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THE PSYCHOLOGICAL IMPACT OF CRIME: A Review

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Preamble

The following literature review on the psychological impact of criminal victimization was written under contract from the Ministry of the Solicitor General. Rather than completely review the field of criminal victimization, this review focussed on the psychological impact of sexual assault against women and children. There was insufficient literature on sexual offenses against men to justify reviewing this topic. Some attention was devoted to nonsexual criminal victimization, but the treatment of these other crimes was not as thorough as that for the sexual offenses. The literature on domestic assault and physical child abuse was not included in the present review.

My review of the sexual assault literature is extensive (over 100 empirical articles). Although I was unable to locate the occasional study mentioned in other reviews (typically unpublished conference papers), the exclusion of these studies is unlikely to influence the general conclusions reached. The adult sexual assault victimization literature is sufficiently thorough and consistent that reviewers can be reasonably confident about the effects of such assaults during the first few years after victimization. The long-term impact (greater than a couple of years) is less well documented. The literature on the effects of child sexual abuse is less consistent than the adult sexual victimization literature, in part due to the greater diversity of activities and victims subsumed under the general category of child sexual abuse. Nevertheless, there is sufficient literature to have

confidence in some general conclusions about the psychological impact of child sexual abuse. Readers who are interested in the general conclusions of this review should turn to the General Summary at the end of the report.

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Introduction

The nature of psychological adjustment

Understanding the psychological impact of crime requires some understanding of psychological adjustment in general. Unlike physical harm, psychological harm cannot be directly revealed to external observers. The personal, inner nature of psychological scars makes them easy for untrained observers to overlook or disregard.

Psychological adjustment can be examined from three basic perspectives: 1) the individual perspective; 2) the community perspective; and 3) the theoretical/values perspective. From the individual perspective, psychological health is related to the subjective experience of distress or wellbeing. To assess mental health, individuals can be directly asked whether they feel they have psychological problems. The community perspective assesses mental health in accordance with individuals' abilities to fulfill their occupational and social duties. For example, a man who works competently at his job and cares for his family would be considered more adjusted than an unemployed man who neglects his children. The theoretical/values perspective assesses mental health in terms of some general model, psychological theory, or set of personal values. Different cultures and different professional orientations can differ in the emphasis they place on certain behaviours or symptoms when determining psychological adjustment. For example, a woman who adopts a lesbian lifestyle after being raped (but is

otherwise asymptomatic) may be considered poorly adjusted or relatively normal, depending on the perspective adopted.

While the different perspectives on mental health need not concur, for most practical situations there is general agreement about the extent of psychological impairment. The Diagnostic and Statistical Manual of Mental Disorders (Third Edition - Revised) (DSM-IIIR), the widely used classification system developed by the American Psychiatric Assocation (1987), includes a rating scale for psychological adjustment. A copy of this scale is reproduced in Table 1. Research with this rating scale suggests that, with brief training, raters show acceptable levels of agreement when assessing adults (Endicott, Spitzer, Fleiss, & Cohen, 1977) and children (Shaffer, Gould, Brasic, Ambrosini, Fisher, Bird, & Aluwahia, 1983). The DSM-IIIR rating scale is only one well known example of a procedure for determining adjustment; numerous other measures have been created for measuring the plethora of symptoms and syndromes associated with mental health problems.

The nature of psychological trauma

Considerable research has been conducted on psychological reactions to stressful and traumatic life events (Lazarus & Folkman, 1984; Horowitz, 1974; Sarason & Sarason, 1987; Silver & Wortman, 1980). While it is beyond the scope of this paper to review this literature, the major findings in this stress research

TABLE 1

GLOBAL ASSESSMENT OF FUNCTIONING SCALE (GAF SCALE)

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Note: Use intermediate codes when appropriate, e.g., 45, 68, 72

Code

90 **Absent or minimal symptoms** (e.g., mild anxiety before an exam), **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g., an occasional
81 argument with family members).

80 **If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g., difficulty concentrating after family argument); **no more than slight impairment in social, occupational, or school functioning** (e.g., temporarily falling
71 behind in school work).

70 **Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal**
61 **relationships.**

60 **Moderate symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR moderate difficulty in social, occupational, or school functioning**
51 (e.g., few friends, conflicts with co-workers).

50 **Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning**
41 (e.g., no friends, unable to keep a job).

40 **Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is
31 defiant at home, and is failing at school).

30 **Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g.,
21 stays in bed all day; no job, home, or friends).

20 **Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death, frequently violent, manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces) **OR gross impairment in communication** (e.g.,
11 largely incoherent or mute).

10 **Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with**
1 **clear expectation of death.**

0 **Inadequate information.**

provide a general context for understanding reactions to criminal victimization. Most people show psychological reactions when they feel that they, or the people and things important to them, are threatened. The development of stress related symptoms tends to be strongest in people who have prior adjustment difficulties. All people, however, will show stress symptoms when the stress became severe enough (e.g., prolonged torture, concentration camps). The relatively most severe stresses are those that are uncontrollable, unpredictable, of long duration, and threatening to highly important aspects of people's lives. Stresses tend to be cumulative, such that people who have experienced many prior stresses tend to cope less well than people who have had few other stresses. Negative reactions to stress are thought to be related to disruptions of the victims' prior beliefs that the world is essential a safe, just place, where serious harm only happens to those who deserve it or fail to take steps to prevent it (Janoff-Bulman & Frieze, 1983). The experience of serious, uncontrollable threat interferes with the victims' self-confidence, trust, and hope - attributes essential to positive mental health.

Mild reactions to stress include diverse symptoms, such sleep disturbances, irritability, worry, subjective distress, relationship problems, concentration difficulties, and the exacerbation of existing mental and physical health problems. Severe psychological reactions to serious stressors are called "post traumatic stress disorders" (PTSD). The symptoms that are

characteristic of this disorder include 1) persistently reexperiencing the traumatic event (e.g., intrusive, distressing memories or dreams about the event, suddenly acting or feeling like the traumatic event is recurring, intense psychological distress when exposed to similar situations); 2) persistent avoidance of situations similar to those involving the traumatic event or numbing of general responsiveness (e.g., efforts to avoid thoughts, feelings or activities associated with the event, amnesia, disinterest in activities, detachment from others, loss of interest in the future); and 3) persistent symptoms of increased arousal (e.g., difficulty falling or staying asleep, irritability, anger, concentration difficulties, hypervigilance, exaggerated startle response).

The PTSD symptoms can appear in different patterns across time. The most common pattern is for the symptoms to be strongest soon after the stressful events, and then for the symptoms to gradually diminish over a period of months or years. Victims of prolonged, severe stress, however, often show a different pattern. Victims of concentration camps and/or brutal war experiences, for example, often show relatively few symptoms immediately following escape from the stressful situtations, but are at increased risk for developing serious pathology for many years later (Weisaeth, 1985).

The PTSD model seems applicable to most of the criminal victimization of adults, such as rape, non-domestic assault, burglary and robbery. In fact, DSM-IIIR states that PTSD is "apparently more severe and longer lasting when the stressor is of human design" (APA, 1987, p.248). Such an judgement, however, seems to be based mainly on informal professional experience since the research literature on this question is limited. Criminal victimization is thought to be particularly stressful since it disrupts the victims' trust in others (Janoff-Bulman, 1985). Crime victims not only have to deal with uncontrollable, threatening events, but they are also faced with the malicious intent inherent in criminal victimization.

While the PTSD model is appropriate for much criminal victimization, this model does not fit well with many forms of domestic violence, especially the physical and sexual abuse of children. Children' reactions to such forms of victimization are not based on a disruption in their self-confidence and trust, but in these children's dysfunctional psychological development. Children often adapt to dysfunctional environments by adopting attitudes and behaviours that are functional in that setting, but are problematic in other contexts (Finkelhor, 1987). For example, a girl who is sexually abused over a long period of time by her father may learn to use sex as a way of manipulating others. This strategy may allow her to cope in her family environment; in fact, the girl may even seek out sexual contact with her father in order

to obtain her physical and emotional needs. The girl may express mild subjective distress at the time, but her behaviour would be considered highly pathological from most community and theoretical/values perspectives. Furthermore, her learned strategy is likely to create problems for her many years later when she uses it in her dating relationships. Her approach may lead her into relationships with abusive men, and to be rejected by potential partners who are non-abusive. Her failures in dating may, in turn, contribute to revictimization and depression in her adult years.

The psychological impact of crime

The following sections of the paper review the literature on the psychological impact of 1) sexual assault against adult females, 2) sexual assault against children, and 3) nonsexual criminal victimization. The literature on the sexual and nonsexual victimization of adults generally fits the Post Truamatic Stress Disorder model. While the PTSD approach is relevant to some forms of child sexual abuse, many of the negative effects of childhood sexual victimization are more easily understood from the perspective of the developmental model suggested above.

The psychological impact of rape

The adult sexual assault victimization literature is sufficiently thorough and consistent that reviewers can be reasonably confident about the effects of such assaults during the first few years after victimization (Ellis, 1983; Katz & Mazur, 1979; Russell, 1984; Stekette & Foa, 1987). The long-term impact (greater than a couple of years) is less well documented. In general, most rape victims show symptoms of PTSD in the days or weeks following the assault. These symptoms diminish during the following months, although a minority, about 20%, continue to show significant adjustment difficulties in the years following the attack.

Initial effects

Almost all rape victims show intense, immediate fear during the attack and for the first few hours afterwards (Veronen, Kilpatrick, & Resick, 1979). Rape victims who present at crisis centers or hospitals in the hours or days after the attack show a wide range of psychological symptoms, such as anxiety, depression, generalized or specific fears, as well as physical symptoms, such as headaches, stomach problems, and dizziness. Gilmartin-Zena (1985) found that 48% of recent rape victims showed severe emotional symptoms, with 41% showing mild to moderate emotional symptoms. Severe physical symptoms were found in 18%. Fewer than 10% of her sample reported no significant symptoms. Ruch and Chandler (1983) found that in their sample 40% had severe symptoms, 26.1 mild symptoms, and only 1.8% displayed no symptoms. Scott and Hewitt (1983) found physical symptoms in 43% of recent raped victims and emotional symptoms in 74%. Scott and Hewitt's (1983) assessment procedure was less thorough than Gilmartin-Zena (1985), which likely contributed to the somewhat lower levels of pathology noted in the Scott and Hewitt study. All three of these studies did not clearly specify the criteria used for determining the severity of symptoms, which makes it difficult to estimate the absolute level of distress in these studies.

Using objective measures, Kilpatrick, Veronen and Resick (1979b) found that 6 to 8 days after the attack, rape victims had

elevations on 25 of the 28 measures used to measure psychological maladjustment. Some symptoms were noted in 94% of the rape victims, which was significantly higher than 72% of the control (nonvictimized) subjects who showed some symptoms (Veronen & Kilpatrick, 1983). Using standardized measures with a different sample, Ledray (1988) found high levels of depression and subjective distress in rape victims two days after the attack. Comparisons with the available norms indicated that the level of distress found in Ledray's rape victims was in the same range as that shown by psychiatric in-patients. Although most rape victims are not usually admitted for in-patient psychiatric treatment, their level of psychological disturbance in the first few days after the attack is equivalent to those patients who are admitted to psychiatric wards for other reasons.

The above studies all assessed rape victims in the days following the attack. Similar results are shown in retrospective studies that months or years later asked victims to recount their experiences at the time of the attack (Becker, Skinner, Abel, Howell & Bruce, 1982; Maguire & Corbett, 1987; Selkin, 1978; Williams & Holmes, 1981). Maguire and Corbett (1987) found that along with high levels of subjective distress, 78% of the rape victims remembered being unable to do ordinary daily tasks in the days immediately following the attack. Burgess and Holmstrom (1976) similarly reported significant disruptions in the victims' abilities to maintain their usual routines.

Intermediate effects

Most of the initial symptoms persist during the weeks or months following the attack, although the intensity of the symptoms decreases. Burgess and Holmstrom (1974) have referred to the pattern of symptoms shown by rape victims as the "rape trauma syndrome." The rape trauma syndrome is a specific form of PTSD, such that it includes persistent, intrusive repetitions of the rape experience (e.g., nightmares, intrusive memories), persistent distress when exposed to rape related events or situations, and persistent symptoms of hypervigilance. Forty-seven percent of the victims in Burgess and Holmstrom's (1974) study showed moderate to severe symptoms, whereas only 16% showed no symptoms.

At two months post-assault, Gilmartin-Zena (1985) found that 30% of her sample showed severe psychological symptoms and another 40% showed moderate psychological symptoms. Severe physical symptoms were noted in 15% of her sample at two months follow-up. These levels are lower than the initial levels, but still indicate considerable disruption in the victims wellbeing.

Many rape victims remain depressed during the first few months after the attack. Frank, Turner and Duffy (1979), in their initial study, found that 23% showed clinically significant depression using a standardized assessment. In another sample, Frank and

Stewart (1984) found that 43% were clinically depressed using the same criteria. They also found that 23% had contemplated suicide. Similar levels of depression were shown at one month following the attack in the studies conducted by Ledray (1988) and by Atkeson et al. (1982; Ellis, Atkeson & Calhoun, 1981). Overall, the levels of depression were similar to the average levels of depression shown by patient seeking out-patient counseling. On average, their distress was not sufficient to justify admission to psychiatric wards, but was nonetheless clinically and individually significant.

Along with depression, rape victims report impairment in social functioning (Resick et al., 1981) and an increase in sexual problems (Becker, Abel & Skinner, 1979; Ellis, Calhoun & Atkeson, 1980). Ellis (1983) found that the number of sexually inactive women in her study increased from 14% before the rape to 43% one month after the rape. Rape victims also show increased levels of fear (Calhoun, Atkeson & Resick, 1982; Kilpatrick, Veronen & Resick, 1979a; Kilpatrick, Resick & Veronen, 1981). Most of the fears are rape related (e.g., walking on a dark street, strangers) although victims can become fearful of other things as well (e.g., loud noises). Scheppele and Bart (1983) found that in the months following the attack, 12% of their sample show no or minimal fears, 33% showed specific fears (e.g., a particular place or person), 32% showed diffuse fears (e.g., afraid of men in general) and 23% showed a "total" fear reactions. Scheppele and Bart described the women with the "total" fear reaction as being sufficiently

disrupted by their fears that they were unable to perform their expected social and occupational duties.

Several longitudinal studies have followed rape victims through the first year post-assault. These studies generally find that the symptoms decrease to near normal levels for most victims, but there tends to be significant minority who show persistent negative effects.

At one year follow-up, standardized assessment procedures find that the average amount of depression for rape victims is in the normal range (Atkeson et al., 1982; Frank & Stewart, 1984; Ledray, 1988). Atkeson et al. (1982), for example, found that 26% of the rape victims showed some depression, which was not significantly different from the 17% rate for the unvictimized control subjects. Resick et al. (1981) found that self-reported social functioning returned to the normal range on most measures within four months, with the exception of work-related functioning, which continued to be slightly below average at one year follow-up. Fears and anxiety decreased to near normal levels within four months, although mild elevations on some measures persist through the first year (Calhoun, Atkeson & Resick, 1982; Kilpatrick, Resick & Veronen, 1981). Ellis (1983) reported that sexual behaviour tended to return to normal within four months. An earlier report of the same study (Ellis, Calhoun & Atkeson, 1980), however, reported that 10-20% of the victims had persistent sexual problems (the baserate for

nonvictimized control subjects was not given in the 1980 study). Twelve percent of the Ellis et al. (1980) subjects reported that a year after the assault they still had intense emotional memories of the rape experience (flashbacks) during sex.

Long-term effects

The persistent effects of rape have typically been assessed by either long-term follow-up of rape victims, or by measuring the psychological adjustment of women who had been raped many years earlier. In general, these studies have found lasting negative impacts in about 25% of the victims studied.

Burgess and Holmstrom (1979) in a 4 to 6 year follow-up of rape victims found that 37% reported that they had recovered within months, but that 26% reported that they had not yet recovered. Nadelson, Notman, Jackson and Gornick (1982) found that 27% of women raped in the previous two years reported lasting negative impact. Veronen and Kilpatrick (1983), using standardized measures, found that after one year, 17% of the rape victims had no symptoms compared to 41% of the nonvictims.

The two most common long-term symptoms are 1) problems in sexual relationships, and 2) general fears. McCahill, Meyer and Fischman (1979), in a large sample study of rape victims, found that 11 months after the assault, victims showed numerous rape-

related fears (e.g., men, city streets). While Calhoun et al. (1980) found that fears decreased substantially during the first few months, they found that 35% of the rape victims continued to show substantially more fears than the average for nonvictimized controls at one year follow-up. The victims' fears included both rape-related fears (e.g., testifying in court) as well as many other fears (e.g., looking down form high buildings, cemeteries). Becker, Skinner, Abel, Howell and Bruce (1982) also reported high levels of specific fears (55 to 85%) in rape victims, although their results are difficult to interpret due to the lack of a comparison group.

Decreased sexual satifaction was found in studies by Feldman-Summers, Gordon and Meagher (1979) and by Orlando and Koss (1983). Although many of the women had been raped years earlier, the time since victimization was not controlled in these studies, and some of the participants had been assaulted as recently as the previous two months. Consequently, it is possible that the overall lower sexual satisfaction for victims compared to control subjects could be attributed to the acute reactions of the recent victims in these studies.

Burt and Katz (1987) reported a study of <u>positive</u> long-term effects of rape. While they believed that rape is a traumatic experience for most victims, they assumed that this trauma might facilitate some positive changes. Following a rape, for example,

a woman may become more aware of women's issues than before, which could lead her to finding support in women's rights organizations. Overall, Burt and Katz (1987) found that their sample reported positive long-term changes on 15 out of the 28 measures used. Most of these positive changes were related to changes in feelings towards oneself, and improvements in the quality of interpersonal relationships. In the areas of sex and intimate relationships, however, they did not find improvements. Fifty percent of their sample reported continued problems and general dissatisfaction with their sexual and love relationships.

Community surveys

Most of the subjects in the above studies were women who attended rape crisis centers or hospital emergency facilities following their assault. A minority of the subjects were solicited by advertisements. Since most rape victims do not report the rape (Russell, 1984), it is possible that only the most distressed rape victims come to professional attention, thereby inflating the observed negative effects of rape. Such a sampling bias seems unlikely, however, since studies that compared the psychological adjustment of victims who did and did not report their sexual assault have found no differences between these groups (Norris & Feldman-Summers, 1981; Santiago, McCall-Perez, Gorceg & Beigel, 1985).

The studies that are least likely to be affected by sampling biases are those that survey individuals selected randomly from the community (Burnam, Stein, Golding, Siegel, Sorenson, Forsythe & Telles, 1988; Kilpatrick, Best, Veronen, Amick, Villeponteaux & Ruff, 1985; Kilpatrick, Saunders, Veronen, Best & Von, 1987). The major findings of these studies will now be examined since they provide some of the best evidence for the negative impact of sexual assault.

Burnam et al. (1988) interviewed 3,132 residents of the Los Angeles area, including both men and women. The primary interest of this study was on the prevalence and incidents of mental disorders; consequently, respondents were extensively probed about mental disorders and only secondarily asked about sexual victimization. The limited probing about sexual assault is likely to identify only the relatively explicit cases, and is less likely to detect coercive sexual contacts in dating and marriage relationships. Overall, 447 respondants reported at least one incident of sexual assault during their lifetime (of which complete data was available on 432). About half of the sexual assaults reported occurred after the victim was 16 years old. Comparisons of sexually assaulted subjects with nonassaulted subjects (matched for gender, age, ethnicity and educational level) showed that those who had been sexually assaulted subsequently had significantly more mental health problems. The assaulted subjects were at increased risk for developing depression, alcohol abuse/dependence, drug

abuse/dependence, phobias, panic disorder, and obsessive-compulsive disorder. Sexual victimization was not associated with the development of antisocial personality disorder, schizophrenia, or mania. The patterns of responses by females and males were similar, with the exception that males were more likely than females to develop alcohol problems. The measures used by Burnam et al. (1988) were not designed to assess the impact of sexual assault, but they nevertheless provided strong evidence that sexual victimization increases the risk for serious mental disorders.

As well as finding increased mental health problems following the assault, Burnam et al. (1988) also found that certain types of mental disorders increased the risk of being sexually victimized.

Table 2.

Percentage of mental disorders in Burnam et al. (1988)

type of mental disorder	sexually assaulted	matched controls
Major depression	13	6
Alcohol abuse/dependence	16	7
Drug abuse/dependence	18	7
Phobia	10	3
Panic disorder	3	1
Obsessive-compulsive disorder	4	1

These disorders included depression, alcohol abuse/dependence, drug abuse/dependence, antisocial personality disorder, and phobias.

Kilpatrick et al. (1985) conducted telephone interviews with a representative, random sample of 2,004 women in South Carolina. Their survey asked about several types of criminal victimization, including rape, other sexual assault (excluding intercourse, anal or oral sex), robbery, and aggravated assault. Kilpatrick et al.'s (1985) assessment of mental health problems was less thorough than Burham et al.'s (1988); the Kilpatrick study simply asked "(a) Have you ever had a nervous breakdown? (b) Have you ever felt so hopeless that you thought seriously of killing yourself? (c) Have you ever attempted suicide?" The rape and

Table 3.

Percentage of crime victims reporting mental health problems in Kilpatrick et al. (1985)

type of crime	nervous breakdown	suicide ideation	suicide attempt
Attempted rape	9 (5)	30	9 (8)
Completed rape	14 (16)	44	19 (13)
Attempted sexual assault	5 (5)	32	8 (8)
Completed sexual assault	2 (2)	22	4 (2)
Attempted robbery	0	9	12
Completed robbery	8	11	3
Aggravated assault	2	15	4
Non victims	3	7	2

Note: percentages in parentheses are the percentage in which the symptoms appeared after the victimization. The timing of the symptoms was not specified for the other percentages.

sexual assault victims were asked whether these symptoms appeared before or after their victimization.

Kilpatrick et al.'s (1985) survey found considerable adjustment difficulties in rape victims. Significantly, 13% of

the rape victims reported that they had attempted suicide some time after the assault. The rate of nervous breakdowns was also high in the rape victims (16%). The Kilpatrick et al. (1985) study, however, contains certain anomalous findings that limits the confidence that can be placed in their results. For example, the study found that the rate of suicide attempts was higher in most victims groups than the rate of nervous breakdowns. They reported that more of the attempted robbery victims had attempted suicide (12%) than had thought about suicide (9%)! They also found that victims who reported mental health problems before the victimization did not report mental health problems afterwards. Such improbable findings suggest that the brief questions used in this study failed to reliably assess the mental health problems in this sample.

Recognizing the limitations of the previous study, Kilpatrick et al. (1987) conducted follow-up interviews with 391 of the female victims indentified in their original study. In the follow-up study, participants were assessed for Post Traumatic Stress Disorder using the standardized criteria presented in DSM-IIIR (APA, 1987). They not only found that rape victims showed high rates of PTSD both at the time of the offense (57%), but they also found that 16% were still suffering from PTSD. The length of time since victimization varied between subjects, but for most of the subjects the victimization occurred many years earlier.

Table 4.

Percentage of crime victims reporting Post Traumatic Stress Disorder (PTSD) in Kilpatrick et al. (1987)

type of crime	PTSD ever	PTSD currently
Attempted rape	16	6
Completed rape	57	16
Attempted sexual assault	11	0
Completed sexual assault	26	6
Robbery	18	9
Aggravated assault	37	10
Burglary	28	7

Overall, the results of the community surveys suggests that the high rates of psychological problems found in the rape victims who receive professional attention cannot be attributed to sampling biases. While the data is presented in different forms across the studies, the pattern of results is consistent with the conclusion that rape is a serious, traumatic experience for most victims, and that about 20% show persistent negative effects.

Rape versus other types of crimes

The Kilpatrick studies reviewed above found that victims of completed rapes consistently showed more evidence of psychological harm than did victims of other offenses. Other studies that have compared types of criminal victimization have also found rape to be the most traumatic. Wirtz and Harrell (1987b) found that sexual assault victims showed more distress than victims of domestic assault, non-domestic assault, robbery and burglary. Preliminary results from Resick (1987) suggest that rape victims tended to show more adjustment problems than robbery victims. With the exception of sexual problems, the differences between the rape and robbery victims in Resick's study tended to be small on most measures.

Maguire and Corbett (1987), in a British study, compared the initial reactions of victims to rape, burglary, robbery/assault,

Table 5.

Percentage of victims reporting selected symptoms in Maguire & Corbett (1987)

symptoms	type of victimization			
	rape	burglary	robbery/ assault	theft
unsettled/uneasy	87	45	47	15
frightened	91	34	53	22
unable to do ordinary daily tasks	78	25	47	4

and theft. Like the other studies, Maguire and Corbett (1987) found that rape was more traumatic that burglary, robbery/assault, or theft. Eighty percent of the rape victims' lives were significantly disrupted immediately following the assault, compared to half of the robbery/assault victims, and one quarter of the burglary victims.

Moderator variables

The results presented so far indicate that the immediate experience of being raped is traumatic for most victims. About 50% of the rape victims show serious disturbance in the weeks and

months following the assault, and only 5 to 10% show no significant symptoms. After one year, most symptoms have diminished, although a significant minority, about 20-25%, still exhibit mild to moderate levels of disturbance.

Since victims vary in the extent to which they show adjustment difficulties, researchers have sought to identify characteristics of the rape situation or of the victims that could predict those victims who are likely to have the most difficulty recovering. In general, the search for these moderator variables has generated surprisingly few significant findings. The effects of specific rape characteristics tend to be small, and conflicting findings are common.

Rape characteristics. The most consistent finding is that victims of completed rapes fare worse than victims of attempted rape (Kilpatrick et al., 1985; Kilpatrick et al., 1987; Sales, Baum & Shore, 1984; Scheppele & Bart, 1983; Selkin, 1978). The only study that failed to find this effect was Becker et al. (1982), but this study used a small sample of victims. (Findings based on small samples tend to be unreliable since such findings are greatly effected by sampling error and biases.)

The expected relationship between severity of the assault and victims adjustment has received surprisingly little support. Studies by Norris and Feldman-Summers (1981), Sales et al. (1984),

and Ellis et al. (1981) all found that victim adjustment was inversely related to global ratings of the severity of the attack. Characteristics that contributed to the global severity ratings included the use of a weapon, injury, more than one assailants, and confinement. Further analysis of the subjects in the Ellis et al. (1981) study failed to show relationships with severity of the attack (Atkeson et al., 1982). As well, the research on specific characteristics that are thought to be related to the severity of the attack has been inconsistent.

The use of a weapon was related to negative victim adjustment in one study (McCahill, Meyer & Fischman, 1979) but not in four other studies (Frank, Turner & Stewart, 1980; Girelli, Resick, Marhoefer-Dvorak & Hutter, 1986; Ruch & Chandler, 1983; Sales et al., 1984). Sales et al. (1984) found that death threats contributed to worse adjustment, but three other studies failed to find this effect (Frank et al., 1980; Girelli et al., 1986; Ruch & Chandler, 1983). Victims who were severely beaten showed worse adjustment in three studies (McCahill et al., 1979; Ruch & Chandler, 1983; Sales et al., 1984) but not in three other studies (Frank et al., 1980; Girelli et al., 1986; Santiago et al., 1985). Sales et al. (1984) found the number of assailants to be related to victim adjustment, but this was not found in studies by Girelli et al. (1986) and Ruch and Chandler (1983). Girelli et al. (1986) similarly found that victim adjustment was unrelated to 1) the

number of sex acts inflicted, 2) the use of restraint, and 3) the length of detainment.

McCahill et al. (1979) has suggested that there is not a direct relationship between the severity of the rape and trauma. Instead, they found that the least psychological trauma was reported by victims who experienced mild injuries, e.g., scratches. What McCahill et al. (1979) argue is that the presence of some physical injury protects the victim from accusations that she fabricated the attack. Ageton (1983), in a study of adolescent rape victims, similarly found victims who suffered mild physical injuries suffered less psychological trauma than victims who experienced no injuries, or those that experienced brutal beatings.

Two studies (Frank & Stewart, 1984; Scheppele & Bart, 1983) have suggested that victims who are raped in safe situations (e.g., at home) show more trauma than victims raped in dangerous situations (e.g., dark streets). Two other studies, however, failed to find any overall effect for the rape situation (Frank et al., 1980; Ruch & Chandler, 1983). McCahill et al. (1979) did not find that victims raped at home had worse overall adjustment than other rape victims. Instead, they found that being raped at home resulted in increased fears of being home alone.

The evidence on whether victims experience more trauma when raped by a stranger or an acquaintance is inconsistent. Ellis et

al. (1981) found more trauma for victims raped by strangers, McCahill et al. (1979) found more for more trauma for victims of acquaintance rapes, and four other studies found no differences (Frank et al., 1980; Ruch & Chandler, 1983; Sales et al., 1984; Santiago et al., 1985). It seems likely stranger rapes influence victims differently than acquaintance rapes, although both can be equally traumatic.

Overall, the relationships between rape characteristics and victim adjustment appear to be weak. Ruch and Chandler (1983) went so far as to concluded that the "prevailing stereotypes of rapes as being traumatic when they involve weapons, strangers, or multiple assailants - and as nontraumatic when they do not - are false" (p. 182).

Victim characteristics. Like the research on assault characteristics, the research linking victim characteristics has yielded many inconsistent results. The victim characteristic that has recieved consistent support, however, is a history of prior sexual victimization (Frank et al., 1980; Frank & Stewart, 1984; McCahill et al., 1979; Ruch & Chandler, 1983; Santiago et al., 1985). While repeat victims do not show worse adjustment on all measures, every study that has examined the adjustment of repeat victims versus nonrepeat victims have found worse overall adjustment for the multiply victimized.

Another attribute associated with poor long term recovery from rape is a history of prior adjustment problems (Atkeson et al., 1982; Sales et al., 1984). Prior psychiatric problems, however, do not appear to be related to the short term effects of rape (Frank & Stewart, 1984; Frank, Turner, Stewart, Jacob & West, 1981). Repeat victims tend to show poor adjustment prior to the rape than nonrepeat victims (Ellis et al., 1982), so it is difficult to separate the long term impact of prior sexual victimization from the influence of prior adjustment difficulties.

Most of the studies examining victim ages have found somewhat worse adjustment for older adults than for young adults (Atkeson et al., 1980, Burgess & Holmstrom, 1974; Frank & Stewart, 1984; Maguire & Corbett, 1987; Ruch & Chandler, 1983; Sales et al., 1984). The difference between the young and old adult victims tends to be small, however, and four studies have failed to find any effects (Burnam et al., 1988; Kilpatrick et al., 1985; Kilpatrick et al., 1987; Williams & Holmes, 1981). The two studies that have directly compared the long term reactions of child victims with adult victim have been contradictory. Burnam et al. (1988) found that the child victims showed more adjustment problems than adolescents or adults, whereas McCahill et al. (1979) found that child victims experience less trauma than adolescent or adult victims. The research on the relationship of age to rape trauma may most cautiously be considered inconclusive, although there is

some suggestion that older adult (> 40 years old) fare worse than young adults.

High levels of subjective distress experience by victims at the time of the attack have been related to poor long-term adjustment in three studies (Atkeson et al., 1982; Girelli et al., 1986; Sales et al., 1984). While this information is somewhat more difficult to assess than some of the other characteristics discussed, it does provide a useful guide to predicting long term psychological problems.

Two studies have suggested that married women show more trauma than unmarried women (McCahill et al., 1979; Ruch & Chandler, 1983). The three studies that examine whether previous sexual experience was related to rape trauma have found no relationship (Burgess & Holmstrom, 1979b; Frank et al., 1980; Santiago et al., 1985). Other factors, such as employment status and ethnicity, have been examined in specific studies, but the results have been weak and inconclusive. Readers interested in additional subject variables can consult the reviews by Ellis (1983) and Steketee and Foa (1987).

Social support. Victims who receive social support from friends and family show better adjustment than victims who lack such support (Atkeson et al., 1982; Burgess & Holmstrom, 1978, 1979a; Norris & Feldman-Summers, 1981; Ruch & Chandler, 1983; Sales et

al., 1984). While victims who received social support did not show better adjustment than other victims on all measures, only one study failed to find any positive effects of social support (Williams & Holmes, 1981). While a detailed review of the treatment of rape victims is beyond the scope of this paper, the available literature suggests that victims who receive counseling fare better than victims who do not receive counseling (Ellis, 1983; Ledray, 1988; Steketee & Foa, 1987).

Summary of rape trauma

The immediate impact of rape is extremely distressing to almost all victims. In the few hours or days after the assault, victims report a wide range of symptoms, including fear, anxiety, and depression. Between 40 and 50% are assessed as showing severe psychological distubance, and only 5-10% are assessed as showing no clinically significant symptoms.

During the weeks and months following the assault, the victims' symptoms gradually decrease. The raped women are generally able to resume their daily tasks, but are suffering under considerable distress. Twenty to 40% of them are clinically depressed on standardized measures. Increased fears are common, with about 25% showing severe, generalized anxiety. Other symptoms include sleep disturbance, nightmares, persistent memories, and

disturbances in social and occupational functioning. Moderate to severe disturbance is shown in about half the victims.

By the end of one year, the women's symptoms are in the normal range on most measures, although they tend to be slightly below the scores of non-assaulted women. This pattern applies to depression, anxiety, fears, social functioning, and sexual problems. Interviews of women who have been raped years earlier generally find that a significant proportion, about 25%, report continuing negative effects. These persistent problems tend to be related to problems in intimate sexual relationship, and increased fears.

In general, there are few relationships between assault characteristics and trauma. The only two assault characteristics that appear to be related to increased trauma are 1) brutality (severe injury), and 2) completed intercourse. Mild levels of physical injury (e.g., superficial scratches or bruises) do not appear to lead to more psychological harm than do sexual assaults not resulting in injury. Victims who have a history of sexual assault (as children or as adults), a history of prior adjustment difficulties, a lack of social support, and who do not receive treatment for the assault are likely to show poorer long term adjustment than other rape victims. Victims of rape show greater psychological trauma than victims of other criminal offenses, including aggravated assault, robbery, and burglary.

The psychological impact of child sexual abuse

Sexual offenses against children include a broader range of activities than sexual offenses against adults. For sexual offenses against adults, some form of force or threat of force is required. Women can be involved in emotionally abusive sexual relationships that do not involve threats or force, but such emotional abuse is not criminalized. In contrast, most definitions of sexual abuse of children include not only forced or coersive sexual victimization, but also any sexual activity between a child and a much older person. Consequently, one common type of child sexual abuse is for an adult in a position of power over the child (e.g., parent, babysitter) to engage the child victim in sexual activities without the overt use of force. The offender, and sometimes even the victim, may describe the activities as consensual. Such adult-child sex is typically considered abuse due to the child's inherent inability to consent to the activity (Finkelhor, 1979b).

In contrast to adult sexual victimization, the sexual abuse of children often does not involve a single traumatic incident. Children can be gradually lured into sexual interactions that are repeated over months or years. The insidious, persistent nature of such abuse is unlikely to create the acute trauma and gradual recovery found in adult rape victims. Instead, child victims are likely to show pathology related to their attempts to adapt to a

pathological, inescapable situation (Finkelhor, 1987; Gelinas, 1983; Summit, 1983). In particular, children may develop strategies that allow them to cope with ongoing sexual abuse, but that are highly dysfunctional in other contexts, strategies such as lying, passive acquiesence, psychological numbing, manipulative sexuality, and substance abuse.

Understanding the trauma of child sexual victimization is more complicated than understanding rape trauma not only because of the greater diversity of offenses and reactions related to child sexual abuse, but also because children are unlikely to spontaneous articulate adjustment difficulties. Consequently, the inner psychological reactions of children are likely to be overlooked unless these reactions are accompanied by external behavioural changes (especially disruptive behaviour). Since many of the strategies for coping with sexual abuse involve secrecy and avoidance (Reich & Gutierres, 1979), the probability of overlooking psychological problems in sexually abused children is high.

While there has been considerable research on the effects of child sexual abuse in recent years, this research has provided fewer firm conclusions than the rape trauma literature. Reviews of the impact of child sexual abuse generally conclude that it has persistent negative effects for some victims, but other victims show few adjustment difficulties (Alter-Reid, Gibbs, Lachenmeyer, Sigal & Massoth, 1986; Browne & Finkelhor, 1986; Conte, 1985; De

Young, 1982; Finkelhor, 1984; Kilpatrick, 1987; Mrazek & Mrazek, 1981; Russell, 1986;). The following sections of this paper provide an overview of the available literature on the psychological impact of child sexual abuse.

Peer rape of adolescent females

While the child sexual abuse literature typically includes a wide range of victims and offenses, one relatively focussed area of research has been the peer sexual assault of adolescents. In general, this research finds that adolescents females' reactions to rape are similar to the reactions of adult females (Ageton, 1983; Burgess & Holmstrom, 1976; Gidycz & Koss, 1989).

Based on a community sample of adolescent rape victims Gidycz and Koss (1989) found that 37% showed moderate to severe symptoms, which was significantly higher than the 7% rate for the adolescents who were not raped. Among the victimized youths, they found high levels of depression and anxiety; they did not find any increase in antisocial or delinquent behaviour. Burgess and Holmstrom (1976) reported that rape was highly traumatic to the adolescent victims who reported to a rape crisis clinic. Most missed two to five days of school following the attack; 41% stopped going to school completely or changed schools.

Ageton (1983), in a well-designed study, assessed a large sample of randomly selected adolescents over a number of years. With this method, she was able to assess not only the adolescents' adjustment following the assault, but their adjustment prior to the assault. Victims of peer rape were more likely than nonvictims to have poor family backgrounds and to be involved in delinquent activities. Following the rape, victims showed levels of distress, depression, and anxiety similar to that shown by adult victims. The distress following rape was acute and could not be reasonably attributed to other events in the victims' lives. Another important finding of Ageton's (1983) study was that some victims showed adjustment difficulties in follow-up interviews, but did not remember their previous sexual victimization. Bagley and McDonald (1984) also found that some victims of serious, prolonged sexual abuse did not acknowledge any childhood sexual victimization during follow-up interviews conducted 10 years later.

Initial impact of child sexual abuse

The studies in the following sections include a wide variety of sexual activities involving children. The results will first be reviewed by combining the findings across different types of child sexual abuse. A later section of the paper will examine the differential effects of specific types of sexual abuse (e.g., incest, single incidents versus prolonged abuse, male versus female victims).

Assessing the initial impact of sexual abuse is difficult since children rarely come to professional attention immediately following the abuse. Once identified, child victims typically lack the conceptual and language skills to describe their reactions. Consequently, what we know about the initial impact of sexual victimization comes from the retrospective accounts of adults. These studies have consistently found that female victims perceived the abuse as negative at the time (Finkelhor, 1979a; Gagnon, 1965; Herman, Russell & Trocki, 1986). Gagnon (1965) found that of a community sample of adult females, 84% reported that their childhood sexual abuse experiences were "completely negative." Only 3% described these experiences as positive. Herman et al. (1986), in a other community sample of adult females, found the 55% remembered their sexual abuse by relatives as being very or extremely upsetting. Only 8% of their sample reported that they were not at all upset by the abuse.

In a retrospective study involving university students, Finkelhor (1979a) found that 66% of the females described their sexual abuse to be negative. Finkelhor defined sexual abuse as coercive sex during childhood, or any sexual activity with a much older person (greater than 5 years) during childhood. The females reported their initial reactions to be fear (58%) and shock (26%). Only 38% of the males, however, described the initial impact of their sexual abuse as negative. The lower rates of negative reactions in Finkelhor's study compared to the other studies could be attributed to sample differences. The individuals who were particularly damaged by sexual abuse would not appear in Finkelhor's sample since they would lack the psychological resources necessary for academic success.

Impact at time of disclosure

The effects of sexual abuse on children is usually examined by assessing children referred because of detected sexual abuse. In general, the method of selecting victims significantly influences the study's findings. Sandfort (1984), for example, interviewed a sample of boys recruited through adult males involved with a pro-pedophilia lobby group. Not surprising, Sandfort found that 21 of the 25 boys interviewed reported exclusively positive effects of their sexual relationship with an adult male. In the other extreme, Livingston (1987) selected sexual abused children from an

inpatient treatment facility. Since the children required serious pathology in order to be admitted to the facility, it is not surprising that 77% of the victims showed clinically significant depression, and 77% were psychotic (delusions, hallucinations, loss of contact with reality). Little information about the impact of sexual abuse can be gained by studying the severity of symptoms in sexual abuse victims who entered treatment for other reasons. Examining cases referred for assessment due to detected (or suspected) sexual abuse likely introduces some sampling biases, since it is possible that only certain types of cases are detected. However, since it is difficult to study previously undetected cases, sexual abuse referrals provide the best source of information currently available on the effects of sexual abuse on children.

Several studies assessed sexual abuse referrals on a variety of standardized assessment measures. Most of these measures were rating scales completed by parents, teachers, or health care workers, although some self-report measures were also used. These measures generally have strong validity in differentiating children with and without significant adjustment problems. These studies typically find that the sexually abused children show more pathology than nonabused control groups, but a significant portion of the victimized children do not show clinically significant adjustment problems (Cohen & Mannarino, 1988; Friedrick, Beilke & Urquiza, 1988; White, Halpin, Strom & Santilli, 1988). Children

in these studies have typically been abused months before the abuse is disclosed, although in some cases the abuse occurred in the days or weeks prior to being assessed.

Conte and Schuerman (1987a, 1987b) found that 21% showed no symptoms, whereas 27% showed four or more clinically significant symptoms. Gentile, Wolfe and Wolfe (1988) found that 71% of their sample of sexually abused children showed significant adjustment problems, which is greater than the rate of 18% expected in the general population. Using somewhat stricter criteria, Friedrick, Urquiza and Beilke (1986) found significant adjustment problems in 35 to 46% of their sample. Similar levels of dysfunction would be expected in only 2% of the general population of children that age. Marrariro and Cohen found 69% of their sample showed at least one clinically significant symptom. Mian, Wehrspann, Klajner-Diamond, Lebaron and Winder (1986), in a study of children under 7, found that 43% showed some psychological symptoms. The Badgley Commission, in a sample of 623 children from 11 different Canadian hospitals, found that 54% of the boys and 49% of the girls showed at least one significant symptom (Badgley, 1984). The various clinicians assessing these children estimated that 19% of the boys and 18% of the girls would suffer long-term psychological harm as a result of their sexual victimization.

Children exhibit a wide range of symptoms in response to sexual abuse, including immaturity, aggression, fear, antisocial

behaviour, and inhibitions (Gomes-Schwartz, Horowitz & Sauzier, 1985). The symptoms that appears to be most common in sexually abused children is inappropriate sexual behaviour (e.g., masturbating in public, requesting sex from adults or other children). While on most measures sexually abused children show less pathology than children in treatment for other reasons, sexually abused children show clinically significant problems with sexual behaviour in all the studies that have assessed it (Cohen & Mannarino, 1988; Friedrick et al., 1987; White et al., 1988).

Several studies have noted that sexually victimized children showed a relative strength in prosocial behaviour and social skills (Cohen & Mannarino, 1988; Gomes-Schwartz et al., 1985; White et al., 1988). White et al. (1988) attributed the victims' high levels of social skills to a pseudosophistication that some victims develop in order to cope with the demands of a sexual relationship with an adult.

Follow-up studies

Friedrich et al. (1986), in a cross-sectional study, found that victims who had been abused recently showed more problems than other victims. The few follow-up studies that have been conducted suggests that the negative effects of child sexual abuse persist for many years. After 30 months, Tong, Oates and McDowell (1987) found that 64% still showed significant problems as rated by

parents, and 36% as rated by teachers. Only 3% of the comparison group of nonabused children showed adjustment problems. Similarly, Rimzsa, Berg and Locke (1988) found that after two years 67% of the abused children showed some lasting negative reaction.

Burgess, Hartmann and McCormack (1987) followed children who had been exploited in sex rings six to eight years earlier. The abused children, when compared to their nonabused siblings, showed a variety of symptoms, including stomach aches, fears, sleep problems, confusions about sex, compulsive masturbation, drug use, and delinquent activity. Of the boys who had been abused in a sex ring involving homosexual, sadistic rituals, all had been arrested within six years. In comparison, only one of the 17 nonabused siblings had been arrested.

Bagley and McDonald (1984) conducted a 10 year follow-up of females who had been separated from their families due to incest

Table 6.

Percentage of subjects in Bagley and McDonald (1984) showing adjustment problems

Symptom	incestuously abused	physical abuse/ neglect
Suicide attempt	25	5
Greater than one month psychiatric hospitalization	10	0
Prostitution	25	0
Beaten as adult	55	8

and those that had been separated for other reasons (e.g., neglect, physical abuse). The found that the incestuously abused females showed significantly lower self-esteem, increased depression, and increased sexual maladjustment than the other females in the study. The also found that 55% of the sexually abused females were physically assaulted in adulthood, compared to only 8% of the comparison group.

Bender and Grugett (1952) provided 11 to 16 year follow-up on children who were originally assessed because of sexual abuse. Although Bender and Grugett tend to minimize any negative long term effects of sexual abuse, my own reading of the case histories suggested that 57% had serious adjustment difficulties, such as

failed adoptions, years in institutions, and delinquency. J. Conte's assessment of the 15 Bender and Grugett case studies was that only two cases had adjusted well at follow-up (Conte, 1985).

In general, the follow-up studies have tended to find persistent negative effects over many years. Most of these studies, however, examined relatively small samples of seriously abused children. Further longitudinal studies are necessary before the long term pattern of recovery from sexual abuse is known.

Childhood sexual abuse victims as adults

Considerable research has been conducted on adults who have been sexually abused as children. These studies either assess their current adjustment or ask the sexual abuse survivors to retrospectively report adjustment problems. As with the child studies, the sample studied significantly effects the results obtained. Studies of victims who seek treatment for sexual abuse provide little information about the severity of the long term impact of sexual abuse because only the most distressed are likely to seek treatment. The strongest evidence for persistent negative effects of childhood sexual abuse comes from studies based on representative community samples (Bagley & Ramsey, 1985; Herman et al., 1986).

Bagley and Ramsey (1985) found in a community sample from Calgary that 15-17% of sexual abuse victims were currently clinically depressed, which was significantly higher than the 7-9% rate for the nonabused adults. They also found that 18% of the abuse victims had sought counseling in the past year, whereas only 1% of the nonabused adults had done so. Bagley and Ramsey were so convinced by their (or others) findings that they concluded that "the early view of childhood sexual abuse in family contexts as rare and perhaps harmless has been disproven" (p. 45). A study by S. Peters of adult women in Los Angeles (reported in Browne & Finkelhor, 1986) similarly found high rates of depression in a community sample of sexual abuse victims. She also found that the rates of alcohol and drug abuse were 2 to 4 times higher in the adults who had been sexually abused compared to adults who were never abused. In another community survey, Herman et al. (1986) solicited retrospective reports about the long terms effect of sexual abuse by relatives. Twenty-seven percent reported that it had a great negative effect, whereas only 22% indicated that it had no long term impact on them.

While the subjects in Gagnon's (1965) survey were not completely representative (they tended to be more educated than average), they were not selected on the basis of the presence of adjustment problems or of reported sexual victimization. Out of a sample of 333 abuse victims, he found that 73% showed no adult adjustment problems. Most of the abuse experienced by his subjects

were single incidents involving exhibitionists. Of the five subjects who had experienced repetitive, coercive sex acts, four showed serious adult adjustment problems. Overall, 15% of his sample showed moderate to severe adjustment difficulties. The rate of adjustment problems for the nonabused subjects was not provided.

Kilpatrick (1986) solicited subjects from several community sources, such as colleges and community organizations. She found no overall difference in adult functioning between those who experienced some sexual abuse and those who had experienced none. The subjects who had been subjected to forced or abusive sex with a parent or relative showed worse adult adjustment than the other participants in her study.

Several studies have examined therelationship between sexual abuse and adjustment among samples of university students. Such studies would tend to underestimate the negative effects of sexual abuse since the most severely damaged would be unlikely to have the psychological resources necessary to succeed in higher education. Most of these studies tend to find that the adjustment of sexually abused students is worse than the nonabused students, although the differences tend to be small on most measures (Alexander & Lupfer, 1987; Briere & Runtz, 1988; Fromuth, 1986; Gagnon, Brender, Arbuckle & Marabini, 1988; Harter, Alexander & Neimeyer, 1988; Haugaard & Emery, 1989; Runtz & Briere, 1986; Sedney & Brooks, 1984). The one area in which clinically significant differences

emerge is the area of revictimization. All studies that examined this question have found women who have been sexually abused as children to be three to four times more likely to be physically assaulted and/or raped as adults (an average rate of about 25%) than women who were never abused (about 7% are revictimized) (Alexander & Lupfer, 1987; Fromuth, 1986; Gagnon et al., 1988; Sedney & Brooks, 1984). Several studies have recruited subjects through advertisements. While it is unclear what motivates sexual abuse victims to participate in research, the studies that have used subjects recruited through advertisements have tended to find more serious long term effects than do the studies based on university samples. Silver, Boon and Stone (1983), in a study of incest victims, found clinically significant adjustment problems in most of their subjects. The amount of psychological symptoms in their victims was equivalent to that of patients attending out-patient treatment. Forty-six percent of their sample reported that they had attempted suicide. Gold (1986) also found the sexually abused subject in her study showed high levels of depression, sexual problems, and other psychological symptoms. The women in Courtois (1979) generally reported that their experience of childhood sexual abuse had long term negative impacts on their sense of self, their sexual activities, and their relationships with men.

Family background and the impact of sexual abuse

While it is generally acknowledged that children who are sexually abused show more adjustment problems than other children, some authors (e.g., Henderson, 1983) have argued against a direct connection between sexual abuse and psychological problems. Since most sexual abuse occurs in dysfunctional families, it is possible that it is the poor family background, not the sexual abuse, that contributes to the adjustment problems. The studies that have attempted to address this issues, however, have generally found that poor adjustment observed in sexually victimized children cannot be solely attributed to dysfunctional family backgrounds.

Ageton's (1983) longitudinal study presents the most convincing data that the impact of sexual victimization is not attributable to family dysfunction. While adolescent rape victims come from relatively dysfunctional families, it is not until after their victimization that they show increased levels of depression and anxiety.

None of the other studies assessed child sexual abuse victims prior to their abuse. Instead, these studies attempted to control for family background through multivariate statistical analyses (multiple repression). Multiple regression analyses can provide estimates of the relationship of sexual abuse to adjustment, when the effects of family background are held constant. Conversely,

these analyses can estimate the effects of family background on adjustment, when the effects of sexual abuse are held constant.

Two studies have used multiple regression analyses to examine the relationship of family background and sexual abuse to adjustment in children (Conte & Schuerman, 1987a, 1987b; Friendrick et al., 1987). Both of these studies found that dysfunctional family background had a strong relationship with childhood adjustment problems, but that sexual abuse predicted poor adjustment even when the effects of family background were statistically controlled. Family background was a better single predictor of maladjustment than was sexual abuse.

A study of adolescent offenders found that sexual abuse predicted low self esteem, when the effects of physical abuse were statistically controlled (Dembo, Williams, La Voie, Berry, Getreu, Wish, Schmeidler & Washburn, 1989). Dembo et al. also found that sexual abuse predicted drug use, even when the effects of both physical abuse and low self-esteem were statistically controlled.

In the community studies of both Bagley and Ramsey (1985) and S. Peters (in Browne & Finkelhor, 1986), sexual abuse history predicted poor adjustment after the effects of dysfunctional family background were controlled. In the Bagley and McDonald (1984) follow-up study, sexual abuse was a stronger predictor of maladjustment than was a dysfunctional family background. Of the two studies that used university samples, Harter et al. (1988)

found an independent contribution of childhood sexual victimization, whereas Fromuth (1986) did not. It is not surprising that Fromuth failed to find an independent contribution for sexual abuse since the abused subjects in her study showed levels of adjustment similar to those of the nonabused subjects.

Overall, the results of Ageton's (1983) longitudinal study and the multiple regression studies using children, adolescents, and adults indicate that the negative effects associated with childhood sexual abuse do not appear to be solely attributable to dysfunctional family backgrounds. This conclusion is further supported by Herman's (1981) finding of worse adjustment in incestuously abused females compared to females whose father were seductive, but not sexually abusive.

Moderator variables

Since sexual abuse involves a diversity of offenses and victims, it is important to identify the types of abuse that are most strongly related to negative adjustment. In general, the research on characteristics related to harm in child sexual abuse has been more consistent than the research examining the moderator variables in rape research. The child sexual abuse literature, nevertheless, remains inconclusive on many issues.

Relationship to offender. Several studies have examined whether abuse by relatives is more traumatic than abuse by strangers. Four studies of children have found that abuse by relatives tends to be more traumatic (Adams-Tucker, 1982; Friedrich et al., 1986; Gentile et al., 1988; Peters, 1976). The differences tend to be small, however, and three studies have failed to find any differences (Cohen & Mannarino, 1988; Johnston, 1979; Rimzsa et al., 1988). These inconsistent finding can perhaps be explained by Conte and Schuerman's (1987a) observation that children who had a subjectively important relationship with the offender showed worse adjustment than other victims. Increased blood relatedness of the offender, by itself, was not associated with increased harm. Conte and Schuerman suggested that it was the experience of emotional betrayal that was especially damaging to the victims.

The studies of adults who were abused as children have again yielded mixed results concerning whether relatedness is associated with increased harm. Herman et al. (1986) found that 73% of those abused by their father reported negative long term impact, whereas only 27% of the women abused by other people reported such negative impact. Five other studies have also reported that abuse by close relations is more traumatic than abuse by nonrelatives (Briere & Runtz, 1988; Finkelhor, 1979a; Harter et al., 1988; Landis, 1956, in Brown & Finkelhor, 1986; Sedney & Brooks, 1984). However, no association between relatedness and trauma was found in five other studies (Alexander & Lupfer, 1987; Briere & Runtz, 1987; Courtois,

1979; Gold, 1986; Tsai, Feldman-Summers & Edgar, 1979). Kilpatrick (1986) found that abuse by relatives was worse only when it involved overt force and coercion.

While the above results are not completely consistent, the overall pattern suggests that abuse by relatives is more likely to be harmful than abuse by nonrelatives. The trauma is most likely to be acute when the offender violates the established trust of the victim. None of the available research indicated that abuse by strangers is more traumatic than abuse by family members.

Sex acts. Abuse involving penetration (digital or phallic) has consistently been related to more trauma than other types of abuse. This pattern is found in studies of children (Cohen & Mannarino, 1988; Friedrick et al., 1986, 1987), adolescent rape victims (Ageton, 1983; Gidycz & Koss, 1989) and in most studies of adult survivors of sexual abuse (Bagley & Ramsey, 1985; Harter et al., 1988; Herman et al., 1986; S. Peters in Browne & Finkelhor, 1986; Sedney & Brooks, 1984). The only studies that failed to find this effect were studies of adults that included few cases of penetration (less than 10) (Alexander & Lupfer, 1987; Briere & Runtz, 1988; Finkelhor, 1979; Tsai et al., 1979).

Duration. Children who are abused over a long period of time are more likely to show adjustment problems than other abuse victims. (Friedrich et al., 1986; Gentile et al., 1988; Johnston,

1979, Rimzsa et al., 1988). Rimzsa et al. (1988) found that of children who were abused for less than six months, 53% showed no symptoms; 36% of those who had been abused between six and 24 months showed no symptoms; and, all (100%) of the children who had been abused for more than two years showed clinically significant symptoms. The only study of sexually abused children that failed to find an effect for duration was Adams-Tucker (1982), who examined a rather small sample. Most of the studies of adult survivors also find worse adjustment for victims who have been abused over a long period of time (Briere & Runtz, 1988; Edwards & Donaldson, 1989; Herman et al., 1986; Tsai et al., 1979). Only two studies failed to find this effect (Courtois, 1979; Finkelhor, 1979a).

Frequency. Consistent with the finding that the duration of sexual abuse is related to increased trauma, there is some evidence that the number of times a child is abused also predicts worse adjustment. Two of the three studies of children found that increased frequency of abuse predicted poorer adjustment (Friedrich et al., 1986; Gentile et al., 1988; but not in Cohen & Mannarino, 1988). The same effect was found in adult survivor studies by Sedney and Brooks (1984) and Tsai et al. (1979), and to a lesser extent in Edwards and Donaldson (1989) and Gagnon et al. (1988). Three studies of adults who were sexually abused during childhood failed to find any relationship between frequency of abuse and adjustment (Briere & Runtz, 1988; Courtois, 1979; Finkelhor,

1979a). Overall, there appears to be a weak relationship between frequency of abuse and adjustment.

Force. The use of overt force by the offender, while related to victim adjustment, appears to make surprisingly little difference in the amount of trauma experienced by child victims. Studies by Cohen and Mannarino (1988) and Conte and Schuerman (1987a) both found weak, but significant, relationships between increased force and increased trauma. Studies by Friedrich et al. (1986) and Gentile et al. (1988), however, failed to find any effects.

As previously mentioned, Ageton (1983) found that adolescent rape victims who experienced mild physical trauma experienced less psychological trauma that victims who did not receive any injuries, or those that received brutal beatings.

The studies of adult survivors have generally found that adults who described their childhood sexual activities with adults as coercive showed poorer adjustment than adults who remembered their childhood sexual activities with adults as relatively consensual (Briere & Runtz, 1988; Finkelhor, 1979a; Gagnon, 1965; Gagnon et al., 1988; Herman et al., 1986; Kilpatrick, 1986). Only two of the eight studies failed to find a relationship between perceived force and increased negative impact (Courtois, 1979; Gold, 1986).

Victim age. The relationships between victim age and trauma tend to be weak and inconsistent. Studies of children tend to find that older children show more trauma than young children (Adams-Tucker, 1982; Cohen & Mannaniro, 1988; Conte & Schuerman, 1987a). Gomes-Schwartz et al. (1985) found that 17% of the 4 to 6 year olds in their sample showed clinically significant pathology, which was less than the 40% rate of the 7 to 13 year olds. Only 8% of the 14-18 year olds in their sample showed symptoms, which they attibuted to a large number of the adolescents perceiving the sexual activity as consensual.

The majority of the studies of adult survivors have found no effect between age at victimization and negative impact (Alexander & Lupfer, 1987; Briere & Runtz, 1986, 1988; Edwards & Donaldson, 1989; Finkelhor, 1979; Herman et al., 1986; Tsai et al., 1979). The adult studies typically include few subjects who report being abused when they were very young, since adults have poor memory of their early years. Most of the abuse reported in adult studies occurred between the ages of six and sixteen. The two adult studies that have found difference in adjustment have been contradictory. Courtois (1979) found that children victimized before puberty showed worse adjustment, whereas Sedney and Brooks (1984) found worse adjustment in children victimized after puberty.

Overall, the research on victim age suggests that very young children (less than six) are less effected than other children, but that there is little difference in the amount of negative impact for children abused during the six to sixteen year old range. The lower level of trauma in the very young may be attributed to these children being less aware of the implications of the activities, being less blamed for the abuse by others, or to the lower rate of penetration in sexual abuse of young children. The low levels of detected distress may also be due to young children being less able to articulate their distress than older children.

Offender age. Herman et al. (1986) and Finkelhor (1979a) both found that the greater the age difference between the victim and the offender, the more negative was the impact of the abuse. Similarly, Briere and Runtz (1988) found increased trauma in adult sexual abuse survivors who were abused by older perpetrators. Only Gagnon et al. (1988) failed to find any effect for the perpetrator's age. All of the above studies examined adult survivors; no studies have examined difference between children recently victimized by young or old offenders.

Sex of victim. Five of the six studies that examined sex differences in child victim reactions have found more negative reactions in female victims (Badgley, 1984; Friedrich et al., 1986; Santilli et al., 1988; Tong et al., 1987; White et al., 1988).

Dembo et al. (1989) did not find a significant sex difference; however, they examined a narrow selection of subjects and outcome measures (drug use among young offenders in secure custody).

All three studies of adults have found more negative effects for females victims than male victims (Finkelhor, 1979a; Fritz, Stoll & Wagner, 1981; Haugaard & Emery, 1989). The definition of sexual abuse used in these studies included any sexual activity between a child and a much older person. When sexual abuse is defined more narrowly as sexual activity that was experienced as coercive, the sex differences disappear in the Finkelhor (1979a) and Haugaaurd and Emery (1989) studies. In general, males tend to report their childhood sexual experiences with adults as less coercive than do females (Finkelhor, 1979a).

Sex of offender. Only one study (Finkelhor, 1979a) examined differences between male and female offenders. He found that abuse by males was more negative than abuse by females for both male and female victims. Such results should be considered cautiously until more extensive research has been conducted.

Summary of moderators

Sexual abuse of children appears to have more serious negative effects when it occurs in a close relationship, with a much older offender, involves children over the age of six, includes

penetration, and is extended over a long period of time. Abuse that is experienced as coercive has a more negative impact than abuse that is perceived as relatively consensual. Female victims appear to show more negative reactions than male victims, although this may be due to males generally experiencing their abuse as less forced than do female victims.

The harmful effects of prolonged, intense sexual abuse are supported by the clinical studies of women who seek treatment for sexual abuse (e.g., Edwards & Donaldson, 1989; Herman et al., 1986; Tsai et al., 1979) The women who seek treatment are much more likely to have been subjected to repeated, coercive intercourse with a close relative than do sexually abused women who do not seek treatment. Lindberg and Distad (1985) found that of a group of women in treatment for sexual abuse, all had prolonged incest experience lasting an average of seven years. All of the women is this study met the criteria for PTSD and considered their abuse to be the most traumatic and damaging event of their lives. In contrast, the studies that have found relatively little long term effects of sexual abuse have predominantly involved single incidents of nonincestuous, noncontact offenses (e.g., Gagnon, 1965).

Summary of child sexual abuse trauma

Retrospective accounts by adults of their childhood sexual victimization overwhelmingly describe their initial reactions as negative. The severity of this immediate psychological distress is unclear since children rarely come to professional attention immediately following the victimization. Fifty to 70% of sexually abused children who are referred for assessment generally show significant psychological symptoms. The most common symptom is inappropriate sexual behaviour (e.g., masturbating in public, requesting sex from adults or other children). They also show a range of other specific symptoms, such as excessive crying, withdrawal, and aggressiveness.

The limited number of follow-up studies that have been conducted suggests that these symptoms tend to persist during the following years. Six to 10 year follow-up of sexually abused children show a wide range of significant adjustment difficulties, including depression, substance abuse, prostitution, and revictimization.

Studies of adults who were sexually abused as children generally find that their overall adjustment is worse than that of non-abused adults. About 50% report that their childhood sexual victimization had at least some lasting negative effect. Fifteen to 25% of abused adults show current clinically significant

psychopathology, compared to a 10% rate for non-abused adults. The specific symptoms include depression, substance abuse, anxiety, and dissociation. Compared to adults who have not been sexually abused, sexual abuse victims are three or four times more likely to be physically and sexually victimized as adults.

Several types of sexual abuse have been identified as being relatively more psychologically damaging. Child sexual abuse is generally more damaging than when the offender has a prior positive relationship with the child, when the offender is much older than the victim, when the offenses involve penetration (digital or phallic) and when they continue over a long period of time. Sexually abused boys tend to show less negative effects than sexually abuse girls, although this sex difference may be due to difference in the types of abuse experienced by boys and girls. Compared to sexually abused adults who report few symptoms, women who experience adjustment difficulties and/or seek treatment for sexual abuse are more likely to have had sexual intercourse with a father figure over a number of years. Such abuse is considered to have significant negative consequences for most victims.

The psychological impact of nonsexual criminal victimization

The research on the psychological impact of nonsexual criminal victimization is less extensive than the research on rape and child

sexual abuse. Most of the research on crimes such as burglary, assault, or bank robbery, have used relatively unstructured interviews to assess the psychological impact of these crime (Bard & Sangrey, 1979; Burt & Katz, 1985; Resick, 1987). Measures with established reliability and validity have been rarely used. While few firm conclusions are suggested by the available research, the literature, nonetheless, provides some guidance on the nature of psychological harm in nonsexual criminal victimization.

Burglary

Maguire and Bennett (1982) found that most burglary victims reported initial distress upon discoving the offense. Seventy-nine percent of the males reported some strong reaction as did 87% of the females. Males tended to react with anger, whereas females reacted with fear and shock. They estimated that for 19% of the sample, the burglary had a "considerable impact"; for 6%, the impact of the burglary was traumatic.

At four to 10 week follow-up, 65% of the victims reported that the burglary still have some effect on their lives. Fifteen percent stated they were still frightened; eight percent had trouble sleeping. A significant proportion of the females victims felt that their home had been violated or polluted by the burglary.

Waller and Okihiro (1978) interviewed a large number of Toronto residents (2,483) in order to identify people who had been burglarized during the past 16 months (116 cases). Their method allowed them to interview victims who had not reported the crime to the police. The burglary victims recalled that their initial reactions were fear, anger, and general distress. In general, they found less fear reactions in males than females. At the time of the interview, 42% of the female victims were still afraid of being alone, compared with only 2% of the males. Thirty-one percent of the females and 8% of the males were afraid of entering their residence.

Hough (1985) reported the results of a large community survey (total sample of over 11,000) conducted in Great Britian. Of the 343 respondents who had been burglarized during the past years, 45% reported that they had no emotional problems associated with the crime. Sixty-one percent indicated that the burglary had a significant impact at the time of the offense, and 24% stated that it still had some impact. Only 8% showed evidence of serious stress reactions. The psychological impact was less for the 227 car theft victims than it was for the burglary victims. Forty-six percent indicated the theft had a significant impact at the time, and only 6% indicated a continuing reaction. Less than 3% showed a serious stress reaction connected with the theft.

Overall, burglary appears to be a distressing event for most victims, but it is not generally associated with the truamatic reactions typically found for rape victims.

Bank robbery

Leymann (1985) conducted an extensive study of victims of bank robbery in Sweden. He found that most victims showed anxiety and fear at the time of the robbery, and mild levels of distress afterwards. Insomnia was reported by 41%, and concentration difficulties by 34%. The robbery did not appear to be traumatic to most of the victims. Only 4% took sick leave following the robbery and 14% accepted the general offer of supportive counseling. The stress symptoms tended to subside for most victims between three weeks and six months after the attack. Leymann estimated that 5-8% showed prolonged psychological effects of the robbery. The individuals who were most likely to show negative long term reactions were females who had experienced previous robberies.

Weisaeth (1985), in his summary of Norwegian research on bank robbery victims, reported that 20-23% of the victims developed sufficient symptoms of PTSD to require treatment. Like Leymann (1985), Weisaeth stated that long term problems are rare in this victim population.

Kidnapping

Terr (1983) reported a unique study of 25 school children who, four years previously, had been abducted on a bus, threaten with death, and confined in a dark enclosure. The entire ordeal lasted more than 27 hours before two of the kidnapped boys dug the group out. All of the children were still suffering from PTSD at four to five years follow-up. Specific symptoms included increased fears (both mundane and kidnap related), nightmares, death dreams, reenactments of the event in play, and limited, pessimistic views of the future.

Comparisons between crimes

Several studies have compared victims' psychological reactions to different types of crimes (Biles, Braithwaite & Braithwaite, 1979; Kilpatrick et al., 1985; Kilpatrick et al., 1987; Maguire & Corbett, 1987; Wirtz & Harrell, 1987a, 1987b). The most informative of these studies is the Kilpatrick et al. (1987) study that was discussed in the section on rape victimization. In general, the studies that compared different offenses find that assaultive offenses are more traumatic than property offenses (Stuebing, 1984; Wirtz & Harrell, 1987a). Sexual offenses are consistently associated with the most psychological trauma (see also Shapland, Willmore & Duff, 1985).

Unspecified crimes

Shapland et al. (1985) reported the psychological reactions of victims of various serious crimes, including physical assaults, robbery and sexual assualts. They found that symptoms of nervousness, anxiety and worry persisted over several years for 30-50% of the victims.

Berg and Johnson (1979) studied the reactions of victims of various juvenile offenders (excluding sexual offenses). While their method did not allow for estimations of the absolute levels of distress, they did find that female victims and elderly victims showed more severe anxiety reactions than did male victims or young (less than 60) victims.

The Canadian Department of Justice (Stuebing, 1984) conducted a study of the reactions of crime victims in Red Deer, Alberta. Based on retrospective interviews, they found that 27% of the victims of personal crimes (assault, sexual offenses) showed contined emotional distress or trauma several years after the attack. In contrast, on 19% of the victims of property offense showed continued negative emotional reactions. The Department of Justice study also noted sex differences in the reactions to crimes. More than twice as many females reacted with fear (41%) than did males (17%). Males, instead, tended to express their distress through anger (61% versus 52% for females). Overall, only

9% of males and 11% of females reported that they were not bothered by their criminal victimization.

Summary of nonsexual criminal victimization

All types of criminal victimization are distressing for most victims. The absolute level of distress is similar for males and females, although males tend to react with anger and females with fear. There is some evidence that elderly victims (over 60) tend to show more severe anxiety reactions than younger victims. The most traumatic offenses are sexual, followed by nonsexual assault, robbery, and noncontact property crimes. Most of the sexual assault victims show traumatic stress reactions. While property crimes are distressing to most victims, only a minority show clinically significant stress reactions.

General Summary

Adult Sexual Victimization

An overview of the trauma associated with the sexual victimization of adult females is diplayed in Table 7. The immediate impact of rape is extremely distressing to almost all victims. During the attack, women are typically intensely afraid and shocked. It is not uncommon for victims to expect to die. In the few hours or days after the assault, victims, on average, show levels of psychological distress equivalent to in-patient psychiatric patients. The major symptoms are fear, anxiety, and depression, although victims show a wide range of reactions. Most are unable to do ordinary daily tasks. Between 40 and 50% are assessed as showing severe psychological distubance, and only 5-10% are assessed as showing no clinically significant symptoms.

During the next few weeks following the assault, the victims' symptoms gradually decrease to the level of psychiatric out-patients. The raped women are generally able to resume their daily tasks, but are suffering under considerable distress. Twenty to 40% of them are clinically depressed on standardized measures. Increased fears are common, with about 25% showing severe, generalized anxiety. Other symptoms include sleep disturbance, nightmares, persistent memories, and disturbances in social and occupational functioning. Moderate to severe disturbance is shown in about half the victims.

Several longitudinal studies have been conducted that follow victims during the first year post assault. These studies find

Table 7.

The severity of trauma associated with adult sexual victimization.

time since attack	severity of trauma
less than two days	75% unable to do ordinary daily tasks. 40-50% severe psychological disturbance. 5-10% no clinically significant symptoms. Overall levels similar to hospitalized psychiatric patients.
two weeks	Most are able to do ordinary daily tasks. 50% moderate to severe symptoms. 20-40% clinically depressed. 25% severe, generalized anxiety. Overall levels similar to psychiatric out-patients.
4 months to 1 year	Gradual return to near normal levels on most indices of mental health.
greater than 1 year	25% report continuing negative effects. Increased vulnerability to other mental health problems.

Factors associated with increased trauma	
assault characteristics	severe brutality completed intercourse
victim characteristics	age (older) history of sexual victimization history of adjustment problems
other factors	lack of social support treatment not provided.

that the assaulted women's symptoms gradually decrease over several months. By the end of one year, the women's symptoms are in the normal range on most measures, although they tend to be slightly below the scores of non-assaulted women. This pattern applies to depression, anxiety, fears, social functioning, and sexual problems.

The extent to which assault-related psychopathology persists beyond the first few years is less clear. Interviews of women who have been raped years earlier generally find that a significant proportion, about 25%, report continuing negative effects. These persistent problems tend to be related to problems in intimate sexual relationships, and increased fears. There is also some evidence that people who have been sexually victimized become more vulnerable to developing other psychological problems, such as depression, substance abuse, and anxiety disorders in the years following the assault.

There are also some studies that compared the effects of sexual victimization with other types of non-sexual criminal victimization. In all these studies, sexual assault inflicted more serious harm than the other offenses. Nonetheless, there is some evidence that the amount of psychological harm caused by aggravated non-sexual assaults is quite high. (About 10% of aggravated assault victims show significant negative effects for many years

after; about 35-50% show moderate to serious psychological disturbance at the time of the assault.)

Since not all victims show serious psychological disturbance, some research has been conducted to identify offense and victim characteristic associated with increased trauma. In general, there are few relationships between assault characteristics and trauma. The only two assault characteristics that have consistently been related to increased trauma are 1) brutality, and 2) completed intercourse. Mild levels of physical assault (e.g., superficial scratches or bruises) does not appear to lead to more psychological harm than sexual assaults that do not result in injury. Victims of brutal beatings, however, consistently show more psychological trauma than other victims. Victims of attempted rape, and non-intercourse sexual assault show less distress than victims of completed rapes.

Several victim characteristics are also related to trauma. Victims are likely to show increased trauma if they are older, have a prior history of sexual assault (as children or as adults), have a history of prior adjustment difficulties, lack social support, and do not receive treatment for the assault.

Another relevant issue is the effect of sexual assault on non-victims. Many women's routine behaviour is significantly affected by the fear of rape, even though they have never been victimized.

More than 2/3 of women report that they have avoided doing necessary activities because of fear of victimization (Riger & Gordon, 1988). Feminists have argued that the seriousness of such fears have been underestimated because women are expected to be fearful, defenseless, and subservient (Brownmiller, 1975; Riger & Gordon, 1981). Several authors have expressed protests against this "invisible impact of rape", claiming that the freedom to walk safely through city streets should be right shared by men and women (see Riger & Gordon, 1988).

Child Sexual Victimization

A summary of the trauma associated with child sexual abuse is provided in Table 8. Sexual offenses against children include a broader range of activities than sexual offenses against adults. For sexual offenses against adults, some form of force or treat of force is required for it to be a criminal offense. In contrast, most definitions of sexual abuse of children include not only forced or coercive sexual victimization, but also any sexual activity between a child and a much older person. Consequently, one common type of child sexual abuse is for an adult in a position of power over the child (e.g., parent, babysitter) to engage the child victim in sexual activities without the overt use of force. In some cases, the offender, and sometimes even the victim, may describe the activities as consensual. Such adult-child sex is typically

considered abuse due to the child's inherent inability to consent to the activity.

Studies of peer rapes of adolescent females have typically shown similar levels of trauma as that found in adult rape victims. Following a rape, adolescent females show symptoms of depression, anxiety, and fears in the range expected for psychiatric outpatients. Many quit school or changed schools abruptly. An excellent longitudinal study found that delinquent behaviour was a precursor and not a consequence of being raped.

Table 8.

The severity of trauma associated with child sexual victimization.

time since abuse	severity of trauma
immediate (prior to disclosure)	Distressing, but the severity of the immediate trauma is not known.
1 to 12 months (after disclosure)	50-70% significant psychological symptoms.
greater than 1 year	Persisting negative effects noted in initial studies.
greater than 10 years (sexually abused children as adults)	50% report some lasting negative effects. Increased risk (double) for depression, substance abuse, anxiety disorders and dissociation. Increased risk (3-4 times) for physical and/or sexual abuse as adults.
Factors associated with increased trauma	
assault characteristics	penetration (digital or phallic) long duration overt coercion
offender characteristics	male much older than victim father prior positive relationship with victim
victim characteristics	female

Most studies of child sexual abuse include different types of sexual victimization, including offenses based on the presence of force, the age differential between victim and offender, and the

degree of relatedness between victim and offender (e.g., incest). The immediate impact of such sexual abuse is difficult to determine since victims are rarely detected until months or years following the onset of the abuse. Retrospective accounts by adults of their childhood sexual victimization overwhelming describe their initial reactions as negative. Fifty to 70% of sexually abuse children who are referred for assessment generally show significant psychological symptoms. The most common symptom is inappropriate sexual behaviour (e.g., masturbating in public, requesting sex from adults or other children). They also show a range of other specific symptoms, such as excessive crying, withdrawal, and aggressiveness.

The limited number of follow-up studies that have been conducted suggests that these symptoms tend to persist during the following years. Six to 10 year follow-up of sexually abused children show a wide range of significant adjustment difficulties, including depression, substance abuse, prostitution, and revictimization.

Studies of adults who were sexually abused as children generally find that their overall adjustment is worse than that of non-abused adults. About 50% report that their childhood sexual victimization had at least some lasting negative effect. Fifteen to 25% of abused adults show current clinically significant psychopathology, compared to a 10% rate for non-abused adults. The

specific symptoms include depression, substance abuse, anxiety, and dissociation. Compared to adults who have not been sexually abused, sexual abuse victims are three or four times more likely to be physically and sexually victimized as adults.

Several types of sexual abuse have been identified as being relatively more psychologically damaging. Child sexual abuse in which the offender has a prior positive relationship with the child is more damaging than when the offender is a stranger. Although there are some conflicting studies, abuse by father figures has more negative consequences than abuse by siblings or other family members. The greater the age difference between the victim and the offender, the greater the likelihood of psychological harm. Increased trauma is also associated with offenses that involve penetration (digital or phallic) and continue over a long duration. One study found that 50% of victims who were abused less than 6 months showed symptoms, whereas all of the victims who had been abused for more than 25 months were symptomatic.

The studies on the relationship between force and trauma have yielded mixed results. Adults who describe their sexual abuse as forced and coercive generally report more negative impact of the abuse than adults who describe their childhood sexual activities with an adult as relatively consensual. Sexually abused boys tend to show less negative effects than sexually abuse girls. It is unclear whether this is due to a sex difference or to the general

finding that the abuse of boys tends to be different than the abuse of girls. Compared to sexually abused adults who report few symptoms, women who experience adjustment difficulties and/or seek treatment for sexual abuse are more likely to have had sexual intercourse with a father figure over a number of years. Such abuse is considered to have significant negative consequences for most victims.

Nonsexual criminal victimization

Sexual crimes are more traumatic than nonsexual assault, robbery and burglary (in that order). Crimes against the person are more traumatic than property crimes. While all crime victims tend to be distressed by their victimization, clinically significant stress reactions are found for a minority of the victims of property crimes. Long term negative reactions to robbery are rare. Children who were subjected to kidnapping, death threats, and extended confinement showed significant stress reactions. Males and females tend to be equally upset by criminal victimization; males, however, express their distress through anger, whereas females become fearful. There is some evidence that elderly victims (greater than 60) show more intense anxiety following criminal victimization than younger victims.

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