contributing factors. Covell and Scalora (2002), for example, have developed a model of sociocognitive deficiencies in sexual offenders that contribute to sexually assaultive behavior. According to this model, deficits in a variety of abilities—including social skills, interpersonal intimacy, and cognitive processes—may have an impact on the development and expression of appropriate empathy and may lead to sexually assaultive behavior. W. Marshall and Marshall (2000) have proposed a comprehensive etiological model of sexual offending that incorporates multiple components, including biological, social, and attachment processes. According to their theory, the early

developmental environment of a sexual offender includes several stressful events such as poor attachment between parent and child, low self-esteem, limited coping abilities, low-quality relationships with others, and a history of sexual abuse. The presence of such stressors leads the child to rely on sexualized coping methods, including masturbation and sexual acts with others, as a way to avoid current stressors. Eventually, the individual is conditioned to rely on sexualized coping mechanisms and, when other factors are present (e.g., access to a victim, disinhibition owing to alcohol use), is predisposed to engage in sexually abusive behavior.

Perhaps the most comprehensive integrative theory to date is the integrated theory of sexual offending (ITSO) proposed by Ward and Beech (2006). ITSO incorporates several single-factor theories including biological factors (e.g., brain development, genetics), neuropsychological factors (e.g., motivations, perceptions, and memory), and ecological factors (e.g., social, cultural, and personal circumstances) that continuously interact in a dynamic way. These multiple factors interact to both produce sexual offending behavior as well as the clinical problems observed in offenders (e.g., deviant sexual arousal, distorted cognitions, and social difficulties). According to ITSO, an individual's level of psychological functioning is determined by the confluence of biological and neuropsychological factors as well as ecological experiences. When early brain development and/or social, cultural, and personal circumstances are compromised in some way (such as through poor genetic inheritance or developmental adversity), psychological dysfunction results and leads to both clinical problems and sexually abusive behavior. The sexual offending behavior results in consequences that then affect the offender's ecological system as well as psychological functioning, which leads to maintaining and/or escalating further abusive behavior.

Consequences Associated With Child Sexual Abuse

Investigators have identified a wide range of outcomes associated with CSA including physical, emotional, behavioral, cognitive, and interpersonal problems. Table 4.2 displays the most common outcomes observed in child and adult victims of CSA. We discuss some of the more severe and pervasive effects, as well as protective factors, below.

The Negative Effects of Child Sexual Abuse

One of the most common symptoms identified in sexually abused children is sexualized behavior (Kendall-Tackett, Williams, & Finkelhor, 1993). **Sexualized behavior** refers to overt sexual acting out toward adults or other children, compulsive masturbation, excessive sexual curiosity, sexual promiscuity, and precocious sexual play and knowledge. Sexually abused children demonstrate significantly more of such symptoms compared with physically abused and neglected children as well as psychiatrically disturbed children (Friedrich, Jaworski, Huxsahl, & Bengtson, 1997; Kendall-Tackett et al., 1993). The sexual behaviors of sexually abused children are often associated with intercourse, such as mimicking intercourse and inserting

Table 4.2 Common Effects Associated With Child Sexual Abuse in Children, Youth, and Adults

Children and Youth	Physical	Emotional	Behavioral	Cognitive	Interpersonal	Psychiatric Disorders
	Adolescent pregnancy	Anger Depression Anxiety Low self-esteem	Sexual behavior problems Aggression Self-harm Running away Substance abuse	Negative self-attributions Dissociation Suicidal thoughts Academic problems Cognitive distortions	Relationship problems	ADHD PTSD Eating disorders Major depressive disorder Substance use disorders
Adults	**Physical**	**Emotional**	**Behavioral**	**Cognitive**	**Interpersonal**	**Psychiatric Disorders**
	Chronic pain Gastrointestinal disorders Obesity Sleep disturbance Seizures Gynecologic disorders Somatization	Anxiety Depression Anger/ irritability Poor self-esteem	Substance abuse Suicidal behavior Self-harm Sexual dysfunction Risky sexual behavior	Cognitive distortions Suicidal ideation Negative self-attributions Dissociation	Relationship distress Sexual revictimization Partner violence	PTSD Borderline personality disorder Major depressive disorder Dysthymia Substance use disorders

SOURCES: References are representative rather than exhaustive: Bensley, Eenwyk, & Simmons, 2000; Chartier, Walker, & Naimark, 2007; Deblinger, Mannarino, Cohen, & Steer, 2006; Fergusson, McLeod, & Horwood (2013); Finkelhor, 2008; Friedrich, 2007; Goodyear-Brown, Fath, & Myers, 2012; Heneghan et al., 2013; Klonsky & Moyer, 2008; Noll, Shenk, & Putnam, 2013; Noll, Shenk, Yeh et al., 2010; Olafson, 2011; Sachs-Ericsson et al., 2010; Trickett, Negriff, Ji, & Peckins, 2011; Trickett, Noll, & Putnam, 2011; Yancey & Hansen, 2010.

objects into the vagina or anus (Chaffin, 2008; Friedrich, 2007). Sexualized behavior is also believed to be the behavioral symptom that is most predictive of the occurrence of sexual abuse, although only approximately one-third of victims exhibit this symptom (Friedrich, 1993).

Another frequently observed outcome in children is post-traumatic stress disorder *(PTSD)* and PTSD-related symptoms. PTSD symptoms include nightmares, fears, feelings of isolation, inability to enjoy usual activities, somatic complaints,

autonomic arousal (e.g., heightened startle response), and guilt feelings. Sexually abused children consistently report higher levels of PTSD symptoms relative to comparison children and are more likely to receive a diagnosis of PTSD than are other maltreated children (e.g., Finkelhor, 2008; Kearney, Wechsler, Kaur, & Lemos-Miller, 2010). Some sexually abused children also receive multiple diagnoses that include depression and other anxiety disorders (Deblinger, Mannarino, Cohen, & Steer, 2006).

The most common problems observed in adult victims of CSA are depression, anxiety, and PTSD (Goodyear-Brown et al., 2012; Sachs-Ericsson et al., 2010; Spataro, Mullen, Burgess, Wells, & Moss, 2004). Additional effects include problems with interpersonal relationships (e.g., Trickett, Negriff, Ji, & Peckins, 2011), difficulties with sexual adjustment (Bartoi & Kinder, 1998; Bensley, Eenwyk, & Simmons, 2000), impaired social and occupational functioning (Zielinski, 2009), physical or health problems (e.g., chronic pain and obesity; see Chartier, Walker, & Naimark, 2007; Kendall-Tackett, 2003; Meagher, 2004), and behavioral dysfunction such as substance abuse, eating disorders, and self-mutilation (e.g., Klonsky & Moyer, 2008; Smolak & Murnen, 2002; Yates, Carlson, & Egeland, 2008).

Risk and Protective Factors Associated With CSA Effects

No single symptom or pattern of symptoms is present in all victims of CSA. Many CSA victims exhibit no symptoms at all, at least in the short term (McClure, Chavez, Agars, Peacock, & Matosian, 2008; Yancey, Hansen, & Naufel, 2011). Why is it that some victims are severely affected, others are moderately affected, and still others are relatively unscathed by their experience of CSA?

This is a very difficult question to answer empirically. Definitions vary dramatically across studies, nonrepresentative clinical samples are common, and often the studies have failed to include comparison groups. Many CSA victims have experienced other childhood traumas or adverse life events (Finkelhor, Ormrod, & Turner, 2009) that could explain negative outcomes equally well. Or perhaps the outcomes vary depending on the relationship between the victim and the perpetrator (e.g., a father vs. a stranger) or the type of reaction the child receives following disclosure (e.g., disbelief vs. support).

Studies conducted within the past 15 years using larger numbers of participants, multiple measures, comparison groups, and longitudinal designs have contributed greatly to what we do know. Researchers attempting to understand the effects associated with CSA have explored associations between preabuse characteristics of the sexually abused child and his or her situation or its aftermath and differential psychological effects. Table 4.3 lists the most influential variables that impact CSA outcomes and the direction of their impact on those outcomes.

The most important *preabuse characteristics* include a history of prior traumatic experiences and a history of prior psychological problems (Berliner, 2011). Dysfunctional family environments, such as those that include parental psychopathology, illness, and domestic violence, also contribute to greater negative outcomes (Fitzgerald et al., 2008; K. Putnam, Harris, & Putnam, 2013).

Table 4.3 Mediators of the Effects of Child Sexual Abuse

Potential Mediators	Influence on Child Sexual Abuse Outcomes
Preabuse Characteristics	
Prior traumatic experiences	A history of experiencing prior traumatic events is associated with greater negative outcomes.
History of psychological problems	A prior history of psychological problems, such as anxiety, is associated with greater negative outcomes.
Dysfunctional family environment	The presence of certain family characteristics such as parental psychopathology, illness, and domestic violence is associated with a greater negative effect.
Abuse Characteristics	
Type of sexual activity	More severe forms of sexual activity (e.g., penetration) are associated with a greater negative effect.
Child–perpetrator relationship	A greater negative effect is associated with fathers, father figures, and intense emotional relationships.
Force or physical injury	Presence of force or physical injury is associated with a greater negative effect.
Multiple traumatic events	Different combinations of child maltreatment are associated with a greater negative effect as are multiple episodes of abuse.
Postabuse Characteristics	
Response toward the victim	Negative responses toward victims' disclosures of abuse are associated with a greater negative effect.
Available social support	Increased social support is associated with a less severe effect.

SOURCES: References are representative rather than exhaustive: Berliner, 2011; Copeland, Keeler, Angold, & Costello, 2007; Fergusson, McLeod, & Horwood, 2013; J. Ford, Elhai, Connor, & Freuh, 2010; Gilbert, Widom et al., 2009; Higgins & McCabe, 2000; Ippen, Harris, Van Horn, & Lieberman, 2011; Kilpatrick et al., 2003; Macdonald, Danielson, Resnick, Saunders, & Kilpatrick, 2010; K. Putnam, Harris, & Putnam, 2013; Ruggiero, McLeer, & Dixon, 2000; Trickett, Noll, & Putnam, 2011; Tyler, 2002; Vranceanu, Hobfoll, & Johnson, 2007.

CSA *situations* are also associated with severity of symptoms. Perhaps the most consistent finding is that threats, force, and violence by the perpetrator are linked with increased negative outcome (Ruggiero, McLeer, & Dixon, 2000; K. Tyler, 2002). Studies have also demonstrated, not surprisingly, that the least serious forms of sexual contact (e.g., unwanted kissing or touching of clothed body parts) are associated with less trauma than are more serious forms of genital contact (Fergusson, McLeod, & Horwood, 2013; Gilbert, Widom et al., 2009). Most studies indicate that when abuse is perpetrated by a father, father figure, or other individual who has an intense emotional

relationship with the victim, the consequences are particularly severe (Trickett, Noll, & Putnam, 2011). In addition, when victims are exposed to multiple episodes of abuse or traumatic events (e.g., polyvictimization), they exhibit increased symptoms (J. Ford, Elhai, Connor, & Frueh, 2010; Ippen, Harris, Van Horn, & Lieberman, 2011).

Research has also found that specific *postabuse events* (e.g., the ways in which family members and institutions respond to disclosure) are related to the effects of CSA. In the opening case study, for example, we saw that Sashim's mother was not supportive upon hearing her daughter's disclosure; she disbelieved Sashim and actually pressured her to recant her story. Recantations are more likely when children are abused by a member of their household and when the nonperpetrating parent expresses disbelief of the allegation (Malloy, Lyon, & Quas, 2007). Studies have consistently found that negative responses tend to aggravate victims' experience of trauma (e.g., Bernard-Bonnin, Herbert, Daignault, & Allard-Dansereau, 2008; Easton, 2013). In contrast, strong social supports, such as maternal support or a supportive relationship with another adult, appear to mitigate negative effects and play a protective role (e.g., Godbout, Briere, Sabourin, & Lussier, 2014; Kouyoumdjian, Perry, & Hansen, 2005).

Intervention and Prevention of Child Sexual Abuse

Throughout this chapter, we have described what is known about CSA in an attempt to explore the relevant issues thoroughly. Improved understanding about CSA has contributed to the establishment of a number of treatment and prevention efforts aimed at addressing the sexual abuse of children. The discussion here focuses on formal programs and strategies; personal responses to address the problem are included in Chapter 11.

Treatment for Children and Adults

Treatment programs must take into account that victims of CSA are diverse in their preabuse histories, the nature of their abuse experiences, and the social supports and coping resources available to them. CSA perpetrators are equally heterogeneous. As a result, treatment programs need to be able to tailor the services they offer to meet the particular needs of each individual client. No single treatment plan will be effective for all victims or all families, or all perpetrators. A comprehensive review of CSA treatment interventions is beyond the scope of this chapter, and we therefore focus on just a few significant interventions in the sections that follow.

Interventions for Children and Nonoffending Parents

There are many treatment approaches that have been developed specifically for child victims of CSA including both individual and group therapies. For further reading we recommend the *Handbook of Child Sexual Abuse: Identification, Assessment, and Treatment*

(Goodyear-Brown, 2012). The most well-supported treatment approach for the problems experienced by CSA victims is trauma-focused cognitive behavioral therapy (TF-CBT) (Pollio, Deblinger, & Runyon, 2011; Saunders, 2012). This form of individual therapy targets a variety of the symptoms associated with sexual abuse victimization, including negative attributions, cognitive distortions, fear, anxiety, and other post-traumatic stress reactions. The treatment includes a number of components that can be remembered using the acronym PRACTICE (J. Cohen, Mannarino, & Murray, 2011; Pollio et al., 2011):

- **P**sychoeducation: Providing accurate information about the problem of sexual abuse and common reactions to this abuse.
- **P**arenting Skills: Training parents in various management techniques to help them become more effective parents.
- **R**elaxation Skills: Training and practice for children in various relaxation skills to reduce fear and anxiety and physical reactions to stress.
- **A**ffective Expression: Building various skills to help children express and manage their feelings effectively.
- **C**ognitive Coping Skills: Helping children to understand and identify the connections between thoughts, feelings, and behaviors.
- **T**rauma Narrative and Processing: Recounting the narrative about the trauma and correcting cognitive distortions.
- **I**n Vivo Mastery: Gradually exposing the child to elements of the abuse experience in order to decondition negative emotional responses to memories of the abuse.
- **C**onjoint Therapy: Sessions involving both parent and child.
- **E**nhancing Safety: Teaching safety skills to help children feel empowered and to help them protect themselves from future victimization.

Researchers who have evaluated the effectiveness of TF-CBT have found that this form of treatment is effective, particularly for reducing post-traumatic stress symptoms in children (e.g., Morina, Koerssen, & Pollet, 2016; Saunders, 2012). However, the variability of responses that children have to CSA dictates the need to additionally develop specialized treatments that complement TF-CBT. A child victim who presents problematic sexual behavior, for example, might have different treatment needs than a child with troubled social functioning (Allen, Timmer, & Urquiza, 2016; Benuto & O'Donohue, 2015). In addition, children and their families might present other problems (e.g., learning problems, marital discord, or attention-deficit/hyperactivity disorder) in addition to a history of CSA, which will need to be addressed as part of the treatment strategy. Research confirms that the best, most successful therapies are those that treat the specific needs of each individual child (Taylor & Harvey, 2010).

Nonoffending parents also have their own traumatic reactions to the abuse and need support to cope with their anger, guilt, depression, and feelings of powerlessness (Wickham & West, 2002). Providing interventions that reduce parental stress and empower parents to help their child is a critical component in the treatment of

CSA (Coohey & O'Leary, 2008). One such approach is Child-Parent Relationship Therapy (CPRT), which is an intervention that is play therapy–based and combines parental support and education with the aim of fostering a healthy parent–child relationship (Bratton, Ceballos, Landreth, & Costas, 2012; Bratton, Landreth, Kellam, & Blackard, 2006). Treatment outcome studies of CPRT suggest that it is a promising intervention that is beneficial in relieving parental stress and enhancing parental empathy in nonoffending parents (Baggerly & Bratton, 2010; Bratton, Landreth, & Lin, 2010). For further reading we recommend *Child Sexual Abuse: A Primer for Treating Children, Adolescents, and Their Nonoffending Parents* (Deblinger, Mannarino, Cohen, Runyon, & Heflin, 2015).

Interventions for Adults Sexually Abused as Children

Treatment of adult survivors likewise requires a variety of approaches, depending on the specific therapeutic needs of the victim. Some clients, for example, might need to learn effective ways to modulate emotions such as anger, anxiety, and fear (Briere, 2002). Others might be suffering from negative attributions and cognitive distortions such as guilt, shame, and stigmatization (Cahill, Llewelyn, & Pearson, 1991; Jehu, Klassen, & Gazan, 1986). Research on the effectiveness of therapy has been promising (see McDonagh et al., 2005; Taylor & Harvey, 2010). For further reading we recommend *Healing the Incest Wound: Adult Survivors in Therapy* (Courtois, 2010).

Interventions for Offenders

The most common form of treatment for adult sex offenders is multicomponent CBT (Kirsch, Fanniff, & Becker, 2011). The behavioral component focuses on altering the deviant sexual arousal patterns of CSA perpetrators. Most behavioral approaches use some form of aversive therapy that pairs an aversive outcome with sexually deviant fantasies. For example, in a technique called **masturbatory satiation**, the perpetrator is instructed to reach orgasm through masturbation as quickly as possible using *appropriate* sexual fantasies (e.g., sexual encounters between two mutually consenting adults). Once he has ejaculated, he is told to switch his fantasies to images involving children and continue to masturbate until the total masturbation time is one hour. The reasoning behind this technique is that it reinforces the appropriate fantasies through the pleasurable feelings of orgasm and diminishes the offender's inappropriate fantasies by associating them with nonpleasurable masturbation that occurs after ejaculation. Sometimes these techniques are supplemented with medical treatments such as **chemical castration**, or the administration of various drugs to reduce sex drive (L. Cohen & Galynker, 2009).

CBT can also target distorted beliefs, levels of empathy, and low self-esteem, all of which are associated with CSA perpetration (W. Marshall & Laws, 2003). Offenders can be taught, for example, how to recognize and change inaccurate beliefs that justify and maintain their deviant sexual behavior (e.g., that the perpetrator is simply teaching the victim about sex). Other therapies focus on nonsexual factors relevant to

perpetration, including social and life skills, in hopes of helping perpetrators reintegrate into the community (e.g., Kirsch et al., 2011; W. Marshall & Laws, 2003).

CBT programs also often include a relapse prevention component designed to assist perpetrators in maintaining the gains they achieved in therapy. Perpetrators are taught how to (a) identify their typical offense pattern, (b) recognize factors (e.g., intoxication) and situations (e.g., being alone with a child) associated with risk, (c) identify coping skills that reduce risk, and (d) create plans to avoid risk (W. Marshall, 1999). Many of these programs also provide long-term, community-based supervision (Miner, Marques, Day, & Nelson, 1990; Pithers & Kafka, 1990).

Whether any of these treatments is successful is hotly debated. The primary goal in working with CSA offenders and in determining treatment effectiveness has been the evaluation of **recidivism rates**. Recidivism rates (the likelihood that offenders will commit repeat offenses) are all but impossible to accurately calculate. Indeed, unless the offender is arrested, it is impossible to determine if or when he or she re-offended. Despite these difficulties, there is preliminary evidence that men who freely choose medical therapy to reduce their sex drive (e.g., chemical castration) demonstrate decreased sexual behavior and offense-supportive cognitions, and increased perceptions of control over their sexual urges (Amelung, Kuhle, Konrad, Pauls, & Beier, 2012). But, of course, the body of knowledge on treatment for sex offenders is far from conclusive. Even if a particular treatment alters a perpetrator's arousal patterns to pictures and/or stories of children, we cannot know for sure whether such changes necessarily apply to arousal patterns toward actual children. For further reading we recommend *Adult Sex Offender Management* (Lobanov-Rostovsky, National Criminal Justice Association, & United States of America, 2015).

Prevention of Child Sexual Abuse

Efforts aimed at eliminating CSA through prevention have focused primarily on equipping children with the skills they need to respond to or protect themselves from sexual abuse. Other CSA prevention programs are geared toward parents, who are often in a position to empower children to protect themselves. Yet other programs focus on preventing the perpetration of sexual abuse by focusing on actual or potential sexual abusers.

Education Programs for Children

During the 1980s, school-based empowerment programs to help children avoid and report victimization became popular across the United States. Such programs generally teach children knowledge and skills that experts believe will help them to protect themselves from a variety of dangers. Most focus on sexual abuse and emphasize two goals: *primary prevention* (keeping the abuse from occurring) by recognizing potentially abusive situations/abusers and by teaching children to resist advances, and *detection* (encouraging children to report past and current abuse) (Miller-Perrin & Wurtele, 2017b). In a 2001 study, Plummer surveyed 87 CSA prevention programs and found

that a wide variety of training formats are used, including special curricula, video, role play, behavioral rehearsal, peer education, and parent follow-up materials.

Evaluations of school-based victimization prevention programs suggest that, in general, exposure to such programs increases children's knowledge and protection skills (Miller-Perrin & Wurtele, 2017b). Whether these programs are effective in actually helping children to avoid abuse is a much more complicated question. There is some evidence to suggest that they are effective in this regard. Zwi and colleagues (2007), for example, found that children who had participated in an education program were 6 to 7 times more likely to demonstrate protective behavior in simulated situations than those who had not participated in such programs. Finkelhor, Asdigian, and Dziuba-Leatherman (1995) found among their 2,000 survey respondents aged 10–16 years that 40 percent reported specific instances in which they used information or self-protection skills taught to them in an education program. These researchers, however, found no differences in actual victimization rates for those who had and had not participated in school-based prevention programs. In contrast, a survey of 825 college women found that women who had participated in "good-touch, bad-touch" prevention programs as children were significantly less likely to report, as adults, any sexual victimization experienced in childhood compared to women who reported having no personal safety training as children (Gibson & Leitenberg, 2000). School-based prevention education is also potentially effective in encouraging children to disclose past or ongoing abuse (Wurtele, 2009). These various findings offer some hope that school-based programs might help prevent CSA.

School-based CSA prevention programs are not without their critics. Reppucci, Land, and Haugaard (1998), among other researchers, have questioned whether the "relatively exclusive focus on children as their own protectors is appropriate" (p. 332). Many children, they argue, may not be developmentally ready to protect themselves. Critics have argued that the skills and concepts taught in child-focused education programs may be too complex for children to understand (Finkelhor, 2009). In addition, there is some danger that an overreliance on these types of programs may give parents and society a false sense of security about a child's safety following participation in such programs. At the same time, it seems reasonable to conclude that children and adolescents have a right to be enlightened about sexuality and sexual abuse and to know about their right to live free from such abuse. Indeed, it might be morally reprehensible *not* to equip children with knowledge and skills to potentially help them to prevent sexual abuse (Finkelhor, 2009).

The Parental Role in Child Empowerment

Because parents potentially play an important role in empowering their own children to protect themselves, some have argued that prevention efforts should focus on parent education (Miller-Perrin & Wurtele, 2017b). Studies indicate that parents not only want to be involved in preventing CSA but are also effective in teaching their children about sexual abuse and appropriate protective skills (e.g., Wurtele, Kast, & Melzer, 1994).

Parents are particularly effective if they are given specific instruction in how to talk to their children about sexual abuse (Burgess & Wurtele, 1998).

Perpetration Prevention

Some education programs target actual or potential offenders. The **Stop It Now!** program was developed by a national nonprofit organization in Vermont and is one of the best-known examples of this type of program. This program encourages offenders and those at risk for offending to self-identify, report themselves to authorities, and enter treatment (Stop It Now!, 2005; Tabachnick, 2003). The program operates through public education and media campaigns targeting adult offenders, those at risk to offend, parents of youth with sexual behavior problems, and families and close friends of these individuals. Prevention messages are delivered through newspaper advertisements, television and radio ads, talk shows, articles, billboards, posters, and news features (Stop It Now!, 2005). Through these mediums, individuals are encouraged to call a toll-free helpline for information and referrals. Other similar approaches are appearing in other countries that specifically target juveniles with a sexual preference for children (Beier et al., 2016). Unfortunately, program evaluation studies documenting the effectiveness of these programs in preventing future CSA are not yet available.

In Massachusetts, the **Enough Abuse Campaign** is a statewide education and community mobilization effort whose mission is "to prevent people from sexually abusing children now and to prevent children from developing sexually abusive behaviors in the future" (Massachusetts Citizens for Children, 2010). The Enough Abuse Campaign provides information about conditions and social norms associated with the occurrence of CSA and offers training for parents and child care professionals to identify and respond to sexual behaviors of children. Along with media coverage and community presentations and workshops, the campaign also provides a variety of CSA prevention materials and resources on its website (www.enoughabuse.org). The campaign also supports efforts to affect public policies related to CSA (e.g., reforming states' statutes of limitations) (Schober, Fawcett, & Bernier, 2012).

Evaluation of the Enough Abuse Campaign supports this approach as a promising avenue for CSA prevention. Following the campaign, it was demonstrated that more Massachusetts residents were likely to endorse the belief that adults, rather than children, should take responsibility for preventing CSA (an increase from 69 percent in 2003 to 93 percent in 2007; Schober et al., 2012). As another potential indicator of program impact, substantiated reports of CSA in Massachusetts declined 69 percent from 1990 to 2007. Similar effects were observed in Georgia, as substantiated reports of CSA decreased four of the five years of the implementation period (Schober, Fawcett, Thigpen, Curtis, & Wright, 2012).

Public policy and law are also viewed as potential perpetrator prevention strategies. As noted previously, all U.S. states have laws criminalizing CSA. There is considerable debate, however, about how severe the criminal sanctions should be. Unlike the other forms of violence and maltreatment discussed in this book, CSA offenders are

more likely to be seen as "sick perverts." Because they are sick, their abuse is less likely to be seen as volitional. Can a "sick pervert" be deterred? Can a "sick pervert" be cured?

Those who answer "no" to both questions argue that communities must be protected from potential perpetrators with community protection policies such as lifetime offender registries, lifetime online community notification, indefinite post-incarceration civil commitment, and expansive sex offender residency restrictions (Letourneau & Levinson, 2011; Lobanov-Rostovsky, 2015). Unfortunately, most legislative initiatives have not been adequately evaluated, and what research is available suggests that sex offender policies, including notification, registration, and residency restrictions, do not prevent sex offenders from repeating their crimes (e.g., Letourneau & Levenson, 2011). Thus, the impact of these legislative initiatives on primary prevention of CSA perpetration is unknown. Letourneau, Eaton, Bass, Berlin, and Moore (2014) argue that strong emotional reactions engendered by CSA often lead to reactionary legislation that may actually be counterproductive to CSA prevention efforts, because such legislation leaves the impression that "legislators are doing everything that can be done," which results in complacency (p. 225). Such reactive legislation is often quickly implemented in response to a dramatic case of CSA (e.g., legislation that includes the name of the child victim in its title) in order to protect children. There are recent signs, however, that the tide of reactive legislation may be subsiding (Letourneau et al., 2014).

Chapter Summary

No one knows exactly how many children experience sexual abuse each year. The difficulty in determining accurate rates of CSA stems from the problems inherent in defining and studying any complex social problem. Although no precise figures are available, it is clear that adults sexually exploit large numbers of children. Conservative estimates derived from the most methodologically sound studies suggest that in the United States, 20 percent of women and between 5 percent and 10 percent of men have experienced some form of CSA.

Research has demonstrated the heterogeneity of CSA victim and offender populations. Victims and perpetrators represent all possible demographic and psychological profiles. A number of risk factors, however, have been consistently associated with CSA. Victims often are female, have few close friends, and live in families characterized by poor family relations and the absence or unavailability of natural parents. Perpetrators of CSA are most often male, and they are often relatives or acquaintances of their victims. The heterogeneity of victim and perpetrator populations has contributed to scholars' difficulty in establishing a single explanation for the occurrence of CSA. One perpetrator may abuse a certain type of child for one reason, and another may abuse a different type of child for a different reason. Risk factors for CSA span various individuals and systems involved in CSA, including individuals as well as the context in which they reside. Several theories have been developed in an attempt to integrate individual risk factors across multiple ecological levels.

The psychological sequelae associated with CSA are variable and consist of short-term as well as long-term effects. Difficulties associated with CSA include a variety of symptoms that affect emotional well-being, interpersonal functioning, behavior, sexual functioning, physical health, and cognitive functioning. The variability of outcomes for victims is associated with a number of factors including pre-abuse characteristics of the victim, the severity of the sexual behavior, the degree of physical force used by the perpetrator, the response the victim received following disclosure, and the relationship of the perpetrator to the victim.

In recognition of the significance of the CSA problem, many professionals are involved in responding to the needs of victims and the treatment of perpetrators. Researchers and mental health practitioners have developed an array of treatment interventions in an effort to address the multiple causes and far-reaching consequences of CSA. Regardless of the type of approach, the therapeutic goals for child victims and adult survivors of CSA generally include addressing significant symptoms as well as common emotions associated with abuse, such as guilt, shame, anger, depression, and anxiety. Treatment programs for offenders include a variety of approaches, but most typically incorporate cognitive and behavioral components to reduce deviant sexual arousal and cognitive distortions associated with abuse. These approaches demonstrate some promise, but further studies are needed to address the limitations of extant research methodologies and to examine potential alternative treatments.

The prevention of CSA begins with social awareness and the recognition that expertise, energy, and money are needed to alleviate the conditions that produce CSA. Many experts maintain, however, that society has not yet sufficiently demonstrated a commitment to prevention. In most communities, monetary resources are tied up in responding to, rather than preventing, CSA. Increasing commitment to the prevention of CSA, however, is evidenced in the many prevention programs appearing across the United States. Several of the strategies employed in these programs seem especially promising. Although additional evaluations are needed, available research indicates that these programs have tremendous positive potential.

RECOMMENDED RESOURCES

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