Expert report

SEXUAL ABUSE OF CHILDREN

Discovery and consequences

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Preface

The work of the National Swedish Board of Health and Welfare includes providing support for the knowledge-based development of social services. Amongst other forums this takes place in within the framework of the KUB project, in which one of the theme areas is sexual abuse of children. Some 20 assignments have been distributed amongst experts within different fields of knowledge. Reports from the experts provide a platform used by the Swedish Board of Health and Welfare to decide on what position to take in matters concerning the sexual abuse of children.

Docent/chief physician Carl Göran Svedin, project leader at BUP-Elefanten, University Hospital, Linköping, has been appointed by the Board of Health and Welfare to compile a report on current research into the discovery and consequences of the sexual abuse of children and young persons.

Svedin's account has been examined by Dr Erik Kreyberg Normann, director of the Barne- og familjeetaten, Oslo.

It is our sincere hope that this report will contribute to increased knowledge and increased understanding about how the sexual abuse of children is usually discovered and what consequences such abuse can have in both the short and the long term.

The regulations applying to expert reports from the KUB project state that the authors of the reports themselves are responsible for content and conclusions.

Lars Pettersson
Director general

Contents

Summary

In the majority of all cases of sexual abuse there are no medical findings at the time of registration, there are no witnesses and it is difficult to collect supportive evidence. Therefore the statement of the child becomes very central. Further, it is important to understand that a certain symptom or behaviour pattern should not be taken as a sign that sexual abuse has taken place. Instead this should lead to us talking to the child and listening to what they have to say.

Any physical symptoms and injuries can generate suspicions of sexual abuse. However, such evidence can be difficult to interpret and so it is absolutely essential that children are examined carefully by highly qualified specialists who are experienced in such matters. In the event of abuse having taken place, this examination should be conducted as soon as possible in order to confirm any findings to be assessed.

Psychic symptoms and behavioural disorders can simultaneously represent signs of sexual abuse and early consequences of sexual abuse. The reactive symptoms of children having suffered sexual abuse can be varied. It is probably true to say that age, sex and personality of children subjected to sexual abuse have a determining effect on symptoms developed. Surveys have found a number of risk factors pertain to children subjected to sexual abuse, including such circumstances as a dysfunctional family pattern with or without physical violence, lack of care, lack of emotional attachment to one or both parents and social isolation. It is known that such circumstances are connected to an increased frequency of symptoms and behavioural disorders, and so difficulties can arise when trying to ascertain a causal connection with any certainty.

Some symptoms, which in themselves do not provide proof of sexual abuse, are nevertheless clinically and theoretically connected to abuse problems. A sexualised behaviour pattern and signs of post-traumatic stress syndrome (PTSD) should always lead to suspicions of sexual abuse once other explanations have been rejected. Moreover, these signs might have other underlying causes which could be important to acknowledge and to take care of.

A fairly large group of children fail to exhibit any symptoms in follow-up surveys. There are probably at least three different reasons for this, and additionally these reasons can co-vary with each other. The first has to do with trauma, i.e. some one-off traumata do not necessarily have to lead to serious consequences. Second, some children have a greater ability than others to withstand and surmount difficult circumstances, grow up in problematic environments and turn out well in the end. And thirdly, what we call the sleeping effect can cause events that have made a serious impression to remain concealed until much later on in life. Proving the validity of this latter theory is difficult, but there are many clinical examples of how earlier experiences come to the surface when a person’s life takes a new turn, and

in someway triggers a recollection of an event which has caused trauma in the past.

The long term consequences of sexual abuse during childhood and adolescence are beginning to become generally more intensively studied and documented. The probability of developing various psychosocial difficulties in the long term increase from two to four times as a result of sexual abuse.

Introduction

This report on the discovery of sexual abuse of children and young persons, and the consequences of this abuse, is based on a traditional survey of available literature and searching the MedLine and Psychlit data bases, using the search words of disclosure, short-term effects, long-term effects, consequences + sexual abuse.

The presentation will try to cast light on how sexual abuse is discovered and the consequences sexual abuse can have in the short and long term.

Discovery of sexual abuse can occur in many different ways, see figure 1. Disclosure of sexual abuse can occur through the child purposely telling someone about it or by talking about it unintentionally. In other cases, other people become suspicious, e.g. owing to the child exhibiting symptoms, behavioural disorders and/or the appearance of physical symptoms. People involved in the discovery can be parents, relatives, day-care centre and kindergarten personnel, school teachers or social welfare officers. In other words, anyone who in any way has everyday contact with the child. And finally, suspicion can arise from medical examination. Anyone seeing, i.e. witnessing sexual abuse or, in their routine work, police coming across evidence to suggest sexual abuse has occurred, are very rare events. The exceptions to this prevalent in Sweden would be through identification of children used in child pornography (Svedin, Back, 1996).

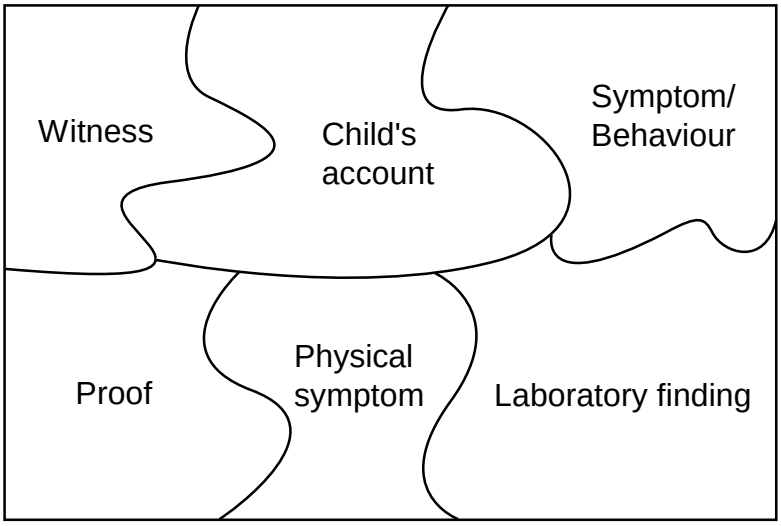

Figure 1. Disclosure – discovery

In a survey of reports of suspected sexual abuse received by the police or the social services, 38 percent resulted from children having talking about this abuse themselves, 32 percent resulted from the child's behaviour or symptoms, including physical symptoms, 20 percent came about through investigations directed at other children, 15 percent due to witnesses and 1 percent due to the confessions of the perpetrator (Sharland et al, 1996).

Reports from children

When does a disclosure occur?

Surveys from the USA and Sweden, usually prevalence studies, have shown less than half of those who have suffered sexual abuse talk about/reveal this in close association with the assault itself. A large proportion only reveal these circumstances later on in life when they seek treatment or participate in research surveys (Finkelhor, Hotaling, Lewis & Smith, 1990, Edgardh, 1992, Elliot, 1993a).

In a survey of women subjected to sexual abuse during childhood, 37 percent had told someone about this at the time of the occurrence (Finkelhor, 1980). In a more recent epidemiological prevalence study, Finkelhor and colleagues showed (1990) that 40 of those subjected had disclosed the abuse when it occurred, 24 percent of women and 14 percent of men disclosed the abuse on a later occasion, 33 percent of the women and 42 percent of the men had never told anyone before the survey was made. Elliot (1993b) noted similar figures amongst qualified professional women, namely that 20 percent had disclosed the abuse when it took place, while 40 percent said nothing about it until they participated in the research survey. Additionally, several surveys show that not many such disclosures (6-12 percent) are reported to the authorities (Elliot, 1993a, Saunders et al 1992).

Clinically and legally based material shows a similar picture. Gomes-Schwartz and colleagues (1990) found in their survey of 156 children included in a treatment project, that 24 percent reported what had happened within a week of the sexual abuse having taken place, 17 percent waited over a year before saying anything and 39 percent failed to say anything until they entered the program for evaluation/treatment. Another survey disclosed that 75 percent of sexually abused children failed to report what they had suffered within one year of the event and that 18 percent waited more that five years before saying anything (Elliot, Briere, 1994).

In the Edgardh (1992) survey of over 2000 seventeen year-olds, 7 percent of the girls and 3 percent of the boys reported they had been subjected to sexual abuse. More than half of these young people said they had talked to an adult about the abuse. Only 9 percent of the young people who stated they had suffered sexual abuse had talked to a qualified professional about what had happened. None of the boys in the survey had talked to a professional. The number of cases reported to the social welfare services was not stated.

Surveys of psychiatric patients paint a similar picture. In a study of 120 adults admitted for acute care, 52 percent of the women and 39 percent of the men reported they had suffered sexual abuse as children. Only 14 percent had previously disclosed this abuse to anyone (Wurr, Partridge, 1996).

The collective results from these studies show that many adults have failed to tell anyone that they have suffered sexual abuse. One explanation could be that the adults do not associate their current psychological, psychi-

atric problems with the earlier assault. Only 16 percent of those who reported having been victims of sexual abuse in childhood connected their complaint with this assault (Wurr, Partridge, 1996).

To whom will a child turn?

Irrespective of when a child talks or of how large a proportion of children talk in various surveys, it is most common for a child to talk to one of their parents, most often the mother.

Bradley and Wood (1996) recount in a study that 35 percent disclosed the abuse to someone inside the family, 16 percent to an outside relative or friend and 13 percent to a member of school staff. In Sharland and colleagues' study (1996) the percentages were about the same between the number of children talking to a parent (40 percent) and to professionals, usually a teacher (43 percent). In a survey from the Save the Children advice centre for boys in Stockholm, 58 percent of the children first disclosed they had been sexually abused to the mother, father or both parents (Svensson, 1998).

The process of disclosure

Sgroi (1982) describes two types of disclosure; intentional and unintentional. In a survey of 117 confirmed cases of sexual abuse, Sorensen and Snow found 75 percent were disclosed unintentionally and 25 percent intentionally (1991). Further, they described disclosure as being more of a process than an event. This description is supported by other authors and researchers (Berliner, Conte, 1990, DeVoe, Faller, 1999).

The most common unintentional disclosures in order of frequency are; the children having been seen together with the perpetrator, sexualised behaviour in the child, unnatural expressions used by the child, behavioural problems, confiding in a friend, bearing the "look" of a victim and the confession of the perpetrator. Unintentional disclosures were more common in younger children, while intentional disclosures were more common in older children. Similar age patterns were reported from a study by Campis and colleagues (Campis et al, 1993). In the Sorensen and Snow survey (1991) incentives to talk included, in order of frequency; sexual information provided by schools, anger, taking the chance when it felt right, support from friends and being encouraged by the perpetrator moving away (safe to talk) or by the perpetrator coming to visit (fear). Only 11 percent of the children started off with a disclosure without showing any hesitation or retraction. The majority of children denied the abuse, later to talk about it in hesitant fashion. 22 percent retracted their disclosure, and later on most of these reasserted that abuse had taken place.

Bradley and Wood (1996) polemized against the conception of disclosure being a process in a study of 249 confirmed cases of sexual abuse. They arrived at completely different results than those obtained by the Sorenson and Snow survey, and were unable to confirm the hypothesis of disclosure as a process. In their survey, most (72 percent) of the children had disclosed the abuse to someone else before they approached the authorities to have their case investigated (6 percent had approached the social welfare services or the police themselves). In the survey, 94 percent of the children said they had suffered sexual abuse, 6 percent started off by denying it. Of those who

had initially disclosed abuse, 4 percent retracted their statements later. The authors failed to find any explanation for the discrepancies between the Sorensen and Snow survey and their own. However, as Jones (1996) points out, it is important we remember that a disclosure is, despite everything, a process that begins long before either social welfare services or the police become involved.

A further difficulty is that children who have talked earlier are not as forthcoming in conditions of formal investigation. This can in itself be explainable by the finding that retraction is usual, although the phenomenon can easily have other explanations, especially where younger children are concerned. In the Keary and Fitzpatrick survey of 251 children in Dublin (1994) it was found that 86 percent of the children who had talked to someone before the formal investigation, repeated what they had said during the investigation. In the 0-5 age group, only 59 percent repeated what they had said. In the group who had not talked before but were included in the investigation due to other reasons (e.g. behavioural problems, sexualised behaviour, physical symptoms) only 14 percent talked during the investigation, mostly teenagers. DeVoe and Faller (1999) came up with similar results in their survey of 76 children aged 5-10 who came in to be interviewed. In this survey, 79 percent disclosed entirely what they had disclosed earlier.

Retraction frequency in surveys has varied from 4 to 22 percent (Elliot, Briere, 1994, Jones, McGraw, 1987, Sorensen, Snow, 1991, Bradley, Wood, 1996).

An *active attitude*, i.e. questioning children, and indeed adults, is important to children revealing a sexual assault. In a study of children and young people being treated as psychiatric outpatients, it was found the proportion of cases increased from 6 to 31 percent if children were specifically asked by qualified personnel if they had been exposed to abuse (Langtree et al, 1991). Similar figures were obtained when questioning adult women in a psychiatric emergency ward. When the women were asked directly, the frequency of abuse reports increased from 6 to 70 percent (Briere, Zaidi, 1989). When the interviewer lacked insight into whether or not an assault had taken place, they did not seem to be able to increase the chances of obtaining a disclosure, probably because an interviewer who lacks preknowledge needs to have more patience and flexibility when listening to the accounts of children (Cantlon et al, 1996). In regard to attitude and interview technique please see other KUB documentation (Cederborg, 1999, Christianson, 1999).

Why is it so difficult to talk?

From the collected empirical and scientific documentation it is clear that children find it very difficult to talk about sexual abuse, both when this is in progress and later on in life. This is emphasised further by the survey of children identified in Sweden as being included in the child pornography rings in Huddinge and Norrköping (Svedin, Back, 1996). The nine children involved in these rings had been subjected to sexual abuse for a total of 28 years and kept this matter to themselves for 42 years without telling anyone. Under police questioning they still could not talk spontaneously about the abuse until they had been shown the actual evidence material. Guilt, shame,

consideration of both the perpetrator and parents and plain fear, were all reasons the children gave for keeping quiet. Direct threats were unusual, although other surveys show that secrets, i.e. that only the victim and the perpetrator know about the sexual abuse, result in events occurring over extended periods of time being forgotten (Elliot, Briere, 1995, Fish, Scott, 1999) and that threats reduce the likelihood of the child talking, especially if the perpetrator has a close relationship with the child (Lyon, 1996).

It seems to be easier to say that abuse has occurred if the perpetrator is a person outside the family (Edgardh, 1992). This means that if the perpetrator is outside the family, the child is more inclined to talk at the time of the abuse actually taking place or shortly afterwards, than if the perpetrator is a member of the family (Gomes.Schwartz et al, 1990). In a study of 3,220 women, where 288 women reported they had been subjected to sexual abuse with penetration before 18 years of age, it was found that a low age at the time of the assault and a close relationship with the perpetrator was significantly coupled with a delayed disclosure (Smith et al, 2000). It also seems that children, and adults too, need a push, a reminder, which provides the required impetus for them to talk or makes talking about the abuse easier, see figure 2, an assertion backed-up by the Sorensen and Snow survey (1991).

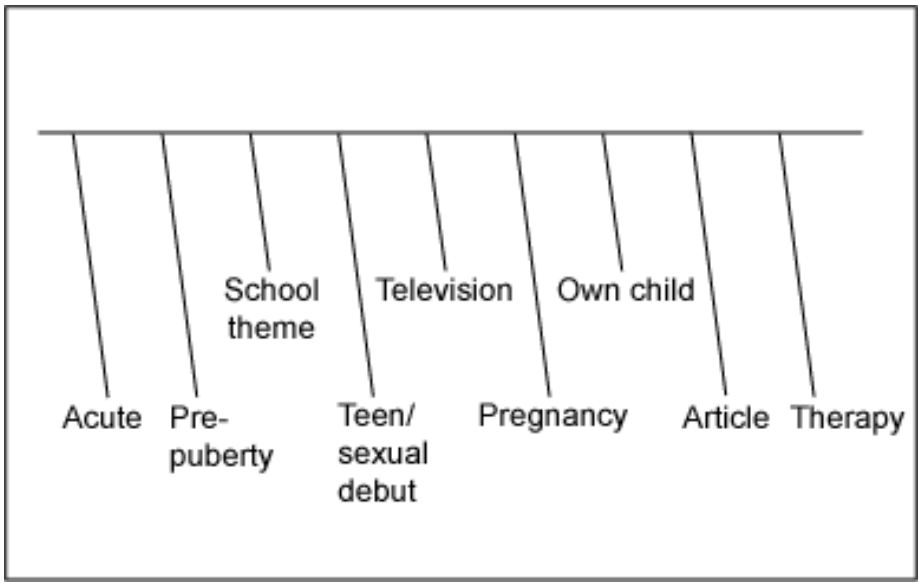

Figure 2. Incentive for disclosure

Other authors have attempted to explain the inability or unwillingness of children to talk about their experiences as an adaptation to the system in which the child lives. The “child sexual abuse accommodation syndrome” describes how the child, due to feelings of guilt and shame and the expectations projected by their surroundings, contains the experience of the abuse within themselves, feels powerless, sometimes retracts their disclosure and adjusts themselves (Summit 1983). A good deal of empirical data supports the Summit description, although the syndrome as such is the object of criticism and has not been scientifically verified. It should be pointed out that

for the most part the Summit model is based on teenagers and intra-family sexual abuse.

Physical symptoms as an indication of sexual abuse

Suspicion of sexual abuse can arise from the child exhibiting physical symptoms at home, within child care services or at a medical examination.

The presence of physical signs and injuries due to sexual abuse varies strongly from survey to survey. In the Lindblad thesis it is stated that findings in the shape of injuries or sexually transferable diseases (STD) vary from 10–82 percent in the four studies referred to (Lindblad, 1989). In one of the surveys of 29 children, 10 cases (34 percent) exhibited positive findings indicating sexual abuse. In a further 9 cases findings corresponded with sexual abuse patterns, but could have been caused by other means such as injury or disease.

The signs we see after sexual abuse has taken place are a consequence of trauma and/or infection. Because healing takes place extremely quickly, signs and findings will depend on the time passed since the most recent assault, the type of assault, the age of the child, earlier abuse and over what length of time these have occurred.

Bamford and Roberts (1989) opine that there are 5 main reasons to medically examine children suspected of having suffered sexual abuse.

- to detect traumatic or infective conditions that may require treatment
- to evaluate the nature of any abuse
- to provide forensic evidence that may be helpful to the furure protection of children
- to reassure the child, who somteimes feels that serious damage have been done
- to start the process of recovery

Whether or not a medical examination is warranted depends on the circumstances. The child's ability to heal injuries is considerable, and the volume of information we can obtain from an injury will be greater the earlier the child is examined after a trauma. When it is suspected that a child has been subjected to sexual abuse within the past 72 hours an examination in order to confirm the presence of semen should be made immediately.

Signs and injury to genitals

The signs and injury visible on *female genitalia* are:

- bruising
- widening of the vaginal opening
- chafing
- bleeding

- inflammation
- secretion
- swelling
- blisters
- ruptures
- warts
- damage to the hymen
- scar formation
- widening of the hymen opening
- labial adhesion

The signs and injury visible on *male genitalia* are:

- swelling
- ruptures
- inflammation
- secretion
- bruising
- warts
- chafing
- burn-marks
- scar formation

Signs and injuries visible in the *anal area*:

- inflammation
- ruptures
- swelling
- scars
- bruising
- bleeding
- chafing
- loose musculature
- ruptures
- leakage of faeces
- warts

Sexually transferable diseases (STD) which could appear are:

- chlamydia
- HIV
- gonorrhoea
- herpes simplex type 2
- trichomonas
- genital warts
- syphilis

Semen can be present on the body and in body orifices. To this we should add other injuries to the skin when violence has taken place, e.g. bruises to the neck in children after oral intercourse, bruising to the hips after anal intercourse and on the inside of the thighs when these have been forced apart. Spots of bleeding in the mucous membrane can sometimes be seen on the roof of the mouth after oral intercourse. Other signs include repeated urinary tract infection or pregnancy.

However, we must not forget that sexual abuse does not always result in body injuries, because it could be a matter of surface manipulation of the genitals. When a child talks about something that seems similar to intercourse it is not unusual to find this to be what is called interlabial intercourse (when the perpetrator has moved the penis backwards and forwards between the labia) or between the upper parts of the thighs (intercrural intercourse). This abuse does not result in signs of penetration of or injury to the genitals, and this might cause the child's assertion to seem questionable.

Specialist examination important in order to eliminate other causes besides sexual abuse

Because several of the signs in this list can have other explanations besides sexual abuse, e.g. inadequate hygiene, infection, skin diseases or other injurious mechanisms, it is important that a specialist with in-depth experience in examining children and young people carry out these examinations. One excellent motivation for this can be found in the considerable variation in the normal appearance of genitals, especially those of small girls. Moreover, extensive experience in examining children is required in order to assess the behaviour of the child in the examination room and in the examination situation. Finally, it must be remembered we are talking about emotionally charged and stressful examinations/investigations demanding skill and experience. For reference material about examination technique, examination findings and the interpretation of these findings, see specialist literature (Kjessler et al, 1994, Meadow et al, 1993, Hobbs, Wynne, 1996, Adams, Knudson, 1996).

Symptoms and behavioural disorders as indications of sexual abuse/early consequences

A suspicion can arise owing to the child exhibiting symptoms and behaviour which lead the observer to – with or without other information – suspect sexual abuse has taken place. Knowledge and expertise are now on hand within this field which support the concept that symptoms and behavioural disorders can be signals, signs of sexual abuse. One method of approaching this question is to study the symptoms of children who have suffered sexual abuse and make comparisons with controlled groups of children who have not been subjected to sexual abuse. Another way has been to compare the symptoms of child and adolescent psychiatric patients, based on whether or not they have been subjected to sexual abuse. Others have turned the method around, and studied how sexual abuse has materialised in anamnesis within differently diagnosed groups in child, adolescent and adult psychiatry.

Initial effects are usually referred to as being those symptoms and behavioural disorders that appear within 2 years of the cessation of the latest occurrence of sexual abuse (Browne, Finkelhor, 1986a). In adults, long-term effects are usually studied either through interviews with clients who have been victims of sexual abuse during childhood, or via retrospective surveys in which the health of adults is studied in relation to the presence or absence of sexual abuse during childhood.

Mechanisms of origins

Unlike adults, children are always going through a critical period in their development when subjected to sexual abuse. When growing up, children form their opinions about themselves, other people and the world about. Children's relationships with themselves (self-esteem, confidence) and with others develop as they form their own concepts of neighbourliness, reciprocity, respect and trust. Child development in knowledge, proficiency and coping ability develops in parallel to this, in an ongoing process.

Consequently, in addition to the immediate crisis generated by a sexual assault, the abuse will have the potential to affect the long term development of the child's psychological and social maturity. That is to say, there is a risk that the effects of the abuse will turn into something both dynamic and highly interactive, unlike the initial reaction to the trauma. John Briere (1992) hypothecates that the consequences of a sexual assault can be divided into three stages:

- the initial reaction

- the adjustment to the continuation of this sexual abuse
- long term development and secondary adjustment

Additionally, Briere says that although the initial reactions to a trauma can be temporary, it is more usual for such reactions, together with specific abuse relations behaviour, to become more generalised and develop over an extended period, if treatment is not forthcoming.

MacCann and colleagues (1988) find the individual to have certain preconceptions and expectations (schemata) in regard to themselves and others, which both create and are created from our experience of the world. When sexual abuse occurs, these schemata are disturbed in regard to security, trust, power and self-esteem. In turn, these disorders create such symptoms as fear and anxiety, confusion, excessive caution, the inability to trust others, passivity, a feeling of meaninglessness, depression, deep negative self-esteem and feelings of guilt and shame.

The Finkelhor and Browne traumatogenic model

The Finkelhor and Browne (1985) traumatogenic model has long been exemplary in areas where we need to understand how it comes about that certain children manage to cope with sexual abuse (can deal with their experience) while others suffer more or less long term difficulties. This model can be seen as an answer for those who opine that the effects of a sexual assault shall be seen solely as a post-traumatic stress syndrome (PTSD). Finkelhor (1988) says that only relatively few children who have suffered sexual abuse meet the criteria for post-traumatic stress syndrome and moreover, that many children do not exhibit the different symptoms associated with PTSD such as flashbacks and the inability to feel emotion.

Finkelhor and Browne describe (1985) four traumatogenic factors which can lead to negative psychosocial effects in children after sexual abuse. These are the betrayal by the adult, stigmatisation, traumatic sexualisation and the powerlessness of the child, see tables 1a-d.

Each factor arises as a result of certain behaviour and the interplay between the perpetrator and the child (dynamics), represents various consequences of the child's thought processes and emotions (psychological effects), and can be observed in the shape of different behaviour patterns in the child (behaviour manifestation).

Table 1a. Sexual traumatisation: dynamics, psychological effects and behaviour manifestation.

Dynamics	**Psychological effects**	**Behaviour manifestation**
The child is encouraged into non-adequate sexual behaviour	Increased forwardness in regard to sexual matters	Sexual preoccupation and compulsory sexual behaviour
The perpetrator offers attention and tenderness in return for sex.	Confusion in regard to sexual identity	Precocious sexual activity
Body parts of sexual	Confusion in regard to sexual norms	Promiscuity Prostitution

significance are fetishized Perpetrator spreads erroneous perception of sexual behaviour and morals Forces sexual activity with negative emotions and memories	Mix up of sex with love and care Negative associations to sexual activity and excitement Aversion to sexual intimacy	Sexual dysfunction such as: Flashbacks, difficulty in becoming sexually excited and in reaching orgasm Avoidance of or phobic fear of sexual intimacy Improper sexualisation in fosterage

The authors are saying that traumatic sexualisation is a process in which the sexuality of the child, including emotions and attitudes, is shaped in a non-developmental and interpersonal, functional manner as a consequence of sexual abuse. This can take place in a number of different ways and by rewards in the guise of attention, benefits, gifts etc. or by attention being focused on the genitals and sexual functions of the child. The relation between the adult and the child is made erotic. This can result in various types of sexual behaviour or disorders, both in the form of over-sexuality and the inhibition of sexual desire/activity.

Table 1b. Stigmatisation: dynamics, psychological effects and behavioural manifestation.

Dynamics	**Psychological effects**	**Behavioural manifestation**
The perpetrator blames the victim The perpetrator and others pressure the child to keep quiet The child concludes the activities were shameful Others exhibit a shocked reaction to disclosure Others blame the child for what happened The victim is regarded as “damaged goods”	Guilt, shame Reduced self-esteem Feeling of being different	Isolation Addiction Criminality Self-destructive behaviour or suicide attempt

Stigmatisation becomes a form of psychological consequence materialising as the child’s negative attitude towards her/himself. Shame, guilt and a feeling of being bad are incorporated into the child’s picture of her/himself through the perpetrator laying the blame on the child or the reaction of the surrounding world after the situation has been disclosed. This lack of self-esteem can lead to isolation and different forms of self-destructive behaviour including suicide attempts.

Table 1c. The adult betrayal: dynamics, psychological effects and behavioural manifestation.

Dynamics	Psychological effects	Behavioural manifestation
Trust and vulnerability are manipulated Violation of child's expectations that others shall provide care and protection The well-being of the child is ignored Lack of support and protection from parent (parents)	Grief, depression Extreme dependency Reduced ability to evaluate reliability of others Lack of trust, especially towards men Anger, hostility	Clinging behaviour Vulnerable to future abuse and exploitation Isolation Uncomfortable in intimate relations Matrimonial problems Aggressive behaviour, criminality

The betrayal by the adult is characterised by the fact that this is an adult with a close relationship to the child who has betrayed, manipulated, exploited and raped the child. The child risks developing a lack of trust in other people and experiencing difficulties in forming close and trusting relationships with other people later in life. This can take many different forms on a scale from isolation to lack of distance.

Table 1d. Powerlessness: dynamics, psychological effects and behavioural manifestation.

Dynamics	Psychological effects	Behavioural manifestation
The child's body has been invaded against their will Vulnerability to exceeding limits continues over a period of time Perpetrator uses force or tricks to involve the child The child feels unable to protect her/himself and stop the abuse Repeated experiences of fear Child incapable of getting others to believe in their description of abuse	Anxiety, fear Reduced strength Regarding self as a victim Need to have control Identification with aggression Nightmares	Phobia Somatic cramps, insomnia Depression Dissociation Running away, problems at school, truancy Problems at work Vulnerable to future abuse Aggressive behaviour, bullying, criminality Self-sexual abuse

The powerlessness a child can feel and develop derives from the fact that the emotional and physical limits of the child are not respected. Attempts of self-protection and to in some way put a stop to the abuse are prevented by the overwhelming power of the adult. Resignation and adjustment lead to a vicious circle in which powerlessness is reinforced. There is a risk of the

child developing a “victim identity” or alternatively, aggressive compensatory behaviour, during the years of growing up and in adulthood.

Furthermore, the degree of trauma in the abused child is thought to depend on five characteristics of the actual abuse; whether or nor penetration has occurred, the relationship between the perpetrator and the child, the frequency and duration of the abuse, whether or not physical violence has taken place, and the degree of erotization.

The Freidrich coping model

Friedrich (1990), who largely supports the Finkelhor model, says however that the latter focuses on the child’s initial cognitive understanding and experience of the abuse, and leaves out many variables which could affect the consequences of the abuse. First and foremost, the model developed by Friedrich takes into consideration the quality of the ongoing influence to which the child is exposed through interaction with the members of the family, and the child’s own network in the shape of e.g. friends, school and social care. Other important elements include the child’s development and maturity, the child’s ability to handle their experiences, the family’s ability to deal with what has happened, and other life situations of significance. The Friedrich model can be likened to a theoretical model dealing with how the child handles the sexual abuse over a period of time (coping model). Although all these parts hang together and are in this way dependent on each other, he divides his model into four sections, see figure 3.

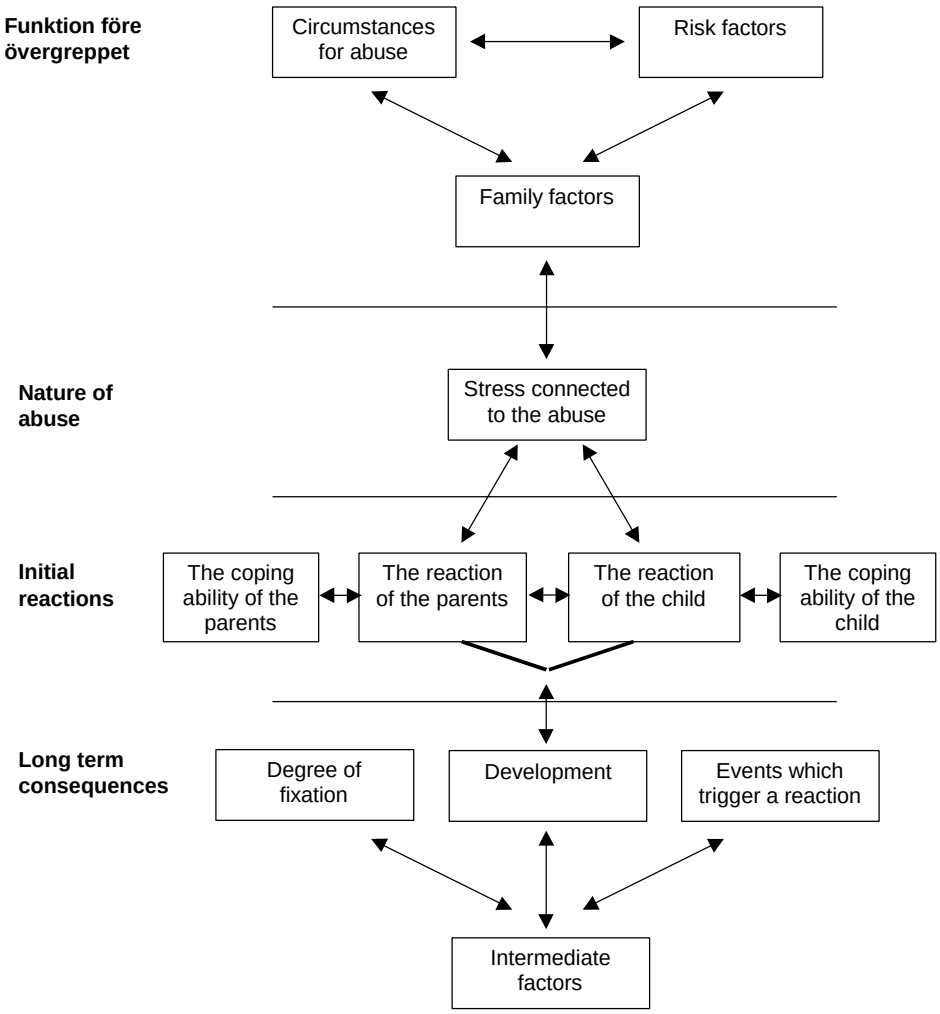

Figure 3. The Friedrich coping model
Risk factors

Function before abuse

The first section takes up factors related to the period before abuse, and includes risk factors, collected mainly from Finkelhor's study of risk factors (1979, see also Svedin 1999a), family factors that explain why abuse occurs in certain families and not in others and other family variables, primarily collected from Finkelhor (1984) and the Finkelhor model as to which circumstances are required in order for sexual abuse to take place (1984, see also Svedin 1999a).

Stress factors associated with abuse

The other section takes up the nature of the abuse, mainly based on the Finkelhor and Browne traumatogenic model, as described earlier. Friedrich points out that abuse entails strain and stress for the child as do the reactions which follow a disclosure of abuse. This does not necessarily mean the materialisation of post-traumatic stress syndrome, even though some children do develop this. Friedrich emphasises how heterogeneous sexual abuse can appear in the form of various sexual acts, subsequent behaviour, the reaction

of the child and the family to treatment and the reaction of society to the disclosure of sexual abuse. Friedrich is saying that the symptoms the child might develop cause continued stress for the child and the family. Additionally, Friedrich opines that it is important to study the materialisation of several stress factors appearing simultaneously, such as conflict in the home and alcoholism, which will be of major importance to how the child reacts after sexual abuse. Friedrich introduces the importance of the interplay between the individual and the surrounding world (transactional effects) and the possibilities offered by this interplay. The child's experiences of sexual abuse and reactions to sexual abuse could be experienced by a parent in a number of different ways. The parent reacts, and the child reacts in turn to the parent and modifies her/himself and her/his behaviour according to the parent's reaction. Within this interplay we find many variables, both positive and negative, and these can result in different courses of events occurring in each individual case.

The reaction of the child and the family

The third section illustrates the reaction (response) of the child and of the family to the abuse and their abilities/resources in handling this stressful situation (coping resources). Friedrich describes various models to illustrate child coping ability, although he himself spotlights the Karen Horney (1950) contribution to coping theories. She describes three solutions to a conflict: the child learns to "move towards" the individual, "move away from" the individual and "move against" the individual. A non-traumatised child learns to use all three attitudes without emphasising any of them. Having probably come to a halt in their development, a traumatised child might learn only one attitude, which will not be an advantage. When we look at the three categories covering the connection between child and parents as described by the attachment theory (Feiring 1983), we find the Horney model to be very similar. Children securely attached (move towards) and those who are uncertainly attached, and who in turn are divided into ambivalently attached (move both against and towards) and evasively attached (move away from).

Different factors are thought to affect children's coping ability, such as predisposition factors; e.g. talents, social group, family composition, potentiation factors, e.g. the stress factor in itself plus protective factors such as network, school performance, problem solving ability and comradeship picture (Garmezy, 1983). Further, the coping concept is associated with what is usually termed stress resilience and salutogenes (Antonowsky, 1979, 1987) where the focus is on studying why some children, despite difficult circumstances, in this case sexual abuse, manage to do well in life.

In regard to parental coping capacity in connection with acute or chronically stressful situations (non-specifically sexual abuse), Friedrich refers us to Folkman and colleagues (1979). According to these authors, the following factors influence parental coping ability: social support/network, a realistic and positive system of values, financial resources, the ability to solve problems, good physical health and energy, high morale and the absence of depression.

The long term effects of abuse.
The fourth and final section describes reactions over a period of time, i.e. long term consequences. Friedrich takes up such phenomena as fixations, development and trigger events. He says fixation is a concept which can be applied to the general halt to development after sexual abuse. Such halt to development can be followed by the child fastening on to some form of symptomatic behaviour. Other children might fasten themselves onto e.g. bulimic behaviour while developing sections of their personality separately, in the shape of academic or musical interest.

Friedrich is supported by Winnecott (1975) in saying that some children have neither the emotional nor the cognative ability to deal with an overwhelming trauma. The result is defective integration, with the victim having diminished access to recollections and experience. This will hinder anyone when they try to help the child therapeutically by referring to the child's memory and experience. Defective integration can coincide with both symptomatic behaviour and symptom free behaviour. In the latter case, later experiences in life, such as sexual debut, pregnancy and childbirth, can trigger the non-integrated trauma and result in first ever appearance of symptoms and behavioural disorders. Friedrich concludes by saying that the delayed consequences of sexual abuse shall be compared with the collected previous experiences during the life of this person (sections 1-3).

Other descriptions of the abuse process

Summit (1983) has described how girls adjust to sexual abuse from men (within the family) in what is called the child's sexual abuse accommodation syndrome. Summit says that sexual abuse has five characteristics which explain the consequent dynamics, and these are; secretiveness; helplessness, entanglement and adjustment; a delayed, conflicting and unconvincing disclosure; plus retraction of the disclosure. Adjustment takes place owing to the child learning to become sexually available without complaint. The child finds various ways of adjusting, e.g. by keeping the secret to themselves in order to keep the family together, by equipping themselves with imaginary friends with whom to talk, and maintaining different levels of awareness. Other children might become aggressive, demanding and hyper-active. "The Syndrome" is designed primarily to assist clinics in understanding the dynamics of abuse, and not for purpose of diagnosing abuse as having taken place.

Sgroi (1982, 1988) describes a pattern typical to intra-family sexual abuse and other forms of sexual abuse which have taken place over a period of time. The process develops in five stages: the involvement stage, in which the perpetrator seduces the child into a special kind of relationship; the sexual abuse phase, in which sexually intimate behaviour is developed from less intimate to increasingly intimate forms of abuse; the secretive phase; the disclosure phase, when the abuse is disclosed; and the say nothing phase, when the family does everything possible to persuade the child to retract their testimony.

Friedrich (1995) found disorders caused by sexual trauma fell into three main areas: attachment, self-regulation and self-perception.

Briere (1996) describes three areas affected by disturbing events in his Self-Trauma Model (which integrates trauma, ego psychology, cognitive and behavioural therapy within a development perspective). These are the feeling of identity, personal limits and the ability to regulate emotions/effects.

Signs and initial consequences of sexual abuse

Browne and Finkelhor (1986b) concluded in an survey of 27 empirical studies describing the consequences of sexual abuse of children, that some children exhibited initial reactions such as fear, anxiety, depression, anger, hostility and an unsuitable sexual behaviour. The inappropriate sexual behaviour takes the form of masturbation, exaggerated sexual curiosity and frequent exposure of own genitals. The weakness of this investigation was that most responders in the surveys were adults when they were included in respective studies, and only four were surveys of children/adolescents.

Beitchman and colleagues (1991) surveyed 42 published studies of the short term effects of sexual abuse of children. With the exception of sexualised behaviour, the symptoms they were able to identify in the different studies were fairly unspecific, and such as we see occurring frequently in clinical situations. The children and adolescents who had been subject to sexual abuse, developed more sexually inappropriate sexual behaviour than those who had not been exposed. The children who had suffered sexual abuse exhibited behaviour such as sexual games, masturbation, seductive or sexually aggressive behaviour, and sexual knowledge which was not age adequate. Amongst young people, sexual lassitude and promiscuity were noted. It was found that more serious symptoms were connected with the following factors: the number of assaults, over how long a period the abuse had continued, if the abuse had included violence or penetration, if the abuse had been performed by the child's father or stepfather. However, it was not possible to identify any post-sexual abuse syndrome.

Green (1993) examined 100 articles on the subject of sexual abuse of children, written for the most part after 1980. Green found that the most common psychological problems found in children who had suffered sexual abuse were: anxiety, such as agitation/fear, nightmares, phobias, somatic cramps and post-traumatic stress syndrome; dissociative reactions and hysteria symptoms such as periods of amnesia, trance-like conditions, and multiple personality disorders; depression, low self-esteem and suicidal behaviour; sexual behavioural disorders included easily awoken sexual excitement and an aggressive sexual behaviour as well as the avoidance of sexual stimuli through phobias and inhibitions. Nor did Green consider there to be any syndrome specific to sexual abuse.

The Kendell-Tacket survey and analysis

The Kendell-Tackett and colleagues (1993) survey and analysis of 45 studies is the survey which is most relevant and which is cited most often. The survey confined itself to studies of children/adolescents who had suffered sexual abuse and who were under 18 at the time of examination. Studies were conducted using quantitative measurements, with either a comparison

between sexually abused children and control groups of children who had not been sexually abused or normal data (clinical and/or non-clinical), or a comparison between ages.

From table 2 we can see that children and adolescents exhibit a number of different symptoms and behavioural disorders.

The majority of all symptoms were identified in 20-30 percent of the children in the studies. Few symptoms were repeated in more than half of the children.

Table 2. Percentage of sexually abused children with symptoms and behavioural disorders.

Symptoms	Studies/Child	% children with symptoms	Spread in % of symptoms between the different surveys
Anxiety	8/688	28	14-68
Fear	5/477	33	13-45
Post-traumatic stress syndrome			
Nightmares	5/605	31	18-68
General	4/151	53	20-77
Depression			
Dejection	6/753	28	19-52
Reserved	5/660	22	4-52
Suicidal	6/606	12	0-45
Low self-esteem	5/483	35	4-76
Somatic cramps	6/540	14	0-60
Mental illness			
Neurotic	3/113	30	20-38
Other	3/533	6	0-19
Aggressiveness			
Antisocial aggressiveness	7/658	21	13-50
Criminality			
Sexualised behaviour			
Unsuitable sexual behaviour	13/1.353	28	7-90
Promiscuity	2/128	38	35-48
School/learning problems	9/652	18	4-32
Behavioural problems			
Hyperactivity	2/133	17	4-28
Regression/immaturity	5/626	23	14-44
Illegal actions	4/570	11	8-27
Running away	6/641	15	2-63
General	2/66	37	28-62
Self-destructive behaviour			
Addiction	5/786	11	2-46
Self-harmful be-	3/524	15	1-71

haviour			
Collected symptoms			
Internalising	3/295	30	4-48
Externalising	3/295	23	6-38

Note. Processed from Kendall-Tackett et al (1993)

Two thirds of the children exhibited different types of symptoms or behavioural disorders, but one important discovery was that about one third of all children failed to exhibit any symptoms or behavioural disorders at the time of examination, with a spread of between 21 percent (Conte, Schuerman, 1987) and 49 percent (Caffaro-Rouget et al, 1989).

Because some symptoms varied a great deal according to the age of the child, the children were divided into three age groups, and from this division a rather different picture was obtained. The commonest symptoms in preschool children (0-6) were agitation/anxiety (61 percent), nightmares (55 percent), generalised post-traumatic stress syndrome (77 percent, inappropriate sexual behaviour (35 percent), regression/ immaturity (36 percent) and the two symptom categories of internalising symptoms (48 percent) and externalising symptoms (38 percent). Amongst school children (7-12) the most common symptoms were fear (45 percent), nightmares (47 percent), neurotic mental illness (38 percent), aggressiveness (45 percent), problems at school (31 percent), hyperactivity (23 percent) and a regressive/immature behaviour (39 percent). Finally, the commonest symptoms in adolescents (13-18) were depression (46 percent), withdrawn (45 percent), suicidal tendencies (41 percent) or self-destructive behaviour (71 percent), somatic complaints (34 percent), promiscuity (38 percent), illegal actions (27 percent), running away (45 percent) and substance abuse (53 percent).

In an analysis of the 26 studies which compared children exposed to sexual abuse with non-clinical control group children who had not been exposed to sexual abuse, many studies showed a significant difference between the groups as regards most symptoms or symptom groups, see table 3.

Table 3. A comparison between sexually abused children and non-clinical control groups.

Symptom	Number of studies	Number (%) reporting a significantly higher proportion of children with symptoms amongst children exposed to sexual abuse
Anxiety	8	5 (62.5)
Fear	5	5 (100)
Post-traumatic stress disorder		
Nightmares	1	1 (100)
General	1	1 (100)
Depression		
Depressed	11	10 (90.9)
Withdrawn	11	11 (100)
Suicidal	1	0 (0)
Low self-esteem	6	3 (50)
Somatic complaints	11	9 (81.8)
Mental illness		
Neurotic	2	2 (100)
Other	7	6 (85.7)
Aggression		
Antisocial aggressiveness	11	10 (90.9)
Cruelty	2	2 (100)
Criminality	6	6 (100)
Unsuitable sexual behaviour	8	8 (100)
School/learning problems	6	5 (83.3)
Behavioural problems		
Hyperactivity	7	5 (71.4)
Regression/immaturity	2	2 (100)
Running away	1	1 (100)
General	2	2 (100)
Self-destructive behaviour	1	1 (100)
Composite symptoms		
Internalising	8	8 (100)
Externalising	7	7 (100)

Note. Processed from Kendall-Tackett et al (1993)

In regard to comparisons between studies which compared children who had suffered sexual abuse with clinical groups of children who had not been exposed to sexual abuse, we found a different picture. In most studies, the clinical children exhibited more symptoms than the sexually abused children in regard to two symptoms, sexual behaviour (6 of 8 studies, 75 percent) and post-traumatic stress syndrome (1 of 1 study, 100 percent).

Analyses of connections between abuse and symptoms

Furthermore, Kendell-Tacket et al (1993) carried out a measurement analysis of the connection between abuse status (abused and not abused) and a number of different symptoms/consequences, such as aggressiveness, anxiety, depression, reserved behaviour, sexualised behaviour and the internalising and externalising symptom groups. The analysis showed that abuse status accounted for 15 percent of the variables in regard to anxiety and a total 43 percent in regard to aggressiveness and sexualised behaviour. Since this kind of variable measurement is somewhat difficult to interpret clinically, Fergusson and Mullen (1999) carried out a re-analysis using the "odds ratio", i.e. how many times more often one variable, in this case a symptom, appears in a group in comparison with another. This was found to be possible in three of the 26 studies (Einbeder, Friedrich, 1989, Deblinger et al, 1989, Gomes-Schwartz et al, 1990).

In the Einbeder and Friedrich study it was 7.3 times more common with externalising symptoms /problems and 5.2 times more common with internalising symptoms /problems in children who had been abused compared with the control group who had not been abused. Deblinger et al compared two groups of psychiatric patients in care, one group having been subjected to sexual abuse, the other not. When looking at sexual abuse behaviour towards other children, this was found to be 12.6 times more common amongst the sexually abused patients and sexually unsuitable behaviour was 45.8 times more common. In the re-analysis of the Gomes-Schwartz et al study, where sexually abused children had come in for therapy, and normal values for instruments applied were compared, it was found that in ten different analyses the odds ratio varied from 1.9 to 44.1, with a median value of 7.8. This suggests, claim Fergusson and Mullen (1999), that children who have come in for treatment for sexual abuse, are at an increased risk of developing a wide spectrum of personal, social or behavioural problems.

In conclusion, Kendell-Tackett et all (1993) say the situation of having suffered sexual abuse as a child is strongly related to certain specific symptoms, such as sexualised behaviour, and to a number of other more general symptoms, such as depression, aggressiveness and reserved behaviour. Simultaneously, sexually abused children do not exhibit more symptoms than other clinical children, apart from sexualised behaviour and post-traumatic stress syndrome.

In the analyses of the longitudinal studies the conclusion could be drawn that after 1-1 ½ years some 20 – 33 percent of children had fewer symptom/behavioural disorders, while 10-24 percent had deteriorated. Between 6 and 19 percent, over a period of between 18 months to five years, will have been victims of further sexual abuse. In a study from England, an increase of symptom frequency from the time of measurement, 4 weeks after disclosure, until a follow-up 9 months after disclosure, could be seen. Symptoms being primarily anxiety / depression, lack of friends, sexualised behaviour, insomnia and anger (Calam et al 1998). Only the increase in anger and lack of friends were statistically significant. Symptoms such as exhibitionism and difficulties at school continued to increase up until 2 years of follow-up, although were not statistically significant. The materialisation of bribery

(girls) and verbal threats (boys) was connected with a larger number of symptoms / behavioural problems.

Factors of importance to symptom development, i.e. more symptoms, included the proximity of the perpetrator (the nearer the more symptoms), a higher frequency of abuse, a longer period of abuse, more violence in connection with abuse, abuse that included penetration and lack of support from the mother. Moreover, a negative attitude and negative coping style were connected to an increase in the number of symptoms in the victim. Age at the time of the first assault, age at the time of survey and the period of time between, and the number of perpetrators, were found to have a more uncertain connection with the number of symptoms exhibited by the victim.

Some studies have focused on the discrepancies in symptoms and behavioural disorders between girls and boys. Surprisingly, most studies have found a similar symptomology amongst girls and boys (Kendell-Tackett, 1993). Boys exhibit similar stress-related symptoms to girls after disclosure, such as sexualised behaviour, anxiety, post-traumatic stress syndrome and difficulties at school and with learning. However, some studies support there being a difference between the sexes when looking at behaviour in such forms as internalising and externalising groupings. On the other hand, this is something we can see generally amongst normal populations and in clinical studies of children with problems. Boys are reported to be more extroverted, rowdy, defiant with aggressive behaviour towards their friends and siblings, while girls are more inclined to show depression. At the same time we also find girls who exhibit more extroverted behavioural reactions and boys who close up and exhibit more anxiety and depression. However the most obvious differences seem to be within the sexual area. Sexually abused boys seem to have a greater tendency towards sexually aggressive behaviour and to engage themselves in coercive sexual behaviour with other children (Sansonnett-Heyden et al, 1987, Friedrich, Leucke, 1988, Watkins, Bentovim, 1992). Additionally, Friedrich and Leucke (1988) found that those boys who exhibited sexually aggressive behaviour lacked parental support and had all suffered physical violence and sexual abuse, including anal penetration. The degree of psychic deviation in boys and their parents was significantly higher than in those boys who had suffered sexual abuse but did not display sexually aggressive behaviour. Although sexually aggressive behaviour is sometimes seen in girls (Johnson, 1989), girls seem more frequently inclined to exhibit sexually reactive behaviour in the form of a seductive or sexualised behaviour, and this makes them vulnerable to further abuse (Gomez-Schwartz et al, 1985).

The seriousness of the consequences

The seriousness of the consequences which a sexual assault brings about for a child depends on both abuse related factors and general factors. Amongst those which are specifically abuse related, we find closeness to the perpetrator and elements of violence or whether or not penetration has occurred (Conte, Schuerman, 1987, Friedrich et al, 1986, McLeer et al, 1988).

An important and positive general factor is the support a child receives from the non-perpetrating parent (Conte, Schuerman, 1987, Everson et al, 1989). Unfortunately, a parent who experiences a large amount of stress

themselves will have less ability to support their child (Deblinger et al, 1993, Kelley, 1990). It is therefore, just as important to provide support and, if necessary, psychotherapeutic help to the parent as to the child. And finally any documentation of the abuse, such as child pornography in the form of photographs, video films, etc., will mean an increased of symptom development and stigmatisation (Burgess et al, 1984, Svedin, Back, 1986).

Sexualised behaviour

In the previous survey articles it was found that sexualised behaviour is the most common consequential symptom in children and adolescents who have suffered sexual abuse (Browne, Finkelhor, 1986b, Beitchman et al, 1991, Kendall-Tackett et al, 1993). Moreover, Friedrich and colleagues (1992) found that sexual behavioural problems are the most commonly reported problems consequent to sexual abuse.

In literature and research we find a number of different concepts/terms for what we summarily call sexualised behaviour. Based on the theories of learning theory, Finkelhor and Browne (1986) opine that sexual abuse can create a traumatic sexualisation, while Cunningham & MacFarlane (1991) opine that children who assault other children act/react out their earlier trauma in a violent, aggressive and sexual fashion (abuse reactive/sexually reactive). Yates (1982) on his part, puts the emphasis on sexual abuse resulting in an easily aroused sexuality – the child becomes eroticized (eroticized child).

Gil (1993) uses the concepts of age adequate and inadequate sexual behaviour and has developed a series of social criteria to determine when sexual behaviour is to be assessed as inadequate.

Johnson and Feldmeth (1993) describe a continuum from normal sexual behaviour to sexually aggressive or molesting behaviour. The four groups are *normal sexual behaviour* which is based on curiosity - that actions shall be seen as an investigative, information gathering process, one-sidedly or mutually voluntary between children of approximately the same age and level of development. In *sexually reactive behaviour* the child displays a larger breadth in behavioural repertoire, with a larger difference in behaviour compared with children the same age. Many are assumed to have suffered sexual abuse or to have been sexually over-stimulated in some other way. When discovered they frequently react with the emotions of shame and guilt and usually cease the activity when told to do so. The child is frequently alone in these sexual activities and any form of force imposed when together with others is a rare occurrence. In the group of children falling *under comprehensive mutual sexual behaviour* we witness repeated adult-like sexual activities with other children, but which do not seem to awaken such emotions of shame and guilt as exhibited in sexually reactive children. The authors believe that many of these children have suffered sexual abuse and that they all have experience of some other form of abuse such as physical and/or emotional assault. The authors designate the fourth group as being children with *sexually aggressive or molesting behaviour*, i.e. perpetrator behaviour. They are described as having an impulsive and compulsive and aggressive component included in their sexual behaviour. They search for their victims amongst other children and force is always in the picture to some degree. The lack of feeling and lack of empathy is always prominent.

Children in this group have often suffered sexual abuse and usually come from the same kind of socially and emotionally dysfunctional environments as the earlier groups. Children in this group have the worst prognoses and are the most difficult to treat.

Friedrich (1990) maintains that sexual behaviour problems can be expressed in the form of a sexually aggressive behaviour, behaviour that reflects a distorted perception of personal limits, a confused sexual identity, inclination to self-arousal (e.g. pronounced masturbation) and inhibited behaviour in sexual matters.

Sexualised behaviour is both connected to socially difficult circumstances when growing up and has a clinical relevance, as is shown by a study over a period of five years of 499 children and adolescents under care at a children's and adolescent's psychiatric unit (Adams et al, 1995). In the study it was found that 41 percent had some form of inappropriate sexual behaviour and that 16 percent had performed some kind of abuse themselves. Amongst those children who did not have sexualised behaviour, 36 percent had been sexually abused themselves during the years of growing up, while in children with sexualised behaviour it was found that 82 percent had suffered sexual abuse. Children with hyper-sexualised behaviour had also experienced physical violence and lack of care to a greater degree, and more often had behavioural disorders and retardation problems. Furthermore, it was more frequent they came from families with a history of being asocial.

To sum up what is meant by a sexualised behaviour or an unsuitable behaviour we can say it is a behaviour that is not age adequate, is difficult to divert and is almost compulsory in character. When seen in relationships with others, it is usually said that the mutual play or the mutual experimentation has taken on a compulsory character in which a child/adolescent forces themselves or manipulates in various ways, one or more other children to participate in sexual play and activities. The sexual behaviour replaces other activities and becomes a focal point of the child's day-to-day life.

Behaviour can take the form of an exaggerated interest/curiosity, in the form of a sexualised language and interest in own genitals, e.g. in the form of masturbation, in sexual activities with other children or in sexual behaviour towards adults. *It is important to emphasise that variations in a child's normal behaviour are considerable, and that adults should be careful not to overreact when a child exhibits nakedness or sexual curiosity.* Sexualised behaviour can have materialised via several different routes during which sexual stimuli have been aroused. It could for example be a consequence of a child living in a generally sexualised environment, having being present during or seen intercourse between parents or seen sexually charged television/video programs. Additionally, behaviour can materialise as auto-stimulatory replacement behaviour in connection with under-stimulation, something previously more frequently observed amongst children from children's homes. Sexualised behaviour can also be observed in connected with some neuropsychiatric disorders (Gillberg 1999). In instances of less severe forms of sexualised behaviour, counselling is usually sufficient, but with more serious forms specialised treatment is usually required (Johnson, Feldmuth, 1993). For further reading about normal sexuality and sexual

behaviour in children another KUB document is recommended (Larsson, 1999).

The risk of subsequent development of perpetrator behaviour in victims

Finkelhor and Dziuba-Letherman (1994) believe the assumption that a child who has been sexually abused will subject others to sexual abuse later on in their lives is well established. In regard to the actual proportion of sex criminals convicted of abusing children and who themselves have been subjected to sexual abuse during their period of growing up, the frequency figures quoted in literature vary to a remarkable extent. Elliot, Browne, Kilcyon (1995) found that about two thirds of 91 persons convicted of sex crimes had themselves been sexually abused as children, while others found frequencies of between 20 and 50 percent (Earls et al, 1984, Bard et al, 1987, Freund et al, 1990, Greenberg et al, 1993, Murphy, Smith, 1996). Hanson and Slater (1988) carried out an evaluation of surveys which defined sexual abuse (sexual activity inflicted upon, or performed by means of persuasion with, someone younger that 16, by a person 5 years or more older than the said younger person) and found that one third of perpetrators performing sex crimes against children had suffered sexual abuse themselves as children, compared with the 10 percent found in a control group made up of men not convicted for sex crimes against children. Irrespective of the exact figures, it seems that assaults amongst sex criminals against children is at least twice or three times more frequent than such assaults registered amongst the normal population.

Although the number of perpetrators who have suffered sexual abuse in childhood is high, this by no means applies to all. Furthermore, not all children who have experienced sexual abuse become perpetrators themselves later on in life. Prendergast (1992) shows a number of characteristics in children who have suffered sexual abuse, but who have not reported the abuse and who have not become sex offenders as adults. These characteristics include a strong and positive self-esteem, a positive attitude towards the future, ambition and a functioning and supportive social network.

Post-traumatic stress syndrome (PTSD)

Symptoms such as anxiety and post-traumatic stress disorder have been associated with sexual abuse for some time (Goodwin, 1985, Kiser et al, 1988). Goodwin (1985) was the first clinician to describe post-traumatic stress symptoms in children who had experienced sexual abuse (incest). Many of the symptoms children can exhibit after sexual abuse fall within the framework of post-traumatic stress disorder, PTSD (Deblinger et al, 1989).

McLeer and colleagues (1988) identified post-traumatic stress syndrome in 48 percent of sexually abused children in a study of children at an outpatient ward for child psychiatry.

In the Kendall-Tackett and colleagues survey (1993), 53 percent of children (20-77 percent spread) exhibited a general post-traumatic stress condi-

tion. The seriousness of the abuse, and the presence of force and violence, increases the risk of development of PTSD (Basta & Peterson, 1990). Children who have experienced both sexual abuse and physical assault are regarded as being an especially high risk group for PTSD development (Kiser et al, 1991). It would seem there are good reasons for regarding, the more serious forms of sexual abuse at least, as traumatic.

Three descriptions of trauma during childhood

Lenore Terr (1991) defines a trauma during childhood as: "the psychic result of a sudden, external and horrid/menacing event or a series of events, which renders the young person temporarily helpless and which breaks through the child's ordinary way of handling their surroundings and the child's defence mechanisms…(including) not only the state characterised by intensive surprise experience, but also that characterised by extended and horrific anticipation. All childhood trauma… originates in external events…Once an event has occurred, a number of changes occur in the child. These changes are permanent".

Judith Herman (1992) describes trauma thus:

"A psychological trauma is the suffering experienced by a helpless person. At the time of trauma the victim is put into a helpless condition by an overwhelming force… Traumatic events overwhelm ordinary self-preservation systems which normally provide people with a sense of control, coherence and meaning".

Van der Kolk and colleagues (1996) believe that:

"…the critical factor making an event traumatic is the subjective evaluation of the victim as to how threatened and helpless they feel…the meaning the victim associates with the events are just as fundamental as the trauma in itself. A person's interpretation of the significance of a trauma continues to develop for a long time after the trauma in itself has stopped".

In addition to experiencing or witnessing physical or sexual assault, children can be exposed to emotional and psychological assault, including the betrayal of care. Trauma in childhood can be a one-off event, but usually in the case of child assault and sexual abuse, this occurs on repeated occasions over a longer period of time. The age and development of the child will be decisive to how the child reacts psychologically and behaviourally, and how the child understands the trauma.

Terr (1994) divides trauma into Type 1 and Type II, where Type 1 can be exemplified by one-off events such as abuse without threat or violence, while Type II is more serious and can be exemplified by repeated abuse which is evidently threatening or violent.

PTSD symptoms as per DSM-IV

PTSD symptoms can be divided into three categories according to DSM-IV (The American Psychiatric Association, 1994). The first is the *re-living of the traumatic event* which can be expressed through insistent and painful recollections, thoughts, nightmares about events or discomfort brought on by inner or outer stimuli which serve as reminders of the event. We can see the theme or different aspects of the trauma in the play behaviour of small children (Terr 1981). Children's nightmares can be either tangible or general

and lacking content, while expressing the traumatic event. The second category entails the *avoidance of anything that could trigger reminders of the event* and *less interest* in participating in normal activities or *indifference* towards others and an inability to feel emotion or any optimism about the future. The third category comprises *increased stress symptoms* such as insomnia, irritability/aggressiveness, difficulties in concentrating, exaggerated vigilance and being easily frightened. Many children who exhibit post-traumatic symptoms, without meeting DSM-IV specifications for post-traumatic stress disorder, can nevertheless be disabled by this complaint (Giaconia et al, 1995)

All-in-all, most studies into this field show that serious trauma in childhood, including assault (all forms), significantly increases the risk of a person developing a number of problems, including eating disorders, personality disorders, anxiety, depression, self-inflicted injuries/self-destructivity, suicidal tendencies, suicidal behaviour and addiction (Atlas, 1995, Harrison et al, 1997, Herman, 1992, Mullen et al, 1996, Pynoos et al, 1993, van der Kolk et al, 1996, Vize, Cooper, 1995).

For more reading into post.-traumatic stress syndrome in children, including treatment, see the Pfefferbaum survey article (1997).

The long term effects of sexual abuse

In the Browne and Finkelhor (1986) survey of the long term effects of sexual abuse in girls, based on 26 empirical studies, they noted an increased presence of depression, self-destructive behaviour, feelings of isolation and stigmatisation, low self-esteem, a higher risk of being subject to new sexual abuse and addiction.

Finkelhor (1990) states, in an update of recently published studies, that there are only minor differences in the long term effects between men and women. On the other hand,

Gold and colleagues (1999) showed, by using a standardised instrument, that men who had experienced sexual abuse exhibited more symptoms than women, when comparing with standardised, normative data for respective sexes.

Schetky (1990) notes that research into the long term effects of sexual abuse indicates an increased incidence of psychiatric hospitalisation, addiction, self-destructive tendencies, somatization, erotization, learning difficulties, dissociated conditions, conversion reactions, running away, prostitution, re-victimisation and interpersonal difficulties.

Beitchman and colleagues (1992) conducted an survey of 32 studies and found that women who reported sexual abuse during childhood, unlike those who did not, were shown to have an increased frequency of sexual weaknesses/dysfunctions, reported more homosexual experiences in adolescence and adulthood, exhibited more symptoms of anxiety and fear, possibly related to violence or the threat of violence, exhibited more depression and depressive symptomatology, had suffered more new sexual assaults, and were more prone to thoughts of suicide and suicidal behaviour, especially if they had been victims of violence. The longer the period over which time incidents of sexual abuse took place, if penetration took place and if the perpetrator was a father or stepfather, all these factors were connected with more long term consequences.

Finkelhor and Dziuba-Leatherman (1994) cite the growing amount of literature on this subject. They estimate that the risk of developing psychiatric illness at some time in life is four times greater, and that the risk of developing addiction in children who have experienced sexual abuse is three times greater, compared with those who have not.

Ferguson and Mullen (1999) state there are now an increasing quantity of studies into the connection between sexual abuse in childhood and psychosocial adjustment as an adult. The problems areas where the authors assess it has been possible to identify a connection and an increase in incidence are:

- Depressive symptoms
- Anxiety disorders
- Antisocial behaviour

- Substance abuse
- Eating disorders
- Suicidal behaviour and self-damaging behaviour
- Post-traumatic stress disorder
- Sexual problems

In the Ferguson and Mullen (1999) survey of 13 municipality based studies with more than 100 participants, with a clear definition of sexual abuse and which had been published since 1990, an odds ratio analysis was made, i.e. how much more usual was it with a certain symptom/problem when comparing those who had suffered sexual abuse with those who had not, see table 4.

Table 4. Odds ratio between sexual abuse in childhood and psychiatric outcome as an adult

Study	Number of women/men	Variable studied	Odds ratio All forms of sexual abuse	Odds ratio Contact abuse	Odds ratio intercourse
Bagley et al, 1994	0/750	Depression		2.3	
		Suicides		5.1	
		Suicide attempts		17.1	
Bifulco et al, 1991	236/0	Depression (¤ PSE)		5.1	
Beautrais et al, 1994	175	Serious suicide attempts		11.7	
Bushnell et al, 1992	30/10	Addiction	1.2		
		Depression / dystymia	2.1		
		Eating disorders	1.5		
Ferguson et al, 1996	1.025	Depression	5.5	5.5	7.0
		Anxiety	4.3	4.0	4.2
		Conduct disorders	2.3	3.2	4.4
		Alcohol addiction	2.6	2.8	3.1
		Other addiction	2.2	2.8	5.0
		Suicide attempts	5.0	6.4	11.2
Gould et al, 1994	292	Suicide attempts		6.2	
Hooper, 1990	418/0	Psychological sickliness	3.1		7.2
Miller et al, 1995	441/0	Required psy-			4.2

		chological help within 12 months			
		Received psychological help in the last 6 years			2.3
Mullen et al, 1993	497 /0	GHQ*	1.7	2.0	4.0
		CGHQ#	2.3	2.6	7.3
		PSE¤	3.6	4.6	9.7
		Eating disorders	3.2	3.1	6.7
		Anxiety syndrome	2.4	3.0	3.0
		Depressive condition	2.6	3.5	5.2
		Suicidal behaviour	20.4	26.2	74.0
Scott, 1992	3.131	Some disorder	3.8		
		Some emotional disorder	2.4		
		Addiction	3.1		
		Pill addiction	5.2		
		Alcohol addiction	2.1		
		Phobia	3.4		
		Depression	3.4		
Silverman et al, 1996	187/0	Depression	6.2		
		Simple phobia	3.4		
		Social phobia	1.3		
		PTSD	28.6		
		Alcohol addiction	8.9		
		Pill addiction	3.8		
		One or more disorders	6.0		
		Suicidal ideas	3.5		
		Suicide attempts	14.1		
Wonderlich et al, 1999	1.099	Compulsive eating	2.0		
		Compulsive eating + vomiting/purging	2.6		
Zierier et al, 1991	186	Pill addiction			1.0

Note. Processed from Ferguson, Mullen, 1999
*General health questionnaire, # General health questionnaire, chronic scoring ¤ Present state examination

Of the 71 odds ratios in table four, 65 were statistically significant ($p < .05$).

Depressive symptoms

Seven studies found a connection between sexual abuse and depressive complaints later in life, all of which were significant. The median value of the odds ratio was 4.3 (spread 2.1 – 7.0), indicating a moderate to strong connection. Depression is perhaps the most frequently examined area of diagnosis in regard to the long term effects of sexual abuse. The prominent position occupied by depression is thought to be due to the accumulated effects of treachery, powerlessness, the emotions of guilt and hopelessness and low self-esteem (Finkelhor, Browne, 1995).

Anxiety and phobias

Four studies reported a connection with a median value where the odds ration was 3.0 (spread 1.3 – 4.3). Conditions of anxiety have also been studied frequently, and there seems to be a connection between the elements of threat and violence in sexual abuse and the appearance of anxiety (Beitchman et al, 1992).

Antisocial behaviour

Only one study was included that studied the connection between conduct disorder and sexual abuse, with an odds ratio varying between 2.3 and 4.4 depending on the seriousness of the abuse.

Sustance abuse

Five studies report a connection between substance abuse, including alcohol addiction, with a median value where the odds ration was 2.8.

In a survey of 12 studies describing the proportion of clients in care for alcohol addiction who have been subject to sexual abuse in childhood, Flemming (1997) found a variation of between 20-74 percent. Flemming (1997) believes that addiction can materialise due to a complex cause process in which sexual abuse increases the risk of entering a relationship with an man addicted to alcohol and that in turn, this relationship increases the risk of alcohol addiction.

In the Edgardh study of 2,153 seventeen year olds, the early consumption of alcohol (< 15 years) was significantly greater amongst both girls and boys who had reported being subjected to sexual abuse during childhood, compared with those who had not reported any abuse.

Eating disorders

Three surveys studied the connection between sexual abuse and eating disorders. The median value of the odds ration in these studies was 2.9 with a spread of 1.5-6.7. Several studies have thus shown a connection between eating disorders and experience of sexual abuse during childhood. According to Vanderlinden and colleagues (1993), the strongest connection seems to be between sexual abuse and later on, the development of compulsive eating (bulimia). In the Edgardh study (1999), more than 12 percent of the girls who had been subjected to sexual abuse reported eating disorders, and

this was three times more than those girls included in the study who had not reported sexual abuse (p<.001). In girls who had broken off their schooling, this situation was even more common.

Suicidal behaviour

Six studies reported a connection between sexual abuse and suicide attempts/suicidal behaviour with an odds ratio varying between 3.5 and 74.0, median value 11.5. This indicates a strong connection between sexual abuse in childhood and later on, attempted suicide in adult years, even if the behaviour in itself is not particularly common. In the Edgardh study (Edgardh, 1999) 17 percent had frequent thoughts of suicide and more than 30 percent had carried out suicide attempts or other self-destructive actions, amongst the girls who had reported being subjected to sexual abuse during their period of growing up. This was significantly more than amongst those who had not reported sexual abuse, and these problems became even more marked when studying the girls who had broken off their schooling (38 and 63 percent respectively). The equivalent figure in boys who had reported sexual abuse was 8 percent in regard to frequent thoughts of suicide. 33 percent had carried out suicide attempts or other self-destructive actions.

Sexual problems

Ferguson and Mullen (1999) report on five studies oriented towards the survey of many different aspects of sexual problems from sexual dysfunction to many sexual contacts to prostitution. Of the 42 calculated odds ratios, 39 were found to be statistically significant (p< 05). The odds ration for pregnancy amongst teenagers was 3.3, for unsatisfactory sexual relations 3.0, for consequent sexual abuse 6.9 and for multiple sexual relations 3.3. These results indicate a strong connection between sexual abuse in childhood and the appearance of sexual weaknesses of various types at a later date.

PTSD

The one study made describes the connection between sexual abuse and post-traumatic stress disorder, and shows a high odds ratio of 28.6. With reservation noted, because this is based on only one study, this indicates a strong connection.

General psychiatric problems

A number of studies reported more general psychiatric ill-health. The odds ratio varied between 1.7 and 9.7, with a median value of 3.8

Conclusion

To sum up, Ferguson and Mullen (1999) conclude the survey shows that the connection between sexual abuse in childhood and psychiatric condition as an adult is of a more overall character, i.e. generates different forms of psychic ill-health, rather than being specifically connected to any special psychiatric condition. In most of the connections studied, there was a 2-4 times greater risk of people developing symptoms/behavioural problems as an adult if they had been subjected to sexual abuse as a child, compared with

those who had not reported any experience of sexual abuse. In most of these studies we note the odds ratio is higher than for more stringent (or more serious) criteria, such as penetration, than for less stringent criteria in which non contact and contact abuse are mixed with penetration abuse. In a statistics control of confounding factors, i.e. other circumstances that can exist simultaneously as explanations to increased psychic ill-health in children, the connection between sexual abuse in childhood and difficulties in adult life later on is reduced. This indicates that family factors and social factors play a large part in the explanation of consequences appearing later on in life.

On the other hand, later studies to control family and social background factors, show the connection prevails (Mullen et al, 1993, Paradise et al, 1994, Stern et al, 1995, Ferguson et al, 1996).

However, in this connection we must not forget that perhaps up to around 40 percent (Finkelhor, 1990) of those who have suffered abuse in childhood do not, in fact, report any psychosocial or psychiatric difficulties in adulthood. Factors which can probably alleviate or hinder development of problems in adulthood have been studied. A supportive family environment seems to reduce the damaging effects of abuse (Romans et al, 1995, Spaccarelli, Kim, 1995). Similarly, good and socially friendly relationships, success at school in the shape of good academic results, success in sports or social life, seem to provide protective and/or supportive factors (Romans et al, 1995). Having a supportive and satisfactory intimate relationship and a supportive social network in adolescence and adulthood provide protective factors against the development of psychic ill-health as an adult (Romans et al, 1995). And finally, more personality dependent factors such as locus of control and high self-esteem seem to have a mitigating effect on the negative consequences of sexual abuse (Moran, Eckenrode, 1992) as does a positive coping ability (Spaccarelli, 1994).

Miscellaneous

In a study of object relations in 2,963 working American women, over 32 percent reported having been subject to sexual abuse before the age of 16 (Elliot, 1994). A questionnaire, “Object Relations Scale of the Ego Functioning Assessment Questionnaire” (Hargrove, 1985), containing 43 questions was used. Those who had been subject to abuse reported a significantly deteriorated ability to develop object relations in total, and in all qualities that the instrument was intended to measure. This is important information, since this sometimes helps us to understand why some people find things difficult when they have children themselves later on in life. The deteriorated ability to conduct interpersonal relations was correlated to a young age at the time of the abuse, long duration of abuse, larger number of assaults, abuse within the family, whether or not penetration had occurred, and not least the experience the abuse incurred to the victim.

Kirkpatrick and Edmunds (1992) followed up a survey of over 4,000 women who had been subjected to rape. 29 percent were less than 11 years of age on the occasion of the first rape, 32 percent were between 11 and 17 years of age, 22 percent were between 18-24 and the rest were older. Of

those women followed up, 31 percent had developed post traumatic stress syndrome (PTSD), 30 percent had experienced at least one period of depression, 33 percent had thought about suicide and 13 percent had attempted to commit suicide.

General comments

In the majority of all cases of sexual abuse there are no medical findings made at the time of report, there are no witnesses and it is difficult to gather supporting evidence. For this reason the account related by the child becomes very central. Furthermore it is important to understand that a symptom or a behaviour should not be taken as proof that a sexual assault has taken place, but should lead to us talking to the child and listening to what the child has to say. Only by caring can we win the confidence of a child and make it possible for the child to say what has happened.

When we remember the difficulties a child has to disclose and talk about anything at all, the interview situation must be optimised. We have every reason to support the concept of *child friendly interviews*. These are conducted in an atmosphere of friendliness towards the child and with professionalism. The interviews should be conducted in an environment in which the child feels at home and secure. Children are now being interviewed in situations and environments which, in worst cases, only serve to reinforce the existing extreme uncertainty, anxiety and fear of the child. Moreover, for some boys the police station and what goes on there with police and police equipment, sirens from police cars etc. provides a considerable distraction from the business at hand. Their concentration is easily dissolved by unavoidable external stimuli. Once in the interview situation, it is important to conduct the interview with the child and gather adequate peripheral information in a well prepared, sympathetic and systematic manner, because the child has difficulty both in telling their story spontaneously and in telling it under questioning. A considerable effort needs to be made in educating and training interrogators in the specialised area of child interviews. Another alternative would be for the social welfare services, using examples taken from e.g. the USA, to train their own specialists who would then conduct these specialised interviews. All this would be in the best interests of ensuring the child's need for protection and help, and for the legal rights of the suspected perpetrator.

The account of the child is therefore central to the continuance of the process. Consequently it is important for the child's initial account to be documented, preferably recorded on tape, unless the first account was given at a police interview. Central questions in the account would be whether or not the child specifically talks about an assault and can provide details as to place, time, method, perpetrator, experiences, peripheral details etc. The style of presentation, affects and the coherence of the account are also evaluated.

Any *physical symptoms and injuries* can lead to suspicions of sexual abuse having occurred. Such observations however can be difficult to interpret, and so it is absolutely essential for the child to be carefully examined by experienced and well qualified specialists. When alleged sexual abuse is

recent, the examination should take place as soon as possible in order to secure any findings that could be assessed for evidence.

Symptoms of psychic strain and behavioural disorders can simultaneously be signs of sexual abuse and of early consequences. A number of surveys of varied design have been conducted in which groups of children who have experienced sexual abuse have been compared with control groups or clinical comparison groups. In these studies a number of different symptoms have been reported in children who have suffered sexual abuse. Therefore, it might seem to be obvious that there is a connection between sexual abuse and increased psychic ill-health or deteriorated social adjustment.

Two clear reservations in making such a "causal connection" must, however be made.

The first is about selection. In most studies the survey groups comprise children who have turned to an official body or a medical health advice centre consequent to assault. They have come to be included in various treatment programs and as such do not represent a random selection of children who have been subjected to sexual abuse. It follows therefore, that there is a risk these children can be more symptomatic or problematic than the average.

The second reservation is concerned with "confounding factors", i.e. other circumstances that can exist simultaneously as alternative explanations to the increase in psychic ill-health in the children. In the risk surveys, children subjected to sexual abuse have (see Svedin 1999a) several background factors such as dysfunctional family patterns with or without physical violence, lack of care, lack of emotional ties to one or both parents, social isolation, etc., all of which we know are associated with an increased frequency in symptoms and behavioural disorders. Therefore it is difficult to determine a causal connection with any certainty.

On the other hand, Fergusson and Mullen (1999) opine there are three factors which support a connection between sexual abuse and the appearance of symptoms and behavioural disorders later in life.

Firstly, there seems to be a dosage/response connection in that the more serious the abuse and/or if the abuse has continued over a long period, the risk of subsequent difficulties increases. Secondly, we can observe a kind of specification in the subsequent symptoms, primarily in the shape of sexualised behaviour. Thirdly, forms of treatment specially designed to deal with sexual abuse seems to be those most effective in reducing psychic symptoms and adjustment difficulties (see Svedin 1999b).

Children who have been subjected to sexual abuse can therefore react with a quantity of different symptoms. Probably, age, sex and personality decide what symptoms develop in each individual child after a sexual assault.

It is important to make clear there is no symptom which can be used as proof of sexual assault, but that these are signals which shall occasion us to talk to the child and to listen to the child in order to understand and help the child with the background problems he or she might have. However, symptoms can lend strength to a child's disclosure if these can be shown to have some connection with the assault. Having said this, we should point out that some symptoms, not in themselves proof of abuse, are clinically and theore-

tically connected to sexual abuse problems. Two groups of symptoms seem to crystallise in literature and everyday clinical environments; sexualised behaviour and post traumatic stress disorder (PTSD). This very probably reflects the fact that sexual abuse is an action or a series of actions connected with sexuality and the risk of trauma. For many children it is likely that an event, including the reactions to the event, has triggered the pattern to which the child reacts in various stressful situations in life, such as illness, accidents, death in the family, divorce, bullying or similar. It is misleading to believe there is a specific response pattern, a "sexual abuse syndrome". So we should always ask ourselves "how can we interpret this?", when a child exhibits symptoms or behavioural disorders of some kind. What are the child and the symptom "communicating" to the surrounding world, how can this be explained? We need to be more observant when a child displays sexualised behaviour or post traumatic stress disorder. Sexualised behaviour and signs of post traumatic stress dissorder (PTSD) should always lead us to suspect sexual abuse has occurred if other explanations can be ruled out. Consequently, we should always look for an explanation for sexualised behaviour and post- traumatic stress disorder. These might have other background causes which could be very important to take note of and remedy.

A fairly large group of children exhibit no symptoms at all in the follow-up survey. This situation can have at least three different explanations, which can also co-vary with each other. The first explanation has to do with trauma, i.e. that some traumas of one-off type do not necessarily leave serious scars, especially if the child has not experienced the abuse as being traumatic, i.e. painful, horrid and frightening. The second has to do with salutary factors. Some children find it easier than others to withstand and get through difficult events, to grow up in problematic environments and to come out well in the end. These salutary mechanisms, which contribute to the materialisation of the "dandelion child" concept, have been described in several different circumstances (Antonovsky, 1979, 1987). This is lent additional support through children with positive attitudes and good coping ability (mastering, Gjaerum et al, 1999) exhibiting fewer symptoms than children who lack these properties (Kendall-Tackett wt al, 1993). The third explanation has to do with the "sleeping effect", which means that although an event leaves an impression, the consequences of this do not reveal themselves until much later in life. When this event takes the form of a sexual assault, then the consequences could remain concealed until the person's sexual debut, pregnancy, etc. Proving the validity of this theory is difficult, but there are many clinical examples of exactly this situation in which earlier experiences have returned in new life situations, stages in life which are in some way reminiscent of the earlier trauma.

The long term consequences we can observe consequent to sexual abuse in the years of childhood and adolescence, are becoming increasingly well studied and documented. The probability of developing diverse psychosocial difficulties in the long term increase 2-4 times after a sexual assault. This means a health problem for a significant population of people, one which is not paid sufficient attention and heed. It is something which, together with the short term consequences exerted by sexual abuse on the growing indivi-

dual, needs to be noticed politically, within Swedish social welfare and within health and medical care.

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