Violating children's rights: The psychological impact of sexual abuse in childhood

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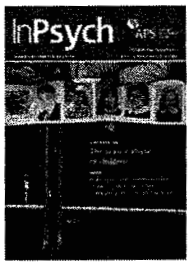

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All forms of child sexual abuse (CSA) are a profound violation of the human rights of children. CSA is a crime under Australian law and an extreme transgression of trust, duty of care and power by perpetrators. The rights violations that define CSA are critically connected to the deleterious behavioural and psychological health consequences that ensue. This article examines the long-term effects of CSA on mental health and the determinants of these outcomes, in order to identify opportunities to ameliorate the profound psychological impacts of CSA on the lives of many victims/survivors. The article is based on a literature review commissioned to inform the APS response to the Royal Commission into Institutional Responses to Child Sexual Abuse, which was established in 2013 by the Gillard Government.

Prevalence of child sexual abuse

Rates of CSA are difficult to gauge accurately given the clandestine, sensitive and criminal nature of the sexual abuse to which children are exposed. Perpetrators of CSA are often close to the victim, such as fathers, uncles, teachers, caregivers and other trusted members of the community (Finkelhor, Hammer & Sedlak, 2008). CSA often goes undisclosed and unreported to professionals or adults for many complex reasons, including fear of punishment and retaliation by the perpetrator, as well as the stigma and shame associated with this type of abuse (Priebe & Svedin, 2008).

A global meta-analysis of child sexual abuse prevalence figures found self-reported CSA ranged from 164-197 in every 1,000 girls and 66-88 per 1,000 boys (Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). In Australia, Fleming (1997) used a community sample of 710 women randomly selected from the Australian electoral roll and found that 20 per cent of the sample reported experiencing CSA involving contact. Another national survey involving both men and women (Najman, Dunne, Purdie, Boyle, & Coxeter, 2005) reported a higher prevalence of CSA, with more than one third of women and approximately one sixth of men reporting a history of CSA. A more recent study in Victoria (Moore et al., 2010) reported a prevalence rate of 17 per cent for any type of CSA for girls and seven per cent for boys when they took part in the study during

adolescence. Both Australian studies involving community samples of women or girls and men or boys indicate that girls are two or more times more likely to experience CSA than boys.

Long-term mental health consequences

A significant body of research has demonstrated that the experience of CSA can exert long-lasting effects on brain development, psychological and social functioning, self-esteem, mental health, personality, sleep, health risk behaviours including substance use, self-harm and life expectancy. CSA often co-occurs with physical and emotional abuse and other negative and stressful childhood experiences that independently predict poor mental and physical health outcomes in adult life.

Nevertheless, the research literature indicates that when other predictors of poor adult mental health are statistically controlled, CSA remains a powerful determinant of psychological disorder in adult life (Kendler et al., 2000). Strong evidence from twin studies indicates that a causal relationship exists between CSA and subsequent mental disorders. Twin studies necessarily control for genetic and family environment factors and a number since 2000 have documented significant associations between CSA, depression, panic disorder, alcohol abuse/dependence, drug abuse/dependence, suicide attempts and completed suicides.

A systematic review and meta-analysis of studies published between 1980 and 2008 (Chen et al., 2010) found that a history of sexual abuse including child sexual abuse was related to significantly increased odds of a lifetime diagnosis of several different psychiatric disorders, including anxiety disorders, depression, eating disorders, posttraumatic stress disorder (PTSD), sleep disorders and suicide. A particularly strong link between CSA and subsequent PTSD has been found.

Although the diagnosis of PTSD may be appropriate for those who have been exposed to relatively circumscribed CSA, Herman (1992) argued more than two decades ago that this diagnosis does not adequately capture the psychological responses of people who are repeatedly traumatised over a long period of time, experience subsequent re-victimisation in adolescence or adult life and typically display multiple symptoms of psychological distress and high levels of psychiatric co-morbidity. For survivors of this kind of CSA, Herman (1992) proposed the expanded diagnostic concept of complex PTSD on the grounds that it was better able to accurately capture the complex psychological sequelae of prolonged, repeated trauma.

Risk of suicide: Australian research

Survivors of CSA face a significantly increased risk of suicide and a higher prevalence of suicide attempts and ideation. An Australian follow-up study (Plunkett et al., 2001) of young people who had experienced CSA compared with those who had not, reported that those with a CSA history had a suicide rate 10.7-13.0 times the national rate. Furthermore, 32 per cent of those sexually abused as children had attempted suicide and 43 per cent had thought about suicide. None of the non-abused participants had completed suicide.

A more recent Australian study confirms and extends this finding. Cutajar and colleagues (2010) conducted a cohort study of 2,759 victims of CSA by linking forensic records from the Victorian Institute of Forensic Medicine between 1964 and 1995 to coronial records up to 44 years later. They found that female sexual abuse victims had 40 times higher risk of suicide and 88 times higher risk of fatal overdose than the rates in the general population. Interestingly these rates were even higher than those for males, in contrast to the usual gender pattern for suicide. The respective rates for males were 14 times and 38 times higher than those in the general population.

Determinants of long-term mental health outcomes

While victims/survivors of CSA face greatly increased risks of poor mental health in adult life, a significant minority do not go on to develop psychological disorders (Saunders, Kilpatrick, Hanson, Resnick, & Walker, 1999). Broadly, two approaches to explaining this finding have informed research: differences in the nature of the abuse that has taken place; and post-abuse factors that positively mediate or intervene in the development of negative long-term mental health outcomes.

Nature of the sexual abuse

The likelihood of experiencing severe, negative mental health outcomes in adult life as the result of CSA is increased by several abuse-specific characteristics. Large scale epidemiological studies have consistently documented that forced penetrative sex, multiple perpetrators, abuse by a relative, and a long duration of CSA (e.g., more than a year) predict more severe psychiatric disturbance and a higher likelihood of being an in-patient in a psychiatric facility in adult life.

More than 20 years ago, Pribor and Dinwiddie (1992) investigated different types of CSA of increasing severity and found that incest victims had a significantly increased lifetime prevalence rate for seven psychological disorders including agoraphobia, alcohol abuse or dependence, depression, panic disorder, PTSD, simple phobia and social phobia. Bulik, Prescott and Kendler (2001) also confirmed that a higher risk for the development of psychiatric and substance use disorders was associated with certain characteristics of the abuse, including attempted or completed intercourse, the use of force or threats and abuse by a relative. More severe and chronic abuse which starts at an early age has also been reported to increase the risk of developing symptoms of dissociation.

Post-abuse mediating factors

Certain factors, both negative and positive, are likely to intervene after CSA has taken place and to mediate adult mental health outcomes.

Coping strategies

Specific coping strategies used by survivors can positively or negatively predict long-term psychological outcomes. Overall, positive, constructive coping strategies such as expressing feelings and making efforts to improve the situation are associated with better adjustment (Runtz & Schallow, 1997; Tremblay, Hebert, & Piche, 1999), and negative coping strategies, including engaging in self-destructive or avoidant behaviours, with worse adjustment (Merrill, Thomsen, Sinclair, Gold, & Miller, 2001). However, the coping strategies used by survivors are contingent to some degree on the availability of social or material resources over which children have little or no control.

In addition, the number of negative or maladaptive coping strategies used is predictive of the likelihood of sexual re-victimisation in adulthood (Filipas & Ullman, 2006). This strongly indicates that the link between CSA, negative coping strategies and adverse adult psychological outcomes is strengthened by sexual re-victimisation. Several studies have confirmed this relationship.

Re-victimisation

CSA is associated with an increased risk of subsequent violent victimisation including intimate partner violence and sexual violence in adolescence and adulthood (see, for example, Classen, Palesh, & Aggarwal, 2005). Sexual re-victimisation involving rape or other types of sexual abuse/assault poses a potent risk for worse psychological health in adult life. A number of studies have confirmed that women who are sexually re-victimised

compared with their non-revictimised counterparts have more severe symptoms of psychological distress in adulthood.

Social support and reaction to disclosure
Historically, the role of social support and other societal and cultural factors in determining survivors' responses to CSA has been under-explored in comparison with the heavy focus on the survivor's role in responding to sexual trauma. Increased interest in the contribution of social support and other sociocultural factors has prompted increased investigation into the social contextual factors that can mediate adult outcomes following childhood violence, many of which are associated with the reactions to disclosure.

Delay in the disclosure of CSA is linked inevitably with other delays, all of which are harmful to the child. These include delay in putting in place adequate means to protect the child from further victimisation, delay in the child receiving meaningful assistance including necessary psychological and physical health care, and delay in redress and justice for the victim. Without disclosure, negative health outcomes are more likely to proliferate and compound. Conversely, disclosure within one month of sexual assault occurring is associated with a significantly lower risk of subsequent psychosocial difficulties in adult life including lower rates of PTSD and major depressive episodes (Ruggiero et al., 2004).

Yet experiences of disclosure are not uniform and whether they are positive or negative depends on the reactions of the person to whom the CSA is disclosed. Unfortunately, negative reactions to disclosure are common, constitute secondary traumatisation and are associated with poorer adult psychological outcomes (Ullman, 2007). Such reactions include not being believed, being blamed and judged, or punished and not supported, all of which can compound the impact of the original abuse and further increase the risk of psychological distress including increased symptoms of PTSD, particularly when the perpetrator is a relative.

Specific characteristics of disclosure appear to be protective against the development of psychiatric disorders. This finding highlights the importance of social support in concert with effective action by the person in whom the child confides. The degree to which someone is affected is likely to reflect various indicators of the severity of the abuse as well as countervailing protective factors such as the strength of family relationships and the survivor's self-esteem. One such factor is a warm and supportive relationship with a non-offending parent, which is strongly associated with resilience following CSA and lower levels of abuse-related stress.

Implications for psychological training and practice

The research outlined above shows conclusively that CSA is associated with multiple adverse psychological outcomes, although such outcomes are not inevitable. The identified mediating or intervening factors that increase or decrease the risk of developing psychological disorders as a result of CSA have important implications for psychological training and for the practising psychologists who work with survivors of CSA.

Training on CSA

It is a matter of grave concern that the issue of CSA has been neglected in psychology training. When psychologists lack appropriate knowledge and skills to work with survivors they put both their clients and themselves at risk and can cause unintended harm. Training on CSA is urgently needed in psychology programs to disseminate evidence to students on the protean psychological consequences of CSA as well as the skills necessary to carry out the demanding mental and emotional work of treating survivors. Survivors can have chronic, complex problems in many areas of functioning and psychological disorders can

overlap with physical health problems, including pain syndromes and high risk health behaviours such as alcohol, tobacco and drug use. Careful long-term psychological care is often necessary. As survivors may seek help from a range of psychologists, it is important that all psychologists are educated about the magnitude and psychological consequences of CSA.

Apart from acquiring more in-depth knowledge of the emotional effects of CSA and experience in trauma-related interventions, postgraduate courses should prepare practitioners for how exposure to their clients' traumatic material can traumatise them as well. To remain psychologically healthy while working with survivors of CSA, psychologists need to be able to recognise symptoms of secondary traumatic stress and develop self-care strategies and support systems that will help them to manage the stress related to working with CSA survivors.

Most practising psychologists today who work with survivors have acquired their knowledge and skills 'on the job' post-graduation or as a result of their own initiative by attending workshops delivered by specialists in the field. An unknown number of registered psychologists may have no training on CSA and a more systematic continuing education program should be available and accessible so that all psychologists are equipped, at the very least, to 'do no harm' to the clients who have experienced CSA.

Implications for psychological practice

Knowing how to facilitate disclosure and take a comprehensive trauma history is an essential first step in developing a treatment plan for survivors of CSA. How a psychologist responds to a client's disclosure will have an enormous impact on whether a survivor continues or abruptly terminates treatment. Any hint of disbelief, blame or judgment is likely to fracture the client's fragile hope that she or he will be believed and that it is safe to undertake the painful task of working through the original abuse and its aftermath. If the response to a disclosure is negative it may be years before a survivor is willing to try again, and in the meantime the psychological burden of the abuse and its effects can proliferate. The effort to remain silent and keep the abuse hidden is extremely isolating and cuts off access to potential avenues of psychosocial support.

It would be a mistake for psychologists to assume, for example, that knowing about prolonged exposure therapy for the treatment of PTSD, would, by itself, be sufficient to offer effective treatment to survivors. Beyond the symptoms of traumatic stress associated with CSA, survivors often struggle with many other pressing concerns. These often relate to the deep betrayal of trust by the adult/s with a duty of care towards them as children. This betrayal can prompt persistent negative self-perceptions, difficulties in trusting others and their own judgement, and abiding feelings of shame and intrinsic 'unloveability' that contribute to insecure, unsatisfying relationships in adult life. These same issues can impinge on the client-psychologist interaction, making it challenging to establish a robust therapeutic alliance or maintain appropriate boundaries.

CSA does not result in a single disorder such as depression, treatable within the 10 sessions supported under the Better Access to Mental Health Care initiative. The chronicity and complexity of the disorders stemming from CSA require much longer term mental health care. The current system under Medicare is very poorly suited to meeting the mental health care needs of perhaps the most numerous and psychologically vulnerable group in society – CSA survivors.

Conclusion

The Royal Commission has provided a timely opportunity to closely examine the enduring, deleterious and multi-faceted impacts of CSA on survivors, how institutions in which abuse took place failed to intervene and the kind of assistance survivors believe will be most helpful in healing from their traumatic experiences.

Psychology has much to contribute to this process and to ensure that the best available psychological evidence is put forward to address the profoundly disturbing phenomenon of child sexual abuse.

Clergy-perpetrated child sexual abuse

In contrast with the large evidence base amassed since the 1980s on the prevalence and health consequences of CSA occurring in the general community, minimal research was published before 2000 on CSA perpetrated by clergy or others working for institutions or organisations, and evidence remains limited in scope.

There is an additional theological and spiritual dimension to clergy-perpetrated abuse that sets it apart other forms of CSA, including a spiritual and religious crisis during and after the abuse (Farrell & Taylor, 2000). CSA perpetrated by priests and other members of the clergy has been described as "a unique betrayal" (Guido, 2008) and the "ultimate deception" (Cook, 2005), and the implications of such abuse for victims are eloquently described by McMackin, Keane and Kline (2008):

> The sexual exploitation of a child by one who has been privileged, even anointed, as a representative of God is a sinister assault on that person's psychosocial and spiritual well-being. The impact of such a violent betrayal is amplified when the perpetrator is sheltered and supported by a larger religious community. (p.198)

Psychological consequences of clergy-perpetrated child sexual abuse

Clergy-perpetrated sexual abuse of children can catastrophically alter the trajectory of victims' psychosocial, sexual and spiritual development (Fogler et al., 2008). In the US, investigation into the Catholic Church by the John Jay Research Team repeatedly identified certain psychological effects of clergy CSA in the personal testimony of survivors and family members. These included major symptoms of PTSD with co-occurring substance abuse, affective lability, relational conflicts, and a profound alteration in individual spirituality and religious practices associated with a deep sense of betrayal by the individual perpetrator and the church more broadly (John Jay College, 2004, 2006; McMackin et al., 2008).

Some of these negative psychological outcomes are shared with survivors of CSA in the general population but those related to spirituality, religious practices and a sense of betrayal by the church alter the nature of the harm caused by clergy-perpetrated CSA. While a diagnosis of PTSD may be useful as a starting point in understanding and treating survivors of clergy CSA, Farrell and Taylor (2000) contend that "there are qualitative differences in [clergy-perpetrated CSA] symptomatology, which the PTSD diagnosis cannot explain" (p. 28). Such symptoms include self-blame, guilt, psychosexual disturbances, self-destructive behaviours, substance abuse, and re-victimisation. These symptoms are argued to emanate from the theological, spiritual and existential features of clergy CSA. For these reasons, Farrell and Taylor (2000) suggest that a diagnosis of complex PTSD (Herman, 1992) offers a better fit for the symptoms reported by survivors of clergy-perpetrated CSA.

Preventing clergy-perpetrated child sexual abuse

The history of denial, cover up and delays in response to disclosures of clergy CSA by churches has been well documented, with their responses to

perpetrators evidencing a failure to implement any effective preventative measures. To stop institutional CSA from occurring, it is critical to understand the situational indicators of such abuse so that the opportunities they afford to perpetrators to commit the crime of CSA can be identified.

Parkinson and colleagues (2009) identified that having immediate and convenient access to minors were the defining characteristics that facilitated abuse. The evidence also suggests the need for parents and their children to be made much more aware of the grooming tactics used by clergy who perpetrate CSA. The John Jay College study (2006) identified the strategies that allowed the perpetrators to become close to the child they subsequently abused including being friendly with the victims' families, giving gifts or other enticements such as taking them to sporting events or letting them drive cars, and spending a lot of time with victims.

A recurrent theme in Australian victims' accounts is how their parents' religious beliefs and trust and reverence for members of the clergy meant that they could not conceive of the possibility that priests could sexually abuse their children and betray their own vows. Yet there is ample evidence that this trust was sadly misplaced and the same caution that would be applied to other members of society needs to be applied to the clergy.

Finally, in tandem with a message from churches that there is zero tolerance for CSA, there needs to be a clear and trustworthy process in place, independent of the churches, that encourages children to disclose CSA safely and confidentially. Educational programs in all schools beginning in primary school might be one way of achieving this.

Victims of clergy-perpetrated CSA need to be heard with respect and compassion, given meaningful assistance to meet their psychosocial needs, and provided with justice through those who perpetrated the abuse and those who covered it up being held fully accountable. Only then will it be possible for recovery from the immense trauma of clergy CSA and the rebuilding of shattered lives to truly begin.

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