Child Sexual Abuse: A Review of Definitions, Instrumentation, and Symptomology

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Issues related to the conceptualization and treatment of child sexual abuse (or sexual abuse), are reviewed by the authors. The variety of child sexual abuse/sexual abuse definitions in the literature, the properties of instruments used in the research, and reported clinical outcomes and symptoms experienced by victims are reported. Symptoms are then grouped according to the Diagnostic and Statistical Manual of Mental Disorders **IV-** TR (American Psychiatric Association, 2000).

The literature pertaining to child sexual abuse (CSA) and sexual abuse (SA) addresses various aspects of this form of victimization. The variety of CSA/SA definitions in the literature, the properties of instruments used in the research, and reported clinical outcomes and symptoms experienced by victims are reported. Symptoms are then grouped according to the Diagnostic and Statistical Manual of Mental Disorders-IV -TR (American Psychiatric Association, 2000).

Various types of research designs and methods comprise the CSA/SA literature, such as quantitative and retrospective designs, interviews and analyses of self-reports and parent/caretaker reports. The most common type of study reviewed in the present paper involves quantitative and retrospective designs using young adult/adult female convenience samples (Alexander & Lupfer, 1987; Briere & Runtz, 1988; Chu & Dill, 1990; Leitenberg, Greenwald, & Cado, 1992; Perrott, Morris, Martin & Romans, 1998; Peters & Range, 1995; Schaff & McCanne, 1998; Wheeler & Walton, 1987; Wolfe, Gentile & Wolfe, 1989; Wozencraft, Wagner & Pellegrin, 1991). In these studies, the data were collected via interview questionnaires and/or self-report instruments. While qualitative studies of CSA/SA are less numerous, one was included in this review. Gill and Tutty (1998) employed standard qualitative techniques such as reflection and probing. Other notable studies have been completed by ~g parent/caretaker reports of victim behavior (Ackerman, Dykman,

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North American Journal of Psychology, 2002, Vol. 4, No.1, 149-160. @NAJP

Jones, McPherson, & Newton, 1998; Dubowitz, Black, Harrington, & Vershoore, 1993; Freidrich, Bielke, & Urquiza, 1986; Kizer, Heston, Millsap & Pruitt, 1991; Steiger & Zanko, 1990; Wells, Adams, Ensign, McCann & Voris, 1995; White, Halpin, Santilli & Strom, 1988). The literature reviewed had commonalities in the description of the instru- ment(s) used and identification of clinical or behavioral outcomes.

DEFINITIONS

Inconsistent definitions of CSA/SA undoubtedly influence both the prevalence rates and the psychological disturbances reported by victims (Briere, 1992). The terms CSA and SA or both are used in the literature. The choice of terminology appears to be based on author preference. Complicating the task of identifying a common definition of CSA are variables in victim responses such as severity of abuse, availability of social support, and attributional styles regarding the causes of negative life events (Ackman, 1991; Russell, 1983, 1984; Wolfe, Gentile & Wolfe, 1989). While Beitchman, Zucker, Hood, DaCosta & Ackman's review (1992) suggested that other salient variables included age at onset, sex of child, relationship to offender, frequency and duration of abuse, type of act and use of force as parameters of abuse, it is currently not clear how these factors affect research outcomes.

Sex Abuse Definitions

The Diagnostic & Statistical Manual of Mental Disorders-IV -TR (DSM-IV-TR, 2000) does not refer to SA and correspondingly lacks substantive information. Specific references to SA in the DSM-IV -TR are reflected in V Codes, which are other conditions that may be a focus of clinical attention or Axis IV-Psychosocial and Environmental factors with no criteria sets for sexual abuse of adults or children provided.

Russell (1984) defines SA as any unwanted sexual experience before age 14, or attempted or completed rape by age 17, or any attempted or completed sexual contact between relatives before the victim turned 18. This definition would seem more appropriate as a description of CSA, due to the inclusion of the age of the victim.

Finkelhor (1979) describes SA as any and all sexual activity or contact with a child where consent is not or cannot be given, including the use of force. Finkelhor (1979) also includes deception and the level of understanding the child has of sexual activity as contributing factors.

In a more recent review of methodological problems in the research, Golfman and Padayachi (2000). suggest four majQr factors to be considered before an experience can be regarded as sexual abuse. These include definition of sexual contact, inclusion of noncontact sexual events

and sexual invitation, inclusion of wanted and unwanted sexual experiences, and age difference between victim and perpetrator.

Child Sexual Abuse Definitions

There are no criteria in the DSM-IV-TR to characterize CSA. The criteria for Pedophilia state "The person is at least 16 years of age and at least five years older than the child or children" (APA, 2000, p. 572). The criteria set given in the DSM-IV-TR applies to the perpetrator, not the victim. Further exploration of the DSM-IV -TR yields information from V Codes. For example, Code V61.21, Sexual Abuse of a child suggests, "this category should be used when the focus of clinical attention is sexual abuse of a child" (DSM-IV-TR, 2000, p 738). Codes are simply used to identify whether the victim is a child or adult.

Friedrich, Urquiza, and Bielke (1986) defined CSA as "sexual contact with an adult, whether by force or consent, to include direct contact (intercourse) and observed contact (adult exposing self to child)" (p.50). The authors purposely excluded the age component of the Finkelhor (1979) and Russell (1983) definition, because they believed that the results would be affected. In a study examining the association between eating disorders and CSA victims, Steiger and Zanko (1990) define CSA by descriptive variables such as age, perpetrator and frequency. Rim sa et al., (1988) identify and measure emotional and somatic reactions to CSA but provide no definition of CSA. They describe results in terms of age at onset of abuse, relationship of assailant (stranger or incest) and type of assault.

Schaaf and McCann (1998) and Leitenberg et al. (1992) use a mod- ified, yet more descriptive and explicit version of Finkelhor's (1979) SA characteristic list to describe CSA. CSA is viewed as any form of sexual contact (from touching to anal intercourse before age 15 with someone at least five years older), thus adding age parameters for both victim and perpetrator. Dubowitz, et al. (1993) have a slightly different version, defining CSA "as any inappropriate sexual contact ranging from fondling to intercourse." A variation of the age descriptor was used by Peters & Range (1995), in a study assessing suicidality in college women and men. They defined CSA as unwanted sexual experiences before the age of 12 with someone who was at least 5 years older.

In a meta-analytic study of child sexual abuse correlates, Rind, Tromovitch, & Bauserman, (1998) define CSA as "a sexual interaction involving either physical contact or no contact e.g. (exhibitionism) between either a child or adolescent and someone significantly older, or between two peers who are children or adolescents when coercion is used" (p.23). Several studies did not include any definition of CSA

(Ackerman, et al., 1998; Beitchrnan, et al., 1992; Chu & Dill, 1990; Gill & Tutty, 1997; Rimsza & Berg, 1988; Wells, et al., 1995; White, et at., 1988; & Wozencraft, et al., 1991).

Implications

The literature shows that researchers during the past twenty years have exercised a great deal of latitude in choosing a definition of *CSA*. Briere (1992) suggests that findings regarding abuse correlates must be evaluated in terms of specific definitions used. The definitions of *CSA* used in research design and subsequent published literature has direct and substantial impact on resulting statistical reports as well as outcomes or symptomology reported (Beichtman, et al., 1992; Briere, 1992; Golfman & Padayachi, 2000). Information from this review suggests there is no one standard or consistent definition of *CSA* or *SA*. Confusion over definition is complicated by the seemingly interchangeable use of *CSA* and SA by those in the field, sometimes using both terms in the same published work. Commonalities do exist in components of definitions, such as age at onset, age difference between victim and perpetrator, frequency and duration of abuse. Peters (1988) states that researchers restricting themselves to earlier definitions of *CSA* may report more extreme outcomes.

INSTRUMENTATION

Types

The second goal of this review is to examine the psychometric properties of instruments used in past CSA research. The purpose of this review is to highlight how the use of different instruments impacts reported outcomes. According to Briere (1992), there are three main concerns related to measurement devices in CSA research: reliability, validity and sensitivity. Interpretation of data and results of CSA studies can be difficult and/or questionable due to the use of homespun measures of unknown reliability and validity (Briere, 1988). Another issue is the lack of sensitivity of author-devised instruments to CSA specific symptoms. **In** addition, many of these author-devised instruments are not psychometrically sound (Beitchman, et al., 1992; Briere, 1992). This hinders identification of relationships between abuse and symptomology. The absence of proven, recognized standards of measurements related to these instruments must necessarily limit interpretation of results.

A related concern is the use of general measures of psychological function applied to victims of CSA (Briere, 1992). There are few standardized instruments devised specifically for use with CSA victims contributing to the use of generic, non-standardized and study specific

instruments. CSA specific, abuse-relevant measures would assist in identifying victims, and in the development of a definition and/or criteria set specific to CSA.

Standardization

A review of the literature produced forty-one instruments (Table 1), seventeen standardized and 24 non-standardized *(Tests in Print IV,* 1994). Nine of the 24 non-standardized instruments were devised by authors specifically for the studies under consideration. Reliability, validity and psychometric soundness cannot be evaluated for the non- standardized instruments and hence caution is needed when interpreting the conclusions generated by these studies.

The significance of using a standardized instrument should be tempered by the realization that reliability, validity and psychometric soundness do not automatically equate with appropriateness for CSA symptomology. Standardized instruments, if not used in accordance with instructions and intended purpose, yield compromised or skewed results (Briere, 1992).

These findings support Briere's (1992) and Golfman and Padayachi's (2000) cautions regarding measurement issues. While this is a cursory examination of instruments using a small sample, the diversity of instrumentation used in CSA research designs and reporting of results is evident.

CLINICAL OUTCOMES

The symptoms and/or outcomes identified in the literature were compared with DSM-IV-TR criteria and are reported in Table 2. The most common outcomes reported in the CSA literature were behavioral, emotional, cognitive or physical symptoms ranging from mild to severe. It should be noted that aggression is a widely reported outcome for male CSA victims (Briere & Elliott, 1994; White et al., 1988), but rarely mentioned for female CSA victims. Few male victims were included in the sample populations and no specific assertions concerning male victims were noted. It was noted that in general males appear to react to CSA with aggressive behaviors and females with depressive behavior (Dubowitz et al., 1993; Peters & Range, 1995).

The controversial meta-analytic study of child sexual abuse correlates by Rind, et.al. (1998) indicates that "CSA does not cause intense harm on a pervasive basis regardless of gender in the college population" (p.46) and that "CSA has no inbuilt or inevitable outcome or set of emotional reactions" (p. 46). Therefore no results for the study are provided in Table 2.

TABLE 1 Instruments Used in Reviewed Articles

Standardired

Brief Symptom Checklist
Child Behavior Checklist

Minnesota **Child** Depression Inventory

Dissociative Experiences Scale
Family Adaptability & Cohesion Scales ill Life
Experiences Questionnaire
Millon Clinical Multi-axiallnventory Minnesota
Multiphasic Personality Inventory Personal
Inventory for Children
Present State Exam
Rorschach
SCL-90-R Slosson Intelligence Test
State Trait Anxiety Scale
Tennessee Self-Concept Scale
Traditional Family Ideology Scale

Authors Reporting Research Results

l.eitenberg et al. (1992)
Beitchman et al. (1991)
Dubowitzetal. (1993) Freidrich
et al. (1986) Kjseretal. (1991)
Wolfe et al. (1989)
White et al. (1988)
Wolfe et al. (1989) Wozencraft
et al. (1991) Chu & DiI1 (1990)
Kjser et al. (1991)
Chu & DiI1 (1990)
Wheeler & Walton (1987)
Wheeler & Walton (1987) Kjser
et al. (1991) Freidrich et al.
(1986) Wheeler & Walton
(1982) Chu & DiI1 (1990)
Beitchman et al. (1991) Wolfe et
al. (1989) Alexander & Lupfer
(1987)

Non-Standardized hlstruments

Adult Physical Trauma Questionnaire Adult
Sexual Experiences Questionnaire Child Manifest
Anxiety Scale
Child Physical Trauma Scale
Child Sexual Abuse Questionnaire
Child Sexual Experiences Questionnaire
Children's Attribution Style Questionnaire
Children's Impact of Traumatic Events Defense
Style Questionnaire
Eating Attitudes Test
Family Environment Scale
Family Experiences Scale
Fear Survey Schedule for Children Gambill-
Rickey Assertion Inventory History of
Victimization Form
Hopkins Symptom Checklist
Leary Interpersonal Checklist
Parent Attributes Inventory
PTSD Questionnaire
Reasons for Living Inventory

Authors Reporting Research Results

Schaaf & McCanne (1998)
Schaaf & McCanne (1998)
Wolfe et al. **(1998)**
Schaaf & McCanne (1998)
Peters & Range (1995) Schaaf
& McCanne (1991) Wofle et al.
(1989)
Wolfe et al. **(1989)**
Steiger & Gascho (**1990)**
Steiger & Zanko (1990) Steiger
& Zanko (1990) Briere &
Runtz (1988) Wolfe et al.
(1989)
Wolfe et al. **(1989)**
Wolfe et al. **(1989)**
Briere & Runtz (1988) Wheeler
& Walton (1987) Wheeler &
Walton (1987) Schaaf &
McCanne (1998) Peters &
Range (**1995)**

Table 1 (Continued)
Instruments Used in Reviewed Articles

Non-Standardized

Sexual Abuse Fear Subscale Structured
hlterview for Sex Abuse Suicide
Behavior Questionnaire Trauma
Symptoms Checklist

Authors Reporting Research Results

Wolfeetal. (1989)
Wells & McCann (1995)
Peters & Range (1995)
Briere & Runtz (1988)

Based on this review of the literature, numerous symptoms are reported as a result of CSA/SA. This may be helpful to those who are providing CSA treatment and are required to provide diagnoses based on similar symptoms. What remains questionable is how prevalence and incidence rates are affected by the range and specificity of definition and measurement methodology.

CONCLUSIONS

The symptoms identified in the literature are not surprising given the wide range of experiences that constitute sexual abuse (Saywitz, Mannarino, Berliner, & Cohen, 2000). No single symptom characterizes the majority of those who are sexually abused (Saywitz et al.) and il is estimated that 55% of children referred for treatment have more than onc diagnosis (Target & Fonagy, 1996). The effects of the abuse are also influenced by variables such as level of pre-abuse functioning and social. emotional, and financial resources (Saywitz, et al., 2000).

Clinicians and other professionals are not yet well informed regarding research and treatment modalities for sex abuse victims (Briere, 1996). Long-term outcomes for CSA victims are not well known (in part due to the lack of longitudinal studies with standardized instruments). The infamous meta-analysis by Rind, Tromovitch, and Bauserman (1998) which disputed the correlation as well as the severity of symptoms with CSA, was completed entirely with college student populations. In fact, a high rate of homelessness occurs for women who have been sexually abused. Goodman, Dutton, and Harris (1995) found that 58% of a sample of mentally ill and previously homeless women had been sexually abused as children and that 65% were sexually abused as adults. These victims were most likely not included in the college population and would have been left out of the Rind study. Future meta-analyses should include samples more representative of the CSA/SA population.

Haugaard (2000) has recently proposed three possible strategies for reducing problems created by ambiguous definitions of CSA. He sug-

gested fIrst that creating a narrower definition could improve the accuracy of CSA estimates. Second, a CSA definition could vary across contexts. For example, a narrower definition could be used by researchers and a broader definition could be used by clinicians. A third possibility would be to maintain the broad definition and create separate subgroups. For example CSA could be based on severity of abuse.

Haugaard (2000) acknowledges limitations to these approaches. Behavior that is abusive may depend on individual and cultural values. Definitions which change depending on context might erroneously exclude some abusers from legal prosecution. While no strategy for creating subgroups has been determined, several possibilities exist. Subgroups could be formed on the basis of the sexual act, the child's reaction to the experience, or the age of the child at the time of the sexual experience.

Recommendations for further research and study are to identify a standard definition for CSA and to develop a criteria set or symptoms-list that could be used in the DSM "V" codes. This would result in substantial improvement in treatment techniques, as well as research methodology. Development of a standardized instrument for use with the CSA population is also recommended. Until this is done, the psychometric properties of any study-specific instruments should be clearly specified in published reports.

In the absence of a clear set of sexual abuse criteria, it is suggested that clinicians provide treatment according to individual symptoms being reported and use the above findings as a guide. Clinicians will need to provide the most efficacious treatments available for screening, assessment, and treatment planning, since no single intervention will be effective for all sexual abuse victims (Saywitz et al. 2000).

TABLE 2 Symptoms/Outcomes Associated with DSM-IV-TR Diagnosis/with Authors Reporting

Axis	**DSM-IV** Diagnosis	Symptom/Outcome
Axis 1	Depression	ww self worth, feelings of hopelessness, isolation, insomnia or hypersomnia, poor or increased appetite, increased thoughts of or attempts of suicide (Ackerman, et ai., 1992; Beitchmnan, et ai. ,1992; Briere & Elliott, 1994); Briere & Runtz , 1988; Dubowitz, et ai., 1993; PeITott et ai" 1998; Peters & Range, 1995),
	Anxiety	Derealization, distortion of reality, Fear of losing control, of being crazy, nightmares, inability to settle down, feeling on "edge," (Ackerrnan et al., 1998; Beitchrnan, et al.1992; Briere & Elliott, 1992; Briere & Runtz, 1988; Peters & Range, 1995).
	Dissociative	Feelings of detachment from one's body, distortion of reality, depersonalization, denial or repression, (Briere & Runtz ,1988; Chu & Dill, 1990; Gill & Tutty, 1997; Leitenberg et al., 1992; Perrott et al., 1998).
	Posttraumatic Stress Disorder	Distressing thoughts, images, perceptions, nightmares, restricted range of feelings, avoidance of anything related to the trauma, hypervigilance, concentration difficulties, irritability or sudden outbursts of anger, lack of interest in normally enjoyable activities (Briere & Elliott, 1994; Finkelhor, et al., 1990; Kiser, et al., 1991; Schaaf & McCanne, 1998; Wells, et al., 1995; Wolfe, et ai. , 1989).
Axis ill	Somatic Complaints	Abdominal pain, nausea, headaches, generalized body malaise or feeling bad, increased incidence of vaginal irritations, increase in sexually transmitted diseases & infections, gastrointestinal disorders (Ackerrnan, et al., 1998; Dubowitz, et al., 1993; Rirnza, et al., 1988; White, et al., 1998).
Axis *N*	Interpersonal Difficulties	Relationship issues (parent, child, partner, friends), Self-esteem/self-worth, control of one's life, sexual difficulties, distrust of self/others, occupational problems, schooVacademic problems, Lack of or poor coping skills, absenteeism/truancy or runaway behaviors (Ackerrnan, et ai. (1998); Leitenberg, et ai. (1992); Peters & Range (1995); Schaaf & McCanne (1998); White, el al. (1988).

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