

**REVICTIMISATION IN A SAMPLE OF 2,759 VICTIMS OF
CHILD SEXUAL ABUSE: A 44 YEAR FOLLOW-UP STUDY.**

Submitted by

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Notice 1

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PUBLICATIONS DURING THE COURSE OF THE THESIS

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ABSTRACT

Background

Child Sexual Abuse (CSA) is recognised as a significant problem within today's society. The literature has established that individuals who have been sexually abused as children may be at an increased risk for revictimisation throughout their life. The primary aim of this study was to examine the relationship between CSA and subsequent revictimisation. This investigation included determining if the severity of the CSA affected the rate of revictimisation, if the age of the child during the initial sexual abusive experience affected the rate of revictimisation, and to determine if there is a mediating role between CSA and mental illness.

Method

The study utilised a prospective design. The forensic medical records of sexually abused children were obtained from the Office of Forensic Medicine (OFM), a state-wide forensic medical service, on children who had been medically confirmed to have experienced sexual abuse (n=2,759) between the years 1964 and 1995. These records were linked to the Victorian Police Law Enforcement Assistance Program (LEAP) and the public mental health database (RAPID) for a follow-up period of 44 years. The victims were compared to similarly aged peers obtained randomly from the Australian Electoral Commission (n=2,677).

Results

The individuals from the CSA cohort were more likely (OR = 1.4, 95% CI, 1.26-1.56) to have had contact with the Victorian Police, more likely (OR = 1.14, 95% CI, 1.02-1.27) to be revictimised and more likely (OR = 5.3, 95% CI, 3.79-7.41) to be sexual revictimised than

the individuals from the general population. The CSA victims were divided into pre-pubertal (<12 yrs.) or post-pubertal (>12 yrs.) categories. The pre-pubertal group had significantly more contact (618, 39.7%) with the Victorian Police than did the post-pubertal group (382, 31.8%) and were significantly more likely to be revictimised in the form of sexual assault and violence. When examining by gender, the males were more likely to be revictimised if they were initially sexually abused post-pubertal (OR = 1.45, 95% CI 1.02-2.07) while the females were more likely (OR = 1.6, 95% CI 1.35-1.92) to be revictimised if they were sexually abused pre-pubertal. No significant difference was observed between the level of severity of the initial abuse and the rate of revictimisation. Almost one quarter (23%) of the CSA victims had had contact with the public mental system during the course of their lifetime compared to 7.7 percent from the general population, revealing that victims of CSA were over 3.5 times more likely to have mental health issues. These mental health issues were observed to have an influence on increasing the level of vulnerability to revictimisation. Rates of alcohol and drug use and self-harm and suicide were all higher within the CSA victim population.

Conclusions

This study confirmed many of the established relationships already seen between CSA and revictimisation. Mental illness was revealed to be a moderating variable for sexual revictimisation; the victim's age at the time of the initial sexual abuse played a significant role in the level of vulnerability of revictimisation; and, surprisingly, the level of the severity of the abuse did not have a significant association with the rate of revictimisation. Overall, CSA was shown to play a substantial role in an individual's vulnerability for being subsequently victimised; however, the question remains whether the relationship between CSA and revictimisation is necessarily causal.

GENERAL DECLARATION

Monash University
Monash Research Graduate School

I hereby declare that this thesis contains no material which has been accepted for the award of any other degrees or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously written by another person, except where due reference is made in the text of the thesis.

Signed:

Date:

CHAPTER ONE

THESIS OVERVIEW AND RESEARCH AIMS

1.0 Introduction

This thesis reports on the revictimisation of victims of child sexual abuse (CSA) by using, to date, one of the largest cohorts of CSA victims. The official records from forensic medical examinations of CSA victims between 1964 and 1995 were linked with the Victorian Police and psychiatric databases for a follow-up period of 44 years. To understand the relative risk of revictimisation for the victims of CSA it was imperative to compare this population with a non-abused population and determine the level of association between CSA and further victimisations. This thesis comprises six chapters which are described briefly below.

1.1 Thesis Overview

Chapter one provides a brief description of each chapter within the thesis and presents the research aims.

Chapter two provides a brief overview of the literature on child sexual abuse and its association with revictimisation. The chapter begins with a review of the history of child sexual abuse and continues on to explore the risk factors for becoming a potential victim of CSA. It then progresses into a review of the most current studies on revictimisation and the factors which have been identified as increasing the risk for being revictimised. The chapter then explores the outcomes which are associated with CSA and revictimisation, again presenting the reviews of the prolific studies in this area.

Chapter three describes the methodological limitations and considerations in the area of CSA and revictimisation research. By reviewing both retrospective and prospective designs it provides a rationale for undertaking the current study in a prospective design format. The chapter also explores the validity and reliability of the self report and sampling and recall biases.

Chapter four illustrates the methodology used in the current research. The chapter begins by discussing the historical cohort study design utilised within the research. It explains in detail the different data sources and cohorts used and progresses into a discussion on the data linkage procedure. To conclude the chapter, the ethical considerations and statistical analysis are discussed.

Chapter five reports the results. This chapter is divided into four sections, with section one presenting the characteristics of the CSA and comparison cohorts. Section two comprises an in-depth account of the CSA cohort's association with the Victorian Police and the comparison of this association with that of the general population. Section three discusses the CSA cohort's association with the Victorian public psychiatric services and how these associations again compare with the general population. The rates of alcohol, drug and substance misuse and rates of suicide and self-harm are also examined within section three. Section four examines the relationship between the CSA victims, a diagnosis of a mental illness and the influence this combination has on the risk for revictimisation.

Chapter six presents an integrated discussion of the overall findings of the research. It provides a review of the findings for each research aim, a discussion of the implications and

the limitations of the study and discusses future directions for this area of research.

1.2 Research Aims

The primary aim of this prospective research was to examine the relationship between CSA and subsequent revictimisation. The current study overcomes many limitations in the previous research by conducting a follow-up, data linkage study of a large representative cohort of both male and female CSA victims with a matched comparison group from the general population. By employing a prospective design and studying such a large cohort of CSA victims, it is hoped that the thesis overcomes the common methodological limitations surrounding this population in the current literature, which is heavily focused on retrospective research design. Finally, the follow-up period of 44 years is of such a length that it provides adequate time to examine the differing levels of revictimisation and the associations which accompany them. More specifically the research will focus on the following:

1.2.1 Aim One

To determine the nature, frequency and outcomes of revictimisation, both sexual and non-sexual, among the CSA victims. To examine the extent the CSA population may be at a higher risk than the general population for experiencing revictimisation and to illustrate any gender differences observed within the association of CSA and revictimisation.

1.2.2 Aim Two

To determine if the severity of the CSA (penetrative vs non-penetrative) affects or is related to the revictimisation outcomes. Also under the severity of abuse umbrella falls the number of assaults and the number of offenders present at the time of the abuse. These will also be examined to determine their influence on the risks and rates of revictimisation.

1.2.3 Aim Three

To identify whether age (pre- or post-pubertal) at the onset of CSA affects the risk of revictimisation. The age of onset of CSA is also examined to determine whether it affects the level of developing disturbances in psychopathology.

1.2.4 Aim Four

To examine and determine if there is a mediating role present between the factors of CSA and mental illness.

CHAPTER TWO

A REVIEW OF THE LITERATURE

2.0 A Review of the Literature on Child Sexual Abuse and Revictimisation

"Child Sexual Abuse is a complex life experience, not a diagnosis or a disorder" (Putnam, 2003, p. 269).

2.1 History of Child Sexual Abuse

Although not a new phenomenon, there is a “long history of cultural denial” regarding CSA (Olafson, Corwin, & Summit, 1993, p. 8; Summit, 1988). It is only within the last two decades that CSA has begun to receive attention both publicly and academically (Koenig, Doll, O’Leary & Pequegnat, 2004). Increased awareness of CSA is finally bringing an appropriate level of understanding to this unspeakable act and the long-term effects which it may cause (Fergusson & Mullen, 1999). The relatively new found interest does not discount the fact that CSA is not a new discovery; in fact literature reveals knowledge of it dating back beyond 1896 when Sigmund Freud first formulated his ‘seduction theory’. The seduction theory was based upon Freud's experiences with his clients, who, he concluded, through their sessions, had been either molested or sexually abused as children (Ahbel-Rappe, 2006; Fergusson & Mullen, 1999). The seduction theory centralised around Freud’s belief that CSA was an aetiological factor in the presentation of neurosis and it was the repressed memories of the abuse which caused this presentation. He noted that there was a link between CSA and an increased vulnerability to psychiatric disorders (Fergusson & Mullen, 1999). Freud believed that the memory of such a traumatic experience was banished from the conscious mind as a natural

defense mechanism of the brain. He originally believed that the power imbalance between children and adults was at the “traumagenic core” of CSA, where the adult had the power to satisfy their needs by using a child who was at the “mercy of this arbitrary use of power” (Masson, 1984, p. 6; Olafson et al., 1993, p. 11). Within 12 months of Freud publishing the information regarding his seduction theory, he himself began questioning the theory as he saw doubts begin to emerge over the ability to distinguish between fantasy and recalled memories (Ellenberger, 1970).

Masson (1985) stated that Freud's abandonment of the seduction theory was a “failure of courage”. Masson (1985) and many others (Ahbel-Rappe, 2006; Garcia, 1987; Herman, 1981; Olafson et al., 1993; Peters, 1976; Rush, 1980; Summit, 1988) have recalled the story about Freud's change of mind, with many questioning his motives behind dispelling the theory. Regardless of the reasoning, this change of focus led to a halt in Freud's work in recovering past memories and a new focus began in the exploration of fantasy theories. Hence, the seduction theory was fleeting and Freud soon replaced it with his newly formulated oedipus complex, which was to later become the “irreducible foundation of psychoanalysis” (Olafson et al., 1993; Summit, 1988, p. 48). Freud's theory now portrayed that “children were traumatized not by actual sexual assault but by projections of their own wishful, masturbatory fantasies” (Olafson et al., 1993; Summit, 1988, p. 48). One of Freud's ‘inner circle’ psychoanalytic colleagues, Sandor Ferenczi, broke from Freud in his beliefs regarding CSA. He believed that CSA did occur and the client's stories were not based on fantasies but in fact were truthful. He argued that some of the consequences of CSA were “personality fragmentation and adult perversions” (Olafson et al., 1993, p. 12), which seems to follow the trend of present belief. “These children feel physically and morally helpless, their personalities are not sufficiently consolidated in order to be able to protest, even if only in thought, for the

overwhelming force and authority of the adult silences them and can rob them of their senses" (Ferenczi, 1955; Olafson et al., 1993, p. 7).

In 1937, psychoanalysts Bender and Blau wrote that they frequently "considered the possibility that the child might have been the actual seducer rather than the one being seduced" (Bender & Blau, 1937, p. 514; Olafson et al., 1993). They felt there were no negative effects which arose for the victims of the abuse. Even as late as the 1950's, there was still belief that CSA was not a harmful act. As stated by Alfred Kinsey, who later went on to become the founder of the Kinsey Institute for Research in Sex, Gender and Reproduction,

It is difficult to understand why a child, except for its cultural conditioning, should be disturbed at having its genitalia touched, or disturbed at seeing the genitalia of other persons, or disturbed at even more specific sexual contacts..... (Kinsey, Pomeroy, Martin, Gebhard, 1953, p. 121)

Kinsey collected large amounts of data regarding CSA from women. In fact Herman (1981), suggests that this was the largest body of data ever collected on CSA at that time. Over a quarter of female respondents (1,075) acknowledged some form of abuse as a child from an individual who was more than five years older than them, and 80 percent of these women reported being frightened over the events. Kinsey dismissed these results and numbers suggesting that the women's fears were "inappropriate" (Olafson et al., 1993). In fact, Kinsey went so far as to side with the offenders stating that they were unfairly imprisoned due to "accidental exposure of the genitalia while intoxicated, for nude swimming, or for the bestowal of "grandfatherly affection" (Kinsey et al., 1953, p. 20-21; Olafson et al., 1993).

In 1978, Alayne Yates published a book, *Sex without Shame: Encouraging the child's healthy*

sexual development in which she reveals that “incest does not necessarily produce damage.” (p. 121). She continues by suggesting that an important lesson can be learnt from incest. “Early erotic pleasure by itself does not damage the child. It can produce sexually competent and notably erotic young women. Childhood is the best time to learn....” (Yates, 1978, p. 121). She did state, however, that parents “may not always be the best teachers” (p. 121). The rationalisation that CSA is a normal biological process is quite unfathomable in today’s society.

Henry Kempe’s article published in 1962, *The Battered Child Syndrome*, was a defining moment in the acknowledgment of the effects and seriousness of physical abuse (Kempe, Silverman, Steele, Droegmueller, & Silver, 1962). This article has, and is continuing to be, hailed as a “landmark” (Brinich, 2013). It was the first article to provide a clear description of what constituted an abused child (Leventhal, 2003). What is so remarkable about Kempe’s article was that for so long doctors, family members and society in general had persistently failed, or chosen not to recognise the abuse which was right in front of them; therefore, for years the child’s voice was silenced by a lack of the adult’s willingness to acknowledge. “Child abuse and neglect often remain hidden only as long as observers do not want to see”. (Brinich, 2013, para. 5). This article achieved what it intended, illustrating that the occurrence of child abuse was not a rare phenomenon but in actuality a common problem (Leventhal, 2003).

It was not until the 1970’s that CSA was “rediscovered”, or perhaps “reexamined” is a better choice of words. This “reexamination” was prompted by the emerging women’s movement and the confidence and courage that women had finally found to speak up about the events which had occurred to them as children (Fergusson & Mullen, 1999; Rush, 1980). Once these personal accounts of CSA began to emerge, society was struck by the realisation of the

profound effects of the abuse. Regardless of this move forward, society continued to conceal the atrocities of CSA just as the victims individually so often do; this way neither has to reveal or relive the pain the abuse caused.

2.2 Definition of Child Sexual Abuse

There are many differing definitions of CSA, with not one universal definition agreed upon (Fergusson & Mullen, 1999). This lack of consensus presents challenges and controversy as it can lead researchers to include or exclude individuals in their data analysis depending on which definition has been chosen. CSA can be in the form of non-contact sexual abuse which includes acts of voyeurism, exhibitionism, verbal comments, and exposure to pornography (Finkelhor, 1993) or contact sexual abuse. Contact sexual abuse is broken into two categories; penetrative or non-penetrative. Penetrative sexual abuse includes the penetration of a vagina, mouth or anus by penile, digital or object (Finkelhor, 1993). Non-penetrative contact sexual abuse includes touching and fondling of the child's genitals, either through clothing or directly, forcing the child to touch the genitals of the perpetrator and kissing. The perpetrator needs to inhabit a position of power related to that child (Koenig et al., 2004), whether it be in age and maturation or in a parent or caretaker relationship role and the sexual acts are carried out with the use of force or deception (Finkelhor, 1993).

The dimension of severity is very difficult to judge as it is situation and victim dependent.

Much of the literature reports penetration to be the most severe act of CSA (Andrews, Corry, Slade, Issakidis & Swanston, 2004), although some victims may report being just as traumatised by sexual visions or threats made to them as they were to a penetrative act.

Other varying dimensions of CSA are: gender, age, sex of the victim, sex of the perpetrator, the

relationship of the perpetrator to the victim, the frequency and duration of the abuse and the degree of force used. These varying dimensions of CSA often create a conflicting nature which in-turn causes results to be inconsistent.

2.3 Prevalence of Child Sexual Abuse

When examining society as a whole, children have been found to be the most victimised portion of the population (Finkelhor, 2011); however, how CSA is defined and consequently operationalised may have an influence on the reported prevalence (Stoltenborgh, van IJzendoorn, Euser & Bakermans-Kranenburg, 2011); therefore, the prevalence rates (Price-Robertson, Bromfield & Vassallo, 2010; Richards, 2011). It is difficult to quantify the overall prevalence rates of CSA due to the numerous methodological factors involved in making the estimates. This is due, in part, to the discrepancies in the definition of CSA, discrepancies in the methodology of data collection, discrepancies in age parameters (i.e., what constitutes a child), and variations in the samples used (Fergusson & Mullen, 1999; Goldman & Padayachi, 2000).

If strictly looking at the data it would seem that there had been a constant increase in the cases of CSA since the 1970's to the 1990's. But upon closer examination this increase should be attributed to the increase in awareness of CSA rather than an increase in abuse itself. Because of this rise in awareness that CSA has been receiving, alarming statistics have been revealed regarding the number of children who have or are currently being sexually abused. In 2010, the child protection agencies in the United States of America had a total of 3.3 million reports of child abuse or maltreatment affecting 5.9 million children. Of these reports, approximately nine percent were reporting CSA (Leventhal & Krugman, 2012).

It must be noted that using data provided from welfare agencies and cases reported to police does not accurately describe the real prevalence of CSA as the majority of CSA cases never reach either of these agencies (Fergusson & Mullen, 1999; Finkelhor, 1994). It is believed that less than 10 percent of abuse cases actually get reported. Due to the varying nature of the definitions of CSA an alarming variability in the percentile estimates of the prevalence of CSA results. The statistics which are currently being reported by the American welfare agencies illustrate a decline in the number of CSA cases since the early 1990's after what appeared to have been two decades of constant increase. One study announced that the rates of reported CSA between 1990 and 2000 had decreased by 53 percent (Finkelhor & Jones, 2004).

Fergusson and Mullen's (1999) meta-analysis on general population studies of CSA revealed that the majority of studies estimated that the prevalence rate for female CSA victims is between 15 and 30 percent. With males, the estimates fell between 3 and 15 percent. When examining the prevalence of sexual penetration the figures were still quite high with the estimates being around 13 percent for females and 11.3 percent for males. Gorey and Leslie's (1997) research in the general population used a CSA definition which excluded non-contact abuse. Their results revealed a CSA prevalence rate of 12 to 17 percent for girls and 5 to eight percent for boys. Bolen and Scannapieco (1999) performed a meta-analysis on 22 American based studies and found that between 30 to 40 percent of girls and approximately 13 percent of all boys experienced some form of sexual abuse during their childhood years. Another meta-analysis, this time examining 169 international studies which examined lifetime prevalence of sexual abuse, found that 25 percent of females and eight percent of males experienced a lifetime prevalence of sexual abuse, while specifically focusing on Northern America found the rates to range from 15 to 22 percent for females (Andrews et al., 2004; Finkelhor, 2011).

Clearly, whatever the statistical figures or definition used, the rates of CSA in the population are quite disturbing. Finkelhor (1994) reported that in no fewer than 19 countries have there been surveys conducted on victims of CSA from nonclinical populations. From these 19 countries the overall prevalence rates of CSA ranged from 7 percent to 36 percent for females and 3 percent to 29 percent for males (Putnam, 2002). Although direct comparison cannot be made between the countries due to differing definitions and methodological procedures, it can be stated that each country's data seem to follow the same general trend of women being abused at a rate of one and a half to three times more than men and in general it has revealed that CSA is an international problem (Finkelhor, 1994).

Furthering on with the global issue of CSA, Stoltenborgh and colleagues (2011) performed a meta-analysis on 217 publications published between 1982 and 2008. From this meta-analysis, they found the global prevalence rate of CSA was approximately 11.8 percent. This figure was based upon 331 independent samples comprising 9,911,748 participants. There were consistencies in the findings across the studies which revealed that higher CSA prevalence rates were reported among girls than among boys and globally, women reported being a victim of CSA more often than did men. When examining the continent of origin of the samples, Asia had the lowest prevalence rate for both genders,

In summary, the prevalence rates of CSA differ greatly depending on which definition and methodological procedure is used within each individual study. However, what needs to be highlighted is that CSA is a serious and prominent global problem in today's society affecting both men and women not only in their childhood but as an ongoing issue throughout their lifespan. The promising notion is it appears statistically that the rate of CSA has declined since

the early 1990's and appears to be continuing on this path. With the increase in knowledgeable professionals and the increase in child protection services it is likely the prevalence of CSA will continue to fall. The general trend which can be seen in the literature is that women (or girls) are sexually abused at a rate of one and a half to three times greater than males (or boys).

2.4 Perpetrator

There are two categories of perpetrators: (1) intrafamilial, where the perpetrator is from within the victim's family, and (2) extrafamilial, where the perpetrator is from outside the victim's family (Black et al., 2001). Allen and Pothast (1994) reported that CSA perpetrators were more likely to be from a blue-collar background, more likely to be unemployed and have a significantly lower education and income level than the general population. They also found that regardless of gender, the CSA perpetrators reported greater emotional and sexual needs in a relationship than their nonabuser counterparts. Finkelhor (1984) found that perpetrators were more likely to be over the age of 21 years. From his sample of 521 families, he found that perpetrators were more likely to be acquaintances (45%) or strangers (45%) and the remaining 10 percent were reported to be intrafamilial (parents or relatives) (Black et al., 2001; Finkelhor, 1984). The relatively low percentage of intrafamilial perpetrators has been supported by a considerable body of literature (Allen & Pothast, 1994; Benedict & Zautra, 1993; Black et al., 2001; Fassler et al., 2005; Finkelhor, 1984; Milner & Robertson, 1990)

The psychological variables of perpetrators have also been examined by some. Allen and Pothast (1994) revealed that the perpetrators of CSA were more likely to have a higher emotional and sexual need than the general population. Milner and Robertson (1990) revealed from a group of intrafamilial perpetrators of CSA that they had higher levels of reported

distress, unhappiness, loneliness and rigidity (Black et al., 2001). There have been numerous studies which have reported that most perpetrators are male (over 90%) (Kendall-Tackett & Simon, 1992; Spataro et al., 2001); however, when the victim is male, the likelihood of the perpetrator being a female increases (Fergusson et al., 1996; Spataro et al., 2001).

2.5 Poly-victimisation

"Poly-victims" is the label Finkelhor, Ormrod, Turner and Holt (2009) used in their study which examined the high levels of different forms of victimisation which occur to the same individual over a relatively short period of time during their childhood. The example of a poly-victim provided in the Finkelhor et al. (2009) study was where the individual could experience "physical and emotional abuse by caregivers, assaults and harassment by peers, sexual victimisations by acquaintances and strangers and exposure to crime and violence in their communities and neighbourhoods" (Finkelhor et al., 2009, p. 316). They examined a nationally representative sample of children aged between two and 17 years. Seven percent of these children had experienced seven different forms of victimisation at the hands of different offenders during the period of one year, while a staggering 20 percent had experienced five or more forms of victimisation (Finkelhor, Ormrod, & Turner, 2007a). Ninety-four percent of children who reported being a victim of sexual abuse also reported they had experienced another form of victimisation in the same year they had been a victim of the original abuse. In Finkelhor, Ormrod, and Turner's (2007b) research, they found that once a child had become a "poly-victim", they remained at an elevated risk of becoming revictimised in the future and poly-victimisation appears to persist over time. Finkelhor (2011) noted that an individual who had been assaulted by their caregiver was 60 percent more likely than others to also report being assaulted by a peer. Mullen, Martin, Anderson, Romans and Herbison (1996) reported

that women who had a history of CSA were five times more likely than women with no history of CSA to experience physical abuse and three times more likely to experience emotional abuse during their childhood. It must be noted that individuals who are willing to disclose one form of abuse may be more inclined to disclose other forms of abuse compared to the victim who struggles to disclose anything (Fergusson & Mullen, 1999).

Finkelhor (2008) found in his studies on poly-victims that the children involved were 20.2 times more likely to be depressed, 10.3 times more likely to be anxious and 5.8 times more likely to be angry than their peers. These figures in themselves are alarming as they reveal CSA is often accompanied by other forms of victimisation which in-turn can attract mental health problems resulting in a lifetime struggle for the individual. According to Finkelhor and his colleagues (2007a), children who encounter one form of victimisation are in a better place to "recover" from their experience. But the individuals who encounter multiple forms of victimisations show signs that they may be "trapped in a downward spiral that should be of the greatest concern to those trying to help" (Finkelhor, 2011, p. 22).

Poly-victimisation did not appear to be associated with age or ethnicity; however, there appeared to be a difference in gender among the poly-victims. Of the individuals who experienced polyvictimisation 54.4 percent were male, who experienced more physical victimisations, and 45.6 percent were female, who experienced more sexual victimisations (Finkelhor et al., 2009). What also appeared in Finkelhor and colleagues' (2007a) research was that the child's environment played a defining role in the pathway to poly-victimisation (Finkelhor et al., 2009; Finkelhor, 2011). A violent family environment opens many doors for recurrent victimisation, such as domestic violence, sexual abuse and general maltreatment. These can create deficits in both cognitive and emotional functioning leading to the increased

risk of becoming subsequently victimised outside the family home (Finkelhor et al., 2009).

Living in a disruptive family environment involving divorce and/or single-parenting leading to poor supervision has also been linked with an increase for poly-victimisation.

The neighbourhood environment also plays a large role in the pathway to poly-victimisation. Being surrounded by a dangerous community where the child is constantly exposed to gang activities, drugs and vandalism can provide a perfect scenario for the individual to become a victim of multiple forms of abuse. A dangerous neighbourhood includes areas of crime hotspots due to the inclination of criminally active individuals, weak social ties and a community with an overall lack of supervision (Finkelhor et al., 2009). The lack of social support that is common within these chaotic neighbourhoods may be a catalyst for the acceptance of an increase in abusive behaviour within the family unit (Coulton, Korbin, & Su., 1999; Finkelhor et al., 2009). This increase in exposure to abusive behaviour may also increase the chance of the child becoming a victim within their home setting them up for further victimisations within their community and peer group (Finkelhor et al., 2009).

2.6 Risk Factors for Child Sexual Abuse

Children are not themselves the cause of sexual victimisation but there are certain factors which have been identified that are associated with an increased risk for CSA. These risk factors include age, gender, ethnicity, environment and disability. Each of these risks are described in detail in the sections below.

2.6.1 Age

Finkelhor (1984) found in a sample of children aged 6-16 years of age that children under the age of 12 years were more likely (81%) to be abused than children over the age of 12 years (19%). Supporting these figures, in a later study, Finkelhor and his colleagues (1990) illustrated, through a national survey conducted on American adults who reported a history of CSA, that the median age of the onset of sexual abuse was 9.9 years of age for males and 9.6 years of age for females. Similarly, other studies have also revealed that children under the age of 12 years are more likely to be the victims of CSA than those who are older than 12 years (Anderson, Martin, Mullen, Romans, & Herbison, 1993; Fergusson & Mullen, 1999; Finkelhor & Baron, 1986; Fleming, 1997).

In contrast to the above studies, three studies have found that children in their early teens were more at risk of CSA than children under the age of 12 years (Boney-McCoy & Finkelhor, 1995; Finkelhor, Moore, Hamby, & Straus, 1997; Sedlak, 1997). The disparate results from the findings may be again due to the use of different definitions of CSA in each study. It may also be a result of the type of reporting used; for example, studies using officially reported CSA cases often use the age at time the report was made, which is often many years after the onset of the original abuse (Finkelhor & Baron, 1986). Although it is impossible to reconcile the apparently inconsistent findings, authors have suggested that other factors may affect the date identifying the age at which children are abused. Finkelhor and Baron (1986) have noted, for example, that older children may be more likely than young children to remember and to reveal the abuse (Finkelhor & Baron, 1986). It has also been suggested that CSA is often retrospectively reported, which may result in variable findings regarding the age at the time of abuse (Fergusson, Horwood, & Woodward, 2000).

2.6.2 Gender

It is consistently reported in the literature that females are more likely to experience CSA than their male counterparts (Black et al., 2001; Fergusson & Mullen, 1999; Finkelhor & Baron, 1986; Fritz, Stoll, & Wagner, 1981; Putnam, 2003; Stoltenborgh et al., 2011). Females have approximately a three times higher risk of being exposed to sexual abuse than males (Fergusson, Lynskey & Horwood, 1996; Fergusson & Mullen, 1999; Finkelhor & Baron, 1986). When examining the statistics it must be taken into account that much of the research has been centered around females as they may have warranted more attention in this area due to the appearance that they are at a greater risk for sexual victimisation (Romano & De Luca, 2001). Females are also more likely to report their childhood sexual experiences than their male counterparts. This may be due to several reasons. In a study which examined court documented CSA cases conducted by Widom and Morris (1997), they found that 64 percent of females retrospectively reported their experiences of CSA compared to only 16 percent of males. Banyard, Williams, and Siegal (2004) found that males may under-report CSA simply to “conform with societal expectations” (p. 225). Believing they may be portrayed in a homosexual manner due to male-on-male abuse, the avoidance of this stigma could be a driving force in the avoidance of reporting. To actually report the abuse may lead them to believe they are admitting that they themselves are also homosexual (Romano & De Luca, 2001; Spataro, Moss, & Wells, 2001). Another reason for the underreporting of CSA from males could be the societal struggle they experience surrounding the belief that it is not manly to seek help, and if they do, they admit that they are weak and failing as a man. The physiological nature in which males respond to sexual advances (e.g., erection and ejaculation) may also lead to the male victim's perception that they encouraged or even desired the abuse. These incidents may be regarded as either sexual experimentation or inappropriate sexual play.

In the case of a female abuser and a male victim, the sexual activity could be seen as a positive sexual experience because having a sexual experience with a woman is often not perceived as a serious and/or traumatic event (Romano & De Luca, 2001). Males have a tendency to minimise the impact that CSA has on them and may be reluctant to disclose their experiences. If they do disclose, they may minimise the abuse and describe it in either a neutral or even positive term (Spataro et al., 2001).

A meta-analysis conducted by Fergusson and Mullen (1999) found that the majority of studies suggested that the prevalence of exposure to some form of unwanted sexual experience during childhood for males was estimated to be up to 30%, with the majority of the estimates falling within the interval of 3% to 15%. Regardless of whether the incidence of CSA is under-reported, the majority of CSA victims studied have been female.

2.6.3 Ethnicity

There have been a limited number of studies conducted on race, ethnicity and culture and how they relate to CSA (Kenny & McEachern, 2000); hence the studies and figures discussed are quite dated.

Boney-McCoy and Finkelhor (1995) performed a study in the United States which incorporated an examination of the relationship between the victim's race and CSA. They found that the children from an African-American community, compared to other children, were at an increased risk (OR = 2.3) for child sexual victimisation (Black et al., 2001). Wyatt (1992) describes African-American women to be less likely to report any sexual abuse and it may be this nondisclosure which creates vulnerability within this race to be revictimised.

However, in a study performed by Sedlak (1997), the relationship between the victim's ethnicity and CSA was related to age; it reported that African-American, Caucasian and Hispanics were all at an increased risk of CSA, over other ethnicities, as their age increased (Black et al., 2001). A study conducted by Urquiza and Goodlin-Jones (1994) recruited a multiethnic sample of 243 women who were attending community colleges. Within this sample of women, the individuals with a history of CSA were three times more likely to be raped as an adult compared to the women who had not experienced CSA. This study revealed that the rates of CSA were roughly similar for African-American and Caucasian women but lower for the Hispanic and Asian-American women; however, when examining the revictimisation rates, more than half of the female African-American CSA victims (61.5%) reported rape in adulthood compared to much lower statistics from the Caucasian women (44.2%), the Hispanic women (40.0%), and the Asian-American women (25%) (Urquiza & Goodlin-Jones, 1994). Contrary to the above findings, Tzeng and Schwarzin (1990) concluded that Hispanic and Asians were four times more likely to become a victim of CSA than Caucasian children and three times as vulnerable as African-American children.

However dated the material may be it still appears that cultural factors do play a role in being a risk factor for the initial abuse and for future revictimisation. It is impossible to rectify the conflicting information in the studies conducted on ethnicity but it may be cultural underreporting which has occurred creating the discrepancies in the findings.

2.6.4 Environment

It has been hypothesised that the environment a child is exposed to can directly affect his or her risk of exposure to CSA (Fassler, Amodeo, Griffin, Clay, & Ellis, 2005). Boney-McCoy and

Finkelhor (1995) found that children from 'dangerous' communities (i.e., their proximity to high crime areas) had a one and a half times greater risk of being sexually victimised than children from 'safe' communities (Black et al., 2001). Child neglect (Finkelhor et al., 1997) and child physical abuse (Boney-McCoy & Finkelhor, 1995) both increased the risk of an individual becoming a victim of CSA. It has even been suggested that there is a causal relationship between an insecure attachment between the parent and child and CSA (Liem & Boudewyn, 1999).

2.6.4.1 Parental Bonding and Family Dysfunction.

Conflict within the family and family structure was reported to be a large risk factor for CSA (Fleming, Mullen & Bammer, 1996). Mothers and fathers who were less caring, over protective or controlling revealed an increased risk as did parents who left their children unattended without adequate supervision (Finkelhor et al., 1997). Distant relationships between mother and daughter increased the risk of intrafamilial CSA (Paveza, 1988) and overall poor relationships between the parent and child also increased this risk (Boney-McCoy & Finkelhor, 1996; Gold, Hyman, & Andres-Hymen, 2004). Gold (2000) suggests that family dysfunction creates vulnerability, unassertiveness and attachment problems. All of these increase the child's risk for sexual abuse. Ray, Jackson, & Townsley (1991) examined the differences in the environments of families of intrafamilial CSA victims, extrafamilial CSA victims and a group of non-abused women. They found no difference between the intrafamilial and extrafamilial family environments, but when compared to the non-abused population they were less cohesive, less organised, less likely to encourage independence and religious values and less involved in recreational activities (Gold et al., 2004).

2.6.4.2 Family Structure

Boney-McCoy and Finkelhor (1996) found that children being raised in a single parent household were at twice as high a risk of becoming a victim of CSA than children raised in a co-parenting environment. Supporting this notion are Finkelhor and colleagues (1997); they found that in families where only one biological parent is present the child is at three times the risk for experiencing CSA than when there are two biological parents present in the household (Black et al., 2001). Benedict (1993) also found that the parental absence was associated with an increased risk of CSA.

2.6.4.3 Family Income

Prior victimisation of a family member and lower socioeconomic households were also associated with an elevation in the risk of CSA for the children of those households (Boney-McCoy & Finkelhor, 1996; Finkelhor et al., 1997; Sedlak, 1997). Derezotes and Snowden (1990) and Kenny and McEachern (2000) reported that living in poverty increases the susceptibility to family and social problems encompassing CSA.

2.6.5 Disabilities/ Mental health problems

It is often believed that a child with disabilities or mental health problems is at a higher risk of becoming a victim of CSA. There has been minimal research conducted in this area, but the research that has been produced tends to support this belief. Westcott and Jones (1999) revealed that children with a physical or mental disability were at an increased risk of becoming a victim of CSA. Disabilities that impair a child's credibility appeared to carry the

highest risk, such as deafness, blindness and intellectual disability. Westcott and Jones (1999) found it was three main factors: "dependency, institutional care and communication difficulties" which increased the child's vulnerability; therefore, increasing their risk of becoming a target for CSA (Putnam, 2004; Westcott & Jones, 1999).

Crosse, Kale and Ratnofsky (1993) collected data from 35 different nationally representative American child protection agencies. Each of the 35 agencies provided information on the substantiated CSA cases within a four to six week period in 1991. A total of 1,249 cases were obtained involving 1,834 children. The disabled children in their sample were 1.7 times more likely to experience some form of abuse than the non-disabled child. The disabled population were 2.8 times more likely to be emotionally neglected, 2.1 times more likely to be physically abused, 1.8 times more likely to be sexually abused and 1.6 times more likely to be physically neglected (Crosse et al., 1993; Westcott & Jones, 1999). Sullivan, Knutson, Scanlon and Cork (1997) merged records of hospitals, police agencies and social services in their study which comprised 2,209 cases of abused and 880 non-abused children from the hospital sample and 792 abused children from residential facilities. They found similar results as did Cross et al. (1993). The disabled child was 1.8 times more likely to be neglected, 1.6 times more likely to be physically abused and 2.2 times more likely to be sexually abused. They also found that a total of 64 percent of the individuals who had experienced some form of abuse had some form of mental impairment (Sullivan et al., 1997).

Findings from a study conducted by Turner, Finkelhor and Ormrod (2010) demonstrated that children who displayed emotional and behavioural problems were at higher risk for becoming victimised and remained in the high risk category for revictimisation if their emotional and behavioral symptomatology remained. Mental health problems in adolescence revealed the

strongest association with sexual victimisation (Turner et al., 2010). In early adolescence the child is facing the onset of puberty and the beginnings of discovering their sexual identity. When this is combined with mental health issues, the individual may have difficulty setting boundaries around sexual experimentation and social environments, ultimately placing them in situations where they may be at an increased risk to encounter sexual predators. Turner and colleagues (2010) state that the sexual victimisation which occurs in prepubescent children (under the age of 12 years) was not tied to any mental health symptomatology but in fact related more closely to the characteristics of the perpetrator.

Although these studies have clearly shown there is a definite increase in the risk for abuse for the disabled population and that children with mental health problems are also at an elevated risk for victimisation, there is no examination of the temporality of the sexual abuse to the diagnosis of the disability. Therefore a definitive conclusion cannot be drawn as to the causal or consequential nature of the relationship between the abuse (Cutajar, Mullen, Ogloff, Thomas, Wells, & Spataro, 2010).

In summary, it is difficult to predict which child will become a victim of sexual abuse; however, there are certain factors which have the potential to elevate the risk for a child to become a victim of sexual abuse. These factors include the child's age and gender, their ethnicity and the environment to which they are exposed. This environment encompasses both the family unit and the community in which the family lives. If the child has a disability or a mental health issue this also increases the risk for them to become a target for sexual abuse. In the following section, revictimisation is discussed along with the prevalence of revictimisation and the factors which play a role in increasing the child's risk of revictimisation

2.7 Revictimisation

Revictimisation is the occurrence of abuse in adulthood following abuse which occurred during childhood. Revictimisation compounds the negative effects of CSA and creates new ones in adulthood (Tusher & Cook, 2010). The reasons for the occurrence of sexual revictimisation, and for any form of revictimisation, are not well understood. Many different theories for 'why' have been proposed but none have been empirically proven (Breitenbecher, 1999). Recent research suggests that once an individual has been victimised they enter a "vicious cycle" whereby their risk for revictimisation significantly increases (Mandoki & Burkhart, 1989).

Most studies examining revictimisation have used a cross-sectional design, relying almost entirely on the retrospective self-report of CSA victims. There have been few studies that have utilised a follow-up method (Widom, Czaja, & Dutton, 2008). Faller (1991) was one of the few who did conduct a follow-up study. He followed a group of sexually abused boys and girls aged between two and 16 years. They had been identified as victims through child protection agencies and referred for treatment. Of this group, 22 percent had been re-referred within three years of their initial contact. West, Williams, and Siegal (2000) also conducted a follow-up study which revealed that 30 percent of the 113 African-American women within their study who had been abused as a child experienced revictimisation in the 17 year follow-up period.

There are many factors which play a role in increasing the risk of revictimisation in adulthood. These include alcohol and drug use, risky sexual behaviours, psychological distress from previous trauma, impaired risk detection and CSA (Arata, 2000; Coid et al., 2001; Gidycz, Coble, Latham, & Layman, 1993; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997; Koss

& Dinero, 1989; Rich, Combs-Lane, Resnick, & Kilpatrick, 2004; Widom et al., 2009; Wilson, Calhoun, & Bernat, 1999). CSA has been shown to have the most direct link to future revictimisation (Coid et al., 2001). Sparks (1981) argued that it was important to study the occurrence of revictimisation so it may "illuminate more general causal processes, and thus help to show how far and in what ways, the attributes of behavior of victims themselves may help to explain their victimization" (p.765). When examining the studies in the area of revictimisation, the majority reveal that there does appear to be an increase in the risk of future revictimisation if CSA is present in the victim's history.

Revictimisation results from a complex combination and complex interactions within environmental and personal factors (Arata, 2002; Macy, 2008). The sexual victimisation of a child has been identified to increase the risk of repeated sexual victimisations over the course of their lives (Arata, 2000; Arata, 2002; Breitenbecher, 2001; Classen, Palesh, & Aggarwal, 2005; Fromuth, 1986; Gidycz et al., 1993; Macy, 2008; Messman-Moore & Long, 2002; Rich et al., 2004; Roodman & Clum, 2001; Urquiza & Goodlin-Jones, 1994; Widom et al., 2008). Fergusson, Horwood and Lynskey (1997) found that having CSA present in a victim's history can increase the likelihood of experiencing rape in adulthood by 11 times. Roodman and Clum (2001) performed a meta-analysis of 19 different empirical studies on revictimisation. They found that overall the effect size for sexual revictimisation was 0.59 which demonstrates that there is a strong relationship present between CSA and adult sexual victimisation (ASV). They also reported that 15 to 79 percent of CSA survivors experienced sexual revictimisation at some stage in their adulthood. This appears to be an exceptionally large range but would likely be due to the diverse methodologies and samples used within the differing studies. It is an area which should be the subject of further investigations.

The results suggest that the more severe the CSA the higher the risk of revictimisation. Arata (2002) theorised that revictimisation is the product resulting from a complex combination of interactions between the environment and the individual. Her evidence supports the notion that there is an increased risk of ASV for CSA survivors. Individuals who were abused as children and revictimised as adolescents were especially at high risk for adult revictimisation. In their research reviews Classen et al. (2005) and Rich et al. (2004) found that the risk of revictimisation was influenced by the period in the child's life in which the original sexual abuse occurred. The more proximal the sexual experience, the higher the risk of revictimisation (Macy, 2008). To continue with the same trend, some have argued that CSA is one of the strongest predictors of continued victimisation in young adulthood (Casey & Nurius, 2005; Merrill et al., 1999; Siegel & Williams, 2003) and should be regarded as a "chief distal risk factor, especially for females" (Barnes, Noll, Putnam, & Trickett, 2009, p. 413).

Revictimisation is the result of a complex interaction between an individual and an array of different risk factors. A child who has been a victim of CSA is at an increased level of vulnerability which, without supports in place, elevates his or her level of risk for becoming a victim again. The prevalence of revictimisation is discussed in the following section.

2.8 Prevalence of Revictimisation

Table 2.1
Prevalence of Revictimisation

Authors	Year	Sample Size and Selection	Method	Prevalence
Barnes, Noll, Putnam and	2008	93 females	Prospective (15 years)	The presence of CSA was associated with an increased

Tickett				risk for revictimisation.
Desai, Arias, Thompson and Basile	2002	16,000 men and women from a community sample	Retrospective	Women with a history of CSA were 1.8 times more likely to experience revictimisation. Men with a history of CSA were 5.5 times more likely to experience revictimisation.
Gidycz, Hanson, and Layman	1995	796 Female undergraduate college students	Prospective (9 months)	9.6-38.3% reported revictimisation
Himelein	1995	100 female college students	Prospective (32 months)	CSA correlated with adolescent victimisation; adolescent victimisation correlated with adult victimisation; CSA was not correlated with adult victimisation.
Kessler and Bieschke	1999	548 female college students	Retrospective	69% of the college students with a history of CSA were revictimised compared to 42% with no history of CSA being revictimised.
Koss and Dinero	1989	3,187 female undergraduate college students	Retrospective	66% of rape or attempted rape victims reported a history of CSA versus 20% of non-victimised women
Mayall and Gold	1995	669 Female undergraduate college students	Retrospective	24.4% CSA victims were revictimised 16.6% non CSA were revictimised
Messman-Moore and Long	2002	300 Females from a community sample	Retrospective	CSA victims more likely than non-victims to meet criteria for both substance use and to report rape.
Randall and Haskell	1995	Community sample	Retrospective	62.4% of the women reporting revictimisation had a history of CSA.
Russell	1986	930 Females from a community sample	Retrospective	61-68% of CSA victims reported sexual revictimisation

Sonenson, Stein, Siegel, Golding and Burman	1987	3,131 Adults	Retrospective	447 (14.3%) were revictimised.
West, Williams, Siegel	2000	113 African-American women with a history of CSA	Prospective	30% of women who reported being revictimised also reported having a history of CSA
Wyatt, Guthrie and Notgrass	1992	248 Females from a community sample	Retrospective	30% of women who reported being revictimised also reported having a history of CSA

Russell (1986) presented one of the first studies to examine the relationship between the rates of CSA and revictimisation. Her study consisted of a probability community sample of 930 women whom she interviewed regarding the presence of sexual abuse in their childhood. From the individuals interviewed, 61 to 68 percent of the women who had experienced CSA reported to experience attempted rape or rape in later life (Arata, 2002; Browne & Finkelhor, 1986; Russell, 1986). The figures for rape or attempted rape for the women who had not experienced sexual abuse as a child were half of those of women whom had been abused. Arata (2002) found that approximately one third of CSA victims experience revictimisation at a later stage in their lives and that these victims are two to three times at greater risk of adult revictimisation than women who were not sexually abused as children.

The United States National Violence against Women survey reported that the 18 percent of women who were raped before the age of 18 years were also raped after the age of 18 years (Tjaden & Thoennes, 2000). This compared to only 9 percent of women who did not report being raped before the age of 18 years. Messman and Long (1996) reviewed clinical studies on this topic and found that from 16 to 72 percent of CSA victims are revictimised later in life.

West, Williams and Siegel's (2000) study of 113 African-American women with a history of CSA and Wyatt, Guthrie and Notgrass's (1992) study of 248 women from the community both found that 30 percent of individuals who had experienced revictimisation had a history of CSA. Mayall and Gold's (1995) study, consisting of 669 female undergraduate college students, reported that 24.4 percent of CSA victims compared to 16.6 percent with no history of CSA were revictimised as adults. Female college undergraduate students were also the participants in Gidycz, Coble, Latham, and Layman's (1993) research where they reported 29.5 to 78.6 percent of CSA victims experienced revictimisation. In another study headed up by Gidycz (1995), including 796 female undergraduate college students, it was reported that 9.6 to 38.3 percent re-counted some form of revictimisation (Gidycz, Hanson, & Layman, 1995). Again in support of the notion that CSA pre-empts ASV, Koss and Dinero (1989) examined a large population ($n = 3,187$) of female undergraduate students and reported that 66 percent of rape or attempted rape victims recorded that they had been victims of CSA compared to 20 percent of non-victimised women (Arata, 2000).

A smaller prospective revictimisation study conducted by Himelein (1995) followed 100 female college students for a period of 32 months. They found that CSA was not a predictor for college victimisation, although a relationship was found between CSA and precollege victimisation; therefore, Himelein suggests that revictimisation may be time-sensitive; the more time passes from the initial CSA without revictimisation, the less the risk of CSA contributing to the overall vulnerability of the individual (Himelein, 1995). In the study described earlier by Gidycz et al. (1993), they demonstrated that women who had been victimised in their childhood presented as higher in anxiety and depression than those with no abuse in their backgrounds. This difference may, in part, help predict future vulnerability for revictimisation (Gidycz et al., 1993; Himelein, 1993).

Even though there may be some discrepancies in the statistical relationship of CSA to ASV, what most of the studies do have in common is that their theories all suggest that it may not in fact be CSA which directly causes or leads to revictimisation but the consequences, both behavioral and emotional, of the abuse (Arata, 2002; Gidycz et al., 1993). The research which is currently available suggests that the prevalence of revictimisation, especially sexual, in victims of CSA is vast (Arata, 2002; Breitenbecher, 2001; Classen et al., 2005; Fergusson et al., 1997; Macy, 2008; Messman-Moore & Long, 2002; Rich et al., 2004; Roodman & Clum, 2001; Russel, 1986; Urquiza & Goodlin-Jones, 1994). In Russell's (1986) study of 930 women, 152 (16.3%) women reported they had experienced intrafamilial rape before the age of 14 years. Of these 152 women, 63 percent reported they had experienced some form of sexual revictimisation before the age of 14 years. This was then compared to the 35 percent of women reporting sexual assault after the age of 14 years with no prior abuse in their childhood histories. These figures would suggest that CSA almost doubled the risk of sexual revictimisation (Classen et al., 2005; Russell, 1986). Coid et al. (2001) found that victims of CSA which included intercourse were two to three times more likely to be sexually assaulted after the age of 16 years, and the victims of CSA which did not include intercourse were three to four times more likely to experience revictimisation before the age of 16 years.

In a study conducted by Desai, Arias, Thompson and Basile (2002), a sample of 16,000 men and women were interviewed by telephone. Women who reported a history of CSA were 1.8 times more likely to experience revictimisation and male CSA victims were a remarkable 5.5 times more likely to be revictimised as an adult (Desai et al., 2002). Kessler and Bieschke (1999) examined a female college student population and found that 69 percent of the women who reported a history of CSA were revictimised as an adult whilst only 42 percent who had no

history of CSA reported revictimisation. Randall and Haskell (1995) also found similar numbers in their community sample with 62.4 percent of revictimised women having a history of CSA. An epidemiological study of 3,131 adults performed by Sorenson and colleagues (Sorenson, Stein, Siegel, Golding, & Burnam, 1987) revealed that of the 3,131 adults surveyed, 447 (14.3%) individuals reported that they had been sexually assaulted on more than one occasion (i.e., revictimised).

Barnes, Noll, Putnam, and Trickett (2008) performed a 15-year prospective longitudinal study examining self-reports of 93 females who had been victims of sexual and physical abuse subsequent to proven CSA. Their goal in this study was to provide an improvement on the research thus far by providing “solid evidence for revictimisation for females who have experienced childhood sexual abuse and to provide a more accurate picture of the rates and characteristics of both physical and sexual revictimisation” (p. 414). The results from their study indicated that CSA places females at a much greater risk for experiencing rather severe levels of revictimisation compared to the females who were not abused as children.

From the prevalence rates above it is indicated that victims of CSA are at a much higher risk of being revictimised; however, it cannot go without notice that there is still a large portion of CSA victims who are not revictimised. Moreover, the reason for the elevated rates of revictimisation is unclear and it is not certain whether the relationship between CSA and ASV is causal.

The most predominant factors related to revictimisation reported in the current literature are presented in the section below. These factors include the level of trauma, age at time of abuse, the severity of the original abuse, danger and risk perception, the individual's self-esteem, their sexual behaviour, substance use, family dynamics, post-traumatic stress disorder (PTSD) and

incarceration.

2.9 Factors Related to Revictimisation

Many studies have begun to examine the link between CSA and the psychological and social functioning in adulthood. The results of these examinations have consistently shown that there is an association present between CSA and an array of difficulties present in adulthood (Fergusson, Boden & Horwood, 2008; Fergusson & Mullen, 1999; Mullen, Martin, Anderson, Romans, & Herbison, 1994). These problems include, but are not limited to, depression, anxiety, antisocial behaviour, substance abuse (including drugs and alcohol), eating disorders (predominately in females) (Romans, Martin, Anderson, O'Shea & Mullen, 1995), increased rates of suicide or self-harming behaviour and post-traumatic stress disorder (Arata, 1999, 2000; Boney-McCoy & Finkelhor, 1995; Chu, 1992; Cutajar, Mullen, Ogloff, Thomas, Wells, Spataro, 2010a; Cutajar et al., 2010c; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Messman-Moore, Ward, & Brown, 2008; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997)

There are numerous studies which support the notion that CSA is a major risk factor for revictimisation later in life (Arata, 2002; Desai et al., 2002; Fergusson et al., 1997; Gidycz et al., 1995; Greene & Navarro, 1998; Himelein, 1995; Humphrey & White, 2000; Koss & Dinero, 1989; Mayall & Gold, 1995; Messman-Moore & Long, 2000; Urquiza & Goodlin-Jones, 1994; West et al., 2000). Currently there is only speculation as to what or which contextual factors exacerbate the victim's vulnerability for revictimisation and which factors increase or enhance the survivor's resilience (Arata, 2002). In their study, Coid and colleagues (2001) revealed that “women who are physically and sexually abused in childhood

are at increased risk of victimisation in adulthood” (p. 450). The findings from this study reveal that childhood abuse considerably increases the risk for revictimisation in adulthood. Multiple childhood abuse increases the risk factors.

The risk factors currently noted for having an influence on the rate of revictimisation include the severity of original abuse, the victim’s perception of danger, the level of trauma, age of victim at time of original abuse, the individual’s self-esteem, their sexual behaviors, substance abuse, family dynamics, the occurrence of PTSD and incarceration. These risk factors are discussed in the following section.

2.9.1 Severity of original abuse

Some studies have revealed that the severity of the original abuse can predict revictimisation (Arata, 2000; Fergusson et al., 1997; Finkelhor & Browne, 1995; Fleming, Mullen, Sibthorpe, & Bammer, 1999; Koverola et al., 1996; Mayall & Gold, 1995; Merrill et al., 1999; West et al., 2000). It appears that the more invasive or severe the original act of CSA the higher the risk of revictimisation (Arata, 2000; Fergusson et al., 1997; Fleming et al., 1999; Gidycz et al., 1995; Humphrey & White, 2000; Koverola et al., 1996; Mayall & Gold, 1995; West et al., 2000). Fleming's (1999) study revealed that if sexual intercourse was present during the original abuse, then the risk for revictimisation tripled. Arata (2000) found in her study of 221 women with histories of CSA that 50 percent of individuals who experienced revictimisation had been victims of penetrative CSA compared with 25 percent of CSA victims who did not experience revictimisation. The duration of the sexual abuse was also reported to play a role in the prediction of revictimisation. The population of revictimised women reported a much lengthier period of CSA, which could impact the severity of abuse.

Moeller, Bachmann and Moeller (1993) revealed that the risk of revictimisation was dependent on the number of abusive experiences during childhood. If an individual had experienced all three forms of abuse including, sexual, physical and emotional abuse as a child, they were in the highest risk category for revictimisation (33.3%). Twenty-one point nine percent of the revictimised subjects had experienced two forms of abuse and 5.6 percent had experienced one form of child abuse (Classen et al., 2005). These figures support the notion that the more severe the initial sexual abuse experience the more likely the victim will be subsequently victimised.

The severity of the sexual abuse experience can differ greatly, ranging from seriously violent, intrusive sexual acts to being a victim of voyeurism. It is this level of severity that appears to have an effect on the vulnerability of the individual's risk of revictimisation. This level of vulnerability also comes into play when examining the danger perception or risk detection the victim associates with their situation. The victim's perception of danger can also be altered depending on the severity of the initial abuse. This subjective judgement can increase the individual's vulnerability for revictimisation. The ability to detect a dangerous or risky situation is discussed in the following section.

2.9.2 Danger perception/ Risk detection

Danger perception or risk detection is a subjective judgement which people make about the severity of a situation. Some studies have found that there is no connection between revictimisation and risk detection (Atkeson, Calhoun & Morris, 1989; Breitenbecher, 1999); whereas, others have hypothesised that an inability to recognise a potentially risky situation may be associated with an elevated risk for revictimisation (Wilson, Calhoun & Bernat, 1999;

Meadows, Jaycox, Stafford, Hambree, & Foa, 1995). Gold's (2008) study of 139 female undergraduate students revealed that after viewing a videotape of a date rape scenario, the survivors of CSA identified the situation as "risky" at a later time frame than the non-victims; therefore, taking longer for the CSA victims to be aware of the dangerous nature of the scenario.

Meadows and colleagues (1995) examined rape narratives of women who had been assaulted and found that the narratives of the women who had been victimised more than once had a significantly poorer recognition of risk than women who had only been victimised once. Meadows, Jaycox, Orsillo, and Foa (1997) performed a subsequent study examining danger perception where they exposed participants to a scenario involving varying degrees of risk. They asked the participants to acknowledge the point where they felt discomfort and indicate at what stage they would leave the situation. No difference was recorded between the participants who had been abused and those who had not for when they began to feel uncomfortable in the situation. However, the individuals who had been abused would leave the situation significantly later than the participants who had not been abused. These studies support that poor risk detection and danger perception may be associated with revictimisation. The individuals who find themselves in a high risk environment have difficulty labeling and responding to the situation and remain there beyond the point at which they may have been able to escape, perpetuating the "cycle of victimisation" (Wilson et al., 1999).

To summarise, the limited research available tends to suggest that an individual who has been a victim of sexual abuse may not be as sensitive to danger signals as their non-abused counterparts. This lowered level of danger perception could consequently place the individual in more high-risk situations, therefore placing them at an increased risk for being a subsequent

victim.

2.9.3 Level of trauma

The majority of current research suggests that the effects of multiple victimisation lead to an increase in trauma levels compared to a single experience of victimisation (Arata, 2002). The trauma a child experiences during CSA can alter a child's cognitive and emotional orientation to their world (Finkelhor & Browne, 1985). This trauma is then heightened by the child's distortion of their self-concept and their world view. Although not strongly empirically supported, it had been theorised that individuals may be at an increased risk of revictimisation due to specific personality and behavioral characteristics which can be determined by the level of trauma they experienced during the initial act of sexual abuse (Ellis, Atkeson, & Calhoun, 1982).

Trying to determine what forms of sexual abuse are more traumatic than others can prove to be difficult, as what may be detrimentally traumatic for one victim may only be mildly traumatic for another. What has been suggested by Finkelhor and Browne (1985) is that sexual abuse which occurs within the family has more serious effects on the child, hence a more traumatic experience. It is important to recognise different levels of trauma and the importance of finding some resolution to the traumatic event. Gidycz et al. (1993) have suggested that if the trauma remains unresolved then it may play a role in the process which increases the risks of being revictimised (Arata, 2000).

Finkelhor and Browne (1985) developed what are known as the "four traumagenic dynamics" to explain the experiences a child undergoes during an act of CSA: traumatic sexualisation,

betrayal, powerlessness and stigmatization. Traumatic sexualisation refers to the "process in which a child's sexuality (including both sexual feelings and attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse" (Finkelhor & Browne, 1985, p. 531). The child who has been a victim will emerge from the abuse with inappropriate ideas of what constitutes "normal" sexual behaviour and "normal" sexual self-concepts and emotions. These internal feelings the child is struggling with can create an increased risk for future revictimisation. The betrayal dynamic refers to when a child discovers that someone they trusted and were dependent on causes them harm. The powerlessness dynamic can also be referred to as disempowerment. This dynamic refers to "the process in which the child's will, desires, and sense of efficacy are continually contravened (Finkelhor & Browne, 1985, p. 532). The final dynamic is stigmatization which refers to the negative connotations communicated to the child during their abusive experience. These negative connotations become incorporated into the child's self-image.

2.9.4 Age at time of abuse

The risk of revictimisation appears to be influenced by the point in one's life in which the original victimisation took place (Classen, Palesh, & Aggarwal, 2005; Macy, 2008; Rich et al., 2004).

Childhood is a time in an individual's life of extreme change in growth, cognitions, relationships, social situations, and overall physical and emotional development. All of these have the potential to affect victimisation (Finkelhor, 1995). The effects of being a victim of CSA can be vastly varied and this variation has caused a division in the literature. Some researchers suggest that the younger the CSA victim, the higher the risk for revictimisation and

disturbances in developmental processes (Barker-Collo & Read, 2003; Finkelhor, 1995; Manly, 2001; Morrison, Frame, & Larkin, 2003). These include, but are not limited to, the process of attachment and self-esteem (Putnam, 1990), highly sexualised behaviours (Finkelhor & Browne, 1985), drugs, dissociation, PTSD, and self-harming behaviours (Briere, 1992). Research has shown that it is more likely to be the young victims of sexual abuse (ages two to six years) who behave in an overtly sexualised manner (Finkelhor, 1995). The girls abused at an older age tend to do the opposite and become more sexually inhibited (Friedrich et al., 1992).

Studies have suggested that the more proximal the abuse the higher likelihood that revictimisation may occur (Macy, 2008). Specifically, the impact the abuse had on the victim may differ as a result of the developmental stage the victim is in at the time of the abuse; and the impact of the abuse may also be affected by the victim's ability to cognitively process the abuse and the symptoms they were able to express during the time of the abuse (Finkelhor, 1995). The victim's developmental stage during the time of abuse may also influence the way they encode their memories of the event. Bremner and Narayan (1998) suggest that the younger the CSA victim the more likely the memory will be fragmented. Read, Perry, Moskowitz, & Connolly (2001) suggest that experiencing a traumatic event (such as CSA) in the early childhood years can disrupt the process of neurodevelopment which would increase the individual's vulnerability to developing severe psychopathology supporting the hypothesis that sexual abuse which occurs at an earlier age is associated with an increase in the psychopathological outcomes (Bolgar, Patterson, & Kupersmidt, 1999; Kaplow, Dodge, Amaya-Jackson, & Saxe, 2005; Kaplow & Widom, 2007; Manly, Kim, Rogosch, & Cicchetti, 2001).

The average age of victims of intrafamilial sexual abuse is between the ages of seven and nine years (Cole & Putnam, 1992). During this age, experiencing sexual abuse challenges the individual's ability to develop a sense of self-competence in both the home and social environments. Feelings of intense shame and guilt would prevent the victim from being able to seek social and professional support (Cole & Putnam, 1992) leaving them vulnerable for the act of revictimisation. Bolgar and colleagues (1999) reported on 107 children who were abused from birth to 12 years. They found this population to have a lower self-esteem than children abused at a later age. Kaplow and colleagues' (2007) prospective study on 156 victims of CSA ranging in age from birth to 13 years found that early abuse was associated with high levels of PTSD when measured up to 16 years of age. Similarly, Manly and colleagues (2001) reported on a series of maltreatment cases where the maltreatment occurred before the age of five years (often in infancy). They found it to be closely associated with an increase in maladaptive outcomes measured in children up until 11 years of age. However, these studies are all limited in their lack of measurement of the long-term outcomes beyond early adolescence.

In contrast, researchers suggest that being sexually abused in adolescence creates a higher risk of revictimisation in adulthood and an increase in adjustment disorders (Browne & Finkelhor, 1986; Finkelhor, 1995; Gidycz et al., 1993; Humphrey & White, 2000; Kendall-Tackett, Williams, & Finkelhor, 1993). During adolescence the victim has a higher cognitive awareness of what may be considered sexual abuse and how this abuse is considered a violation of societal norms. The implications which may arise from experiencing sexual abuse will cause a higher level of distress for the victim compared to when they were younger and did not have the same level of cognitive awareness (Cole & Putnam, 1992; Finkelhor, 1995).

The most predominant feature of adolescence is the onset of puberty, involving both

physiological and social adjustments which accompany their emerging sexuality (Cole & Putnam, 1992). When the adolescent is sexually abused it jeopardises the ability to integrate the multiple aspects of the self into a united, coherent being (Cole & Putnam, 1992). Their ability to understand the developmental changes of their body and self-image, the development of a sexual identity and the ability to form trusting, intimate relationships all become jeopardised (Mullen & Fleming, 1998). The adolescent coping strategies usually fall into the categories of denial and dissociation. By using these means of coping, it heightens the risk for the adolescent developing severe psychopathology (Cole & Putnam, 1992). Patton and Viner (2007) also discuss the physiological changes to the neurological processes which occur during puberty and their susceptibility to disruption and distortion when abuse occurs, further heightening the risk of developing severe psychopathology.

Gidycz et al. (1993) and Humphrey and White (2000) conducted studies including college students. Humphrey and White (2000) revealed that women who reported a history of both CSA and adolescent sexual abuse were at the greatest risk for ASV. Victims of adolescent sexual abuse with no history of CSA were the next highest risk category for women to be revictimised. Gidycz and colleagues (1993) also revealed that there was a stronger connection between adult revictimisation and adolescent victimisation than between CSA and adult revictimisation (Classen et al., 2005). Himelein's (1995) prospective study also supported this notion by revealing that women who had experienced sexual abuse prior to their college years, but later than early childhood provided a strong indicator for revictimisation (Arata, 2000). A prospective study performed by Thornberry, Ireland and Smith (2001) on 738 official cases of CSA (ages ranged from birth to 17 years) whom they followed over an 18 year period found that abuse which occurred during adolescence (after the age of 12 years) demonstrated a significantly higher rate of both internalising and externalising problems when compared to the

victims of early CSA (before the age of six years). Calam, Horne, Glasgow and Cox (1998) and Ruggiero, McLeer and Dixon (2000) also found that sexual abuse in adolescence resulted in greater disturbances in psychopathology.

2.9.5 Self-esteem/ Self-blame

It has often been theorised that low self-esteem leads to increased vulnerability for revictimisation and lower self-esteem resulting from abuse as a child can be a predictor of revictimisation in adulthood (Arata, 2002; Chu, 1992). Chu (1992) suggested that an impairment in a child's self-image due to being abused as a child will increase the risk for revictimisation. Greene and Navarro's (1998) study found a relationship not only between self-esteem and revictimisation but also between levels of assertiveness and revictimisation. Finkelhor and Browne (1985) reported that many CSA victims suffer from guilt and shame over the abuse which can then lead to issues of low self-esteem where the victim suffers from the thoughts that they are "spoiled merchandise." Romans, Martin, Anderson, O'Shea and Mullen, (1995) reported that being sexually revictimised during adolescence was associated with a lowered self-esteem; however, if the victim was sexually revictimised after the age of 20 years there was no association seen between the act of revictimisation and a lowered self-esteem.

Self-blame has also been hypothesised to be a mediating variable in revictimisation (Arata, 2000). Feelings of self-blame involve a focus on the internal self, including one's behaviour and characteristics. If the focus is solely on this, then the external factors are being ignored which may cloud the ability to sense what is a dangerous and high-risk situation. These feelings of self-blame may cause the individual to partake in self-destructive behaviours including

increased promiscuity and increased drug and alcohol use, which could in-turn increase the risk of revictimisation. Arata's (2000) study revealed a significant difference between the levels of reported self-blame for the victims of repeated abuse compared to the CSA victims who did not experience any revictimisation. It has been hypothesised that an increase in sexual activity may in fact be an effect of self-blame. This anomaly of self-blame can cause feelings of guilt, shame and a low self-worth and in order to dissipate these feelings and achieve some form of self-worth, an increase in consensual sexual behaviors may be performed.

In summary, both self-esteem and self-blame have not only been examined as an effect of revictimisation but they have also been theorised to be mediating variables (Arata, 2002); therefore, a lowered self-esteem and an increase in self-blame can not only stem from revictimisation but also increase an individual's vulnerability to becoming revictimised. The prevalence of a lowered self-esteem and self-blame in the individuals who have been revictimised is not noted in the literature.

2.9.6 Sexual behaviour

Increased sexual behaviour has been recorded as both a risk factor for and a result of revictimisation. Myall and Gold (1995) examined women who had multiple victimisations and compared them to a population of child-only victims and adult-only victims. The repeated victims reported a much higher level of consensual adult sexual experiences when compared to the child-only victims. However, no significant difference was revealed in the level of consensual sexual experiences between the adult-only victims and the repeated victims (Arata, 2002; Mayall & Gold, 1995). Several studies have shown that revictimisation can actually be predicted by an increased rate of consensual sexual behaviour (Derman, Cooper & Agocha,

1996; Himelein 1995). Supporting this hypothesis is a study by Beitchman, Zucker, Hood, DaCosta and Akman (1991) who reported that promiscuity or precocious sexual behaviour was a direct consequence of CSA with the CSA population engaging in a higher level of sexual activity compared to the non-abused population. As adults, the women who had histories of CSA were engaging in a higher level of consensual sexual behaviour than the women without a history of CSA (Arata, 2000; Himelein, 1995; Koss & Dinero, 1989; Mandoki & Burkhart, 1989; Summit, 1983). Koss and Dinero (1989) suggest through their research, that an increase in sexual behaviour would ultimately increase the woman's exposure to sexually violent males and therefore exposure to the possibility of revictimisation. Fergusson et al. (1997) found that in their longitudinal study of New Zealand children with a history of CSA, they were more likely than the general population to experience multiple sexual partners, engage in unprotected sex (i.e., risky sexual behaviours), and to have experienced a rape or attempted rape by the time they were 18 years of age.

Studies of adolescents conducted by Ageton (1983) and Hall and Flannery (1985) both revealed that if an adolescent's peer group was known to be sexually active, this directly increased their risk of being a victim of sexual assault (Koss & Dinero, 1989). Fergusson, Horwood, and Lynsky (1997) found the relationship between CSA and revictimisation was partially mediated by sexual behaviour (Arata, 2002). On the other hand Gidycz et al. (1995) found only a limited relationship between revictimisation rates and sexual behaviour and Merrill, Newell, Thompsen, Gold, Milner, Koss, and Rosswork (1999) and West et al. (2000) found no relationship between revictimisation rates and sexual behaviour. As an aside, it was revealed in the study by West et al. (2000) that revictimised women were three times more likely to have engaged in prostitution (Arata, 2002). Three older studies have supported this statement by illustrating that victims of CSA have a higher likelihood of engaging in

prostitution (Brown, 1979; Finkelhor & Browne, 1981; James & Meyerding, 1977; Silbert & Pines, 1981).

2.9.7 Substance use

Alcohol and drugs have been implicated in many studies as playing a mediating role in adult revictimisation (Bensley, Spieker, Eenwyk, & Schoder, 1999; Corbin, Bernat, Calhoun, MacNair, & Seals, 2001; Derman et al., 1998; Fergusson & Lynsky, 1996; Greene & Navarro, 1998; Harrison, Fulkerson, & Beebe, 1997; Koss & Dinero, 1989; Messman-Moore et al., 2009). Several studies have found that increased alcohol consumption in adolescence is associated with an increase in risky sexual behaviour (Derman et al., 1998; Fergusson & Lynsky, 1996). Alcohol intoxication impairs judgment which can in-turn impair self-protective behaviours which may increase the likelihood of coming into contact with a potential perpetrator (Messman-Moore et al., 2009). Individuals with a history of CSA or child physical abuse have been shown in several studies to use substances at an earlier age and at a greater level than the individuals with no history of abuse (Bensley et al., 1999; Corbin et al., 2001; Greene & Navarro, 1998; Harrison et al., 1997). It has also been shown that these greater levels of drug use are associated more closely with the victims of penetrative CSA than non-penetrative CSA (Dube et al., 2005; Fergusson et al., 2008; Fergusson et al., 1996a; Mullen et al., 1993; Nelson et al., 2002). Koss and Dinero (1989) proposed the "vulnerability hypothesis" which states that the "likelihood of victimization increase directly with the amount of contact a women has with potential perpetrators under conditions that foster sexual aggression" (Koss & Dinero, 1989, p. 243). Basically, they were trying to identify variables which place particular women at greater risk of revictimisation when compared to other women. They used this as an explanation for an increase in the risk of rape among some women. They found that women in their study with a history of CSA combined with an above

average level of alcohol consumption increased the risk of revictimisation which was consistent with their vulnerability hypothesis.

2.9.8 Family dynamics

Poor family functioning has been thought of as a risk factor for revictimisation due to the lack of parental interest or parental support following the initial abuse (Messman-Moore & Browne, 2004). However, there have been many inconsistencies in the findings when examining the family dynamics role in revictimisation. Some studies have revealed that a connection is present between the relationship of a victim with their family or individual family members and revictimisation in adult life (Mayall & Gold, 1995; Roman et al., 1995). Other studies have shown that the risk for revictimisation is independent from family relationships (Fergusson et al., 1997; Koverola, Proulx, Battle & Hanna, 1996). Messman-Moore and Long (2004) suggest that regardless of where the abuse occurred, whether it be intrafamilial or extrafamilial, the level of support, or lack of, received from the family following the initial CSA experience may increase the risk for abuse in their future. Long and Jackson's (1991) study examined repeated CSA victims and found that the families of children who were revictimised were less cohesive, less expressive, more conflicted and highly controlled (Messman-Moore & Long, 2004) when compared to the families of abuse victims who did not experience revictimisation. To further support this theory, they found there was no difference between the families of non-victims and the families of single CSA victims and suggests that dysfunctional family dynamics does place the CSA victims at a higher risk for revictimisation (Long & Jackson, 1991). Although there are conflicting results surrounding the actual influence that family dynamics have on the risk for revictimisation, enough evidence may be present to support the suggestion that the family's impact on the individual's perceptions and expectations of interpersonal and intimate relationships does in fact impact their level of vulnerability (Messman-Moore & Brown, 2004).

2.9.9 Post-Traumatic Stress Disorder

Post-traumatic Stress Disorder (PTSD) is a disorder which reflects a response to a traumatic experience which results in intense fear, helplessness and distress (APA, 2013). PTSD has been studied as being a possible mediator of revictimisation. It has been found that between 48 and 85 percent of CSA survivors have experienced PTSD symptoms at some time during their lives (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Messman-Moore, Ward, & Brown, 2008; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997). Wolfe, Gentile and Wolfe (1989) and McLeer, Deblinger, Henry and Orvaschel (1992) found that between 20 to 70 percent of children with a history of CSA had PTSD.

Arata (1999b) examined the development of PTSD symptoms following CSA and the likelihood that these symptoms increased the vulnerability of the victim's chance of revictimisation. In a later study conducted by Arata (2000), it was found that women with PTSD symptoms relating to CSA were associated with a higher risk of revictimisation. This study revealed that there was not a direct relationship between CSA and revictimisation but in fact an indirect one through the effects of PTSD, elevated consensual sexual behaviour and self-blame. Chu (1992) proposed that PTSD was also related to a vulnerability to revictimisation. Chu (1992) theorised that the different stages of PTSD would be associated with differing levels of vulnerability to revictimisation. During the phase where the individuals are re-experiencing symptoms of the initial abuse, they would be in a hyper-vigilant mode; therefore, much less likely to put themselves in a situation where revictimisation could occur. However, when individuals move into the numbing phase where their affect is constricted, they

would be at an elevated risk for revictimisation due to their mental removal from the situation. The decrease in memory of the initial abuse and the decrease in awareness of a potentially dangerous situation could have a marked elevation in the risk for revictimisation as the individual's ability to engage in self-protective behaviors would be diminished (Arata, 2002; Chu, 1992).

2.9.10 Incarceration

Victimisation has been found to be a possible precursor to incarceration (Dehart, 2008; McDaniels-Wilson & Belknap, 2008; Tusher and Cook, 2010). Browne, Miller and Maguin (1999) found that women who were incarcerated had a higher rate of experiencing a traumatic event in their childhood compared to women from the general population. In their study of 150 incarcerated women, Browne et al. (1999) found that 40 percent of women who reported to be victims of CSA also reported that they were victims of sexual abuse in adulthood. This was compared to 23 percent of the women who reported being victims of adult sexual abuse only; therefore, no revictimisation. Tusher and Cook (2010) performed a secondary analysis on data which had been collected by the American National Institute of Justice from 188 incarcerated and 171 non incarcerated women. Incarcerated women who reported they were victims of contact CSA were 13.6 times more likely than women who did not report a history of contact CSA to report physical abuse in adulthood. Non-incarcerated women who were victims of contact CSA were 2.3 times more likely than women with no history of contact CSA to report adult revictimisation. Overall, incarcerated women were 1.6 to 3.3 times more likely to experience revictimisation in adulthood than non-incarcerated women. Tusher and Cook's (2010) study was limited in its results by only examining the adult victimisation which occurred at the hands of an intimate partner. It excluded adult victimisation which may have

occurred by a non-partner; therefore, even though high rates of revictimisation were seen it is highly likely that it is a gross underestimation of the true numbers.

Breitenbecher (2001) stated that poverty and homelessness, which often precede incarceration, also increase the risk of revictimisation, which supports Tusher and Cook's (2010) findings. Their results suggest that the experiences and life circumstances of the incarcerated women differed from the non-incarcerated women in a manner that predicted the revictimisation of the incarcerated population.

In summary, it is difficult to estimate the magnitude of each risk factor for revictimisation due to the disparity of findings in the current literature. What must be noted is that there are many contributing factors to the risks of revictimisation with the main one being CSA itself as it appears that victims who are sexually abused as children are two to three times more likely to be revictimised as an adult (Arata, 2002). The risk factors discussed in detail above include the severity of the original sexual abuse; the individual's level of danger perception and risk detection; the level of trauma witnessed during the initial sexual abusive act and the age of the victim at the time of the abuse. Self-esteem and self-blame are both affected by CSA and have been shown to not only be an effect of revictimisation but can also play a mediating variable role. An increase in the victim's sexual behaviour, an increase in the level of substance use and the victim's family dynamics and community environments also play a large role in increasing the vulnerability of the victim's risk for revictimisation. Finally, the remaining two risk factors discussed for revictimisation were the symptoms of PTSD and how these symptoms elevated the individual's risk for revictimisation by a lack of engagement in self-protective behaviours, and incarceration and how the life circumstances and experiences of the incarcerated female increase the risk of revictimisation.

The consequences of the sexual abuse and the acts of revictimisation have revealed some serious and severe outcomes. These include many mental health issues which will be discussed in the following section.

2.10 The Outcomes Associated with Child Sexual Abuse and Risks for Revictimisation

2.10.1 Psychiatric outcomes

Both CSA and revictimisation have been associated with a pronounced risk for mental health problems in both childhood and adulthood (Cutajar et al., 2010a, 2010b; Fergusson & Mullen, 1999; Lau & Kristensen, 2010; Putnam, 2003; Spataro, Mullen, Burgess, Wells, & Moss, 2004). Mannarino, Cohen and Gregor (1989) concluded that victims of CSA "manifest a variety of emotional and behavioral difficulties" (p. 438).

Borderline personality disorder, major depression, PTSD, schizophrenia, dissociative identity disorder, somatisation disorder, substance abuse disorders, suicide and self-harm behaviours and eating disorders are several of the disorders which have been recorded to have an association with CSA (Bagley, Wood & Young, 1994; Beautrais, Joyce, & Mulder, 1994; Bebbington, et al., 2011; Beitchman, Zucker, Hood, DaCosta, Akman & Cassavia, 1992; Collishaw, Pickles, Messer, Rutter, Shearer & Maughan, 2007; Cutajar et al., 2010c; Fergusson et al., 1997; Fergusson & Mullen, 1999; Kendler, Bulik, Silberg, Hettema, Myers, & Prescott, 2000; Mullen, Martin, Anderson, Romans, & Herbison, 1993; Putnam, 2003; Spataro et al., 2004). Putnam (2003) states that along with this list of disorders, CSA has also been associated with "problematic behaviours and neurobiological alterations" (p. 271). Studies have revealed

that the relationship the perpetrator has with the victim can influence the victim's mental health outcomes; the closer the relationship the perpetrator has with the victim (i.e., intrafamilial), the worse the mental health outcome (Trickett, Noll, Reiffmann, & Putnam, 2001).

Gender has also shown an influence over the psychiatric outcomes with males tending to have more severe symptomatology (Garnefski & Diekstra, 1997). Kendler and colleagues (2000) conducted a population based study of 1,411 female adult twins. Their reported findings suggest that CSA is "strongly related to lifetime psychopathologic disorders" (p. 958). The twins within this study, despite being raised together in the same family environment, with the same genetic relationship with their parents, revealed that the twin who had been a victim of CSA was consistently elevated in her risk for psychopathologic disorders (Kendler et al., 2000). These findings support a causal relationship between CSA and psychiatric disorders.

The following section outlines the more prominent psychopathologies which have illustrated an association with CSA. These include depression, personality disorders (with a focus on borderline personality disorder and antisocial personality disorder), schizophrenia, suicide and self-harm behaviours, and eating disorders. PTSD is a psychiatric illness which is a result of both CSA and revictimisation; however, it will not be discussed in this section as it has been previously discussed in the section of risk factors for revictimisation.

2.10.2 Depression

Major depressive disorder is one of the most prevalent psychiatric disorders within the community (APA, 2013). There have been a multitude of studies which have revealed a moderate to strong association between CSA and depression (Andrews, Slade, Issakidis, &

Swanston, 2004; Bagley et al., 1994; Beitchman et al., 1992; Dube et al., 2005; Fergusson et al., 2008; Fergusson & Mullen, 1999; Mullen et al., 1993, 1996; Putnam, 2003; Silverman, Reinherz, & Giaconia, 1996; Weiss, Longhurst, & Maxyre, 1999). A review of the research on the impact of CSA by Browne and Finkelhor (1986) revealed that depression was the symptom most commonly reported among the victims of CSA. A meta-analysis reported by Fergusson and Mullen (1993) revealed an odds ratio for the presence of CSA in an individual's history as 2.1 to 7.0 times greater in those with depression.

Putnam (2003) states that a "lifetime prevalence of major depression in women with a history of CSA is typically three to five times more common than in women without such a history" (p. 271). When examining gender differences in the rate of depression within the CSA population, several studies reported a similarity in the prevalence of depression in the male and female CSA victims. This would suggest that the gender differences in the rate of depression normally seen in the general population, where women rate twice as high as men, is not present due to the male CSA victim's presenting with higher rates of depression (Banyard et al., 2004; Dube et al., 2005; Kessler, Davis, & Kendler, 1997; Putnam, 2004; Spataro et al., 2004, Whiffen & Clark, 1997). In a study conducted by Zlotnick, Mattia, & Zimmereman (2001) it was found that women who had been abused in their childhood were significantly more likely to have "prolonged durations of depression" (Putnam, 2003, p. 272) which suggests that a history of CSA may effect the response to the normal treatments of depression. In a birth cohort study consisting of 1000 New Zealand Children conducted by Fergusson et al. (1996a, 1996b), it was revealed that children with a history of non-penetrative CSA were 4.6 times more likely to experience major depression than those who had not been abused. The children with a history of penetrative CSA were 8.1 times more likely to experience major depression and 11.8 times more likely to attempt suicide. It is unclear within the literature whether all the individuals who

committed suicide had depression. Cutajar and colleagues (2010c) used the same linked dataset as the current study to reveal that the victims of CSA were significantly more likely to die from suicide or accidental drug overdose than the individuals in the general population. Regardless of the type of sexual abuse, either non-penetrative or penetrative, the presence of depression is significantly higher within the abused population.

2.10.3 Personality disorders

A personality disorder is a persistent, inflexible pattern of distortions in emotions, cognitions and behaviours which cause a significant functional impairment and distress in the individual's personal and social experiences. A personality disorder will typically first appear in adolescence or early adulthood (APA, 2013). It has been estimated that personality disorders appear within five to 13 percent of the general population (Ekselius, Tillfors, Furmark, & Fredrikson, 2001; Lewin, Slade, Andrews, Carr, & Hornabrook, 2005; Samuels, Eaton, Bienvenu, Brown, Coasta, & Nestadt, 2002; Torgerson, Kringlen, & Cramer, 2001). In a prospective cohort designed study conducted by Spataro and colleagues (2004), individuals within the CSA cohort ($n = 1,612$) had a primary diagnosis of personality disorder almost five times the rate of the comparison cohort. Goldman, D'Angelo, DeMaso and Mezzacappa (1992) and Weilor and Widom (1996) also found similar rates of personality disorders present in the CSA populations they examined.

When examining specific diagnoses, approximately 60 to 83 percent of individuals with a diagnosis of dissociative disorder were found to have a history of CSA (Bliss, 1984; Coons, & Milstein, 1986; Nurcombe, 2000; Putnam, Guroff, & Silberman, 1986). Dissociative disorder refers to when an individual experiences an alteration in their awareness such as

"depersonalization, derealization, disengagement (e.g., "spacing out") and trauma-related amnesia" (Briere & Scott, 2007, p. 353). Chu and Dill (1990) found that victims of CSA recorded a higher score on the 28-item Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1986) than the individual with no history of CSA (Briere & Runtz, 1993). Although dissociative disorder isn't a personality disorder it is often associated with borderline personality disorder which is discussed below.

Borderline personality disorder is characterised by a "pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity" (APA, 2013, p. 706). This personality disorder appears within the literature to have a close association with CSA (Barnard & Hirsch, 1988; Briere & Runtz, 1988; Brown & Anderson, 1991; Herman, Perry & van der Kolk, 1989; Stone, 1990; Zanarini et al., 1997). Studies have revealed the prevalence of CSA in the histories of individuals with a diagnosis of borderline personality disorder range from 16 to 71 percent (Herman et al., 1989; Ogata, Goodrich, Lohr, Western & Hill, 1990; Paris, Zweig-Frank & Guzder, 1994a, 1994b; Salzman et al., 1993, Shearer, Peters, Quaytman, & Ogden, 1990; Western, Ludolph, Misle, Ruffins, & Block, 1990; Zanarini et al., 1997). This wide range in the prevalence of CSA may be due to the diversity in the methodologies and samples used within the different studies. Zanarini and colleagues (1997) studied a group of 358 individuals who were "criteria-defined borderline patients" (p. 1,102). Their results revealed that 27.4 percent of the borderline patients reported a history of sexual abuse by a caretaker during their childhood and an overall rate of CSA, not taking into account the perpetrator, of 61.5 percent.

Herman et al. (1989) found that within a sample of 21 individuals with a diagnosis of borderline personality disorder, 14 (67%) had a history of CSA. Although this study has a

relatively small sample size it still supports the notion that CSA is prominent within the histories of individuals with borderline personality disorder. Briere and Zaidi (1989) also found that 93 percent of 14 psychiatric emergency room patients with a diagnosis of borderline personality disorder or borderline traits had recorded a history of CSA before the age of 17 years (Briere & Runtz, 1993).

In conclusion, CSA seems to play a major role in the etiology of borderline personality disorder; however, the complexity of the borderline characteristics means that the occurrence of CSA in the individual's history is not a definitive precursor to the development of borderline personality disorder (Zanarini et al., 1997).

Antisocial personality disorder involves a "pervasive pattern of disregard for, and violation of, the rights of others" (APA, 2013, p. 701), where deceit and manipulation are key factors. In a prospective study conducted by Horowitz et al. (2001), 588 adult men who were victims of CSA had a higher level of symptoms and diagnoses of antisocial personality disorder than their matched controls. In a comparison of the abused group with the national averages it was revealed that the rates of antisocial personality disorder were five times higher in the abused population than the non-abused (Kessler & Magee, 1994). In support, Luntz and Widom's (1994) study had 699 participants, 416 with histories of abuse and 283 from the comparison group. They found that abused men were significantly more likely to have a diagnosis of antisocial personality disorder than the matched control from the matched non-abused population. Luntz and Widom (1994) continue on and report that CSA was a significant predictor of the symptoms and diagnosis of antisocial personality disorder even when demographics such as, gender, ethnicity, socioeconomic status and criminal history were controlled.

2.10.4 Schizophrenia

Schizophrenia is a psychotic disorder which has been reported to have an association on some level with CSA (Bebbington et al., 2004; Bebbington et al., 2011; Bikmaz, 2007; Cutajar et al., 2010a, 2010b; Friedman & Tin, 2007; Read, Van Os, Morrison & Ross, 2005; Scott, Chant, Andrews, Martin, & McGrath, 2007; Shelvin, Dorahy, & Adamson 2007; Spataro et al., 2004). Much of the research has surrounded the question of whether CSA is a causative factor in the development of schizophrenia (Friedman & Tim, 2007). Read et al. (2005) conducted a review on 51 studies focusing on psychiatric inpatients and outpatients. From this review, they concluded that child abuse (including sexual and physical) is a causal factor for schizophrenia and psychosis; however, this conclusion must be observed in the context that 31 out of the 51 studies were based on a diagnostically heterogeneous sample where the rate of psychosis was ambiguous (Morgan & Fisher, 2007; Read et al., 2005).

Spataro and colleagues (2004) conducted a prospective study involving 1,612 CSA cases which revealed there was an association between CSA and schizophrenia diagnoses, although the strength of this association was not enough to conclude that there was a causal link between the two. In contrast, two other large studies have been conducted which examine the relationship between CSA and the later development of schizophrenia. In the UK a study conducted by Bebbington and colleagues (2004) where they examined 8,580 adults from the British National Survey of Psychiatric Morbidity and concluded that victimisation contributed to the vulnerability of developing a psychotic illness. There were 60 cases that met the criteria for a psychotic disorder and from these, 34.5 percent reported they had experienced a history of

sexual abuse. Cutajar and colleagues (2010a) are within the same research group as the current study and using the same sample cohort of 2,759 CSA victims and matched community-based control group they conducted a study whose results robustly stated that victims of penetrative CSA were at an elevated risk for developing psychotic and schizophrenic symptoms sometime during their life.

A study conducted by Scott, Chant, Andrews, Martin and McGrath (2007) involved 10,641 participants, over the age of 18 years, from the 1997 National Survey of Mental Health and Wellbeing. They reported that the participants who confirmed they were experiencing current psychotic features were significantly more likely to have experienced trauma in their past. The association between the exposure to trauma and the presence of a psychotic illness was strengthened when the trauma was perceived to be more severe, including penetrative sexual abuse compared to non-penetrative sexual abuse. These findings were supported by Shelvin, Dorahy and Adamson's (2007) study, which examined data on 5,877 individuals from the American National Comorbidity Survey. They found that a history of CSA, including rape, had the strongest association with the presence of symptoms associated with schizophrenia (Shelvin et al., 2007).

Although an association has been observed between CSA and the development of schizophrenia, the level of correlation differs greatly between the studies. The causal relationship between the two remains inconclusive and is an area which requires further in-depth investigation.

2.10.5 Suicide/ Self-Harm

Several studies have revealed an increase in suicidal thoughts and behaviours in the population of CSA victims compared to their non-abused counterparts (Bagley & Ramsey, 1986; Briere & Runtz, 1993; Cutajar et al., 2010c; Dube et al., 2005; Herman, 1981). In a study conducted by Lau and Kristensen (2010) involving 161 women with a history of CSA, they found the rate of attempted suicide in the individuals who had experienced revictimisation was 47 percent, compared to 30 percent in women who had only experienced CSA and not been revictimised. In a series of different studies done on the association between CSA and suicidal behaviour (Bagley et al., 1994; Beautrais et al., 1994; Fergusson et al., 1996; Gould et al., 1994; Mullen et al., 1993; Silverman et al., 1996), the odds ratios ranged from 3.5 to 74.0 which reveal a strong relationship between CSA and suicidal behaviour. It must be noted that the confidence intervals were quite large placing significant doubt on the exact strength of the relationship (Fergusson & Mullen, 1999). Briere and Runtz' (1987) study of 152 sexually abused adult female crisis clients revealed that 51 percent had attempted suicide on at least one occasion. Brier and Zaidi's (1989) study of female psychiatric emergency room patients revealed that 66 percent had attempted suicide compared to 27 percent from the comparison counterparts (Briere & Runtz, 1993). Dube and colleagues (2006) found within their retrospective cohort study of 17,337 adults, that for both men and women with a history of CSA, they were twice as likely to attempt suicide compared to individuals without a history of CSA.

As mentioned previously in section 2.8.2, Cutajar and colleagues' (2010c) study illustrated that the victims of CSA were significantly more likely to die by suicide or accidental drug overdose than non-victims. Using the same sample as the current research, they revealed that the female CSA victims were at a 40 times greater risk of committing suicide and 88 times more likely to fatally overdose than the general population while males were 14 times more likely to commit suicide and 38 times more likely to die from an overdose than the general population.

A strong association between CSA and suicidal behaviour may be due to the damaged self-esteem which arises from the abuse or from the increased rates of personality disorders including borderline personality disorder (Mullen et al., 1993) which is often accompanied by recurrent suicidal behaviour or self-mutilation (APA, 2013).

2.10.6 Eating disorders

An eating disorder is distinguished by severe disturbances in an individual's eating patterns and in the perception of their body shape and weight (APA, 2013). Mullen et al. (1993) revealed that in their cohort of CSA victims, 12 percent recorded the presence of an eating disorder compared to only four percent from the control cohort. The rate of eating disorders was even higher (22%) when focusing on the presence of penetrative sexual abuse. Overall, Mullen et al. (1993) reported that the rate of eating disorders was tripled in individuals with a history of CSA. Eating disorders have also been linked to adult sexual revictimisation (Briere & Scott, 2007; Dansky, Brewerton, Kilpatrick, & O'Neil, 1997). Piran, Lerner, Garfinkel, Kennedy and Brouillette's (1988) study of 68 females with a diagnosis of an eating disorder who were consecutively admitted or on the waiting list for admission to a specialised inpatient eating disorder unit found that CSA may be more closely related to bulimia than to anorexia nervosa. Root and Fallon (1989) support this statement and suggest that victimisation may not be the cause of an eating disorder, specifically bulimia, but rather the victimisation may be a risk factor in the development of bulimia. However, some studies have produced conflicting conclusions such as Bushnell, Wells and Oakley-Browne (1992) and Connors and Morse (1993), who failed to find a significant association between the presence of eating disorders in the general population compared with the abused population. Whereas Mullen et al. (1993) and

Wonderlich, Wilsnack, Wilsnack and Harris (1996) reported a definite association being present (Fergusson & Mullen, 1993). It is still unclear to what extent having been a victim of CSA is associated with the development of an eating disorder. This is an area which deems further investigation but is beyond the scope of this research.

In summary, the psychiatric outcomes of CSA and revictimisation can be detrimental to the functioning and wellbeing of the victim's life. The damage caused to the victims can be irreversible, ultimately setting them up for a potential lifetime of struggle with depression, psychotic disturbances, personality disorders, eating disorders and/or suicidal thoughts and behaviours.

2.11 The Relationship between Victims and Offenders

One of the most commonly held beliefs, both in scholarly and popular literature is that abused children are at an increased risk to become abusers (Widom, 1989a&b). In fact, there have been several researchers who believe that the form of abuse the victim experiences in childhood influences a similar form of abuse perpetuated later in life, ultimately stating that victims of CSA will likely become sexual abusers (Bagley et al., 1994; Dutton & Hart, 1992; Ford & Linney, 1995; Ryan, 1989). In a study conducted by Carter and Prentky (1990), 57% of males in a treatment program for sex offenders against children had been victims of CSA themselves (Bagley et al., 1994). The cycle of victim to abuser is an area which still has many gaps in the understanding of how and why a child who was sexually abused becomes sexually abusive in adulthood. Examining the extent of the offending population is beyond the scope of this research, but it must be noted that there are several CSA victims who fall into both the offender and victim category.

2.12 Summary

In summary, substantial knowledge in the area of CSA and revictimisation has emerged over the past 30 to 40 years; however, the relationship between CSA and revictimisation remains unclear. It is apparent from the current literature that many factors are involved in both the initial act of abuse and subsequent victimisations. Confirmed relationships have been recorded between CSA and revictimisation. Two of the more predominant areas which have been recorded to increase the victim's risk of revictimisation are the age at the time of abuse and the severity and longevity of the original abuse. These factors have been found to increase the individual's vulnerability to subsequent victimisation. Becoming aware of the increased risk, within not only the two above mentioned areas but also in the many risk factors for revictimisation which have been discussed throughout the introduction, is vital in the development and implementation of recovery and prevention programs. These programs need to target both improving the victim's mental health and empowering the victim in order to decrease their involvement in the risk factors which may ultimately result in revictimisation.

CHAPTER THREE

METHODOLOGICAL LIMITATIONS AND CONSIDERATIONS OF PREVIOUS STUDIES

3.0 Overview of the Methodological Limitations and Considerations

There have been an appreciable number of studies conducted over the previous 30 years on the short-term and long-term effects of CSA on the victims. Generally speaking, there are two different methodological approaches to studying the long-term effects of CSA. The first one is retrospective in nature and typically involves asking adults systematic questions concerning possible sexual victimisation in childhood. Comparisons are then made regarding the outcomes of interest for those people who report having been sexually abused and those people who reported that they were not sexually abused. The second approach is prospective or pseudo-prospective methodologies where children who have been confirmed to have been sexually abused in childhood are then compared to others at some further point in time (i.e., when they are adults). Much of the existing research has typically relied on the use of retrospective recollections of childhood events from the adult perspective due to the difficult and ethical issues which may arise when using a prospective model to obtain information on CSA (Fergusson, Horwood & Boden, 2011). Due to the limitations which may arise from retrospective methodologies, the confidence in the robustness of the results regarding the effects associated with CSA has been questioned. A review of the limitations and considerations of the research design of previous studies will be discussed in the following sections. Firstly, the advantages and disadvantages of retrospective and prospective designs will be examined. Secondly, the issues regarding sampling bias, recall bias, and confounding variables will be discussed.

3.1 Retrospective Designs

Many of the studies regarding CSA and revictimisation have been based on retrospective design. Retrospective studies provide a greater opportunity to standardize the study conditions and manipulate or observe the outcomes. They are studies which can be conducted with a shorter wait time for the outcome, they normally have a minimal loss of participants to follow-up, and are generally time efficient and low in cost; however, the retrospective study does have its disadvantages. Data collections in the retrospective designed studies are most commonly conducted through a self-reporting method. This is usually conducted by means of interviews (either structured or unstructured) and/or questionnaires either conducted in a face-to-face manner, by anonymous mail-out, or by telephone. Firstly, the cross-sectional designs of the retrospective data make it difficult to ascertain the relative importance of life events, in addition to the abuse, that may have led to adverse outcomes (Arata, 2000; Barnes, Noll, Putnam & Trickett, 2009; Koss & Dinero, 1989; Mandoki & Burkhart, 1989; Mayall & Gold, 1995). Due to this, data collection is limited to one point in time (i.e., the interview). This is a major limitation as the causal relationship between the effects and outcomes of CSA are difficult to determine and analyse when the series of events are retrospectively recalled. Fivush (1993) stated that "it becomes difficult to determine whether an individual is recalling the actual details of a particular experience or reconstructing what must have occurred based on general event knowledge" (p. 2). Since the cross-sectional design promotes a concurrent assessment of victimisation and revictimisation experiences, it is difficult to distinguish whether the rates of revictimisation for victims of CSA in adulthood would differ for individuals with similar backgrounds excluding the sexual abuse (Widom et al., 2009). Again, due to the nature of the cross-sectional design where the data collection is limited to one point in time, the mental state of the victim at the time of the study may strongly

influence their recollection of the events and experiences surrounding the CSA and therefore, may not be an accurate portrayal of the abusive experience (Brown & Harris, 1978). Another major limitation to the retrospective study is the absence of a corroborated account of events surrounding the alleged CSA from the engaged service providers (i.e., the Department of Human Services) (Arata, 2000; Barnes et al., 2009; Classen et al., 2005).

The retrospective recall of sexual victimisation can be considered controversial as abusive experiences which occur in childhood may not be encoded in memory as objective occurrences, such as the death of a parent (Horwitz et al., 2001). They are ultimately encoded as recollections. These recollections can be manipulated according to the individual's beliefs about what constitutes an abusive experience, and the memories can also change according to what occurs throughout the victim's lives (Horwitz et al., 2001; Loftus, 1993). And finally, there is always the risk of retrospectively underreporting the abuse (Barnes et al., 2009; Fergusson, Horwood & Woodward, 2000). There can be a significant loss or distortion of information when it is being recalled from a later time period (Widom & Morris, 1997). Unconscious denial, embarrassment, or a change in current circumstances may all contribute to an inaccurate, or biased, recollection of events surrounding the alleged CSA (Widom & Morris, 1997). The validity and reliability of self-reported victimisation data must be cautiously viewed; therefore, the reliance on the retrospective data, which constitutes the majority of this area of research, questions the reliability of the findings (Widom & Morris, 1997).

Due to this uncertainty, several studies have used a “test-retest paradigm” to examine the reliability of the retrospective reports of CSA (Fergusson et al., 2011 p. 94). In a study performed by Fergusson and colleagues (2011), which examined the retrospective reports of

both childhood sexual and physical abuse from 980 individuals, a “structural equation model was developed to estimate the contributions of test unreliability and recall bias to reporting variation” (Fergusson et al., 2011 p.93). They found that the retrospective model of reporting CSA was open to two measurement errors, unreliable reporting and recall bias; however, they found that the net effect of the recall bias on the study validity was small (less than 1% of the reporting variance). Therefore the effects of the bias on the estimates of the association between CSA and later outcomes may in fact be relatively small (Fergusson et al., 2011). The reliability of the self-report is discussed below.

3.2 Validity and reliability of the self-report

Accuracy of CSA memories is one the greatest limitations to the retrospectively designed study. Williams (1994) performed a study consisting of 129 women who had clinically documented severe CSA. The study re-interviewed these women 17 years after they had been originally treated for the abuse. Thirty-eight percent of these women failed to report their severe CSA experiences. Consistent with Williams’ (1994) findings were the results found in Widom and Morris’s (1997) study. They re-examined a sample of 75 women with documented cases of CSA 20 years after the initial abusive event. From the small sample of 75 women, 36% did not report their history of CSA (Hardt & Rutter, 2004). In the same study by Widom and Morris (1997), there were 19 men with a documented history of CSA. Quite strikingly, only 16 percent reported that they had been a victim of CSA; therefore, most of the males did not recall or report they had been a victim of sexual abuse. This lack of reporting may be due to the likelihood that the male victim did not actually consider what was initially reported as CSA to be abuse.

One theory which has been examined in the event of memory recall is the age of the individual at the time of the abuse. This may affect their ability to not only recall the sexual abuse but also affect the accuracy of the memories of the abuse. Herman and Schatzow (1987) found a vigorous association between the ability to recall specific memories and the severity and longevity of the sexual abuse. If the abuse continued from childhood into adolescence they had a much higher recall ability compared to the individuals whose sexual abuse began in early childhood and ended shortly after. This latter population often revealed severe deficits in their memory recollection (Herman & Schatzow, 1987; Widom & Morris, 1997). However, Loftus (1993) has suggested that to have no memory of such a traumatic event, such as sexual abuse, the trauma would most likely have occurred to the individual before the age of three years; any older than three years and they would be unlikely to forget such a traumatic event.

Another likelihood for the lack of recollection is that the memories of the original abuse may become merged with memories of any subsequent acts of abuse. The individual may believe they are accurately recalling an event when in fact they are combining a series of memories to form one single memory. Alternatively, they may only recall the sexual abuse which occurred later. This notion was supported by Williams' (1994) study on 129 women with clinically documented cases of severe CSA discussed previously. During the interview process two-thirds of the women reported they had experienced additional sexual abusive incidents other than the ones originally reported in childhood (Hardt & Rutter, 2004). Williams (1994) interpreted this to mean that the 38 percent of women who failed to report the initial CSA but were able to recall additional sexual abusive experiences did so due to forgetting or repression rather than consciously not wanting to reveal the CSA. This interpretation supports the statement made earlier where the victim may only recall the sexual abuse which occurs

later in their lifetime and fails to recall the abuse which occurred in early childhood; however, this process of forgetting may not be the sole reason for the amount of underreporting which appears to be present. There may be other factors controlling the failure to report, including a basic refusal to acknowledge the sexual abuse due to embarrassment, denial, wanting to protect the perpetrator or a basic lack of rapport with the interviewer (Fleming, 1997; Hardt & Rutter, 2004; Melchert & Parker, 1997).

3.3 Prospective designs

Prospectively designed studies regarding the long-term effects of CSA offer some advantages over the retrospectively designed studies, although they are not without their own disadvantages which will be discussed below. The methodological advantages seen in the prospective study include the possible avoidance of sample and recall biases by the selective inclusion of participants, the ability to establish the order of cause and effect, the control of confounding variables and the ability to follow-up the victims of CSA over long periods of time (Fergusson & Mullen, 1999). The results from a prospective design provide strong support for the hypothesis that CSA leads to increased risk of further victimisations throughout the individual's lifetime (Widom et al., 2009). The prospective study also allows the researcher to follow a group of people who were abused in childhood throughout their lives, regardless of the outcomes being investigated (Widom et al., 2004).

Regardless of the advantages of prospective designs, they also have their own methodological limitations. The implications of following a substantial representative sample of children from birth into adulthood and assessing, on multiple occasions, the family dynamics, structures and onset of CSA are substantial (Fergusson & Mullen, 1999). Firstly, the ethical

considerations which must come into play when considering this form of research are important. When one is exposed to the knowledge of CSA this presents complex ethical issues for the researcher and this knowledge must then be reported to the appropriate agencies and interventions and support would need to be provided. The knowledge that the CSA would need to be reported to the authorities may prevent some victims from exposing their experiences due to the ramifications this action may cause. Secondly, prospective research also necessitates the involvement of parents, children and others to be informants and disclose any CSA experiences during the multiple assessment points throughout the research period. Accompanying this exposure may include a high risk of legal ramifications faced by the informants and their families (Bertolli, Morgenstern, & Sorenson, 1995; Fergusson & Mullen, 1999).

Due to the issues identified above, the completion of a fully prospective study is challenging. There have been some proposals for other research designs which incorporate aspects of the prospective design but overcome some of its limitations. One design, proposed by Bertolli et al. (1995) and Fergusson and Mullen (1999), includes a large representative cohort of children from birth to adulthood, which at several intervals throughout their lives provide information regarding their childhood, social and family circumstances (Fergusson & Mullen, 1999). When the individuals within the cohort reach adulthood, they would reflect back retrospectively for the researchers to collect data pertaining to any accounts of CSA which they may have experienced. This process would eliminate the ethical and practical difficulties which would arise if they were attempting to collect this data prospectively (Bertolli et al., 1995; Fergusson & Mullen, 1993). This combination of the prospective and retrospective models may provide a strong method which would limit the effects of memory and recall bias which may be present.

Alternatively, using CSA data that have been collected by protection agencies or medical institutions can overcome the ethical dilemmas of the researchers having to report the CSA but still manages to maintain a prospective design. Using this form of collected information is more likely to present an unbiased account of the CSA seeing it is a third party who is recording the abusive experience. It is less likely to be distorted by a recollection bias (Fergusson & Mullen, 1999). This would provide a more valid account of the CSA; however, it is usually the more severe cases of CSA which are reported to the officials. It is necessary to be aware that the information gathered from the reporting agencies may be skewed toward the severe end of the abuse spectrum which can cause questions regarding the validity and reliability of the study.

3.4 Bias

A bias is a source of variation due to a systematic error in the design, conduct or analysis of a study leading to an outcome that differs from the underlying truth. The different biases must be taken into account when planning the design of the study. Sampling bias and recall bias are often seen in CSA research and these are discussed below.

3.4.1 Sampling bias

Sampling bias is a methodological limitation seen in both the retrospective and prospective CSA and revictimisation studies. A sampling bias can occur when the study examines the long-term effects of CSA by using a specific and convenient population of victims. This can sometimes be quite inadequate to procure any conclusive results. These usually include, but are not limited to, college students, individuals self-referred for counseling, prisoners,

individuals who have used child protection services and psychiatric patients (Fergusson, Boden, & Horwood, 2008). The extent to which individuals from these populations generalise to individuals from the broader spectrum of society is not well known. This leads to another significant problem; many of the studies fail to provide an adequate representation of the general population. The findings from the studies could be regarded as quite meaningless if there is no control group in which to compare (Arata, 2000; Horowitz, Widom, McLaughlin & White, 2001).

3.4.2 Recall Bias

A recall bias occurs when there are a series of accuracy or inaccuracy in the reporting of past events due to the current functioning of the individual's psychological or physical health (Widom et al., 2004). Maladjusted individuals appear to take on a more negative attitude when reporting childhood experiences and therefore place a higher emphasis on the negative experiences. This can overly exaggerate the relationship between the event of CSA and its potential outcomes (Widom et al., 2004).

There also have been indications that depression fosters the recollection of unhappy memories and inhibits the ability to recall happy ones (Bower, 1981; Hardt & Rutter, 2004; Schraedley, Turner, & Gotlib, 2002; Widom, Raphael, & DuMont, 2004). This essentially creates a recall bias. However, Brewin, Andrews and Gotlib (1993) provided empirical evidence which suggests the effects of such a bias would be minor.

To date, it has been impossible to draw any concrete conclusions regarding causal relationships between CSA and outcomes occurring later in an individual's life. Events which

occur in childhood affect adult-life experiences; however, experiences occurring later in life also affect how consequential the early-life experiences will be (Horowitz et al., 2001).

By providing a comparison cohort of randomly selected individuals from the general population, sampling and recall bias can be limited; however, retrospective studies which rely on an adult's recollection of their childhood memories will always be subjected to problems with accuracy, forgetfulness, and memory repression.

3.5 Confounding

Confounds are unspecified and unmeasured factors that are causally related to the outcome of a study. They are associated with the treatment or exposure of interest but they are not the result of them. The presence of confounds has the potential to obscure the true relationship between exposure to CSA and the outcome, which in turn causes the association to appear either stronger or weaker than it actually is; therefore, representing significant threats to the validity of the CSA study (Kelsey, Whittemore, Evans & Thompson, 1996). CSA is correlated with a wide range of childhood adversities therefore it is important for the studies which examine the effects of CSA to attempt to measure and control for the possible confounding factors that may arise.

Both the retrospective and prospective research methods have advantages and disadvantages and the methodological issues associated with studying CSA prevent a single best design to be chosen for this area of study. In studying a phenomenon such as the long-term effects of CSA on re-victimisation, it is helpful over time to conduct both retrospective and prospective studies in order to obtain convergent validity. The current research comprises a prospective study that will be described in the method section.

CHAPTER FOUR

METHODOLOGY

4.0 Overview of Methodology Section

This chapter describes the methodology used to examine a population of CSA victims to determine the prevalence of revictimisation within the group. The research design employed, the data sources used, and the linkage procedures are outlined. The criteria for inclusion and exclusion in the study are noted as are the ethical considerations. A summary of the statistical analyses used concludes the chapter.

4.1 Research Design - An Historical Cohort

The methodology was developed to overcome the limitations outlined in the literature review. This was achieved by employing an historical cohort study which examined a large population of CSA victims who were impartially determined to have been sexually abused following medical examination. Their long term outcomes were also objectively determined by their subsequent contact with the Victorian Police, rather than relying on self-report. Finally, a comparison group was obtained and matched with the CSA group on gender and age.

The long term effects of CSA on revictimisation are examined by the use of an historical cohort study. An historical cohort design consists of investigating a group of people who share a common theme or experience, in this instance a sample of CSA victims, assembled from existing records. It is a longitudinal study design where the subjects are followed up

over time (up to 44 years in the current study) with the collected information initially being recorded for uses other than intended for the current study. All recorded events occurred before the commencement of this study and contacts with the police were recorded where they occurred subsequent to the identification of CSA. For the purpose of the current thesis a data linkage procedure was performed.

The sample employed in this study was constructed from cases from the Office of Forensic Medicine (OFM). In Victoria, when the police investigate children who are suspected to have been sexually abused, the children are referred for medical examination. The cases included are those where the medical practitioners were able to confirm that sexual abuse had occurred. The sample of people who were reported to be abused as children were linked to the Victorian Police Law Enforcement Assistance Program (LEAP) database. The Victoria Police records all formal contacts with police, including offences and cases where the person was the victim of crime.

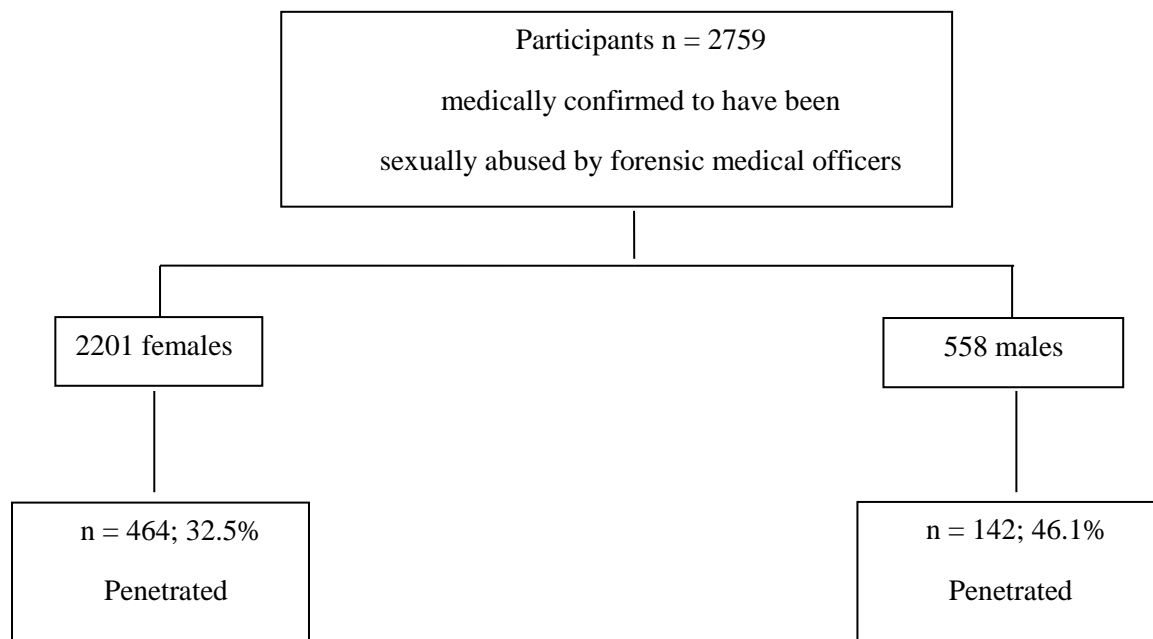
The people in the CSA population extracted from the OFM records were reviewed between 13 and 44 years after their initial contact by using specific identifiers including full name, gender and birthdate. These identifiers were then cross-referenced with the LEAP database and any exact matches were extracted and used for the purpose of this thesis. The CSA population was then compared to a random group of subjects, obtained from the Australian Electoral Commission, on the same outcomes, to ascertain if the CSA population was in fact at an increased risk of revictimisation compared to the general population. They were matched on age and gender only.

4.2 Data Sources

Four different data sources were utilised as part of the data linkage process. The database consisting of the CSA cohort was developed in a program of research undertaken by staff and students of the Centre for Forensic Behavioural Science. The records of the OFM were used to collect data for the CSA cohort and the comparison cohort was obtained from the Australian Electoral Commission (AEC) database. These relate to the subjects. The LEAP database and the Redevelopment of Acute Psychiatric Information Database (RAPID) were employed to examine the outcomes of revictimisation and mental illness. Each database will be described in detail below.

4.3 Study Cohort

The CSA population cohort was comprised of 2,759 children; 2,201 females and 558 males. The mechanisms as to how the cases were obtained for the study is described in the following sections.

Figure 4.1*Flow diagram - Overview of the study cohort*

4.3.1 Child sexual abuse database: Office of Forensic Medicine

The OFM was a statutory body established in 1957 and was employed to perform all forensic medical services in Victoria until 1995 when it later became the Victorian Institute of Forensic Medicine (VIFM), which remains until the present day.

All suspected cases of CSA reported to the police, child welfare or protection agencies were examined and reported by the OFM. The main purpose of the examination was to determine whether sexual abuse had occurred, and if so, to formulate a medical opinion on what form of sexual abuse had taken place (e.g., penetrative or non-penetrative). The non-penetrative cases of abuse were difficult to determine during the medical examination as they resulted more in

psychological symptoms rather than physical ones; therefore, the findings of the CSA examinations were often restricted to acts of penetration.

The ability of the OFM to determine whether penetration had occurred depended on the elapsed time between the abusive episode and the time of examination. The ability to provide a conclusive examination increased in difficulty dependent on the elapsed time frame since the abusive event. Many victims of CSA are unwilling to disclose their experiences which could often result in a non-conforming physical and verbal account of the abuse. The physical results may have had time to heal before the victim had the courage to verbally disclose the abuse. Due to this, the amount of information included in the reports of the OFM differed substantially from comprehensive (police reports and behavioral observations) to minimal (name, date of exam and physical findings). To try and prevent such differences in the level of reporting, in 1989 a new documentation system was introduced within the OFM. The new system promoted consistency within the reporting process. This consistency included recording the victim's full name, their date of birth, gender, the date of examination, the findings of the physical examination (penetration or no penetration), and when available, the characteristics of the abuse. This information was utilised to develop the CSA database used within the current study. Specifically, the date of birth was used for data-matching with the comparison cohort and the date of exam was used in order for ages to be calculated.

To establish operational consistency for the benefit of this study, penetration was defined as, "Completed, partial or attempted insertion of a penis, finger or object of an orifice where conclusively, probably or possibly indicated in the opinion provided by the OFM doctor" (Cutajar, Ogloff & Mullen, 2011, p.17). To ensure this was certain in all cases the historical records were assessed and recoded.

The term "alleged" is implied when referring to all CSA cases examined in this study. The role of the OFM was to record and establish physical findings in a medical exam, not to provide substantiated information on the case itself. This role is reserved ultimately for the courts. It is important to note that the method of ascertainment of abuse cases is quite conservative since the medical practitioners only confirm CSA in cases where there is compelling medical and psychological evidence to confirm that the abuse has occurred.

All the cases which were assessed for CSA between the years 1964 and 1995 were collected from the OFM. Each case was examined and included in the current study dependent on meeting the following criteria:

- the victim reported being sexually abused; and,
- the victim was 16 years or younger at time of alleged sexual abuse.

Where contemporaneous information of the CSA was collected, the inclusion criteria consisted of:

- the victim was sexually assaulted by a peer; or
- the victim claimed to have consensual sexual intercourse with an individual five years or more their senior.

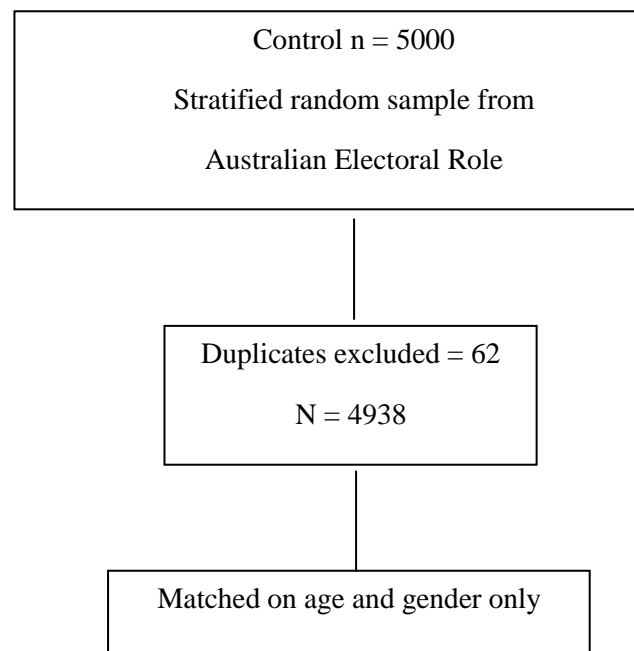
Each CSA case was assigned a record identification number and entered onto an excel spreadsheet. Following this, data integrity checks were performed. Any CSA case that did not meet the inclusion criteria was removed from the spreadsheet. After the data integrity checks, the completed database included a total of 2,759 (2,201 females and 558 males) CSA victims.

4.4 Comparison Cohort

To achieve a full understanding of the effects of CSA on revictimisation, a random sample of the general population, with no known history of CSA, was required. In order to achieve this, a comparison group of randomly selected individuals was obtained from the Victorian Commonwealth Electoral Roll.

Figure 4.2

Flow diagram - Overview of the comparison cohort



4.4.1 General population database: The Australian Electoral Commission

The Australian Electoral Commission (AEC) was established on 21 February 1984 due to major amendments being made to the *Commonwealth Electoral Act 1918*. The AEC is

responsible for conducting federal elections and referendums and maintaining the commonwealth electoral roll. The AEC can also provide electoral information for use in approved medical research under provisions of the Commonwealth Electoral Act 1918.

It is mandatory for every Australian citizen, 18 years or older, to enrol on the electoral roll and to vote in the federal, state and local elections. The AEC has a computerised Commonwealth Electoral Roll management system where every adult Australian citizen's name, address and gender are registered. For the purpose of providing a comparison cohort for this study, on the 31st July 2008 the AEC provided the names and gender of 5,000 (2,500 males and 2,500 females) randomly selected Victorian citizens, from an approximate pool of five million, between the ages of 16 years and 61 years. Date of birth information was not provided, only the ages in two year age brackets; therefore, for the purpose of this study the age was taken as the median split of each age bracket. In order to assist with the data matching procedures, due to the lack of birthdate, data integrity checks were carried out resulting in the elimination of 62 duplicates. After removing the duplicates, 4,938 individuals remained. The matching process did not involve names which prevented the ability to perform a cross check on an individual's inclusion in both the CSA cohort and the comparison cohort. There may have been some subjects from the comparison cohort who were sexually abused as a child but there was no way for that information to be extracted for the purpose of this study. This lack of knowledge on any prior history of abuse within the control group provides potential confounding.

The general population database provided a matched comparison cohort with no known history of CSA to our current CSA population database. It fulfilled one of the main aims of the current study - to compare the prevalence of revictimisation rates in the CSA population

to the revictimisation rates in the general population.

4.5 Law Enforcement Assistance Program Database

The Law Enforcement Assistance Program database (LEAP) was used to assist with the examination of subsequent victimisations within both the CSA and comparison cohorts.

The current LEAP system was implemented on the 1st March 1993. All information collected prior to this date is kept on Information Bureau of Records (IBR) cards subsequently stored as hard copy files. The information stored on the IBR was examined and linked with the LEAP database where necessary.

LEAP is a dynamic database used to record and store any and all contact members of the general public have had with the Victorian Police. Data suggest that between 547,000 and 584,000 LEAP reports are generated annually (Carcach & Makkai, 2002. p.19). Both offender and victim information is documented on the database with many different variables being recorded. In a typical LEAP report these include: gender, age, ethnicity, country of birth, multiple victimisations, occupation, marital status, location of offence, weapon involvement, witnesses of crimes, family incidents and missing persons. The Victorian Police Manual instructs its members “where the facts indicated that a crime has been committed the employee must complete and submit all relevant LEAP reports” (Carcach & Makkai, 2002 p.6). This database provided the information necessary to examine the subsequent effects that CSA has on revictimisation in both the CSA population and the general population.

4.6 RAPID Database

To examine the effects of mental health and its association with CSA and further victimisations the Victorian psychiatric database RAPID was utilised.

The Redevelopment of Acute and Psychiatric Information Directions (RAPID) database is an online, centralised, state-wide patient information system. Access to this system is limited to authorised public mental health personnel by use of security measures such as passwords. RAPID came online in the year 2000 replacing the Victorian Psychiatric Case Register (VPCR) which had been established in 1961 to record the details of each individual who had contact with the Victorian public mental health system. This register was described as the world's largest psychiatric database (Spataro et al., 2004). Together, the two databases, VPCR and RAPID, contain approximately 637,000 recorded cases (Cutajar et al., 2011. p, 31). Both databases were utilised during this research as only the cases which have had subsequent contact with the public mental health system after the year 2000 have been transferred from the VPCR to the RAPID database; therefore, the VPCR database was needed to provide information on all cases utilising the public mental health services between 1961 and 2000. Both RAPID and VPCR contain information on all public psychiatric in-patient admissions including primary diagnosis, date of admission or contact with the services and the demographics of the individual. For the previous 20 years any contact with the community mental health services and the emergency rooms has also been recorded on to RAPID. The diagnoses recorded are made by psychiatrists and provide an accurate representation of psychiatric illness.

Both databases lack information on the individuals who have had contact with the private

mental health sector, which constitutes approximately 29 percent of psychiatric in-patient beds in Victoria; therefore, any individuals within the private sector with inpatient admissions are not recorded on to the RAPID database. Similarly with the individuals who had contact with privately practicing mental health professionals, including general practitioners, are also not recorded on the database. Combined with the legal provision under the Victorian Mental Health Act 1996 and the difficulty in managing individuals with schizophrenia spectrum disorders in the private setting, the patients who are certified for inpatient hospital treatment are admitted to public facilities; therefore, everyone with a schizophrenic illness will have had contact with the public mental health system at some stage and should appear on either the VPCR or RAPID database. However, in comparison, the individuals with less severe forms of mental illness who may not need inpatient hospitalisation and which could be managed within the private sector are less likely to seek out public treatment; therefore, the rates of less severe forms of mental illness may possibly be under-represented on the psychiatric databases.

4.7 Data Linkage

The data linkage process involved the linking of the CSA and the comparison cohort to both the LEAP and the RAPID databases. The process of this linkage is described in the following section.

4.7.1 Linking child sexual abuse and comparison cohorts to LEAP database

Linking the CSA and comparison cohorts to the LEAP database provided the opportunity to determine the prevalence of revictimisation for CSA victims. The procedure used for this

linkage is outlined below.

As a member of the general public it is not possible to gain access to the LEAP database; therefore, a member of the Victorian Police was authorised the position of gathering the information required from the database. The authorised individual was furnished with a password protected file containing information on each individual in both the CSA and comparison cohorts. This information included: the individual's full name, their gender, date of birth or age range and the unique record identifying number assigned to them.

Initially, a manual search was conducted to select exact matches on full name, gender and date of birth for the CSA and comparison individuals who also appeared on the RAPID database. Secondly, for the cases where a birth date had not been supplied, probabilistic matches were carried out using gender, full name and age group. If a match had not been generated, then thirdly, a State driver's license check was issued. If any driving offence was recorded, then this information was used to identify a match. If this final check still did not produce a match with the LEAP database then we can deduce that the individual had no formal contact with the Victorian Police.

Following these checks the authorised police officer extracted the relevant data and returned it to the researcher in a de-identified encrypted format. This data had been linked with the created CSA and comparison database by the unique record identifying number previously given to each individual in the two cohorts. Eliminated from the dataset were any acts of sexual victimisation reported to the Victorian Police that corresponded with the initial CSA victimisation reported by the OFM. The data collected and the statistical analyses were conducted on events occurring prior to Oct 6, 2009; therefore, the current study includes 44

years of follow-up data.

4.7.2 Linking child sexual abuse and comparison cohorts to RAPID database

The ability to evaluate the prevalence of mental illness among the CSA victims relied on linking the created CSA and comparison cohort database to the RAPID database. This linkage procedure is explained below.

The VPCR and RAPID databases are both managed by the Department of Human Services (DHS); therefore, a DHS data analyst was authorised the position of linking the CSA and comparison cohorts with the VPCR and RAPID database. The analyst was provided with a password protected file containing all the CSA and comparison cohort's information. This included their full name, their gender, date of birth or age range and unique record identifying numbers. Initially, a deterministic approach was used in the data linkage procedure.

Structured Query Language (SQL) scripts based on identifying information were used to extract exact matches for the CSA cases based on full name, gender and date of birth. The comparison cases were also examined for exact matches on full name and gender, although their date of birth was examined based on the two year age band. This was viewed as a match with RAPID if it corresponded with the same two year age band of the identified individual.

Female CSA cases may have changed their surname due to marriage, or the marriage of their mother, therefore, a probabilistic approach was performed on the female subjects only. A second SQL search was conducted using full name, gender and date of birth as the identifiers. This was not done for the females within the control group as the data matching procedure was performed shortly after receiving their details. The extracted exact matches were

delivered to the researcher in a de-identified password protected file.

The data linkage procedure was performed for every individual in both the CSA and comparison cohorts on RAPID from January 15, 2008. A total of 1,612 cases from the total number of 2,759 CSA cases had been previously cross-referenced on VPCR until 30 June 2000. This involved the "implementation of a computer-matching algorithm" which extracted potential matches by full name and date of birth (Spataro et al., 2004). The remaining 1,147 CSA individuals and all the comparison individuals were cross referenced with VPCR in January 2009. If there were individuals identified on VPCR but not found on the RAPID database they were rerun through the VPCR in February 2009 to establish reliability in diagnostic operations.

4.8 Ethical Considerations

Four independent committees granted ethical approval: The Monash University Standing Committee on Ethics in Research involving Humans granted approval for all phases of the research. The Victorian Police Human Ethics Research Committee granted approval for access to the police database (LEAP), the Department of Human Services granted approval for access to their psychiatric databases (VPCR and RAPID) and the Human Research Ethics Committees of VIFM for access to the records of the OFM.

The main ethical consideration for this research was the potential breach of one's privacy and confidentiality by not gaining the consent of each individual in the CSA cohort and the comparison cohort. The information gathered from these individuals was not initially intended for use in the current research but instead for administrative purposes. According to

the *Victorian Information and Privacy Act 2000*, personal information may be disclosed without the consent of the individual if it is within the context of research and it is considered necessary for the interest of the general public and if there is no feasible alternative to gaining the individual's consent. The impracticality of gaining consent from approximately 5,500 subjects, and the impossibility of trying to individually access each subject, especially within the CSA cohort where there were no current contact details, deemed it appropriate to use their personal information without individual consent. It was also considered inappropriate and unethical to contact each individual in the CSA cohort for the following reasons: the individual may have experienced the sexual abuse when they were very young and they may not actually be aware that they were in fact a victim of CSA; victims may have tried to forget about the sexual abuse which they experienced and by bringing it to their attention may be quite distressing and confronting for the individual; and finally, the victim may not wish for anyone to know that they were a victim of CSA.

Due to the nature of the information in this study, maximum care and regard for personal privacy and confidentiality was undertaken by securing password protected files and de-identifiers were initialised immediately following the matching procedure. All of the de-identified data, the data analysis and data linkage were conducted at the secure facility at the Centre for Forensic Behavioural Science, Monash University, on a stand alone computer with a three level, specifically log-on, file open, and file modification, password protected file. The primary researchers were the only individuals granted access to these files.

Initially, it was necessary for the data to contain identifiers such as name, gender and date of birth so the data could be cross-referenced to the LEAP database and the RAPID database. Once the data matching procedure was complete, the identifiers were immediately removed.

The authorised personnel conducting the data matching procedure did so blindly as they were unaware of the nature of the research and each agency was only granted access to their particular discipline. All files exchanged were password protected and all data provided to the primary researcher were de-identified. The subsequent linkage between the LEAP (police) and RAPID (psychiatric) database to the information provided by the OFM was carried out by the assignment of an identification number attributed to each individual which had no connection to any of their previous medical or AEC records.

Due to the nature of the safety precautions implemented throughout the data gathering phase, the ethical bodies involved in the current research judged the risks to each subject as comparatively small compared to the knowledge gained from the outcome of the current research. CSA and revictimisation are significant public issues needing to be addressed and with the data collected for this thesis providing the "largest known study of medically examined CSA victims in conjunction with contemporaneous accounts to be systematically followed up over four decades on objectively long term outcomes on victimisation" (Cutajar et al., 2011, p. 36), it is providing the sought after information needed to begin to implement strategies to assess risk. In particular, identifying CSA victims who are at high risk of revictimisation. Furthermore, by providing a comparison cohort from the general population the current research allows a true evaluation of the nature and significance of the relationship between CSA and revictimisation. After examination, it is believed that the general public's interest in the understanding and possible prevention of future revictimisation outweighs the individual's privacy rights. The four ethical bodies who granted ethical approval (Monash University Standing Committee on Ethics in Research involving Humans, Victorian Police Human Ethics Research Committee, Department of Human Services and Human Research Ethics Committees of VIFM) supported these views.

4.9 Data Analyses

The statistical procedures used in this research were performed using the Statistical Packages for Social Sciences for Mac, version 21.0 (SPSS, Chicago, 2008). Where appropriate, the significance level was set at $p = .05$.

4.9.1 Data screening

To check the data for potential errors, descriptive statistics (frequencies, means, medians, and range) were used to inspect each categorical variable. The continuous variables were examined by a range of tests to examine for the potential violation of assumptions and the impact of existing outliers. The 5% trimmed mean value was examined and it was found to be similar to the original means; therefore, the outliers did not have a strong influence on the mean, and as such they were not removed from the data.

4.9.2 Statistical analyses

The demographics of the CSA and comparison cohorts were distinguished by performing descriptive statistics, which also examined the nature of the contact each victim had with the Victorian Police. Basically, the victimisation outcomes of the CSA cohort were compared to the victimisation outcomes of the comparison cohort. The cohorts were compared by initially using t-tests (for continuous variables) which compared the extent in which continuous variables differ between the two groups and the chi-squared tests of association (for categorical variables). Odds ratios were utilised to examine the comparison of the victimisation in the CSA cohort to the victimisation in the matched cohort group and 95%

confidence intervals were used. Cross-tabulations were performed to observe any significance of associations using chi-square analyses or a Fisher's exact statistic if the 2 x 2 cross-tabulation produced any cells with a count of less than five.

CHAPTER 5

RESULTS

5.0 Overview of the Results Section

The results chapter is divided into four sections. The first section describes the characteristics of the CSA cohort. Section two comprises an in-depth analysis of contacts that people in the CSA cohort had with the Victorian Police and how their association compares to that of the general population. Section three presents an in-depth analysis of the association the CSA cohort had with the public mental health system compared to the general population. Included in the analyses are comparisons of gender and severity of abuse. Finally, section four examines the relationship between CSA, mental illness, and criminal revictimisation.

5.1 Section One - Characteristics of the Cohorts

5.1.1 Characteristics of child sexual abuse cohort

The CSA cohort consists of 2,759 individuals, including 2,201 (79.8%) females and 558 (20.2%) males. The mean age of the individuals within this cohort at the time of the initial alleged sexual assault examination was 10.22 years ($SD = 4.44$), with the age range spanning from 0.27 years to 16.99 years. The male CSA victims were significantly younger at first presentation to the OFM than the female CSA victims ($M = 9.41$ years, $SD = 4.22$ vs. $M = 10.43$ years, $SD = 4.48$; $t = 5.08$; $p < 0.000$) respectively.

The mean age for the CSA cohort at the time of follow-up examinations was $M = 35.55$ years

(SD = 10.93; range 15.34 years - 62.25 years). Males were significantly older than females at follow-up (M = 36.65 years, SD = 11.05 vs. M = 31.59 years, SD = 9.5; $t = 15.63$; $p < 0.000$); however, there was no significant difference between the mean age at follow-up between people in the CSA group and the control group (M = 35.58 years vs M = 35.53 years; $t = 0.19$; $p = 0.85$). The follow-up period from the time the abuse occurred to the point at which data were collected ranged from 13.97 years to 44.77 years (M = 25.36, SD = 8.16).

The sexual abuse recorded was classified into two groups: penetrative or non-penetrative. The penetrative abuse consisted of completed, partial or attempted penetration of an orifice including the vagina, anus or mouth by a penis, finger or object. A significantly higher portion of the CSA population (1,737, 63%) experienced penetrative abuse than non-penetrative abuse ($t = 4.26$; 95% CI 0.04 - 0.11; $p = 0.000$). The non-penetrative form of abuse was experienced by 1,022 (37%) of the CSA population. Non-penetrative abuse includes all acts in which penetration was not attempted. Within the 1,737 reported cases of penetration, 1,429 (82.3%) occurred within the female group compared to 308 (17.7%) in the male group. The rate of penetrative abuse was significantly higher for the female CSA victims (1,429, 64.9%) than for the males (308, 55.2%; $X^2 = 18.06$; $p < 0.001$).

Close to half of the CSA victims, 735 out of 1,532 (47.98%) were sexually abused by a relative.¹ The female CSA population was significantly more likely to experience

¹ Data concerning whether the perpetrator of abuse was from within the family or outside of it was missing in a number of cases; therefore, it must be noted that the analyses regarding relationship with the relationship of the perpetrator have different totals than the rest of the study.

intrafamilial sexual abuse when compared to the male CSA victims (606, 51.53% vs 129, 36.3%; $p < 0.000$). Concomitantly, the male CSA population were significantly more likely than the female CSA victims to encounter extrafamilial sexual abuse (227, 63.8% vs 570, 48.5%; $X^2 = 24.9$; $p < 0.000$).

Overall, 1,832 (66.4%) victims were abused by one offender, 63 (2.3%) were abused by two offenders and 46 (1.7%) victims were abused by more than two offenders. No differences in gender were revealed.

Table 5.1

Summary of the characteristics of child sexual abuse victims

	Females (n = 2201)	Males (n = 558)
Mean age at initial sexual abuse	10.43 years	9.41 years
Mean age at follow-up	36.65 years	31.59 years
Victim of penetrative abuse	1,429 (64.9%)	308 (55.2%)
Intrafamilial Sexual Abuse	606 (51.5%)	129 (36.3%)
Extrafamilial Sexual Abuse	570 (48.5%)	227 (63.8%)

Note: As specified in the text, differences between females and males were significant for all of the above characteristics.

5.1.2 Characteristics of the comparison cohort

The comparison cohort consists of 2,677 individuals; 2,055, 76.8% females and 622, 23.2% males.

5.2 Section Two

Section two comprises the in-depth account of the CSA cohorts contact with the Victorian Police and how their association compares to the general population. Included are the mediating factors: age at time of abuse and at follow-up, the severity of abuse, the frequency of abuse and the number of perpetrators. It also examines the effects of early versus late abuse (pre or post pubertal). What forms of victimisation were recorded as most frequent and how this played out between genders.

5.2.1 Contact with the Victorian police (LEAP database)

A total of 3,070 (56.5%) individuals from the CSA and the comparison cohorts were registered on the LEAP database, indicating they had some form of contact with the Victorian Police either as a victim, an offender, or both. Of these 3,070 individuals, 1,671 (60.1%) were from the CSA cohort while the remaining 1,399 (52.3%) were from the control cohort. The data reveal the CSA victims are 1.4 times more likely than the general population to have had any contact with the Victorian Police (OR = 1.40, 95% CI, 1.26-1.56; $t = 6.193$; $p = 0.000$). There is a significant difference between the number of people in the CSA and comparison cohorts having contact with the Victorian police; the significance remained true when examining by gender. There were 1,253 (56.9%) females (OR = 1.39, 95% CI, 1.23 - 1.57; $p = 0.000$) and 418 (74.9%) males (OR = 1.69, 95% CI, 1.32 - 2.18; $p = 0.000$) from the CSA cohort who had formal contact with the police, compared to 1,002 (48.8%) females and 397 (63.8%) males in the control group.

Table 5.2

Comparison of contact with the police between child sexual abuse victims and control populations

Registration on LEAP	Contact with LEAP			
	CSA (n = 2759)		Control (n = 2677)	
	n	%	n	%
Total Victimisations Recorded				
on LEAP	1000	36.2	892	33.4
Victim Only	348	12.6	735	27.5
Offender Only	652	23.6	157	5.9
Combined Victim + Offender	450	16.3	109	4.1

Of the 3,070 individuals registered on LEAP, 809 (26.4%) were registered as offenders and 1,892 (61.6%) were registered as victims. To break this down even further, from the offender population of 809, 652 (23.6%; $M = 0.59$, $SD = 0.24$) were from the CSA cohort and the remaining 157 (5.9%; $M = 0.24$, $SD = 0.42$) derived from the comparison cohort. A significant difference was seen between the CSA cohort and the general population in the number of offenders who had been reported to the police ($p = 0.000$). Of the 1,892 (61.6%) individuals who were reported on LEAP, 1,000 (36.2%; $M = 0.36$, $SD = 0.48$) were from the CSA cohort and 892 (33.3%; $M = 0.33$, $SD = 0.47$) from the comparison cohort. A significant difference was reported between the number of individuals from the CSA cohort who had had contact with LEAP when compared to the general population ($p = 0.025$).

Almost one out of five, 559 (18.21%) individuals registered on LEAP fall into both the offender and the victim category: 450 (16.3%) cases from the CSA cohort compared to 109 (4.1%) from the comparison cohort. Violence and theft were two categories which recorded

the highest number of cases for the individuals who fell into both the offender and the victim category.

Victims within the CSA cohort had a significantly higher contact rate with the police (499, 18.1%) compared with the comparison cohort (146, 5.5%) when examining contact not leading to charges. These contacts included intervention orders and family incidents. Overall, 473 (17.1%) CSA victims took out an intervention order (IVO) against another person compared to 131 (4.9%) individuals from the comparison cohort. When examining the overall figures there is appears to be a significant difference between the total number of IVO's recorded for the CSA victim versus the general population, but on closer inspection there was one outlying number (21) in the range of total number of IVO's taken out by people in the comparison cohort (range 1 - 21 IVO's, $M = 2.41$, $SD = 2.23$ v range 1 - 17 IVO's, $M = 2.84$, $SD = 2.39$; $t = 1.891$, $p = 0.059$); therefore, a significant difference was not recorded.

Total family disputes where the victim was the aggrieved family member resulted in another significant difference. A total of 401 (14.5%) incidences for the CSA victims and 140 (5.2%) for the comparison cohort (range 1 - 27, $M = 3.15$, $SD = 3.57$ v range 1 - 20, $M = 2.13$, $SD = 2.62$; $t = 3.109$, $p = 0.002$) were recorded. Within the recorded family disputes, it was broken down to reveal intimate relationships (401 (14.5%), $M = 2.27$, $SD = 3.30$ v 140 (5.2%), $M = 1.34$, $SD = 1.85$; $t = 3.182$, $p = 0.002$), other family incidents (393 (14.2%), $M = 0.65$, $SD = 1.15$ v 140 (5.2%), $M = 0.55$, $SD = 1.33$; $t = 0.814$, $p = 0.416$), other persons (393 (14.2%), $M = 0.12$, $SD = 0.42$ v 140 (5.2%), $M = 0.09$, $SD = 0.49$; $t = 0.560$, $p = 0.576$) and finally unknown relationships (393 (14.2%), $M = 0.14$, $SD = 0.38$ v 140 (5.2%), $M = 0.15$, $SD = 0.45$; $t = 0.192$, $p = 0.848$).

5.2.2 Association between child sexual abuse and revictimisation (including control comparisons)

Overall, 1,893 (34.82%) (1,391, 73.5% female; 502, 26.5% male) individuals were identified on the LEAP database as having been victimised subsequent to the initial sexual abuse they experienced as a child; resulting in 1,000 (36.2%) individuals (745, 33.8% female; 255, 45.7% male) derived from the CSA cohort who were revictimised. The comparison cohort had 893 (33.4%) (646, 31.4% female; 247, 39.7% male) individuals recorded as being victimised. The number of individual revictimisation events reported by the CSA cohort to the Victorian Police range from 1 (38.2%) to 19 (0.2%) and 1 (55.8%) to 16 (0.2%) for the control. The mean number of victimisation incidents reported for the CSA cohort was significantly higher than the comparison group ($M = 2.94$, $SD = 2.63$ v $M = 1.93$, $SD = 1.63$; $t = 9.88$, $p = 0.000$); however, even though the CSA cohort reported up to 9 separate sexual revictimisation incidents compared to 6 for the comparison cohort, no significant difference in the range of separate sexual revictimisation incidents was produced ($M = 1.62$, $SD = 1.21$ v $M = 1.45$, $SD = 1.13$; $t = 0.846$, $p = 0.399$). On examination of the average ages when reporting the first revictimisation, there was a significant difference between the victims of CSA and the general population (range 2.93 years - 55.26 years, $M = 22.73$ years, $SD = 9.32$ v range 2.57 years - 54.46 years $M = 27.65$ years $SD = 9.89$; $t = 11.061$, $p = 0.000$), although there was no significant difference between the ages of the CSA victims and the controls when reporting the first sexual revictimisation (range 3.33 years - 49.69 years, $M = 16.79$ years, $SD = 9.06$ v range 2.80 years - 42.64 years, $M = 18.34$ years, $SD = 11.04$; $t = 0.944$, $p = 0.346$).

Table 5.3*Comparison of types of victimisation between child sexual abuse and control populations*

Victimisation Type	Control (n=2677)		CSA (n=2759)		OR	95% CI	p
	n	%	n	%			
Total Recorded on LEAP	892	33.4	1000	36.2	1.14	1.02-1.27	0.025
Sexual Assault	42	1.6	215	7.8	5.3	3.79-7.41	0
Violence	154	5.8	389	14.1	2.69	2.21-3.27	0
Kidnapping	0	0	8	0.3	-	-	-
Threat of Violence	15	0.6	64	2.3	4.21	2.41-7.41	0
Property Damage	175	6.5	258	9.4	1.48	1.21-1.80	0
Weapons Offence	0	0	10	0.4	-	-	-
Stalking	16	0.6	34	1.2	2.08	1.14-3.77	0.014
Deception	15	0.6	25	0.9	1.62	0.85-3.09	0.136
Theft	740	27.6	691	25	0.88	0.78-0.99	0.03
Bad Public Behaviour	4	0.1	1	0	0.24	0.23-2.17	0.212*

* Fisher's exact test

Table 5.3 presents the comparisons of the different victimisation types between the CSA and comparison cohorts. The victims of CSA (n=1,000; 36.2%) were 1.14 times more likely than the general population (n=893; 33.4%) to experience some form of victimisation (p = 0.000). It is 5.3 times more likely for the victims of the CSA cohort to re-experience some form of sexual revictimisation than the general population is to experience a sexual victimisation (95% CI, 3.79 - 7.41, p = 0.000). Overall, with the exception of theft and bad public behaviour, the victims of CSA were significantly more likely than the general population to be revictimised.

Table 5.4

Comparison of various types of revictimisation between child sexual abuse and comparison subjects by gender

Victimisation Type	Males						Females						Abused males vs. females p
	Control (n=622)		Cases (n=558)				Control (n=2055)		Cases (n=2201)				
	N	%	n	%	OR	95%CI	n	%	n	%	OR	95%CI	
Sexual Assault	5	0.8	30	5.4	7.01*	2.70-18.21	37	1.8	185	8.4	5.01*	3.51-7.16	0.017
Violence	67	10.8	108	19.4	1.99*	1.43-2.76	87	4.2	281	12.8	3.31*	2.58-4.25	0
Kidnapping	0	0	2	0.4	-	-	0	0	6	0.3	-	-	0.667 ⁺
Threat of Violence	4	0.6	9	1.6	2.53	0.78-8.27	11	0.5	55	2.5	4.76*	2.49-9.12	0.214
Property Damage	44	7.1	44	7.9	1.13	0.73-1.74	131	6.4	214	9.7	1.58*	1.26-1.98	0.183
Weapons Offence	0	0	3	0.5	-	-	0	0	7	0.3	-	-	0.433 ⁺
Stalking	0	0	6	1.1	-	-	16	0.8	28	1.3	1.64	0.89-3.04	0.707
Deception	3	0.5	7	1.3	2.62	0.68-10.19	12	0.6	18	0.8	1.4	0.68-2.92	0.331
Theft	205	33	194	34.8	1.08	0.85-1.38	535	26	497	22.6	0.83***	0.72-0.95	0
Bad Public Behaviour	1	0.2	0	0	-	-	3	0.1	1	0	0.31	0.03-2.99	0.615

* p=0.000

** p<0.001

*** p<0.01

+ Fisher's Exact test

With the victimisation data divided by gender, as seen in Table 5.4, the significant difference between the control and the CSA cohorts for contact on LEAP as a victim only remained significant for the males (OR 1.28, 95% CI, 1.01 - 1.61, $p = 0.38$) but not for the females (OR 1.12, 95% CI, 0.98 - 1.27, $p = 0.94$). The males from the CSA cohort were significantly more likely than the males from the comparison cohort to have been identified as being a victim of sexual assault (OR = 7.01, 95% CI 2.7 - 18.21, $p = 0.000$) and violence (OR = 1.99, 95% CI 1.43 - 2.76, $p = 0.000$). The females from the CSA cohort were also significantly more likely than their counterparts in the comparison cohort to have been victims of sexual offences (OR = 5.01, 95% CI 3.51 - 7.16, $p = 0.000$) and violence (OR = 3.31, 95% CI 2.58 - 4.25, $p = 0.000$). But unlike the males, the females from the CSA cohort were 4.76 times more likely to report victimisation in the form of threats of violence (95% CI 2.49 - 9.12, $p = 0.000$), property damage (OR = 1.58, 95% CI 1.26 - 1.98, $p = 0.000$) and theft (OR = 0.83, 95% CI 0.72 - 0.95, $p = 0.009$).

Within the CSA cohort, females were significantly more likely than males to have been revictimised ($p = 0.000$); however, when the male CSA victims were compared to males from the general population they were more likely to be sexually revictimised. Overall the female CSA population was significantly more likely to be sexually revictimised ($M = 0.05$, $SD = 0.23$ v $M = 0.08$, $SD = 0.28$; $t = 2.39$, $p = 0.017$). Upon examination of violent revictimisation, female CSA victims were more likely than females from the general population to be involved in a violent revictimisation and the male CSA victims were significantly more likely than the CSA female population to be violently revictimised ($M = 0.19$, $SD = 0.41$ v $M = 0.13$, $SD = 0.33$; $t = 4.004$, $p = 0.000$). The CSA males were also significantly more likely to be a victim of theft than the CSA female cohort ($M = 0.35$, $SD = 0.48$ v $M = 0.23$, $SD = 0.42$; $t = 5.97$, $p = 0.000$). No significant differences between the male

and females from the CSA cohort were revealed in the remaining types of victimisation.

5.2.3 Examining early versus late abuse

The data were examined for the effects of age on revictimisation. Based on previous research with this sample, differences were found in outcomes for children abused prior to the age of 12 years and those abused from the age of 12 years onward (Anderson et al., 1993; Fergusson & Mullen, 1999; Finkelhor, 1984; Finkelhor & Baron, 1986; Finkelhor et al., 1990; Fleming, 1997). Using the same age ranges here, subjects were divided into two groups, pre-pubertal (<12 yrs.) and post-pubertal (>12 yrs.). From the CSA cohort (n = 2,759), there were 1,557 (56.43%) pre-pubertal victims and 1,202 (43.57%) post-pubertal victims. The pre-pubertal victims had significantly more contact with the Victorian Police (618, 39.7%) compared to 382 (31.8%) post-pubertal victims (OR = 1.41, 95% CI 1.2 - 1.67; t = 4.299, p = 0.000). The pre-pubertal victims from the CSA cohort were also significantly more likely than the post-pubertal group to be revictimised in the form of sexual assault (OR = 2.22, 95% CI 1.61 - 3.03; p = 0.000) and violence (OR = 1.35, 95% CI 1.09 - 1.69; p = 0.007). Becoming a victim of stalking and/or theft were also more likely to occur to the younger population (OR = 1.25, 95% CI 0.41 - 1.6 and OR = 1.03, CI 0.82 - 1.15). Being revictimised in the form of deception proved to have the strongest relationship to the post-puberty age group, being 2.32 times more likely to occur than within the pre-pubertal group (OR = 2.32, 95% CI 1.02 - 5.27). Although the overall numbers for the category of kidnapping were small, the chances of being a victim of kidnapping were 9.12 times more likely when the victim was abused after the age of 12 years.

Table 5.5

Comparison of various types of victimisation of the child sexual abuse victims by early versus late abuse.

Victimisation Type	CSA < 12 yr		CSA > 12 yr		OR	95% CI	p
	(n=1557)		(n=1202)				
	n	%	N	%			
Vic Police Contact	618	39.7	382	31.8	1.41	1.20-1.67	0
Sexual Assault	157	10.1	58	4.8	2.22	1.61-3.03	0
Violence	244	15.7	145	12.1	1.35	1.09-1.69	0.007
Kidnapping	1	0.1	7	0.6	9.12	1.12-74.18	0.025*
Threat of Violence	35	2.2	29	2.4	1.08	0.65-1.77	0.776
Property Damage	134	8.6	124	10.3	1.22	0.95-1.58	0.126
Weapons Offence	5	0.3	5	0.4	1.31	0.36-4.49	0.681
Stalking	21	1.3	13	1.1	1.25	0.41-1.60	0.528
Deception	9	0.6	16	1.3	2.32	1.02-5.27	0.038
Theft	394	25.3	297	24.7	1.03	0.82-1.15	0.72
Bad Public Behaviour	0	0	1	0.1	-	-	0.436*

* Fisher's exact test

Upon examination of gender in the pre-pubertal and post-pubertal groups, the males who were sexually abused after the age of 12 years were 1.45 times more likely to have had contact with the Victorian Police than their younger counterparts (OR = 1.45, 95% CI 1.02 - 2.07; p = 0.39). Whereas, the females were 1.61 times more likely to have had contact with the Victorian Police if they were sexually abused before the age of 12 years (OR = 1.61, 95% CI 1.35 - 1.92; p = 0.000). The males were more likely to be revictimised in all victimisation types, except for stalking, if they were sexually abused for the first time when they were older than 12 years. The females, however, were 2.78 times more likely to be revictimised sexually (95% CI 2.0 - 4.0; p = 0.000) if they were initially abused before the age of 12 years.

This same group were 1.49 times more likely to experience violent revictimisation (95% CI = 1.15 - 1.92; $p = 0.002$), 1.03 times more likely to experience threats of violence (95% CI 0.57 - 1.66), 1.15 times more likely to be stalked (95% CI 0.41 - 1.85) and 1.23 times more likely to experience theft (95% CI 1.03 - 1.45) than the female CSA victims who were abused after the age of 12 years. The male victims were 1.37 times more likely to experience sexual revictimisation if the initial act of abuse occurred above the age of 12 years; however, no significant difference was illustrated ($p = 0.413$) between the male pre-pubertal and post-pubertal sexual revictimisation.

Table 5.6

Comparison of various types of victimisation in male and female child sexual abuse victims by early versus late abuse.

Victimisation Type	Males (n=558)						Females (n=2201)					
	CSA <12 yr (n=373)		CSA >12 yr (n=185)				CSA <12 yr (n=1184)		CSA >12 yr (n=1017)			
	n	%	N	%	OR	95%CI	n	%	n	%	OR	95%CI
Vic Police Contact	159	42.6	96	51.9	1.45****	1.02-2.07	459	38.8	286	28.1	1.61*	1.35-1.92
Sexual Assault	18	4.8	12	6.5	1.37	0.64-2.9	139	11.7	46	4.5	2.78*	2.0-4.0
Violence	69	18.5	39	21.1	1.18	0.76-1.83	175	14.8	106	10.4	1.49***	1.45-1.92
Kidnapping	0	0	2	1.1	-	-	1	0.1	5	0.5	5.85	0.68-50.11
Threat of Violence	5	1.3	4	2.2	1.63	0.43-6.13	30	2.5	25	2.5	1.03	0.57-1.66
Property Damage	25	6.7	19	10.3	1.59	0.85-2.98	109	9.2	105	10.3	1.14	0.86-1.51
Weapons Offence	2	0.5	1	0.5	1.01	0.09-11.19	3	0.3	4	0.4	1.55	0.35-6.96
Stalking	5	1.3	1	0.5	2.5	0.05-3.45	16	1.4	12	1.2	1.15	0.41-1.85
Deception	2	0.5	5	2.7	5.15***	0.99-26.82	7	0.6	11	1.1	1.84	0.71-4.76
Theft	110	29.5	84	45.4	1.99*	1.38-2.87	284	24	213	20.9	1.23	1.03-1.45
Bad Public Behaviour	0	0	0	0	-	-	0	0	1	0.1	-	-

* p=0.000

** p<0.001

*** p<0.01

**** p<0.05

There was no significant difference ($p = 0.532$) between the pre-pubertal and post-pubertal CSA victims when examining the severity of abuse (penetration or no penetration) or duration of abuse (once versus multiple times); however, when looking at the number of offenders present at the time of the abuse there was a significant difference. For the victims younger than 12 years, they were 3.92 times more likely to be sexually revictimised by one offender versus multiple offenders (95% CI 2.46 - 6.25; $t = 6.774$; $p = 0.000$) and it was a similar situation for the victims older than 12 years, they were 3.07 times (95% CI 1.33 - 7.09; $p = 0.006$) more likely to experience sexual revictimisation by one offender.

5.2.4 Risk of revictimisation based on the timing and severity (penetrative/non-penetrative) of the sexual abuse

The victims who had initially experienced penetrative forms of sexual abuse were significantly younger at the time of their first revictimisation (Age range 2.93 years to 55.26 years; $M = 24.11$ years; $SD = 9.79$; $t = 5.84$; $p = 0.000$) compared to the individuals who had experienced an initial non-penetrative form of abuse (age range 3.61 - 50.24; $M = 20.64$, $SD = 8.13$); however, no significant difference was observed between the penetrative and non-penetrative groups when examining the age of the first sexual revictimisation ($M = 17.48$, $SD = 9.30$ vs. $M = 15.93$, $SD = 8.74$; $p = 0.487$).

The relationship between the severity of the abuse (penetrative/non-penetrative) and the age of first revictimisation and the age of first sexual revictimisation was investigated by using the Pearson product moment correlation coefficient. A small but significant correlation ($r = 0.182$, $n = 1,000$, $p < 0.000$) was found between the severity of abuse associated with age at first revictimisation. However no significant relationship was found between the severity of

abuse and the age of first sexual revictimisation ($r = 0.086$, $n = 201$, $p = .226$). Significant correlations were found for both the association between the age of initial CSA and the age of the first revictimisation ($r = 0.593$, $n = 1000$, $p = 0.0000$) and first sexual revictimisation ($r = 0.598$, $n = 201$, $p = 0.000$).

Table 5.7 illustrates the relationship between the level of severity of abuse (penetration and non-penetration) and the rate of revictimisation within the male and female CSA victims.

Upon examination there were no significant differences present between either the female or the males when analysing the level of severity and the rate of revictimisation.

Table 5.7

The relationship between the level of severity of abuse and the rate of revictimisation within the child sexual abuse cohort.

	Revictimisation		Sexual Revictimisation		Violence Revictimisation	
	n	%	n	%	n	%
Females						
Penetration (n=1429)	464	32.5	102	7.1	180	12.6
No Penetration (n=772)	281	36.5	83	10.8	101	13.1
Males						
Penetration (n=308)	142	46.1	14	4.5	55	17.9
No Penetration (n=250)	113	45.2	16	6.4	53	21.2

5.3 Section Three

Section three is comprised of the in-depth analyses of the CSA cohorts' contact with the Victorian public mental health services (RAPID and VPCR) and how their association compares to the general population. Included are the mediating factors: Age at time of first contact with the mental health system, diagnosis, substance misuse and suicide and self-harm rates. It also examines the effects of early versus late abuse (pre-pubertal or post-pubertal) on mental health and the characteristics of childhood sexual abuse associated with psychiatric disorder.

5.3.1 Relationships between child sexual abuse and psychiatric disorders

The total number of individuals in the CSA sample who had been registered with the public mental health system was 904 (32.8%), (684, 31.1% females; 220, 39.4% males). Of those 904 registered, 71 individuals (49 females and 22 males) from the CSA cohort had initial psychiatric contact prior to their reported initial sexual assault; therefore, those 71 individuals were removed for the following statistics.

A lifetime record of contact with the public mental health system was found in 627 cases (23.3%, 485, 18% females; 142, 5.3% males) from the CSA cohort compared to 206 (7.7%, 151 females and 55, males) from the comparison cohort (OR = 3.65, 95% CI, 3.09 - 4.32; $p < 0.001$). These figures reveal that a CSA victim was 3.65 times more likely to have had contact with the public mental health system than the general public. This figure remained consistent for female victims (OR = 3.67, 95% CI, 3.02 - 4.45) and male victims (OR = 3.73, 95% CI, 2.66 - 5.22; $p < 0.001$). The CSA victims were significantly younger (range <1year -

50 years, $M = 18.87$ years, $SD = 10.84$; $t = 5.911$, $p = 0.000$) when they first presented to the public mental health system when compared to the general population (range 13.98 years - 47.85 years, $M = 29.89$ years, $SD = 9.39$).

People in the CSA group who were diagnosed with an Axis I clinical or Axis II personality disorder were significantly older when abused than the CSA victims who did not have contact with the public mental health system, ($M = 10.83$ years, $SD = 4.27$ vs. $M = 9.97$ years, $SD = 4.49$; $t = 4.28$; $p < 0.001$); ($M = 10.79$ years, $SD = 4.33$ vs. $M = 10.03$ years, $SD = 4.47$; $t = 3.47$; $p < 0.001$); ($M = 11.81$ years, $SD = 4.15$ vs. $M = 10.11$ years, $SD = 4.46$; $t = 3.69$; $p < 0.001$) respectively.

Victims of CSA which included penetration were 1.28 times more likely to have contact with the public mental health system than the victims of non-penetrative sexual abuse ($OR = 1.28$, 95% CI, 1.06 – 1.55; $p = 0.01$). These same individuals were also 1.98 times more likely to be diagnosed with psychosis ($OR = 1.98$, 95% CI, 1.16-3.37; $p = 0.01$) and 2.02 times more likely to experience some form of alcohol abuse ($OR = 2.02$, 95% CI, 1.17 - 3.50; $p = 0.01$).

Table 5.8 reveals the associations between CSA and Axis I clinical disorders compared to the comparison group and Table 5.9 reveals these associations by gender. More than two thirds (682, 81.8%) of the individuals registered on RAPID were given an Axis I clinical diagnosis comprising of 495 (18.4%) individuals from the CSA cohort and 187 (7.0%) from the comparison cohort. From the CSA cohort, 78 individuals (2.8%) (57, 2.6% females; 21, 3.7% males) were given a diagnosis of psychosis (encompassing schizophrenia, schizoaffective, affective disorder with psychotic features and delusional disorder) and from the comparison cohort there were 37 individuals (1.4%) (27, 1.3% females; 10, 1.6% males). The likelihood

of experiencing some form of psychosis is 2.1 times more likely for the individuals who were abused as a child (OR = 2.1, 95% CI 1.41 - 3.08; $p < .001$).

Table 5.8

Comparison between the rates of mental health contact and diagnoses in the control and the child sexual abuse subjects.

Diagnostic Group	Control (n = 2677)		CSA (n = 2688)		OR	95% CI	p
	n	%	n	%			
Mental Health							
Contact	206	7.7	627	23.3	3.65	3.09-4.32	<0.001
Axis I Clinical							
Disorder	187	7	495	18.4	3.01	2.52-3.59	<0.001
Psychotic Disorder	37	1.4	78	2.9	2.13	1.44-3.17	<0.001
Posttraumatic Stress							
Disorder (PTSD)	20	0.7	108	4	5.56	3.44-8.99	<0.001
Affective Disorder	86	3.2	173	6.4	2.07	1.59-2.70	<0.001
Eating Disorder	6	0.2	7	0.3	1.16	0.39-3.46	0.79
Organic Disorder	0	0	9	0.3	-	-	-
Anxiety Disorders							
(other)	60	2.2	155	5.8	2.67	1.97-3.61	<0.001
Alcohol Abuse	13	0.5	75	2.8	5.88	3.26-10.63	<0.001
Drug Abuse	20	0.7	115	4.3	5.94	3.68-9.58	<0.001
Pedophilia	0	0	3	0.1	-	-	-
Other Disorders	17	0.6	60	2.2	3.57	2.08-6.14	<0.001

With the sole exception of eating disorders, the rate of Axis I clinical disorders was significantly higher in all cases for the CSA group than for the control group. As can be seen from the table, the most marked elevation came from the cases of posttraumatic stress disorder (PTSD) and known drug and alcohol use.

Table 5.9

Comparison between the rates of various diagnostic disorders for the control and the child sexual abuse subjects by gender.

Diagnostic Group	Males						Females					
	Control (n = 622)		CSA (n = 535)				Control (n = 2055)		CSA (n = 2153)			
	N	%	N	%	OR	95%CI	N	%	n	%	OR	95%CI
Mental Health Contact	55	8.8	142	26.5	3.73***	2.66-5.22	151	7.3	485	22.5	3.67***	3.02-4.45
Axis I Clinical Disorder	54	8.7	108	20.2	2.66***	1.88-3.78	133	6.5	387	18	3.17***	2.57-3.90
Psychotic Disorder	10	1.6	21	3.9	2.50*	1.17-5.36	27	1.3	57	2.6	2.04**	1.29-3.24
Posttraumatic Stress Disorder (PTSD)	7	1.1	13	2.4	2.19	0.87-5.53	13	0.6	95	4.4	7.25***	4.05-12.99
Affective Disorder	23	3.7	19	3.6	0.96	0.52-1.78	63	3.1	154	7.2	2.44***	1.81-3.29
Eating Disorder	0	0	0	0	-	-	6	0.3	7	0.3	1.11	0.37-3.32
Organic Disorder	0	0	1	0.2	-	-	0	0	8	0.4	-	-
Anxiety Disorders (other)	12	1.9	29	5.4	2.91***	1.47-5.77	48	2.3	126	5.9	2.60***	1.85-3.65
Alcohol Abuse	7	1.1	20	3.7	3.41**	1.43-8.13	6	0.3	55	2.6	8.96***	3.85-20.84
Drug Abuse	10	1.6	26	4.9	3.13***	1.49-6.54	10	0.5	89	4.1	8.82***	4.58-17.00
Pedophilia	0	0	3	0.6	-	-	0	0	0	0	-	-
Other Disorders	7	1.1	24	4.5	4.13***	1.76-9.66	10	0.5	36	1.7	3.48***	1.72-7.03

* p<0.05

** p<0.01

*** p<0.001

Table 5.9 examines the associations between CSA and Axis I clinical disorders compared to the comparison group by gender. These figures reveal that for the female CSA population all the disorders, except the eating disorder, were significantly higher than the female comparison group. However, no significant differences emerged for affective disorders and PTSD when examining the male group.

Table 5.10

Comparison between the rates of the Axis II diagnostic groups in the control and the child sexual abuse victims

Diagnostic Group	Control (n = 2677)		CSA (n = 2688)		OR	95% CI	p
	n	%	n	%			
Mental Health Contact	206	7.7	627	23.3	3.65	3.09-4.32	<0.001
Axis II Personality Disorder							
Disorder	18	0.7	96	3.6	5.47	3.30-9.08	<0.001
Non-cluster B PD	7	0.3	31	1.2	4.45	1.96-10.13	<0.001
Cluster B PD	12	0.4	65	2.4	5.51	2.97-10.22	<0.001
Antisocial PD	4	0.1	17	0.6	4.26	1.43-12.66	<0.007*
Borderline PD	8	0.3	48	1.8	6.07	2.87-12.85	<0.001
Non-psychiatric complaint	18	0.7	92	3.4	5.24	3.15-8.70	<0.001

* Fisher's exact test

Table 5.10 shows the associations between CSA and Axis II personality disorders compared to the comparison cohort and Table 5.11 shows these associations by gender. A diagnosis of an Axis II personality disorder was recorded for 114 individuals registered with the public mental health system. There were 96 (3.6%) from the CSA cohort and 18 (0.7%) from the comparison cohort. The individuals who were sexually abused as a child were 5.47 times

more likely to develop a personality disorder than an individual with no history of CSA (OR = 5.47, 95% CI, 3.30 - 9.08; $p < 0.001$).

Table 5.11

Comparison between the rates of various diagnostic disorders for the control and the child sexual abuse subjects by gender.

Diagnostic Group	Males						Females					
	Control (n = 622)		CSA (n = 535)				Control (n = 2055)		CSA (n = 2153)			
	n	%	N	%	OR	95% CI	n	%	n	%	OR	95% CI
Mental Health Contact	55	8.3	142	26.5	3.73***	2.66-5.22	151	7.3	485	22.5	3.67***	3.02-4.45
Axis II Personality Disorder	8	1.3	16	3	2.37*	1.00-5.57	10	0.5	80	3.7	7.89***	4.43-15.55
Non-cluster B PD	2	0.3	4	0.7	2.34	0.43-12.80	5	0.2	27	1.3	5.21***+	2.00-13.55
Cluster B PD	6	1.9	13	2.4	2.56*	0.97-6.77	6	0.3	52	2.4	8.45***	3.62-19.72
Antisocial PD	4	0.6	13	2.4	3.84***+	1.25-11.87	0	0	4	0.2	-	-
Borderline PD	2	0.3	1	0.2	0.58	0.52-6.42	6	0.3	47	2.2	7.62***	3.25-17.86
Non-psychiatric complaint	1	0.2	14	2.6	16.69***+	2.19-127.32	17	0.8	78	3.6	4.51***	2.66-7.65

* p<0.05

** p<0.001

*** p<0.001

+ Fisher's exact test

The Axis II personality disorders along with the non-psychiatric complaints were all significantly higher for the CSA group than for the comparison group. But on examination of gender in Table 5.11, it reveals that the male population no longer remained significantly higher than the comparison group in the non-cluster B personality disorder and the borderline personality disorder.

When compared to being abused by a single offender, victims of sexual abuse by more than one offender were significantly more likely to subsequently have had contact with the public mental health system and to attract diagnoses. They were 1.81 times more likely to have some form of contact with the mental health system (95% CI, 1.19-2.75; $p=0.005$) and 4.72 times more likely to be diagnosed with psychosis (95% CI, 2.36-9.45; $p < 0.001$). A diagnosis of psychosis was also significantly more likely to occur when the victim-perpetrator relationship was extrafamilial (OR = 1.88, 95% CI, 0.98 - 3.61; $p = 0.05$). They were 2.05 times more likely to have an Axis I clinical disorder (95% CI, 1.33 - 3.17; $p = 0.001$) and 2.40 times more likely to have an Axis II personality disorder (95% CI, 1.12-5.17; $p = 0.021$), including personality disorders other than those categorised in cluster B (OR = 4.99, 95% CI, 1.61 - 15.44; $p = 0.002$). Alcohol abuse was also higher within this population (OR = 3.45, 95% CI, 1.64-7.25; $p = 0.001$) as were anxiety disorders (OR = 1.92, 95% CI, 1.02-3.61; $p = 0.04$).

5.4 Alcohol, Drug and Substance Misuse

A significantly higher proportion of CSA victims ($n=75$, 2.8%) than controls ($n=13$, 0.5%) were registered on the public mental health system as having alcohol misuse (OR = 5.88, 95% CI, 3.26 - 10.63; $p < 0.001$) and drug misuse ($n = 115$, 4.3% of CSA versus $n = 20$,

0.7% of comparison cases, OR = 5.94, 95% CI, 3.68 - 9.58; $p < 0.001$). Of the individuals in the comparison cohort who were registered, 31 (3.4%) had a known substance abuse problem versus 154 (17%) individuals from the CSA cohort ($p < 0.05$). A significant difference was seen in all cases between the CSA and comparison cohorts within alcohol, drugs and substance usage.

5.5 Rates of Suicide/ Self Harm

Within the CSA cohort, 21 (0.8%) people were reported to have died from unnatural causes between 1991 and 2008; of whom 8 (0.29%) were concluded as suicide and 13 (0.47%) were from fatal self-harm/overdose. There were no statistical differences seen between the rates of suicide for male and females. The mean age of suicide in the CSA cohort was 31.12 years (SD = 11.69) and for fatal harm/overdose it was 31.38 years (SD = 9.7). Compared to the control group, the mean age at the time of the suicide was 37.0 years (SD = 12) and for fatal self-harm/overdose was 33.4 years (SD = 9.8).

Overall the risk for suicide within the CSA cohort was 18.09 times greater than the general population (95% CI, 10.96 - 29.85; $p < 0.001$) and for fatal self harm/overdose, the risk was 49.22 times greater within the CSA cohort (95% CI, 36.11 - 67.09; $p < 0.001$).

5.6 Section Four

Section four examines the relationship between the victims of CSA and a diagnosis of mental illness and how this influences the vulnerability for revictimisation. For the purpose of this analysis, an individual is regarded as having a mental illness if they have been registered on

either the RAPID database or the VPCR database and were recorded as having received any relevant mental health diagnosis.

Table 5.12

Percentage of people with victimisation by condition and presence or absence of mental health contact

	Category of Victimisation						
	Victim on LEAP	Sexual Assault	Violence	Threat of Violence	Property Damage	Stalking	Theft
CSA + Mental Illness (n=698)	364 (52.1%)*	104 (14.9%)*	182 (26.1%)*	31 (4.4%)*	107 (15.3%)*	16 (2.3%)*	249 (35.7%)*
CSA + No Mental Illness (n=2061)	636 (30.9%)*	111 (5.4%)*	207 (10.0%)*	33 (1.6%)*	151 (7.3%)*	18 (0.9%)*	442 (21.4%)*
Control + Mental Illness (n=206)	89 (43.2%)*	11 (5.3%)*	34 (16.5%)*	5 (2.4%)*	20 (9.7%)*	2 (1.0%)*	65 (31.6%)*
Control + No Mental Illness (n=2471)	804 (32.5%)*	31 (1.3%)*	120 (4.9%)*	10 (0.4%)*	155 (6.3%)*	14 (0.6%)*	675 (27.3%)*

* p=0.000

** p<0.001

*** p<0.01

**** p<0.05

Table 5.12 illustrates the relationship between CSA, mental illness and victimisation. A significant difference was present between the victims of CSA with a mental illness who had been revictimised (n=364, 52.1%) and the CSA victims with no history of mental illness who had also experienced revictimisation (n=636, 30.9%; p = 0.000). A significant difference is also present between the proportion of individuals within the comparison cohort with mental illness who have been victimised (n=89, 43.2%) and the proportion of individuals with no history of a mental illness who have been victimised (n=804, 32.5%; p = 0.000). The victims

of CSA with a mental illness were three times more likely to experience sexual revictimisation (n =104, 14.9%) than the general population with a history of mental health contact (n=11; 5.3%; $p = 0.000$).

CHAPTER SIX

DISCUSSION

6.1 Overview of the Discussion Section

The primary aim of the current thesis was to examine the relationship between CSA and revictimisation. This study is part of a larger program of research which used the same data sample to examine the relationship between CSA and schizophrenia, other psychotic disorders, suicide, fatal self-harm and offending (Cutajar et al., 2010a, 2010b, 2010c; Ogloff, Cutajar, Mann, & Mullen, 2012). The majority of the CSA literature suggests that there is a relatively strong association between CSA and revictimisation (Arata, 2002; Breitenbecher, 2001; Classen et al., 2005; Coid et al., 2001; Cutajar et al., 2010c; Fergusson et al., 1997; Fromuth, 1986; Gidycz et al., 1993; Macy, 2008; Messman-Moore & Long, 2002; Ogloff et al., 2012; Rich et al., 2004; Roodman & Clum, 2001; Urquiza & Goodlin-Jones, 1994; Widom et al., 2008). Although many of these studies have used a retrospective design, this study differs in its utilisation of a prospective design with a follow-up period of 44 years. Regardless of the research design, the question being asked remains the same: Does childhood sexual abuse lead to or contribute to an increased vulnerability of revictimisation? The findings of this study reveal that CSA does contribute to an increase in the risk of revictimisation when compared to the general population. These findings are discussed below as they relate to each research aim.

6.1.1 Aim One: Nature, frequency and outcomes of revictimisation, including any gender differences

Aim one sought to examine the nature, frequency and outcomes of revictimisation which occurred subsequent to the initial CSA experience. In this study, 10 different categories of victimisation were examined. The victims of CSA were more likely than the general population to be revictimised in eight out of the 10 types, with theft and bad public behaviour being the only forms of victimisation where the general population had higher numbers occurring. These results suggest that there is an increased vulnerability in the victims of CSA to being subsequently victimised, which has been supported in the literature (Arata, 2000; Barnes et al., 2009; Casey & Nurius, 2005; Fergusson et al., 1997; Macy, 2008; Merrill et al., 1999; Ogloff et al., 2012; Roodman & Clum, 2001; Siegel & Williams, 2003). Overall, this study illustrated that victims of CSA were slightly more likely (1.14 times) than the general population to be revictimised in some form and much more likely (5.3 times) to experience sexual revictimisation. In general, females were more likely than males to have contact with the police, regardless of which cohort they were in; however, both female and male CSA victims were significantly more likely to experience repeated victimisations than their counterparts from the general population.

Upon examination of the frequency of sexual revictimisation by gender, both the male and female CSA victims were significantly more likely to experience repeated episodes of sexual abuse throughout their lives when compared to the general population. The findings from the current study report that there were up to nine separate episodes of sexual victimisations identified for one individual. This result supports the notion, which has been strongly suggested throughout the literature, that CSA is one of the predominant precursors for future

sexual revictimisation, regardless of gender (Arata, 2002; Desai et al., 2002; Faller, 1991; Roodman & Clum, 2001; Sorenson et al., 1987). Further investigations into the backgrounds of the individuals who experienced repeated sexual abuse throughout their lives would provide an insight and information to assist in the development of intervention strategies to decrease the CSA victim's risk for revictimisation. There was no difference in the age when the CSA victims or the individuals from the general population reported their first sexual revictimisation.

Upon examination of revictimisation in general, there was one case where an individual had made contact with the police on 19 different occasions for subsequent victimisations. This provides another area which would warrant further investigation to understand why individuals with large numbers of victimisation were so vulnerable to revictimisation. The female CSA victims were more likely than the general population to experience subsequent victimisations in the form of violent acts, threats of violence, property damage and theft. Interpretation of these results may suggest that the effects of CSA place the individual on a path of risky and destructive behaviour. From these figures it is evident that the revictimisation cycle needs to be broken.

The CSA victims who were registered on the police database were recorded either to have had contact as a victim or as an offender. Although it is beyond the scope of the current research to extensively examine CSA victims who became offenders, it must be noted that there was a significant difference between the CSA cohort and the general population in the number of offenders who had been registered on the police database (Cutajar et al., 2010a). In a separate group, one in four individuals who were registered with the police fell into both categories of offender and victim. By being registered in both categories, one could assume

that the individual's life may be relatively unstable. This instability may occur within the individual's family or community environments, it may be centered around drug and alcohol abuse or it may be a combination of both. Instability ultimately leads to an increase in vulnerability, which in-turn causes an increase in the risk of having further contact with the police, in either an offender or a victim capacity (Arata, 2000, 2002; Beitchman et al., 1991; Bensley et al., 1999; Corbin et al., 2001; Derman et al., 1998; Fergusson & Lynsky, 1996; Fergusson et al., 1997; Greene & Navarro, 1998; Himelein, 1995; Koss & Dinero, 1989; Messman-Moore et al., 2009).

Intervention orders are a court ordered action made by a Magistrate, under the *Family Violence Protection Act 2008* or the *Personal Safety Intervention Orders Act 2010*, to protect an individual against violence or stalking acts (<http://www.magistratescourt.vic.gov.au/jurisdictions/intervention-orders>). In the current study, the intervention order and other family incidents (e.g., domestic violence) are classified as informal contact with the police. Within the CSA cohort, 28.3 percent of victims reported to have been granted an intervention order against another individual compared to the comparison cohort where only 9.4 percent had reportedly taken out an intervention order. Due to the large number of intervention orders granted to the CSA victims, it can be suggested that experiencing sexual abuse as a child, can lead to a life which is potentially faced with danger and risk surrounded by individuals who could potentially place the victim in a vulnerable position for revictimisation (Messman-Moore & Long, 2004).

The number of family disputes was also significantly higher for the victims of CSA (24.1%) than the comparison group (10.1%). This again leads to the presumption that the risk factors which were present during childhood which placed them at a high risk for initial

victimisation, remain in their lives; creating an elevated risk for revictimisation (Mayal & Gold, 1995; Messman-Moore & Browne, 2004; Roman et al., 1995).

Several previous studies have found that females are more likely than males to experience interfamilial CSA (Dhaliwal, Gauzas, Antonowicz, & Ross, 1994; Kendall-Tackett & Simon, 1992; Spataro, Moss, & Wells, 2001) and males are more likely to be abused by an acquaintance or a stranger (Faller, 1989; Gordon, 1990; Spataro et al., 2001). Supporting the literature, the current study illustrates that almost half of all CSA victims were abused by a family member. The female victims were significantly more likely to be abused intrafamiliially than male CSA victims, who were more likely to be abused extrafamiliially.

Overall, the findings from the current study reveal that CSA is a predictor of revictimisation and not only sexually but in almost all other forms of physical victimisation which were examined within the context of this study. The significant finding would suggest that the incorporation of further protective, long-term, follow-up studies in this area of research are highly warranted.

6.1.2 Aim Two: Severity of the abuse affects revictimisation rates

Aim two sought to examine the effects that the severity of CSA had on the rate of revictimisation. For the current study, the level of severity was based on the type of sexual abuse, either penetrative or non-penetrative. A significantly higher proportion of CSA victims within this study experienced penetrative sexual abuse than non-penetrative sexual abuse. The literature is divided in regards to gender and who experiences the more severe form of sexual abuse (Arata, 2000; Classen et al., 2005; Fleming, 1999; Moeller et al., 1993). Several

older studies suggest that males are more likely to experience an increased level of severity, including penetration, compared to females whom are more likely to experience the "lesser" severe forms of non-penetrative sexual abuse (Dhaliwal et al., 1996; Gordon, 1990; Pierce & Pierce, 1985). These findings must be read cautiously as the male portion of CSA victims who actually report the abuse may be at the pointy end of the severity spectrum (Spataro et al., 2001). It is highly likely that much of the less severe (non-penetrative) sexual abuse which occurs within the male population remains unreported. The findings from the current study reveal that the severity of abuse, operationalised as having been sexually penetrated, was significantly higher among the female CSA victims and the average age at the time of revictimisation was significantly younger for the victims of penetrative sexual abuse.

Previous literature states that the severity of the original abuse is related to the likelihood that the individual will be revictimised in the future (Arata, 2000, 2002; Classen et al., 2005; Fergusson et al., 1997; Fergusson et al., 2008; Finkelhor & Browne, 1995; Finkelhor et al., 2007a; Fleming, Mullen, Sibthorpe, & Bammer, 1999; Humphrey & White, 2000; Koverola et al., 1996; Mayall & Gold, 1995; Merrill et al., 1999; West et al., 2000). Straying from this trend is the current study which revealed there was no significant difference between the rates of revictimisation and the level of severity of abuse; therefore, a strong relationship was not seen between the level of severity of the original sexual abuse and the risk for revictimisation. This lack of association remained true when examining the relationship by gender. The likelihood for the lack of a significant relationship may be due to the high level of underreporting which occurs with subsequent victimisations (Arata, 2002). Moreover, the rate of penetration (approximately two-thirds of the sample) in the present study was higher than in most other studies, which leaves a restricted range for the correlation to be calculated.

The number of perpetrators present during the time of the abusive event is considered as another aspect of the severity of the abuse. Within the current study, the majority of the abusive acts were performed by one offender. Only 5.6 percent of CSA victims experienced an abusive act at the hands of more than one perpetrator.

Further investigation in this area is warranted as it appears that results are divided on how great a role the level of severity plays in increasing the risk for revictimisation. Two areas specifically which would benefit from further attention are examining the duration of the initial abuse in combination with the level of severity. This combination has been linked to increasing the vulnerability for subsequent victimisations (Barnes et al., 2009; Macy, 2008). Secondly, it would be useful to examine other forms of abuse, such as emotional and physical abuse, alongside sexual abuse, as an association has been seen between the risk for revictimisation and experiencing more than one form of abuse (Classen et al., 2005).

6.1.3 Aim Three: Age at time of abuse affects revictimisation rates

The third aim investigated the victim's age at the time of the original abuse and examined whether the age played a role in the rate of revictimisation seen across the individual's lifespan. The findings from the current study reveal that, overall, the CSA victims who were abused before the age of 12 years were more likely to be revictimised than the CSA victims who were initially abused after the age of 12 years. Not only were people in the pre-pubertal group more likely to be revictimised generally, they were more likely to be sexually and violently revictimised. People in the pre-pubertal group were also more likely than the post-pubertal group to be a victim of stalking and theft. The children over the age of 12 years were more likely to be revictimised in the form of deception and more likely to be a victim of

kidnapping. These findings are consistent with the previous literature in suggesting that the younger the victim is at the time of the initial abuse increases the level of damage which may occur throughout the individual's lifespan (Barker-Collo & Read, 2003; Briere, 1992; Finkelhor, 1995; Finkelhor & Browne, 1985; manly, 2001; Morrison et al., 2003; Putnam, 1990); however, when we examined the pre-pubertal and post-pubertal groups by gender a different result was revealed.

The male CSA victims were more likely to experience revictimisation if their initial sexual abuse occurred post-pubertal rather than pre-pubertal. The female CSA victims were more likely to be generally revictimised if the abuse occurred pre-pubertal and 2.8 times more likely than their non-abused counterparts to experience sexual revictimisation. These mixed results are consistent with the division seen in the literature (Barker-Collo & Read, 2003; Classen et al., 2005; Cole & Putnam, 1992; Finkelhor, 1995; Macy, 2008; Manly, 2001; Morrison et al., 2003; Mullen & Fleming, 1998).

6.1.4 Aim Four: Mediating role between CSA and mental illness (including suicide), which in-turn increases the risk of revictimisation

The literature reveals that there are many factors which come into play when examining the risks for revictimisation. Several of the most significant factors for the revictimisation of victims of CSA are the development of PTSD (Arata, 1999b; Chu, 1992), depression (Andrews et al., 2004; Dube et al., 2005; Fergusson et al., 2008; Fergusson & Mullen, 1999; Mullen et al., 1993), personality disorders (Cutajar et al., 2010a, 2010b; Spataro, 2004), eating disorders (Briere & Scott, 2007; Mullen et al., 1993), and drug and alcohol misuse (Bensley et al., 1999; Corbin et al., 2001; Derman et al., 1998; Messman-Moore et al., 2009).

There can be confusion about which comes first, the symptom or the stressor. It is difficult to conclude whether the sexual abuse experienced as a child is enough to cause the individual to find him or herself in a situation which leads to revictimisation. Perhaps more likely, it is the cumulative effects and outcomes of a life damaged at age that ultimately leads to revictimisation.

Findings from this study suggest that there is a relationship between CSA and the subsequent risk for both childhood and adulthood psychopathology. The likelihood of experiencing some form of psychosis during their lifetime was significantly more likely for the victims of CSA. This study reports that psychosis is present within 2.9 percent of the CSA cohort and the likelihood of experiencing some form of psychosis is 2.1 times greater for the victims of CSA.

The victims of CSA were significantly younger at the time of presentation to the mental health system when compared to people from the general population whom also had contact with the mental health system. This could be interpreted to mean that the onset of psychopathology occurred at an accelerated rate for the victims of CSA. This would suggest, along similar lines of Ellis et al. (1982) and Miller et al. (1978), that the psychiatric disorder played some form of a role in the increased risk and vulnerability to revictimisation. Also in support of this notion was the research done by Gidycz et al. (1993) who suggested that revictimisation risk was in part due to the emotional and psychological problems stemming from the original abuse (Arata, 2002).

The literature suggests that PTSD may be a mediator for revictimisation (Chu, 1992; Kessler et al., 1995; Messman-Moore et al., 2008; Roth et al., 1997). The current study reveals that

amongst the victims of CSA, more than 17 percent received a diagnosis of PTSD in the public mental health system. CSA victims were 5.5 times more likely to experience PTSD than their non-abused counterparts. These figures support the notion that the development of PTSD following the initial act of sexual abuse increases the vulnerability to be revictimised in some form (Kessler et al., 1995; McLeer et al., 1992; Messman-Moore et al., 2008; Roth et al., 1997; Wolfe et al., 1989).

The current study provides relatively strong evidence suggesting there is also a relationship between being a victim of CSA and the development of a personality disorder. When examining the personality disorders as a group, 3.6 percent of the CSA victims presented with some form of personality disorder which was almost five times greater than the number of personality disorders reported within the comparison group. It must be noted that this would be an under representation of the actual presence of personality disorders as there is generally an underreporting of personality disorders made to the public mental health service. This is due to the individuals with less severe forms of mental illness being more likely to be treated by general practitioners and private psychologists/psychiatrists than to receive care in the public mental health service. Indeed, in Australia both publically funded Medicare and private health insurance provide for mental health care provided by private practitioners (general practitioners, psychologists, and psychiatrists).

The literature highlights two main personality disorders when examining an association with CSA: borderline personality disorder and antisocial personality disorder (Cutajar et al., 2010a; Zanarini et al., 1997). Within this study, 1.8 percent of CSA victims had a diagnosis of borderline personality disorder compared to only 0.3 percent in the comparison cohort. It illustrated that, overall, the victims of CSA were 6.1 times more likely to develop borderline

personality disorder and 4.3 times more likely to develop antisocial personality disorder compared to the general population. The question still remains regarding the cause and effect of CSA and borderline personality disorder. The results from this research and other studies conducted previously (Goldman et al., 1992; Spataro et al., 2004; Weilor & Widom, 1996) suggest that there is a relationship between the victims of CSA and the development of borderline personality disorder percent (Herman et al., 1989; Ogata, Goodrich, Lohr, Western & Hill, 1990; Paris, Zweig-Frank & Guzder, 1994a, 1994b; Salzman et al., 1993, Shearer, Peters, Quaytman, & Ogden, 1990; Western, Ludolph, Misle, Ruffins, & Block, 1990; Zanarini et al., 1997). However, further research is necessary to begin to develop a clearer picture of the cause and effect relationship between CSA and the development of a personality disorder.

Upon examination of gender and mental illness, the male CSA victims who presented to the public mental health system were diagnosed with antisocial personality disorder more frequently than the female CSA victims who had contact with the public mental health system; they were more likely to be diagnosed with borderline personality disorder. Female CSA victims were seven times more likely than their comparison cohort to have a diagnosis of borderline personality disorder. These results are consistent with the proposed association in previous literature (Johnson, Cohen, Brown, Smailes, & Bernstein, 1999; Van de Kolk, Hostetler, Herron, & Fisler, 1994). It has been suggested by Spataro et al. (2001) that the findings of a higher rate of antisocial personality disorder within the male CSA population may be due to males having a higher tendency to externalise their distress than women. Spataro and colleagues (2001) also stated that CSA appears to have a more traumatic influence on the male victims than female victims. This increased level of experienced trauma leads to more damaging psychological outcomes for the males in later life.

Alcohol and drug misuse was illustrated to be dramatically heightened within the CSA population, which places the addicted individual in a heightened risk category for revictimisation. The risk for suicide was also drastically heightened within the CSA population, they were 18 times more likely than the general population to commit suicide and almost 50 times more likely to fatally self-harm or overdose.

The victims of CSA who had mental health contact were significantly more likely to have been revictimised than the victims of CSA with no history of a mental illness (n=364, 52.1% v. n=636, 30.9%). This group was also significantly more likely than the comparison cohorts, both with and without a history of mental health issues, to be revictimised. When examining the risk of sexual revictimisation, the victims of CSA with a mental illness were three times more likely to be sexually revictimised than individuals from the general population with a mental illness. These figures illustrate how mental illness is a strong moderating variable for the increase in vulnerability for revictimisation in the victims of CSA with a mental illness.

All six categories of victimisation examined in Table 5.12 reveal there is a significant difference present between the rates of revictimisation for the victims of CSA with and without the presence of a mental illness. The combination of CSA and the presence of a mental illness is shown to be a strong predictor for revictimisation in general. These findings illustrate the dramatic effect that mental illness can have on the trajectory of an individual's life and just how important it is to provide intervention and prevention programs for the victims of CSA.

These results are very revealing and provide some insight into the detrimental effects that CSA can have on its victim over the long-term. It is imperative to the child's future to be able

to provide support, encouragement and intervention strategies in order to break the cycle of revictimisation. The implications from the findings of the study are discussed below.

6.2 Implications

To date, research has ultimately failed to completely explain the dynamic factors which may lead to revictimisation. What has been explained is that revictimisation involves a combination of a multitude of different risk factors which are apparent or more present in the lives of the survivors of CSA compared to the general population. Many studies over the years have addressed the topic of CSA and the effects the abuse has on their future lives (Arata, 2000; Fergusson & Mullen, 1999; Finkelhor, 2011; Mandoki & Burkhart, 1989; Tusher & Cook, 2010). The questions regarding victims of CSA and their increased risk of being revictimised are yet to be definitively answered; why are some victims more vulnerable to subsequent repeated victimisations whilst some remain resilient?

This area of research is characterised by weaknesses in the methodological procedures of self-reporting CSA. The strength of the current research is removing the self-report and using medical documented cases of CSA with a long follow-up period, which allowed the researchers to examine the victims of the documented CSA and review the events in their lives for a period of 44 years without having to rely on the retrospective self-report of the individuals involved. Using the police database to confirm subsequent victimisations has allowed a clearer picture to emerge as to just how much greater the risks of revictimisation are for the victims of CSA; however, it must be taken into account that most victimisation likely goes unreported.

Although the establishment of an association between CSA and revictimisation was seen, the

actual causal relationships still could not be concluded due to confounding factors, including dysfunctional families, dangerous environments and the presence of other abusive factors, which were not controlled for in the data used within this study. Therefore, the actual contribution of CSA, independent of other factors, was not discerned. Despite the limitations of the confounding factors, the findings of the current study illustrate the extreme differences in the rates of revictimisation between the victims of CSA and the general population. This is at least strongly suggestive that CSA leads to an increase in the risk and vulnerability to future victimisations throughout the individual's life. Further investigations of individuals who have been victimised as children and then again as adults is a necessary area for future research.

A considerable amount of research has been conducted to ascertain the risk factors which may increase the victim's vulnerability (Arata, 2002; Classen et al., 2005; Coid et al., 2001; Rich et al., 2004; Widom et al., 2009). The findings from the current study reveal that half of the CSA victims were sexually abused by a relative, illustrating that a child's familial relationships and environment may play a large role in the influence of not only the initial sexual abusive experience, but also in the future risk and vulnerability for revictimisation. If the victim has the courage to inform a third party of the abuse they risk the possible intervention of child protection services and in extreme cases the child may be removed from the family home. One can predict that being removed from the family home will ultimately affect the child's self-esteem and create self-blame for the actions their disclosure set in motion. Literature has revealed a strong association between self-esteem, self-blame and an elevated risk of revictimisation (Arata, 2002; Chu, 1992; Romans et al., 1995). Clinically the lowering of self-esteem can lead to many issues including excessive drug and alcohol use and sexual promiscuity. Both of these have been shown to play a role in the increase of

vulnerability for revictimisation. Tragically suicide may be the end result if an intervention is not made (Cutajar et al., 2010c).

The level of severity of the abuse was found to have an important role in revictimisation rates. This could be interpreted as the more severe the initial abuse (i.e., penetrative sexual abuse), the more likely the victim experienced a prolonged exposure to sexual abuse and struggled to tell a third party of their experiences. This inability to disclose the abuse may be indicative of the functioning of the family and the level of trust and the relationship the victim feels they have with their parents or the members of their household. This relationship (i.e., family functioning) could potentially play a role in the degree and duration of the sexual abuse. The level of trust between the child and the parent ultimately plays a role in the length the abuse can continue. The female CSA victims from within the current study were significantly more likely to be sexually abused by a member of their family or from someone within their family unit. This would most certainly break the cycle of trust and create an environment where the individual feels unsafe and possibly frightened to mention their experiences. Often the severity of the abuse is higher when the abuse is intrafamilial (Arata, 2000); therefore, the cycle of increased severity causing an increased risk for revictimisation combined with a lack of trust and poor relationships within the family increases the risk for revictimisation. In general, poor family functioning increases the risk for sexual abuse initially and consequentially.

The age of the victim at the time of abuse is crucial in determining risk for revictimisation. The findings of the current study are consistent with the literature which suggests that the younger the victim is during the initial sexual abusive experience the more vulnerable that individual is for future victimisation (Barker-Collo & Read, 2003; Classen et al., 2005;

Finkelhor, 1995; Manly 2001; Morrison et al., 2003). The implications of this finding are incredibly important as they point out the necessity of structuring an intervention program whilst the child is still young and before there is an opportunity for the victimisation cycle to continue. These intervention programs need to focus on self-protection skills and enhancing the child's knowledge on what constitutes appropriate or inappropriate behaviour from others. Kindergarten and school programs run by child protection groups such as the "keep safe with Ditto" program run by Bravehearts Inc (<http://www.bravehearts.org.au>) are providing young children with knowledge which may help prevent them from becoming a victim of CSA. These programs are aimed at children between the ages of 2 and 5 years and provide them with the basic information required to avoid risky situations and teach them to understand that they have the right to control what happens to their bodies, what their private parts are and how they are not for others to touch. These programs focus on the use of basic terms such as 'yes feelings' and 'no feelings' and how the no feelings should be avoided.

To address the areas of vulnerability for revictimisation including the above mentioned self-esteem, self-blame, family functioning and age of victim, early interventions must be in place to effectively prevent future revictimisation (Briere, 1992; Fryer & Miyoshi, 1994). Cases of CSA must be assessed from all angles beginning with a thorough assessment of the initial abuse including the presence of any other forms of abuse in addition to the risk for future revictimisation. Much of the research has been performed on the effects of CSA and the ramifications which may stem from it. The focus needs to now be on the identification of effective early intervention prevention programs. Psychoeducation must be aimed at high-risk behaviours including areas of drug use, promiscuity, and criminal behaviours. The findings from this study are consistent with the literature which theorises that the more physical contact present in the sexual abuse, the more likely the individual will be involved in higher

rates of sexualised behaviour which would in-turn ultimately increase their risk for revictimisation (Arata, 2000; Fergusson et al., 1997; Finkelhor & Browne, 1995; Flemming et al., 1999; Koverola et al., 1996; Mayall & Gold, 1995; Merrill et al., 1999; West et al., 2000). The increase in vulnerability of the CSA victim has been shown to increase their chances of becoming revictimised, which is again consistent with the findings of the current study.

First and foremost, intervention programs which focus on the prevention of CSA would be the most desirable strategy; however, interventions that help minimise the effects and outcomes of CSA and help establish the improvement of the lives of the victims is a step in the right direction (Arata, 2000). Due to the current studies focus on the outcomes of CSA and the risks for future revictimisation, the following practical implications are centered on post-abuse intervention strategies. Programs which are specific to the prevention of revictimisation need to be established focusing on a combination of psychoeducation and skills training. These programs would need to increase the individual's factual knowledge on their experience of CSA and provide practical strategies for preventing future sexual abuse; including the promotion of effective problem solving and communication skills, basic assertiveness practices and risk recognition strategies to prevent the individual from finding themselves in dangerous situations without the ability or resourcefulness to remove themselves (Hanson & Gidycz, 1993; Marx, Calhoun, Wilson, & Meyerson, 2001). In combination with the prevention programs the individual should be provided with some basic psychological therapy following the initial sexual abuse. This would be of great importance in order to address the individual's trauma and the issues which arise from their experiences, often including developmental challenges involving trust, intimacy and sexuality.

The current literature discusses, at length, the risks that CSA appears to pose for the

development of mental health problems (Bebbington et al., 2011; Collishaw et al., 2007; Cutajar et al., 2010a, 2010b, 2010c; Fergusson & Mullen, 1999; Lau & Kristensen, 2010; Putnam, 2003). The findings from the current study also reveal a strong connection between CSA and the vulnerability to psychopathology. The risks for the development of mental health problems can extend a long time beyond the initial sexual abusive event and therefore short-term intervention programs would not be adequate to address the needs of this group. It would be necessary to have something in place in order for the individual's mental health status to be monitored on an ongoing basis. If there are limited family structure or supportive networks surrounding the individual then, situation dependent, a case worker or a general practitioner may be the most appropriate source to monitor the mental health status and provide guidance and interventions when deemed necessary. If the development of a personality disorder or any other mental health issues arise then it would be imperative to provide structured therapy and psychoeducation to the individual.

The findings from the study also have implications for policing practices. The police officers who come into contact with an individual who has been victimised, especially the individuals who have been sexually victimised, should be aware that they may be possibly dealing with an individual with a prior history of sexual abuse. The police officer must make respect and sensitivity a priority when dealing with these individuals, especially due to the possible fragility of the revictimised individual.

Although it is beyond the scope of the current study, literature has revealed that CSA is often accompanied by other forms of abuse including physical, emotional and neglect (Fergusson et al., 2011; Widom et al., 2004). Interventions need to focus on this broader range of abuse to begin to effectively reduce the risk and vulnerability to future revictimisation.

6.3 Study Limitations

There are a number of limitations present within the current study which must be considered when interpreting the findings. Firstly, although the use of a comparison cohort from the general population is considered a strength, within this comparison cohort some of the individuals may have experienced CSA. As the individuals within the comparison cohort were chosen randomly, from the electoral poll, with no background checks, the possibility that some of the participants may have experienced CSA could not be prevented. This introduces a possible bias against the findings of a significant difference between the CSA and comparison cohort; however, this possible bias means that, at worst, the findings from the current study are conservative and the differences between the CSA and comparison cohorts can only be greater.

Secondly, data may have been lost from the original CSA cohort due to the individuals moving out of state or dying. In regards to the female population of the study, during the 44 year follow-up period, the individual may have become married and therefore possibly changed their last name; however, the majority of the subjects within this study were able to be found within the 44 year follow-up period. Indeed, police records include all known names of the individuals, including maiden names, married names, and pseudonyms. Due to the nature of the data being originally collected for purposes other than intended for the current study, another limitation which presents itself is the inability to control for the possibility that there may be biases present in the CSA cohort where the individuals are more likely to represent children from dysfunctional and disadvantaged families; therefore there is no guarantee that the individuals coming to the attention of the VIFM for CSA are a representative of those who are actually exposed to CSA. The possibility that the sample

contains a disproportionate number of children experiencing CSA are from high risk backgrounds means that the sampling methodology leads to a confounding of the measurement of CSA with processes by which CSA comes to official attention. Due to this, the sample used for this study cannot be treated as though it were a true representation sample of cases of CSA.

The police database provided a useful source of victimisation follow-up; however, another limitation to the findings of the current study is the reliance on the contact of the individual with the police to record subsequent victimisations. There will always be an underrepresentation of the actual revictimisation which occurs creating a bias. However, there is no reason to believe that the relative underreporting of revictimisation would be different between the CSA and the control cohorts.

Due to the fact that the data were originally collected for other purposes than the ones intended within the current study, there were certain limitations placed on what could and could not be examined. The further examination of intrafamilial and extrafamilial sexual abuse seems warranted because of the high levels of intrafamilial sexual abuse, especially for females, recorded in this study. It would be beneficial for the research area of risk revictimisation to closely examine the perpetrator and their relationship (i.e., father, step-father, uncle) to the victim and if this relationship was able to provide a level of prediction for revictimisation. To obtain this information, data would need to be collected on the original perpetrator and a consideration made regarding whether the relationship they had with the victim influenced the vulnerability for revictimisation. Another area of data collection which would be beneficial is the examination of the environment in which the CSA victim was living when the revictimisation occurred. Were they still in the household

where the original abuse took place or had they moved to a new environment, and does this influence their risk of revictimisation?

6.4 Future Research Directions

The research into CSA is bound to face uncertainty and doubt due to the nature of defining CSA and trying to categorise or measure the individual's personal sexual experience. Despite the numerous studies performed in the area of CSA and revictimisation, it is apparent that the majority of the literature focuses on a cross-sectional design, including mainly female victims, and relies almost exclusively on the retrospective self-report of CSA. Since the cross-sectional design promotes a concurrent assessment of victimisation and revictimisation experiences, it is difficult to distinguish whether the rates of revictimisation for victims of CSA in adulthood would differ for individuals with similar backgrounds, excluding the CSA (Widom et al., 2009). It also raises the question when using a cross-sectional design that the mental state of the victim at the time of the study may strongly influence their recollection of the CSA experience (Brown & Harris, 1978). Due to this, it is imperative for future studies in this area to begin examining closely the cause and effect of CSA in order to eliminate the present blurred lines between the causal direction of revictimisation.

A theoretical deficiency in the studies of CSA is the assumption which is made over the causal direction leading from the abuse which occurred in childhood to the mental health outcomes and further victimisations which may occur in later life (Horwitz et al., 2001).

Very little research has been performed in the area of the survivors of CSA who are not revictimised later in life. It would be extremely beneficial to the body of knowledge to

examine this population in order to assess what factors are present or not present in their lives compared to the lives of the individuals who become revictimised. What prevents some victims from becoming revictimised and what makes other victims more vulnerable to being revictimised? The limited research in this area suggests that women's self-efficacy, sense of mastery and their situational assertiveness may be factors which play a role in helping them prevent future victimisations (Breitenbecher, 2001; MacGreene & Navarro, 1998; Macy, 2008). Continued research in this area is imperative in distinguishing the order of prevention for further victimisations from occurring.

Evidence-based intervention strategies to help prevent revictimisation from occurring are of great importance. The results of the current study reveal just how detrimental the effects of revictimisation can be on an individual both physically and mentally. To begin to improve the knowledge in this area studies which focus on providing clarity to the order of events are paramount –i.e., is it the risk stemming from the CSA experience which causes the revictimisation, or is it a result of the revictimisation event itself?

And finally, the current literature states that an increased risk for subsequent victimisations increases when more than one form of abuse is present (Classen et al., 2005; Moeller et al., 1993); therefore, all forms of abuse (physical, emotional, neglect and sexual) need to be included within the examination as possible mediating variables for revictimisation.

6.5 Conclusion

This is the largest prospective follow-up study to date on ascertained victims of CSA. The overall conclusion that can be drawn from this research is that CSA appears to play a

substantial role in the vulnerability for revictimisation. The causal relationship between CSA and revictimisation is complicated and will remain this way due to the nature of the factors involved. This study confirmed many of the established relationships already seen between CSA and subsequent victimisation and provides compelling evidence of just how vulnerable the victims of CSA are to the development of mental health problems. This vulnerability to mental health problems and the results which suggest that mental illness is a strong moderating variable for revictimisation (especially sexual revictimisation), emphasise the need for early intervention treatment programs in order to address both the child's traumatic experiences and the damaging and lasting effects of the sexual abuse.

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APPENDIX A: FORENSIC MEDICINE CHILD SEXUAL ASSAULT EXAMINATION PROFORMA



Department of Forensic Medicine Child Sexual Assault Examination

CONFIDENTIAL

CHILD

SURNAME	ETHNIC BACKGROUND	
GIVEN NAMES	GENDER	
DATE OF BIRTH	AGE IN YEARS	
ADDRESS	POSTCODE	

EXAMINATION

DATE	TIME
DOCTOR	D.F.M. STATISTICS CODE
PLACE	
PERSONS PRESENT	COUNSELLOR/ADVOCATE
PHOTOGRAPHY Y / N	SPECIMENS Y / N: HANDLED TO ON / / AT HOURS

POLICE INVOLVEMENT

NAME	RANK REG. No
STATION / UNIT	INVOLVED Y / N


C.S.V. INVOLVEMENT

NAME	INVOLVED Y / N
ADDRESS	

D.F.M. CODINGS

UNIT RECORD NUMBER	RESEARCH DATABASE ENTRY No: Date:	STATISTICS ENTRY Code: Date:	REPORT DICTATED: REPORT TYPED: REPORT SENT: SENT TO:
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 Department of Forensic Medicine 2000 University Road #	SURNAME
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CHILDS LEGAL GUARDIAN

SURNAME	GIVEN NAMES	PRESENT AT EXAM Y / N	
RELATIONSHIP TO CHILD		1) BIOL MOTHER 2) BIOL FATHER 3) STEP PARENT 4) OTHER FAMILY 5) C.S.V. 6) OTHER	
PROTECTION APPLICATION CURRENTLY IN FORCE		1) NO 2) YES	
CONSENT GIVEN FOR 1) EXAMINATION Y / N 2) MEDICAL REPORT Y / N 3) SPECIMENS Y / N			

CHILDS FAMILY


ADULTS RESIDING AT CHILDS HOME AT TIME OF INCIDENT- LIST ALL	1) BIOLOGICAL MOTHER 2) BIOLOGICAL FATHER 3) STEP/DEFACTO MOTHER 4) STEP/DEFACTO FATHER 5) OTHER ADULT FAMILY 6) OTHER ADULT - NON FAMILY	
CHILDREN RESIDING AT HOME AT THE TIME OF THE INCIDENT	Specify Total No of children	
	Specify No of Full biological siblings	
	Childs birth position in family (1st = eldest)	
EMPLOYMENT STATUS OF FAMILY'S PRIMARY INCOME EARNER	1) EMPLOYED 2) UNEMPLOYED	
IF EMPLOYED - LIST PRIMARY OCCUPATION		
IF UNEMPLOYED - LIST TYPE OF SOCIAL SECURITY BENEFIT RECEIVED		

CHILD'S MEDICAL HISTORY

MEDICAL HISTORY

GENITO-URINARY PROBLEMS - (list with dates)	1) NONE 2) URINARY TRACT INFECTION 3) VAGINAL DISCHARGE 4) VAGINAL BLEEDING 5) BLEEDING - SITE UNKNOWN 6) INGUINAL RASH 7) TRAUMA 8) OTHER	
ANORECTAL PROBLEMS	1) NONE 2) BLEEDING 3) CONSTIPATION 4) OTHER	
PHYSICAL IMPAIRMENT	1) NONE 2) MILD 3) MODERATE 4) SEVERE	
INTELLECTUAL IMPAIRMENT	1) NONE 2) MILD 3) MODERATE 4) SEVERE	
PROFESSIONAL AGENCIES INVOLVED WITH CHILD PRIOR TO THIS PRESENTATION	1) NONE 2) C.S.V 3) INTELLECTUAL DISABILITY SERV 4) PSYCHIATRY 5) PSYCHOLOGY 6) SPECIAL EDUCATION 7) PAED HOSPITAL (R.C.H OR M.M.C) 8) OTHER	
PREVIOUS CONCERNS OF PHYSICAL ABUSE - (NOT connected with current presentation)	1) NO 2) YES	
PREVIOUS CONCERNS OF SEXUAL ABUSE - (NOT connected with current presentation)	1) NO 2) YES	
PREVIOUS GENITAL EXAMINATION FOR SEXUAL ABUSE	1) NO 2) YES - FORENSIC PHYS. (FULL TIME) 3) YES - FORENSIC PHYS. (PART TIME) 4) YES - PAEDIATRICIAN - RCH OR MMC 5) YES - PAEDIATRICIAN - OTHER 6) YES - LOCAL DOCTOR 7) YES	

INFORMATION CONCERNING ABUSE PROVIDED BY - (list all sources)	<ul style="list-style-type: none">1) CHILD THEMSELVES2) PARENT3) SIBLING4) POLICE5) C.S.V6) OTHER	
DETAILS OF ALLEGATIONS		

 Department of Community Services NEW SOUTH WALES CHILD PROTECTION PAGE 4	REFUGEE
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DETAILS OF ABUSE (cont)

CONCERNS OF SEXUAL ABUSE RAISED PRIMARILY BY - (list one only)	1) DISCLOSURE BY CHILD 2) PHYSICAL INDICATORS 3) BEHAVIOURAL CHANGES 4) CONTACT WITH SEX OFFENDER 5) SIBLING SEXUALLY ASSAULTED 6) OTHER	
IF CHILD DISCLOSED - TO WHOM DID IT OCCUR	1) NO DISCLOSURE 2) PARENT 3) SIBLING 4) OTHER FAMILY MEMBER 5) PEER 6) NEIGHBOUR / FAMILY FRIEND 7) PROFESSIONAL 8) OTHER	
TIME PERIOD BETWEEN LAST INCIDENT AND REPORTING (in days)	1) UNKNOWN 2) LESS THAN 48 HOURS 3) 2 - 14 DAYS 4) 2 WEEKS - 3 MONTHS 5) GREATER THAN 3 MONTHS	
DATE OF LAST INCIDENT (if known) / /		
WHERE WAS/WERE INCIDENT/S ALLEGED TO HAVE OCCURRED	1) UNKNOWN 2) CHILD'S HOME 3) OFFENDERS HOME 4) OTHER BUILDING 5) OTHER	
TIME PERIOD OVER WHICH INCIDENTS WERE ALLEGED TO HAVE OCCURRED	1) UNKNOWN 2) ONE INCIDENT ONLY 3) LESS THAN ONE WEEK 4) 1 WEEK TO 3 MONTHS 5) 3 MONTHS TO 1 YEAR 6) GREATER THAN 1 YEAR	
SEX OF THE ALLEGED OFFENDER	1) UNKNOWN 2) FEMALE 3) MALE	
RELATIONSHIP ALLEGED OFFENDER TO CHILD	1) OFFENDER UNKNOWN 2) NO RELATION 3) BIOLOGICAL PARENT 4) BIOLOGICAL GRANDPARENT 5) UNCLE / AUNT 6) STEP / DEFACTO PARENT 7) OTHER FAMILY	

TYPE OF CHILD / OFFENDER CONTACT

HAVE SPECIFIC ALLEGATIONS OF CONTACT BETWEEN CHILD AND OFFENDER BEEN MADE	1) NO 2) YES	
IF YES - COMPLETE TABLE BELOW USING THE FOLLOWING CODES eg Offenders hand touching child's anus is U / C		

CHILD	OFFENDER	TYPES OF CONTACT
A) VULVA / VAGINA	U) FINGERS / HANDS	1)
B) PENIS	V) PENIS	2)
C) ANUS	W) VULVA / VAGINA	3)
D) MOUTH	X) MOUTH	4)
E) FINGERS / HANDS	Y) ANUS	5)
F) OTHER	Z) OTHER	6)


 Department of Forensic Medicine GEN RECORD PAGE 1	
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GENERAL PHYSICAL EXAMINATION

GENERAL PHYSICAL EXAMINATION		
HEIGHT - (use percentile chart) <div style="text-align: right;">_____ CM</div>	1) <3rd %ile 4) 90-95 %ile 2) 4-10 %ile 5) >97th %ile 3) 11-89 %ile	
WEIGHT - (use percentile chart) <div style="text-align: right;">_____ KG</div>	1) <3rd %ile 2) 4-10 %ile 3) 11-89 %ile 4) 90-95 %ile 5) >97th %ile	
SIGNS OF NON ACCIDENTAL INJURY DETECTED	1) NO 2) YES	

GENITAL AND ANAL EXAMINATION

RECORD ALL GENITAL AND ANAL EXAMINATION FINDINGS
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 Department of Health Services 1000 Broadway, Suite 200 Seattle, WA 98101	SURNAME
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FEMALE GENITAL EXAMINATION - CODING

STAGE OF PUBERTY	RECORD TANNER STAGE (1 TO 5)	
INJURIES TO LABIA	1) NONE 2) BRUISING 3) ABRASION 4) BRUISING PLUS ABRASION 5) OTHER	
INJURIES TO INTROITUS	1) NONE 2) BRUISING 3) ABRASION 4) BRUISING PLUS ABRASION 5) OTHER	
INJURIES TO PERINEUM	1) NONE 2) BRUISING 3) ABRASION 4) BRUISING PLUS ABRASION 5) OTHER	
SIGNS OF GENITAL INFECTION	1) NONE 2) REDNESS 3) DISCHARGE 4) REDNESS AND DISCHARGE 5) GENITAL WARTS 6) THREADWORM	
ANATOMICAL APPEARANCE OF HYMEN	1) ANNULAR 2) CRESCENTIC 3) LAX OR FOLDED 4) OESTROGENISED 5) OTHER	
BUMPS (outgrowth of tissue) IN HYMEN	1) NONE 2) 1 OR 2 NONTRAUMATIC 3) > 2 NONTRAUMATIC 4) ASSOCIATED WITH INJURY	
	POSITION ON HYMEN (use clockface notation)	
NOTCHES (deficit of tissue) IN HYMEN	1) NONE 2) 1 OR 2 NONTRAUMATIC 3) > 2 NONTRAUMATIC 4) ASSOCIATED WITH INJURY	
	POSITION ON HYMEN (use clockface notation)	
FRESH INJURIES TO HYMEN - (list all injuries observed)	1) NONE 2) BRUISING 3) ABRASION 4) LACERATION 5) OTHER	
BLEEDING PRESENT	1) NO 2) YES	
HEALED INJURIES TO HYMEN - (list all injuries observed)	1) NONE 2) THICKENING 3) SCARRING 4) ADHESIONS	
POSITION OF INJURIES ON HYMEN - (use clockface notation) - (if no injuries present leave blank)	BRUISING PRESENT AT _____	
	LACERATION PRESENT AT _____	
	ABRASION PRESENT AT _____	
	THICKENING PRESENT AT _____	
	SCARRING PRESENT AT _____	
	ADHESIONS PRESENT AT _____	

Trends & issues

in crime and criminal justice

No. 440 June 2012



Australian Government
Australian Institute of Criminology

Foreword | *Up to 30 percent of children experience childhood sexual abuse (CSA) and whether this impacts re-victimisation or offending as an adult has been the subject of numerous studies.*

This study investigates whether a disproportionate number of CSA victims subsequently perpetrate offences and experience future victimisation compared with people who have not been sexually abused. In a sample of 2,759 CSA victims who were abused between 1964 and 1995, it was found CSA victims were almost five times more likely than the general population to be charged with any offence than their non-abused counterparts, with strongest associations found for sexual and violent offences. CSA victims were also more likely to have been victims of crime, particularly crimes of a sexual or violent nature.

This research highlights the need for therapeutic interventions targeted at adolescent male CSA victims, particularly with regard to offender treatment programs, where many programs currently do not allow for exploration of offenders' own sexual victimisation.

Adam Tomison
Director

Child sexual abuse and subsequent offending and victimisation: A 45 year follow-up study

James RP Ogloff, Margaret C Cutajar, Emily Mann and Paul Mullen

Childhood sexual abuse (CSA) continues to occur in our communities at an alarming rate, with up to 30 percent of children experiencing CSA of any kind and between five and 10 percent experiencing severe abuse (Fergusson & Mullen 1999). CSA has been associated with an array of emotional, behavioural and social difficulties (Cutajar et al. 2010a, 2010b; Fergusson & Mullen 1999; Gilbert et al. 2009). Of considerable interest is the relationship between CSA, offending and re-victimisation, particularly sexual offending re-victimisation. Existing studies that have investigated these relationships have suffered from a lack of empirical sophistication, which has left a large gap in our understanding of the fundamental questions pertaining to how many sexually abused children later offend or experience re-victimisation. In particular, most studies have been marred by small samples, have relied upon adults' self-reports of CSA, have included samples with relatively few males and the follow-up of offending and victimisation has often been based upon self-report.

Subsequent offending by childhood sexual abuse victims

Retrospective self-report studies of child sex offenders indicate up to 75 percent report a history of CSA, with Hanson and Slater's (1988) review of 18 studies showing that 33 percent of perpetrators reported experiencing CSA (Johnson et al. 2006). The reported rates are higher than the 10–20 percent of males in the general population who experience CSA (Fergusson & Mullen 1999). By contrast, a meta-analysis of studies comparing the self-reported sex abuse histories of sex offenders and others found that the most studies did not find a significant difference between groups in reporting histories of sexual abuse (Jespersen, Lalumiere & Seto 2009).

In an Australian study (Nathan & Ward 2002) with a very small sample size, 75 percent of the 12 female sex offenders examined for a pre- or post-release evaluation reported a history of CSA. Other studies have found that female sexual offenders reported experiencing CSA at a higher frequency than other female offenders, male sex offenders and non-sex offending female students (Fromuth & Conn 1997; Kaplan & Green 1995; Mathews, Hunter & Vuz 1997; Miccio-Fonseca 2000; Pothast & Allen 1994).

Siegel and Williams (2003a) compared 206 cases of sexually abused girls with 205 matched cases of non-abused girls. The samples were obtained from hospital emergency room records of females aged up to 12 years who were sexually abused between 1973 and 1975 (67% penetration) and same-aged girls who were not sexually abused. Official offence histories obtained in 1995 (20 years later) revealed that victims (20.4%) were significantly more likely than controls (10.7%) to have been arrested as adults. Sex offences were not identified or studied separately.

Widom and Ames (1994) studied 908 substantiated cases of children who were abused between 1967 and 1971 and matched the sample to 667 non-abused cases. They followed up all subjects through arrest records in 1988 and 1994 (Widom & Maxfield 2001). Abused children were victimised prior to the age of 11 years; with abuse consisting of physical abuse, neglect and/or sexual abuse (125 of the cases, 84% girls). A higher proportion of abused than non-abused cases were arrested as a juvenile (27% vs 17%) or an adult (42% vs 33%; Widom & Maxfield 2001). More males than females in both groups were arrested for violent offences (including rape and sodomy); however, a significant difference was only established for abused females relative to their non-abused counterparts. In an earlier study, however, Widom and Ames (1994) found 3.9 percent of abused children compared with 0.4 percent of controls were arrested for a violent sex crime and this was largely attributed to the physically abused group.

Subsequent victimisation of childhood sexual abuse victims

In addition to offending, sexual re-victimisation of CSA victims has also been studied (Beitchman et al. 1992; Noll 2005; Roodman & Clum 2001). Results indicate that males and females who report an adult experience of sexual assault, or interpersonal violence, were more likely to report a history of CSA than those who did not report such abuse (Briere & Elliott 2003; Elliott, Mok & Briere 2004).

An Australian study of 183 substantiated cases of CSA followed up six years later revealed that 17 percent of youth had notifications of further CSA (Swanston et al. 2002). An American study followed up and interviewed 74 confirmed intrafamilial female CSA victims seven years after their initial assessment and found 20.9 percent reported experiencing rape or sexual assault compared with 10 percent of comparisons (Noll et al. 2003), although this difference did not reach statistical significance. However, CSA victims were significantly more likely (1.6 times) to be the victim of a physical assault. In an extension of Siegel and Williams' (2003b) study on 206 CSA female victims, 84 victims and 84 comparisons were interviewed up to 24 years later. There were no differences between the abused and comparison groups in self-reporting of sexual assault in adolescence (28.7% vs 24.1%) or adulthood (48.3% vs 37.9%); however, a third of the comparison group had also been sexually abused in childhood.

These findings suggest that many female CSA victims are subsequently victimised; however, due to the limited and flawed prospective studies it cannot be concluded that CSA among female victims poses an increased risk factor for later sexual assault.

The present study

The primary aim of this study is to examine the relationship between CSA and subsequent criminal offending and victimisation. This study overcomes many limitations of previous studies by conducting

a follow-up study of a large sample of both male and female victims, whose sexual abuse was confirmed, with a matched comparison group. This will allow the determination of rates and risks in the perpetration of offences or victimisation, including those of a low base rate such as sexual offences. This study linked cases of children who were medically confirmed to have been sexually abused to police databases between 13 and 44 years following their abuse to determine whether victims of CSA were at increased risk of offending and victimisation than a comparison group. It should be noted that medical evidence of abuse is not available in most cases of sexual abuse (eg see Adams et al. 2003); however, in Victoria it is common practice, where possible, for children to be examined by a forensic medical officer where allegations of child sexual offending are made.

Data sources

The CSA population studied was obtained from records collected between 1964 and 1995 by the Victorian Institute of Forensic Medicine (VIFM), or its predecessor. VIFM provides forensic medical examinations for all cases of suspected CSA reported to the police to provide a medical opinion regarding whether the abuse occurred. Only cases of contact offending were included; although, as detailed below, not all children were sexually penetrated. Where it did occur, sexual penetration was operationalised as including completed, partial or attempted insertion of a penis, finger or object into an orifice where conclusively, probably or possibly indicated in the opinion provided by the doctor. The established database comprised 2,759 cases of CSA over a 31 year period, making this the largest known population of CSA victims studied. A comparison group of 2,677 people was drawn from a sample of Victorians from the Australian Electoral Commission, matched with CSA victims on gender and age range.

Offence and victimisation data for the CSA and comparison groups were obtained from the Victoria Police database in which all police contacts are recorded. Offending

data included the nature and date of offence, verdict, sentence type and duration and in some circumstances, information pertaining to the victim.

Ethical approvals

Ethics approval was granted by the Monash University Standing Committee on Ethics in Research involving Humans, the Human Research Ethics Committees of VIFM and the Victoria Police Human Ethics Research Committee.

Description of childhood sexual abuse cohort

The sample included 2,759 CSA cases (2,201, 79.8% females; 558, 20.2% males), with a mean age of 10.22 years (SD=4.4) when examined and 35.58 years (SD=11.05) at follow up. All cases involved sexual contact, with 63 percent (n=1,732) including penetration (64.9% females; 55.2% males; $\chi^2=18.06$; $p<0.001$). Males (63.76%) were more likely than females (48.47%) to experience extra-familial abuse, $\chi^2=24.90$; $p<0.001$). Most (94.4%) were sexually abused by one offender, on more than occasion (62%). The follow up period from abuse to data collection ranged from 13.97 to 44.77 years (M= 25.36 years, SD=8.16).

Association between childhood sexual abuse and offending

Almost one-quarter (n=652, 23.63%) of CSA victims had a recorded offence, compared with 5.9 percent (n=157, 87 males and 70 females) of control subjects (see Table 1). The average number of charges was significantly higher for CSA cases than the comparison group (31.59 vs 19.18, $t=2.11$, $p<0.05$) and more CSA victims (n=114, 4.1%) than controls (n=14, 0.052%) received a custodial sentence.

CSA victims were 4.97 times more likely than their peers from the general population to have been charged with an offence and this difference remained significant for both male (OR=4.34, 95% CI 3.28–5.76, $p=0.000$) and female (OR=6.71, 95% CI 5.17–8.71, $p=0.000$) victims. CSA cases were significantly more likely to be charged with all types of offences compared with the general population. Four CSA victims (2 males and 2 females) were charged with homicide, compared with no control cases. Charges with the most marked elevation among CSA cases compared with controls were sexual offences, violent offences and breach of orders.

All offences were significantly higher for both male and female CSA victims compared with their general population peers; although, the associations were stronger for female victims, with charges for threatening violence and assault being the strongest. Sexual offences, violent offences and breach of order remained most strongly associated with CSA among male victims. However, when comparing male and female CSA cases, sexually abused males were significantly more likely than their abused female counterparts to have been charged with all types of offences with the exception of homicide and prostitution.

Considering sexual offending more specifically, five percent (1 out of 20) of male CSA cases were subsequently convicted of a sexual offence, which was significantly greater than for males in the control group, of whom only 0.6 percent (6 out of 1,000) accrued a sexual offence conviction (OR=8.16, 95% CI 2.84–23.42, $p=0.0001$). The difference was even greater when considering boys who had been victimised at age 12 years and above, where 9.2 percent (almost 1 in 10) was subsequently found to have been convicted of a sexual offence. This was significantly greater than

Table 1 Comparison of offence charges between childhood sexual abuse and comparison subjects

Criminal offence	Comparisons (n=2,677)		Cases (n=2,759)		OR	95% CI	p
	n	%	n	%			
Any police contact	1,399	52.3	1,671	60.6	1.43	1.26–1.56	0.000
Criminal history	157	5.9	652	23.6	4.97	4.13–5.97	0.000
Homicide	0	0.0	4	0.1	–	–	–
Sexual offences	4	0.1	31	1.1	7.59	2.68–21.54	0.000 ^a
Prostitution	0	0.0	35	1.3	–	–	–
Violence	35	1.3	271	9.8	8.22	5.76–11.74	0.000
Kidnap	0	0.0	19	0.7	–	–	–
Threat of violence	13	0.5	71	2.6	5.41	2.99–9.80	0.000
Property damage	32	1.2	173	6.3	5.53	3.78–8.09	0.000
Weapons offence	21	0.8	114	4.1	5.45	3.41–8.71	0.000
Stalking	16	0.6	47	1.7	2.88	1.63–5.10	0.000
Drug offences	43	1.6	249	9.0	6.08	4.38–8.44	0.000
Deception	55	2.1	312	11.3	6.08	4.54–8.14	0.000
Theft	75	2.8	428	15.5	6.37	4.95–8.19	0.000
Breach order	26	1.0	247	9.0	10.03	6.67–15.07	0.000
Bad public behaviour	60	2.2	302	10.9	5.36	4.04–7.11	0.000

a=Fisher's exact test

Table 2 Comparison of re-victimisation of childhood sexual abuse and comparison subjects

Victimisation type	Comparisons (n=2,677)		Cases (n=2,759)		OR	95% CI	p
	n	%	n	%			
Any contact as victim	893	33.4	1,000	36.2	1.14	1.02–1.27	0.000
Sexual assault	42	1.6	215	7.8	5.30	3.79–7.41	0.000
Violence	154	5.8	389	14.1	2.69	2.21–3.27	0.000
Kidnap	0	0.0	8	0.8	–	–	–
Threat of violence	15	0.6	64	2.3	4.21	2.41–7.41	0.000
Property damage	175	6.5	258	9.4	1.48	1.21–1.8	0.000
Weapons offence	0	0	10	0.4	–	–	–
Stalking	16	0.6	34	1.2	2.08	1.14–3.77	0.014
Deception	15	0.6	25	0.9	1.62	0.85–3.09	0.136
Theft	740	27.6	691	25	0.88	0.78–0.99	0.030
Bad public behaviour	4	0.1	1	0.0	0.24	0.03–2.17	0.212 ^a

a=Fisher's exact test

the rate for male CSA cases who were abused when under the age of 12 years (2.9%; OR=3.33, 95% CI 1.53–7.27, $p<0.001$). By contrast, for girls, there were no significant differences in the percentage who went on to be convicted of a sexual offence, regardless of whether they were abused before or after 12 years of age (0.1% or 1 out of 1,000 cases).

Association between childhood sexual abuse and victimisation

The mean number of victimisation incidents was higher for CSA cases than for the comparison group (2.94 vs 1.93, $t=9.88$, $p=0.000$). There was no significant difference in the mean number of separate sexual victimisation incidents reported (1.62 vs 1.45, $t=0.86$, $p=0.39$). Overall, CSA victims were significantly younger than the others when they were first re-victimised (range=2.93–55.26 years; $M=22.73$, $SD=9.32$ vs range=2.57–54.46 years; $M=27.60$, $SD=9.92$; $t=10.94$, $p=0.000$). However, there was no significant age difference between CSA victims and the general population when comparing the average age of first sexual (re)victimisation (16.79 vs 17.81 years, $t=0.64$, $p=0.53$).

CSA victims (36%) were 1.14 times more likely than others (33.4%) to have been victimised for any offence ($p=0.000$); however, this difference remained significant only for male victims (OR=1.28, 95%

CI 1.01–1.61.76, $p=0.038$). With the exception of theft and bad public behaviour, CSA cases were significantly more likely to be victimised for all types of offences compared with the general population. Male CSA cases were significantly more likely than male comparisons to have been victimised for sexual and violent offences. Female CSA cases were significantly more likely than comparison females to report victimisation for a sexual offence, threat of violence, violence and property damage. The association for sexual victimisation was stronger for male CSA cases relative to their male peers compared with females; however, female CSA cases were significantly more likely than CSA males to be sexually re-victimised. Conversely, while male CSA cases were significantly more likely to have been a victim of violence than the CSA females, the association with being a victim of violence compared with the general population was stronger for female CSA cases.

Mediating factors between childhood sexual abuse and offending

When examining the effects of the sexual abuse variables of age at abuse (before and after 12 years of age), penetration, frequency of abuse (1 vs multiple) and number of perpetrators (1 vs multiple), upon the presence of criminal history among the CSA population, older age at abuse was found to be significant. As noted above, the

strongest relationship yielded was for males sexually abused after the age of 12 years, being 3.33 times more likely than younger males to be subsequently charged with a sexual offence (95% CI 1.53–7.27, $p=0.001$). This remained significant even when other factors, such as severity or duration of abuse, were considered.

Discussion

Overcoming many limitations of previous studies, this study revealed that, in general, CSA victims were 1.4 times more likely to have some form of contact with the police for any matter compared with other members of the general community. Although most (77%) CSA victims did not have an official criminal record, CSA victims were almost five times more likely than others to be charged with any offence, with the strongest associations yielded for sexual and violent offences and breach of orders. It was contact with the police for being a victim of crime that accounted for a large proportion of all contacts. Nonetheless both male and female CSA victims were significantly more likely than non-abused people to be charged all types of offences, in particular violence and sexual offences. Not only were CSA victims more likely than others to offend, they had a greater number of charges, a higher proportion of charges resulting in a guilty verdict, more custodial sentences and they continued offending to an older age. These findings suggest that offences committed by sexual abuse victims

are not isolated to sexual offences or being male (Benoit & Kennedy 1992).

While the majority (99%) of male and female victims of CSA were not charged for a sexual offence, CSA victims were 7.6 times more likely to be charged with sexual offences than the general population. Moreover, as the results show, a surprisingly high percentage of male victims were subsequently convicted of a sexual offence (5% of all male victims and 9.25 of those aged 12 years and above at the time of their victimisation). Some other research has found no association between childhood victims of sexual abuse and future sexual offending; however, this may be due to the small sample size of CSA victims and the fact that the samples comprised mostly females (Widom 1989a, 1989b). In a meta-analysis of factors related to recidivism in sex offenders, Hanson and Bussiere (1998) did not find a relationship between sexual abuse victimisation and subsequent sexual offending. This is, of course, due to the nature of the studies included in the meta-analysis, which have largely relied on self-report and retrospective methodology.

As expected, male CSA victims were largely responsible for the increased rate of sexual offences, in particular those boys abused at 12 years or older. Given that almost one in 10 boys who were sexually abused in this age group subsequently were convicted of a sexual offence, sexual victimisation may be an important risk factor for this population (but not for females). The hallmark feature of this period is psychosexual development, where heightened sexual arousal may be paired with cognitive distortion/implicit theories relating to sexual relations (Ward 2000) and aberrant sexual urges, which may develop and underlie sexual offending. Possible explanations for the phenomenon were not examined in this study, but should be investigated in subsequent studies.

Surprisingly, four CSA cases committed homicide compared with no control cases. Applying statistics from the wider Australian population, two or three murders per 100,000 persons would be expected—not anywhere near the 145 murders per 100,000 CSA victims revealed here. Findings also showed female victims were

as likely as male victims to be charged with homicide. These findings must be interpreted cautiously given the limited sample size.

This study extends upon and lends further support to the association between CSA and re-victimisation. With the exception of theft and bad public behaviour, CSA cases were more often victims of crime than non-abused comparisons, with highest associations found for sexual offences (5x more likely), threats of violence (4x) and violent offences (3x). On average, CSA cases reported more separate victimisation incidents than the general population; however, there was no difference in the number of separate incidents relating to sexual assault. This is the first prospective study to demonstrate that male victims of CSA were significantly more likely than males in the general population, but significantly less likely than their female abused counterparts, to be a victim of a subsequent sexual assault.

These findings have a number of implications for clinical, policing and judicial practices. One clear implication is the need for therapeutic interventions targeted at adolescent male CSA victims with a focus on positive sexuality in attempt to reduce their heightened risk of committing a sexual offence. The benefits of psychological treatment for trauma, addressing victims' mental health problems and preventing or addressing criminogenic risk factors such as low education and employment attainment, substance abuse and negative supports, in the aftermath of sexual abuse to both male and female victims is also likely to reduce the risks of offending in general and violent offences in particular. Legal and judicial representatives, as well as forensic psychologists and psychiatrists who may assess offenders, should take into consideration the complex interplay between history of CSA, mental illness and offending. Offender treatment programs in the community or custodial settings may need to be adapted to consider the role of childhood abuse in attempts to reduce recidivism. Many now do not allow for the discussion of offenders' own sexual victimisation.

In conclusion, this is the largest prospective study to demonstrate with confidence that the majority of victims sexually abused during childhood do not perpetuate the cycle of violence by becoming an offender or by the ongoing victimisation of violence. However, relative to members of the general population, both male and female CSA victims are at an increased risk for committing or experiencing a range of offences, in particular those of a sexual or violent nature. This study also indicates that adolescent males who experience serious sexual abuse form a high-risk group for those who subsequently commit sexual offences and require active intervention and follow up.

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APPENDIX C: ETHICS APPROVAL



MONASH University

Standing Committee on Ethics in Research Involving Humans (SCERH)
Research Office

Prof James Ogloff
School of Psychology, Psychiatry and Psychological Medicine
Faculty of Medicine, Nursing and Health Sciences
Campus

29 August 2007

CF07/1727 - 2007/0531ED: Child sexual abuse and subsequent criminal offending and victimisation

Dear Researchers,

Thank you for the information provided in relation to the above project. Given the sensitive nature of the data, the Committee approves the research to start at the Department of Human Services and the Victoria Police but work must not commence at the Victorian Institute of Forensic Medicine until permission is obtained from their committee. Please forward the approval letter to SCERH once it is available.

Please note that SCERH has granted an exemption under the guidelines approved under the Health Records Act 2001 (Vic) Statutory Guidelines on Research issued for the purposes of Health Privacy Principles 1.1(e) (iii) and 2.2 (g) (iii).

Terms of approval

1. This project is approved for five years from the date of this letter and this approval is only valid whilst you hold a position at Monash University.
2. It is the responsibility of the Chief Investigator to ensure that all information that is pending (such as permission letters from organisations) is forwarded to SCERH, if not done already. Research cannot begin at any organisation until SCERH receives a letter of permission from that organisation. You will then receive a letter from SCERH confirming that we have received a letter from each organisation.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by SCERH.
4. You should notify SCERH immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must contain your project number.
6. **Amendments to the approved project:** Changes to any aspect of the project require the submission of a Request for Amendment form to SCERH and must not begin without written approval from SCERH. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. Please provide the Committee with an Annual Report determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. SCERH should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by SCERH at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

All forms can be accessed at our website www.monash.edu.au/research/ethics/human/index.html

We wish you well with your research.



Dr Souheir Houssami
Executive Officer, Human Research Ethics (on behalf of SCERH)

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ABN 12 377 614 012 CRICOS Provider #00008C

Victorian Institute of Forensic Medicine


Document Name: RESEARCH AND RELATED PROJECTS ETHICS COMMITTEE APPROVAL

NAME OF PROJECT:

Child sexual abuse and subsequent
criminal offending and victimization
EC 8/2008

APPLICANT:

Ms. Margaret Cutajar PhD Candidate
in association with
Professor Paul Mullen, Professor S. Osloff
A Professor D. Wells

ADDRESS:

Monash University
Locked Bag 10, Fairfield 3078

The VIFM Ethics Committee has approved your application for research using human tissue or related projects.
Please complete the attached agreement which sets out the terms and conditions under which the tissue will be made
available or how related projects will be conducted.
Please return the completed agreement form to Ms Patricia O'Brien.
Please then contact Mr Justine Mizen on 9684 4444 to make required arrangements.

CHAIRMAN'S SIGNATURE

 DATE: 23rd August 2008



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HUMAN RESEARCH ETHICS COMMITTEE

69/07

Ethics Committee Secretariat
Telephone: (03) 9096 5239 Fax: (03) 9096 9176
50 Lonsdale St
MELBOURNE 3000
Email: research.ethics@dhs.vic.gov.au

Our Ref:
Your Ref:

23 August 2007

Professor R P Ogloff
Monash University and Victorian Institute of Forensic Mental Health
Locked Bag 10
Fairfield
VIC 3078

Dear Professor Ogloff,

Re: 69/07 - Child sexual abuse and subsequent offending and victimisation

The Department of Human Services Human Research Ethics Committee, at its meeting on 5 September 2007, ratified the approval of the response, dated 16 August 2007, for the above project.

Should you have any queries please do not hesitate to contact Ms Vicki Xafis on [REDACTED] or email [REDACTED]

Yours sincerely

[REDACTED]

PROF CAROL MORSE
ACTING CHAIR





Department of Justice

Human Research Ethics Committee

Level 21, 121 Exhibition
Street Melbourne 3000
Telephone: (03) 8684 1514
Facsimile: (03) 8684 1525
DX210077

9 April 2008

Reference: CF/08/4835

Professor James Ogloff
c/o Ms Margaret Cutajar
Monash University
School of Psychology, Psychiatry, & Psychological Medicine, Monash University,
Building 17, Wellington Rd, Clayton, VIC 3800

Re. Child sexual abuse and subsequent offending and victimisation: A prospective study

The Chair of the Department of Justice Human Research Ethics Committee considered your response in relation to the project *Child sexual abuse and subsequent offending and victimisation: A prospective study*, (out of session) and granted full approval for the duration of the investigation. The Department of Justice reference number for this project is CF/08/4835.

You must ensure that the Department of Justice Research Ethics Committee is notified immediately of any matter which arises that may affect the conduct or continuation of the approved project. To enable the Committee to fulfil its reporting obligations, you are asked to provide an Annual Report every 12 months and to report on the completion of your project. Annual Report and Completion of Research forms are available on the Justice Research Ethics website which is located at [REDACTED] About Us > Our Values > Ethics.

The Department of Justice would also appreciate receiving copies of any relevant publications, papers, theses or conferences presentations that result from this research.

All future correspondence regarding this project must be sent electronically to [REDACTED] and include the Department of Justice reference number as well as the project title. Hard copies of signed documents or original correspondence should be sent to The Secretary, Human Research Ethics Committee at the following address: Level 21, 121 Exhibition St, Melbourne, VIC 3000.

Please sign the Undertaking attached and return within ten business days. If you have any queries regarding this application you are welcome to contact me at any time on [REDACTED] or email: [REDACTED]

Yours sincerely,

Ann Bruce
Secretary
Human Research Ethics Committee