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PERSPECTIVES ON COPING WITH CHILD SEXUAL ABUSE

Child Sexual Abuse and Psychological Impairment in Victims: Results of an Online Study Initiated by Victims

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Sexual abuse of children has been a topic of scientific investigation for the past few decades. Research in this area, however, is rarely initiated, conceptualized, and conducted by victims themselves. Apart from possibly having painted a one-sided picture of sexual abuse, this presumed dominance of nonvictims might also have marginalized victims in a research area central to their lives. This study was conducted by a victims interest group as an effort to meet the need to add victims' perspectives to our current understanding of this topic. The online survey focused on investigating victims' psychosocial impairment, which was found to be extensive. Results indicated that an intact social support system facilitates better health, especially when offered early on.

KEYWORDS child sexual abuse, victims, perpetrators, psychosocial impairment, gender differences, victim support group

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Over the past several decades, public awareness regarding the societal problem of child sexual abuse (CSA) has grown steadily. This is reflected in there being a vast body of both scientific and popular literature on the topic. CSA encompasses "showing pornography to a child, engaging in sexual talks with a child, undressing or masturbating in the presence of a child, as well as more intrusive physical acts, such as fondling, oral sex, or penetration" (Neutze, Seto, Schaefer, Mundt, & Beier, 2010, p. 213). While CSA has received increasing attention within academia with respect to perpetrators as well as victims, it appears that research is rarely noticeably initiated, conceptualized, or conducted by individuals affected most by the abuse—the victims. As a result, specific aspects of CSA might not have received appropriate attention, producing a one-sided picture of the phenomenon and its ramifications. More important, by ignoring the "insider" perspective, the wrong message may have been sent to victims, suggesting that they shall remain predominantly passive in academia's dealing with the problem. They are talked *about*, and research is conducted *on* them, when instead a mindset promoting togetherness and cooperation is likely to be more appropriate and promising.

Against this background, the victim-run support group MOGiS e.V.[1] conducted a study that investigated whether impressions and experiences gained from working with its members and people closely related to the organization could be supported by empirically based findings. The study was initiated, conceptualized, and led by the first author, president of MOGiS and a victim of CSA. One specific aim was to investigate how being affected by CSA directly or indirectly influences one's estimate of the prevalence of CSA and how these estimates compare with the rates found in a German study using a representative sample (Wetzels, 1997). Wetzels found that prevalence rates varied between 2.8% and 7.3% for men and between 8.6% and 18.1% for women, depending on the definition of CSA. Another aim of the MOGiS study was to determine the magnitude of symptoms of impaired psychosocial functioning among CSA victims, as this can be one indicator of an impaired quality of adult life (Phillips & Rasmussen, 2004). Some concrete assumptions were also tested. On a broader note, however, the main objective of this study was to consciously take on an active and visible role in the scientific investigation of a topic that has been, and for many always will be, a central part of their daily life. Thus, this research was triggered more by an interest group's need to add victims' perspectives to academia's discussion on the topic than to confront gaps in the literature. The study was also designed to keep participants' distress as minimal as possible. Because of its motivational background and methodological approach, comparisons with findings from other research are limited.

The main hypotheses were: (a) victims, their relatives and partners, and professionals working in the field estimate the incidence of CSA to be higher compared to people who are not involved with the topic; (b) females are

more likely to be victims than males; (c) very young and young children (before age six) are less likely to be victims than schoolchildren; (d) below the age of 10, boys and girls experience sexual abuse in equal proportions; (e) with increasing age (older than 10 years of age), a higher proportion of females experience sexual abuse whereas boys experience less, as they become less interesting to heterosexual abusers (who become appalled by boys' masculinity/maturity); (f) victims often experience other adverse childhood experiences in addition to CSA; (g) victims experience a large pattern of psychosocial impairment; (h) due to their personal difficulties, a large percentage of victims report problems integrating themselves into society; (i) more severe forms of sexual abuse coincide with a higher incidence of psychosocial impairment; and (j) the more the victim can distance himself or herself from taking on responsibility for the abuse, the less he or she will be affected by psychosocial impairment. Overall, as the literature disproportionately focuses on female victims, it was of interest how the findings differ for men and women.

METHOD

Procedure

This was a cross-sectional study using an online survey. Potential participants were made aware of the opportunity to take part through various sources: via the initiators' Website (http://mogis-verein.de/umfrage), using Twitter, through references made by several well known political activists, and via contacts with other victim support groups. As online surveys are very useful for discussing topics that are considered taboo, taking a network approach and implementing a freely available Web formula for data collection was considered helpful in achieving a large sample size. It was explicitly mentioned that both victims and nonvictims were invited to participate. As a victims' organization, MOGiS has a strong standing in the civil rights movement in Germany and, thus, it was assumed that people in general were keen to support this study. As an incentive especially for nonvictims to participate, all participants were offered the opportunity to register with an undisclosed recipient list that was detached from the questionnaire and to which the results of the study would be e-mailed once they were published. It was clearly stated that participation was voluntary.

To collect data, a questionnaire was posted online (http://dunkelfeldbefragung.de). Its scope and content was fully transparent from the onset. To make their data available for analysis, participants had to consciously submit their completed questionnaire. To withdraw from participation, the window could be closed at any time, without data being submitted. Any part of the questionnaire could be skipped if found too distressing.

Measure

The questionnaire was divided into four sections. First, participants were asked to answer questions regarding their gender, age group, exact age, and the nature of their relation to the topic (*victim, relative of victim, partner of victim, professional working in the field, acquaintance of victim, nonvictim*; participants could select all that applied). Participants were then asked to estimate the prevalence of CSA in the general population as well as for males and females separately. The frequencies were graded in an approximation of a logarithmic scale (*<1%, 1–2%, 2–3%, 3–4%, 5–7%, 8–10%, 11–15%, 16–20%, 20–30%, 30–50%, >50%*). In addition, participants could give an exact percentage estimate. They were also invited to indicate how confident they were regarding their estimate (*not specified, very sure, sure, slightly sure, a little sure, unsure, very unsure*).

The third section included items assessing various adverse childhood experiences (ACE) they might have experienced personally as a child or adolescent. Participants were reminded to monitor their well-being and were assured that it was absolutely acceptable to either skip this section or to submit their questionnaire at this point if they felt too distressed. Data on the occurrence of beatings, neglect, humiliation, and emotional exploitation were collected, as was information regarding various forms of CSA (*had involuntary sex, had sex with adults, was shown pornography, had to watch others engaged in sexual activity, had to perform sexual acts on others, had to perform sexual acts on myself, had sexual acts performed on myself, other things*; participants could select all that applied). Regarding the three items on sexual acts performed, participants could specify whether penetration took place.

Within the same section, age group at victimization (*up to 2 years of age, age 3–4, 5–6, 8–10, 11–13, 14–16*; participants could select all that applied) and specific age at victimization was assessed. Next, information regarding the perpetrator(s) was collected, such as gender, age (*younger, approximately same age, more than 5 years older, more than 20 years older, specific age*; participants could select all that applied), and relationship to perpetrator (*mother/father, siblings, uncle/aunt, grandmother/grandfather, relatives, friends of family, acquaintances of family, own friends, own acquaintances, teacher/coach, stranger*; participants could select all that applied). Furthermore, participants were asked whether any (legal) consequences followed (*no comment, I was not believed, it was not followed up, it was settled in private, a police report was filed, criminal proceedings followed, a verdict was spoken*). Finally, participants could indicate to what extent they felt responsible for what they experienced (*well distanced, feelings of partial guilt, full responsibility taken*; participants could select all that applied).

The fourth section asked participants to indicate which symptoms of psychosocial impairment affected them, offering a list of 53 items referring to everyday life, interpersonal difficulties, and intrapersonal difficulties. Because the initiator of the study wished to encourage victims to experience themselves as subjects rather than objects of victimization, the questionnaire tried to capture the experiences of the participants themselves as they encountered them rather than adhere to clinical or scientific definitions of mental and psychological disorders. Thus, these data represent subjectively experienced impairment and not clinically derived diagnoses of diseases.

Group Comparison

The following categories were combined into distinct groups for comparisons: estimates of prevalence and confidence in one's estimates; *victim*, *relative of victim, partner of victim, and professional working in the field* were combined to *affected*, and *acquaintance of victim* and *nonvictim* were combined to *nonaffected*. A participant was classified as *victim* if he or she selected *victim* or, in case the respective question was not answered, if details were reported with respect to the nature of sexual offense and/or to the perpetrator. CSA described as *was shown pornography* and *had to watch others engaged in sexual activity* were combined to *hands-off* offenses; all other categories were classified as *hands-on* offenses. Classifying *had to perform sexual acts on myself* as *hands-on* seemed justified because the victim's body was touched by hands, albeit the victim's own hands. If a participant selected more than one category with respect to his or her relationship to the perpetrator, the category implying more emotional involvement was chosen for analyses. Emotional involvement was assumed to decrease in the following order: *victim* (highest), *relative of victim and partner of victim, professional working in the field, acquaintance of victim, nonvictim* (lowest). With respect to how responsible victims felt for what happened, the answer indicating the strongest feeling of guilt was chosen when more than one category was selected.

Participants

Overall, 502 datasets were entered during the approximately five-month assessment period between October 2009 and March 2010. Arguably, each dataset represents one individual. Two participants reported being both victim and nonvictim. Four participants reported neither being a victim nor a nonvictim, nor reported information regarding the incident or the perpetrator. Three further participants reported data that was evaluated as unreliable. As result of excluding these participants from further analysis,

the final sample size was 493. Due to the questionnaire's design, the data of nonvictims may only be analyzed for a few items. For example, it was not possible to determine whether a participant chose to skip the section on psychosocial impairment or simply had nothing to report (i.e., did not select any of the response options). Nonselection of response options was often found among the nonvictims. Therefore, for all but three variables the data analyzed will be from the subsample of victims only ($N = 245$).

SPSS 19.0 was used for data analyses. Group comparisons were tested for significance using Mann-Whitney U Test, Kruskal-Wallis Test, t-test, and chi-squares.

RESULTS

Due to missing data, the sample size per analysis varied between 115 and 493. The proportions of male (53.7%, $n = 263$) and female (46.3%, $n = 227$) participants were almost equal. The youngest participant was 13 years of age at the time of participation, and one participant stated to be "older than 65." The median age category was 25–30 years of age ($n = 484$), with an average age of 26 ($n = 200$). Almost half the sample (42.4%, $n = 208$) identified as victims. A few participants were a relative or partner of a victim (4.5%, $n = 22$) or a professional in the field (1.8%, $n = 9$). Over half of participants (51.3%, $n = 252$) stated they were unaffected by the topic; 20 of these identified as an acquaintance of a victim. As some participants did not categorize themselves as a victim but reported details regarding the offense ($n = 17$) or the perpetrator ($n = 21$), the true proportion of victims in this study was 49.7% ($n = 245$).

With respect to estimating the prevalence of CSA, affected participants estimated significantly higher rates compared to nonaffected participants. While the first groups' estimates are 8%–10% for male victims, 20%–30% for female victims, and 16%–20% for the general population, nonaffected participants' estimates are 3%–4% for male victims and 8%–10% for both female victims and the general population ($U = 13101.5$, $p < .01$; $U = 11646.0$, $p < .01$; $U = 10627.0$, $p < .01$, respectively). Overall, participants were largely insecure and somewhat insecure regarding their estimates, with affected individuals being significantly less insecure ($U = 13775.0$, $p < .01$; 199<N>213).

Victims of CSA ($N = 245$)

Two thirds (65.2%, $n = 159$) of victims were females. At the time of participation, the mean age category among women and men was 21–24 and 31–40 years of age, respectively ($N = 240$). Distribution over all age categories for men and women separately is reported in Table 1. Among victims,

TABLE 1 Victim Ages by Victim Gender

	Male victims		Female victims		Total	
	#	%	#	%	#	%
Age at time of data collection (multiple choices possible)	$n = 83$		$n = 157$		$N = 240$	
14–17 years of age	3	(3.6%)	11	(7.0%)	14	(5.8%)
18–20 years of age	6	(7.2%)	23	(14.6%)	29	(12.1%)
21–24 years of age	11	(13.3%)	44	(28.0%)	55	(22.9%)
25–30 years of age	15	(18.1%)	38	(24.2%)	53	(22.1%)
31–40 years of age	28	(33.7%)	24	(15.3%)	52	(21.7%)
41–50 years of age	14	(16.9%)	13	(8.3%)	27	(11.3%)
50–65 years of age	6	(7.2%)	4	(2.5%)	10	(4.2%)
Age at (first) victimization (multiple choices possible)*	$n = 74$		$n = 140$		$N = 214$	
Maximum 2 years of age	4	(5.4%)	14	(10.0%)	18	(8.4%)
Maximum 4 years of age	8	(10.8%)	32	(22.9%)	40	(18.7%)
Maximum 6 years of age	26	(35.1%)	40	(28.6%)	66	(30.8%)
Maximum 10 years of age	37	(50.0%)	50	(35.7%)	87	(40.7%)
Maximum 13 years of age	35	(47.3%)	69	(49.3%)	104	(45.6%)
Maximum 16 years of age	22	(29.7%)	52	(37.1%)	74	(34.8%)
Maximum 17 years of age	2	(2.7%)	4	(2.9%)	6	(2.8%)

*Nonadditive categories.

women estimated the prevalence of CSA to be significantly higher compared to men, with rates of 20%–30% and 8%–10%, respectively ($U = 2751.5$; $p < .01$). Both male and female victims were rather insecure regarding their estimates (72<N>141).

Age at Victimization ($N = 214$)

When first sexually abused, the most prominent age category was between 11 and 13 years of age for girls (27.9%, $n = 39$) and five to six years of age for boys (28.4%, $n = 20$). Many victims were sexually abused at various times in their life. Taking multiple answers into account, Table 1 shows that the proportion of male and female victims increases until the age of 10 and 13 respectively. A marked proportional increase was found for male victims between the second age category (3–4 years of age) and the third (5–6 years of age) as well as between the third and fourth age category (7–10 years of age). A marked decrease occurs between the fifth (11–13 years of age) and sixth (14–16 yeas of age) age category. Significantly more females (22.9%) than males (10.8%) were sexually abused as a 3- to 4-year-olds, $\chi 2\ (1, N = 40) = 4.622$, $p < .05$, and significantly more males (50%) than females (35.7%) were sexually abused as a 7- to 10-year-olds, $\chi 2\ (1, N = 87) = 4.095$, $p < .05$.

Nature of CSA ($N = 193$)

As only a small proportion of the victims (8.3%, $n = 16$) experienced hands-off offenses exclusively, the vast majority (91.7%, $n = 177$) experienced arguably more severe forms of hands-on CSA. Over one third (37.3%, $n = 72$) of these offenses included penetration, with girls experiencing this form of CSA more often than boys (40.6% and 30% respectively; see Table 2).

Nonsexual Abuse (N = 240)

In addition to the different forms of CSA, Table 2 lists four forms of nonsexual abuse experienced within this sample (beaten, neglected, humiliated, emotionally exploited). While one-third (29.2%, $n = 70$) of the victims experienced CSA exclusively, one-third (28.8%, $n = 69$) experienced one additional form of abuse, 17.5% ($n = 42$) experienced two, and 17.0% ($n = 41$) experienced three additional forms of abuse. All four of the listed nonsexual forms of abuse were experienced by 7.5% ($n = 18$) of CSA victims.

Perpetrator Gender and Age (N = 218)

Having been sexually abused by men and women was reported by 17.9% ($n = 14$) of male victims and by 7.9% ($n = 11$) of female victims. A female perpetrator was reported 43 times, which represents a fifth (19.6%) of the cases. Male and female victims reported to have been sexually abused by a female perpetrator only in 12.8% ($n = 10$) and 5.7% ($n = 8$) of cases,

TABLE 2 Adverse Childhood Experiences by Victim Gender

	Male victims		Female victims		Total	
	#	%	#	#	%	#
Nature of sexual abuse (multiple choices possible)	$n = 60$		$n = 133$		$N = 193$	
Hands-off	26	(43.3%)	43	(32.3%)	69	(35.8%)
Hands-on (no penetration)	50	(83.3%)	127	(95.5%)	177	(91.7%)**
Hands-on with penetration	18	(30.0%)	54	(40.6%)	72	(37.3%)
Additional ACE* (multiple choices possible)	$n = 83$		$n = 157$		$N = 240$	
Beaten	44	(53.0%)	72	(54.1%)	116	(48.3%)
Neglected	25	(30.1%)	62	(39.5%)	87	(36.3%)
Humiliated	13	(15.7%)	34	(21.7%)	47	(19.6%)
Emotionally exploited	20	(24.1%)	78	(49.7%)	98	(40.8%)

*ACE = adverse childhood experiences.
**U = 3505.0, $p < .01$.

TABLE 3 Perpetrator Gender and Age by Victim Gender

	Male victims		Female victims		Total	
	#	%	#	#	%	#
Perpetrator gender (multiple choices possible)	$n = 78$		$n = 140$		$N = 218$	
Only female perpetrator	10	(12.8%)	8	(5.7%)	18	(8.3%)
Only male perpetrator	54	(69.2%)	121	(68.4%)	175	(80.3%)
Male and female perpetrator	14	(17.9%)	11	(7.9%)	25	(11.5%)
Perpetrator age* (multiple choices possible)	$n = 68$		$n = 123$		$N = 191$	
Younger	1	(1.5%)	1	(0.8%)	2	(1.0%)
Same age	17	(25.0%)	22	(17.9%)	39	(20.4%)
Minimum 5 years older	17	(25.0%)	47	(38.2%)	64	(33.5%)
Minimum 20 years older	44	(64.7%)	83	(67.5%)	127	(66.5%)

*In relation to victim.

respectively. Overall, boys (30.8%) were sexually abused by female perpetrators significantly more often than girls (13.5%), $\chi 2$ (1, $N = 218$) = 9.16; $p < .01$. Table 3 also shows that in one-third (33.5%, $n = 64$) of the cases the perpetrator was more than five years older, and in two-thirds (66.5%, $n = 127$) of the cases more than 20 years older than the victim ($N = 191$).

Perpetrator–Victim Relationship (N = 208)

Overall, two-thirds (67.8%, $n = 141$) of the victims were sexually abused within their extended family, including friends of the family. This proportion was 61.1% ($n = 44$) and 71.3% ($n = 97$) for male and female victims, respectively. For seven of the eight female victims who reported a female perpetrator only, the perpetrator was their own mother. In contrast, of the 10 male victims who reported a female perpetrator only, one-third (30%, $n = 3$) were sexually abused by their mothers and in one case a sister was named as the perpetrator. Thus, in the majority of these cases, boys were sexually abused by female perpetrators outside their family. Having been abused by a stranger only was reported by 9.6% ($n = 20$). Further results regarding the relationship between victim and perpetrator are listed in Table 4.

Legal Action ($N = 115$)

Half the sample of victims ($n = 129$, 52.7%) either skipped this item or selected "no comment." Thus, the following results are based on a reduced sample size ($N = 115$). Overall, the proportion of cases that resulted in a court verdict was 8.7% ($n = 10$). In addition, as shown in Table 5, criminal

TABLE 4 Perpetrator–Victim Relationship by Victim Gender

	Male victims		Female victims		Total	
	#	%	#	#	%	#
Perpetrator–victim relationship (multiple choices possible)	$n = 72$		$n = 136$		$N = 208$	
Father or mother	31	(43.1%)	41	(30.1%)	72	(14.7%)
Siblings	3	(4.2%)	9	(6.6%)	12	(2.4%)
Uncles or aunts	3	(4.2%)	17	(12.5%)	20	(8.2%)
Grandfather or grandmother	1	(1.4%)	9	(6.6%)	10	(4.1%)
Other relatives	3	(4.2%)	14	(10.3%)	17	(6.9%)
Friends of the family	11	(15.3%)	29	(21.3%)	40	(16.3%)
Person in charge (teacher/coach)	5	(6.9%)	13	(9.6%)	18	(7.3%)
Stranger	14	(19.4%)	21	(15.4%)	35	(14.3%)
Own friend	19	(26.4%)	38	(27.9%)	57	(23.3%)

TABLE 5 Consequences by Victim Gender

	Male victims		Female victims		Total	
	#	%	#	#	%	#
Consequences/prosecution	$n = 34$		$n = 81$		$N = 115$	
I was not believed/it was not followed up	25	(73.5%)	56	(69.1%)	81	(70.4%)
It was "settled" in private	4	(11.8%)	5	(6.2%)	9	(7.8%)
A police report was filed	1	(2.9%)	11	(13.6%)	12	(10.4%)
Criminal proceedings followed	0	(0.0%)	3	(3.7%)	3	(2.6%)
A verdict was spoken	4	(11.8%)	6	(7.4%)	10	(8.7%)
Feelings of guilt	$n = 68$		$n = 145$		$N = 213$	
Well distanced	49	(72.1%)	57	(39.3%)	106	(49.8%)
Feelings of partial guilt	16	(23.5%)	71	(49.0%)	87	(40.8%)
Full responsibility assumed	3	(4.4%)	17	(11.7%)	20	(9.4%)

proceedings were reported by 2.6% ($n = 3$) and a police report was filed in 10.4% ($n = 12$) of cases, with all of these cases involving male victims ($n = 3$ and $n = 11$, respectively).

Feelings of Guilt ($N = 213$)

Approximately half the sample (49.8%, $n = 106$) were able to distance themselves well enough from the experience of CSA. Many (40.8%, $n = 87$) felt partial guilt, and a smaller but still sizeable proportion (9.4%, $n = 20$) took full responsibility for what happened. Table 5 shows results by gender of victim. A significantly higher proportion of female victims than male victims reported feelings of guilt, $U = 3286.0$, $p < .01$.

Psychosocial Impairment ($N = 221$)

Overall, victims allocated to the first quartile reported up to 9 symptoms, while those allocated to the second quartile reported between 10 and 16 symptoms, and those allocated to the third quartile reported between 17 and 24 symptoms. The highest number of reported symptoms was 43 of 53 possible. Females reported significantly more symptoms ($M = 18.4$; $SD = 9.08$; $N = 152$) compared to males ($M = 13.1$; $SD = 8.6$; $N = 69$), $t(219) = -4.074$, $p < .001$. Table 6 shows the distribution by victim gender for all symptoms offered to the participants in this study.

Psychosocial Impairment and Severity of CSA ($N = 179$)

Overall, there is a significant relationship between the severity of the experienced offense and the number of reported symptoms of psychosocial impairment, $\chi 2\ (2, N = 180) = 11.21$, $p < .01$. The more severe the offense, the more symptoms were reported. However, this was only significant for female victims, $\chi 2\ (2, N = 127) = 8.79$, $p < .01$.

Psychosocial Impairment and Feelings of Guilt ($N = 203$)

Overall, the more responsibility a victim took on, the more symptoms of psychosocial impairment were reported, $\chi 2\ (2, N = 204) = 54.20$, $p < .01$. This was found to be significant for both female victims ($\chi 2\ [2, N = 141] = 34.44$, $p < .01$) and male victims ($\chi 2\ [2, N = 62] = 7.86$, $p < .05$).

DISCUSSION

This study set out to investigate perceptions of victimization, the perpetrator, and impaired psychosocial functioning in victims of CSA. The high proportion of victims (49.7%) in this study may be easily explained by the sampling procedure (i.e., actively approaching victim organizations and support groups and motivating their members to participate). Other findings, such as the higher rate of female victims, frequent multiple victimizations, and higher rate of victims within the extended family were also not that surprising. Likewise, with respect to female victims, the higher rate of CSA involving penetration found in this study confirms previous research (Maikovich-Fong & Jaffee, 2010). In this study, a fifth of the perpetrators were female, and male victims of female perpetrators were predominantly abused outside the family. The peculiarities of the research on female-perpetrated CSA have resulted in respective prevalence rates that vary widely (Deering & Mellor, 2010), and as such reflect the status in this area of

TABLE 6 Psychosocial Impairment

	Male victims		Female victims				
	$n = 69$		$n = 152$				
$N = 221$	#	%	#	%	χ^2	df	P
Affecting everyday life							
Depressiveness	42	(60.9)	107	(70.4)	1960	1	.161
Sadness	35	(50.7)	96	(63.2)	3039	1	.081
Anxiety	26	(37.7)	104	(68.4)	18514	1	.000**
Feelings of weakness	22	(31.9)	78	(51.3)	7233	1	.007**
Testiness	27	(39.1)	71	(46.7)	1105	1	.293
Despair	21	(30.4)	71	(46.7)	5174	1	.023*
Fears	20	(29.0)	71	(46.7)	6156	1	.013*
Anger	26	(37.7)	59	(38.8)	.026	1	.872
Passivity	29	(42.0)	54	(35.5)	.856	1	.355
Panic	13	(18.8)	68	(44.7)	13707	1	.000**
Aggressiveness	20	(29.0)	58	(38.2)	1748	1	.186
Obsessive-compulsive behaviors	18	(26.1)	48	(31.6)	.683	1	.408
Violence	3	(4.3)	12	(7.9)	.944	1	.331
Relating to self-worth and self-harm							
Strong mood swings	39	(56.5)	105	(69.1)	3296	1	.069
Low self-esteem	34	(49.3)	102	(67.1)	6374	1	.012*
Strong uncertainty regarding own emotions	27	(39.1)	95	(62.5)	10481	1	.001**
Body image is not confirmed[1]	18	(26.1)	101	(66.4)	31106	1	.000**
Self-hate	17	(24.6)	82	(53.9)	16486	1	.000**
Self-injuries	11	(15.9)	88	(57.9)	33776	1	.000**
Overweight	22	(31.9)	69	(45.4)	3576	1	.059
Excessive use of alcohol	21	(30.4)	33	(21.7)	1956	1	.162
Underweight	6	(8.7)	27	(17.8)	3072	1	.080
Excessive use of drugs	14	(20.3)	19	(12.5)	2267	1	.132
Bulimia	0	(0.0)	26	(17.1)	13376	1	.000**
Anorexia	2	(2.9)	20	(13.2)	5572	1	.018**
Affecting relationship issues							
Strong need for closeness	34	(49.3)	76	(50.0)	.010	1	.920
Strong need for distance	29	(42.0)	70	(46.1)	.311	1	.577
Inability to build up or sustain a partnership	32	(46.4)	55	(36.2)	2066	1	.151
Difficulties allowing sexual contacts	14	(20.3)	54	(35.5)	5172	1	.023
Inability to have satisfying sex	12	(17.4)	54	(35.5)	7452	1	.006
Fear of parenthood	18	(26.1)	25	(16.4)	2814	1	.093
Inability to build up relationship to men	11	(15.9)	28	(18.4)	.201	1	.654
Excessive sexual activity	13	(18.8)	20	(13.2)	1206	1	.272
Inability to build up relationship to women	13	(18.8)	17	(11.2)	2371	1	.124
Continued abusive relationships	2	(2.9)	23	(15.1)	7079	1	.008

(*Continued*)

TABLE 6 (Continued)

	Male victims		Female victims				
	$n = 69$		$n = 152$				
$N = 221$	#	%	#	%	χ^2	df	*P*
Affecting social and work life							
Inability to work regularly	21	(30.4)	53	(34.9)	.419	1	.518
Bullying	15	(21.7)	46	(30.3)	1726	1	.189
Continued victimization	4	(5.8)	30	(19.7)	7084	1	.008
Affecting learning							
School failure	18	(26.1)	30	(19.7)	1126	1	.289
Dyscalculia	1	(1.4)	10	(6.6)	2640	1	.104
Stuttering	5	(7.2)	5	(3.3)	1720	1	.190
Dyslexia	4	(5.8)	5	(3.3)	.764	1	.382
Other symptoms							
Intrusion of pictures in everyday life	15	(21.7)	88	(57.9)	24930	1	.000
Nightmares	18	(26.1)	83	(54.6)	15554	1	.000
Intrusion of pictures in dreams	11	(15.9)	81	(53.3)	27241	1	.000
Feelings of being broken	19	(27.5)	69	(45.4)	6316	1	.012
Feelings of persecution	18	(26.1)	64	(42.1)	5218	1	.022
Disembodiment	18	(26.1)	56	(36.8)	2465	1	.116
Fear of offending	20	(29.0)	26	(17.1)	4064	1	.044
Feelings of being remote controlled	12	(17.4)	26	(17.1)	.003	1	.958
Hearing voices	4	(5.8)	20	(13.2)	2656	1	.103
Feelings of being perpetrator	7	(10.1)	13	(8.6)	.146	1	.702
Certain of being perpetrator	3	(4.3)	5	(3.3)	.152	1	.696

[1]Meaning that a discrepancy exists between how the person sees him/herself and how other see them.
*p < .05. **p < .01

research in general (Pereda, Guilera, Forns, & Gómez-Benito, 2009a, 2009b). While the findings in this study are difficult to compare with other published findings regarding female perpetrators of CSA, they support the statement by Deering and Mellor (2010) that "female-perpetrated sexual abuse of children may occur with sufficient frequency to warrant much more attention" (p. 25).

Affected individuals (victims, relatives of victims, partners of victims, professionals working in the field) estimated the prevalence of CSA to be of similar prevalence to that found in a representative study using a broad definition of CSA (Wetzels, 1997). Interestingly, the significantly lower estimates by nonaffected individuals (acquaintances of victims, nonvictims) in this study resemble those figures found when using a narrow definition of CSA (Wetzels, 1997). These findings, therefore, appear to reflect the continued underestimation of the problem of CSA despite a growing public awareness.

Some findings shed new light on aspects of inconsistencies from one study to another. For example, exclusively hands-off offenses were reported by 8.3% of the victims and, thus, reported to a lesser degree than in the literature (Wetzels, 1997). Wetzels also found more than twice as many perpetrators to be a stranger compared with this study (26.0% vs. 9.6%).

A vast body of scientific literature identifies CSA as an important risk factor of developing psychological distress or other mental health problems. Due to the complexity of the relationship of CSA and adult psychosocial impairment, which includes many mediating factors such as severity of abuse, the relationship is rather unspecific but undoubted (Fossati, Madeddu, & Maffei, 1999; Hillberg, Hamilton-Giachritsis, & Dixon, 2011; Jumper, 1995; Neumann, Houskamp, Pollock, & Briere, 1996; Putnam, 2003; Rind & Tromovitch, 1997; Rind, Tromovitch, & Bauserman, 1998; Smolak & Murnen, 2002). However, there are many mixed results regarding the mediating factors and their role as risk factors for developing psychosocial problems. In line with two other studies (Banyard, Williams, & Siegel, 2004), the present study found a higher degree of psychosocial impairment for more severe forms of abuse. Despite this, there is limited influence of the severity of CSA when controlling for other risk and protective factors associated with the CSA, such as social support and self-esteem (Jonzon & Lindblad, 2006; McClure, Chavez, Agars, Peacock, & Matosian, 2008).

A disturbing finding in this study was the extent to which victims were not believed or the many cases in which no steps were taken after the incident had been uncovered. Arguably, such a hostile atmosphere can be seen as a considerable lack of social support and would increase feelings of guilt. Guilt, according to these results, is associated with increased psychosocial impairment. In addition, the high amount of additional adverse childhood experiences reported by CSA victims in this study highlights another important risk factor, as it has been shown that multiple adverse childhood experiences increase the risk of developing psychosocial impairment (Green et al., 2010).

Although studies investigating male victims are becoming more common, research on CSA generally focuses on female victims. Thus, it remains unclear if findings to date are generalizable to male victims. Altogether, the findings regarding gender differences are mixed (Hillberg et al., 2011). Overall, the data in the present study show impaired psychosocial functioning for women in many ways, with the exception of the fear of offending reported more frequently by male victims.

Limitations

The questionnaire used in this study was designed to keep the level of distress experienced by participants when answering the questions as minimal

as possible. Clearly, this approach had some negative side effects with respect to both the quantity and quality of collected data. For example, the very short questionnaire contained no definition of "child" and "adolescent." There was only a general comment at the beginning that multiple answers were often possible (it was not always specified for which question this was the case). At the same time, limiting the number of questions for which multiple answers were possible could have enabled clearer categorization regarding some variables. While the wording in some items clearly implied involuntary actions ("Had to perform sexual acts on others," "Had sex involuntarily"), other items were worded rather neutrally ("Had sex with adults," "Performed sexual acts on myself"). Also, brevity of language could have sacrificed clarity in some cases, resulting in unnecessary missing data. As participants were invited to skip sections they found too distressing, a differentiation between "missing data" and "not applicable" was often not possible, resulting in exclusion of respective data from further analysis. This particular disadvantage of the instrument's design resulted in the most regretful loss of information on psychosocial impairment among nonvictims. A further design fault must be seen in not offering the answer "did not disclose" for the question regarding legal actions. Some minor errors might also have occurred due to overlapping answering categories in three cases (e.g., age categories 41–50 and 50–65).

Conclusion

Without doubt, it would be best if CSA did not occur, and promising prevention efforts to reduce the prevalence of CSA are to be fully supported. However, as long as children and adolescents are sexually abused it is equally important to maximize victim's chances to develop in good health despite their experiences with CSA. The results of this study strongly suggest that sexual victimization may have a less impairing effect on victims if they are believed and if measures are taken to reduce feelings of guilt. As the psychosocial functioning of victims is impaired in many different ways and the proportion of victims affected by these symptoms is high, professional therapeutic care should be made available more readily. Since many victims wait a long time before they seek professional help, the provision of respective treatment should be offered regardless of how much time has passed.

Obviously, this study did not investigate a representative sample and, thus, the proportion of sexually abused participants has to be interpreted with great caution. However, nothing suggests that the findings presented here with respect to CSA victims' psychosocial impairment might not be true for many other victims of CSA as well. The victims who participated in this study could be affected more severely than others by the CSA they experienced and, thus, turned to support groups for help. However, on the other hand, they might be less impaired with respect to psychosocial functioning

and therefore better capable of getting involved in support groups. Despite the study's limitations some of its main results emphasize what some might assume to be common knowledge by now but, in fact, rather seems to have been forgotten in everyday (political) life.

From that perspective, reflecting on our reactions as adults to the voices of victims must develop into a conscious and regular behavior. Listening carefully, getting involved, and being the victim's advocate at the time when he or she voices what happened is the least we can and should do. This may help ward off the cycle of shame and guilt and the development of symptoms of psychosocial impairment leading, ultimately, to the onset of mental health problems. As a society and as individuals we must be aware of both the responsibility and potential we have not only with respect to preventing CSA from occurring but also regarding the provision of emotional support and professional help that victims deserve.

Overall, the results of this study suggest that the approach of conducting respective research from an "insider" perspective (from the victims' point of view) can be regarded as a valuable add-on. It is therefore hoped that other victims of CSA follow the example of getting actively involved in research within this field. In view of the magnitude of psychosocial impairment, it is also hoped that this pilot study will lead to more in-depth work looking at the quality of life of CSA victims. It is recommended to consult professional researchers on such issues as questionnaire design as early as possible in the process. If based on results that come from such research, the measures initiated by politicians and/or health professionals will be well received by victims.

NOTE

1. MOGiS e.V. is a German organization and incorporated association of victims of CSA. It was established in April 2009 as MissbrauchsOpfer Gegen InternetSperren (Abuse Survivors Against Internet Blocking). Its full name is MOGiS e.V.—Eine Stimme für Betroffene (MOGiS e.V.—A Voice for Victims).

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