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Andrea R. Perry* David K. DiLillo †

*University of Nebraska - Lincoln

†University of Nebraska - Lincoln, ddilillo2@unl.edu

Published in *The Encyclopedia of Domestic Violence,* Nicky Ali Jackson, editor. New York & London: Routledge, 2007. Pages 147–156.

Child Sexual Abuse

Historical Perspective

Child sexual abuse (CSA), a social problem of endemic proportions, has existed in all historical eras and societies (Conte 1994; Fergusson and Mullen 1999; Wekerle and Wolfe 1996; Wolfe 1999). Since antiquity, anecdotal records (e.g., legal, artistic, philosophical, and literary accounts) have documented activities that would today be classified as CSA (deMause 1974; Kahr 1991; Olafson, Corwin, and Summit 1993). For instance, a sizable portion of adults in ancient Greek and Roman cultures openly engaged in what is now considered pederasty or rape (deMause 1974; Kahr 1991). Although adult-child sexual encounters have occurred throughout history, perceptions of such practices have fluctuated, ranging from societal acceptance (adult-child sex viewed as healthy or justifiable) to rejection (adult-child sex believed to be inappropriate or abusive) (Barnett, Miller-Perrin, and Perrin 1997; Kahr 1991; Olafson et al. 1993). With this oscillation of cultural ideologies, establishing behaviors as sexually abusive has not been an additive or linear process. Rather, scholars have called attention to cycles of "recognition (or 'discovery') and suppression" that, until the 1970s, largely obscured public awareness of the magnitude of the problem (Conte 1994; Olafson et al. 1993). In the late nineteenth and early to mid-twentieth centuries, for example, physicians (e.g., Tardieu), psychoanalysts (e.g., Freud), and researchers (e.g., Kinsey) had, to some extent, discovered and documented sexual victimization in their patients. Representative of the general sentiment at the time, however, these findings were subsequently minimized, discounted, or justified, resulting in victim blame and a cycle of "suppression" (Bolen 2001; Conte 1994; Olafson et al. 1993). Sigmund Freud's work perhaps best exemplifies the "recognition and suppression" cycle (Fergusson and Mullen 1999). Specifically, although Freud initially publicized the reality of CSA with his "seduction theory," he later rescinded this account, indicating that most of the alleged instances were false and that children, via the Oedipal complex, exhibit a natural and erotic sexual desire toward their opposite-sex parent (Bolen 2001; Olafson et al. 1993; Tharinger 1990). In one explanation of Freud's "suppression," Bolen (2001) highlighted the Victorian social and political atmosphere which encased Freud and concluded that he "effectively colluded with a society that wished to deny the existence of child sexual abuse" (p. 20).

This cycle of "recognition and suppression" regarding the sexual abuse of children was disrupted in part by two events more associated with the physical abuse of children. The first of these events was the inception of the child protection movement in New York State. Imbued within a culture where children were viewed as parental property and where family lives were kept discreetly out of public view, the establishment of formal child protection reflected the convergence of several salient factors, particularly related to the 1874 case of Mary Ellen, a girl who experienced physical and psychological cruelty by her stepmother (MacMillan 2000; Wolfe 1999). In contrast to the majority of cases at that time, which went undetected or were ignored, a culmination of necessary ingredients—including the persistent voices of advocates for Mary Ellen, public concern, and a political and social atmosphere more prepared for reform—enabled Mary Ellen's story to affect legal change. Contrary to the "suppression" cycle that typically followed, the tragedy of Mary Ellen's case contributed to the founding of the New York Society for the Prevention of Cruelty to Children (NYSPCC), which paralleled the already flourishing Society for the Prevention of Cruelty to Animals and was the first child protection organization (Barnett et al. 1997; NYSPCC 2000; Wolfe 1999). This late-nineteenth-century event signified that the protection of children against physical abuse and neglect was an idea that had begun to take root.

A second watershed event that ultimately helped to draw attention to the problem of sexual abuse was the publication of the seminal study by Kempe, Silverman, Steele, Droegemueller, and Silver (1962). This study, on the physical abuse of children, scientifically documented medical injuries resulting from child abuse and focused particular at-

tention on the presumed pathology of maltreating parents. In the aftermath of Kempe et al.'s (1962) landmark publication, several factors (e.g., enhanced societal awareness of child maltreatment, the effects of the Vietnam war and the concomitant raising of "social consciousness" of the era, the growth of the women's movement) coalesced and again provided impetus for increased recognition of CSA as a pervasive problem for children and adult survivors (Bolen 2001. p. 21; Fergusson and Mullen 1999; Finkelhor 2002. p. xii; Olafson et al. 1993).

Even after the problem of CSA became widely recognized and reached the mainstream of public awareness in the 1970s, the topic has remained controversial. For instance, despite increased media and research attention on CSA throughout the 1980s and 1990s, these two decades (and onward into the twenty-first century) witnessed a backlash that engendered skepticism about the magnitude and long-term sequelae of CSA (Fergusson and Mullen 1999; see also the meta-analysis of Rind, Tromovitch, and Bauserman 1998), as well as the validity of CSA allegations (Bowen 2001; Olafson et al. 1993). The impact of this "child abuse backlash," which is evidenced via increasingly visible and organized "opposition" groups (e.g., attorneys, websites, and layperson or legal groups specifically geared to those who believe they have been falsely accused of perpetrating CSA), complicates scientific inquiry and professional advocacy/practice (Finkelhor 2002, p. xiv). Despite these controversies, however, the sexual abuse of children has been referred to as "one of the defining cultural themes of our age" (Fergusson and Mullen 1999, p. 1), a phenomenon that ultimately "emerged from the cloak of social secrecy and [has] become a leading concern of mental health professionals" (Cole and Putnam 1992, p.174).

Definition of Child Sexual Abuse

Ever since the recognition in the 1970s of the sexual mistreatment of children as a widespread problem, professionals have wrestled with how to conceptualize and define CSA (Haugaard 2000). Although formulating a universally accepted definition is complicated by several theoretical and ideological considerations, some agreement has emerged among professionals regarding the defining features of sexual abuse. These characteristics are captured by the most recent Child Abuse Prevention and Treatment Act (CAPTA), which defines CSA as "the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or interfamilial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children" (National Center on Child Abuse and Neglect [NCCAN], 2005a, p. 1). In addition to this legal conceptualization, many researchers distinguish sexual offenses involving contact (e.g., penetration) or noncontact (e.g., child pornography, exhibitionism) (American Psychological Association 2001; Hansen, Hecht, and Futa 1998). Definitions also encompass the age differential between the perpetrator and the victim, with victims of CSA (in contrast to those of statutory rape or adolescent sexual assault) generally being under sixteen years of age and perpetrators being at least five years older (Hansen et al. 1998). Notably, the age differential becomes less important if force is involved in the sexual abuse incident (Berliner and Elliott 2002).

Prevalence

Just as establishing an operational definition of CSA is difficult, obtaining accurate incidence and prevalence rates of CSA is also challenging. Data collection methods (e.g., self-report versus interview methodology), measurement variations (e.g., single-item versus in-depth measures of CSA), study design issues (e.g., prospective versus retrospective design, sampling techniques), and extraneous factors (e.g., underreporting, response rates) all obscure estimates (Goldman and Padayachi 2000; Putnam 2003). Despite these hurdles, researchers have sought to uncover estimates of CSA in the general population through national incidence studies and self-report data.

National Incidence Study

The government-mandated National Incidence Study (NIS) represents perhaps the most expansive attempt to ascertain the incidence of CSA in the United States (Sedlak and Broadhurst 1996). Sedlak (2001) points out that children who come to the attention of the legal system as a result of abuse or neglect exemplify only the "tip of the iceberg" (p. 6). For this reason, the third National Incidence Study (NIS-3) measures maltreatment according to a five-tier system, which involves substantiated child protective services (CPS) reports and the reports of trained teachers, courts, police, and hospital personnel, as well as cases indicated by other agencies. Further, NIS-3 evaluates child maltreatment against two standards: the Harm Stan-

dard (i.e., the child has already suffered known harm as a result of abuse/neglect) and the Endangerment Standard (i.e., the child [who has experienced maltreatment] is at high risk for developing abuse-related consequences or has yet to evidence known sequelae) (Sedlak and Broadhurst 1996). Results from NIS-3 reflecting 1993–1994 data indicated that 217,700 children experienced CSA according to the Harm Standard and 300,200 via the Endangerment Standard, both reflecting substantial increases from NIS-2 (Sedlak and Broadhurst 1996); the most current data collection as of this writing (NIS-4) is currently under way and will conclude sometime in 2008 (National Incidence Study 4, 2005). Finally, another national database utilizing reports to child protective agencies, the National Child Abuse and Neglect Data System (NCANDS) revealed per capita child maltreatment rates of 12.4 per 1,000 children, with 10 percent of those being sexual abuse victims (NCCAN 2005b).

Self-Report Data

Although NISs provide an indication of the magnitude of CSA, they probably underestimate rates of sexual victimization because of a heavy reliance on cases that come to the attention of the legal and child protective systems (e.g., Walch and Broadhead 1992). In contrast, retrospective surveys of adults (particularly with representative community samples) may gain access to individuals whose abuse never came to the attention of the legal system. In reviewing sixteen such studies, Gorey and Leslie (1997) found that the prevalence of CSA in nonclinical samples in the United States is 22.3 percent for women and 8.5 percent for men. When they included only studies with a 60 percent or higher response rate, the percentages for women and men dropped to 16.8 percent and 7.9 percent, respectively (even more conservative rates were shown with stricter inclusion criteria). The authors concluded that the "truth" likely falls between these estimations (p. 395). As can be seen, CSA prevalence rates vary, depending on factors such as the methodology employed, the type of sample, and the instrument used. For example, in their review of the literature, which included community-based and convenience samples, Fergusson and Mullen (1999) estimated that the most inclusive rates of CSA (which included noncontact experiences) ranged from 8.0 to 62.1 percent for women and 3 to 29 percent for men, though the majority of studies estimated between 15 and 30 percent for women and 3 and 15 percent for men. Results from another national study, utilizing a randomized telephone sampling, found that 27 percent of women and 16 percent of men met the most liberal criteria for CSA (Finkelhor, Hotaling, Lewis, and Smith 1990). These results were similar to a national sample by Briere and Elliott (2003), who indicated that 32.3 percent of women and 14.2 percent of men were classified as sexually abused. In Finkelhor's (1993) estimate, sexual abuse is likely to be present in approximately one in four girls and one in ten boys. Finally, although the NIS-3 indicated that CSA rates had increased substantially in recent years, this finding has not been consistent. Jones, Finkelhor, and Kopiec (2001), for example, discussed contrary indicators that CSA had declined by 39 percent. Specifically, they (among others) noted that it is challenging to determine whether the rates of CSA have actually diminished or whether definitional criteria and research methodologies are responsible for these patterns (Jones et al. 2001; Leventhal 2001).

Demographic Factors Associated with Child Sexual Abuse

Victim Characteristics

In addition to examining overall prevalence rates, researchers have also explored whether CSA trends emerge based on various demographic characteristics. For example, regarding victim gender, the majority of studies indicate that girls experience sexual abuse at much higher rates than boys. Indeed, girls not only are three times more likely to experience CSA under both the Harm and Endangerment Standards used in NIS-3 (Sedlak and Broadhurst 1996), but also are more likely to experience forceful and injurious sexual abuse (Levesque 1994). In a study examining international prevalence rates, Finkelhor (1994) found that, overall, gender findings tended to parallel those in the United States, with girls experiencing a significantly greater likelihood of being sexually victimized (between one and a half and three times more likely). Despite these trends, it is important to note that boys still constitute a significant minority of CSA victims and may in fact be under-represented in studies (Finkelhor 1993).

Similar to relatively consistent gender findings, results concerning age of the victim indicate that CSA risk and age increase simultaneously, with the highest risk being in mid to late childhood, between the ages of six and eleven years (Putnam 2003; Sedlak and Broadhurst 1996). In their review of the literature, Fergusson and Mullen (1999) indicated that, for girls, CSA peaks at between ten and twelve

years of age; these authors, however, cautioned that underreporting or undiscovered incidents may be more prevalent before that time. Finkelhor (1993) indicated that although CSA occurs at every age level, risk appears to manifest around ages six to seven years and be most common at around age ten. Thus, it appears that middle and later childhood are the most common times for CSA to onset, or at least to be acknowledged or discovered. Socioeconomic status (SES) is an additional demographic variable of interest. Most studies to date have not substantiated a drastic impact of SES (Finkelhor 1993; Putnam 2003). Thus, although CSA may pose a greater risk for girls and children in their middle years, it has been documented in every social stratum.

Perpetrator Characteristics

As in the case of victim gender, certain trends also have emerged regarding perpetrator gender. Namely, men make up the large majority of perpetrators of sexual abuse both in the United States (Finkelhor et al. 1990; Sedlak and Broadhurst 1996) and internationally (Finkelhor 1994). However, women do constitute a portion of CSA perpetrators, and the role of female perpetrators should not be discounted. In addition to gender, the relationship of the perpetrator to the victim tends to extend across the gamut of possible relationships. In the NIS-3, perpetrators of CSA included birth parents (approximately 25 percent) and individuals other than biological parents or those serving in parental roles (approximately 75 percent) (Sedlak and Broadhurst 1996). Notably, according to Berliner and Elliott (2002), CSA by family members seems to be overrepresented in clinical settings.

Consequences of Child Sexual Abuse

Developmental Framework

Part of the complexity surrounding CSA stems from the heterogeneity of its short- and long-term correlates. According to Nash, Hulsey, Sexton, Harralson, and Lambert (1993), there is no emergent "delimited replicable pattern of sequelae" associated with early abuse (p. 276). Instead, CSA may impact victims according to a more "nonspecific" symptom pattern. Thus, the mental health consequences of CSA cannot be placed into a single diagnostic classification within the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association 2000; Finkelhor 1990). Furthermore, while some victims experience a wide range of adverse emotional, behavioral, and interpersonal sequelae, others appear asymptomatic (Cicchetti and Toth 2000; Cole and Putnam 1992; Finkelhor 1990; Kendall-Tackett, Williams, and Finkelhor 1993). This variation in outcomes can be understood within a developmental framework (Cicchetti and Toth 2000; Cole and Putnam 1992; DiLillo, Perry, and Fortier, in press; Wolfe 1999). That is, as infants and children progress through various phases of development, they must confront and master a range of stage-salient tasks (Cicchetti 1989; Cicchetti and Toth 2000; Cole and Putnam 1992; Wolfe 1999). In the absence of significant environmental or biological adversity, most individuals will progress along expected developmental pathways. Early sexual abuse, however, represents a substantial form of interpersonal trauma and, as such, may impede normal developmental processes, setting the stage for possible short- and long-term adjustment difficulties (Cole and Putnam 1992; Wolfe 1999).

Short-Term Sequelae

Overall, the research has revealed that the immediate aftermath of CSA often engenders a wide array of consequences but that boys and girls, with few exceptions, appear to be impacted by CSA in many of the same ways (Finkelhor 1990). According to Wolfe and Birt's (1997) review, there are several "sets" of findings related to the short-term sequelae of CSA, including: (1) increased internalizing and externalizing difficulties in CSA victims, (2) the presence of a range of behavioral and emotional problems that relate directly to the CSA, the home environment, or both, and (3) the risk of post-traumatic stress disorder (PTSD) symptomatology and sexuality difficulties. A fourth area that may be useful to consider is the differentiated mental health and interpersonal sequelae, both of which appear to be impacted even in the immediate aftermath of CSA. Paralleling the aforementioned "sets" of short-term difficulties are findings that victims experience increased depression (e.g., Swanston, Plunkett, OToole, Shrimpton, Parkinson, and Oates 2003), anxiety (e.g., Chaffin, Silovsky, and Vaughn 2005; Spataro, Mullen, Burgess, Wells, and Moss 2004), personality disorders (Spataro et al. 2004), suicidal ideation (e.g., Martin, Bergen, Richardson, Roeger, and Allison 2004), nightmares (Mannarino and Cohen 1986; NCCAN 2003), guilt, anger, and fear (Barnett et al. 1997), somatization (Emiroglu, Kurul, Akay, Miral, and Süha 2004), and attachment-related problems (e.g., Shapiro and Levendosky 1999). PTSD symptomatology appears to be particularly salient

among victims (e.g., Kendall-Tackett et al. 1993; NCCAN 2003). In the area of externalizing difficulties, the experience of CSA is related to self-injury (Kendall-Tackett et al. 1993), academic/school trouble (Barnett et al. 1997), behavioral problems (Kendall-Tackett et al. 1993), bedwetting (NCCAN 2003), problem eating behaviors (NCCAN 2003), delinquency and aggression (Swanston, Parkinson, O'Toole, Plunkett, Shrimpton, and Oates 2003), running away (NCCAN 2003), and a range of sexualized behaviors (Barnett et al. 1997) (see excellent reviews by Hecht and Hansen 2001; Kendall-Tackett et al. 1993; and Paolucci, Genuis, and Violate 2001).

In addition to these internalizing and externalizing difficulties, CSA sequelae also manifest in the interpersonal and physiological realms. Regarding interpersonal functioning, CSA has been linked to difficulties in interpersonal relationships, including poor social adjustment (Friedrich, Urquiza, and Beilke 1986) and developmentally inappropriate sexual behaviors and disturbed attitudes related to sexuality (Kendall-Tackett et al. 1993; NCCAN 2003; Tharinger 1990). Studies have also documented several physiological or neurobiological linkages, such as diminished salivary cortisol levels in recently abused children (King, Mandansky, King, Fletcher, and Brewer 2001), earlier onset of menarche (Vigil, Geary, and Byrd-Craven 2005), increased sympathetic nervous system activity, and a range of neurobiological sequelae (see Putnam 2003 for review).

There is also evidence that certain symptoms are more likely to emerge when the abuse is perpetrated during specific developmental stages. For example (although perhaps due to methodological/measurement issues), internalizing symptoms such as depression and anxiety are reported less frequently in early childhood but emerge with greater frequency in adolescence (Berliner and Elliott 1996). In a separate review of childhood versus adolescence findings, Arias (2004) indicated that children were more likely to experience problems related to school, attention, social skills, and aggression, whereas adolescents were at greater risk for delinquency/violence, sexual problems, substance use, and self-injurious behavior. Finally, in Kendall-Tackett and colleagues' (1993) review of CSA sequelae, the authors overviewed the most commonly occurring symptoms at various developmental levels, including preschool-aged children (anxiety, nightmares, PTSD, internalizing, externalizing, and inappropriate sexual behavior), school-aged children (fear, neurotic/general illness, aggression, nightmares, school difficulties, hyperactive behaviors, and regression), and adolescents (depression, withdrawal, suicidality/self-injurious behaviors, somatization, illegal activity, running away, and substance use).

Long-Term Sequelae

In addition to short-term sequelae, investigators have illuminated a myriad of adult mental health as well as behavioral, societal, and physical correlates of CSA (NCCAN 2005c). Among these long-term mental health sequelae are elevated levels of psychopathological symptomatology, such as depression (e.g., Denov 2004; Hill, Davis, Byatt, Burnside, Rollinson, and Fear 2000; Jackson, Calhoun, Amick, Maddever, and Habif 1990; Hunter 1991; Roberts, O'Connor, Dunn, Golding, and the ALSPAC Study Team 2004), anxiety (Greenwald, Leitenberg, Cado, and Tarran 1990; Steel, Sanna, Hammond, Whipple, and Cross 2004), PTSD (Putnam 2003), obsessive-compulsive disorder (Steel et al. 2004), and personality disorder concerns or diagnoses, including antisocial and borderline (Callahan, Price, and Hilsenroth 2003; Putnam 2003). Additional cognitive and behavioral effects include suicidal ideation and suicide attempts (Anderson, Tiro, Price, Bender, and Kaslow 2002; Read, Agar, Barker-Collo, Davies, and Moskowitz 2001), dissociation (Putnam 2003), substance use/abuse (Denov 2004; Molnar, Buka, and Kessler 2001), somatization (Polusny and Follette 1995; Putnam 2003), disordered eating behaviors (Putnam 2003; Smolak and Murnen 2002), risk of aggression toward others, including one's children (DiLillo, Tremblay, and Peterson 2000), diminished self-esteem (Hunter 1991; Jackson et al. 1990), and academic/vocational difficulties (Arias 2004). At a broader societal level, victims of CSA have been found to have higher health care costs and lower self-perceptions of good health (Arias 2004). A meta-analysis conducted by Paolucci et al. (2001), for example, found that PTSD, depression, suicide, sexual promiscuity, victim-perpetrator cycle, and poor academic performance all represented, to varying degrees, substantially elevated risks for CSA survivors.

More recently, interest has increased in exploring the associations between a history of childhood maltreatment and adult interpersonal functioning. Within this domain, adult survivors of child maltreatment are more likely not only to display social maladjustment in dating and extracurricular activities (Jackson et al. 1990), but also to experience greater overall relationship dysfunction in comparison with nonmaltreated individuals. This dysfunction may in-

clude decreased relationship satisfaction and trust, as well as a greater likelihood of infidelity and relationship instability or termination (Colman and Widom 2004; Denov 2004; DiLillo 2001; DiLillo and Long 1999; Hunter 1991). Child maltreatment also appears to be related to the occurrence of physical violence in adult dating and marital relationships (Barnett et al. 1997; DiLillo, Giuffre, Tremblay, and Peterson 2001). DiLillo et al. (2001), for example, found that women with a history of CSA were more likely to be involved in relationships characterized by minor and severe forms of interpartner aggression (e.g., breaking things, hitting/kicking, beating), as well as greater amounts of bidirectional, reciprocal (i.e., male-to-female and female-to-male) acts of violence. Research in this area also suggests that sexual abuse during childhood is associated with problems related to sexual functioning, including preoccupation with sexuality, negative attitudes toward sex, fear of intimacy, unrestricted sexual behavior, sexual dissatisfaction, and sexual maladjustment (Davis, Petretic-Jackson, and Ting 2001; Meston, Heiman, and Trapnell 1999; Noll, Trickett, and Putnam 2003; Rumstein-McKean and Hunsley 2001).

Recent literature has helped to elucidate factors that accompany CSA and its correlates. For example, researchers documented the frequent co-occurrence of maltreatment subtypes (e.g., high overlap between sexual abuse and physical abuse) (Davis et al. 2001; Dong, Anda, Felitti, Dube, Williamson, Thompson, Loo, and Giles 2004; Higgins and McCabe 2000). Similarly, it appears that the long-term effects of CSA are cumulative, with symptom presence and severity increasing as more forms of maltreatment are experienced (Anderson et al. 2002; Clemmons, DiLillo, Martinez, DeGue, and Jeffcott 2003; Higgins and McCabe 2000, 2003). Finally, when considering long-term sequelae, there are many concomitant or intervening factors that may mediate or moderate the impact of the consequences associated with CSA (e.g., Beitchman, Zucker, Hood, DaCosta, Akman, and Cassavia 1992; Nash et al. 1993; Rind et al. 1998). For example, childhood family environment has been shown to be more chaotic, dysfunctional, and conflictual in victims of CSA (Bennett, Hughes, and Luke 2000; Long and Jackson 1994). It has been documented that the long-term sequelae of CSA diminish in significance after accounting for family environment issues (Rind et al. 1998). However in most cases, even when these mediating and moderating variables are controlled, an array of CSA sequelae remain (Molnar et al. 2001; Sachs-Ericsson, Blazer, Plant, and Arnow 2005).

Current Controversies Related to CSA

Although there is a general consensus that CSA is a prevalent and deleterious societal phenomenon, several issues, such as ritualistic/satanic abuse, accuracy of children's testimony in court regarding CSA, children's suggestibility and adults' false memories surrounding CSA experiences, and multiple personality disorder, remain controversial or unresolved (Fergusson and Mullen 1999; Wolfe and Birt 1997). Professional groups commenting on each of these "hot topics" demonstrate distinctly polarized viewpoints. In the area of recovered memory, for instance, professionals often display inclinations toward one of two positions, promoting either the belief that so-called "recovered memories" are often accurate representations of the past, or the belief that it is essentially impossible to forget (or repress) and subsequently recover a memory of early abuse (Farrants 1998). Further complicating this division, research in the area of recovered memory has both supported and debunked aspects on both sides of this issue, thereby inflaming each viewpoint (Farrants 1998). In commenting on ritual abuse, Gallagher (2001) notes the paradox that the various parties involved in the debates regarding CSA "are passionately committed to upholding the welfare and interests of children and survivors. However, if this is to be done, then all of us working in this area must be equally committed to finding out the truth irrespective of our preconceptions and beliefs" (p. 84). This comment reflects the notion that even though the topic of CSA generates passionate debate, the underlying goals—to prevent abuse and assist victims—must be achieved by advancing science and identifying commonalities.

Summary

Since antiquity, children have experienced sexual abuse by adults. Following a period of alternately being recognized then suppressed, CSA ultimately garnered public attention in the aftermath of Kempe et al.'s (1962) study on the physical abuse of children. Since that time, attempts to define CSA have remained difficult and fraught with differing professional opinions. Nonetheless, research focusing on the prevalence and consequences of CSA has confirmed that it is a widespread societal problem with a range of negative intra- and interpersonal outcomes across the lifespan. At the same time, some victims of CSA seem to suffer few ill effects. To date, the intersection of research and policy work has placed CSA in the public consciousness by un-

derscoring its magnitude and adverse correlates. Following closely behind the widespread recognition of CSA as a serious societal problem, various controversies, such as the existence of recovered memories, emerged among professionals and laypersons alike. Understanding of CSA and its consequences will best be furthered by a commitment to objective scientific inquiry and a focus on commonalities of the various parties interested in the protection and well-being of children.

Andrea R. Perry & David DiLillo
University of Nebraska–Lincoln

[*See also* Bullying and the Family; Child Abuse and Juvenile Delinquency; Child Maltreatment, Interviewing Suspected Victims of; Child Neglect; Incest; Post-Incest Syndrome; Prosecuting Child Abuse; Ritual Abuse-Torture in Families; Sibling Abuse; Victim-Blaming Theory]

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