VIOLENCE, SEXUAL TRAUMA, PERTURBATION, AND SUICIDALITY: A MULTIFACTORIAL ANALYSIS OF SEXUAL VICTIMISATION TYPOLOGY AND OUTCOME

A thesis submitted in fulfilment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

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January 2011
DECLARATION

I certify that, except where due acknowledgement has been made, the work described in this thesis is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of this thesis is the result of work which has been undertaken since the official commencement date of the approved research program; and any editorial work, paid or unpaid, carried out by a third party is acknowledged.

Andrea Alexandra Stewart
January 26th 2011
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Sections of this thesis have been disseminated as:

**Book Chapters**


**Conference Presentations**


*Conference Proceedings*

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<tr>
<td>AAPCA</td>
<td>American Academy of Pediatrics Committee on Adolescence</td>
</tr>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>ACSSA</td>
<td>Australian Centre for the Study of Sexual Assault</td>
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<tr>
<td>ACER</td>
<td>Australian Council for Educational Research</td>
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<tr>
<td>ACT</td>
<td>Australian Capital Territory</td>
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<tr>
<td>AIC</td>
<td>Australian Institute of Criminology</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>AIFS</td>
<td>Australian Institute of Family Studies</td>
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<tr>
<td>AIHI</td>
<td>Assault Information and History Interview</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<tr>
<td>AISRAP</td>
<td>Australian Institute for Suicide Research and Prevention</td>
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<tr>
<td>AIV</td>
<td>Acceptance of Interpersonal Violence scale</td>
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<tr>
<td>ALRC</td>
<td>Australian Law Reform Commission</td>
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<tr>
<td>AN</td>
<td>anorexia nervosa</td>
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<tr>
<td>APA</td>
<td>American Psychological Association</td>
</tr>
<tr>
<td>APS</td>
<td>Australian Psychological Society</td>
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<tr>
<td>AQ</td>
<td>Aggression Questionnaire</td>
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<tr>
<td>ARIA</td>
<td>Accessibility/Remoteness Index of Australia</td>
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<td>ASA</td>
<td>adult sexual abuse</td>
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<td>ASA-Revised</td>
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<td>ASB</td>
<td>Adversarial Sexual Beliefs Scale</td>
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<td>ASGC</td>
<td>Australian Standard Geographical Classification</td>
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<td>ATSA</td>
<td>Association for the Treatment of Sexual Abusers</td>
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<tr>
<td>Auseinet</td>
<td>Australian Network for Promotion, Prevention and Early Intervention for Mental Health</td>
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<tr>
<td>AVO</td>
<td>Apprehended Violence Order</td>
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<tr>
<td>BAI</td>
<td>Beck Anxiety Inventory</td>
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<td>BDHI</td>
<td>Buss-Durkee Hostility Inventory</td>
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<td>BDI</td>
<td>Beck Depression Inventory</td>
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<tr>
<td>BN</td>
<td>bulimia nervosa</td>
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<tr>
<td>BPD</td>
<td>borderline personality disorder</td>
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<tr>
<td>CALD</td>
<td>culturally and linguistically diverse</td>
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<tr>
<td>CAPS</td>
<td>Clinician-Administered PTSD Scale</td>
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<td>CASA</td>
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<td>CBT</td>
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<td>closed circuit television</td>
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<td>country of birth</td>
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<tr>
<td>CSE</td>
<td>Collective Self-Esteem Scale</td>
</tr>
<tr>
<td>CSS</td>
<td>Coercive Sexuality Scale</td>
</tr>
</tbody>
</table>
Commonwealth

Revised Conflict Tactics Scales

Depression Anxiety Stress Scales

Depression Anxiety Stress Scales – 21 item short form

Department of Education, Employment, and Workplace Relations

Department of Education, Science, and Training

Commonwealth Department of Health and Aged Care

United States Department of Health and Human Services

Department of Human Services

Department of Justice

Director of Public Prosecutions

deliberate self-harm

deliberate self-poisoning

domestic violence

Domestic Violence and Incest Resource Centre

driving under the influence (of alcohol)

emergency department

for example

and others

Extended Satisfaction With Life Scale

frequently asked questions

family violence

Geographic Information Systems

National Centre for Social Applications of GIS

gay lesbian bisexual

gay lesbian bisexual transgender intersex

general practitioner

gender role conflict

Gender Role Conflict Scale

Human Immunodeficiency Virus

International Association for Suicide Prevention

International Statistical Classification of Diseases and Related Health Problems, 10th Revision

International Classification of External Causes of Injury

that is

Index of Education and Occupation

Impact of Events Scale

Intervention Order

intimate partner violence

indirect self-destructive behaviour

International Society for Prevention of Child Abuse and Neglect

International Society for Traumatic Stress Studies

interpersonal violence

Journal of the American Medical Association

key performance indicator

Life Events Checklist
LGB 
LGBTI 
LRWCA 
LTE 
MMPI-2 
MVA 
NCCH 
NESB 
NGO 
NHMRC 
NMH 
NSPCC 
NSW 
NT 
NZLRC 
ODCCP 
PCI 
PCL-C 
PCL-M 
pdf 
PFSQ2 
PHIDU 
PK 
PLS 
PSE 
PTCI 
PTE 
PTSD 
Qld 
QOL 
RA 
RANZCP 
RCT 
RSES 
SA 
SA 
SA 
SAC 
SAQ 
SASS 
SCLJ 
SCRGSP 
SD 
SEIFA 
SES 
SES-LFV 
SI 
SLESQ
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUD</td>
<td>substance use disorder</td>
</tr>
<tr>
<td>TAC</td>
<td>Transport Accident Commission</td>
</tr>
<tr>
<td>Tas</td>
<td>Tasmania</td>
</tr>
<tr>
<td>TCF</td>
<td>The Compassionate Friends New South Wales, Inc.</td>
</tr>
<tr>
<td>TLEQ</td>
<td>Traumatic Life Events Questionnaire</td>
</tr>
<tr>
<td>TSP</td>
<td>Tellsomeone Project</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>UN-ODCCP</td>
<td>United Nations Office for Drug Control and Crime Prevention</td>
</tr>
<tr>
<td>URL</td>
<td>uniform resource locator</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
</tr>
<tr>
<td>USSC</td>
<td>United States Study Centre</td>
</tr>
<tr>
<td>VIF</td>
<td>Variance Inflation Factor</td>
</tr>
<tr>
<td>VAAW</td>
<td>violence and abuse against women</td>
</tr>
<tr>
<td>VAW</td>
<td>violence against women</td>
</tr>
<tr>
<td>VDHS</td>
<td>Victorian Department of Human Services</td>
</tr>
<tr>
<td>Vic</td>
<td>Victoria</td>
</tr>
<tr>
<td>VIS</td>
<td>victim impact statement</td>
</tr>
<tr>
<td>VLRC</td>
<td>Victorian Law Reform Commission</td>
</tr>
<tr>
<td>VOCAT</td>
<td>Victims of Crime Assistance Tribunal</td>
</tr>
<tr>
<td>VP</td>
<td>Victoria Police</td>
</tr>
<tr>
<td>WA</td>
<td>Western Australia</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>YPLL</td>
<td>years of potential life lost</td>
</tr>
</tbody>
</table>
ABSTRACT

Violence directed toward the self and others continues to manifest as a profound human problem, despite concerted amelioration efforts. Effective redress is hampered by taboos and underreporting, particularly in relation to sexual and familial violence and mental illness. Major objectives of the current research were to devise an inclusive, nonthreatening methodology to facilitate disclosure and circumvent previous research shortcomings, to achieve representation from underresearched and marginalized cohorts; derive comprehensive data to measure sexual abuse impact and sequelae; and examine victim offence-related perceptions and attributions, offending patterns, and relationships between sexual victimisation and suicidal ideation and behaviour.

Quantitative and qualitative data were derived from 2503 Australian males and females, aged 16-83 years, using a nationwide online survey. Extensive analyses were conducted to differentiate victims and nonvictims of child and adult sexual abuse; and nonsuicidal individuals from those reporting past suicidality. Comparative examination encompassed domains such as gender, assault-related attributions and cognitions, psychosocial wellbeing, trauma symptomology, and police-reporting. Multivariate analyses were conducted to identify and examine perpetrator modus operandi; offence typology and impact; victim reactions, perceptions, and attributions; and suicidal ideation and behaviours.

Current psychopathology was strongly associated with sexual abuse and suicidality histories. Heightened perturbation and suicidality were associated with childhood abuse and adulthood revictimisation. Males exhibited greater nondisclosure and help-seeking reticence than females, yet similar post-abuse psychopathology. Victims experienced multiple reporting barriers and frequent suboptimal reactions upon disclosure. Few perpetrators were reported. Suicidality history was significantly more present amongst victims of both childhood and adulthood sexual abuse.

Sociopolitical, judicial, clinical, and social change implications are discussed emphasizing needs for deconstructing silence, fostering help-seeking, nonthreatening methodologies, primary prevention initiatives, and strengthened client-centred responses toward mental illness and victims and perpetrators of violence. Importance of fostering greater discourse and disclosure through broader social acceptance, inclusive practices, and responsive, strengths-based initiatives to address mental illness, suicidality, and offence-precipitating factors are addressed. The need to better suicidality detection and intervention through targeted and strategic change processes is emphasised.
If I diminish you, I diminish myself. All humanity is interlinked. Thus, the humanity of the perpetrators of apartheid was inexorably bound to those of their victims. When they dehumanised another by inflicting suffering and harm, they dehumanised themselves. The only way we can ever be human is together. The only way we can be free is together.

- Desmond Tutu, 2007
CHAPTER 2
GENERAL METHOD

This chapter provides the general methodology pertaining to the research series reported in the current thesis. Contained within three sections, the chapter presents participant details and content-related and procedural information related to the online survey, entitled The Tellsomeone Project (TSP), from which the data for this thesis derive. Total sample size and characteristics and participant information are presented in Section 2.1; survey composition and details of the psychometric measures comprising the TSP are described in Section 2.2. Procedural issues such as recruitment methods and statistical analyses are discussed in Section 2.3, alongside broader methodological and ideological issues, with particular focus directed to the use of online research methods in psychological research. Additional methodology and particular characteristics specific to individual studies are presented within the Method sections of Studies 1, 2, and 3, respectively.

2.1 PARTICIPANTS

2.1.1 Sample Size and Composition
Between September 21 2005 and May 29 2007, 3061 individuals were registered as having visited the TSP website and had indicated their consent to participate in the research. In so doing, these individuals gained entry to the survey and the opportunity to peruse survey contents before making a final decision to participate. All visitors to the website were able to directly access and download a document entitled Support and Information (see Appendix B), an Australia-wide victim support, information, and referral section, without necessitating participation in the survey or provision of any details. Of the registered website visitors who elected to proceed with participation, and after data cleaning and deletion of invalid cases, 2,502 participants provided valid response sets. Notably however, individual data sets varied considerably in size across participants, given that not all questions were applicable to all individuals; and that, with the exception of five mandatory demographic questions, all other questions were optional. For example, other than the
initial screening questions, questions pertaining to CSA and ASA were not applicable to persons who had not experienced these abuse forms; and participants were at liberty to omit any questions or sections or to discontinue the survey at any point. Accordingly, as evident in the Results sections throughout this thesis, sample sizes varied across analyses.

2.1.2 Participant Characteristics

Age and gender

The entire sample comprised 2,502 participants, ranging in age from 16 to 83 years, with a mean age of 34.60 years ($SD = 13.02$, $Range = 67$ years). In terms of gender, 1,864 females comprised 74.5% of the sample, ranging in age from 16 to 75 years, with a mean age of 33.81 years ($SD = 12.55$, $Range = 59$ years). Males, ranging in age from 16 to 83 years, with a mean age of 36.92 years ($SD = 14.05$, $Range = 67$ years), comprised 25.5% of the sample ($n = 638$). These details are presented in Table 2.1.

Table 2.1
Participant Age by Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>$n$</th>
<th>$M$</th>
<th>$SD$</th>
<th>$Range$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>1864</td>
<td>33.81</td>
<td>12.55</td>
<td>16-75</td>
</tr>
<tr>
<td>Males</td>
<td>638</td>
<td>36.92</td>
<td>14.05</td>
<td>16-83</td>
</tr>
<tr>
<td>Total</td>
<td>2502</td>
<td>34.60</td>
<td>13.02</td>
<td>16-83</td>
</tr>
</tbody>
</table>

Cultural background

Country of birth. Overall, 83.1% of respondents were born in Australia ($n = 966$), and 16.9% were born elsewhere ($n = 196$). Within the cohort of respondents born outside Australia, forty countries were represented, although the majority of individuals hailed from English-speaking countries, namely, the United Kingdom (44%; $n = 87$), New Zealand (15%; $n = 29$), and the United States and Canada (8%; $n = 16$). Next most commonly represented countries were India (4%; $n = 7$), Malaysia (3%; $n = 6$), Netherlands (3%; $n = 5$); followed by Hong Kong, South Africa, Phillipines, Russia, and Vietnam (2%; $n = 3-4$, respectively). Smaller numbers of respondents hailed from a further 25 countries, namely, Austria, China,
France, and Singapore (1%; \( n = 2 \), respectively); and Brazil, Chile, Croatia, Denmark, Eastern Europe, Egypt, Former Yugoslavia, Germany, Hungary, Indonesia, Italy, Papua New Guinea, Romania, Serbia, Sri Lanka, Sudan, Syria, Tanzania, Thailand, Turkey, and Uruguay (1%; \( n = 1 \), respectively).

Amongst male respondents, 83.3% were born in Australia (\( n = 245 \)) and 16.7% were born elsewhere (\( n = 49 \)). Similarly, 83.1% of female respondents were born in Australia (\( n = 721 \)), and 16.9% were born outside Australia (\( n = 147 \)).

Language other than English spoken at home. Overall, 8.7% of respondents reported speaking a language other than English at home (\( n = 100 \)), and 91.3% responded negatively to this item (\( n = 1,051 \)). Specifically, 10.1% of male respondents (\( n = 29 \)) and 8.2% of female respondents (\( n = 71 \)) reported speaking a non-English language at home, in contrast to 89.9% of males (\( n = 259 \)) and 91.8% of females (\( n = 792 \)) who reported not speaking a non-English language at home.

In summary, the majority of respondents were Australian-born or hailed from English-speaking countries and reported English as the primary language spoken at home. Nonetheless, sizable minorities represented forty birth countries outside Australia and reported a non-English language in the home, reflecting the cultural diversity present within Australian society. Proportions of representation by non-Australian born individuals and those speaking a language other than English in the home were remarkably similar across gender, suggesting that groups were able to be compared without high likelihood that cultural differences might serve as confounding factors.

Current marital status
Overall, 41.0% of respondents (\( n = 489 \)) endorsed Single; 27.6% of respondents (\( n = 329 \)) endorsed Married; 15.4% of respondents (\( n = 184 \)) endorsed De Facto; 5.0% of respondents (\( n = 60 \)) endorsed Separated; 6.8% of respondents (\( n = 81 \)) endorsed Divorced; 1.3% of respondents (\( n = 15 \)) endorsed Widowed; and 2.9% of respondents (\( n = 35 \)) endorsed Engaged.

Specifically, 45.0% of male respondents (\( n = 135 \)) and 39.8% of female respondents (\( n = 355 \)) were single; 22.7% of male respondents (\( n = 68 \)) and 29.1% of female respondents (\( n = 260 \))
were married; 15.0% of male respondents (n = 45) and 15.6% of female respondents (n = 139) were in de facto relationships; 7.0% of male respondents (n = 21) and 4.4% of female respondents (n = 39) were separated; 7.7% of male respondents (n = 23) and 6.5% of female respondents (n = 58) were divorced; 2.0% of male respondents (n = 6) and 1.0% of female respondents (n = 9) were widowed; and 0.7% of male respondents (n = 2) and 3.7% of female respondents (n = 33) were engaged.
2.2 MEASURES AND SURVEY COMPOSITION

2.2.1 Composition of the Survey Instrument

All data used in the research program reported in the current thesis derive from an online survey instrument, entitled the Tellsomeone Project (TSP), constructed by the researcher to meet the purposes of, and specific identified criteria demanded by, the research topics under investigation. The instrument comprised seven sections (including a support services, information, and referral section). An introductory section (including a Plain Language Statement [PLS], Frequently Asked Questions [FAQ], acknowledgement of consent, construction of a password and codename, and initial demographic questions) was followed by Sections 1-7, as presented in Table 2.2.

The TSP is underpinned by a theory-driven instrument comprising: (i) a battery of standardised psychometric measures of traumatic sexual and nonsexual events and sequelae, mental health, and wellbeing (some adapted and others extended for the research); and (ii) a large number of item sets constructed by the researcher to obtain specific data pertaining to the various areas under examination that were unable to be gleaned from existing measures. Measures used in each section of the TSP are listed in Table 2.2 and described under the relevant section headings below.

It is noted that numerous published scales exist to measure each of the single constructs under examination in this thesis. In all cases, the scales selected were chosen for their established psychometric excellence and to minimise redundancy and between-scale overlap. The constructs measured in this research instrument were included in order to provide holistic and comprehensive information (both quantitative and qualitative) pertaining to areas empirically identified as strongly related to sexual trauma and reduced quality of life.
Table 2.2  
The TSP: Survey Instrument Components

<table>
<thead>
<tr>
<th>Section</th>
<th>Component topic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction</strong></td>
<td>Welcome &amp; orientation</td>
</tr>
<tr>
<td></td>
<td>* Information, FAQ, PLS</td>
</tr>
<tr>
<td></td>
<td>* Consent</td>
</tr>
<tr>
<td></td>
<td>* Basic demographic survey</td>
</tr>
<tr>
<td><strong>Section 1</strong></td>
<td>Stressful life events</td>
</tr>
<tr>
<td></td>
<td>* Constructed inventory of stressful &amp; traumatic life events – Expanded &amp; adapted from the List of Threatening Experiences questionnaire (LTE; Brugha &amp; Cragg, 1990)</td>
</tr>
<tr>
<td></td>
<td>* PTSD Checklist (PCL; Weathers, Litz, Herman, Huska, &amp; Keane, 1993)</td>
</tr>
<tr>
<td></td>
<td>* Additional constructed items</td>
</tr>
<tr>
<td><strong>Section 2</strong></td>
<td>Unwanted sexual experiences in childhood</td>
</tr>
<tr>
<td></td>
<td>- Adapted for CSA &amp; gender neutrality</td>
</tr>
<tr>
<td></td>
<td>* Constructed CSA history inventory – expanded, compiled, &amp; adapted from existing sexual assault interview schedules, batteries, &amp; measures (e.g., Assault Information &amp; History Interview [AIHI; Foa &amp; Rothbaum, 1998]; Sexual victimisation history [Breitenbecher &amp; Scarce, 2001; Breitenbecher, personal communication, 13 November 2001]; Coercive Sexuality Scale [CSS; Rapaport &amp; Burkhart, 1984])</td>
</tr>
<tr>
<td></td>
<td>* Additional constructed item sets</td>
</tr>
<tr>
<td><strong>Section 3</strong></td>
<td>Unwanted sexual experiences in adulthood</td>
</tr>
<tr>
<td></td>
<td>* Modified &amp; extended SES-LFV - Adapted for gender neutrality</td>
</tr>
<tr>
<td></td>
<td>* Constructed ASA history inventory – expanded, compiled, &amp; adapted from existing sexual assault interview schedules &amp; batteries (e.g., AIHI, Foa &amp; Rothbaum, 1998; Breitenbecher &amp; Scarce, 1999, 2001; Breitenbecher, personal communication, 13 November 2001; CSS, Rapaport &amp; Burkhart, 1984)</td>
</tr>
<tr>
<td></td>
<td>* Additional constructed item sets</td>
</tr>
<tr>
<td><strong>Section 4</strong></td>
<td>Distress since the sexual assault</td>
</tr>
<tr>
<td></td>
<td>* Sexual Assault Symptom Scale (SASS; Ruch, Gartell, Amedeo, &amp; Coyne 1991)</td>
</tr>
<tr>
<td></td>
<td>* Additional constructed item sets</td>
</tr>
<tr>
<td><strong>Section 5</strong></td>
<td>Thoughts and feelings</td>
</tr>
<tr>
<td></td>
<td>* Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965, 1989)</td>
</tr>
<tr>
<td></td>
<td>* Depression Anxiety Stress Scales – 21-Item Form (DASS-21; S. H. Lovibond &amp; P. F. Lovibond, 1995b)</td>
</tr>
<tr>
<td></td>
<td>* Harder Personal Feelings Questionnaire-2 (PFQ2; Harder &amp; Zalma, 1990)</td>
</tr>
<tr>
<td></td>
<td>* Aggression Questionnaire (AQ; Buss &amp; Perry, 1992)</td>
</tr>
<tr>
<td></td>
<td>* Gender Role Conflict Scale – Male Version (GRCS-Male; O’Neil, Helms, Gable, David, &amp; Wrightsman, 1986)</td>
</tr>
<tr>
<td></td>
<td>* Gender Role Conflict Scale – Female Version (GRCS-Female; O’Neil et al., 1986)</td>
</tr>
<tr>
<td></td>
<td>* Revised Attraction to Sexual Aggression Scale (ASA-Revised; Malamuth, 1989a, 1989b, 1998)</td>
</tr>
</tbody>
</table>
Extensive examination of relevant literatures was conducted to inform and guide survey construction and content at each stage of program development. Where published scales were employed, the specific wording of the original instrument was preserved, except where terminology was altered to achieve gender-neutrality or other non-directional or inclusive effects. In cases where such adaptations were made, these are described under the relevant heading for each scale. Additional sections, questions, and items were constructed to address both broader gaps in the literature, and smaller specific shortcomings in existing measures. For example, some adaptation and expansion arose through necessity from the need to accommodate male victimisation. Other additions arose from the need to modernise and expand existing measures in order for these to remain pertinent and able to contribute new knowledge within the context of advances in understanding and findings that have arisen since their original publication. Although predominantly a quantitative instrument, the TSP was designed also to proffer a large volume of qualitative data pertaining to a wide number of research questions.

As with the selection of psychometric tools, construction of item sets was underpinned by empirically-derived rationale and knowledge drawn from diverse literatures. In addition, preeminent authorities were consulted on various issues of process and content specific to their areas of expertise (e.g., Breitenbecher, Brugha, Burkhart, Creamer, Harder, Koss, Malamuth, O’Neil, Ruch, Ullman; personal communications, 2004). Reference to personal communications is made in relevant sections throughout the forthcoming chapter. As with modifications made to psychometric tools, construction of individual items and item sets was typically inspired and guided by existing scales and previous research with changes and additions made to accommodate new findings, modernise outdated or nonoptimal language
or terminology, or achieve gender neutrality and nondirectionality. Broader discussions pertaining to rationale, content, and construction of the TSP survey instrument and the seven sections contained therein are provided below and in forthcoming sections of this chapter.

2.2.2 Introductory Section

The introductory section, incorporating a PLS, Consent Form, and general instructions, was formatted with clear easily visible subheadings and sans serif font (Arial) to optimise online readability. This format was repeated throughout the survey. The PLS incorporated a FAQ format to maximise ease of navigation and comprehension (see Appendix C). A prominent message was included guiding website visitors to a direct link to the Support Services Section (Section 7), in the event that they experienced distress upon entering the site. It was made clear that this section was freely accessible to all website visitors at any time without any requirement to commence or complete the survey.

In accordance with RMIT University ethical guidelines, the PLS was also presented in portable document format (i.e., as a ‘pdf’ document), enabling respondents to print and retain a hard copy. This document was presented on RMIT University letterhead and contained the signatures and full contact details of the Principal Researcher and the Primary Supervisor. The invitation was extended to respondents to contact the Principal Researcher or the Primary Supervisor in case of distress, or to provide comment or feedback, and contact details were provided to enable lodgement of formal complaints or ethical concerns.

The Consent Form comprised a series of statements to which individuals who wished to participate were required to indicate consent by endorsing each statement with a tick (see Appendix C). Each tick box constituted a mandatory field so that survey access was not possible until each statement had been endorsed, and an “I agree” button had been clicked.

Upon completion of the consent process, respondents were provided instructions for creating their code name. As with subsequent pages throughout the survey, respondents were taken to the next page by clicking a ‘Continue’ button at the completion of their current page. The final page of the Introduction Section contained five demographic questions considered integral for the purposes of the research. For this reason, the
response boxes to these questions were configured as mandatory fields, and these questions were located at the beginning of the survey. This was done to ensure that data sets of varying stages of completeness would be able to be utilized in the study and gainfully analysed. This was a critical criterion for the design and compilation of the survey instrument given that, in consideration of the online format, the length and complexity of the survey, the potentially emotionally taxing content, and therefore, the level of respondent commitment required, a high attrition rate was to be expected.

Accordingly, essential demographics were configured as mandatory fields and placed at the beginning, followed by content domains presented in order of importance to research questions, such that domains of lesser importance would provide ‘bonus’ data if completed, but that their omission would not compromise major research aims. Hence, additional, detailed (but nonessential) demographic items were located at the end of the survey (in Section 6). To minimise attrition, no mandatory fields (other than the initial five items) were included in the survey. In retrospect, these were very important precautions given that, as predicted, datasets varied substantially in their degree of completeness, and that all incomplete datasets (i.e., those provided by persons who did not proceed to the final section) would have been unusable if key demographic and classificatory questions had been located at the end. Whilst splitting demographic questions into two sections might appear unusual, in the context of the current research, it appears that the decision to do so impacted substantially on the size and quality of the database.

2.2.3 Section 1: Stressful Life Events

Section 1 was constructed to measure experiences of stressful and traumatic life events and their sequelae, and comprises a constructed inventory of potentially stressful life events and a published measure of posttraumatic symptomology.

Constructing inventory of stressful and traumatic life events

This inventory of potentially traumatic events (PTEs) was based on, and adapted from the LTE (Brugha & Cragg, 1990). Construction and inclusion criteria were guided and informed by extensive examination of the relevant literature and existing measures of PTEs (e.g., Life Events Checklist [LEC; Gray, Litz, Hsu, & Lombardo, 2004]; Stressful Life Events Screening Questionnaire [SLESQ; Goodman, Corcoran, Turner, Yuan, & Green, 1998]; Traumatic Life Events Questionnaire [TLEQ; Kubany et al., 2000]).
With permission from the principal author (T. S. Brugha, personal communication, 18th August, 2004), the LTE was chosen as a basis for the current inventory. The LTE is a self-report measure examining twelve categories of negative life events that have been identified as the strongest predictors of depression (Brugha, Bebbington, Tennant, & Hurry, 1985). In the original scale, participants are asked to indicate whether they have experienced these stressors over the previous six months. For the current research, this wording was changed in order to measure lifetime experience of these events. Participants were subsequently asked to identify the most distressing of these events and to specify ‘how long ago’ this event occurred. The LTE has been reported to have high test-retest reliability, agreement with informant, specificity, and sensitivity; and a high score has been associated with depression (Brugha & Conroy, 1995; Brugha & Cragg, 1990). The use of the LTE has been particularly recommended for its brevity and utility in psychiatric, psychological, and social research in which other variables (e.g., social support, coping, cognitive factors) are of interest and resources prohibit the use of extensive interview measures of stress (Brugha & Cragg, 1990).

The LTE assesses negative life events involving moderate or long-term threat such as illness or injury, loss of significant relationships, and death of a close friend or relative. For the purposes of the current research, additional negative life events were included, with a particular focus on those strongly associated with severe negative impact and posttraumatic symptomology (e.g., sexual abuse, violent assault, life-threatening or perceived life-threatening events) (Herman, 1992; Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). These inclusions enabled screening and subsequent posttraumatic symptomology assessment for a total of 41 PTEs.

**PTSD Checklist (PCL)**

The PTSD Checklist (PCL; Weathers et al., 1993) is a 17-item self-report inventory designed to assess the 17 items contained in the DSM diagnostic criteria for PTSD. This instrument has been applied extensively in a variety of traumatised populations (e.g., survivors of military combat, terrorism, sexual assault, motor vehicle accidents [MVAs], cancer, bone marrow transplantation, HIV-AIDS, and childhood maltreatment) and associated findings have been widely published (Andrykowski, Cordova, Studts, & Miller, 1998; Blanchard, Jones Alexander, Buckley, & Forneris, 1996; Campbell et al., 1999;
Cordova et al., 1995; Creamer, Bell, & Failla, 2003; Forbes, Creamer, & Biddle, 2001; Hoge et al., 2004; Keane, Weathers, & Foa, 2000; Koivisto & Haapasalo, 1996; Manne, Du Hamel, Gallelli, Sorgen, & Redd, 1998; McKenzie et al., 2004; Peterlin, Tietjen, Meng, Lidicker, & Bigal, 2007; Rayner, 2005; Smith, Redd, Du Hamel, Vickberg, & Ricketts, 1999; Weathers, Litz, Herman, Huska, & Keane, 1993).

The psychometric soundness of the PCL has been demonstrated in Persian Gulf and Vietnam veteran samples (Weathers et al., 1993) and nonveteran samples, such as MVA and sexual assault victims (Blanchard et al., 1996). Specifically, Weathers et al found excellent internal consistency (alpha = .97), excellent test-retest reliability (.96 over a 2-3 day period), and strong, positive correlations with other measures of PTSD, namely, .93 with the Mississippi Scale for Combat-Related PTSD (Keane, Caddell, & Taylor, 1988), .90 with the Impact of Event Scale (IES: Horowitz, Wilner, & Alvarez, 1979), and .77 with the Keane PTSD Scale of the MMPI-2 (PK: Keane, Malloy, & Fairbank, 1984; Lyons & Keane, 1992). In their studies of MVA and sexual assault victims, Blanchard et al. (1996) found a correlation of .93 between the PCL and the Clinician-Administered PTSD Scale (CAPS: Blake et al., 1990; Keane et al., 1984), and an overall diagnostic efficiency of .90 for the PCL, compared to the CAPS. Whilst there exists a military version (PCL-M), a civilian version (PCL-C), and a stressor-specific version of this instrument (PCL-S), these are differentiated by only minor variations in wording. The PTSD Checklist – Civilian version (PCL-C) has demonstrated a sensitivity of .94 and specificity of .86 compared with the CAPS, and excellent test-retest reliability (Keane, Newman, & Orsillo, 1996; Keane et al., 2000), and is widely used to screen for trauma (Rayner, 2005). Hence, this version was chosen for use in the current research.

The 17 PTSD symptoms are rated by respondents, indicating the degree to which the respondent has been ‘bothered by that problem over the past month’, along a 5-point Likert scale, ranging from 1 (Not at all) to 5 (Extremely). In the current research, it was of interest to assess lifetime presence of PTSD symptomology, rather than current symptomology. Accordingly, this instruction was amended, such that respondents were asked to indicate how much they had been ‘bothered by that problem following a traumatic/stressful event in [your] life?’ Advice was sought (and received) from a recognised authority in the field that this amendment was acceptable, and able to be made without compromising the integrity of the instrument (Mark Creamer, personal
communication, 18th August, 2004). Clearly however, it must be noted that this alteration renders the resultant data not directly comparable to other PCL data.

A score of ≥ 50 on the PCL-C is recommended as a good predictor of a PTSD diagnosis, and has been endorsed with an Australian military sample (Australian Government Department of Veterans' Affairs, 2003; Deans, 2002; Forbes et al., 2001; Rayner, 2005) and in the assessment of Persian Gulf veterans (Hoge et al., 2004), as an indicator of ‘caseness’ for trauma in these (predominantly male) samples. Accordingly, this cut-off score is commonly used by prominent PTSD researchers (e.g., Creamer et al., 2003). Notably however, Blanchard, et al. (1996) found that a cut-off of 44 led to greater diagnostic efficiency in their (predominantly female) sample of MVA and sexual assault victims, and amongst some researchers, a total score ≥ 44 is considered to denote clinical significance for PTSD (e.g., Peterlin et al., 2007). Total scores on the PCL range from 17 to 85.

2.2.4 Section 2: Unwanted Sexual Experiences in Childhood

Section 2 was constructed to examine unwanted sexual experiences under the age of 16. To enable comparative analyses between child and adult sexual abuse experiences and sequelae, the format and most of the content of this section were replicated in Section 3, to examine unwanted sexual experiences in adulthood. However, a notable difference between the Childhood and Adulthood sections related to the issue of consent. Whereas it is taken as a given in the Adult Section that ‘unwanted’ sexual experiences occurred in the absence of consent, ‘unwanted’ sexual experiences in childhood were deemed to be such, irrespective of whether ‘consent’ had been given a) by a child under the age of ten, b) by a person under 16 to a sexual experience with a person aged more than two years older, or c) by a person under 16 to a sexual experience with a person in a position of authority, care, or trust over that person, as a child is deemed incapable of giving consent in these circumstances. Other differences pertain to items and questions that were applicable to either CSA or ASA experiences, but not to both (e.g., ‘As a child, I did as I was told’). In answering items related to issues such as police reporting, disclosure, and counselling, CSA respondents were asked to qualify their responses: ‘while I was still a child’; ‘as an adult’. With respect to sexual abuse frequency, CSA respondents were asked to quantify how often each abuse type occurred ‘before you were 10 years old?’ and ‘between the ages of 10 and 15 years?’, along a 6-point scale (i.e., 0, 1, 2, 3, 4, 5-10, 11+). In Section 3, ASA respondents instead asked to quantify the frequency of each abuse type ‘in the last 12 months?’ and ‘since the age of 16 years?’
The survey components comprising Section 2 are described in turn under the following subheadings.

**Modified Sexual Experiences Survey – Long Form Victimisation Version (SES-LFV)**

The Modified SES-LFV (Koss & Bachar, personal communication, 19th August, 2004; Koss & Gidycz, 1985; Koss & Oros, 1982; Koss et al., 1987) was used, with author permission, to measure both CSA and ASA (M. Koss, personal communication, 19th August, 2004). This instrument was substantially extended for the current research and adapted for CSA and gender neutrality.

The SES-LFV, originally developed by Koss and Oros (1982), was constructed to assess sexual victimization history, and measures various forms of sexual victimisation using behavioural descriptors and excluding label terms such as the word ‘rape’. This is important given indications that wording of questions may impact their effectiveness in identifying and measuring traumatic life events including sexual abuse (e.g., Acierno, Kilpatrick, & Resnick, 1997; Resnick, Falsoetti, Kilpatrick, and Freedy, 1996). Specifically, it has been suggested that assaultive trauma and abuse, especially of a sexual nature or occurring within familial contexts, are prone to underreporting when emotionally laden or legal terms are employed (e.g., ‘rape’, ‘domestic violence’, ‘assault’) (Koss, 1993a). Further, it is important to note that the relative contributions of language to assessment sensitivity and possible underenumeration remain undetermined (Watson & Haynes, 2007). By using behavioural descriptors, the SES is capable of reflecting varying forms of sexual victimisation and identifying ‘hidden’ rape survivors (i.e., individuals who do not conceptualise their experience as rape or who would not report the event as such). Items assess whether sexual victimisation occurred as a result of coercion, threat, substance use, misuse of authority, or use of force.

Research suggests that females respond to the SES in a truthful and accurate manner, and that this instrument has good internal consistency reliability (Koss & Gidycz, 1985). The original SES has previously been modified in a variety of ways. For example, previous modifications have expanded the definition and altered the delineations of ‘intercourse’. The original SES assessed vaginal intercourse (one item) separately from oral and anal intercourse (another item) (Koss et al., 1987). Using a modified SES, Breitenbecher and Scarce (2001) assessed vaginal, oral, and anal intercourse with a single ‘gender neutral’ item,
beyond vaginal intercourse, to also include anal and oral intercourse. Subsequent modified versions examine respondents’ experiences of completed and attempted rape (vaginal, oral, and anal) and unwanted sexual contact and sexual coercion from the age of 14 years using separate items for each victimisation type (e.g., Koss & Bachar, 2004). Further, whilst the original SES was constructed in a ‘yes/no’ format, modified versions have permitted greater response variance, for example, facilitating responses to SES items on a 6-point Likert-type scale ranging from 0 (Never) to 5 (5 or more times) (e.g., Breitenbecher, 2008).

Modified versions of the SES have also provided information regarding a range of perpetrator strategies (e.g., ‘Have you ever experienced sexual intercourse when you didn’t want to because a person threatened or used some degree of physical force [twisting your arm, holding you down, etc.] to make you?’). Other types of perpetrator strategies include verbal pressure, misuse of authority, impairment of capacity for consent (e.g., exploiting or inducing intoxicated state) (e.g., Breitenbecher, 2008). Modified versions continue to be developed and have been widely applied to date in investigations of sexual victimisation and offending (e.g., Breitenbecher, 2006, 2008; Ullman & Filipas, 2001b).

For the purposes of the current study, the modified SES was adapted and expanded to measure eight forms of CSA: (i) unwanted sexual contact (e.g., kissing, fondling, masturbation); (ii) oral sex; (iii) vaginal penetration; (iv) anal sex; (v) other sexual experience; (vi) attempted oral sex; (vii) attempted vaginal penetration; and (viii) attempted anal sex. For every sexual abuse type endorsed (‘True/False’), respondents were asked to complete a range of questions. These measured factors such as victim age; abuse frequency; perpetrator gender; number of perpetrators; relationship to perpetrator; and revictimisation with same or different perpetrator. Emphasis was placed on ensuring gender neutrality and nondirectional questioning (e.g., avoiding implications that victims were female and perpetrators were male). No known study has previously applied the SES to the examination of CSA, nor utilised such an extended version.

**Constructed CSA history inventory**

This inventory of CSA history was constructed to extend and supplement the data collected via the modified SES. Construction and inclusion criteria were guided and informed by examination of relevant literature and existing sexual victimisation measures (e.g., Assault Information & History Interview [AIHI; Foa & Rothbaum, 1998]; Ullman & Filipas, 2001).
In particular, with permission from the principal author (K. H. Breitenbecher, personal communication, 13 November, 2001), the current CSA inventory was adapted from, and informed by an extensive assessment battery constructed by Breitenbecher and Scarce (2001). Inventory construction was also influenced by the Coercive Sexuality Scale (CSS; Rapaport & Burkhart, 1984). Accordingly, this scale is described below. Detailed item sets were constructed to measure physical and non-physical perpetrator strategies (e.g., ‘giving me drugs without my knowledge’; ‘using some degree of physical violence [e.g., hitting, punching, biting, choking]’; ‘making me feel guilty or somehow obliged to do it’; ‘verbally ordering me’; ‘telling me lies or tricking me in some way’). Situational and victim-centred variables were also assessed (e.g., ‘As a child, I did as I was told’; ‘It made me feel loved or secure or gave me affection’; ‘I feared rejection if I didn’t do it’; ‘I was unable to say no because I was scared, numb, or “frozen”’; ‘I was unable to say no because I was embarrassed or shy’; ‘I was unable to say no (under the influence of alcohol)’; ‘I feared the effects on my family if I told someone’). Responses were provided via a 5-point Likert-type scale from 1 (Not at all) to 5 (Extremely).

Additional item sets were constructed to assess circumstances and victim feelings and perceptions prior to, during, and subsequent to experience of CSA. Examples of items include: (i) Before: ‘Had the person been drinking any alcohol?’; ‘Had you been using recreational drugs?’; ‘I trusted the person’; ‘I loved the person’; (ii) During: ‘I thought I might die’; ‘I thought I would be seriously injured’; ‘I felt like I was somewhere else or like it wasn’t really happening’; (iii) After: ‘I felt hurt or rejected or betrayed’; ‘I felt ‘dirty’ or like I was bad’; ‘I felt guilty’; ‘I tried to pretend nothing had happened’; ‘In the days or weeks after the event/s, I thought seriously about killing myself’. Responses were provided along a 5-point Likert-type scale from 1 (Not at all) to 5 (Extremely).

Other item sets were constructed to assess: (i) disclosure patterns (e.g., ‘I have never told a family member about it’); (ii) disclosure reactions from family or friends (e.g., ‘awkwardness, discomfort, we avoided it’); (iii) victim preferences regarding confidante gender and type (e.g., friend, psychologist, partner); (iv) police reporting practices (e.g., ‘I made a report to the police’ T/F), perceived and actual outcomes (e.g., ‘Overall, this was helpful’; ‘Overall, do you think there was a fair outcome?’; ‘Was the person convicted?’); and victim regrets (e.g., ‘I wish I had reported sooner’); (v) perpetrator offending/recidivism (against self or others) (e.g., ‘Did the person(s) commit any additional crimes against you [e.g., bashing, theft, abduction]’); (vi) counselling frequency and outcomes (e.g., ‘I received services or counselling for this’; ‘Overall, this was helpful’); (vii) CSA-related victim perceptions (e.g., ‘What happened to me was rape’; ‘I was responsible for what
happened’; (viii) injuries sustained; (ix) STI exposure and transmission; (x) rape-related pregnancy; and (xi) perpetrator condom use. Responses were typically given along a 5-point Likert-type scale from 1 (Not at all) to 5 (Extremely).

Coercive Sexuality Scale (CSS)

The Coercive Sexuality Scale (CSS; Rapaport & Burkhart, 1984) was constructed to provide more detailed information about offence circumstances than what was obtainable from the SES during concurrent timeframes. Parallel forms were created for victims and perpetrators to allow comparison between responses. The CSS has undergone several iterations in order to optimise the utility of the scale for various research applications, and specifically, to optimise the information available to researchers with varying research questions (B. Burkhart, personal communication, 24th June 2004). This scale is similar to the SES in that perpetrators and victims respectively, indicate how often they have engaged in, or experienced, 19 different sexually coercive behaviours (Murnen, Wright, & Kaluzny, 2002). Responses are given along a 4-point Likert-type scale from Never to Often, with higher scores indicating more coercive behaviour and greater victimisation, respectively. An internal consistency of .96 has been reported for the CSS (Hall, Hirschman, & Oliver, 1994), and correlations have been found for the CSS with the Adversarial Sexual Beliefs scale (ASB; Burt, 1980) and the Acceptance of Interpersonal Violence scale (AIV; Burt, 1980) (Rapaport & Burkhart, 1984). Permission to use the CSS was received from the principal author (B. Burkhart, personal communication, 24th June 2004).

2.2.5 Section 3: Unwanted Sexual Experiences in Adulthood

Section 3 was constructed to examine unwanted sexual experiences from the age of 16. As noted above, the format and content of this section was constructed to closely mirror that of Section 2, in order to allow comparative analyses between child and adult sexual abuse experiences and sequelae. As detailed earlier, minor differences necessarily exist between Sections 2 and 3. For example, in the Adulthood version, additional categories were created for the item describing perpetrator relationship, to include ‘partner/de facto’, ‘spouse’, and ‘ex-partner’. The major survey components comprising Section 3 (namely, the modified SES-LFV and a constructed sexual abuse history inventory) are near replicas of those used in Section 2 (albeit, modified to apply to adulthood sexual victimisation); and are described under the relevant (previous) heading in this chapter.
2.2.6 Section 4: Distress Since the Sexual Assault

Section 4 was constructed to measure sexual assault impact in persons who responded affirmatively to screening questions relating to either CSA or ASA, or both. Persons who reported never having experienced sexual abuse omitted this section.

This section comprises a published measure (SASS; Ruch, Gartell, Amedeo, & Coyne, 1991) and a number of constructed item sets designed to assess varying aspects of sexual assault impact and sequelae. The SASS was used with the permission of the principal author (L. Ruch, personal communication, 12th August 2004). Descriptions follow of this scale and the domains examined by the additional item sets constructed for the purposes of the current research.

**Sexual Assault Symptom Scale (SASS)**

The Sexual Assault Symptom Scale (SASS) is a 32-item instrument developed by Ruch et al., (1991) to measure self-reported sexual assault trauma experienced in the immediate aftermath of the assault. Factor analysis has identified four subscales of the SASS: disclosure shame (DS: items 4, 7, 16, 20-22); safety fears (SF: items 1, 9, 14, 18); depression (D: items 23-25); and self-blame (SB: items 5, 6, 13, 29). The SASS assesses both global trauma symptoms (e.g., ‘feeling hopeless about the future’; ‘trouble concentrating’) and those specific to sexual abuse (e.g., ‘feeling embarrassed about what you had to do to survive the assault’).

Each item is an emotional concern (e.g., ‘Feeling sad or depressed about how other people will react to the assault’; ‘Thoughts of ending your life’). Each concern is rated in terms of the respondent’s feelings, specifically pertaining to the degree of distress or discomfort he or she has experienced ‘since the assault, including right now’. For the purposes of the current study, this wording was modified, as follows, to accommodate respondents who had experienced multiple forms of sexual abuse: ‘since the most distressing sexual assault, including right now’. Items are rated along a 5-point Likert scale, ranging from 0 (Not at all) to 4 (Extremely), with higher scores signifying greater levels of sexual assault trauma. Summed scores range from 0 to 24 on the DS subscale, 0 to 16 on the SF subscale, 0 to 12 on the D subscale, and 0 to 16 on the SB subscale. A total SASS score derives from the summing of the four subscales.

The SASS has demonstrated high internal consistency for each factor subscale, with Cronbach alpha coefficients ranging between .72 and .83 in the original validation study (Ruch et al., 1991), and between .86 and .89 in subsequent research (Crown & Roberts,
and good internal consistency has been found the whole scale ($\alpha = .69$). Intercorrelations between factor scores derived from victims’ self-reported symptoms and client assessments by crisis workers suggest that the SASS has construct validity; and a multitrait-multimethod matrix has demonstrated both convergent and discriminant validity.

Aside from the excellent psychometric properties of the SASS, a number of additional attributes render this scale a useful addition to the current assessment battery and of particular utility in the assessment of sexual assault trauma in both research and clinical contexts. Applying psychometric instruments that are sensitive in assessing trauma symptoms specific to sexual assault victims is important given that victims vary with respect to dimensions and manifestations of trauma (Ruch & Wang, 2006). Specifically, assessment tools with too few dimensions may fail to capture assault impact because victims may be traumatised in terms of certain dimensions but not others (Ruch & Wang, 2006). For instance, Finkelhor (1988) found PTSD symptoms were absent in many CSA victims who nonetheless exhibited other manifestations of trauma. Resnick, Kilpatrick, and Lipovsky (1991) similarly recognised that PTSD is not the sole disorder associated with sexual victimisation. Other mental health concerns commonly associated with sexual abuse include major depression, substance abuse, sexual dysfunction, and anxiety disorders. However, scales measuring such problems typically neglect trauma symptoms concomitant with sexual abuse and identified in the relevant literature. Examples include health-related fears; self-blame; self-revulsion; fear of negative appraisal due to stigma, stereotypic notions, and myths surrounding sexual abuse; fears of testifying in court and associated perpetrator reprisal and public debasement (Ruch & Wang, 2006). An instrument that is both able to capture such specific dimensions of sexual abuse trauma and assess more general trauma symptoms is necessary in order to accurately assess sexual abuse impact without overburdening victims with multiple scales separately measuring constructs such as fear and depression. The SASS is a comprehensive, yet concise, empirically derived measure by which to assess sexual assault impact and sequelae.

**Constructed item sets**

A number of item sets were constructed in order to measure:

(i) victim-appraised subjective measure of sexual assault distress (e.g., ‘How distressing was the [most distressing] assault?’);
(ii) victim-perceived [positive and negative] corollaries of sexual abuse (21 items measuring perceived effects of sexual abuse in areas such as body image, quality of life, intimate relationships, health behaviours such as food, nicotine, drug, and alcohol consumption, and suicidality). Examples of such items include: ‘I have increased my alcohol intake as a consequence of the assault’; ‘The assault has lowered my ability to have a successful intimate relationship’; ‘I feel my understanding of people has increased as a consequence of the assault’; ‘I am a stronger person as a consequence of the assault’;

(iii) victim-perceived similarities between separate sexual abuse experiences (9 items; e.g., ‘During two or more of the events..... the person had consumed alcohol or drugs/the person used verbal pressure to engage me in the event/I felt too embarrassed or shy to stop the person/the person used physical force to engage me in the event’);

(iv) victim strategies for averting sexual abuse (17 items; e.g., ‘asking the person “nicely” to stop [or using apologies or excuses]’; ‘stiffening, turning away, or moving away from the person’; ‘verbally threatening, scaring, or warning the person’; ‘screaming’; ‘deciding it would be safer for me not to try to resist physically’; ‘using physical defence [e.g., hitting, punching, scratching, kicking, biting, etc.]’);

(v) victim-perceived effectiveness of resistance attempts (17 ratings measuring whether each strategy employed improved, worsened, or made ‘no difference’ to the assault outcome);

(vi) victim-centred barriers to police reporting (15 items assessing barriers such as self-blame; lack of faith in system; fear of perpetrator reprisal and social consequences; and concern for, or loyalty toward perpetrator; e.g., ‘I believed that I was responsible for the assault’; ‘I thought I would not be believed’; ‘I was afraid or worried about what the person might do if I reported it’; ‘I believed the police would be ineffectual in investigating the crime’).

Responses were typically given along 5-point or 7-point Likert-type scales (e.g., from 1 [Not at all] to 5 [Extremely] or from 1 [Strongly agree] to 7 [Strongly disagree]). For other item sets, responses were provided in dichotomous (True/False or Yes/No) format. For example, in identifying similarities between assaults, respondents answered True or False to a range of statements such as ‘During two or more of the events... I was afraid the person would physically hurt me’. With respect to resistance strategies, respondents answered Yes or No to indicate which
strategies they had applied, before rating the strategy as beneficial, counterproductive, or neutral to the assault outcome.

2.2.7 Section 5: Thoughts and Feelings
This section was constructed in order to obtain comprehensive mental health profiles for victims and nonvictims of sexual abuse. A battery of published psychometric tools was applied to measure a range of mental health and cognitive domains. Additional health domains (such as health-related and risk behaviours, and suicidality) were assessed through a number of item sets constructed for the purposes of current research. Psychometric measures and constructed item sets are described in turn. Psychometric measures are discussed in the order in which they were presented to survey respondents.

Rosenberg Self-Esteem Scale (RSE)
The Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965, 1989) is a 10-item, uni-dimensional measure of self-rated global self-esteem. The RSE, alongside the Coopersmith Self-Esteem Inventory (Coopersmith, 1967/1981), is among the most popular and widely applied measures of self-esteem, and indeed, is commonly regarded as the benchmark against which to judge other self-esteem measures. Extensive psychometric information exists to demonstrate the reliability (internal consistency and test-retest) and validity (convergent and discriminant) of the RSE. Four response choices range from 0 (Strongly disagree) to 3 (Strongly agree), with higher scores reflecting higher self-esteem. Scale scores range from 0 – 30. Scores between 15 and 25 are considered to be within normal range; scores below 15 are suggestive of low self-esteem.

Depression Anxiety Stress Scales-21 (DASS-21)
The Depression Anxiety Stress Scales (DASS; S. H. Lovibond & P. F. Lovibond, 1995) comprise a set of three self-report scales designed to measure the negative emotional states of depression, anxiety, and stress, and specifically, the core symptoms of these states. Two versions of this instrument exist – the basic 42-item DASS, and a shorter 21-item form, the DASS-21. An earlier version of the DASS was known as the Self-Analysis Questionnaire (SAQ). The DASS-21 was chosen for use in the current study, for the sake of brevity, given findings from several studies that this short form yields the same factor structure and similar results to those of the full DASS (see further details below) (Antony,
Each of the DASS-21 scales is composed of 7 primary symptoms of depression, anxiety, and stress (or 14 symptoms when using the DASS) which are rated on frequency/severity over the past week, along a 4-point Likert-type scale, ranging from 0 (Did not apply to me at all) to 3 (Applied to me very much, or most of the time). Thus, the DASS ascertains the recent experience of these negative emotional states, as distinct from the presence of enduring traits. Whilst it is possible to adopt the DASS as a trait measure by instructing respondents to indicate how they characteristically feel or experience each item, it was desirable, for the purposes of this research, to maintain the original wording. In so doing, it was possible to examine very recent negative emotional states in the context of victimisation and suicidality experiences over a lifetime. Retaining the original wording also enables direct comparison of results with normative data and published results for the DASS, as derived from other studies.

The DASS was derived through a series of rigorous procedures beginning in 1979 using varying Australian populations, including several clinical samples. The resultant instrument is a psychometrically sound, and clinically sensitive measure of three commonly experienced negative emotional states, able to yield meaningful discriminations in a variety of contexts. Specifically, from a clinical sample of 437 persons, the DASS scales have demonstrated excellent internal consistency, with alpha coefficients of .96, .89, and .93, for depression, anxiety, and stress, respectively; and test-retest reliability coefficients over a 2-week period of .71, .79, and .81. Similar evidence of reliability has been replicated in other studies (Antony et al., 1998; P. F. Lovibond & S. H. Lovibond, 1995). Validity of the DASS, including construct and concurrent validity, confirmatory factor analysis, and known-groups validity, is similarly evidenced by the findings of a number of studies (Antony et al., 1998; Brown, Chorpita, Korotitsch, & Barlow, 1997; Crawford & Henry, 2003; P. F. Lovibond & S. H. Lovibond, 1995; S. H. Lovibond & P. F. Lovibond, 1995; Taylor, Lovibond, Nicholas, Cayley, & Wilson, 2005). Convergent and discriminant validity is evidenced by the high correlations found between the depression scale and the Beck Depression Inventory (BDI) ($r = .74$) and between the anxiety scale and the Beck Anxiety Inventory (BAI) ($r = .81$) (Brown et al., 1997; P. F. Lovibond & S. H. Lovibond, 1995). These correlations were significantly higher than the corresponding cross-correlations (i.e.,
between the DASS anxiety scale and the BDI, DASS anxiety and DASS depression, and DASS depression and the BAI), indicating higher convergent validity than found in many comparable self-report scales (Brown et al., 1997; P. F. Lovibond & S. H. Lovibond, 1995).

Scores for the depression, anxiety, and stress scales are each calculated by summing the scores of the 14 items in each scale (or 7 items for the DASS-21). Notably, in scoring the DASS-21, scale scores are multiplied by two, so as to be directly comparable to the normative, and other published data for the DASS. Scores on each of the three scales range from 0 to 42, with higher scores signifying greater levels of negative emotional states.

Normative data are available for both community and clinical populations. A sample of 2914 adults reported means (and standard deviations) of 6.34 (6.97), 4.7 (4.91), and 10.11 (7.91) for the depression, anxiety, and stress scales, respectively. From a clinical sample, the means (and standard deviations) were 10.65 (9.3), 10.90 (8.12), and 21.1 (11.15) for the three scales, respectively (S. H. Lovibond & P. F. Lovibond, 1995).

The DASS and DSM diagnoses The DASS is founded on the conceptualisation of psychological disorders as existing along a continuum of severity, and therefore, as intrinsically dimensional entities, as distinct from categorical. Thus, the development of the DASS was underpinned by the assumption that differences between ‘normal’ and clinically disturbed individuals, with respect to experience of depression, anxiety, and stress were essentially differences of degree, rather than categorical in nature. This contention was confirmed by the DASS authors’ research data. Accordingly, allocation of individuals to the discrete diagnostic categories postulated by DSM and ICD classification systems is not directly implied by the DASS. Nonetheless, recommended bands for conventional severity labels are provided by the DASS authors, and these are reproduced in Table 2.3. Notably however, the authors caution against misinterpretation and reification of these arbitrary delineations, noting that DASS severity labels describe the full range of scores in the population. Thus, for example, whilst ‘mild’ signifies a score higher than the population mean, such a score is nevertheless, well below the typical severity of persons seeking professional help, and does not equate with a mild level of a ‘disorder’ (S. H. Lovibond & P. F. Lovibond, 1995).
Table 2.3

*DASS Score Interpretation: Recommended Bands for Conventional Severity Labels*

<table>
<thead>
<tr>
<th>Scale</th>
<th>Normal</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Extremely Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>0-9</td>
<td>10-13</td>
<td>14-20</td>
<td>21-27</td>
<td>28+</td>
</tr>
<tr>
<td>Anxiety</td>
<td>0-7</td>
<td>8-9</td>
<td>10-14</td>
<td>15-19</td>
<td>20+</td>
</tr>
<tr>
<td>Stress</td>
<td>0-14</td>
<td>15-18</td>
<td>19-25</td>
<td>26-33</td>
<td>34+</td>
</tr>
</tbody>
</table>

*Comparison of the DASS and the DASS-21* Whilst the DASS offers somewhat more reliable scores, and more information relating to specific symptoms, several published studies demonstrate that the DASS-21 yields similar results and the same factor structure, with the advantage of demanding only half the administration time (Antony et al., 1998). The authors of the scales suggest that whilst in general, the DASS is often preferable for clinical applications, the DASS-21 is frequently more appropriate for use in research (S. H. Lovibond & P. F. Lovibond, 1995). The items retained in the DASS-21 were chosen by applying a number of key selection criteria, including favourable factor loadings; adequate coverage of each of the three scales; and item means, such that each scale score on the DASS-21 should be very close to exactly half the scale score deriving from the full DASS (S. H. Lovibond & P. F. Lovibond, 1995). As noted earlier, DASS-21 scores are directly comparable to normative, and other published data for the DASS.

*Harder Personal Feelings Questionnaire-2 (PFQ2)*
The Harder Personal Feelings Questionnaire-2 (PFQ2; Harder & Zalma, 1990) is a 22-item instrument designed to measure self-rated proneness to shame and guilt. The PFQ2 is composed of two subscales, one for measuring shame (comprising items 1, 3, 6, 7, 10, 12, 14, 16, 18, and 21), and one measuring guilt (comprising items 2, 4, 8, 11, 17, and 22); the remaining six items are fillers. Whilst theoretically and conceptually, shame and guilt are considered distinct emotional states, these states can be difficult to differentiate in clinical practice, experientially, and in research settings (Irwin, 1998). Thus, the inclusion of separate shame and guilt subscales renders the PFQ2 an instrument of particular value for both clinical and research applications.
Each item is a descriptor of affect (e.g., Feeling “stupid”, Feeling humiliated). These are rated by respondents, in terms of the frequency with which the nominated feeling is experienced, along a 5-point Likert-type scale, ranging from 0 (Never) to 4 (Continuously or almost continuously). Scores range from 0 to 40 on the shame subscale, and from 0 to 24 on the guilt subscale, with higher scores on each subscale signifying greater proneness to the affective experience.

The PFQ2, a refinement of its predecessor, the PFQ, has been established through extensive investigation, as a psychometrically sound instrument (Harder, Cutler, & Rockart, 1992; Harder & Lewis, 1987; Harder, Rockart, & Cutler, 1993; Harder & Zalma, 1990; Irwin, 1998). Both PFQ2 subscales demonstrate good to excellent test stability (with 2-week, test-retest correlations of .85 for guilt, and .91 for shame); and fair to good internal consistency (with alpha coefficients of .72 for guilt, and .78 for shame). The PFQ2 has empirically demonstrated good construct validity, with construct validity variables including a number of well-known instruments, including the Beck Depression Inventory, suggesting that the PFQ2 is a valuable and valid measure of shame and guilt proneness.

Aggression Questionnaire (AQ)

The Aggression Questionnaire (AQ; Buss & Perry, 1992) is a 29-item instrument that measures self-perceived propensity for aggression and ability to restrain from employing destructive aggressive behaviours. The AQ is composed of four subscales that each assess a subtrait of aggression: physical aggression (PA: items 1, 5, 9, 13, 17, 21, 24, 26, 28), verbal aggression (VA: items 2, 6, 10, 14, 18), anger (A: items 3, 7, 11, 15, 19, 22, 29), and hostility (H: items 4, 8, 12, 16, 20, 23, 25, 27), providing a measure of overall aggression (by using total scores), as well as measuring manifestations of aggression (determined by subscale scores). Items are rated by respondents along a 5-point Likert-type scale, ranging from 1 (Extremely uncharacteristic of me) to 5 (Extremely characteristic of me).

The AQ is a refinement of the widely used Buss-Durkee Hostility Inventory (BDHI; Buss & Durkee, 1957). This questionnaire has been established by the authors, and by several independent investigators, as a psychometrically sound measure of four aggression subtraits and overall aggression. Specifically, it has been established as a stable instrument with good test-retest reliability (with 9-week, test-retest correlations of .80, .76, .72, and .72 for the PA,
VA, A, and H subscales, and .80 for total scores); very good internal consistency (with alpha coefficients of .85, .72, .83, and .77 for the PA, VA, A, and H subscales, and .89 for total scores), demonstrated theoretical and construct validity; and good concurrent validity for subscale scores (Buss & Perry, 1992; García-León et al., 2002; Harris, 1995, 1997). It has also been demonstrated that the AQ is able to discriminate between forensic (prison inmates) and general populations (university students) (García-León et al., 2002).

In terms of normative data, the AQ was found by the authors to have the following subscale score means (and standard deviations) for a sample of 612 undergraduate males: PA = 24.3 (7.7), VA = 15.2 (3.9), A = 17.0 (5.6), H = 21.2 (5.5); total scores had a mean of 77.8 with a standard deviation of 16.5. For a sample of 641 female university students, subscale means and standard deviations were: PA = 17.9 (6.6), VA = 13.5 (3.9), A = 16.7 (5.8), and H = 20.2 (6.3); the mean for total scores was 68.2 with a standard deviation of 17.0. A total score is the sum of all item scores and ranges from 29 to 145, with higher scores reflecting greater aggression.

**Gender Role Conflict Scale (GRCS)**

The Gender Role Conflict Scale (GRCS; O’Neil, Helms, Gable, David, & Wrightsman, 1986) is a 37-item scale developed to measure the construct of male gender role conflict (GRC). This construct is underpinned by a conceptual model proposing that male psychological problems are related to multiple masculine gender role conflicts and related patterns that males learn through gender role socialization. Under this model, it is proposed that males are oppressed by rigid gender role socialization processes (i.e., sexism) that compromise their capacity to be ‘fully functioning human beings’ (O’Neil, 1981, 1990, 2008). Since the publication of the GRCS in 1986, extensive research has been conducted using this scale and more than 230 empirical studies using the GRCS have been reported in the literature, resulting in an expansive and thoroughly evaluated database (see review by O’Neil, 2008).

The GRC model suggests that gender role strain and restrictive sex-role socialization is also destructive to the wellbeing of women and children (O’Neil, 1981, 2008), and that GRC occurs when restrictive, rigid, or sexist gender role expectations effect restriction, devaluation, or violation of others or self (O’Neil, Good, & Holmes, 1995). Yet surprisingly, the strong research interest shown toward male GRC has not hitherto been
extended to the study of this construct in females, and to date, no known female equivalent of the GRCS has been developed. To allow comparative analyses, a female version of the GRCS was created for the purposes of the current research. The GRCS was used with permission from the principal author (J. O’Neil, personal communication, 19th August 2004).

The GRCS comprises four subscales: (i) Success, Power, and Competition (SPC; 13 items; e.g., ‘I worry about failing and how it affects my doing well as a man’); (ii) Restrictive Emotionality (RE; 10 items; e.g., ‘I have difficulty expressing my tender feelings’); (iii) Restrictive Affectionate Behaviour Between Males (RA; 8 items; e.g., ‘Affection with other men makes me tense’); and (iv) Conflicts Between Work and Leisure (CWL; 6 items; e.g., ‘My work or school often disrupts other parts of my life [home, family, health, leisure]’). Responses are provided along a 6-point Likert-type scale from 1 (Strongly disagree) to 6 (Strongly agree), with higher scores reflecting greater degrees of conflict regarding the GRC factors represented by each subscale. The GRCS has been extensively factor analysed and tested for psychometric properties. Construct validity has been demonstrated through factor analyses suggesting that the four consistently identified factors are related to each other yet constitute separate entities, and has also been demonstrated by tests of reliability and validity from varied samples (O’Neil, 2008). Correlational data indicate the GRCS has convergent validity with commonly used measures of masculinity and discriminant validity with homophobia and sex role egalitarianism; and validity data suggest that the GRCS measures a construct distinct from other masculinity scales, relating to measures of masculinity ideology, masculine norms, gender role stress, and reference group identity (for review, see O’Neil, 2008). Test-retest reliability has also been established across the four factors, and social desirability tendencies of the GRCS have been assessed as low and practically insignificant (O’Neil, 2008).

**Revised Attraction to Sexual Aggression Scale (ASA)**

The ASA was developed and revised by Malamuth (1989a, 1989b, 1998) to measure self-reported attraction to sexual aggression and likelihood of engaging in a wide range of sexually aggressive behaviours, including rape. In order to minimise the demand characteristics of assessing attraction to sexual violence, additional items measuring proclivity to engage in both nonsexual aggressive/criminal behaviours (e.g., ‘seriously assaulting someone [nonsexually]’, ‘committing a robbery without hurting anyone’) and nonaggressive sexual behaviours (e.g., ‘deep kissing’, ‘oral sex’, ‘homosexual acts’) were embedded within the measure.
Evidence exists to support the reliability and validity of both the original and revised ASA (Malamuth, 1989a, 1989b; Voller, Long, & Aosved, 2009). Adequate test-retest reliability and internal consistency of .91 has been reported for the original ASA, and item-total correlations have ranged from .46 to .77 (Malamuth, 1989a, 1989b). Validity has been shown through significant relationships between the ASA and both rape supportive attitudes and sexual arousal response to depiction of rape (Malamuth, 1989b). With respect to the revised ASA, calculation of internal consistency across all items has resulted in an $\alpha$ of .94, and good internal consistency was found for three scores created by Voller et al. (2009) for attraction to sexual violence ($\alpha = .90$), attraction to criminality ($\alpha = .89$), and attraction to CSA ($\alpha = .86$).

The full ASA poses four questions in relation to each item in order to assess proclivity and likelihood of engaging in each behaviour: (i) ‘For each kind of activity listed, please indicate how often you have thought of trying it’ [followed by Likert choices from 1 = Never to 3 = Often]; (ii) ‘Whether or not you have ever thought of it, do you find the idea of [behaviour]’ [followed by Likert choices from 1 = Very unattractive to 4 = Very attractive]; (iii) ‘If you were sure that no one would ever find out and that you’d never be punished for it, how likely would you be to do the following?’ [followed by Likert choices from 1 = Very unlikely to 7 = Very likely]; and (iv) ‘How likely do you think it is that at some point in the future you might try the following activities?’ [followed by Likert choices from 1 = Very unlikely to 7 = Very likely].

For the sake of brevity, only question (iii) was used in the current study. Items of particular relevance included those that assess proclivity to perpetrate rape (both named using the term ‘rape’ and unnamed); CSA; and other sexual coercive behaviours (e.g., ‘sexual activity with a person under 10 years of age’, ‘forcing a female to do something sexual she didn’t want to do’, ‘threatening physical force or harm to obtain sex’). The scale was expanded for the purposes of the current study to include ‘male’ items corresponding with existing ‘female’ items (e.g., ‘raping a male’ was included to correspond with ‘raping a female’). In total, 35 items were assessed using question (iii): ‘If you were sure that no one would ever find out and that you’d never be punished for it, how likely would you be to do the following?’ The revised ASA scale was used with permission from the author (N. Malamuth, personal communication, 30th November 2004).

*Extended Satisfaction With Life Scale (ESWLS)*
The Extended Satisfaction With Life Scale (ESWLS; Alfonso, Allison, Rader, & Gorman, 1996) is a self-administered 50-item measure of subjective quality of life (QOL) that assesses satisfaction with life in ten domains (general life satisfaction, and satisfaction relating to social life, sex life, self, physical appearance, family life, school life, work life, and current or past relationship). Subscales each contain five items and can be used in combination or separately, creating a versatile measure that can be utilised in many ways depending on the nature of the research. For the purposes of the current research, three subscales were used to assess general life satisfaction, sex life satisfaction, and relationship satisfaction, respectively. Statements representing items from these subscales include: ‘In most ways my life is close to ideal’; ‘I am satisfied with my sex life’; and ‘So far I have gotten the important things I want from my relationship’. Responses are provided along a 7-point Likert-type scale from 1 (Strongly disagree) to 7 (Strongly agree). Subscale scores are summed, with higher scores reflecting greater life satisfaction.

Factor analysis and extensive psychometric testing have demonstrated the excellent measurement properties and utility of the ESWLS as a survey instrument (Gregg & Salisbury, 2001). Specifically, findings by Alfonso et al. (1996) have identified the ESWLS as a valuable survey tool for examining diverse populations and the subjective assessments of QOL among heterogenous groups. The ESWLS demonstrates strong validity and reliability and yields a factor structure with eight clearly discernible domains of life satisfaction that explain a large proportion of covariance. The factors produce relatively independent subscales that satisfy psychometric testing criteria for convergent and discriminant validity and reliability. The ESWLS evidences excellent internal consistency with Cronbach α coefficients ranging from .81 (school satisfaction) to .96 (several subscales) for the nine subscales. Excellent stability has been demonstrated by two-week test-retest reliability coefficients ranging from .74 (school satisfaction) to .87 (sex satisfaction) for the subscales (Alfonso et al., 1996). Preliminary norms exist and the tool builds on research spanning over two decades and conducted by leading scholars in the field of subjective life quality research (Gregg & Salisbury, 2001). The ESWLS was used with the permission of the principal author (V. Alfonso per A. Drost, personal communication, 7th December, 2004).
An item set was constructed to measure psychological, physical, and sexual abuse within intimate partnerships. Amongst other influencing scales, inspiration and guidance were drawn from the revised Conflict Tactics Scales (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). Accordingly, this measure and the derived item set are described under the current heading. Content was also drawn from the CSS (Rapaport & Burkhart, 1984). However, as this scale was described earlier (in Section 2.2.4), this information is not repeated here.

The CTS2 is a 78-item self-report measure of physical and psychological aggression against a partner and the use of negotiation within marital, cohabiting, or dating relationships. This tool is configured to allow assessment of five modes of conflict resolution within romantic relationships: Negotiation, Psychological Aggression, Physical Assault, Sexual Coercion, and Injury. Amongst a broad range of ancillary factors that can be assessed through the CTS2, this scale provides a particularly useful measure of relationship violence, and indeed, constitutes one of the most commonly used measures of IPV (Calvete, Corral, & Estévez, 2007).

The CTS2 comprises two parallel forms – one to measure participants’ perpetration of IPV and one to measure IPV victimisation. For the current research, an item set was constructed by drawing on the content of the victim form. Since it was specifically for measurement of IPV that content domains from the CTS2 were included for use in the current research, and for the sake of brevity, the Negotiation subscale was also omitted. An item set was constructed informed by the three remaining scale components.

The CTS2 measures frequency of conflict tactics ‘in the past year’ and includes two additional response choices: ‘Not in the past year, but it did happen before’; and ‘This has never happened’. It was of interest in the current study to measure lifetime occurrence of IPV, in line with the measurement of lifetime occurrence of sexual victimisation and suicidality. Thus, the current item set was measured by providing a 7-point Likert-type scale (i.e., 0, 1, 2, 3, 4, 5-10, 11+) as a response mode to the following question:

**INSTRUCTIONS:** Please select how many times an OPPOSITE SEX partner has acted in this way towards you.’
To avoid repetition from the use of other scales and overburdening of participants, concepts from the CTS2 were collapsed or summarised to create smaller subscales. For instance, single items such as ‘My partner slapped me’ and ‘My partner kicked me’ were collapsed into a single item: ‘My partner hit, slapped, punched, or kicked me’. Additional items were included to measure aspects of IPV not assessed by the CTS2 (e.g., ‘My partner did any of the things listed above, because I talked about leaving the relationship’). Participants who endorsed such items were provided a drop-down list on which to specify what had occurred. In contrast to items assessing IPV in terms of behavioural descriptors, items were also constructed to measure participants’ subjective appraisal of their experiences with partner conflict (e.g., ‘Do you consider yourself to have been the victim of domestic [or partner] violence?’). Further items were constructed to measure related victim perceptions, behaviours, and outcomes (e.g., ‘Are you or were you ever frightened for your physical safety due to your partner?’; ‘Have concerns for your own [or someone else’s] safety stopped you from leaving a partner, or from leaving sooner?’; ‘Have you ended one or more relationship[s] because of domestic [or partner] violence?’; ‘I agreed to sex because I was frightened about saying no’; ‘How many different partners have been violent toward you?’; ‘How many different partners have been emotionally or psychologically abusive toward you?’).

Both the original CTS (Straus, 1990b) and the revised version (CTS2) have been extensively employed and examined. Indeed, many books and hundreds of papers on partner violence have used CTS data derived from over 70,000 participants from diverse cultural backgrounds (Straus, 1990b, 2004; Straus et al., 1996); and the CTS2 has been used to assess relationship conflict tactics in studies involving over 7,000 participants across 17 countries (Straus, 2004). Extensive research indicates construct validity (Straus, 1990a); a stable factor structure; and moderate to high reliability for the CTS (Archer, 1999; Yodanis, Hill, & Straus, 1997). Similarly, psychometric testing of the CTS2 evidences construct validity, high alpha coefficients of internal consistency across 17 testing sites, and low confounding by socially desirable responding (Straus, 2004). Whilst the CTS2 has been extensively applied to the measurement of heterosexual IPV with an overarching emphasis on male perpetration against female victims, the application of this useful measure to the assessment of same-sex IPV and male victimisation represents an area yet to be developed. Given the considerable research interest that has been directed to testing the reliability and validity of the CTS2 in culturally diverse groups (Calvete et al., 2007; Straus, 2004; Straus et al., 1996) and other specific populations, such as incarcerated women (Jones, Ji, Beck, & Beck, 2002), it is surprising that this measure has not yet been more gainfully utilised or
tested with underresearched cohorts such as sexual minority groups and male victims of IPV.

**Constructed item sets**

As supplements to the listed measures comprising Section 5 (and already described), a number of item sets were constructed in order to measure the following additional domains:

(i) consent, sexual debut, and desire for sexual activity (12 items measuring readiness and desire for first experience of intercourse and subsequent sexual activity; e.g., ‘Did this occur with your consent?’ ‘How much did you want this to happen at the time?’). Possible responses ranged along a 6-point Likert-type scale from 1 (Not at all) to 5 (Extremely) and 6 (Not applicable).

(ii) empathy for victims of rape, convicted rapists, and persons accused of rape; and exposure to rape victims and perpetrators (11 items: e.g., ‘How much empathy do you feel for…. male victims of rape/females accused of rape?’; ‘Not including yourself, do you personally know someone who has been raped?’). Respondents were provided with a 5-point Likert-type scale with anchor points from 1 (No empathy) to 5 (Extreme empathy);

(iii) likelihood to report rape and encourage reporting in others (2 items; ‘If someone I cared about were raped, I would encourage that person to report it’; ‘If I were raped, I would report it’). Possible responses ranged from 1 (Definitely) to 7 (Definitely not);

(iv) self-rated subjective and behavioural measures of physical and mental health (10 items; e.g., ‘Overall, how would you rate your physical health?’ [1 = Extremely poor to 6 = Excellent]; ‘Do you currently take medication for a psychological problem or mental illness [e.g., depression]?’ [No/Yes; If yes, please describe]; ‘Have you had a psychological problem or mental illness in the past [e.g., depression]?’ [No/Yes; If yes, please describe]; ‘Over the past couple of weeks, have you…. Been having restless or disturbed nights/felt unable to overcome your difficulties/been feeling unhappy or depressed? [No/Yes]).

(v) problematic eating (2 items – past and present; e.g., ‘Do you consider that you have a problem with eating [e.g., binge eating, starving yourself, excessive dieting, overeating, etc.]?’). Possible responses ranged from 1 (Definitely not) to 5 (Definitely yes).
(vi) substance use (27 items assessing tobacco, drug, and alcohol use in terms of behavioural patterns [i.e., frequency, amount, & substance type] and subjective ratings; e.g., 'Do you consider that you have a problem with alcohol use?'; Which drugs have you used in the last 12 months? Please tick all that apply [12 drug categories provided, including ‘Other’]; Which best describes how often you use any drugs for “recreational purposes” [including prescription drugs]? [Possible responses ranged from 1 = Every day or most days to 10 = Not at all in the last year]).

(vii) risk behaviours (9 items measuring risk behaviours related to sexual activity, substance use, and substance-affected driving; e.g., ‘How often do you drive whilst at [or close to] the legal blood alcohol level, or above?’; ‘How often are you the passenger of a driver who has consumed an illegal substance?’; ‘How often have you had sex with someone that you had met within the 24 hours before?’; ‘Over the last 10 years, how often have you had unprotected sex [i.e., with a partner whose health status is unknown to you]?’; ‘How often do you consume an illegal drug before engaging in sexual activities?’). Possible responses varied as applicable (e.g., Driving and passenger: 1 = Every day or most days to 10 = Never and 11 = Not applicable – I don’t drive; Stranger and unprotected sex: 1 = Never to 7 = Over 50 times; Substance-affected sexual activity: 1 = Always or almost always to 8 = Never and 9 = Not applicable – not sexually active).

(viii) suicidality (14 items measuring suicidal ideation and behaviour, suicidality disclosure, and future suicidality propensity; e.g., ‘Have you ever seriously thought of taking your own life?’; ‘Have you ever made a suicide attempt?’; ‘If yes, did you speak to anyone about your suicidal thoughts or attempt/s?’; ‘If yes, how helpful was this?’; ‘Please describe the type of person [e.g., male friend, female GP, psychologist, etc.]; ‘If you spoke with more than one person, please specify the type of person you found to be most helpful to you [e.g., male friend]; ‘How likely is it that you would seriously consider suicide again at some time in your life?’).

2.2.8 Section 6: Demographics

Constructed item set

This section contained questions (additional to those asked in the Introductory Section) concerning further demographic characteristics of the respondent, such as cultural background, rural/urban location, religiosity, and relationship status. To assess degree of representation from culturally and linguistically diverse (CALD) communities, items measuring variables such as country of origin, language other than English spoken at home
were included. Current relationship status was classified according to six categories: single, married, de facto, separated, divorced, and widowed.

Given the extremely large volume of data derived from the current research, reporting on all of the domains examined was beyond the scope of this thesis and it was necessary to omit certain topics (e.g., rural/urban location, substance use, risk behaviours) from further discussion. Instead, exploration of these domains will be undertaken and reported separately. Information is available to the interested reader.

The questionnaire section of the survey ended with the following message: ‘Thank you for completing the TSP survey. Your contribution is valuable and greatly appreciated. Please go to Section 7 to access referral details and information for your use.’

2.2.9 Section 7: Support Services, Information, and Referral Details
This final section of the TSP survey comprised a comprehensive Australia-wide victim support, information, and referral resource, available to all visitors to the website and able to be downloaded (see Appendix B). In the absence of any existing integrated and comprehensive resource, the current directory was created by the principal researcher for the current study. Site visitors were invited to print and retain this document for reference: ‘This section does not contain any further questions. However, it contains important information, including referral details, should you have any concerns. Feel free to print this section, and keep it for future reference’. Distressed individuals were encouraged to seek assistance and provided with relevant information and referral options. Information and contact details were provided via Uniform Resource Locators (URLs or web addresses) configured as links and under national and state headings, as outlined in the following sections. Site visitors were able to navigate through Section 7 by clicking on links for national and state listings or by scrolling through the document.

Information services
This section offered activated URLs for a range of education and information websites under the following headings: Emergency numbers – Who to call in a crisis; Sexual assault; Young adult health; Domestic violence; Gay & lesbian counselling & community services; Sexual health – Guidelines, information, and publications; Risk-taking; Drink spiking; and Australian Law Online.
Support services – National

This section provided contact details and brief descriptions for a range of Australia-wide support services and service directories. Information provided included relevant FREECALL numbers and listings for emergency services; telephone crisis and assistance lines (e.g., Kids Help Line; Men’s Line; Confidential Helpline); sexual assault referral services; the Domestic Violence and Incest Resource Centre (DVIRC) Australian and international service directory for survivors and workers; information, links, and a national service directory for GLBTI individuals; depression information websites; all sexual health clinics in Australia and New Zealand (available to download and print as a pdf file); translating and interpreting services; Relationships Australia; Alcoholics Anonymous; Family Law Hotline; and the Regional Law Hotline.

Support services – Listings by state

Contact details, opening hours, and brief descriptions were provided for a range of support services in each Australian state and territory. Emphasis was placed on listing services able to address suicidality; grief; crime victimisation; crises involving women and children; pathological gambling; parenting; domestic violence and incest; male violence against partners; sexual assault; sexual health; GLBTI health, support, and counselling needs; and substance misuse.

Common myths surrounding rape

Fifteen common myths surrounding rape (and facts to counter each myth) were presented in this section. For example, the myth that ‘rapists are usually strangers lurking in dark alleyways’ is countered by Fact # 2: ‘Most victims know their rapists. The majority of rapes are perpetrated by acquaintances, dates, or marital partners in places where the victim usually feels safe, such as in their own home or their date’s home’.

What is rape?

This section provided general guidelines for legal definitions of rape and consent. However, it was emphasised that variations exist among states and that such guidelines should not be substituted for professional legal advice applicable to the relevant state or territory.
2.3 Procedure

Overview 2.3.1
The following sections contain discussions pertaining to six procedural issues. Section 2.3.2 presents a literature review and rationale for online research methodology. Online and conventional data collection methods are compared; applicability of online research methods for LGB populations is discussed; and feasibility of such methodology is explored in terms of Internet accessibility and usage. Development of the online survey instrument is described in Section 2.3.3. Recruitment strategies are presented in Section 2.3.4, with details provided for direct and indirect general community recruitment initiatives, and those targeted toward specific cohorts, namely, males and victims of sexual abuse. Issues relating to statistical analyses employed in the current thesis are presented in Section 2.3.5.

2.3.2 Online Research Methodology: Literature Review and Rationale
Comparison of online and conventional data collection methods
A rapidly expanding body of evidence exists that online research methodologies have wide applicability and confer many advantages over traditional methods of data collection (Hanna et al., 2005; Reimers, 2007). Beyond the many generic advantages conferred by online research over traditional survey methods (e.g., anonymity; lower costs and use of human resources; speed of data collection; ease of application and ‘user-friendliness’ for both researchers and target groups; quantitative and qualitative data immediately accessible obviating the need for manual data entry; potential for wide geographical and demographic reach and large datasets), the additional benefits for researchers examining sensitive topics or wishing to target hidden populations are substantial.

Common to many research projects are budget constraints that impose limitations such as small sample sizes and convenience sampling that frequently undermine the quality of the research and the utility of findings. Indeed, samples are often limited to young university populations and those in relatively close proximity to universities, resulting in disproportionate representation, or exclusion, of older age cohorts, and rural, marginalised, and sociodemographically and culturally diverse populations. Student research projects without external funding sources are particularly prone to such limitations. Conversely,
online methodologies offer opportunities for research of a magnitude and scope rarely within the reach of modestly funded, or unfunded, independent researchers. The interested reader is directed to the substantial literature in which both favourable prospects and caveats associated with the conducting of psychological and other research through online methodologies have been discussed thoroughly (for reviews, see, for example, Birnbaum, 2000, 2004; Gosling, Vazire, Srivastava, & John, 2004; Hanna et al., 2005; Reips, 2002). Whilst limitations exist with all methodologies, favourable overall outcomes of online survey methods over traditional methods have been repeatedly documented (Hanna et al., 2005; Reimers, 2007), and these are particularly pronounced in research examining sensitive topics (Hanna et al., 2005).

Given such welcome corollaries, it is not surprising that online methods of research hold wide appeal and are increasingly adopted as the method of choice by researchers in many disciplines. Indeed, online methodologies have been gainfully applied to research spanning a diverse range of subject arenas and specialties, such as medicine (Shikiar, Flood, Siddique, Howell, & Dodd, 2005), commerce (Englis & Solomon, 2000), librarianship (Fikar & Keith, 2004), psychology (Reimers, 2007), and social work (Daneback, Cooper, & Månsson, 2005). Recently conducted online research includes the study of gastroesophageal reflux disease treatment satisfaction (Shikiar et al., 2005); male sexual dysfunction in Turkish men (Oksuz & Malhan, 2005); characteristics of Latino men who have sex with men and others who complete or exit online sexuality questionnaires (Ross, Daneback, Månsson, Tikkanen, & Cooper, 2003); characteristics of cybersex participants (Daneback et al., 2005); perceived parental approval of drinking (Boyle & Boekeloo, 2006); social workers’ knowledge and training in suicide intervention (Feldman & Freedenthal, 2006); utility of the Internet in reaching hidden, highly stigmatised populations in rural areas (Bowen, 2005); sexual preferences and behaviours, self-evaluation, and values (Reimers, 2007); information needs of LGBT health professionals (Fikar & Keith, 2004); legal recognition of same-sex relationships (Harding & Peel, 2006, 2007); and dating violence and risk behaviours (DuRant et al., 2007).

A number of commonalities are present amongst these studies. Many have targeted hidden, highly stigmatised populations, and addressed topics of a highly personal nature, often subject to stringent taboo or other disclosure-inhibiting factors. Within forums in which anonymity cannot be guaranteed, disclosure pertaining to sensitive topics confers the
possible risk of negative appraisal and other negative sequelae. Hence, findings are potentially marred by desirable response patterns, lack of candour, and high rates of nondisclosure or dropout. Given the anonymity afforded by the Internet, the solitary action of engaging in ‘conversation’ with a computer screen, and the nonthreatening and private confines of one’s own home or office, it might be expected that response quality and degree of honest and open disclosure can be enhanced and facilitated through the use of online methodology. Alternatively, it may be that web methodology reduces response quality by providing increased opportunity for error, dishonesty, and inaccuracy, and by reducing engagement and motivation to complete. In fact however (and as noted above), whilst some limitations exist with online methodology (Birnbaum, 2004), as with all methodologies, convergent empirical evidence has been furnished over recent years, of favourable overall outcomes of online research methods, relative to traditional approaches (Hanna et al., 2005; Reimers, 2007). Of specific relevance to the current studies is the finding that enhancement of both data quality and quantity through the use of online methodologies is particularly evident in research examining sensitive topics (Hanna et al., 2005).

Specifically, research in the computer-mediated communication (CMC) literature has demonstrated that CMC in general has a disinhibiting effect, promoting increased intimacy and friendliness (Walther, 1996); and increasing the propensity for personal disclosure, above that which is likely in face-to-face interactions (Hiltz, Johnson, & Turoff, 1986; Kiesler, Siegel, & McGuire, 1984), and in paper surveys (Hanna et al., 2005). The CMC literature also documents consistent evidence of a heightened sense of private self-awareness and self-reflection amongst online users (Hanna et al., 2005; Matheson & Zanna, 1988), allowing more thoughtful and greater expression of true feelings, particularly in relation to issues of a deeply personal nature (Hanna et al., 2005). Studies have also furnished evidence of a self-perpetuating effect, in that, heightened self-awareness increases self-disclosure (Kalin & Schuldt, 1991), and self-disclosure of personal information in turn, generally heightens self-awareness (Archer, Hormuth, & Berg, 1982). Consistent with this evidence is the finding that, under conditions of anonymity, online respondents exhibit greater self-reflection and self-disclosure than their paper counterparts (Hanna et al., 2005). Further research demonstrates that online respondents exhibit less socially desirable responding (Joinson, 1999; Kiesler & Sproull, 1986) and less social anxiety (Joinson, 1999), relative to paper respondents.
With respect to anonymity, research has revealed that less socially desirable responding is procured under anonymous conditions, than under identified conditions for both online respondents (Kiesler & Sproull, 1986), and paper survey respondents (Joinson, 1999). Moreover, high rates of item omission and low response rates have been frequently encountered under user-identified conditions, suggesting that erosion of anonymity inhibits self-disclosure (Bachmann, Elfrink, & Vazzanna, 1996; Mehta & Sivadas, 1995). Evidence demonstrating that heightened awareness amongst online respondents may be undermined by the absence of user anonymity (Hanna et al., 2005) is consistent with this suggestion. Further evidence suggests that anonymity can assuage feelings of vulnerability associated with disclosure of high-risk information, and hence, impact on the degree of self-disclosure, more powerfully than previously recognised (Archer, 1980; Derlega, Metts, Petronio, & Margulis, 1993; Hanna et al., 2005; Kelly & McKillop, 1996; Moon, 2000).

Earlier research has demonstrated that cosy, familiar surroundings (e.g., soft furnishings and lighting) engender greater disclosure of intimate information than sparse settings with harsh lighting (Chaiken, Derlega, & Miller, 1976). This finding lends further credence to the utility of conducting research within the private and familiar confines of the respondent’s own environment, and more specifically, within their environment of choice (e.g., home, office). Given that a trusted, ‘safe’ climate and an unencumbered, optimised sense of self expression are traditionally regarded as integral components of an optimal psychotherapeutic environment, online methodologies seemingly have much to offer in creating conditions that are highly conducive to psychological research.

Early evidence also exists that increased reporting of sexual behaviours, substance use, and violence, may be derived through the use of computer survey technology (Turner et al., 1998). Moreover, indications exist that benefits of online methods will be greatest for research targeting hitherto elusive populations and seeking to examine areas subject to taboo, negative appraisal, shame, and socially desirable response patterns. Thus, given that mental health generally, and suicide, sexual abuse, and substance use specifically, are subjects notoriously shrouded in secrecy, the utility of an online methodology for examining these issues is clear.
Given the obvious advantages and demonstrated success of online methodologies for conducting research examining sensitive topics and marginalised populations generally, it is surprising that to date, such methodology has been utilised in relatively few studies examining suicide and sexual assault. Indeed, no known online studies have examined suicidality, sexual abuse, and psychological wellbeing in combination and in a holistic and thorough manner, using psychometrically sound instruments.

The application of online research methods to the study of sexual abuse, mental health, and suicidality has the potential to gainfully inform the expanding generic literature pertaining to online research methodologies (Birnbaum, 2000, 2004; Englis & Solomon, 2000; Gosling et al., 2004; Joinson, 1999; Kiesler et al., 1984; Kiesler & Sproull, 1986; Mehta & Sivadas, 1995; Nosek, Banaji, & Greenwald, 2002; Reimers, 2007; Reips, 2002; Rhodes, Bowie, & Hergenrather, 2003; Stern, 2003; Strickland et al., 2003; Thomas, Stamlcr, Lafreniere, & Dumala, 2000); and the literature pertaining to research methods within taboo areas such as suicide and sexual assault (Bowen, 2005; Hanna et al., 2005; Moon, 2000; Ochs, Mah, & Binik, 2002; Stern, 2003; Turner et al., 1998).

Aside from the sizable, numerous process-specific benefits of online research (as outlined above), the choice of an online methodology for the current research was driven by the aim to recruit a large and diverse national sample of males and females residing in both urban and rural Australia. As detailed in relevant chapters of this thesis, previous research examining sexual abuse, suicidality, and perturbation has often been compromised by small sample sizes, opportunistic sampling, and resultant over-reliance on university populations or those living in close proximity to universities or other research centres. Given the additional barriers to mental wellbeing and healthcare services conferred by rural location, and the higher suicide rates evident in rural Australia, relative to urban centres, undersampling of nonurban Australians is an issue of considerable concern. Moreover, given the taboos surrounding sexual abuse, incest, and domestic violence, and the added pressures and difficulties to maintain anonymity in rural settings, barriers to disclosure and help-seeking (and therefore, threats to wellbeing) are particularly heightened for victims of such abuses in rural locations. An online methodology is able to provide a ‘safe’ mechanism for disclosure, irrespective of geographic isolation and circumventing concerns for loss of anonymity commonly held by victims in rural settings.
Accuracy in understanding all sectors of society clearly augers well for building reforms and services to better and more equitably meet the needs of all. The wide reach of the Internet provides an ideal forum through which to circumvent barriers that derive from taboos, shame, and ‘victim’ status; as well as cultural, sociodemographic, or geographic differences and isolation.

Feasibility of online research: Internet accessibility and usage

Rapidly expanding accessibility to, and usage of, computers and the Internet provide increasingly rich opportunities for research, education, and therapeutic intervention to be conducted through online methods. Such expansion allows initiatives of this type to be conducted on a scale not previously possible, and for these to reach hitherto neglected cohorts (such as rural, remote, and marginalised groups).

In 2005, 67% of households held a computer, representing a substantial increase from 1998, when less than half (44%) of Australian households contained a computer. More significantly, the number of households connected to the Internet more than tripled during this reference period, from 16% in 1998 to 56% of households in 2005. Moreover, in 2005, 28% of households had broadband Internet connection (ABS, 2006a), suggesting increasingly efficient Internet access and usability within private homes.

In 2006-07, 64% of Australian households had Internet access in the home, representing an increase of 4 percentage points from the previous year (2005-6), and a quadruple increase from 16% in 1998 (ABS, 2007a). Notwithstanding such high levels of Internet connectivity across Australia, it must be noted that socioeconomic characteristics of households continue to impact both computer and Internet access (ABS, 2007a). This factor should be included in considerations regarding the limitations of any research design. Specifically, households with no children aged under 15 years, those located outside metropolitan or in remote areas, and those with lower incomes remained less likely to have computer and/or Internet access within the home (ABS, 2007a). Moreover, Internet access from any location was significantly lower than average for unemployed and older Australians, and those with below median household income. Conversely, significantly higher than average levels of Internet access were registered for Australians aged 15 to 17 years, and amongst Australians with high income, higher educational attainment, and current employment (ABS, 2007a). During 2006-07, 69% of Australians aged 15 years or
over reported having accessed the Internet within the previous year, most commonly from home. Indeed, 61% of Australians over 14 years had accessed the Internet from home and reported this as their most common location for Internet access, followed by places of employment (31%) and the homes of neighbours, friends, or relatives (26%) (ABS, 2007a).

During 2006-07, use of the Internet in the workplace was highest amongst professionals (75%), administrative or clerical workers (64%), and managers (60%), and reported by less than forty percent of community workers, retail staff, and tradesman, less than twenty percent of machinery operators and drivers, and only 10% of labourers. Importantly, however, access to the Internet at any location was much higher for all occupational groups, such that most Australians, including those with the lowest likelihood of Internet access at work (e.g., labourers [57%]; machinery operators and drivers [60%]; and technicians and tradesmen [73%]) reported access to the Internet at some location. For professionals (94%), clerical and administrative workers (89%), retail workers (85%), and managers (83%), access to the Internet from any location was extremely high (ABS, 2007a).

As discussed earlier, the home has been identified as an ideal location for generating online survey data, particularly in the examination of sensitive topics. Of the estimated 9.9 million Australians who accessed the Internet within the home during 2006-7, more than two thirds (68%) reported personal or private purposes as the principal reason for Internet access, in contrast to less than one in five (17%) who cited work related purposes as the main purpose (ABS, 2007a). In summary, recent statistics show that Australians enjoy high levels of Internet connectivity within the home and that, in the absence of a home-based Internet connection, access to the Internet at another location is available to most Australians (ABS, 2007a).

2.3.3 Developing the Online Survey Instrument

The survey content was piloted with both victims and nonvictims of sexual assault prior to final placement online. Detailed feedback was received and edits and formatting changes were made accordingly. The online version was then subjected to a thorough process of testing and troubleshooting for usability, clarity of navigation instructions, correct functioning of links, and correct data submission and retrieval, both prior to, and after ‘going live’. Further refinements and corrections were made as required.
Upon submission of each section of the survey by the respondent, survey responses were automatically entered into a secure encrypted database, and immediately accessible to the researcher. Thus, partially completed datasets were available for access, and these were updated if and when respondents returned to the site to provide additional responses at a later time. Datasets were unable to be linked in any way to email addresses or other identifying information. Respondents who wished to be contacted by the researcher needed to initiate and facilitate such action by providing contact details via email or telephone. After initial cleaning, the data were exported into SPSS for statistical analyses.

2.3.4 Recruitment

Recruitment scope and approach
Respondents were recruited from the general community via an intensive, multimedia nationwide campaign, targeting both capital cities and rural and regional locations. As a result, a large, sociodemographically diverse sample was obtained, comprising participants from all states and territories of Australia and from both urban and rural locations. Additionally, targeted recruitment campaigns were directed toward males, in order to attract individuals traditionally underrepresented in research of this nature. Targeted recruitment strategies (described below) were undertaken in an effort to counteract the known reticence of males to participate in psychosocial research (particularly, on matters of a sensitive nature); and to ensure inclusive research practices. Multifaceted approaches were used to recruit participants both directly and indirectly (e.g., through service providers), as described in turn in the forthcoming sections.

Heavy emphasis was placed on web-based publicity and recruitment efforts, resulting in a high level of exposure in general and specialized fora. Indeed, on a search performed using the web-based search tool, ‘Acronym finder’ ([http://www.acronymfinder.com/TSP.html](http://www.acronymfinder.com/TSP.html)) (on Friday 3 March 2006), the Tellsomeone Project acronym, ‘TSP’, was ranked 3rd worldwide in the category, ‘Organisations, Schools, etc’, and 4th overall, in response to the question, “What does TSP stand for?”, generating the answer: ‘Tellsomeone Project (Australia)’, as the third and fourth response, respectively.

The TSP logo
As with the name of the project, the TSP logo (see Appendix D) was created by the principal researcher with the aim of fostering a nonjudgmental, welcoming, and nonthreatening
research environment, conducive to open disclosure of sensitive material. Specifically, a logo was needed that would convey a sense of trust in the context of dialogue between two parties. The individuals engaged in dialogue were designed to look friendly, approachable, and nonjudgmental, rather than to show any facial expression that might connote shock, disapproval, or other negative reaction. Both characters were designed to look neutral and ‘ambiguous’ with respect to gender and to avoid heterosexist or other directional assumptions or biases. Initial sketches were piloted with male and female colleagues who were asked to rate the gender of each character. Amendments were made to the sketch until sufficient ambiguity was reflected by the variation and relatively even ‘split’ of rater responses.

Direct general community recruitment

Direct general community recruitment was conducted by disseminating information about the survey via multiple means. As exemplified in Table 2.4, these comprised: interviews with the principal researcher on urban and rural radio stations; articles placed in The Age, local newspapers, and newsletters (electronic and hardcopy); verbal presentations at RMIT undergraduate and postgraduate lectures and tutorial groups; exhibitor stands at RMIT Orientation Week – Bundoora, City, and Brunswick campuses; exhibitor stands at various Melbourne venues during Mental Health Week (October 9th - 15th 2005); media releases conducted through the RMIT University Media Office; distribution of bookmarks and displayed flyers at a wide range of venues (e.g., universities; public libraries; public sports centres; cafés, bookshops, and other retail outlets); and information placed in RMIT student newsletters (electronic and hardcopy) and on the RMIT home page. Samples of recruitment flyers and bookmarks and selected media excerpts are presented in Appendix E. Individuals and organizations were encouraged to further disseminate survey information and calls for participants via personal and professional networks. This method, known as the snowball sampling technique (Bailey, 1994; Penrod, Preston, Cain, & Starks, 2003), is a traditional and commonly referenced technique that is particularly useful for accessing hidden and difficult-to-reach populations (Penrod et al., 2003; Polit & Beck, 2008). The snowballing method was implemented using both Internet (formal and informal emailing to individuals and mailing lists; articles and links placed on websites; e-newsletters) and non-Internet approaches (individual and organization-based word of mouth and dissemination of printed promotional material).
Indirect general community recruitment

In terms of indirect general recruitment, emails and letters were written to a large number of service providers and organizations across urban and rural Australia who, in turn, were able to disseminate information to consumers directly, and via electronic or hardcopy newsletters, websites, noticeboards, and displayed bookmarks in places such as counters and waiting rooms. Both electronic and hardcopy versions of flyers and bookmarks were sent to agencies and other bodies who indicated an interest in supporting the research through information dissemination. Examples of the prominent agencies, networks, and associations that supported the project by assisting with general community publicity and information include ABC Radio; Beyond Blue; the Rural Women’s Network; Auseinet (Australian Network for Promotion, Prevention and Early Intervention for Mental Health); Australian Institute of Family Studies (AIFS); Australian Centre for the Study of Sexual Assault (ACSSA); The Compassionate Friends New South Wales, Inc. (TCF NSW); and the Mental Health Foundation of Australia (Victoria).

Targeted recruitment

Direct and indirect recruitment targeted toward males followed the same formats, with wording and emphasis in radio interviews, verbal presentations, and printed material altered to highlight the particular need for male research participants.

Table 2.4
Selected Recruitment Activities, 2005-6

<table>
<thead>
<tr>
<th>Recruitment type</th>
<th>Activity details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral submission</td>
<td>Senate Mental Health Inquiry. Meeting chaired by Senator Lyn Allison, Chair of the Senate Select Committee on Mental Health (18 November 2005), Treasury House, Melbourne. TSP presented by principal researcher.</td>
</tr>
<tr>
<td>2005</td>
<td>Joy Melbourne 94.9 FM: Saturday Magazine with Marg and Paul, 15 October</td>
</tr>
</tbody>
</table>
Joy Melbourne 94.9 FM: Rainbow Report with Doug Pollard, 15 November
Joy Melbourne 94.9 FM: Powder Room: Penny Mitchell & Friends, 26 November
ABC Mildura-Swan Hill: Breakfast with Penny Munger, 2 December
3CR 855 AM Community Radio: Out of the Pan with Sally Goldner, 18 December

**Selected media articles & press releases**


**Selected research related press releases:**
ABC 774 AM Melbourne, 6 February 2006:
http://www.abc.net.au/melbourne/stories/s1563280.htm

**RMIT media releases:**
RMIT University public media release 28 November 2005
RMIT *Updates* - regular entries in weekly editions 2005-6 (e.g., No.45/2005, 14 November 2005)
RMIT *What's On at RMIT* – regular entries in weekly editions 2005-6
http://www.whatson.rmit.edu.au
RMIT University public media release 9 February 2006:
*RMIT Tellsomeone Project calls for help to break the walls of silence.*
http://www.rmit.edu.au/browse;ID=s67k6or9mvvez;STATUS=A;QRY=tellsomeone%20project;STYPE=ENTIRE

**Online research participants urgently needed**
http://www.rmit.edu.au/browse/News%20and%20Events%2FNews%2FRMIT%20Update%2Fby%20date%2F;ID=ehjvlg7fzn45z;STATUS=A

**Research generated newspaper articles:**
Also featured in 2006 in: Herald Sun; Leader Newspapers group; MX
Women's Information and Referral Exchange (WIRE)
Rural Women's Network newsletters and mailing lists

**Selected website placements:**
www.whatson.rmit.edu.au
ABC Online
ABC Victoria
ABC Melbourne
http://www.abc.net.au/victoria/stories/s1565272.htm
http://www.abc.net.au/melbourne/stories/s1563280.htm
www.thecompassionatefriends.org.au
www.communitynews.infoxchange.net.au
Technology for Social Justice section
www.mentalhealthvic.org.au/mhw/mhw_events.asp?list=loondon
www.ausein.org.au Australian Network for Promotion, Prevention and Early Intervention for Mental Health
2.3.5 Determination of Geographical Location and Remoteness

Respondents in the current studies were classified both in terms of geographical location and remoteness. First, individuals were categorised by residential postcode into three location types (urban, rural, and remote). These classifications were determined using the ASES file exported from DestPac2004, containing geographical categorisations set by DEST, and described earlier.

Second, individuals were classified into remoteness categories using the Australian Standard Geographical Classification (ASGC) Remoteness Structure (ABS, 2001). This is a structure used by the ABS and other agencies and institutions to describe Australia in terms of a measurement of remoteness and to classify regions which share commonalities with respect to remoteness into six aggregations of non-contiguous geographical areas or spatial units, known as Remoteness Areas (RAs). The ASGC Remoteness Structure comprises the following six classes: Major Cities of Australia; Inner Regional Australia; Outer Regional Australia; Remote Australia; Very Remote Australia; and Migratory.

Within this structure, the category ‘Major Cities of Australia’ encompasses most capital cities, in addition to major urban locations such as Newcastle, Geelong, and the Gold Coast. Inner Regional Australia encompasses cities and towns such as Hobart, Launceston, Noosa, and Tamworth. Examples of Outer Regional Australia include cities and towns such as Darwin, Whyalla, Cairns, and Gunnedah. Remote Australia incorporates towns such as Alice Springs, Mount Isa, and Esperance. Much of central and western Australia is categorised as Very Remote Australia within the Remoteness Structure. Included in this class are towns such as Tennant Creek, Longreach, and Cooper Pedy (ABS, 2007c).
Remoteness is measured in terms of the Accessibility/Remoteness Index of Australia (ARIA), developed by the Commonwealth Department of Health and Aged Care (DHAC) and the National Centre for Social Applications of Geographic Information Systems [GIS] (GISCA). The ARIA determines the remoteness of a location by using the road distance to the nearest Urban Centre (ASGC 1996) in each of the five classes that are based on population size. The Remoteness Structure is defined in census years based on population statistics (ABS, 2001).

In the current study, the ASGC 2001 Remoteness Postcode List (derived from the 2001 Census) was used to determine remoteness on the basis of residential postcode. Respondents from five categories were represented: Major Cities; Inner Regional Australia; Outer Regional Australia; Remote Australia; and Very Remote Australia. Respondents from Remote Australia \((n = 3)\) and Very Remote Australia \((n = 3)\) were insufficient in number to allow for meaningful inclusion (as separate entities) in statistical tests (such as chi-square analyses). Accordingly, these respondents were included in the Outer Regional group for the purposes of quantitative analyses, allowing comparison of respondents from major cities, inner regional Australia, and ‘outer regional Australia and remote locations’.

2.3.6 Statistical Analyses

Data Scrutiny

As each study in this research program employed respondents from a single sample, data preparation and screening procedures reported in this section are applicable to each study. Both quantitative and qualitative data were carefully screened and cleaned following recommend protocols (Field, 2000; Pallant, 2005; Tabachnick & Fidell, 2001). This included manually checking for errors (e.g., values falling outside the possible range values for each variable), locating the errors in the data file, and manually correcting them where possible. Forty-four cases were deleted from the data file due to the provision invalid data. All data analyses were conducted using the Statistical Package for the Social Sciences (SPSS), Version 17.0.

After the process of data cleaning and deletion of invalid cases, 2052 valid response sets were retained for analysis. Inspection of this data showed that within measures there were relatively few missing values. For missing data within scales, the decision was made to use
the SPSS option of *Exclude cases listwise*. While this method has the potential to limit sample size (Pallant 2005), it was considered that, given the large sample available, this method avoided the disadvantages of other methods (e.g., the *Replace with mean* option that can severely distort findings; Pallant, 2005). For missing data that was not mandatory to the calculation of scale specific scores, the *Exclude cases pairwise* option was utilised. This strategy excludes cases only if they are missing data required for a specific analysis.

**Assumption Testing**

To ensure that statistical assumptions underlying the parametric procedures to be conducted were not violated, normality was assessed by obtaining skewness and kurtosis and by examination of stem-and-leaf and normality plots. The results of these procedures showed that there were no major violations in the normality and linearity assumptions that would distort the validity of the data analytic procedures to any concerning extent (Pallant, 2005; Tabachnick & Fidell, 2001).

**Data testing**

A broad range of multivariate statistical techniques were used to conduct descriptive and comparative analyses and explore relationships among variables. Specifically, multivariate analyses of variance, *t*-tests, and chi-square analyses were conducted to compare sexual abuse victims and nonvictims and past suicidal and nonsuicidal groups, and relationships between abuse, suicidality, gender, and a range of health-related variables were explored using Pearson product-moment correlation coefficient. These analyses are introduced in the Overview sections included in the Results section of each study. Where appropriate, references are made to recognized authoritative texts (namely, Field, [2000]; Pallant [2005]; and Tabachnick and Fidell, [1989, 2001]); and conventional guidelines and recommendations for best practice are discussed and implemented. For example, as discussed in Pallant (2005), Cohen (1988) offers guidelines for interpreting the value of Pearson correlation coefficients (*r*); and these have been adopted in the current thesis, such that *r* values of .10 to .29 or -.10 to -.29 signify a small strength of correlation; .30 to .49 or -.30 to -.49 signify a medium strength of correlation; and .50 to 1.0 or -.50 to -1.0 signify a large strength in the correlational relationship. Other statistical conventions are detailed and referenced where applicable.
Throughout the survey, respondents were given opportunities to provide ‘Additional comments’ or asked to specify or expand their quantitative responses (e.g., If ‘Yes’, please specify.; If ‘Other’, please specify). Where applicable, selected examples of qualitative data are presented in the current thesis to augment statistical findings. The volume of both quantitative and qualitative data received was extensive, such that only a portion has been able to be reported within the constraints of one thesis. Specifically, findings pertaining to geographical location, substance use, risk behaviours, and extended qualitative analyses pertaining to sexual abuse and suicidality will form the basis of subsequent papers.
PART II
STUDY OF SEXUAL ABUSE
PROCESS AND TRAUMA

CHAPTER 3
STUDY 1
CHILD SEXUAL ABUSE AND ADULT
PERTURBATION

3.1 INTRODUCTION

There can be no keener revelation of a society’s soul
than the way in which it treats its children.
- Nelson Mandela

3.1.1 Overview
Convergent data proffer unequivocal evidence that sexual abuse of children is a common occurrence both in Australia and globally (ABS, 2005b; Boudreaux & Lord, 2005; Krug et al., 2002; Mouzos & Makkai, 2004; Sanderson, 2004), and that such abuse is concomitant with devastating, negative health outcomes across the lifespan (Anda, Felitti, Walker, et al., 2006; Dong et al., 2004; Finkelhor, Hotaling, Lewis, & Smith, 1990; Krug et al., 2002; Nelson et al., 2002; United Nations Secretary-General, 2006; van der Kolk, Perry, & Herman, 1991; World Health Organisation [WHO] & International Society for Prevention of Child Abuse and Neglect [ISPCAN], 2006). Moreover, protracted negative sequelae are most likely experienced in the absence of disclosure and apposite supportive networks (Ullman, 2004), yet it is estimated that over 90% of sexual abuses are never reported (ABS, 1996; de Visser et al., 2003; Lievore, 2003; Sanderson, 2004; Stubbs, 2003; Victorian Law Reform Commission [VLRC], 2004), and known that the vast
majority of sex offenders are never held accountable for their offences (Sanderson, 2004; VLRC, 2004).

Sadly, it is the most insidious and protracted child sexual abuse (CSA) forms, such as those perpetrated by trusted figures and primary carers (Bagley & Ramsey, 1986; Finkelhor, 1981, 1984, 1986; Friedrich, Beilke, & Urquiza, 1986; Russell, 1984; Tufts New England Medical Center, 1984), that are least likely to be detected or reported (Sanderson, 2004; VLRC, 2004), thus commonly creating climates in which chronic abuse can be perpetrated with seeming impunity, within the most private of settings. Indeed, preverbal children and infants are at heightened risk for deliberate targeting by those with sexual predatory intent given (amid other innate vulnerabilities concomitant with early childhood) their inability to disclose (Sanderson, 2004). Moreover, whilst single episodes of abuse can have lethal or life-changing negative impact, it is chronicity of abuse that is most commonly associated with poorer outcomes (Bagley & Ramsey, 1986; Russell, 1986; Ullman, 2004). Thus, victims of the most serious childhood abuses are those most likely to carry the burden of such victimisation in isolation and in the absence of professional supports. Accordingly, it is clear that available data provide a skewed view of ‘reality’, revealing only a minute proportion of CSA experiences and a narrow and inaccurate view of the aftermath that occurs in the wake of such violation, whilst masking the most serious of abuses.

Secrecy, taboos, and nondisclosure surrounding CSA are pivotal factors in perpetuating such abuse and compounding the devastation that commonly ensues, hampering both detection and prevention efforts, and treatment of victims and perpetrators. As noted earlier, it is known that protracted abuse and severe symptomology, negative sequelae, and intractability of trauma impact are more likely in the absence of disclosure and appropriate supports (Ullman, 2004). Further, whilst it is thought that sizable treatment gains can be achieved for the majority of child sexual offenders, such that one third to one half will not reoffend (Salter, 2003; Sanderson, 2004), only the minute proportion of offenders that are detected and convicted are ordinarily able to benefit from such gains. Indeed, currently most treatment for perpetration of CSA is offered whilst the perpetrator is serving a custodial or noncustodial sentence, or upon release (Sanderson, 2004). Yet, a small minority of sex offenders are reported and far less are apprehended and prosecuted, such that convictions eventuate for less than 5% of those reported to
police (Lievore, 2003; Sanderson, 2004; Sentencing Advisory Council [SAC], 2007a, 2007b; VLRC, 2004).

This situation is far from optimal given that early intervention is recognised as critical in impeding sexual recidivism and entrenchment of offending patterns (Boyd, 2006; Nisbet, Rombouts, & Smallbone, 2005; Nisbet, Wilson, & Smallbone, 2004; Tidmarsh, 1997). A further problematic situation stems from the fact that extant knowledge about sexual offending derives primarily from the estimated 10% of perpetrators who come to the attention of criminal justice or health systems, and is thus, extremely narrow. To what extent this information can be extrapolated and considered representative of the approximately 90% of sex offenders who successfully evade detection can only be surmised. The need for enhanced understanding of child sexual offending is also evidenced by the estimated one-third of paedophiles who fail to respond to treatment, and who, according to Salter (2003) have no desire to change and will continue as sexual offence recidivists. Sexual abuse victims, though rarely asked, are uniquely placed to proffer first-hand, detailed information about offenders, offending practices and processes, and factors that inhibit or facilitate sexual offending.

Utilising an online methodology and an empirically derived inclusive approach, this study was designed to circumvent many of the barriers and methodological artefacts that preclude disclosure of CSA and the gathering of data that can gainfully inform those engaged in efforts to redress this insidious social problem. The current study examines, across multiple parameters, perpetrator strategies, disclosure and reporting practices, processes and artefacts of CSA, and the impact of such abuse on adult wellbeing, perturbation, and suicidality. It examines CSA experiences, and their impact, both from the perspective of the victim (now, an adult), and by delineating disparities in adult wellbeing between victims and nonvictims of CSA. Guided by the notion that the victim is well placed (given the opportunity) to divulge unique comment and insights, not only in regard to their own abuse, but also with respect to processes of reporting, inhibitors and responses to disclosure, and a range of perpetrator variables, opinions and questions were asked of victims in a manner and breadth that has not previously been undertaken. By including male victims and a nonvictim comparison group, this study further addresses current knowledge deficits and limitations common in the extant literature. Myriad data were gleaned that should be of interest to those concerned with reducing
CSA and the concomitant negative impact felt widely by victims and the communities in which they live.

3.1.2 Child Sexual Abuse Impact: Current Understanding and Knowledge Deficits

Whilst all persons against whom violence is perpetrated are at increased risk for many disorders and negative sequelae, abuse perpetrated against children is considered amongst the most potentially harmful, potentiating risk for anxiety, mood, and eating disorders, suicide, substance misuse, borderline and antisocial personality disorders, and other mental illness (Anda, Felitti, Walker et al., 2006; Dong et al., 2004; Finkelhor et al., 1990; Krug et al., 2002; Nelson et al., 2002; UN Secretary-General, 2006; van der Kolk et al., 1991; WHO & ISPCAN, 2006). Compared to their nonvictimised counterparts, individuals who have been physically or sexually abused in childhood or adulthood also experience heightened susceptibility to physical malaise and major adult physical illnesses, such as ischaemic heart disease, cancer, and chronic lung disease; increased vulnerability to risk behaviours additional to alcohol and drug misuse (such as inactivity and smoking); and increased need for health services (including operative surgery), relative to nonabused counterparts (Anda, Felitti, Walker et al., 2006; Dong et al., 2004; Finkelhor et al., 1990; Krug et al., 2002; Nelson et al., 2002; UN Secretary-General, 2006; van der Kolk et al., 1991; WHO & ISPCAN, 2006). Moreover, histories of physical or sexual victimization are consistently associated with disorders that frequently lack identifiable medical causes (e.g., gastrointestinal complaints, irritable bowel syndrome, chronic pain, fibromyalgia) (Krug et al., 2002). Violent child sexual victimization and use of physical force confers further increased risk of serious, often protracted, negative health outcomes (e.g., depression, anxiety, phobias, suicidality, psychosomatic disorders), proportional to the severity and chronicity of the abuse (Finkelhor, 1981, 1984, 1986; Friedrich, 1988; Fromuth, 1985; Russell, 1986; Sanderson, 2004; Tufts New England Medical Center, 1984).

In particular, myriad data attest to the diverse manifestations of psychological maladjustment concomitant with child sexual abuse, both in childhood and in later life (e.g., Finkelhor, 2008; Nelson et al., 2002; Sanderson, 2004). Specifically, child victims of sexual abuse are at heightened risk of further abuse, PTSD, depression, self-destructive and suicidal behaviours, adult sexual and relational problems, sexual revictimisation, and familial violence (Davis & Petretic-Jackson, 2000; DiLillo, 2001; Dorais, 2002; Lievore,
Indeed, a CSA history confers a four times greater likelihood of partner relationship discord and more than twice the likelihood of experiencing IPV (Lievore, 2003), with problems such as chronic relationship dissatisfaction, partnership dissolution, sexual difficulties, and physical violence comprising a typical cluster of psychosocial repercussions to CSA experiences (Davis & Petretic-Jackson, 2000; DiLillo, 2001; Rumstein-McKean & Hunsley, 2001).

Yet, compared with other health consequences of child abuse (e.g., child mortality; physical injury), relationships between such abuse and psychiatric illness and suicidality have been inadequately considered within conceptualisations of wellbeing until relatively recently, and have only latterly received concerted research attention and wider recognition (Fergusson, Horwood, & Lynskey, 1996; Krug et al., 2002; Mezey & King, 2000; Trowell et al., 1999; Wolfe, 1999). Similarly, in contrast to physical (and overt) abuses of children, sexual abuse and associated emotional harm perpetrated against children have historically received far less recognition and attention both globally and at the ‘micro’ level (such as within families, institutions, and communities) (Krug et al., 2002). Consequently, many specific knowledge deficits remain to be addressed. For instance, whilst associations between CSA history and multiple manifestations of psychopathology and suicidality have been established in the literature, pathways and mechanisms by which these relationships are formed, and importantly, how these can be interrupted and prevented, remain to be adequately understood.

More generally, why divergent outcomes amongst individuals emanate from similar adverse events (the concept of multifinality) and why disparate stressors result in phenotypically similar behavioural manifestations (the concept of equifinality) remain important areas for investigation both within specialist areas such as childhood and adulthood sexual abuse, and in the general trauma field (Cichetti & Rogosch, 1996; Flouri, 2005; McMahon, Grant, Compas, Thurm, & Ey, 2003). For example, whilst it is known that only a minority of persons exposed to similarly traumatic events will develop PTSD (Breslau, 2002; Flouri, 2005), causative and inhibitory pathways for the development of this disorder remain to be adequately understood (Flouri, 2005; McMahon et al., 2003). Moreover, whilst it was recognised over two decades ago in the
revised third edition of the Diagnostic and Statistical Manual of Disorders (DSM-III-R; American Psychiatric Association, 1987) that children’s trauma reactions may diverge from those of adults, reviews examining PTSD in young people generally concur that information remains sparse in relation to the epidemiology of this disorder in children (Cohen et al., 1998; Overstreet & Braun, 2000; Pfefferbaum, 1997; Salmon & Bryant, 2002).

Given increased recognition of the importance of fostering climates conducive to recovery (and circumventing progression to PTSD), particular emphasis has recently been placed on the salience of examining factors that mitigate trauma impact; promote resilience and positive coping and adjustment; protect against PTSD development; and augment treatment outcome in children (Ruggiero, Morris, & Scotti, 2001). Emergent literatures examining domains such as adaptive problem-solving; cognitive appraisal of traumatic and other events; social support; parental warmth and coping style; and low family conflict; have recently yielded some promising results that may in the future be able to be gainfully applied to the fields of CSA trauma and suicidology (see for example, Buka, Stichick, Birdthistle, & Earls, 2001; Punamäki, Qouta, & El-Sarraj, 2001; Silva et al., 2000). However, sizable further advances are needed in order for such findings to be appositely incorporated into practical strategies by which to ameliorate trauma impact, perturbation, and suicidality (Flouri, 2005; McNally, 2003).

Understanding and addressing diversity in trauma reactions is particularly salient in the area of childhood trauma, given the profound negative effects on the human psyche that are felt by many, but not all, individuals who experience extreme adversity in childhood. However, it has been suggested (Fergusson & Mullen, 1999) that (amongst other hindrances) conceptualisation and treatment of CSA is complicated by the fact that such abuse is not a disorder, but rather a presumed cause of disorder, thus rendering assessment and determination of treatment goals, protocols, and apposite clinical practice more difficult. It has also been posited that a gendered understanding of CSA is yet to be appropriately incorporated into conceptualisations of this problem, and that instead, myths pertaining to CSA prevail in society, often to the detriment of both victim and offender service provision (Rokvic, 2002). The current study incorporates examination of such myths, and delineates, across many domains of wellbeing and behaviour, factors that increase or mitigate perturbation in persons with a CSA history, and differences that
exist between victims and nonvictims of CSA. In so doing, the study seeks to advance extant understanding of mechanisms and social climates that foster resilience and thwart pathways to psychopathology.

3.1.3 The Need for an Expanded Empirical Evidence Base

Over recent decades, advances in human rights, legislative reforms, forensic medicine, and psychosocial and public health have raised awareness of the global problem of child abuse, albeit to an extent that is far from sufficient (WHO & ISPCAN, 2006). Nonetheless, the accumulation of a large body of evidence demonstrates that impaired wellbeing as a function of child abuse comprises a sizable proportion of the global burden of disease (Krug et al., 2002). Sadly however, despite all concerted efforts, the problem of child abuse continues in many forms, of which sexual violations remain amongst the most hidden, intractable, and devastating in terms of impact on individuals and families (Davis & Petretic-Jackson, 2000; DiLillo, 2001; Dorais, 2002; Lievore, 2003; Rumstein-McKean & Hunsley, 2001; Sanderson, 2004; Spataro et al., 2004; van der Kolk et al., 1991; WHO & ISPCAN, 2006).

In seeking to redress the complex problem of CSA, it is clear that a multifaceted approach is needed, yet it is salient to note that extant knowledge is lacking in all relevant facets. Specifically, sizable knowledge deficits remain with respect to primary prevention, victim and offender treatment, sexual revictimisation, and sexual offender recidivism (Australian Centre for the Study of Sexual Assault [ACSSA], 2005; Crome, 2006; WHO & ISPCAN, 2006).

Such deficits remain despite concerted efforts, the production of seminal and definitive works, and substantive resultant progress over recent decades in understanding and assisting both the victims of sexual violations (e.g., Breitenbecher, 1999, 2000a, 2000b, 2001; Breitenbecher & Scarce, 1999, 2001; Briere, 1992, Briere, Elliott, Harris, & Cotman, 1995; Briere & Jordan, 2004; Briere & Scott, 2006; Easteal, 1993; Finkelhor, 1981, 1984, 1986, 1987, 2008; Finkelhor et al., 1990; Foa, Hembree, & Rothbaum, 2007; Foa & Rothbaum, 1998; Koss, 2005; Koss, Bachar, Hopkins, & Carlson, 2004; Resick & Schnicke, 1996; Rothbaum & Foa, 2005; Rothbaum, Foa, & Hembree, 2007; Ullman, 2004); and the perpetrators responsible for such violations (see for example, Barbaree, Langton, & Peacock, 2006; Doren, 2002; Gannon, Ward, Beech, & Fisher, 2007;
Notwithstanding the significant advances that have been made in sex offender risk assessment, treatment, and promulgation of actuarial and nonactuarial instruments for recidivism prediction (Andrews & Bonta, 2006; Barbaree et al., 2006; Bonta & Andrews, 2007; Briggs & Kennington, 2006; de Vogel, de Ruiter, van Beek, & Mead, 2004; Gannon et al., 2007; Hanson, 1997, 1998, 2005; Hanson & Bourgon, 2008; Hanson & Bussière, 1998; Hanson, Gordon, et al., 2002; Hanson & Harris, 2000, 2001; Hanson & Morton-Bourgon, 2004; Hanson & Thornton, 1999, 2000; Hare, 1998, 2003; Hollin, 2001, 2006; Kemshall, 2001; Kemshall & McIvor, 2004; Law et al., 2000; Looman et al., 2005a, 2005b; Lund, 2000; MacKenzie, 2006; Mann, 2004; Marshall & Anderson, 2000; Marshall et al., 1991a, 1991b, 2006a, 2006b; Marshall & Marshall, 2007; Ogloff, 2002; Ogloff et al., 1990; Proeve et al., 2006; Proeve & Reilly, 2007; Quinsey et al., 1993, 1998; Serin, Mailloux, & Malcolm, 2001; Thornton & Doren, 2002; Ward, 1999; Ward & Keenan, 1999; Ward et al., 2004), a fundamental limitation hampering the sex offender literature derives from the fact that this literature is built largely on information gleaned directly from, or about, sexual perpetrators who have been apprehended or at least detected in some form. Yet, it is known that the vast majority of sex offenders are never reported or apprehended (ABS, 1996, 2005a; Easteal, 1993; Fleming, 1997; Lievore, 2003; Sanderson, 2004; Stubbs, 2003; VLRC, 2004). A valuable and unique opportunity to learn about the undetected majority of sex offenders lies therefore, in seeking information about perpetrator strategies and characteristics from the recipients of such abuses.
To date, CSA victim studies have focused predominantly on the important area of victim impact whilst seminal studies, such as those conducted by Koss (e.g., Koss & Oro, 1982) and Ullman (e.g., Ullman, 1998, 1999a; Ullman & Knight, 1995), that have examined offender and offence-oriented variables from the perspective of victims, have concentrated on sexual abuse perpetrated against adult females. New and broadened approaches are necessary since an urgent need exists for an improved empirical evidence base to inform current practices and guide prevention and intervention initiatives pertinent to both CSA victims and offenders (WHO & ISPCAN, 2006). In the current study, victims are questioned in detail regarding perpetrator strategies and characteristics, yielding data that have not previously been collected.

On global and national levels, a paucity of empirical evidence also exists to support the use of some widely implemented practices, such as child protection services, mandatory reporting, mandatory offender treatment programs, and child-friendly court processes (Australian Centre for the Study of Sexual Assault [ACSSA], 2005; WHO & ISPCAN, 2006). At a time when increased recognition of the problem of child abuse places increasing pressure on governments to implement effective preventive and reparative measures, lack of evidence for the efficacy of existing practices raises concerns that limited resources may be misdirected to well-intentioned but unsystematic and unproven programs (WHO & ISPCAN, 2006). Thus, notwithstanding the publication of myriad Australian and international works created to assist health professionals, parents, teachers, and victims themselves to deal with CSA and associated distress (e.g., Briere, 1992; Briere & Scott, 2006; Bullen, Jacobs, Le Pont, Martin, & Smith, 2004; Finkelhor, 1981, 1984, 1986, 2008; Foa, Hembree, & Rothbaum, 2007; Foa & Rothbaum, 1998; Holden, 2002; Resick & Schnicke, 1996; Rokvic, 2002; Rothbaum & Foa, 2005; Rothbaum, Foa, & Hembree, 2007; Stojadinovic, 2003), the need for an increased empirical evidence base has been underscored at both global and local levels, and the wider implementation of evidence-based practice recommended as a fundamental step in preventing child abuse occurrence and traumatic aftermath (WHO & ISPCAN, 2006).

3.1.4 Child Sexual Abuse Prevalence: Issues of Enumeration, Definition, and Nondisclosure

Worldwide, an estimated 150 million female and 73 million male children under 18 years of age have experienced forced sexual intercourse or other types of contact sexual abuse (Boudreaux & Lord, 2005). Yet, as most sexual abuse is unreported (ABS, 1996; Lievore,
2003; Sanderson, 2004; Stubbs, 2003; VLRC, 2004), and CSA is ostensibly the most hidden form of sexual victimisation, prevalence statistics represent a small minority of the abuses perpetrated (Sanderson, 2004). Nevertheless, a wealth of evidence shows that sexual abuse of children occurs at high prevalence in most societies (Krug et al., 2002). Enumeration of CSA is further hindered by variations in methods of data collection (e.g., from children directly, retrospectively from adolescents or adults, or from parents) and cultural and legal definitions and inclusion criteria (e.g., recording rape only, excluding or including abuses such as nonpenetrative abuse, date rape, involvement of children in pornography production). Not surprisingly, such variations produce widely disparate prevalence findings (Krug et al., 2002; Sanderson, 2004). For instance, adult males have reported childhood sexual victimisation ranging from 1% (Pederson & Skrondal, 1996), employing a narrow definition of CSA comprising contact involving force or pressure, to 19% (Goldman & Padayachi, 1997), employing a wider definition of sexual abuse. Similarly, females have reported lifetime prevalence of CSA ranging from 0.9% (Choquet, Darves-Bornez, Ledoux, Manfredi, & Hassler, 1997), when rape was applied as the definition of CSA, to 45% (Goldman & Padayachi, 1997), applying a much broader definition.

Similar variances arise from differences in methods of data collection. In a recent study of Romanian families, 0.1% of parents admitted having sexually abused their children, whilst 9.1% of children reported having experienced CSA (Browne et al., 2002). Whilst this discrepancy may be explained in part by the fact that children may be reporting CSA perpetrated by persons other than their parents, it highlights the impact of methodological practices on research outcomes, and the fact that victims are uniquely placed to reveal the circumstances of their abuse. Notwithstanding such discrepancies and obvious limitations, evidence deriving from international research undertaken over the last three decades reveals an average lifetime prevalence of CSA of 20% amongst adult females and 5-10% amongst adult males (Finkelhor, 1994a, 1994b; Krug et al., 2002). Notably, the flaw in reliance on data proffered by CSA perpetrators in relation to their own offending seems apparent, given that denial, minimisation, and cognitive distortions have come to be regarded almost as standard ‘prerequisites’ that are synonymous with, or necessarily present hallmarks of, sex offender testimonies (Abel, Becker, & Cunningham-Rathner, 1984; Andrews & Bonta, 2006; Gannon et al., 2007; Garland & Dougher, 1991; Kear-Colwell & Pollack, 1997; Kennedy & Grubin, 1992;
Langevin & Lang, 1985; Marshall & Eccles, 1991; Marshall et al., 2006b; Salter, 1988; Sanderson, 2004). Yet, it remains the case that the literature pertaining to the psychology of sex offenders is built primarily on perpetrator-derived information.

As eye-witnesses to their own abuse, victims are uniquely able to proffer information about offenders and offender practices from a perspective categorically different to that of offenders themselves. Such information can advance extant understanding in both offender and victim literatures. Moreover, given that it is the perspective, perceptions, and feelings of the victim themselves (rather than the views and feelings of others) that are pertinent in determining their wellbeing, and that many elements of their abuse experience are known only to them, victims are critically important sources of information in regard to victim-centred offence characteristics, trauma impact, treatment needs, and resilience. Thus, on multiple levels, it was appropriate for the purposes of this research to survey victims directly in relation to their experience of CSA. Given the importance of understanding subjective views, appraisals, and opinions of individuals in subsequently understanding their feelings and behaviours, attention was duly given to examination of subjective understanding and views surrounding CSA processes and aftermath. However, questions tapping subjective understanding, opinion, and appraisal were embedded within a large number of concrete, behaviourally descriptive, and quantitative questions so as to also facilitate maximum objectivity (e.g., number of perpetrators, penetrative or nonpenetrative offence types, offender strategies employed).

For the purposes of this study, CSA was defined as unwanted (or inappropriate) sexual events that had occurred prior to the age of 16. These included events that had taken place against the wishes of the individual or without their ‘consent’, or with a person more than two years older or in a position of care or authority over the child (either with or without ‘consent’). In line with recognised best practice recommendations in the literature (e.g., Groth-Marnat, 2003), behaviourally descriptive questions followed initial screening questions, to allow accurate understanding and quantification of CSA (e.g., nonpenetrative, penetrative, oral sex, anal sex), quantitative analyses, and comparisons within the sample and with other studies.

This definition allowed for the inclusion of CSA perpetrated by assaultive peers, strangers, dating partners, siblings, extended family members (such as cousins or step-
relatives), and others who have access and inclination to offend sexually against a minor. This was necessary in order to prevent the narrow, exclusionary effects of some other definitions, which by default underenumerate the multiple forms of sexual abuse experienced by children. For example, the WHO defines CSA as acts by which a child is used for the sexual gratification of a caretaker (Krug et al., 2002), thus excluding the myriad abuse forms perpetrated by individuals other than caretakers that are commonly present in the lives of children, such as peers, non-caretaker authority figures, relatives, family friends, partners of parents, strangers, and dating partners. This is a serious omission since such figures in a child’s life are commonly cited as CSA perpetrators, and given evidence suggesting that 12 - 35% of all alleged sexual offences are perpetrated by young offenders, mainly adolescents (Cawson, Wattam, Brooker, & Kelly, 2000; Home Office, 2006; Home, Glasgow, Cox, & Calam, 1991; Kelly, Regan, & Burton, 1991; Lovell, 2002; Morrison, 1999; Royal Belfast Hospital & Queen’s University of Belfast, 1990; Sanderson, 2004; Victorian Department of Human Services [DHS], 1998; Vizard, Monck, & Misch, 1995; VLRC, 2004).

3.1.5 Police Reporting of Child Sexual Abuse

In Australia, experiencing sexual abuse whilst aged 16 years or under has been reported by 12-18% of women and 4.5% of men (ABS, 2005b; Mouzos & Makkai, 2004), and highest police-recorded sexual victimisation rates are found amongst children (Australian Institute of Criminology [AIC], 2008). Specifically, in 2006, the highest rate of sexual assault reported to police was recorded for females aged 10-14 years, at a rate of 544 per 100,000 females in that age cohort (AIC, 2008). Similarly, reported sexual assault rates for males were highest for boys aged 10-14 years (95 per 100,000) and those aged under 10 years (78 per 100,000) (AIC, 2008). Indeed, boys comprised 32% of sexual assault victims aged under 10 years (AIC, 2008).

Data from other years similarly demonstrate the disproportionately high presence of child and adolescent victimisation in recorded sexual assaults. Of the Australian police-recorded sexual assaults in 2003, the majority (72%) were perpetrated against persons aged 24 yrs or less (ABS, 2005b). Indeed, for both males (70%) and females (62%), the majority of reported sexual assaults were against persons aged 19 years and younger, with small boys and adolescent girls most highly represented. Specifically, for females, the highest sexual assault victimisation rate occurred within the 10-19 year age group (497
per 100,000 population), over three times the rate for the general female population. Of all reported sexual assaults against females, 24% were against females aged 15-19 years, 21% were against females aged 10-14 years, and 17% were against girls aged 0-9 years. In contrast, the highest percentage of reported sexual assaults against males was found in boys aged 0-9 years, with 37% of all reported sexual assaults of males perpetrated against boys in this age group, and 19% perpetrated against boys aged 10-14 years. Overall, the highest victimization rate of any male age group was for boys aged 14 yrs and under (89 per 100,000 population), nearly three times that of the general male population, and 70% of all reported male sexual assaults were against males aged 19 and under (ABS, 2005b).

Whilst national police data such as these underscore the disproportionately high vulnerability of children to sexual abuse, these figures are additionally concerning given that police reported sexual assaults represent a very small proportion of actual sexual victimisation (ABS, 1996; de Visser et al., 2003; Lievore, 2003; Sanderson, 2004; Stubbs, 2003; VLRC, 2004). Indeed, as noted earlier, it is generally estimated that over 90% of sexual assaults are never reported to police (ABS, 1996; Lievore, 2003; Sanderson, 2004; VLRC, 2004), and both Victorian and national data indicate that sexual assault victims are those least likely, relative to all victims of crime, to report to the police (ABS, 1996, 2005a, 2005b, 2005c; AIC, 2008; Lievore, 2003; Mouzos & Makkai, 2004; Smith & Stewart, 2008; Victorian Department of Justice [DOJ], 1999).

Further, it remains open to conjecture to what degree such victimisation figures reflect actual patterns of abuse or rather, gender differences in reporting practices, general reluctance to report sexual abuse, and the fact that, unlike the situation for most older victims, the decision to report victimisation of young people is generally made by persons other than the victim themselves. Nonetheless, the acute powerlessness and vulnerability of younger children to incest and other CSA is evident. It is salient to note that, as discussed earlier, the inability of preverbal children and infants to disclose abuse renders this age cohort particularly vulnerable to undetected abuses (Sanderson, 2004), and hence, disproportionately prone to underenumeration and non-intervention. As children enter puberty, additional risk of extrafamilial abuse (e.g., date rape, power relationship abuse) is conferred by their growing independence and movement outside the family environs (Krug et al., 2002). Self-blame, guilt, and fear of punishment or chastisement for what may be deemed naïve, foolish, ‘promiscuous’, risky, or unsanctioned behaviours, or
behaviours that ‘invite’ sexual victimisation (e.g., drinking, dress code) may further preclude disclosure of CSA amongst adolescent cohorts.

Given evidence that police reporting of all crimes, but particularly those of a sexual nature, becomes increasingly unlikely the closer the relationship between perpetrator and victim (ABS, 1996; Sanderson, 2004; VLRC, 2004), it is salient to note that amongst police reported sexual assaults in 2003, victims were nonetheless, four times more likely to know the offender than not, and indeed, for both males and females, the offender was a family member in around 29% of cases (ABS, 2005b). Given well-established evidence from the literature that most sexual abuse victims know their offender (VLRC, 2003); that family members are very often responsible for sexual abuse of children (VLRC, 2003); and that young children are most vulnerable to incestuous abuse, high levels of nonreporting of CSA are expected on the basis of multiple factors, particularly in relation to abuses perpetrated by family members and against young children (Sanderson, 2004). Thus, it is expected that the most chronic and insidious forms of CSA (such as abuses perpetrated by individuals closest to the child, who have ongoing and unfettered opportunities for offending); abuses that occur at highest prevalence; and those perpetrated against the youngest and most vulnerable in society are also those amongst the least likely to be reported to police (Sanderson, 2004; VLRC, 2004). As noted earlier, whilst exceptions inevitably occur, it is chronicity of abuse that is most commonly associated with more severe psychopathology, relative to that experienced in relation to isolated events (Bagley & Ramsey, 1986; Russell, 1986; Ullman, 2004).

Given that the high level of silence that continues to persist in relation to CSA seriously impedes prevention efforts and intervention initiatives for both victims and perpetrators, and that such secrecy heightens the pain experienced by victims and their families, and increases the risk for revictimisation, the need to break extant cycles of silence and provide practical information to those concerned with addressing this global problem provides the impetus for the current study. However, conducting empirically sound research of practical utility and obtaining accurate data pertaining to CSA is complicated by myriad factors in addition to low police reporting of such abuse. As police data are not intended for detailed psychological research, limited information is able to be gleaned from these in relation to psychological health and other victim outcomes. However, the ethical and logistic barriers to conducting research with children directly are also clear.
The alternative of examining CSA from the perspective of victims who have subsequently reached adulthood remains the most viable option for most researchers. However, the application of retrospective research methodologies similarly confers obvious limitations and has attracted a level of criticism in the literature, not only because of problems related to recall fallibility and biases, but also because of the propensity of individuals to reconstruct histories based on current or other experiences, cognitive stances and belief systems, salience, norms, and expectations (for discussion, see Belk, 2006; East & Uncles, 2008; Gearing, Irfan, Mian, Barber, & Ickowicz, 2006; Gotlib & Hammen, 2009; Koop & Strang, 2002; Teitler, Reichman, & Koball, 2004; Sheinberg & Fraenkel, 2001; Sherer, Schorr, & Johnstone, 2001; Tomlinson, 1984).

Nonetheless, cogent arguments have also been made in the literature that retrospective research methods have been unnecessarily underutilized and undervalued in many research arenas including child, adolescent, and adult psychiatry and other areas of mental health (Brewin, Andrews, & Gotlib, 1993; Gearing et al., 2006; Gotlib & Hammen, 2009). For example, following an extensive review of research, Brewin et al. (1993) classified several concerns regarding memory reliability, however contended that data generally failed to substantiate these concerns. Indeed, evidence exists that retrospective research (such as autobiographical history collection) constitutes an indispensable methodology with distinct advantages and the potential to provide valuable research opportunities and rich, unique, and in some cases, more valid, data that are not otherwise attainable (Belk, 2006; East & Uncles, 2008; Gearing et al., 2006; Gotlib & Hammen, 2009; Koop & Strang, 2002; Teitler et al., 2004; Sheinberg & Fraenkel, 2001; Sherer et al., 2001; Young, 1976). In fact, interviews and questionnaires are classical cornerstones of psychological research, assessment, and interventions and are typically underpinned by retrospective self-report and self-appraisal. Detailed discussion of advantages and disadvantages of retrospective research methods is beyond the scope of this thesis, however the interested reader is directed to the literature pertaining to examination of this topic (for example, see Belk, 2006; Brewin et al., 1993; East & Uncles, 2008; Gearing et al., 2006; Gotlib & Hammen, 2009; Koop & Strang, 2002; Lerner, Zachariah, & White, 2002; Teitler et al., 2004; Sheinberg & Fraenkel, 2001; Sherer et al., 2001; Tomlinson, 1984; Young, 1976).
It is also noteworthy that, whilst all other research methods are often compared unfavourably to the randomised clinical trial (the commonly recognised 'gold-standard' in research design), such a methodology is clearly not able to be applied in many areas of psychological or human research, for example, with respect to CSA (Lerner et al., 2002). Thus, specifically with respect to CSA, few if any more effective alternatives remain than to collect retrospective data from adult victims. Accordingly, for reasons pertaining to ethical considerations, feasibility, and practicality, the largest worldwide and Australian victimisation and population surveys are similarly reliant on retrospective data in relation to CSA, given that such surveys routinely exclude individuals under 18 (ABS, 2005b; Krug et al., 2002). It is salient to note that such exclusion by definition excludes Australians at highest risk of sexual victimisation (i.e., minors). It is of further salience to note therefore that all Australian population survey-derived figures pertaining to victimisation rates within the preceding 12 months, by definition similarly fail to capture victimisation amongst the age cohorts experiencing the highest levels of abuse (i.e., those under 18 years), and should be interpreted judiciously with consideration of the implications arising from such exclusion. The finding from one recent Australian national survey that 1.6% of females and 0.6% of males aged 18 years and over reported having experienced sexual violence within the preceding 12 months (ABS, 2005b), provides an example of the illusion of low prevalence and understatement of sexual abuse in the community overall that may be conveyed by such data to the casual reader. It is of further importance to note that, of those surveyed, few Australians had spoken to others about their experiences of sexual abuse, and 80% had not sought professional support. Yet, as noted earlier, protracted negative impact is most likely in the absence of disclosure and appropriate supports (Ullman, 2004).

In combination, such findings highlight the underenumeration concomitant with CSA at multiple levels, the concomitant isolation and vulnerability faced by many victims, the challenges inherent in researching and addressing this insidious and complex social problem, and the importance of finding and applying creative ways to circumvent such barriers. In utilising an online methodology, the current study applies a practical and proactive strategy to address the limitations conferred by conventional methodologies and mitigate the taboos, shame, and stigma that foster high rates of nondisclosure in relation to CSA.
3.1.6 Issues of Disclosure and Nondisclosure

Given the stigma, shame, victim-blaming attitudes, and minimising responses commonly encountered by victims upon disclosure of sexual abuse, high levels of secrecy and trepidation surrounding disclosure, and ultimately, high levels of nondisclosure of sexual abuses, are not surprising. In relation to CSA, disclosure by child victims may be additionally precluded by strong emotional bonds and loyalty toward the perpetrator, or alternatively, by intense fears the child may have regarding possible effects of disclosure on their family or themselves (NSW Standing Committee on Law and Justice [SCLJ], 2002). As such fears are often actively cultivated by the perpetrator as a means of ensuring continued secrecy, and commonly built on threats that disclosure will result in family dissolution, serious harm, or even death of the child or significant others (Sanderson, 2004), compliance and nondisclosure under such circumstances are even less surprising.

Unfortunately however, secrecy and nondisclosure commonly pave the way for further deleterious effects for victims, their perpetrators, and the wider community (e.g., continuation of abuse; lack of professional intervention; protracted and entrenched psychopathology; isolation and concomitant exacerbation of distress). Indeed, in the absence of accountability, offenders are able to reoffend with seeming impunity against new victims, and problems that are inadequately recognised within communities are unlikely to receive adequate attention and redress. Elliot, Browne, and Kilcoyne (1995) found that 70% of CSA perpetrators had offended against between one and nine victims. However, evidence also exists that in some cases the number of victims per perpetrator is extremely high, with reports of up to 450 children sexually victimised by a single offender (Elliot et al., 1995).

Similar findings derive from other studies. For example, Long and McLachlan (2002) found that many paedophiles sexually offend against as many as 200 children prior to being apprehended, and earlier research has revealed that, on average, child molesters had abused 150 boys and/or 20 girls prior to being caught (Abel et al., 1987). Some evidence also suggests that, amongst children who have experienced CSA, one in eight children (Sanderson, 2004), or as many as one in five boys (Watkins & Bentovim, 1992), become sexually abusive in later childhood or adulthood. Thus, the exponential nature of CSA (such that each paedophile could potentially be responsible for producing 25
future paedophiles [or other sexual offenders], who, in turn, could each abuse as many as 200 children) has been highlighted in the literature (e.g., Sanderson, 2004). Moreover, given that by far the most perpetrators and victims of CSA remain undetected, and that many other problems arise for the overwhelming majority of CSA victims who do not themselves sexually offend, such figures ostensibly represent only a small fraction of the negative corollaries of CSA and grossly understate the true gravity of the problem.

In summary, the imperative of early detection and appropriate intervention for both victims and perpetrators appears abundantly clear on multiple levels, and the pivotal importance of disclosure in enabling such detection and intervention is similarly evident. Early intervention is known to be of integral importance both in preventing sexual offending escalation and recidivism amongst sexual offenders (Boyd, 2006; Nisbet et al., 2004, 2005; Salter, 2003; Sanderson, 2004; Tidmarsh, 1997) and in preventing revictimisation and mitigating psychopathology in victims of sexual and other trauma (Bagley & Ramsey, 1986; Russell, 1986; Ullman, 2004). Thus, given the many and far-reaching undesirable outcomes of nondisclosure, and the benefits of early intervention, it might be concluded that disclosure of sexual abuse is something that should be routinely and broadly encouraged. However, the reality that there is evidence that could equally serve to caution against disclosure of sexual abuse and specifically, against police reporting of such abuse, must also be considered. Indeed, findings that pertain to disclosure of traumatic experiences, social support, and psychosocial adjustment reveal an ostensible paradox (Ullman, 1996).

Whilst numerous findings demonstrate that disclosure of traumatic experiences is beneficial, both psychologically and in terms of physical health outcomes (Arata, 1998; Pennebaker, Kiecolt-Glaser, & Glaser, 1988), a wealth of data demonstrate that many victims encounter adverse responses upon disclosure of their plight (Regehr, 1990; see also Herbert & Dunkel-Schetter, 1992, for a review). In fact, whilst victims may derive benefits from emotional release on disclosing traumatic experiences (Pennebaker et al., 1988); and failure to speak about a traumatic event has been related to elevated physiological activity and heightened risk of physical ill health over time (Pennebaker, 1985), whether such disclosure is therapeutic (or conversely, maladaptive) may be largely contingent on reactions proffered by recipients of one’s disclosure (Pennebaker, 1985; Ullman, 1996).
Indeed, it has been demonstrated that female adult CSA survivors who received adverse reactions upon disclosure fared worse psychologically, relative to women who had not disclosed their abuse, and women who had received a supportive response (Everill & Waller, 1994). Additionally, research indicates that many adult CSA survivors who seek professional assistance experience suboptimal agency responses, substantial difficulties in accessing health professionals able to identify and address their needs, and an absence of a satisfactory therapeutic alliance (Armsworth, 1989; Frenken & Van Stolk, 1990; Gibbons, 1996). Such conflicting and disconcerting empirical findings present a dilemma for those who seek to assist CSA victims and wish to avoid making recommendations that, whilst well-intentioned, might serve to further victimise those already vulnerable and distressed. Whilst the ‘second injury’ that can be experienced by sexual assault victims as a result of rejection and lack of social support was first described by Symonds in 1980, very little is known empirically of the reactions encountered by CSA victims in Australia, the reactions encountered by male CSA victims, or the victim-perceived efficacy of support services accessed by Australian CSA survivors.

As with other aspects of the sexual assault literature, most findings pertaining to sexual assault disclosure derive from North American studies and the degree to which these are generalisable to the Australian population remains unclear, given that little is known of how reactions and attitudes to sexual abuse victims in Australia might differ from those of Americans. Given that such attitudes are also likely to change over time in line with social and legal reform initiatives, it is important that ‘fresh’ data are available to inform clinical and criminal justice practices. Specifically, it remains unknown whether CSA victims regret having disclosed CSA or alternatively, regret their nondisclosure, and whether those who access support services find this to be helpful. Thus, whilst research suggests that the minority of sexual assault victims seek professional services, and seeking professional help is consistently recommended to victims of sexual assault and other trauma, it remains largely open to conjecture whether the Australian health system and health professionals deliver services commensurate with the needs of those who heed this advice.

Given that messages to ‘break the silence’ and ‘tell an adult’ are widely promulgated in efforts to address child sexual abuse (Sanderson, 2004), it is important to clarify whether
in fact, such messages are beneficial or detrimental to CSA victims, or whether perhaps, qualifiers should be added to such messages. Specifically, given the implications that can arise for the victim from either supportive or unsupportive reactions to CSA disclosure, examination of such reactions is of particular salience and practical relevance. Victim wellbeing and the possibility of serious adverse outcomes for victims upon sexual abuse disclosure should be at the forefront of considerations surrounding disclosure and nondisclosure. Specifically, in terms of ethical considerations and victim safety and wellbeing, it must be determined whether advising victims to disclose sexual abuse may be a disservice and in effect, facilitating a form of revictimisation. Conversely, steering vulnerable and easily dissuaded persons away from police reporting and disclosure may be well-intentioned, but may similarly be a disservice, precipitating a path of inaction that is disempowering for victims and a source of later regret, and possibly allowing the continuation of abuse and non-intervention and against the community interest of apprehending the perpetrator.

The current study examines directly the reactions received by victims upon CSA disclosure, and ultimately, whether the victim regrets their decision to disclose. If indeed, negative reactions are found to have been widely encountered by CSA victims, then such findings have direct application for community education and awareness programs, underscoring the importance of building public knowledge and empathy surrounding CSA aftermath, and the importance of appropriate support from parents, teachers, and others concerned with the welfare of children. Further, such findings would gainfully inform intervention programs for victims hindered in their recovery by adverse reactions from others. Alternatively, if positive reactions to CSA disclosure were to be reported, this would augur well for the widely promulgated message to children to ‘tell an adult’ when sexual or other abuse occurs, and encourage the broader dissemination of this message. At present, whilst this message is widely touted, it remains unclear to what extent child and adult victims of CSA may be vulnerable to additional hurt and broken trust as a consequence of heeding such advice.

3.1.7 Sequelae of Child Sexual Abuse Disclosure

Whilst considerable data exist in relation to community levels of rape myth adherence and attitudes toward hypothetical adult victims of sexual abuse (e.g., Xenos & Smith, 2001) and child sexual abuse myth acceptance (e.g., Collings, 2003; Collings & McArthur,
2000; Suliman & Collings, 2005), fewer studies have examined community attitudes in terms of the consequences encountered by sexual abuse victims upon disclosure, and these have commonly focused on adult sexual assault victims (e.g., Ullman, 1996). Moreover, measuring community attitudes to the ‘hypothetical’ victim is substantively different to measuring reactions encountered by actual victims. For example, it might be that even persons who espouse harsh, judgmental opinions in regard to a hypothetical situation would react with empathy when confronted with the reality of a child victim who discloses CSA. Thus, measurement of ‘hypothetical’ opinions or responses, divorced from a ‘real person’ scenario, might suggest less supportive attitudes in the community than would be evident in ‘real world’ situations.

It is also noteworthy that, with the exception of the Australian study by Xenos and Smith (2001), most of the hypothetical rape attitudinal research data derive from North American studies, many of which are now somewhat dated (e.g., Campbell, 1995; Corne, Briere, & Esses, 1992; Cowan & Campbell, 1995; Flores & Hartlaub, 1998; Hinck & Thomas, 1999; Jones, Russell, & Bryant, 1998; Marolla & Scully, 1986; Payne, Lonsway, & Fitzgerald, 1999). Thus, these may reflect culturally specific attitudes or opinions that have since been mediated by rape reform initiatives, general societal progression, and movement in attitudes with changes in the Zeitgeist over recent decades.

Similarly, whilst a plethora of studies have examined processes and content of CSA disclosure (e.g., Bruck, Ceci, & Hembrooke, 2002; Carnes, 2000; Ceci & Bruck, 1995; Ceci & Friedman, 2000; Chaffin, Lawson, Selby, & Wherry, 1997; Fergusson, Horwood, & Woodard, 2000; Ford, Schindler, & Medway, 2001; Freckelton, 1997; London, Bruck, Ceci, & Shuman, 2005; Salter, 1995; Summit, 1983, 1992; see also Conte, Sorenson, Fogarty, & Rosa, 1991, for a survey of professionals’ beliefs), and models of CSA disclosure such as that formulated by Summit (1983) have gained widespread currency in mental health and forensic arenas (London et al., 2005), these have typically focused on areas other than the disclosure reactions encountered by victims.

Rather, the overarching foci of such endeavours has been to examine and conceptualise issues of veracity, and the credibility and reliability (or lack thereof) of the child witness, typically by observing children and the testimonies they proffer (e.g., Bruck et al., 2002; Carnes, 2000; Ceci & Bruck, 1995; Ceci & Friedman, 2000; Chaffin et al., 1997;
Fergusson et al., 2000; Freckelton, 1997; London et al., 2005; Summit, 1983, 1992), or to retrospectively measure CSA disclosure rates and delays thereof (e.g., Fergusson, Lynskey, & Horwood, 1996; Finkelhor et al., 1990; Hanson, Resnick, Saunders, Kilpatrick, & Best, 1999; Smith et al., 2000; Somer & Szwarcberg, 2001; Tang, 2002; Ussher & Dewberry, 1995), moreso than sequelae and regrets pertaining to disclosure.

As with most CSA research, studies that have examined disclosure effects have typically relied on exclusively female samples (e.g., Arata, 1998; Roesler & Wind, 1994;) or predominantly female samples (e.g., Lamb & Edgar-Smith, 1994; Roesler, 1994). Whilst these studies have yielded mixed or inconclusive results, they suggest nonetheless, that reactions received (particularly from family members) upon CSA disclosure may have an important mediating effect between CSA and adult psychopathology. Specifically, Roesler (1994) found that for those who disclosed CSA during childhood, disclosure reactions had a mediating effect between CSA and adult trauma symptomology, such that children who experienced an adverse reaction from the first person to whom they disclosed fared worse on dissociation, general trauma, and PTSD symptoms. Although it was unclear from the findings of Lamb and Edgar-Smith (1994) whether revealing CSA had a therapeutic effect, Arata (1998) found that disclosure by female CSA victims, whilst unrelated to overall current functioning, may have been helpful in inhibiting onset of specific PTSD symptoms, although disclosure was least likely in relation to abuses associated with the greatest psychopathology.

Overall, childhood disclosure was found to be less helpful (Lamb & Edgar-Smith, 1994) and met with worse reactions relative to CSA disclosures made in adulthood (Roesler, 1994; Roesler & Wind, 1994), with women who disclosed incest during childhood more often encountering blame or disbelief (Roesler & Wind, 1994). Indeed sadly, for 52% of women who disclosed incest to parents before the age of 18, this abuse continued for more than one year (Roesler & Wind, 1994).

No known research in Australia has previously examined disclosure-related regret or reactions encountered by male and female CSA victims by asking victims directly. Yet clearly, such information is important to ascertain, given the implications for long term victim wellbeing and the potential opportunities that exist for creating attitudinal shift and increased parental awareness and empathy through community and parenting
education initiatives. The current study examines disclosure-related regret and reactions to CSA disclosure both in childhood and in adulthood, from the perspective of the victim.

3.1.8 Child Sexual Abuse Aftermath: Consideration of Mitigating and Exacerbating Factors

Convergent evidence indicates that most CSA victims do not make a disclosure of their abuse during their childhood (London et al., 2005). This highlights not only the myriad opportunities for unimpeded offending that exist for child sex offenders, but also the intense isolation and resultant vulnerability experienced by many children thus violated and devoid of support. However, as noted above, disclosure (particularly in childhood) does not necessarily proffer apposite support and positive outcomes. Therefore, it is difficult to know how best to advise and educate children so as to minimise the risk of further harm. Further, the need exists for reform and education for those entrusted by children (and adult victims of CSA), in order to maximise supportive responses. The success of both approaches is contingent on an advanced empirically derived understanding of what changes are needed.

With respect to mitigating effects, factors such as parental warmth (Punamäki, Qouta, & El-Sarraj, 2001), family support and low family conflict (Buka, Stichick, Birdthistle, & Earls, 2001), and high intelligence (McNally, 2003) have been shown to modify the impact of traumatic events and exposure to violence in children. However, even when such fairly predictable associations have been found, the mechanisms by which these factors serve to mitigate traumatic impact are complex and nonlinear, and remain far from clear (Sanderson, 2004). For example, the pathways by which intelligence has a potentially buffering effect on trauma remain to be elucidated. The effect may arise, for instance, from differences in how children of higher intelligence encode traumatic events, process such events via language, or mobilise coping strategies and resources (McNally, 2003). Identifying such pathways is important given that individual components such as coping strategies can be taught and are amenable to change, whereas the construct of intelligence as a ‘single unit’ is more commonly conceptualised as an immutable entity.

Further, it might be expected, on the basis of findings by Punamäki et al. (2001) and Buka et al. (2001), amongst others, that children who received warm, supportive reactions to disclosure of CSA would fare better than children who received harsh, negative responses.
In fact, evidence exists that negative parental responses to CSA disclosure can aggravate the trauma and impact of the abuse (Anderson & Alexander, 1996; Tufts New England Medical Center, 1984) and limited clinical evidence exists that disclosure to a trustworthy adult or peer has a positive effect on the child (Sanderson, 2004). Whilst these outcomes make intuitive sense, it is salient to note the many ways in which disclosure can also effect adverse outcomes for the child (e.g., family dissolution, upheaval, blame from self or others for the ensuing turmoil) (Sanderson, 2004), especially given that the message to disclose CSA is widely disseminated to children.

Whilst observers have theorised about the effects of disclosure on the CSA victim (whether child or adult), this topic has rarely been examined empirically by asking victims themselves about the effects of disclosure and the presence of regrets (if any) in regard to disclosure or lack thereof. Yet such information, if available, would be important to disseminate to parents and those in whom children confide. The current study examines reactions received by victims in response to CSA disclosure; preferences that victims may have formed in relation to confidante gender and type (e.g., friend, family); victim perceived helpfulness of confidantes by gender and type; and regrets that victims may be experiencing, either in relation to disclosure or nondisclosure, and similarly, in relation to police reporting or lack thereof.

Given that these aspects of CSA aftermath have not hitherto been examined systematically in male and female victims, such research can extend the literature pertaining to CSA victim wellbeing, outcomes, treatment needs, and gender differences; and more generally, inform the persistent debate surrounding confidante and therapist gender preferences amongst clients (e.g., Cooper, 2006; Dacy & Brodsky, 1992; Fowler, Wagner, Iachini, & Johnson, 1992; Moon, Wagner, & Fowler, 1993; Pikus & Heavey, 1996; Wintersteen, Mensinger, & Diamond, 2005; Zlotnick, Elkin, & Shea, 1998), and the importance of gender matching in the therapeutic alliance and treatment retention (e.g., Fowler & Wagner, 1993; Fowler et al., 1992; Howard, Orlinsky, & Hill, 1970; Moon, Wagner, & Kazelskis, 2000; Okamoto, 2002; Orlinsky & Howard, 1976; Wagner, Kilcrease-Fleming, Fowler, & Kazelskis, 1993; Wintersteen et al., 2005; Zlotnick et al., 1998).

The sizable literature examining the impact of therapist gender on the therapeutic alliance and treatment outcome has yielded equivocal findings, even in female abuse survivors.
who are widely recognised as a particularly vulnerable client group with a common pre-
treatment preference toward female therapists (see for example, Fowler & Wagner, 1993).
Considerable data exist to support the notion that gender impacts substantively on 
therapeutic relationships and therapeutic gain (e.g., Adams-Tucker & Adams, 1984; 
Howard et al., 1970; Lo Fo Wong et al., 2006; Orlinsky & Howard, 1976; Moon et al., 
2000), with some studies revealing stronger alliances and better treatment completion 
rates with gender-matched dyads (e.g., Wintersteen et al., 2005). Yet numerous other 
studies fail to provide evidence that gender matching facilitates improved therapeutic 
outcome (Cottone, Drucker, & Javier, 2002; Fowler & Wagner, 1993; Nelson, 1993; 
Wagner et al., 1993; Zlotnick et al., 1998) or treatment retention (e.g., Sterling, Gottheil, 
Weinstein, & Serota, 1998). Indeed, even in female CSA victims (aged 7-15 years) with a 
pretreatment preference for a female therapist, Fowler and Wagner (1993) found that, 
upon treatment completion, girls assigned a male therapist were no less comfortable with 
their therapist than their female-treated counterparts.

In summary, given that most CSA victims do not disclose their abuse as children (London 
et al., 2005), and that adverse outcomes can ensue for child victims who do disclosing 
sexual abuse (Anderson & Alexander, 1996; Buka et al., 2001; Lamb & Edgar-Smith, 
1994; Punnami, F, et al., 2001; Roesler, 1994; Roesler & Wind, 1994; Sanderson, 2004; Tufts 
New England Medical Center, 1984), better evidence is needed about how to create 
climates conducive to safe disclosure and ensure therapeutic (rather than deleterious) 
outcomes. To this end, it is important to learn both from victims who have experienced 
positive and negative reactions to disclosure, and from the majority who do not report or 
disclose, in order to identify barriers and facilitate positive disclosure experiences in the 
future. Further, given that most sexual abuse victims do not seek therapy, examination of 
gender preferences in this nontherapy-seeking majority may be beneficial in highlighting 
avenues by which climates conducive to help-seeking and engagement in therapy might be 
able to be created. The current study examines victim preferences regarding gender of 
CSA confidantes, and victim perceived helpfulness of confidantes by gender. Such 
research has not previously been conducted in male and female CSA survivors.

3.1.9 Decisions and Outcomes Pertaining to Child Sexual Abuse-Related Police and Judicial Processes

The process of formally reporting sexual abuse and proceeding through the judicial 
system as a sexual abuse victim has often been cited as a harrowing process (Brereton, 
1997; Koss et al., 2004; Marx, 2005; Taylor, 2001; VLRC, 2003, 2004) with commonly

Specifically, of the minority of sexual offences that are ever reported, the attrition rate from initial reporting to conviction is extremely high, such that, even when a sexual offence is reported to police and the defendant is apprehended and prosecuted, both guilty pleas (Stubbs, 2003) and conviction rates remain lower than those for other crimes (ABS, 1996; Lievore, 2003; SAC, 2007a, 2007b; Sanderson, 2004; Stubbs, 2003; VLRC, 2003, 2004). Indeed, it has been estimated that less than 2% of sexual assaults recorded in victimisation surveys result in convictions (Lievore, 2003).

Attrition rates from reporting to conviction appear even higher in relation to sexual offences involving children (VLRC, 2003). In comparison to adult rape, a lesser proportion of penetrative offences against children result in prosecution, even though a greater proportion of individuals prosecuted for penetrative offences against children plead guilty or are convicted (VLRC, 2003). This suggests that police are significantly instrumental in eliminating penetrative offences against children for which the likelihood of successful prosecution is low. In turn, such outcomes are likely attributable to a significant degree to judicial procedures that render it difficult or impossible for children (particularly young children and infants) to deliver admissible testimony in cases of sexual abuse (VLRC, 2003). The VLRC found that, in the years 1997-8 to 1998-9 in Victoria, of the sexual offences reported to police, fewer than one in six rapes, and fewer than one in seven reports of incest or sexual penetration of a child proceeded to prosecution (VLRC, 2003). Of the accused who were prosecuted for penetrative offences other than rape (such as incest and sexual penetration of a child), less than half (44.9%) were convicted of at least one penetrative offence (VLRC, 2003). Thus, compounding effects of low rates of disclosure, reporting, prosecution, and conviction in relation to child sex offences, relative to sex offences against adults, are such that child sex offenders are even more likely to escape criminal sanction than those who offend sexually against adults (VLRC, 2003).
In terms of complainant distress, it is recognised that cross-examination and other court processes are often stressful for witnesses involved in criminal prosecutions (VLRC, 2003). However, difficulty and distress is compounded in sexual offence cases due to the intensely personal issues the complainant is required to address. Specifically, complainants must often undergo extensive cross-examination on intimate sexual matters, anatomical details, and their own behaviours, preceding and during events that are typically acutely traumatic (VLRC, 2003). Moreover, evidence exists that witness cross-examination in sexual offence cases is typically continued for much longer periods than cross-examination of witnesses in prosecution cases for other acts of violence or assault (Brereton, 1997; Taylor, 2001; VLRC, 2003).

Victims of CSA face additional challenges in proceeding through the judicial system both as children and in later adulthood, through factors such as: (i) judicial perceptions of child witness competence, reliability, and credibility; (ii) loyalty, dependence, and close emotional bonds that children abused within the family may have toward the perpetrator; (iii) confusion, perturbation, and conflict surrounding the abuse; (iv) coercion or threats to maintain secrecy; (v) reluctance to testify or take action that may result in family breakdown or incarceration of the perpetrator; (vi) intimidation, confusion, and unfamiliarity with criminal justice processes; and (vii) problems of delayed reporting by adult CSA victims (e.g., associated difficulties in substantiating offences and even more rigorous testing of the prosecution case) (Cashmore, 1995; Cashmore & Bussey, 1994, 1996; SCLJ, 2002; VLRC, 2003).

Not surprisingly, despite reforms over recent years, research has found that around half of children who testified in sexual offence cases in New South Wales and Queensland would not report a sexual offence again if one was perpetrated against them (Eastwood & Patton, 2002; VLRC, 2003), and a similar proportion of child complainants evaluated having proceeded through the criminal justice system as an entirely negative experience (Cashmore, 1995; Cashmore & Bussey, 1994, 1996). Interestingly, these findings contrast with those of Western Australia, where special procedures have been implemented for some time for children testifying in sexual offence cases, and where 64% of child complainants indicated that they would report a sexual offence again (Eastwood & Patton, 2002; VLRC, 2003). Important as such findings are, these clearly represent only
the views of the small minority of CSA victims who proceed through the system to the point of testifying in court, and fail to represent the majority of victims who do not disclose CSA during their childhood (London et al., 2005) or report to police either then or in adulthood. Little is known about the perceptions, experiences, and regrets held by victims who never reported, or who reported to police but whose cases (for a variety of reasons) failed to proceed to court.

In combination, such findings suggest dire prospects for victims of sexual abuse in relation to seeking and obtaining judicial redress. Indeed, on the basis of such results, those engaged as advocates for, and concerned with the welfare of, sexual abuse victims not uncommonly advise them to desist from making a police report and proceeding through the judicial system, which could be conceived as an ineffectual process at best, and at worst, extremely traumatic. However, with the exception of studies examining the experiences of child complainants who have testified in court (as cited above), no empirical evidence exists that derives from CSA victims’ own opinions in relation to outcomes of police reporting (or lack thereof).

The current study takes the approach of asking victims directly regarding their experiences of police reporting, and tests for the presence of any regrets in this regard. Given that even the most harrowing experiences can nevertheless be perceived as worthwhile, strengthening, affirming, and even ‘therapeutic’, positive and negative aspects are not necessarily mutually exclusive. To deny victims their voice and potentially, their ‘day in court’, even because of well-intentioned wishes to ‘protect’ them, may in fact be disempowering and constituting a great disservice, given that nonreporting can be a source of great regret and a contributor to perturbation in the longterm.

In short, evidence exists that navigating through judicial processes is commonly perceived as both harrowing and ineffectual by victims of sexual abuse and particularly distressing and difficult for child complainants. Amongst those concerned with the best interests of the victim, this can raise the question of whether police reporting should in fact be routinely encouraged or at least in some cases, discouraged. Whilst seeking the opinions of victims has provided information that the process is fraught, distressing, and often ineffectual, to date, the question of whether victims ultimately regret having reported (or not reported) to the police and pursued legal pathways has rarely been
asked, and only posed to the minority of CSA victims who ultimately testify in court. A broadened understanding of the views and experiences of victims can lead to positive process changes and client-focussed approaches that better serve the interests of this vulnerable cohort.

Thus, it is a principal aim of the current study to identify aspects of CSA aftermath that have rarely been addressed in previous research or which have hitherto commonly remained undetected within conventional research methods (e.g., regrets and experiences related to reporting and nonreporting of CSA and criminal justice proceedings). No known research of this nature has previously been conducted with adult male and female CSA survivors.

3.1.10 Child Sexual Abuse: Considerations of Gender Impact

It has been recognised that sexual victimization, particularly of female adolescents and young adult women, is endemic (Ullman, 2004). Indeed, it is a sad indictment on society that for many individuals worldwide, particularly females (up to 33% of adolescent girls in some countries), rape or other sexual violence comprised their first sexual experiences (Krug et al., 2002). However, amongst the many erroneous beliefs surrounding sexual abuse is the notion that sexual violence against males occurs rarely. In fact, as noted earlier, male sexual victimisation (especially in childhood) occurs in sizable proportions, both in relative and absolute terms, most commonly (though not exclusively) perpetrated by other males. In an Australian national survey in 2005, 5.5% of men (compared with 19% of women) reported experiencing sexual violence since age 15, and comprised 22% of sexually victimised individuals (ABS, 2005b). Similarly, 18% of police recorded sexual assaults in 2003 were against males (ABS, 2005b).

Yet, male victims have been comparatively neglected within the sexual assault literature, and commonly excluded from research, intervention, and prevention initiatives pertaining to both childhood and adulthood sexual abuse (Crome, 2006; Walker, Archer, & Davies, 2005). Indeed, to the chagrin and pain of many males and those concerned with their welfare, ‘maleness’ within the sexual assault literature and arenas of service provision has commonly been relegated to considerations of perpetrators but rendered largely invisible or inconsequential in considerations of victims (Crome, 2006; Griffiths, 2003; Mezey & King, 1989, 2000; Neame & Heenan, 2003; Stott, 2001; Walker et al.,
Where female-targeted victim services have been extended to include male victims, this has typically taken the form of an adjunct to services conceptualised and focused on the treatment needs of women, in the absence of adequate empirical data to inform service providers of the treatment needs specific to males (Crome, 2006; Griffiths, 2003; Worth, 2003). Indeed, such services have been offered seemingly under the assumption that generic services designed for women will suffice equally for males (Worth, 2003). Moreover, services for male victims of sexual abuse have commonly been offered from within traditionally ‘female’ precincts such as women’s hospitals and rape crisis centres, which themselves may be located within women’s hospitals or environs.

The reticence of vulnerable males to access such services, given the stigma and even mirth associated with male sexual abuse (Crome, 2006; Hunter, 1990b), and the notion that ‘maleness’ in such environments may be more often perceived as synonymous with ‘perpetrator’ than with ‘victim’, particularly by female clientele with whom male victims might ostensibly be required to share waiting rooms. However, such reluctance and subsequent underutilization of rape crisis services by male victims has commonly been interpreted as evidence that sexual abuse of males is either extremely rare, or that male victims do not require or desire support services.

Whilst obvious flaws exist in drawing such conclusions, refuting these arguments is difficult in the absence of sound empirical data pertaining to male victims and their symptomology. It is contended in this thesis that, whilst male victims underdisclose CSA relative to females, such silence is not commensurate with a lack of perturbation. Indeed, it is hypothesised that males experience similar amounts of psychological distress in the aftermath of CSA, but are less able, through patterns of socialisation and gender role expectations (see Good, Sherrod, & Dillon, 2000), to mobilise both formal and informal supports. Lack of societal recognition of the problems of male sexual abuse, and more broadly, the physical and psychosocial hindrances that males experience in obtaining succour, result in far fewer resources available to males, relative to females; and intensify the barriers that males experience in accessing those resources that do exist.

It is a goal of the current study to highlight, or alternatively to lay to rest, the argument that males (moreso than their female counterparts) are underresourced with respect to
access to succour and receive supports at a level not commensurate with need. Such a contention is consistent with copious evidence that males, relative to females, die younger and more often succumb to suicide, and other maladaptive coping mechanisms and manifestations of perturbation, such as substance abuse, risk-taking behaviours, externalised anger, violence, and crime (ABS, 2003b, 2005a, 2005b, 2005c, 2007b; DHS, 2007; Giancola, 2002; Good et al., 2000; Laslett, Matthews, & Dietze, 2006; Möller-Leimkühler, 2003; Smith & Stewart, 2008; Stewart & Smith, in press-a; WHO, 2004).

In addition to the direct negative health effects concomitant with sexual abuse in childhood, CSA has been identified as one of the strongest predictors of adulthood sexual victimisation (Cloitre, 1998). Specifically, substantial evidence attests to the heightened susceptibility for future sexual victimisation conferred by a history of sexual abuse in childhood or adulthood (Brietenbecher, 2001). However, whilst the phenomenon of sexual revictimisation has been well established in the literature over recent years, mechanisms by which to explain and mitigate this unwelcome pattern remain inadequately understood (see Breitenbecher, 2001 for a review). Moreover, such findings (along with most data and review articles in the CSA literature) derive overwhelmingly from studies of female samples (e.g., Brietenbecher, 2001; DiLillo, 2001; Gidycz, Hanson, & Layman, 1995; Messman & Long, 1996; Rumstein-McKean & Hunsley, 2001). Thus, it remains largely unknown how accurately the extant data (and importantly, the treatment and prevention protocols deriving from such data) reflect the experiences and treatment needs of male CSA victims.

The small number of empirical studies that have examined gender differences in long-term correlates of childhood abuse have generated mixed findings, with attention given to only a limited number of psychosocial variables (Godbout, Lussier, & Sabourin, 2006). Specifically, whilst some CSA studies have found a mixed depiction of victims, with both common and distinct clusters of symptoms across gender (Whiffen, Thompson, & Aube, 2000), others have found sizable commonalities between males and females (see Holmes, Offen, & Waller, 1997, for a review). Indeed, Godbout et al. (2006) found only small gender differences in long term psychosocial sequelae to CSA, leading these authors to conclude that the findings generated by their study were not consistent with a gender-specific model of psychosocial repercussions.
Where gender differences have been revealed, these have commonly identified a susceptibility for internalising problems amongst females (e.g., depression, anxiety) and externalising problems amongst males (e.g., substance abuse, risk taking, impulsive disorders, aggression) (Godbout et al., 2006). Given the exclusion of male victims from most CSA studies, the limited number of gender comparative studies pertaining to CSA, the inconsistent findings generated to date, and the limited number of domains examined across gender, sizable need exists for differential examination with respect to CSA aftermath in males and females.

In Australia, the experience of physical abuse before the age of 15 has been reported by 10% of males and 9-18% of females (ABS, 2005b; Mouzos & Makkai, 2004). In many countries and cultural contexts, boys experience higher risk of severe corporal punishment, relative to girls. Possibly, harsh treatment is perceived as necessary for disciplining boys or as preparation for manhood and male responsibilities (Krug et al., 2002). Whilst traditional male gender role expectations encourage stoicism and render males disproportionately likely to both experience and use physical violence as a means of conflict resolution and evidence of ‘manly’ prowess, entrenched traditional expectations and views of girls as submissive, subordinate, and compliant, similarly compound their vulnerability to sexual and other abuse in many cultures (Krug et al., 2002).

Indeed, convergent evidence exists that girls are at higher risk of sexual abuse than boys in most countries, with reported rates of CSA 1.5-3 times higher among girls (Krug et al., 2002). In most countries, a heightened risk for girls also exists in relation to infanticide, educational and nutritional neglect, and forced prostitution (Krug et al., 2002). Cultural expectations for females to assume subservient, serving, and self-sacrificing roles within families and societies render them not only more vulnerable to sexual servitude and objectification but also, in many traditional societies, to diminished educational opportunities compared with their male siblings. That is, if their menial role within the home is perceived correct and necessary, education of girls is consigned lower priority. The reality that girls are required, in many traditional societies, to assist the family economically by working or caring for siblings, reduces their educational opportunities, thus perpetuating the power imbalance between them and their male counterparts, and adding to their current and future sociopolitical vulnerability. Thus, in both subtle and
overt ways, many of the gender inequalities pertaining to abuse could likely be explained by varying cultural attitudes regarding the roles of women and men and male and female children (Krug et al., 2002).

The current study seeks to examine gender differences in the experience and aftermath of CSA by conducting comparative analyses across multiple domains, including disclosure and reporting practices, confidante preferences, and mental health and suicidality. Enhanced understanding of differences and commonalities across gender can gainfully inform funding decisions and service provision and practices to better meet the needs of CSA survivors.

It is hypothesised that males, constrained by social pressures and notions of masculinity, will be less likely than females to disclose and seek help in relation to such abuse. Such findings would be consistent with those in the extant health literature that males, relative to females, are less amenable in general to disclosure and communication pertaining to sensitive information, less likely to engage in proactive health behaviours, and more prone to eschew professional assistance. Further, such results would be consistent with the notion that sexual abuse of males is perceived by many as particularly shameful and emasculating (Crome, 2006; Donnelly & Kenyon, 1996; Good et al., 2000; Hunter, 1990b; Kassing, Beesley, & Frey, 2005; Kassing & Prieto, 2003; Richey-Suttles & Remer, 1997; Washington, 1999).

Finally, such findings would suggest the importance of gender-specific treatment foci and service provision and targeted community awareness initiatives surrounding CSA aftermath and appropriate harm minimisation strategies. It is also hypothesised that cultural attitudes toward females and socialisation of female children to acquiesce to the wishes of others, and to be submissive, nonaggressive, obedient, and ‘polite’ to adults not only confers vulnerability for CSA, but extends also to conferring disparate risk of sexual revictimisation in adulthood. Thus, it is hypothesised that female CSA victims are susceptible to adulthood sexual abuse more so than their male counterparts, especially given that females are more prone to self-blame, and internalised reactions to abuse, such as lowered self-esteem and confidence, in contrast to males who are more likely to externalise their distress (e.g., aggression, substance use) (Godbout et al., 2006).
3.1.11 The ‘Victim-to-Perpetrator’ Cycle: A Matter of Consternation, Controversy, Contestation, and Confusion

The propensity for a minority of CSA victims to themselves become sexually abusive in later life is a source of considerable consternation, debate, and confusion in community, academic, and therapeutic arenas (Boyd, 2006; Crome, 2006; Allan, 2006; Bentovim, 2002; Bentovim & Williams, 1998; Durham, 2003, 2006; Glasser, Kolvin, Campbell, Glasser, Leitch, & Farrelly, 2001; Kelly, 1996; Rezmovic, Sloane, Alexander, Selser, & Jessor, 1996; Salter, 2003; Salter et al., 2003; Sanderson, 2004; Slattery, 2000). Importantly, this is also a matter that in itself causes further emotional turmoil for many victims (Crome, 2006; Walker et al., 2005). Internalised societal labelling of CSA victims as ‘future perpetrators’ and/or homosexual is frequently carried into adulthood by male victims, with concomitant internalised homophobia, conflict, distress, or confusion regarding sexuality, and pervasive fears of becoming a child abuser (Walker et al., 2005).

In particular, many male victims are burdened by immense fears that becoming a sexual perpetrator, and possibly offending against their own children, may be their immutable destiny (Crome, 2006; Walker et al., 2005). This fear frequently has pervasive impact on the manner in which sexually abused males conduct their lives, engage with children or desist contact, and view and approach parenting, and indeed, even the decision regarding whether or not to become a parent (Crome, 2006). Not surprisingly, fears of being perceived (and treated) by society as a child molester are frequently instrumental in further promulgating the secrecy and nondisclosure that surrounds CSA, particularly for male victims (Mezey & King, 1989, 2000; Neame & Heenan, 2003; Stott, 2001). Thus, both actual and feared effects of CSA on current and future family and loved ones contribute further to the breadth and enormity of CSA aftermath, and underscore the need for effective means to redress this immense and far-reaching social problem.

However, many barriers and knowledge deficits serve to complicate and impede ameliorative efforts. For instance, research by Salter et al. (2003) and Skuse et al. (1998) suggests that around one in eight children who have experienced sexual abuse are subsequently sexually abusive to others, and an earlier review revealed inconclusive findings ranging from 7-26% (Rezmovic et al., 1996). Further, international research suggests that 25-35% of all alleged sexual abuse is perpetrated by young offenders, mainly adolescents (Cawson, Wattam, Brooker, & Kelly, 2000; Home Office, 2006; Home,
Glasgow, Cox, & Calam, 1991; Kelly, Regan, & Burton, 1991; Lovell, 2002; Morrison, 1999; Royal Belfast Hospital & Queen’s University of Belfast, 1990; Sanderson, 2004; Vizard, Monck, & Misch, 1995). Similarly in Victoria, Department of Human Services data reveal that adolescents comprise around 20% of all recorded sex offenders (Department of Human Services [DHS], 1998) and Victoria Police Crime Statistics 2001/2002 record that juveniles comprise 12.4% of all alleged sex offenders (VLRC, 2004). Yet causal pathways for these phenomena remain to be elucidated.

Whilst various factors have been associated with increased propensity of CSA victims to become sexually abusive (e.g., proclivity to externalise, rather than internalise, responses to CSA; experiencing or witnessing physical violence; exposure to familial violence or other trauma; discontinuity of care and failure to form sound attachments) (Bannister & Gallagher, 1995; Lovell, 2002; O’Callaghan & Print, 1994; Rasmussen, Burton, & Christopherson, 1992; Sanderson, 2004; Skuse et al., 1998), such explanations are partial at best. Definitive conclusions are precluded by insufficient and unreliable data, secrecy, nondisclosure, ambiguity of sexual abuse reporting, and the complex interplay of risk factors that implicate sexual offending (Crome, 2006). However, it is clear, despite the paucity of dependable evidence, that the majority of CSA victims do not become perpetrators (Bentovim & Williams, 1998) and that a sexual abuse history is neither a necessary or sufficient condition to explain or adequately predict sexual offending (Bentovim & Williams, 1998; Durham, 2003; Glasser et al., 2001).

Nonetheless, notwithstanding the absence of clear evidence and demonstrated causal connections, the cycle of ‘victim-to-perpetrator’ is an important and controversial issue that is influential in popular and professional discourse pertaining to CSA (particularly against male victims) (Crome, 2006). Specifically, the concept of a victim-to-offender cycle has been (and continues to be) widely applied in explaining sexual abuse (Allan, 2006; Boyd, 2006; Crome, 2006), yet remains subject to wide criticism and contestation by others (see Kelly [1996], for a focused critique; and Durham [2006] and Slattery [2000], for further discussion). Given the stigmatising, deleterious, and revictimising effects of labelling CSA victims as potential ‘future perpetrators’ (Mezey & King, 1989; Neame & Heenan, 2003; Stott, 2001) and conversely, the risks concomitant with failing to circumvent the progression to offending that occurs in a minority of victims (Rezmovic et al., 1996; Skuse, 2003; Salter, 2003), this is an area that demands urgent further attention.
Uncovering differential impact and sequelae of CSA on male and female victims and deconstructing barriers to disclosure and help-seeking (and thereby fostering detection and early intervention for both victims and offenders) can likely assist substantively in advancing understanding and circumventing progression from victim to offender.

Indeed, early detection and intervention are recognised as pivotally important in circumventing offending progression, establishment of firm patterns of abuse, and offence escalation (Boyd, 2006; Nisbet et al., 2004, 2005; Nisbet, Wilson, & Smallbone, 2004; Tidmarsh, 1997). Evidence exists that a high proportion of adult sexual offenders initiate offending behaviours at a young age (e.g., Tidmarsh, 1997), and that likelihood of recidivism increases the older the age of young male sex offenders at the time of initial assessment (Nisbet et al., 2004). Importantly, evidence also exists that male sex offenders who offend against children in adulthood and who have themselves experienced CSA, demonstrate a more severe level of offending, relative to child sex offenders without a CSA history (Proeve et al., 2006; Proeve & Reilly, 2007). Specifically, sexually abused offenders have been found to be more likely than their nonabused counterparts to have an additional history of nonsexual offending, and to have perpetrated sexual offences against multiple victims and transgressed gender, age, and relationship boundaries with victims in the course of sexual offending (Proeve & Reilly, 2007). Such findings attest further to the importance of early intervention for both victims and offenders, and the development and timely implementation of strategies that are able to thwart progression from victim to offender.

3.1.12 Current Study

Given the profundity of the problem of CSA, the persistent silence and ensuing scarcity of detailed information pertaining to such abuse, and the unwelcome corollaries that derive from unknowns and silencing, the need for advanced understanding and approaches is clear. Moreover, given that victims are primary witnesses, not only to their abuse, but also to their symptomology and experience of judicial proceedings, the importance of seeking to better current understanding and approaches by asking victims directly is also apparent. Yet, the voices of victims of crime often remain inadequately heard within research settings and adversarial criminal justice systems, and this is particularly so for victims of sexual abuse and child victims (VLRC, 2003).
The current study examines, across multiple parameters, the experiences, perceptions, beliefs, and appraisals of adult CSA victims. Particular emphasis is placed on examining offence typologies and perpetrator strategies, disclosure and reporting practices, processes and artefacts of CSA, and the relationship of such abuse with adult wellbeing, sexual revictimisation, perturbation, and suicidality. Emphasis is also placed on the delineation of gender differences with respect to CSA aftermath and on delineating disparities in adult wellbeing between victims and nonvictims of CSA. Underpinned by the notion that victims are able (given the opportunity) to proffer unique information and insights related to their abuse; reporting patterns; inhibitors and reactions to disclosure; victim psychopathology, regrets, beliefs, and barriers to wellbeing; and a range of perpetrator variables; opinions and questions are asked of CSA victims in a manner and breadth that has not previously been undertaken.

*I know of no more sacred duty than … the care and education of a child.*

- Ludwig van Beethoven, 1770-1827
3.2 Method

3.2.1 Participants
The data presented in the current chapter derive from a sample of 2,177 individuals who participated in the Tellsomeone Project (TSP) and completed the sections pertaining to CSA and wellbeing. Of these individuals, 44.3% (\(n = 965\)) had experienced sexual abuse in childhood and 55.7% identified as nonvictims (\(n = 1,212\)). The mean age of CSA victims and nonvictims was 37.0 years (\(SD = 12.8; \text{Range} = 16 - 83\) years) and 32.6 years (\(SD = 12.8; \text{Range} = 16 - 75\) years), respectively. The sample comprised 795 female and 170 male victims of CSA, and 834 female and 378 male nonvictims. Thus, CSA victims comprised 48.8% of the female sample and 31% of the male sample. The mean age of female and male CSA victims was 36.1 years (\(SD = 12.4; \text{Range} = 16 - 70\) years) and 41.2 years (\(SD = 13.8; \text{Range} = 18 - 83\) years); and the mean age of female and male nonvictims was 31.4 years (\(SD = 12.3; \text{Range} = 16 - 75\) years) and 35.2 years (\(SD = 13.5; \text{Range} = 16 - 71\) years), respectively. A more detailed description of this sample of respondents is provided in the General Method in Chapter 2.

3.2.2 Definitions
Childhood sexual abuse (CSA) was defined as sexual events experienced whilst under the age of 16 that ‘you now consider to have been inappropriate, abusive, or damaging’. This definition was used given that sexual abuse definitions that rely on lack of consent fail to capture the many victims of CSA who believe themselves to have been complicit or consenting to their abuse, notwithstanding the fact that their ‘consent’ may have been invalid due to their status as legal minors or due to its delivery under duress or coercion. Fuller discussion of issues relating to CSA definitions and terminology is provided in the General Method in Chapter 2.

The age of 16 was chosen as this is currently the age of consent for heterosexual and homosexual sex in most states and territories of Australia (i.e., Australian Capital Territory, New South Wales, Northern Territory, Victoria, and Western Australia), with the exception of South Australia and Tasmania, where the age of consent is 17 years.
Queensland is the only state to retain a disparate age of consent for vaginal and anal sex (i.e., 16 and 18 years, respectively) (AFAO, 2006), although until relatively recently, age of consent in Australia varied more broadly across states and territories, differing according to gender and to the nature of the sexual intercourse (e.g., heterosexual, gay male, lesbian) (Simpson & Figgis, 1997).

3.2.3 Procedure, Measures, and Data Analyses

Procedure and measures utilised in this study are detailed in the General Method presented in Chapter 2. A comprehensive battery of data analyses was applied; these analyses are similarly detailed in the General Method.
3.3 RESULTS

3.3.1 Overview
Extensive quantitative analyses were conducted to measure (across multiple domains) abuse-related experiences, perceptions, beliefs, and appraisals reported by adult victims of CSA; and the relationship of such variables with adult wellbeing, sexual revictimisation, IPV, perturbation, and suicidality. Emphasis was placed on measuring victim-reported offence typologies and processes (e.g., penetrative, nonpenetrative, frequency of abuse, revictimisation by different perpetrator/s) and perpetrator characteristics and strategies (e.g., perpetrator relationship to victim, use of coercion, physical force, inveigling, grooming). Particular emphasis was also placed on delineating gender differences with respect to CSA aftermath and disparities in adult wellbeing between victims and nonvictims of CSA.

The results of these analyses are presented in the forthcoming chapter under relevant headings. Where appropriate, statistical results are augmented by excerpts of qualitative data, in the form of direct quotations from participants. As noted earlier, these have been reproduced faithfully, with the exception that spelling and obviously typographical errors have been corrected. All quotations are presented in italics.

General descriptive statistics are presented in Section 3.3.2, to provide a qualitative and quantitative overview of the CSA reported by the sample (e.g., CSA prevalence by victim age and gender). Section 3.3.3 presents prevalence statistics pertaining to specific offence typologies; and Sections 3.3.4 and 3.3.5 provide prevalence statistics pertaining to nonpenetrative and penetrative CSA, respectively. Perpetrator strategies and offence characteristics are reported in Section 3.3.6; followed by discussion of both perpetrator and victim variables in Section 3.3.7.

Disclosure results and perceived benefits of CSA disclosure are presented in Sections 3.3.8 and 3.3.9, respectively; followed by discussion of confidante gender preferences, confidante type choices, preferred confidante types, and disclosure reactions reported by
CSA victims, in Sections 3.3.10 – 3.3.13. Counselling experiences of CSA victims are examined in Section 3.3.14; followed by presentation of statistics related to perpetrator confrontation in Section 3.3.15.

Offence characteristics, victim perceptions, and outcomes related to police reporting of CSA in childhood and adulthood are presented in Sections 3.3.16 and 3.3.17, respectively, followed by discussion of non-reporting of CSA in Section 3.3.18. In Section 3.3.19, CSA victims and nonvictims are compared with respect to adulthood sexual victimisation and experience of intimate partner violence. Physical injuries and risk exposure resultant from child sexual abuse are examined in Section 3.3.20. Sections 3.3.21 and 3.3.22 examine feelings experienced by victims subsequently to CSA exposure; and adult perceptions of their childhood abuse. Relationships between CSA and current psychological wellbeing and a gender comparison of psychological wellbeing in CSA survivors are presented in Sections 3.3.23 and 3.3.24, respectively. Finally, suicide attempts and suicidal ideation are examined comprehensively in the context of CSA in Sections 3.3.25 – 3.3.37.

### 3.3.2 General Sample Characteristics Pertaining to Child Sexual Abuse Prevalence

**Experience of child sexual abuse within the sample**

Experience of sexual abuse in childhood was reported by 44.3% of respondents ($n = 965$) – defined in the initial screening question as ‘sexual experiences whilst under the age of 16 that you now consider to have been inappropriate, abusive, or damaging’.

**Child sexual abuse across gender**

Males and females differed significantly with respect to reported experience of CSA, $\chi^2(1, N = 2177) = 52.54, p < .0005$, Cramér’s $V = .16$. In contrast to 31.0% of male respondents ($n = 170$), 48.8% of females ($n = 795$) reported experience of sexual abuse in childhood. Inspection of standardised residuals (SRs) reveals that males were the most disproportionately represented, being most significantly underrepresented amongst CSA victims (SR = -4.7), and very significantly overrepresented amongst nonvictims (SR = 4.2). Conversely, females were significantly overrepresented amongst CSA victims (SR = 2.7), and significantly underrepresented amongst nonvictims (SR = -2.4).
Whilst most respondents (91.30%, \( n = 881 \)) identified the perpetrator/s as male, it is pertinent to note that a sizable minority (13.06%, \( n = 126 \)) identified a female perpetrator. Note: These percentages total greater than 100% because 42 respondents identified both male and female perpetrators. Within male CSA victims, 88.82% reported a male perpetrator/s (\( n = 151 \)) and 18.24% reported a female perpetrator (\( n = 31 \)). Similarly, 91.82% of female CSA victims identified a male perpetrator (\( n = 730 \)) and 11.95% identified a female/s perpetrator (\( n = 95 \)).

Most respondents reported that the CSA was perpetrated by one person (most commonly male). However, a significant/large minority of respondents reported CSA perpetrated against them by more than one person. Indeed, 36.66% of respondents perpetrated against by males (\( n = 323 \)), and 22.22% of respondents perpetrated against by females (\( n = 28 \)) reported more than one perpetrator.

Within male CSA victims, 27.15% of those who reported male-perpetrated abuse identified more than one male perpetrator (\( n = 41 \)) and 25.81% of those reporting female-perpetrated CSA reported more than one female perpetrator (\( n = 8 \)). Similarly, within female CSA victims, 38.63% of those who reported male-perpetrated abuse identified more than one male perpetrator (\( n = 282 \)) and 21.05% of those reporting female-perpetrated CSA reported more than one female perpetrator (\( n = 20 \)).

**Number of incidents of child sexual abuse**

The minority of CSA victims (23.56%, \( n = 205 \)) reported experiencing only a single incident of unwanted sexual activity. Indeed, one half of respondents identifying as CSA victims reported at least five separate incidents of unwanted sexual activity (50.0%; \( n = 435 \)). Specifically, 17.93% of victims reported 5-10 separate incidents (\( n = 156 \)), and 32.07% reported more than 10 separate incidents (\( n = 279 \)). Whilst disturbing, such statistics alone fail to accurately portray the chronicity of the CSA experienced by many respondents. Qualitative responses however, potently clarify the enormity of the abuse encountered by many respondents:

- Over the course of years, untold times.
- Probably 1000’s… sometimes nearly every day - always at least weekly my whole life from my earliest memory until I ran away at 16.
Every Saturday morning from 7 until 13.

All the time (by my grandfather) until he died when I was 13. Then once by a doctor when I was 14.

12 years worth. I would say perhaps 500 but that may be conservative, especially if each experience is taken individually rather than grouped by date.

2-3 times a week over a 5 year period

3 or 4 times per week for the 7 years

300+

Age 6-12 - most weekends for 6 years

Every single day for 3 years; almost every second between school hours.

Every time I was in contact with a maternal half-sister and her evil paedophilic now ex husband, who abused at least one other female of about the same age demographics as myself.

Every week-end and sometimes throughout the week this took place.

Everyday for quite a few years.

Almost daily for five to six years

At least a hundred. I really don’t have a number. It was over a 12 year period, different frequencies at different times, etc.

3.3.3 Sample Prevalence of Child Sexual Abuse by Abuse Typology

Child sexual abuse typologies
Respondents were asked questions pertaining to six types of CSA, phrased as unwanted sexual activities ‘whilst under the age of 16’:

Nonpenetrative sexual experiences
These were described as ‘unwanted sexual contact (e.g., fondling, kissing, petting, forced masturbation, exposure to pornography, or other sexual activity) that DID NOT INCLUDE oral sex or intercourse (vaginal or anal)’.

Oral sex
This was phrased as ‘someone performed oral sex on me, or had me perform oral sex on them. (By oral sex we mean contact between the mouth and either male or female genitals)’.

Sexual intercourse
This was phrased as ‘someone had sexual intercourse with me. (By sexual intercourse we mean vaginal penetration, no matter how slight, by a penis or other object [e.g., finger, candle]. Ejaculation is not required.)’.
**Anal sex**
This was phrased as ‘someone had anal sex with me or had me perform anal sex on them. (By anal sex we mean anal penetration, no matter how slight, by a penis or other object [e.g., finger, candle]. Ejaculation is not required.’.

**Other unwanted sexual experience**
This was phrased as ‘I had some other kind of unwanted sexual experience, that has not already been described.’.

**Attempted child sexual abuse:**

i) **Attempted oral sex**
This was phrased as ‘someone ATTEMPTED to perform oral sex on me, or attempted to make me perform oral sex on them, but oral sex DID NOT OCCUR.’

ii) **Attempted sexual intercourse**
This was phrased as ‘someone ATTEMPTED to have sexual intercourse with me (e.g., got on top of me, attempted to insert penis or object) but INTERCOURSE DID NOT OCCUR.’

iii) **Attempted anal sex.**
This was phrased as ‘someone ATTEMPTED to have anal sex with me, but it DID NOT OCCUR.’

**Child sexual abuse prevalence by typology**

**Nonpenetrative sexual experiences**
More than one third of the entire sample reported experience of nonpenetrative CSA (39.4%; n = 845). Within CSA victims, 87.57% of respondents reported this type of abuse.

**Oral sex**
One fifth of the entire sample reported experience of unwanted oral sex in childhood (21.4%; n = 448). This figure represents almost half of respondents (46.43%) who identified as having experienced CSA.
Sexual intercourse

One quarter of the entire sample reported experience of unwanted sexual intercourse in childhood (26.1%; $n = 537$). This figure represents more than half of respondents (55.65%) who identified as having experienced CSA.

Anal sex

Of the entire sample, 8.3% of respondents reported experience of unwanted anal sex in childhood ($n = 166$). This figure represents almost one fifth of respondents (17.20%) who identified as having experienced CSA.

Other unwanted sexual experience

Of the entire sample, 16.0% of respondents reported experience of some other type of unwanted sexual activity in childhood ($n = 310$). This figure represents almost one third of respondents (32.12%) who identified as having experienced CSA. Under this category, respondents included experiences such as: forced participation in the production of pornographic material; exposure to exhibitionism; forced viewing, exposure, or engagement with sexual activities, materials, or conversations; bestiality; provision of the child by a caregiver for the sexual gratification of another; and overt or tacit approval, condoning, non-intervention, or complicity by a parent or other authority figure regarding the sexual abuse of the child.

Attempted child sexual abuse:

i) Attempted oral sex:

Of the entire sample, 8.6% of respondents reported experience of attempted oral sex in childhood ($n = 169$). This figure represents almost one fifth of respondents (17.51%) who identified as having experienced CSA.

ii) Attempted sexual intercourse

Of the entire sample, 14.3% of respondents reported experience of attempted sexual intercourse in childhood ($n = 268$). This figure represents more than one quarter of respondents (27.77%) who identified as having experienced CSA.
iii) Attempted anal sex

Of the entire sample, 3.4% of respondents reported experience of attempted anal sex in childhood ($n = 65$). This figure represents 6.74% of respondents who identified as having experienced CSA.

The two categories of CSA most reported by participants (i.e., nonpenetrative CSA and vaginal sexual intercourse) were explored in detail through the following analyses.

3.3.4 Prevalence of Nonpenetrative Child Sexual Abuse by Victim Age and Perpetrator Typology

Victim age

As noted above, nonpenetrative CSA was reported by more than one third of the entire sample (39.4%; $n = 845$), and by most CSA victims (87.57%). Within this victim group, most respondents reported a male perpetrator, acting alone (94.44%; $n = 798$). However, female-perpetrated nonpenetrative CSA was also reported by 14.08% of victims ($n = 119$). Moreover, 11.01% of victims ($n = 93$) reported nonpenetrative CSA perpetrated by a group of males (acting together), 1.07% of victims ($n = 9$) reported such abuse perpetrated by a group of females (acting together), and 8.41% of victims reported perpetration of this abuse form by a group of mixed gender ($n = 29$).

More than half of victims of nonpenetrative CSA reported experiencing this form of abuse whilst under the age of 10 years (61.8%; $n = 540$), and more than one third had this experience on five or more occasions whilst under 10 (34.2%; $n = 299$). Indeed, 21.6% of nonpenetrative CSA victims experienced this on more than 10 separate occasions whilst aged under 10 years ($n = 189$), and only a minority had this experience on only a single occasion whilst under 10 (14.2%; $n = 124$). Additionally, three quarters of nonpenetrative CSA victims reported experiencing this abuse form between the ages of 10 and 15 years (74.5%; $n = 652$), indicating that many victims had such experiences both within prepubescent/young childhood and in adolescence. Again, the minority of those reporting nonpenetrative CSA experienced this on only a single occasion between 10 and 15 years (15.1%; $n = 132$). Indeed, 41.8% reported five or more occasions ($n = 366$), and 24.3% reported more than 10 occasions between the ages of 10 and 15 years ($n = 213$).
The recurrent nature of such abuse is also evidenced by the finding that 70.1% of nonpenetrative CSA victims reported that the abuse occurred with the same person on more than one occasion \((n = 592)\). Moreover, 37.09% of victims of male-perpetrated nonpenetrative CSA \((n = 296)\) reported having been offended against by at least two different males (acting alone). Similarly, of the victims of female-perpetrated nonpenetrative CSA, 21.01% reported being perpetrated against by more than one female (acting independently) \((n = 25)\).

**Perpetrator typology**

As evident in Table 3.1, trusted figures and relatives were identified most commonly as the perpetrators of nonpenetrative CSA. Indeed, both trusted figures (42.13%; \(n = 356\)) and relatives (41.07%; \(n = 347\)) were identified as the perpetrator by almost half of victims of this form of abuse. Notably, the finding that the cumulative percentages in Table 3.1 sum to 172.58%, expands on the earlier finding that many respondents experienced abuse by multiple perpetrators, by showing that respondents also experienced abuse perpetrated by different types of perpetrators (e.g., relative AND trusted figure). The group of perpetrators identified as relatives comprised predominantly males, mostly brothers (24.21%; \(n = 84\)), fathers (22.77%; \(n = 79\)), and uncles (21.61%; \(n = 75\)), and to a lesser extent, grandfathers (10.09%; \(n = 35\)), brothers-in-law (2.59%; \(n = 9\)), great uncles (0.87%; \(n = 3\)), stepbrothers (0.87%; \(n = 3\)), and stepfathers (0.58%; \(n = 2\)). Other male perpetrators identified as relatives included a great grandfather, foster brother, father’s stepfather, grandmother’s stepbrother, sister’s fiancé, stepfather, and stepgrandfather. Additionally, cousins of unspecified gender (but presumably, predominantly male) also comprised almost one quarter of identified relatives (22.48%; \(n = 78\)).

Female relatives identified as perpetrators were predominantly mothers (6.05%; \(n = 21\)) and sisters (4.04%; \(n = 14\)), and in rare instances, also aunts (0.87%; \(n = 3\)), grandmothers (0.58%; \(n = 2\)), and a stepsister (0.29%). Also identified within the group of ‘perpetrator-relatives’ were small numbers of individuals whose gender was not specified (e.g., ‘siblings’, ‘grandparents’, ‘relative’, ‘parent’, ‘step-sibling’, ‘step-cousin’, ‘parent’, ‘family’ ‘stepmother’s cousin’, and ‘herd tester’). Given the predominance of reported male perpetrators relative to female perpetrators, it may be assumed that the majority of the perpetrators of unknown gender would also be male, suggesting that the
‘true’ proportion of male perpetrators, relative to their female counterparts, is even higher than indicated by the earlier reported gendered findings.

Included amongst perpetrators identified as authority figures were teachers (including preschool, school, music, and Sunday school); youth group and scout leaders; priests, nun, and other clergy (including a father and grandfather); babysitters; bosses/employers; football trainer/coaches; carers/foster carer/guardian; institutional staff; doctors; school counsellor and camp counsellor; academics; an older foster brother; and a psychiatrist; dentist; policeman; remedial masseuse; member of parliament; soldier; and politician.

Table 3.1
_Perpetrator Type Identified by Victims of Nonpenetrative Child Sexual Abuse (N = 845)_

<table>
<thead>
<tr>
<th>Perpetrator type</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trusted figure</td>
<td>42.13</td>
<td>356</td>
</tr>
<tr>
<td>Relative</td>
<td>41.07</td>
<td>347</td>
</tr>
<tr>
<td>Stranger</td>
<td>18.60</td>
<td>157</td>
</tr>
<tr>
<td>Well known acquaintance</td>
<td>15.86</td>
<td>134</td>
</tr>
<tr>
<td>Authority figure*</td>
<td>14.56</td>
<td>123</td>
</tr>
<tr>
<td>Friend</td>
<td>11.60</td>
<td>98</td>
</tr>
<tr>
<td>Casual acquaintance</td>
<td>11.01</td>
<td>93</td>
</tr>
<tr>
<td>Other**</td>
<td>9.23</td>
<td>78</td>
</tr>
<tr>
<td>Recent acquaintance</td>
<td>8.52</td>
<td>72</td>
</tr>
<tr>
<td>Boyfriend/girlfriend</td>
<td>6.98</td>
<td>59</td>
</tr>
<tr>
<td>Step/de facto parent**</td>
<td>6.39</td>
<td>54</td>
</tr>
<tr>
<td>Exboyfriend/girlfriend</td>
<td>2.37</td>
<td>20</td>
</tr>
<tr>
<td>First date</td>
<td>2.25</td>
<td>19</td>
</tr>
<tr>
<td>Occasional date</td>
<td>2.13</td>
<td>18</td>
</tr>
</tbody>
</table>

* As described above; predominantly male
** As described below; predominantly male

Note: Cumulative percentages sum to > 100, as many respondents experienced abuse by multiple perpetrators.

Perpetrators identified under the category ‘Step parent, de facto parent, or other parent figure’ included mothers’ boyfriends, lovers, and de facto partners, in addition to step
parents, other relatives and family friends, and a godfather, grandmother’s boyfriend, male servant, and sister (as primary carer). Respondents also placed a wide variety of persons in the ‘Other’ category, most commonly including babysitters, doctors, brothers’ friends, fathers’ friends/coworkers, brothers-in-law, sisters’ boyfriends/husbands, classmates, fathers/stepfathers/brothers/grandfather of friends, family friends, neighbourhood boys, older school boys, and shopkeepers. Additionally identified within this category were individuals such as: ‘family friend I was childminding for’, BMX track operator, handyman, worker employed in family home, elderly neighbour, school janitor, school bus driver, psychiatrist, boss, ‘cruise ship barman’, son of mother’s boyfriend, son of father’s girlfriend, person at a party, grandfather’s friend, boarder, flatmate, stepfather’s nephew, stepgrandfather, and ‘Satanists’. Additionally, for reasons that remain unclear, a number of perpetrators for whom specific categories existed (e.g., ‘Relative’, ‘Stranger’) were nonetheless placed into the Other category by some respondents. Such perpetrators included fathers, brothers, other relatives, teachers, doctors, scout masters, employers, strangers, and family friends. Thus, the percentages given under these headings in Table 3.1 represent a level of underenumeration within perpetrator types.

3.3.5 Prevalence of Penetrative Child Sexual Abuse by Victim Age and Perpetrator Typology

**Victim age**

As noted earlier, one quarter of the entire sample (26.1%; n = 537), and more than half of CSA victims (55.65%) reported experience of unwanted sexual intercourse in childhood. Most victims reported vaginal penetrative CSA (hereafter, referred to in this section as penetrative CSA) perpetrated by a male, acting alone (89.39%; n = 480). However, female-perpetrated penetrative CSA was also reported by 12.29% of victims (n = 66). Moreover, 10.62% of victims (n = 57) reported penetrative CSA perpetrated by a group of males (acting together), 1.86% of victims (n = 10) reported such abuse perpetrated by a group of females (acting together), and 2.98% of victims reported perpetration of this form of abuse by a group of mixed gender (n = 16).

Almost one half of victims of penetrative CSA reported experiencing this form of abuse whilst under the age of 10 years (44.13%; n = 237), and 30.8% had this experience on five or more occasions whilst under 10 (n = 161). Indeed, nearly one quarter of victims of penetrative CSA experienced this on more than 10 separate occasions whilst aged
under 10 years (23.3%; \( n = 122 \)), and only a minority had this experience on only a single occasion whilst under 10 (9.4%; \( n = 49 \)).

Additionally, most victims of penetrative CSA reported experiencing this abuse form between the ages of 10 and 15 years (83.7%; \( n = 451 \)), indicating that many victims had such experiences both within prepubescent/young childhood and in adolescence. A minority of those reporting penetrative CSA experienced this on only a single occasion between 10 and 15 years (18.7%; \( n = 101 \)). Indeed, almost half reported five or more occasions (49.6%; \( n = 261 \)), and 33.8% reported more than 10 occasions between the ages of 10 and 15 years (\( n = 182 \)).

As with nonpenetrative CSA, the recurrent nature of penetrative CSA is also evidenced by the finding that 74.0% of victims reported that the abuse occurred with the same person on more than one occasion (\( n = 367 \)). Moreover, 29.8% of victims of male-perpetrated penetrative CSA (\( n = 143 \)) reported having been offended against by at least two different males (acting alone). Similarly, of the victims of female-perpetrated penetrative CSA, 22.7% reported being perpetrated against by more than one female (acting independently) (\( n = 15 \)).

The phenomenon amongst victims of CSA of revictimisation by multiple perpetrators is exemplified by the following excerpts:

- I had problems with peers as a 13 year old. It was like I had a tattoo on my forehead "screw me"
- Almost entire childhood. I was sexually abused by father regularly, and by a few brothers, but one in particular dozens of times. So all up there would be hundreds of experiences....
- All the time (by my grandfather) until he died when I was 13. Then once by a doctor when I was 14.
- Almost daily for several years in the time frame. One male during the day; another during the night
- 2 of these times were with minors. The others, too many to count were with my father.
- 3-15yrs old, continual sexual abuse by father. Up to age 16 regular sexual assault by 1 brother. Handful of incidents involving 3 other brothers. One occasion of sexual abuse by stranger, age 3.
- First unwanted sexual experiences were with one older man. I was raped by about 6 men a few years later for many years

Perpetrator typology

As with nonpenetrative CSA, relatives and trusted figures were identified most commonly as the perpetrators of penetrative CSA (as evident in Table 3.2). Indeed,
relatives (32.59% \(n = 175\)) and trusted figures (24.21% \(n = 130\)) were identified as the perpetrators of this form of abuse by one third and one quarter of victims, respectively. Similarly, almost one quarter of victims reported boyfriends/girlfriends as the perpetrators of penetrative CSA (23.46% \(n = 126\)). Notably, males (i.e., boyfriends) comprised 80.2% of this perpetrator group \(n = 101\), females comprised 5.6% \(n = 7\), and for 14.3% of the group \(n = 18\), the gender was unspecified, suggesting that male perpetrators are likely underenumerated within the sample.

Table 3.2

*Perpetrator Type Identified by Victims of Penetrative Child Sexual Abuse (N = 537)*

<table>
<thead>
<tr>
<th>Perpetrator type</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative</td>
<td>32.59</td>
<td>175</td>
</tr>
<tr>
<td>Trusted figure</td>
<td>24.21</td>
<td>130</td>
</tr>
<tr>
<td>Boyfriend/girlfriend*</td>
<td>23.46</td>
<td>126</td>
</tr>
<tr>
<td>Well known acquaintance</td>
<td>13.04</td>
<td>70</td>
</tr>
<tr>
<td>Friend</td>
<td>12.29</td>
<td>66</td>
</tr>
<tr>
<td>Recent acquaintance</td>
<td>8.94</td>
<td>48</td>
</tr>
<tr>
<td>Casual acquaintance</td>
<td>8.94</td>
<td>48</td>
</tr>
<tr>
<td>Authority figure**</td>
<td>8.38</td>
<td>45</td>
</tr>
<tr>
<td>Stranger</td>
<td>8.01</td>
<td>43</td>
</tr>
<tr>
<td>Other**</td>
<td>6.52</td>
<td>35</td>
</tr>
<tr>
<td>First date</td>
<td>4.84</td>
<td>26</td>
</tr>
<tr>
<td>Step/de facto parent**</td>
<td>4.10</td>
<td>22</td>
</tr>
<tr>
<td>Occasional date</td>
<td>3.35</td>
<td>18</td>
</tr>
<tr>
<td>Exboyfriend/girlfriend</td>
<td>2.24</td>
<td>12</td>
</tr>
</tbody>
</table>

* As described above; predominantly male
** As described below; predominantly male

Note: Cumulative percentages sum to > 100, as many respondents experienced abuse by multiple perpetrators.

As with nonpenetrative CSA, the finding that the cumulative percentages in Table 3.2 sum to 160.91%, extends the earlier finding that many respondents experienced abuse by multiple perpetrators, by showing that respondents also experienced abuse perpetrated
by different types of perpetrators (e.g., relative AND trusted figure). The group of perpetrators identified as relatives comprised predominantly males, mostly fathers (33.14%; \( n = 58 \)), brothers (30.29%; \( n = 53 \)), and uncles (17.14%; \( n = 30 \)), and to a lesser extent, grandfathers (10.86%; \( n = 19 \)), brothers-in-law (4.00%; \( n = 7 \)), and stepbrothers (2.86%; \( n = 5 \)). However, cousins (of unspecified gender) also comprised 14.29% of identified relatives (\( n = 25 \)).

Female relatives identified as perpetrators were predominantly mothers (4.00%; \( n = 7 \)) and sisters (4.00%; \( n = 7 \)), and in rare instances, aunts (1.14%; \( n = 2 \)), and a grandmother (0.57%) and stepsister (0.57%).

Also included within the group of ‘perpetrator-relatives’ were a great uncle, father’s stepfather, and stepgrandfather, individuals of unspecified gender (e.g., ‘siblings’, ‘parent’, and ‘stepmother’s cousin’). Included amongst perpetrators identified as authority figures were teachers, bosses/employers, doctors, carers, father’s friends, family members, neighbours, child minder, clergy, nun, pilot, mother’s de facto, older foster brother, scout master, and lodger.

Perpetrators identified under the category ‘Step parent, de facto parent, or other parent figure’ included mothers’ boyfriends and de facto partners, in addition to stepfathers, ‘father figures’, babysitter, and family friend. Respondents placed a wide variety of persons in the ‘Other’ category, including babysitters, teachers, neighbourhood boys, brothers’ friends, brothers-in-law, sisters’ boyfriends, classmates, fathers/brothers of friends, family friends, teenage strangers at dance, neighbours, school bus driver, son of father’s girlfriend, stepgrandfather, person befriended in park, abductor, dentist, doctor, employer, friend’s boss, foster brother, and ‘Satanists’. Additionally, some respondents

* Just whenever my grandfather could he would touch me. I had cystitis from it starting when I was about 3. When I got my head around it being wrong and stopped him, he would 'stalk' me, hang around trying to catch me undressing or showering or whatever. That was worse, cos now i understood, was avoiding contact but he was still trying it on. Before I knew it was wrong, I must have thought the contact was because he cared (I didn’t get affection much) but after I understood and stopped him, I realised it was because he DIDN’T care, and exactly how much he didn’t care. The event that happened to make me realise it was wrong was when he tried to involve a friend in it. I was about 9, starting to realise that his interest in me was nqr, but that made it REALLY clear. Oh and having seen the authority figure question below, my father and grandfather were men of the cloth, so authority of the lord too...

* Over a three year period, while receiving counselling at school for the death of my brother’s suicide.
placed relatives within this category, including fathers, brother, sister, cousin, and ‘parent’, indicating a level of underenumeration within the perpetrator types presented in Table 3.2.

3.3.6 Perpetrator Strategies and Offence Characteristics

Respondents were asked to indicate which of a range of perpetrator strategies were applied in order to engage them in unwanted sexual activity in childhood. As evident in Table 3.3, victim grooming was the most dominant theme reported by CSA victims. Specifically, over three quarters of CSA victims reported that being treated ‘nicely’ by the perpetrator/s assisted to some degree in gaining their compliance and thereby, in facilitating abuse, and over half strongly endorsed this statement. Perpetrators’ use of lies or trickery; strategies of instilling a sense of guilt and obligation to comply; disregard of protests and expressed wishes to stop; and physical force or restraint, were also dominant tactics reported by the majority of CSA victims, and strongly used against more than one third of CSA victims. Use of intimidation, anger, verbal aggression, emotional manipulation, and physical violence was also reported by one third to one half of CSA victims. Similarly, being sought out by the perpetrator/s whilst asleep was reported by one third of victims, and acutely applicable to one quarter of CSA victims. This finding further illustrates the acute vulnerability to abuse confronting many children, and the abuse of trust encountered by many children in the absence of sanctuary within their home and under the protection of their principal carers.

Table 3.3
Victim-Identified Perpetrator Strategies Employed to Facilitate Child Sexual Abuse

<table>
<thead>
<tr>
<th>Strategy</th>
<th>To some degree</th>
<th>Very much or extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Treating me in a ‘nice’ manner so that, at the time, I went along with it</td>
<td>77.4</td>
<td>380</td>
</tr>
<tr>
<td>Telling me lies, or tricking me in some way</td>
<td>66.9</td>
<td>291</td>
</tr>
<tr>
<td>Making me feel guilty or somehow obliged to do it</td>
<td>65.0</td>
<td>326</td>
</tr>
<tr>
<td>Ignoring my protests and statements that I wished him to stop</td>
<td>63.6</td>
<td>309</td>
</tr>
</tbody>
</table>
Using some degree of physical force or restraint (e.g., holding me down with his or her body weight, or pinning my arms) 52.6 260 35.4 175

Using strong arguments or continual verbal pressure or showing displeasure (getting angry). 51.9 198 27.4 105

Verbally ordering me 49.6 209 28.7 121

Using emotional blackmail or tactics (e.g., ‘If you really loved me…’ or making false promises about the future, threatening to end the relationship or spread rumours about me). 48.4 213 29.4 129

Finding me when I was asleep 35.5 181 24.9 127

**Using strong arguments or continual verbal pressure or showing displeasure (getting angry).** 51.9 198 27.4 105

For a three year period. The word love was used at the time, however, I now understand it to have been molestation and rape/assault.

Respondents were also asked to indicate which of these strategies 'best describes what happened in [your] case'. As evident in Table 3.4, being treated 'nicely' or made to feel 'special' by the perpetrator was rated by the highest proportion of CSA victims (i.e., over one quarter of victims) as the single strategy that best described their abuse circumstance/s. In order of next highest rated perpetrator strategies, use of physical force or restraint and perpetrator-instilled sense of guilt and obligation to comply were identified as most pertinent in facilitating CSA.

- Frequently, over a three year period. The word love was used at the time, however, I now understand it to have been molestation and rape/assault.
Table 3.4
Victim-Identified Perpetrator Strategy Most Instrumental in Facilitating Child Sexual Abuse

<table>
<thead>
<tr>
<th>Strategy</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treating me in a ‘nice’ manner or making me feel ‘special’ so that, at the time, I went along with it.</td>
<td>202</td>
<td>27.1</td>
</tr>
<tr>
<td><strong>Using</strong> some degree of physical force or restraint (e.g., holding me down with his or her body weight, or pinning my arms)</td>
<td>85</td>
<td>11.4</td>
</tr>
<tr>
<td>Making me feel guilty or somehow obliged to do it.</td>
<td>76</td>
<td>10.2</td>
</tr>
<tr>
<td>Other (e.g., parent/caregiver facilitated sexual exploitation of child by another; cult, occult, or ‘satanism’ involvement)</td>
<td>61</td>
<td>8.2</td>
</tr>
<tr>
<td>Telling me lies, or tricking me in some way</td>
<td>53</td>
<td>7.1</td>
</tr>
<tr>
<td>Using emotional blackmail or tactics (e.g., ‘If you really loved me…’ or making false promises about the future, threatening to end the relationship or spread rumours about me).</td>
<td>47</td>
<td>6.3</td>
</tr>
<tr>
<td>Finding me when I was asleep</td>
<td>43</td>
<td>5.8</td>
</tr>
<tr>
<td>Ignoring my protests and statements that I wished him to stop</td>
<td>39</td>
<td>5.2</td>
</tr>
<tr>
<td><strong>Threatening</strong> to use some degree of <strong>physical</strong> force, restraint, or violence on me (or someone else).</td>
<td>21</td>
<td>2.8</td>
</tr>
<tr>
<td>Using strong arguments or continual verbal pressure or showing displeasure (getting angry).</td>
<td>21</td>
<td>2.8</td>
</tr>
<tr>
<td><strong>Using</strong> some degree of physical violence or aggression (e.g., hitting, punching, biting, choking)</td>
<td>19</td>
<td>2.6</td>
</tr>
<tr>
<td>Verbally ordering me</td>
<td>17</td>
<td>2.3</td>
</tr>
<tr>
<td>Harming me in a <strong>non-physical</strong> way.</td>
<td>17</td>
<td>2.3</td>
</tr>
<tr>
<td>Encouraging me to use alcohol or finding me when I was alcohol affected</td>
<td>12</td>
<td>1.6</td>
</tr>
<tr>
<td><strong>Threatening</strong> some sort of <strong>non-physical</strong> harm against me (or against someone else)</td>
<td>10</td>
<td>1.3</td>
</tr>
<tr>
<td><strong>Using</strong> a weapon</td>
<td>6</td>
<td>0.8</td>
</tr>
<tr>
<td>Encouraging me to use drugs or finding me when I was drug affected</td>
<td>5</td>
<td>0.7</td>
</tr>
<tr>
<td>Giving me drugs without my knowledge</td>
<td>4</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Threatening</strong> to use a weapon or implying or indicating that a weapon was present</td>
<td>4</td>
<td>0.5</td>
</tr>
<tr>
<td>Serving me high alcohol content drinks when they appeared to be regular strength drinks</td>
<td>3</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>745</td>
<td>100.00</td>
</tr>
</tbody>
</table>
3.3.7 Circumstances of Child Sexual Abuse: Perpetrator and Victim Variables

Respondents were also asked to indicate which of a range of internal and external factors (i.e., situations, victim variables, and perpetrator strategies) were applicable in their situation – either actively applied to advantage by the perpetrator in order to engage them in unwanted sexual activity, or otherwise serving (indirectly) to facilitate their abuse. As evident in Table 3.5, this list included both victim-centred variables (e.g., ‘As a child, I did as I was told’), and perpetrator-centred variables (e.g., ‘The person used physical force or violence.’) in order to gauge victims’ opinions regarding both internal and external factors that may have assisted in facilitating their abuse.

Obedience in childhood (i.e., ‘As a child, I did as I was told’) was ranked as applicable by the vast majority of CSA victims, and very or extremely applicable by almost two thirds, followed by emotional inability to stop the perpetrator, fear of blame or disbelief, and the perpetrator’s use of authority. Additionally, in order of ranked importance, more than half of CSA victims attributed a degree of applicability to the following factors: fearing the effects on family of CSA disclosure; being rendered fearful, numb, or ‘frozen’; being reassured by perpetrator; perpetrator disregard of protests and statements; inability to ‘say no’ through embarrassment or shyness; being physically overpowered; receiving special attention or made to feel ‘special’; perpetrator use of emotional blackmail; fearing the consequences of trying to stop the perpetrator, fearing rejection, and childhood curiosity. One quarter to one half of CSA victims identified such factors as very or extremely applicable to their abuse situation/s.

Table 3.5
Situations and Strategies Used by Perpetrators to Facilitate Child Sexual Abuse

<table>
<thead>
<tr>
<th>Situation or strategy</th>
<th>To some degree %</th>
<th>n</th>
<th>Very much or extremely %</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>As a child, I did as I was told.</td>
<td>83.4</td>
<td>620</td>
<td>61.3</td>
<td>456</td>
</tr>
<tr>
<td>I was emotionally unable to stop the person.</td>
<td>76.0</td>
<td>558</td>
<td>55.4</td>
<td>406</td>
</tr>
<tr>
<td>I feared I would be blamed or not believed.</td>
<td>70.7</td>
<td>511</td>
<td>55.2</td>
<td>399</td>
</tr>
</tbody>
</table>
The person used his or her authority. 69.7 512 48.0 353
I feared the effects on my family if I told someone. 63.6 459 47.5 343
I was unable to say no because I was scared, numb, or “frozen”. 67.9 496 45.9 335
The person said it was ok. 70.3 517 45.3 333
The person ignored my protests and statements. 67.6 492 43.8 319
I was unable to say no because I was embarrassed or shy. 65.8 478 40.5 294
The person overpowered me physically. 53.8 393 36.1 264
The person gave me attention or special treatment or made me feel special. 60.8 443 35.8 261
Person used emotional blackmail/tactics (I felt guilty / obliged / sorry for him) 56.0 406 33.4 242
I was too worried about the consequences of trying to stop them. 53.3 386 31.2 226
I feared rejection if I didn’t do it 51.0 370 24.8 180
The person used physical force or violence. 39.4 285 24.6 178
As a child, I was curious. 58.3 429 23.5 173
It made me feel loved or secure or gave me affection. 47.1 345 22.5 165
The person was angry, nasty or humiliating 41.5 300 22.3 161
The person threatened to physically hurt or punish me. 32.0 231 19.7 142
The person did not know or understand that it was against my wishes 40.1 290 17.3 125
The person threatened to hurt or punish me in some non-physical way. 29.4 211 15.5 111
The person gave me gifts, money or candy. 30.4 220 14.8 107
As a child, it felt good. 42.3 308 14.7 107
The person threatened to hurt or punish someone else (including pets). 18.9 136 12.1 87
I thought I (or someone else) might be killed or seriously injured if I resisted. 20.6 148 11.4 82
Other (e.g., parent/caregiver facilitated sexual exploitation of child by another; cult involvement) 10.5 76 9.8 71
I was unable to say no (under influence of alcohol) 9.4 67 4.5 32
I was unable to say no (under influence of drugs) 6.1 45 2.6 19
Perpetrator abuse of power and exploitation of childhood obedience are exemplified by these excerpts:

- In a way we "knew" these men and yet we didn’t. They were linked to the adults we knew - an extension of them. So, in a way they were "family" and to be respected and obeyed without questioning.
- Until 17 - whenever I wouldn’t do as I was told.
- Every night before being allowed to go to sleep.

The vulnerability of children to sexual abuse is demonstrated further by the finding that almost half of CSA victims reported that the abuse was a source of affection or made them feel loved or secure, and more than one in five endorsed this statement strongly. Moreover, whilst the use of anger, aggression, and violence was less commonly identified as applicable to the circumstances of the abuse, such tactics were nonetheless experienced by a sizable minority of CSA victims. Indeed, use of physical force, violence, anger, humiliation, or spite was identified by more than one third of CSA victims, and strongly applicable for almost one in four. Threats of physical harm or punishment were experienced by one third of CSA victims, and strongly applicable to the circumstances of abuse for one in five. Indeed, one in five CSA victims reported believing that they (or someone else) might be killed or seriously injured if they resisted, and more than ten percent rated this factor as strongly applicable to their abuse circumstance/s.

Respondents were also asked to indicate which of these factors was ‘most true for [you]’. As evident in Table 3.6, fear of being blamed or not believed as a child; fearing the effects on family of disclosing CSA; being rendered ‘frozen’ and unable to ‘say no’ through fear or numbness; and ingrained obedience and compliance in childhood were identified most commonly by CSA victims as single factors most strongly applicable to their abuse circumstances, followed by being physically overpowered, and made to feel ‘special’.

Table 3.6
Factor Most Instrumental in Perpetrator Engagement of Child in Sexual Abuse

<table>
<thead>
<tr>
<th>Situation or strategy</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feared I would be blamed or not believed</td>
<td>97</td>
<td>12.7</td>
</tr>
<tr>
<td>I feared the effects on my family if I told someone</td>
<td>67</td>
<td>8.8</td>
</tr>
</tbody>
</table>
I was unable to say no because I was scared, numb, or “frozen”. 61 8.0
As a child, I did as I was told. 54 7.1
The person overpowered me physically. 45 5.9
The person gave me attention or special treatment or made me feel special. 44 5.8
Other (e.g., parent/caregiver facilitated sexual exploitation of child by another; cult involvement) 37 4.8
I was unable to say no because I was embarrassed or shy. 33 4.3
It made me feel loved or secure or gave me affection. 32 4.2
As a child, I was curious. 30 3.9
The person said it was ok. 28 3.7
The person used physical force or violence. 27 3.5
Person used emotional blackmail/tactics (I felt guilty / obliged / sorry for him) 27 3.5
I was emotionally unable to stop the person. 24 3.1
The person used his or her authority. 23 3.0
The person ignored my protests and statements. 22 2.9
As a child, it felt good. 22 2.9
I thought I (or someone else) might be killed or seriously injured if I resisted. 14 1.8
I feared rejection if I didn’t do it 12 1.6
The person did not know or understand that it was against my wishes. 11 1.4
I was too worried about the consequences of trying to stop them. 9 1.2
The person gave me gifts, money or candy. 9 1.2
The person threatened to physically hurt or punish me. 8 1.1
The person threatened to hurt or punish someone else (including pets). 8 1.1
The person was angry, nasty or humiliating 7 0.9
I was unable to say no (under influence of alcohol). 6 0.8
The person threatened to hurt or punish me in some non-physical way. 4 0.5
I was unable to say no (under influence of drugs) 4 0.5

**TOTAL**

N = 765 100.00
3.3.8 Disclosure of Child Sexual Abuse

As evident in Table 3.7, almost half of CSA victims reported never having disclosed their experience/s of CSA to a family member, and fourteen percent reported never having disclosed this abuse to anyone. Respondents were relatively unlikely to disclose CSA during childhood. However, those who did so were more than twice as likely to have disclosed to a female (32.2%; \(n = 247\)), than to a male (14.8%; \(n = 113\)). Disclosure of CSA was much more likely to occur in adulthood, with only a marginal preference evident for disclosure to a female. Specifically, half of CSA victims reported having disclosed to a female (50.7%; \(n = 388\)), and only slightly fewer reported having disclosed to a male (47.2%; \(n = 360\)). More than one third of CSA victims expressed the desire to tell someone, more than one quarter expressed this desire but felt it was too difficult to do so, and one quarter expressed having 'no intentions of telling anyone'.

**Table 3.7**

*Disclosure of Child Sexual Abuse*

<table>
<thead>
<tr>
<th>Disclosure comment</th>
<th>True</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
</tr>
<tr>
<td>I have never told a family member about it</td>
<td>47.5</td>
</tr>
<tr>
<td>I told a female about it when I was a child (&lt;16)</td>
<td>32.2</td>
</tr>
<tr>
<td>I told a female about it only once I was an adult</td>
<td>50.7</td>
</tr>
<tr>
<td>I told a male about it when I was a child (&lt;16)</td>
<td>14.8</td>
</tr>
<tr>
<td>I told a male about it only once I was an adult</td>
<td>47.2</td>
</tr>
<tr>
<td>I have never told anyone about it</td>
<td>14.1</td>
</tr>
<tr>
<td>I would like to tell someone</td>
<td>39.2</td>
</tr>
<tr>
<td>I would like to tell someone but it is too difficult</td>
<td>27.7</td>
</tr>
<tr>
<td>I have no intentions of telling anyone.</td>
<td>25.6</td>
</tr>
</tbody>
</table>

Gender differences were found with respect to certain elements of disclosure. Indeed, males were significantly more likely than females to have never disclosed their experience of CSA to a family member, \(\chi^2(1, N = 773) = 12.49, p < .0005\), Cramér's \(V = .13\). In
contrast to 55.6% of females (n = 349), only 39.3% of males (n = 57) reported having disclosed CSA to a family member. Inspection of standardised residuals (SRs) reveals that males were the most disproportionately represented, being both significantly underrepresented amongst respondents who disclosed CSA to a family member (SR = -2.2), and significantly overrepresented amongst respondents who had not disclosed their CSA to a family member (SR = 2.3).

Males were also significantly less likely than females to have disclosed CSA to a female whilst under 16, \( \chi^2(1, N = 766) = 19.16, p < .0005, \) Cramér’s \( V = .16. \) In contrast to 35.7% of females (n = 224), only 16.5% of males (n = 23) reported having, whilst still in childhood, disclosed CSA to a female. Inspection of standardised residuals (SRs) reveals that males were the most disproportionately represented, being both significantly underrepresented amongst respondents who made such a disclosure (SR = -3.3), and significantly overrepresented amongst respondents who had not, as a child, made such a disclosure (SR = 2.2).

Additionally, males were almost twice as likely to have never disclosed their experience of CSA to anyone, relative to females, \( \chi^2(1, N = 757) = 13.30, p < .0005, \) Cramér’s \( V = .13. \) In contrast to only 12.0% of females (n = 74), 23.9% of males (n = 33) reported having never told anyone about their CSA. Inspection of standardised residuals (SRs) reveals that males were significantly overrepresented amongst respondents who had never disclosed their experience of CSA (SR = 3.1).

Similarly, males were more resolute than females in their intention not to disclose in the future, \( \chi^2(1, N = 746) = 9.10, p = .003, \) Cramér’s \( V = .11. \) In contrast to 23.3% of females (n = 142), 35.8% of males (n = 49) endorsed the statement, ‘I have no intentions of telling anyone.’ Inspection of standardised residuals (SRs) reveals that males were significantly overrepresented amongst respondents who endorsed this statement (SR = 2.4).

In contrast, no significant gender differences were found with respect to: i) disclosure towards a female only after reaching adulthood, \( \chi^2(1, N = 766) = 2.25, p = .13, \) Cramér’s \( V = .05; \) ii) disclosure towards a male either in childhood, \( \chi^2(1, N = 763) = 0.17, p = .68, \) Cramér’s \( V = .02, \) or in adulthood, \( \chi^2(1, N = 762) = 1.53, p = .22, \) Cramér’s \( V = .05; \) iii)
desire to disclose, $\chi^2(1, N = 744) = 0.07, p = .79$, Cramér’s $V = .01$; or iv) a wish to disclose but finding it too difficult to do so, $\chi^2(1, N = 746) = 0.27, p = .60$, Cramér’s $V = .02$. Specifically, 56.3% of males ($n = 80$) and 49.4% of females ($n = 308$) reporting disclosing CSA to a female only after having reached adulthood. A minority of males (15.9%; $n = 22$) and females (14.6%; $n = 91$) reported having disclosed CSA to a male whilst still under 16 years of age. Only disclosing CSA to a male after having reached adulthood was reported by 42.6% of males ($n = 60$) and 48.3% of females ($n = 300$). Thus, whilst females did not differ in their propensity to disclose CSA to females or males, males appeared marginally more likely to disclose to females than to males.

The wish to disclose CSA was expressed equally amongst males and females. Specifically, 38.2% of males ($n = 52$) and 39.5% of females ($n = 240$) endorsed the statement ‘I would like to tell someone’. Similarly, 25.9% of males ($n = 35$) and 28.2% of females ($n = 172$) endorsed the statement ‘I would like to tell someone, but it is too difficult’.

3.3.9 Perceived Benefit of Child Sexual Abuse Disclosure

As evident in Table 3.8, disclosure of CSA in adulthood was perceived as more beneficial than disclosure in childhood. By far the highest proportion of CSA victims rated disclosure to a female in adulthood as the most beneficial, although it is also notable that one quarter of victims reported no preference.

<table>
<thead>
<tr>
<th>What was most beneficial?</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telling a female as an adult</td>
<td>44.4</td>
<td>214</td>
</tr>
<tr>
<td>No preference</td>
<td>24.3</td>
<td>117</td>
</tr>
<tr>
<td>Telling a male as an adult</td>
<td>16.2</td>
<td>78</td>
</tr>
<tr>
<td>Telling a female as a child</td>
<td>12.7</td>
<td>61</td>
</tr>
<tr>
<td>Telling a male as a child</td>
<td>2.5</td>
<td>12</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100.0</td>
<td>N = 482</td>
</tr>
</tbody>
</table>

The wish to disclose CSA was expressed equally amongst males and females. Specifically, 38.2% of males ($n = 52$) and 39.5% of females ($n = 240$) endorsed the statement ‘I would like to tell someone’. Similarly, 25.9% of males ($n = 35$) and 28.2% of females ($n = 172$) endorsed the statement ‘I would like to tell someone, but it is too difficult’.  

Table 3.8
Perceived Benefit of Child Sexual Abuse Disclosure
3.3.10 Confidante Gender Preferences of Child Sexual Abuse Victims

Respondents were also asked to specify in overall terms, the gender type they had found it most helpful to converse with in relation to their experience of CSA. Consistent with the earlier findings, and as evident in Table 3.9, the majority of respondents reported finding it most helpful to speak with a female, although over one fifth of respondents stated no gender preference, and a sizable minority identified speaking with a male as most helpful. Respondents who endorsed ‘Other’ were asked to specify. Their responses reflect the importance of factors such as SO, personality type, individual differences, and also the futility and negative outcomes of disclosure perceived by some CSA victims.

Table 3.9
Confidante Gender Preferences of Child Sexual Abuse Victims

<table>
<thead>
<tr>
<th>Gender</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>58.9</td>
<td>365</td>
</tr>
<tr>
<td>No preference</td>
<td>22.3</td>
<td>138</td>
</tr>
<tr>
<td>Males</td>
<td>14.4</td>
<td>89</td>
</tr>
<tr>
<td>Other (e.g., SO, personality type)</td>
<td>3.9</td>
<td>24</td>
</tr>
<tr>
<td>Not applicable as I told no one or only one person</td>
<td>0.7</td>
<td>4</td>
</tr>
</tbody>
</table>

100.0  \( N = 620 \)

Given that such gender preferences may well vary as a function of victim gender and that these results may have been, at least to some extent, an artefact of a predominance of females within the victim sample, it was important to also examine confidante gender preferences within victim gender groups. As expected on the basis of the previous (whole sample) results, female victims showed a strong preference for female confidantes, such that 66.0% of female victims for whom this question was applicable stated a preference for female confidantes (\( n = 322 \)), and only 11.9% stated a preference for male confidantes (\( n = 58 \)). It is notable however, that 22.1% of female victims stated having no gender preference (\( n = 108 \)). Male victims similarly showed a preference for female confidantes, albeit, a less pronounced preference than that seen amongst female victims,
such that males were more evenly divided in terms of gender preferences. Specifically, 41.4% of males preferred a female confidante \((n = 43)\), 29.8% preferred a male confidante \((n = 31)\), and 28.9% stated having no gender preference \((n = 30)\).

### 3.3.11 Confidante Type Choices of Child Sexual Abuse Victims

Respondents were asked to indicate with whom they had spoken about their CSA experience/s, in terms of confidante type. As shown in Table 3.10, a friend was the most popular choice of confidante, with two thirds of respondents reporting that they had spoken with a friend/s regarding their CSA. Whilst partners were the next most popular choice of confidante, followed by family, counsellor, psychologist, and psychiatrist, reported figures indicate nonetheless that less than sixty percent of CSA victims had actually spoken with a partner about their childhood experience/s of sexual abuse, only half had spoken with family, less than one third had spoken with a counsellor, and fewer had spoken with a psychologist or psychiatrist, or others. These findings highlight the continuation into adulthood of the secrecy, loneliness, and isolation which characterise the lives of many who experience sexual abuse in childhood.

These findings demonstrate also the privileged position in which both health professionals and those close to victims of CSA, are placed, and concomitantly, the potentially critical implications of their response on victim wellbeing. Whilst the imperative of competent responses from health professionals is clear, these results also underscore the importance of public education to raise empathic awareness and understanding of the issues surrounding childhood sexual abuse.

<table>
<thead>
<tr>
<th>Confidante type</th>
<th>%</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friend</td>
<td>66.67</td>
<td>500</td>
</tr>
<tr>
<td>Partner</td>
<td>58.27</td>
<td>437</td>
</tr>
<tr>
<td>Family</td>
<td>49.89</td>
<td>374</td>
</tr>
<tr>
<td>Counsellor</td>
<td>31.07</td>
<td>233</td>
</tr>
<tr>
<td>Psychologist</td>
<td>28.93</td>
<td>217</td>
</tr>
<tr>
<td>Confidante Type</td>
<td>Percentage</td>
<td>N</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>------------</td>
<td>----</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>21.20</td>
<td>159</td>
</tr>
<tr>
<td>Sexual assault counsellor</td>
<td>19.6</td>
<td>147</td>
</tr>
<tr>
<td>Doctor/nurse</td>
<td>18.8</td>
<td>141</td>
</tr>
<tr>
<td>No one</td>
<td>13.60</td>
<td>102</td>
</tr>
<tr>
<td>Police</td>
<td>10.53</td>
<td>79</td>
</tr>
<tr>
<td>Colleague</td>
<td>10.00</td>
<td>75</td>
</tr>
<tr>
<td>Stranger</td>
<td>6.53</td>
<td>49</td>
</tr>
<tr>
<td>Religious figure</td>
<td>6.00</td>
<td>45</td>
</tr>
<tr>
<td>Friend's parent</td>
<td>5.47</td>
<td>41</td>
</tr>
<tr>
<td>Teacher</td>
<td>5.33</td>
<td>40</td>
</tr>
<tr>
<td>Other (e.g., coach, manager)</td>
<td>5.07</td>
<td>38</td>
</tr>
</tbody>
</table>

\[N = 750\]

### 3.3.12 Confidante Type Perceived Most Helpful by Victims of Child Sexual Abuse

Respondents who had disclosed their CSA experience/s were asked to indicate with which confidante type they had found it most helpful to converse (i.e., *Which of these figures (e.g., friend) did you find it most helpful to talk to?*). As seen in Table 3.11, friends were rated as the most helpful of the confidante types, followed by partners, psychologists, family members, counsellors, and sexual assault counsellors. Together, these confidante types accounted for 79.1% of respondents’ preferences \((n = 498)\), with almost half accounted for by friends, partners, and family \((48.6%; n = 306)\). This highlights not only the important role of psychologists and counsellors in assisting victims of CSA, but also the critical role played by nonhealth professionals. Thus, these findings further demonstrate the need to disseminate accurate information and develop informed understanding of childhood sexual abuse at the community level. Ostensibly, nonhealth professionals are frequently privileged by vulnerable individuals who entrust them with important and sensitive information. To avoid revictimisation through inappropriate confidante responses, it is important that public education occurs such that disclosures of CSA and other sensitive issues are appositely received and associated needs of distressed individuals are addressed in effective, nonjudgmental, and nonpunitive ways. It is of concern to note that seven percent of respondents found that ‘no one’ was of help to them in regard to speaking about CSA \((n = 44)\).
Table 3.11
Confidante Type Perceived Most Helpful by Victims of Child Sexual Abuse

<table>
<thead>
<tr>
<th>Confidante type</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friend</td>
<td>21.9</td>
<td>138</td>
</tr>
<tr>
<td>Partner</td>
<td>15.1</td>
<td>95</td>
</tr>
<tr>
<td>Psychologist</td>
<td>12.4</td>
<td>78</td>
</tr>
<tr>
<td>Family</td>
<td>11.6</td>
<td>73</td>
</tr>
<tr>
<td>Counsellor</td>
<td>10.6</td>
<td>67</td>
</tr>
<tr>
<td>Sexual assault counsellor</td>
<td>7.5</td>
<td>47</td>
</tr>
<tr>
<td>No one</td>
<td>7.0</td>
<td>44</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>4.6</td>
<td>29</td>
</tr>
<tr>
<td>Other (e.g., coach, manager)</td>
<td>3.3</td>
<td>21</td>
</tr>
<tr>
<td>Teacher</td>
<td>1.4</td>
<td>9</td>
</tr>
<tr>
<td>Doctor/nurse</td>
<td>1.1</td>
<td>7</td>
</tr>
<tr>
<td>Police</td>
<td>1.0</td>
<td>6</td>
</tr>
<tr>
<td>Stranger</td>
<td>1.0</td>
<td>6</td>
</tr>
<tr>
<td>Colleague</td>
<td>0.8</td>
<td>5</td>
</tr>
<tr>
<td>Religious figure</td>
<td>0.6</td>
<td>4</td>
</tr>
<tr>
<td>Friend’s parent</td>
<td>0.3</td>
<td>2</td>
</tr>
</tbody>
</table>

N = 631

3.3.13 Reactions to Child Sexual Abuse Disclosure

As evident in Table 3.12, only 36.1% of CSA victims reported having, whilst still a child, to some extent discussed their experience/s of CSA with a friend/s or relative/s (36.1%; \( n = 220 \)), and less than one in ten reported doing so ‘very much’ or ‘extremely’ (9.9%; \( n = 60 \)).
### Table 3.12

Reactions to Child Sexual Abuse Disclosure

<table>
<thead>
<tr>
<th>Victim statement</th>
<th>To some degree</th>
<th>Very or extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Positive, supportive, understanding, protective</td>
<td>50.9</td>
<td>137</td>
</tr>
<tr>
<td>Awkwardness, discomfort, we avoided it</td>
<td>74.2</td>
<td>198</td>
</tr>
<tr>
<td>Suspicious, challenging, didn’t understand</td>
<td>59.0</td>
<td>157</td>
</tr>
<tr>
<td>Hostility, rejection, blaming</td>
<td>50.4</td>
<td>135</td>
</tr>
<tr>
<td>Overall, talking to family or friends was helpful to me as a child</td>
<td>40.6</td>
<td>110</td>
</tr>
<tr>
<td>Overall, I regret talking to family or friends about this as a child.</td>
<td>50.0</td>
<td>135</td>
</tr>
</tbody>
</table>

Unfortunately, positive reactions from family and friends were substantially lacking. Three quarters of respondents reported encountering awkwardness, discomfort, and avoidance, and almost half reported acutely experiencing such reactions. More than half encountered suspicion, challenging reactions, and lack of understanding, and one third experienced such reactions acutely. Similarly, half of respondents reported hostility, rejection, and blame, with almost one third acutely experiencing such reactions. In contrast, only half of respondents reported to some extent receiving ‘positive, supportive, understanding, and protective’ reactions from family or friends, and only one in five reported receiving such reactions ‘very much’ or ‘extremely’.

Regrettably, only 40.6% of respondents reported that overall, speaking with family or friends had been helpful to some degree ($n = 110$), and only 13.7% had found this very or extremely helpful ($n = 37$). Conversely, half of respondents expressed some degree of regret overall, with respect to talking with friends or family about their CSA experience/s (50.0%; $n = 135$), and one in four expressed very much or extreme regret (24.8%; $n = 67$).
My mother bought me pink champagne to take to a friend’s house for my 14th birthday, and I was made to drink it. After I fell asleep, a friend’s brother attempted to have sex with me, and the stress caused amenorrhea, which resulted in me thinking I was pregnant. No support from mother at all, only blame for being “that kind of girl”. Very stressful.

3.3.14 Counselling for Child Sexual Abuse

As seen in Table 3.13, few respondents received counselling in childhood in relation to their sexual abuse. Moreover, it is concerning to note that, of those who did receive counselling in childhood, only one third perceived this to be have been helpful to some degree, and only 8.5% of victims found this very or extremely helpful. In contrast, more optimistic results were found in relation to counselling received in adulthood in relation to sexual abuse experienced in childhood. Of the 52.8% of CSA victims who had received counselling in adulthood, 82.8% reported finding this helpful to some extent. Nonetheless, it remains of concern that less than half of these respondents found counselling very or extremely helpful, less than one third reported having had a substantial amount of counselling, and close to half reported having had no counselling in adulthood in relation to CSA.

Table 3.13
Counselling for Child Sexual Abuse

<table>
<thead>
<tr>
<th>Victim statement</th>
<th>To some degree</th>
<th>Very or extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>As a child [&lt;16], I received services or counselling for this.</td>
<td>10.1</td>
<td>63</td>
</tr>
<tr>
<td>Overall, this was helpful</td>
<td>34.7</td>
<td>33</td>
</tr>
<tr>
<td>As an adult, I received services or counselling for this.</td>
<td>52.8</td>
<td>285</td>
</tr>
<tr>
<td>Overall, this was helpful</td>
<td>82.8</td>
<td>246</td>
</tr>
</tbody>
</table>
3.3.15 Confronting the Perpetrator

Only 6.5% of CSA victims ($n = 40$) reported confronting the perpetrator/s about the event/s at the time, and only 14.2% reported doing so many years later ($n = 88$). Thus, by far the majority of CSA perpetrators were never confronted by their victim (79.3%; $n = 491$). Similarly, a minority of perpetrators were known by the victim to have been confronted by a third party regarding the event/s, either at the time (10.2%; $n = 62$), or many years later (12.4%; $n = 75$). Over half of CSA victims (57.0%; $n = 346$) reported that the perpetrator/s was never confronted by a third party, and 20.4% were unsure ($n = 124$). These findings highlight again, the secrecy surrounding CSA, the relative rarity of perpetrator accountability, and the impunity with which many perpetrators of CSA are able to offend.

3.3.16 Police Reporting of Child Sexual Abuse During the Victim’s Childhood: Offence Characteristics, Victim Perceptions, and Outcomes

Victim perceptions regarding police reporting

Only a small minority of respondents reported that the incident/s of CSA was reported to the police whilst they were still a child under 16 years (6.9%; $n = 53$). Of those, 59.6% perceived this ‘Not at all’ helpful ($n = 31$), 28.9% found this to have been ‘A little’ or ‘Moderately’ helpful ($n = 15$), and only 11.5% of respondents found such reporting to have been ‘Very’ or ‘Extremely’ helpful ($n = 6$). Moreover, 76.7% of these respondents perceived that overall, the outcome had been ‘Not at all fair’ ($n = 33$), 18.6% perceived the outcome to have been a little or moderately fair ($n = 8$), and only 4.7% perceived there to have been a very or extremely fair outcome ($n = 2$).

Notwithstanding such perceptions, it is salient to note that, with respect to the question ‘Do you regret reporting to the police?’, over half of these respondents responded ‘Not at all’ (57.4%; $n = 27$). A further 19.2% reported ‘A little’ or ‘Moderate’ regret ($n = 9$), and more than one in four respondents reported ‘Very much’ or ‘Extremely’ regretting that they had reported the matter (25.6%; $n = 11$). Moreover, almost half of these respondents reported some regret over not having reported sooner to police (42.9%; $n = 12$), with one in four expressing very much or extreme regret (25.0%; $n = 7$), and almost one in five expressing a little or moderate regret (17.9%; $n = 5$).
Offence and offender characteristics

Of these respondents, more than one in four had had additional (nonsexual) crimes (e.g., violent physical assault, theft) perpetrated against them by the perpetrator of their sexual abuse (26.0%; \( n = 13 \)), and 41.2% were aware that the perpetrator had also committed offences against another person \( (n = 21) \).

Perpetrator outcomes of police reporting

Of the respondents whose CSA had been reported whilst they were still a child, less than half reported that the person was caught (41.2%; \( n = 21 \)), 51.0% reported that the person was not caught \( (n = 26) \), and 7.8% reported not having this information \( (n = 4) \). Most respondents reported that the person was not charged (63.3%, \( n = 31 \)), with 22.5% of respondents reporting that the person was charged \( (n = 11) \), and 14.3% reporting not being privy to this information \( (n = 7) \). Similarly, the majority reported that the person was not convicted (58.5%; \( n = 24 \)), 19.5% reported not having this information \( (n = 8) \), and 22.0% reported that a conviction was made against the person \( (n = 9) \).

Given that only a small minority of CSA victims had had the matter reported to the police during their childhood, these percentages represent a small proportion of actual perpetrators. Indeed, given that 770 CSA victims responded to the questions regarding police reporting (but of those, 93.1% had not made a police report), the low levels at which perpetrators were apprehended, charged, or convicted at the time, is clear. Specifically, when one considers the perpetrators pertaining to both the CSA victims whose matter had been reported to police and those for whom no report had been made, only 6.9% were reported to police during the victim’s childhood \( (n = 53) \), 2.7% were known to have been caught \( (n = 21) \), 1.4% were reported as having been charged \( (n = 11) \), and 1.2% were reported to have been convicted \( (n = 9) \).

3.3.17 Police Reporting of Child Sexual Abuse During the Victim’s Adulthood: Offence Characteristics, Victim Perceptions, and Outcomes

Victim perceptions regarding police reporting

As with police reporting of CSA during the victim’s childhood, only a small minority of CSA victims reported their abuse to police upon reaching adulthood (7.4%; \( n = 52 \)). However, of those who did so, most reported this to have been helpful to some degree (62.7%; \( n = 32 \)). Specifically, 45.1% found this to have been a little or moderately helpful
(n = 23) and 17.6% found it very or extremely helpful (n = 9), whilst 37.3% perceived such reporting to have been ‘Not at all’ helpful (n = 19). Nonetheless, 75.5% of these respondents perceived that overall, the outcome had been ‘Not at all fair’ (n = 37), 18.4% perceived the outcome to have been a little or moderately fair (n = 9), and only 6.1% perceived there to have been a very or extremely fair outcome (n = 3).

In the context of such mixed findings, it is salient to note that, with respect to the question ‘Do you regret reporting to the police?’, over half of these respondents responded ‘Not at all’ (55.8%; n = 29). A further 26.9% reported ‘A little’ or ‘Moderate’ regret (n = 14), and almost one in five respondents reported ‘Very much’ or ‘Extremely’ regretting that they had reported the matter in adulthood (17.3%; n = 9). Conversely, most of these respondents reported some regret over not having reported sooner to police (76.6%; n = 36), with almost half expressing very much or extreme regret (46.8%; n = 22), and more than one in four expressing a little or moderate regret (29.8%; n = 14).

Offence and offender characteristics
Of these respondents, almost half had had additional (nonsexual) crimes (e.g., violent physical assault) perpetrated against them by the perpetrator of their sexual abuse (46.0%; n = 23), and most were aware that the perpetrator had also committed offences against another person (63.5%; n = 33).

Perpetrator outcomes of police reporting
Of the respondents who reported their CSA to police after reaching adulthood, less than half reported that the person was caught (48.1%; n = 25), 44.2% reported that the person was not caught (n = 23), and 7.7% reported not having this information (n = 4). Most respondents reported that the person was not charged (63.5%, n = 33), with 32.7% of respondents reporting that the person was charged (n = 17), and 3.9% reporting not being privy to this information (n = 2). Similarly, the majority reported that the person was not convicted (71.4%; n = 35), 10.2% reported not having this information (n = 5), and 18.4% reported that a conviction was made against the person (n = 9).

Given that only a small minority of CSA victims had the matter reported to police either during their childhood or in adulthood, apprehension, charges, and convictions reported reflect only a small proportion of actual perpetrators. Overall, amongst the 770 CSA
victims that responded to the questions regarding police reporting, only 10.2% perpetrators were known to have been caught, either in the victim’s childhood or during their adulthood \((n = 52)\), 6.0% were reported as having ever been charged \((n = 30)\), and 4.8% were reported to have ever been convicted \((n = 21)\).

### 3.3.18 Nonreporting of Child Sexual Abuse to Police: Offence Characteristics, Victim Perceptions, and Outcomes

**Victim perceptions in relation to non-reporting of CSA**

For the vast majority of CSA victims, their abuse as not reported to police in either childhood or adulthood \((87.3\%; n = 672)\). Notably, more than half of those whose CSA was never reported to police expressed some level of regret in this regard \((52.6\%; n = 273)\), with 36.0% expressing a little or moderate regret \((n = 187)\), and 16.6% expressing very much or extreme regret \((n = 86)\).

**Offence and offender characteristics**

Of the respondents whose CSA had never been reported to police, 10.1% had had additional (nonsexual) crimes (e.g., violent physical assault, theft) perpetrated against them by the perpetrator of their sexual abuse \((n = 56)\), and 25.8% were aware of offences that the perpetrator had committed against another person \((n = 148)\). Comparison of these findings with those reported above in relation to police-reported CSA suggests that police reporting was more likely when additional crimes had been perpetrated and when the victim was aware that crimes had also been perpetrated against others.

### 3.3.19 Adult Sexual Victimisation and Intimate Partner Violence: Comparison of Child Sexual Abuse Victims and Nonvictims

**Adult sexual abuse**

Respondents who had experienced CSA were proportionately much more likely to have also experienced sexual abuse in adulthood, relative to CSA nonvictims, \(\chi^2(1, N = 1663) = 50.73, p < .0005\), Cramér’s \(V = .18\). Indeed, 43.0% of respondents who had experienced CSA \((n = 294)\) had also experienced adulthood sexual abuse (ASA), in contrast to 26.3% of respondents who had not experienced CSA \((n = 258)\). Amongst respondents who had experienced ASA, more than half \((53.3\%, n = 294)\) had also experienced CSA, in contrast to 35.0% of respondents who had not experienced ASA \((n = 389)\). Inspection of standardised residuals (SRs) reveals that victims of CSA and ASA
were the most disproportionately represented, relative to nonvictims. Specifically, victims of CSA were particularly overrepresented amongst victims of ASA ($\text{SR} = 4.5$), and underrepresented amongst nonvictims of ASA ($\text{SR} = -3.2$). Equally, victims of ASA were significantly underrepresented amongst respondents who had not experienced CSA ($\text{SR} = -3.7$), and nonvictims of CSA were significantly overrepresented amongst nonvictims of ASA ($\text{SR} = 2.6$).

A significant gender difference was found in CSA survivors with respect to sexual revictimisation in adulthood, $\chi^2(1, \ N = 683) = 20.50, p < .0005, \text{Cramer's } V = .17$. Female CSA survivors were almost twice as likely to report experience of sexual abuse in adulthood, with 47% reporting ASA ($n = 265$), in contrast to 24.4% of male CSA victims ($n = 29$). Inspection of standardised residuals ($\text{SRs}$) reveals that male victims of CSA and were both significantly underrepresented amongst ASA victims ($\text{SR} = -3.1$), and significantly overrepresented amongst nonvictims of ASA ($\text{SR} = 2.7$).

**Intimate partner violence**

Respondents who reported experience of CSA were also at significantly disproportionate risk of intimate partner violence (IPV), relative to non-CSA victims, $\chi^2(1, \ N = 1103) = 40.35, p < .0005, \text{Cramer's } V = .191$. Indeed, victims of CSA were more than twice as likely (29.1%, $n = 136$) to have also identified as victims of IPV in adulthood, relative to those who had not reported CSA (13.5%, $n = 86$). Moreover, 61.36% of IPV victims had also reported CSA ($n = 136$), in contrast to 37.7% of non-IPV victims ($n = 332$). Inspection of standardised residuals ($\text{SRs}$) reveals that victims of CSA and IPV were the most disproportionately represented, relative to nonvictims. Specifically, victims of CSA were particularly overrepresented amongst victims of IPV ($\text{SR} = 4.3$), and significantly underrepresented amongst nonvictims of IPV ($\text{SR} = -2.2$). Moreover, victims of IPV were significantly underrepresented amongst respondents who had not experienced CSA ($\text{SR} = -3.7$).

Whilst a trend suggested that female CSA survivors were more prone to IPV, the gender difference was not statistically significant, $\chi^2(1, \ N = 468) = 3.02, p = .08, \text{Cramer's } V = .08$. Specifically, 30.6% of female CSA survivors ($n = 122$), and 20.3% of male CSA survivors ($n = 14$) identified as victims of IPV in adulthood.
3.3.20 Physical Injury and Risk Exposure Resultant from Child Sexual Abuse

Physical injuries
Thirty-one percent of respondents \( (n = 231) \) reported sustaining some level of physical injury as a result of CSA (e.g., bleeding, anal and vaginal tearing, bruising, soreness, ‘love’ bites). Moreover, 11.0% of respondents reported Extremely (6.8%; \( n = 51 \)) or Very Much (4.2%; \( n = 31 \)) sustaining such injury. Such injuries included head, genital, and internal injuries and ruptures requiring hospitalisation and in some cases, surgery.

Exposure to risk of sexually transmitted infection
One third of CSA victims reported having been exposed to the risk of a sexually transmitted infection (STI) as a consequence of CSA (33.9%; \( n = 257 \)). However, only 16.5% of CSA victims reported having been tested for any infection possibly contracted from the perpetrator/s \( (n = 125) \). Given that respondents may have undergone testing after some (but not all) exposure to risk of STI, the option to respond both Yes and No to this question was provided. Notably, 86.3% of CSA victims reported not having undergone testing for STI contracted from a CSA perpetrator/s \( (n = 655) \), indicating that only 2.8% of respondents were, in fact, tested after some (but not all) exposure \( (n = 21) \).

Notably, only 10.0% of respondents reported that the perpetrator/s ‘used a condom on every occasion of unwanted penile penetration’ \( (n = 33) \), suggesting that respondents’ own summation of their exposure to risk of STI represents a substantial underestimation.

An STI contracted following CSA was reported by 2.4% of CSA victims \( (n = 18) \). A further 10.7% of respondents reported being Unsure as to whether they had contracted an STI from the perpetrator \( (n = 81) \).

Exposure to possibility of pregnancy
Amongst female victims of all forms of CSA, 29.1% reported having been exposed to the possibility of a pregnancy in the course of CSA \( (n = 179) \). A further 23.9% reported that this question was not applicable \( (n = 147) \), and 47.0% reported no such exposure \( (n = 289) \). Thus, this figure represents 38.3% of female victims for whom this question was applicable (i.e., because penile-vaginal penetrative CSA had occurred, and puberty had been reached).
However, with respect to condom use, only 10.0% of female victims reported that a condom had been used on every occasion of penile penetration ($n = 27$), suggesting, as with risk perception regarding STI, that respondents’ appraisal of risk represents an underestimation of actual risk. (Notably, male CSA victims responded almost identically to this question, in that only 9.7% reported condom use on every occasion of unwanted penile penetration [$n = 6$]).

Forty females reported that such exposure within the context of CSA resulted in a pregnancy. This represents 5.0% of female respondents who reported any form of CSA (i.e., including nonpenetrative CSA). However, this figure also represents 22.4% of the females who reported exposure to the possibility of pregnancy in the course of CSA.

3.3.21 Feelings Experienced Subsequently to Child Sexual Abuse

Victims of CSA were asked to describe the feelings they experienced following the sexual abuse event/s, by rating a range of both positive and negative statements (listed in Table 3.14). As evident in this table, negative feelings predominated, with the largest majority of victims reporting to some degree ‘trying to pretend nothing had happened’, and two thirds strongly endorsing this statement. This finding reveals some of the pressures of secrecy, repression, and isolation that exist for many child victims of sexual abuse. Similarly, shame; guilt; and feeling ‘dirty’ or bad were reported by over 80% of respondents and acutely present in 58-64% of respondents. Feelings of sadness; anger; hurt, rejection, or betrayal; and hate toward the perpetrator were also reported by most CSA victims and acutely present in around half of victims.

The findings that one third of respondents reported seriously considering suicide in the days or weeks following their experience/s of CSA, and one in five reported ‘very much’ or ‘extreme’ suicidal ideation within this timeframe, attest further to the high level of negative emotion experienced by many children following such abuse. These results are also consistent with the finding that less than one third of respondents reported ‘feeling good about [themselves]’ to some degree, and less than one in ten reported feeling very or extremely good about themselves in the period following the abuse.

Moreover, more than two thirds of CSA victims reported such suicidal ideation at some later point in their lives, and over half reported very much or extreme suicidal ideation at
some time subsequent to the event/s. More than one third of CSA victims reported having attempted suicide since their experience of CSA. Notably, 81% of CSA victims who had attempted suicide subsequently to experience of sexual abuse attributed the attempt/s to the CSA to some degree, and over half did so ‘very much’ or ‘extremely’.

Whilst two thirds of CSA victims reported feeling some degree of hate towards the perpetrator/s and close to half reported acute feelings of hate, it is notable that a sizable minority of respondents also reported varying degrees of positive feelings toward the perpetrator/s. Specifically, more than one third of CSA victims reported to some degree liking, trusting, or loving the person/s, and feeling loved by, or ‘special’ because of the person/s, and 15-19% reported strongly experiencing such feelings. These findings offer testimony to the conflictual nature of the relationship many child victims of sexual abuse have with the perpetrator, demonstrating the mix of emotions experienced by many sexual abuse victims, and the confusion, hurt, and cognitive dissonance surrounding betrayal and abuse of trust, affection, and love felt toward the perpetrator.

Particularly for child victims perpetrated against by their primary carers, such conflict is intensifed due to their dependency for survival on these figures, and the implicit trust and love ordinarily held by children toward these the central figures in their lives. The continued presence of residual trust, love, and affection for some perpetrators following abuse highlights also the vulnerability of victims for revictimisation, the difficulties many victims experience in distancing themselves from the perpetrator/s, and specifically, the potential for exploitation of such emotions by the original and subsequent perpetrators.

Clearly, for children perpetrated against by primary carers and close relatives, distancing themselves is rarely viable or within their control, exacerbating not only their vulnerability for revictimisation but also the perturbation and risk to wellbeing frequently concomitant with powerlessness to affect change in one’s circumstances and perceived hopelessness of one’s situation. Indeed, the strong relationship known to exist between hopelessness and suicidality may explain much of the link also found between suicidality and child sexual abuse.
Table 3.14  
*Feelings Experienced by Victims Subsequently to Child Sexual Abuse (N = 763)*

<table>
<thead>
<tr>
<th>“How I felt after….”</th>
<th>To some degree</th>
<th>Very or extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>I tried to pretend nothing had happened.</td>
<td>87.1</td>
<td>665</td>
</tr>
<tr>
<td>I felt ashamed</td>
<td>84.5</td>
<td>645</td>
</tr>
<tr>
<td>I felt ‘dirty’ or like I was bad.</td>
<td>82.0</td>
<td>626</td>
</tr>
<tr>
<td>I felt guilty</td>
<td>81.0</td>
<td>618</td>
</tr>
<tr>
<td>I felt sad</td>
<td>79.1</td>
<td>604</td>
</tr>
<tr>
<td>I felt angry</td>
<td>71.1</td>
<td>543</td>
</tr>
<tr>
<td>At some later point in my life I thought seriously about killing myself.</td>
<td>67.5</td>
<td>515</td>
</tr>
<tr>
<td>I hated the person</td>
<td>65.5</td>
<td>500</td>
</tr>
<tr>
<td>I felt hurt or rejected or betrayed.</td>
<td>63.6</td>
<td>485</td>
</tr>
<tr>
<td>I liked the person</td>
<td>47.5</td>
<td>362</td>
</tr>
<tr>
<td>I trusted the person</td>
<td>43.9</td>
<td>335</td>
</tr>
<tr>
<td>I loved the person</td>
<td>41.0</td>
<td>313</td>
</tr>
<tr>
<td>I felt loved by the person</td>
<td>38.8</td>
<td>296</td>
</tr>
<tr>
<td>I felt special because of the person</td>
<td>36.7</td>
<td>280</td>
</tr>
<tr>
<td>I felt good about myself</td>
<td>31.6</td>
<td>241</td>
</tr>
<tr>
<td>In the days or weeks after the event(s), I thought seriously about killing myself.</td>
<td>30.6</td>
<td>234</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>True</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
</tr>
<tr>
<td>I have attempted suicide since the event(s).</td>
<td>38.8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If true, how much do you believe your attempt(s) was due to the event(s)?</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80.5</td>
<td>238</td>
</tr>
</tbody>
</table>
3.3.22 Victim Adulthood Perceptions Regarding Child Sexual Abuse

As evident in Table 3.15, the overwhelming majority of CSA victims considered the event/s to have been damaging to some degree, and more than half rated the event/s as very or extremely damaging to themselves. Similarly, over ninety percent of victims conceptualised the event/s as sexual assault to some extent, and three quarters endorsed this perception ‘very much’ or ‘extremely’. Ninety percent of respondents viewed the event/s as a crime to some degree, and two thirds endorsed this perception ‘very much’ or ‘extremely’. Respondents were less inclined to conceptualise the event/s as ‘rape’. Nonetheless, more than half of CSA victims to some degree endorsed the statement “What happened to me was rape”, and over one third of victims held this view ‘very much’ or ‘extremely’. This finding demonstrates the importance of using behavioural terminology in preference to label descriptors of sexual assault in order to minimise ambiguity, effects of variations in definitions of terms such as ‘rape’, and possible effects of applying terminology with highly emotive and social overtones and widely variant nuance.

Whilst the overwhelming majority of CSA victims strongly attributed responsibility for the event/s to the perpetrator/s, it is noteworthy that almost half of CSA victims also perceived themselves to some degree responsible for the event/s, and more than one in ten perceived themselves ‘very much’ or ‘extremely’ responsible. Such findings have clear implications for understanding child sexual assault trauma and guiding therapeutic intervention. Examples include the following excerpts:

- … but I do think it happened more because of my behaviour as a child - I did things I could never admit to anyone - but maybe it’s normal if you are abused over a long period of time?

- I can’t remember the exact number, with this particular person. It may have been around 10-15 times. Please note that these experiences were followed by a period of very destructive sexual behaviour where I engaged with sexual acts with other men who were more than 2 years older than me, however it’s hard to recall exact numbers and ages, so I only recorded the one male whom I considered to have sexually abused me and set of the chain of self-abuse. However I attempted to remember these incidences below.

Most respondents reported some degree of difficulty in talking about their experience/s of CSA, and over half reported finding this very or extremely difficult. Such difficulties clearly impede help-seeking and service provision and exacerbate isolation, and thereby, vulnerability to perturbation, revictimisation, and suicidality. Indeed, implications for victim needs and wellbeing arise also from the finding that most respondents expressed
some degree of regret, and over one third expressed very much or extreme regret in regard to not having spoken sooner or more about their CSA experience/s.

Table 3.15  
Victim Adulthood Perceptions Regarding Child Sexual Abuse (N = 765)

<table>
<thead>
<tr>
<th>Victim perception</th>
<th>To some degree</th>
<th>Very or extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>What happened was damaging to me.</td>
<td>90.7</td>
<td>694</td>
</tr>
<tr>
<td>What happened to me was a crime.</td>
<td>89.2</td>
<td>682</td>
</tr>
<tr>
<td>What happened to me was sexual assault.</td>
<td>92.7</td>
<td>709</td>
</tr>
<tr>
<td>What happened to me was rape.</td>
<td>55.6</td>
<td>425</td>
</tr>
<tr>
<td>I was responsible for what happened.</td>
<td>43.7</td>
<td>334</td>
</tr>
<tr>
<td>The other person was responsible for what happened</td>
<td>97.4</td>
<td>745</td>
</tr>
<tr>
<td>I regret not talking sooner or more about what happened</td>
<td>70.4</td>
<td>539</td>
</tr>
<tr>
<td>How difficult has it been to talk about the event(s)?</td>
<td>89.2</td>
<td>682</td>
</tr>
</tbody>
</table>

3.3.23 Relationships Between Childhood Sexual Abuse and Current Psychological Wellbeing

A one-way between-groups multivariate analysis of variance was performed to examine the relationship between CSA and psychological wellbeing. Nine parameters of psychological health were used as dependent variables to assess overall wellbeing: (i) depression; (ii) anxiety; (iii) stress; (iv) self-esteem; (v) shame; (vi) guilt; (vii) aggression; and (viii) posttraumatic symptomotology; and (ix) life satisfaction. A statistically significant difference was found between nonvictims and victims of CSA on the combined dependent variables, \( F(9, 871) = 8.35, p < .0005, \) Wilks’ \( \Lambda = .92, \) partial \( \eta^2 = .08. \) When the results for the dependent variables were considered separately, significant differences were found for seven of the nine variables, using a Bonferroni adjusted alpha level of .006. Specifically, differences between victims and nonvictims were found with respect to anxiety, \( F(1, 879) = 14.05, p < .0005, \) partial \( \eta^2 = .02; \) stress, \( F(1, 879) = 10.24, p = .001, \) partial \( \eta^2 = .01; \) shame, \( F(1, 879) = 19.66, p < .0005, \) partial \( \eta^2 = .02; \) guilt, \( F(1, 879) = 17.06, p < .0005, \) partial \( \eta^2 = .02; \) aggression, \( F(1, 879) = 15.25, p < .0005, \) partial
\( \eta^2 = .02; \) posttraumatic symptomatology, \( F(1, 879) = 63.63, p < .0005, \) partial \( \eta^2 = .07; \) and life satisfaction, \( F(1, 879) = 11.30, p = .001, \) partial \( \eta^2 = .01. \) No significant difference was found with respect to depression, \( F(1, 879) = 6.91, p = .009, \) partial \( \eta^2 = .01; \) or self-esteem, \( F(1, 879) = 5.39, p = .02, \) partial \( \eta^2 = .01. \)

Inspection of the mean scores indicated that victims reported greater anxiety (\( M = 11.11, SD = 10.89 \)), relative to nonvictims (\( M = 8.46, SD = 9.87 \)); more stress (\( M = 17.69, SD = 11.70 \)) than nonvictims (\( M = 15.23, SD = 10.89 \)); more shame (\( M = 15.97, SD = 8.12 \)) than nonvictims (\( M = 13.61, SD = 7.50 \)); more guilt (\( M = 9.80, SD = 5.04 \)) than nonvictims (\( M = 8.41, SD = 4.84 \)); higher aggression (\( M = 67.18, SD = 19.92 \)) than nonvictims (\( M = 62.02, SD = 18.89 \)); greater posttraumatic symptomatology (\( M = 53.50, SD = 16.58 \)) than nonvictims (\( M = 44.25, SD = 17.18 \)); and lower life satisfaction (\( M = 22.78, SD = 10.10 \)) than nonvictims (\( M = 25.15, SD = 10.45 \)).

### 3.3.24 Current Psychological Wellbeing of Child Sexual Abuse Survivors: A Gender Comparison

A one-way between-groups multivariate analysis of variance of these nine psychological health parameters was repeated in order to compare current psychological wellbeing of male and female survivors of CSA.Whilst a statistically significant difference was found between male and female victims of CSA on the combined dependent variables, \( F(9, 353) = 2.39, p = .01, \) Wilks’ \( \Lambda = .92, \) partial \( \eta^2 = .06, \) when the results for the dependent variables were considered separately, differences for individual variables were not statistically significant, using a Bonferroni adjusted alpha level of .006. However, gender differences with respect to posttraumatic symptomatology, \( F(1, 361) = 3.86, p = .05, \) partial \( \eta^2 = .01, \) and aggression, \( F(1, 361) = 3.17, p = .08, \) partial \( \eta^2 = .01, \) approached significance, with a trend suggesting higher posttraumatic symptomatology (\( M = 54.27, SD = 16.29 \)) and lower aggression (\( M = 66.34, SD = 19.82 \)) in female CSA victims, relative to male victims (posttraumatic symptomatology: \( M = 49.74, SD = 17.60 \); aggression: \( M = 71.27, SD = 20.10 \)).

### 3.3.25 Child Sexual Abuse and Suicide Attempt

Respondents who had experienced CSA were proportionately more likely to have attempted suicide, \( \chi^2(1, N = 1177) = 47.82, p < .0005, \) Cramér’s \( V = .202. \) Indeed, 29.1% of respondents who had experienced CSA (\( n = 195 \)) had attempted suicide, in contrast to 21.1% of respondents who had not experienced CSA (\( n = 144 \). Amongst
suicide attempters, more than half (57.5%, \( n = 195 \)) had experienced CSA. In contrast, 35.6% of nonattempters had experienced CSA \( (n = 298) \). Inspection of standardised residuals (\( SRs \)) reveals that victims of CSA were the most disproportionately represented, being most significantly overrepresented amongst suicide attempters \( (SR = 4.4) \), and underrepresented amongst nonattempters \( (SR = -2.8) \). Conversely, respondents who had not experienced CSA were most significantly underrepresented amongst suicide attempters \( (SR = -3.8) \), and overrepresented amongst nonattempters \( (SR = 2.4) \).

No statistically significant gender difference was found with respect to attempted suicide in CSA survivors, \( \chi^2(1, \, N = 493) = 2.33, \, p = .13, \) Cramér’s \( V = .07 \). Specifically, 41.1% of female CSA survivors \( (n = 168) \) and 32.1% of male survivors \( (n = 27) \) reported having attempted suicide.

### 3.3.26 Child Sexual Abuse and Suicidal Ideation

Respondents who had experienced CSA were proportionately also more likely to have seriously contemplated suicide, relative to nonvictims of CSA, \( \chi^2(1, \, N = 1205) = 20.19, \, p < .0005, \) Cramér’s \( V = .13 \). Indeed, 74.1% of respondents who had experienced CSA \( (n = 374) \) had contemplated suicide, in contrast to 61.7% of respondents who had not experienced CSA \( (n = 432) \). Amongst suicide contemplators, 46.4% had experienced CSA \( (n = 374) \), in contrast to 32.8% of noncontemplators \( (n = 131) \). Inspection of standardised residuals (\( SRs \)) reveals that victims of CSA were significantly overrepresented amongst suicide contemplators \( (SR = 2.0) \), and underrepresented amongst noncontemplators \( (SR = -2.8) \). Conversely, respondents who had not experienced CSA were overrepresented amongst noncontemplators \( (SR = 2.4) \).

As with suicide attempt, no statistically significant gender difference was found with respect to occurrence of suicidal ideation (SI) in CSA survivors, \( \chi^2(1, \, N = 505) = 1.81, \, p = .18, \) Cramér’s \( V = .06 \). Specifically, 75.2% of female CSA survivors \( (n = 316) \) and 68.2% of male survivors \( (n = 58) \) reported having seriously contemplated suicide.

### 3.3.27 Comparison of Suicidal Ideation Across Four Time Points

A one-way repeated measures ANOVA was conducted to compare SI across four time-points: (i) in the days or weeks preceding CSA (Shortly Before: SB); (ii) some earlier time preceding CSA (Earlier Time: ET); (iii) in the days or weeks following CSA (Shortly
After: SA); and (iv) at some later time following CSA (Later Time: LT). The means and
standard deviations are presented in Table 3.16. A significant effect was found for time,
\[ F(3, 629) = 246.86, p < .0005, \text{Wilks’ } \Lambda = .46, \text{ multivariate partial } \eta^2 = .54. \] Repeated
measures \( t \)-tests were conducted to identify where significant differences were present.
Statistically significant differences, using a Bonferroni adjusted alpha level of .008, were
for found between all time periods. Specifically, there was a significant increase in SI
between Shortly Before CSA and Shortly After CSA, \( t(669) = -9.98, p < .0005, \eta^2 = .13; \)
and a larger significant increase between Shortly Before and a Later Time, \( t(673) = -
28.28, p < .0005, \eta^2 = .54 \) (signifying a very large effect size). Similarly, a significant
increase in SI was found an Earlier Time before CSA and Shortly After CSA, \( t(646) = -
6.41, p < .0005, \eta^2 = .06; \) however, a much larger significant increase was found between
an Earlier Time before CSA and a Later Time after CSA, \( t(647) = -24.25, p < .0005, \eta^2 =
.48 \) (a very large effect size).

Table 3.16

Suicidal Ideation Prior and Subsequently to Child Sexual Abuse \((N = 632)\)

<table>
<thead>
<tr>
<th>Time period</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earlier in life (ET)</td>
<td>1.46</td>
<td>1.12</td>
</tr>
<tr>
<td>Shortly before CSA (SB)</td>
<td>1.32</td>
<td>.92</td>
</tr>
<tr>
<td>Shortly after CSA (SA)</td>
<td>1.81</td>
<td>1.41</td>
</tr>
<tr>
<td>Later in life (LT)</td>
<td>3.26</td>
<td>1.76</td>
</tr>
</tbody>
</table>

The two time periods before CSA (Shortly Before and Earlier Time) were also examined
for differences in SI frequency using a repeated measures \( t \)-test. A statistically significant
lower frequency of SI was noted, using a Bonferroni adjustment for multiple
comparisons, between the time period Shortly Before, and an Earlier Time, \( t(696) = -
3.57, p < .0005, \eta^2 = .02. \) In itself, this result is not surprising given that SB represents a
short time period whereas ET refers to all years of life prior to CSA. Similarly, upon
examination of the two time periods following CSA (Shortly After and Later Time), a significantly higher frequency of SI was found in the Later Time period compared with the time period Shortly After, $t(741) = -22.39, p < .0005, \eta^2 = .40$ (signifying a very large effect size). Again, this is not so surprising given that ‘shortly after’ represents a short time frame, in contrast to ‘later time’ which encompasses all time elapsed since childhood, and given the fact that respondents are now adults of all ages. Further, the difference between earlier and later time is not altogether surprising given that ‘earlier’ is a time-limited period (limited by young age at one end and the occurrence of CSA at the other) that falls in childhood, and given that SI becomes less likely the younger the child. In contrast, ‘later time’ represents a wide timeframe (i.e., spanning from occurrence of CSA until survey participation – a period that could span decades). In view of these considerations, it can be argued that the most telling finding from this analysis is the difference found between the equal time periods: ‘shortly before’ and ‘shortly after’ - even though the effect size signified a smaller effect than found for ET & LT, and SB & LT. The significant result found between ET and SA is also noteworthy given that the later measure represents a shorter timeframe, and therefore a conservative test, that nevertheless still produced a moderate effect. Nonetheless, in light of the limitations noted with respect to this analysis of SI frequency across time, it may be more meaningful to examine percentages pertaining to SI across time. These are presented in Table 3.17.

Inspection of Table 3.17 reveals that, of the respondents who identified as CSA victims, 82.8% had never seriously contemplated suicide prior to their experience of CSA ($n = 589$), and 86.6% had not contemplated suicide in the days or weeks preceding the assault ($n = 640$). Yet, within the days or weeks after the CSA, the proportion of respondents who had not contemplated suicide within this timeframe had fallen to 69.4% ($n = 519$), and indeed, only 32.5% of CSA victims reported having never subsequently contemplated suicide. Instead, the proportion of respondents reporting ever contemplating suicide ‘extremely’ increased from 6.2% at any time prior to CSA ($n = 44$) to 41.6% at some time point post-CSA ($n = 315$). As with the previous analysis, it can still be argued that pre-CSA only represents a short period of childhood. Thus, the more telling result is that deriving from a comparison between shortly before and shortly after. Shortly before the CSA, only 3.4% of respondents had ‘extremely’ contemplated suicide
(n = 25). Within the days and weeks following the CSA, this proportion had risen to 11.9% (n = 89).

Table 3.17

Suicidal Ideation in Time Periods Before and After Child Sexual Abuse

<table>
<thead>
<tr>
<th>Time period</th>
<th>% Not at all</th>
<th>% A little</th>
<th>% Moderately</th>
<th>% Very much</th>
<th>% Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earlier in life</td>
<td>82.8 (589)</td>
<td>3.9 (28)</td>
<td>3.7 (26)</td>
<td>3.4 (24)</td>
<td>6.2 (44)</td>
</tr>
<tr>
<td>Shortly before</td>
<td>86.6 (640)</td>
<td>3.8 (28)</td>
<td>3.9 (29)</td>
<td>2.3 (17)</td>
<td>3.4 (25)</td>
</tr>
<tr>
<td>Shortly after</td>
<td>69.4 (519)</td>
<td>8.0 (60)</td>
<td>5.6 (42)</td>
<td>5.1 (38)</td>
<td>11.9(89)</td>
</tr>
<tr>
<td>Later in life</td>
<td>32.5 (246)</td>
<td>6.7 (51)</td>
<td>9.0 (68)</td>
<td>10.2 (77)</td>
<td>41.6(315)</td>
</tr>
</tbody>
</table>

3.3.28 Comparison of Suicide Attempts Before and After Experience of Child Sexual Abuse

The temporal relationship between CSA and suicide attempt was also explored (i.e., suicide attempt pre- and post-CSA). Of the CSA survivors who responded to this question series, 6.4% had attempted suicide on at least one occasion prior to their experience of sexual assault (n = 48). In contrast, 38.8% of CSA victims attempted suicide at least once subsequently to their sexual victimisation (n = 119). The limitation must be noted that the time subsequent to CSA can potentially span decades of adulthood, in contrast to the comparatively short and time-limited period that can exist prior to CSA.

Nonetheless, of the latter respondents, only 19.5% considered their suicide attempt/s to be ‘not at all’ related to their experience of sexual victimisation in childhood (n = 60). In contrast, 80.5% believed their suicide attempt/s to be related to their experience of CSA to some degree (n = 247). Specifically, 10.1% of respondents believed the attempt/s to
be due to the CSA to a small degree ($n = 31$); $19.2\%$ attributed the attempt/s ‘moderately’ to the CSA ($n = 59$); $18.9\%$ believed the attempt/s to be ‘very much’ due to the CSA ($n = 58$); whilst the largest proportion of respondents ($32.2\%$) believed the attempt/s to be ‘extremely’ due to the CSA ($n = 99$).

### 3.3.29 Victim Perceptions of Child Sexual Abuse: Comparison Between Subsequent Suicide Attempters and Nonattempters

Within respondents who had experienced CSA, a one-way between-groups multivariate analysis of variance was performed to examine differences in perceptions regarding the sexual abuse between respondents who had attempted suicide subsequently to CSA, and those who had not. Six dependent variables were used to assess overall perception: (i) ‘What happened was damaging to me’; (ii) ‘What happened to me was a crime’; (iii) ‘What happened to me was sexual assault’; (iv) ‘What happened to me was rape’; (v) ‘I was responsible for what happened’; and (vi) ‘The other person was responsible for what happened’. A statistically significant difference was found between suicide attempters and nonattempters on the combined dependent variables, $F(6, 722) = 15.00, p < .0005$, Wilks’ $\Lambda = .89$, partial $\eta^2 = .11$. When the results for the dependent variables were considered separately, significant differences were found for five of the six variables, using a Bonferroni adjusted alpha level of .008.

Specifically, differences were found in the degree to which the CSA was regarded as damaging, $F(1, 727) = 54.88, p < .0005$, partial $\eta^2 = .07$; the degree to which the CSA was regarded as a crime, $F(1, 727) = 32.13, p < .0005$, partial $\eta^2 = .04$; the degree to which the CSA was regarded as sexual assault, $F(1, 727) = 29.87, p < .0005$, partial $\eta^2 = .04$; and in the degree to which the CSA was regarded as rape, $F(1, 727) = 61.42, p < .0005$, partial $\eta^2 = .08$. Moreover, attempters and nonattempters varied in the degree to which they attributed responsibility for the CSA to themselves, $F(1, 727) = 7.25, p < .007$, partial $\eta^2 = .01$. No significant difference was found in the degree to which attempters and nonattempters attributed responsibility for the CSA to the perpetrator, $F(1, 727) = .65, p = .42$, partial $\eta^2 = .001$.

Inspection of the mean scores indicated that suicide attempters were more likely to regard the CSA as very damaging ($M = 4.09, SD = 1.21$) compared with nonattempters ($M = 3.35, SD = 1.39$); more likely to view the CSA as a crime ($M = 4.25, SD = 1.21$)
than nonattempters ($M = 3.65, SD = 1.49$); more likely to view the CSA as sexual assault ($M = 4.39, SD = 1.09$) than nonattempters ($M = 3.86, SD = 1.39$); more likely to view the CSA as rape ($M = 3.34, SD = 1.77$) than nonattempters ($M = 2.32, SD = 1.67$); and likely to attribute more responsibility for the CSA to themselves ($M = 2.01, SD = 1.24$) than nonattempters ($M = 1.77, SD = 1.13$).

### 3.3.30 Victim Disclosure & Attribution of Suicide Attempt to Prior Child Sexual Abuse Experience

Within CSA victims who had attempted suicide, a series of independent-samples $t$-tests, with Bonferroni adjustments for multiple comparisons, were conducted to examine the degree to which they believed their suicide attempt/s to be due to their CSA experience. Specifically, it was of interest to examine whether the extent to which this belief was held varied with respect to various aspects of CSA disclosure.

#### General disclosure of child sexual abuse

Of the CSA victims who had attempted suicide, 87.96% had made a disclosure of their CSA experience ($n = 263$). It was found that respondents who had disclosed CSA to another person attributed their suicide attempt/s more strongly to their CSA experience ($M = 3.48, SD = 1.44$), relative to respondents who had never told anyone of their CSA ($M = 2.08, SD = 1.38$), $t(297) = -5.49, p < .0005, \eta^2 = .09$.

#### Disclosure of child sexual abuse to a family member

Of the CSA victims who had attempted suicide, 52.32% had disclosed their experience of CSA to a family member ($n = 144$). It was found that attempters who had made this type of disclosure attributed their suicide attempt/s more strongly to their CSA experience ($M = 3.92, SD = 1.25$), relative to attempters who had not made such a disclosure ($M = 2.67, SD = 1.49$), $t(280.09) = -7.90, p < .0005, \eta^2 = .17$.

#### Disclosure to a female or male figure whilst still a child (under age 16)

Of the CSA victims who had attempted suicide, 31.23% had disclosed their experience of CSA to a female whilst still a child (under 16) ($n = 94$). Respondents who had made this type of disclosure more strongly attributed their suicide attempt/s to their CSA experience ($M = 3.71, SD = 1.32$), compared with respondents who had not disclosed to a female during childhood ($M = 3.15, SD = 1.55$), $t(209.71) = 3.25, p = .001, \eta^2 = .03$. In contrast, only 16.94% of the CSA victims who had attempted suicide had disclosed their
experience to a male whilst still a child \((n = 94)\). No statistical difference was found in attribution of suicide attempts to CSA between respondents who had disclosed to a male \((M = 3.55, SD = 1.54)\), and those who had not \((M = 3.28, SD = 1.49)\), \(t(299) = 1.19, p = .24\).

Desire and intention to disclose child sexual abuse
Of the CSA victims who had attempted suicide, 41.08\% endorsed the statement “I would like to tell someone” about the CSA \((n = 122)\). Respondents who expressed this desire more strongly attributed their suicide attempt/s to their CSA experience \((M = 3.65, SD = 1.41)\), relative to respondents who did not wish to tell someone \((M = 3.08, SD = 1.51)\), \(t(295) = 3.27, p = .001, \eta^2 = .04\).

Similarly, 76.43\% of respondents disagreed with the statement “I have no intention of telling anyone” \((n = 227)\). These respondents more strongly attributed their suicide attempt/s to their CSA experience \((M = 3.62, SD = 1.39)\), relative to respondents who reported having ‘no intention of telling anyone’ \((M = 2.33, SD = 1.41)\), \(t(295) = -6.76, p < .0005, \eta^2 = .02\).

Barriers to child sexual abuse disclosure
Over one quarter of CSA victims (27.8\%) endorsed the statement that “I would like to tell someone but it is too difficult” \((n = 203)\). These respondents were more likely to have attempted suicide at some later time, \(\chi^2(1, N = 729) = 12.91, p < .0005\), Cramér’s \(V = .13\). Indeed, 49.3\% of respondents who endorsed this statement \((n = 100)\) had attempted suicide, in contrast to 34.8\% of respondents who disagreed with this statement \((n = 183)\).

Moreover, 35.3\% of suicide attempters endorsed this statement \((n = 100)\), in contrast to only 23.1\% of nonattempters \((n = 103)\). Inspection of standardised residuals (\(\delta R\)s) reveals that respondents who endorsed this statement were significantly overrepresented amongst suicide attempters \(\delta R = 2.4\).

Reporting child sexual abuse to the police
Of the CSA victims who had attempted suicide, 9.64\% reported that, whilst they were still under 16, the incident/s was reported to the police \((n = 29)\). Respondents whose CSA matters were reported to the police more strongly attributed their suicide attempt/s
to their CSA experience \((M = 3.97, SD = 1.27)\), than respondents for whom no police report was made \((M = 3.26, SD = 1.51)\), \(t(37.06) = 2.80, p = .008 \eta^2 = .03\).

Similarly, 9.19% of respondents indicated that they reported the CSA in adulthood \((n = 26)\). Respondents who reported the CSA in adulthood more strongly attributed their suicide attempt/s to their CSA experience \((M = 4.31, SD = 1.12)\), relative to respondents who did not report the matter in adulthood \((M = 3.22, SD = 1.51)\), \(t(34.91) = 4.53, p < .0005, \eta^2 = .07\).

3.3.31 Disclosure Reactions and Related Victim Regrets: Comparison Between Suicide Attempters and Nonattempters

Within CSA victims, a one-way between-groups multivariate analysis of variance was performed to examine differences in disclosure and its effects between respondents who had attempted suicide subsequently to CSA, and those who had not. Six dependent variables were used to assess CSA disclosure and its effects: (i) helpfulness of talking to friends or family as a child; (ii) regrets regarding talking to friends or family as a child; (iii) hostile, rejecting, or blaming reactions from family or friends as a child; (iv) as a child, receiving counselling or services for CSA; (v) as an adult, receiving counselling or services for CSA; and (vi) degree of difficulty experienced in talking about CSA. A statistically significant difference was found between suicide attempters and nonattempters on the combined dependent variables, \(F(6, 183) = 9.80, p < .0005\), Wilks’ \(\Lambda = .76\), partial \(\eta^2 = .24\).

When the results for the dependent variables were considered separately, significant differences were found for five of the six variables, using a Bonferroni adjusted alpha level of .008. Specifically, differences were found in the regrets experienced in regard to discussing CSA with family/friends in childhood, \(F(1, 188) = 22.01, p < .0005\), partial \(\eta^2 = .11\); the level of hostile, blaming, or rejecting reactions experienced, \(F(1, 188) = 16.63, p < .0005\), partial \(\eta^2 = .08\); the extent of counselling or services for CSA received as a child, \(F(1, 188) = 17.22, p < .0005\), partial \(\eta^2 = .08\); the extent of counselling or services for CSA received in adulthood, \(F(1, 188) = 20.32, p < .0005\), partial \(\eta^2 = .10\); and in the degree of difficulty experienced in talking about the CSA, \(F(1, 188) = 24.13, p < .0005\), partial \(\eta^2 = .11\). No significant difference was found in the degree to which attempters
and nonattempters found it helpful to talk about the CSA in childhood, $F(1, 188) = 6.78$, $p = .01$, partial $\eta^2 = .04$.

Inspection of the mean scores indicated that suicide attempters experienced more regrets regarding disclosure to family/friends in childhood ($M = 2.84, SD = 1.69$) compared with nonattempters ($M = 1.83, SD = 1.29$); more hostile, blaming, or rejecting reactions in childhood ($M = 3.01, SD = 1.64$) than nonattempters ($M = 2.06, SD = 1.53$); more counselling or services for CSA in childhood ($M = 1.97, SD = 1.45$) than nonattempters ($M = 1.29, SD = .83$); more counselling or services for CSA in adulthood ($M = 3.27, SD = 1.54$) than nonattempters ($M = 2.23, SD = 1.53$); and more difficulty in talking about the CSA ($M = 4.17, SD = 1.16$) than nonattempters ($M = 3.17, SD = 1.49$).

Within CSA victims, an independent-samples $t$-test, with a Bonferroni adjustment for multiple comparisons, was conducted to compare levels of regret experienced by suicide attempters and nonattempters in relation to not talking more or sooner about their experience/s of CSA. Suicide attempters reported significantly more regrets with respect to insufficient or delayed disclosure ($M = 3.09, SD = 1.59$), than nonattempters ($M = 2.77, SD = 1.55$), $t(737) = -2.78, p = .006, \eta^2 = .01$.

Within CSA victims, an independent-samples $t$-test, with a Bonferroni adjustment for multiple comparisons, was conducted to compare subsequent suicide attempters and nonattempters in terms of the extent of physical injuries sustained as a result of CSA. Subsequent suicide attempters reported sustaining a significantly higher degree of physical injuries ($M = 2.04, SD = 1.39$), than nonattempters ($M = 1.47, SD = 1.04$), $t(468.74) = -5.91, p < .0005, \eta^2 = .05$.

3.3.3.2 Police Reporting of Child Sexual Abuse During Childhood: Comparison Between Suicide Attempters and Nonattempters

Few cases of CSA (7.0%) were reported to the police whilst the victim was still a child (under 16 years) ($n = 52$). However, of the respondents for whom the matter was reported, more than half attempted suicide at some later time, $\chi^2(1, N = 748) = 8.56, p = .003$, Cramér’s $V' = .11$. Indeed, 57.7% of respondents whose matter was reported during childhood ($n = 30$) had attempted suicide, in contrast to 37.2% of respondents whose case was not reported to the police ($n = 259$). Moreover, 10.4% of suicide attempters had
had their matter reported to police \((n = 30)\), in contrast to only 4.8% of nonattempters \((n = 22)\). Inspection of standardised residuals \((\delta R_s)\) reveals that respondents whose matter was reported to police were significantly overrepresented amongst suicide attempters \((\delta R = 2.2)\).

### 3.3.33 Police Reporting of Child Sexual Abuse in Adulthood: Comparison of Suicide Attempters and Nonattempters

A similar minority of CSA cases \((7.3\%)\) were reported to the police when the victim had reached adulthood \((n = 50)\). However, no significant difference was found in suicide attempts between respondents who reported the matter and those who did not, \(\chi^2(1, N = 688) = 2.54, p = .11\), Cramér’s \(V = .06\).

### 3.3.34 Experience of Additional Crimes: Comparison Between Suicide Attempters and Nonattempters

A minority of CSA victims \((13.8\%)\) reported that the perpetrator/s had committed additional crimes against them \((n = 90)\). These respondents were substantially more likely to have attempted suicide at some later time, \(\chi^2(1, N = 654) = 24.92, p < .0005\), Cramér’s \(V = .20\). Indeed, most of the respondents who reported additional crimes against them \((63.3\%)\) had attempted suicide \((n = 57)\), in contrast to 35.6% of respondents who reported no additional victimisation by the perpetrator/s \((n = 201)\).

Moreover, 22.1% of suicide attempters reported additional victimisation \((n = 57)\), in contrast to only 8.3% of nonattempters \((n = 33)\), representing an almost three-fold overrepresentation of additionally victimised respondents amongst suicide attempters. Inspection of standardised residuals \((\delta R_s)\) confirms that respondents who reported additional victimisation by the perpetrator/s were both significantly overrepresented amongst suicide attempters \((\delta R = 3.6)\) and significantly underrepresented amongst nonattempters \((\delta R = -2.9)\).

### 3.3.35 Perpetrator Crimes Against Others: Comparison Between Suicide Attempters and Nonattempters

Almost thirty percent \((29.7\%)\) of CSA victims reported an awareness that the perpetrator/s had also committed an offence/s against another person/s \((n = 203)\). These respondents were more likely to have attempted suicide at some later time, \(\chi^2(1, N = 684) = 9.04, p = .003\), Cramér’s \(V = .12\). Indeed, 48.3% of respondents who reported
offences against another person/s \((n = 98)\) had attempted suicide, in contrast to 36.0% of respondents who reported no victimisation by the perpetrator/s against others \((n = 173)\).

Moreover, 36.2% of suicide attempters reported victimisation against another \((n = 98)\), in contrast to 25.4% of nonattempters \((n = 105)\). Inspection of standardised residuals (SRs) confirms that respondents who reported offences against others were significantly overrepresented amongst suicide attempters \((SR = 2.0)\).

### 3.3.36 Exposure to Risk of Sexually Transmitted Infection: Comparison Between Suicide Attempters and Nonattempters

Over one third of CSA victims \((34.2\%)\) reported having been exposed to the risk of a sexually transmitted infection (STI) by the perpetrator/s \((n = 252)\). These respondents were more likely to have attempted suicide at some later time, \(\chi^2(1, N = 736) = 19.12, p < .0005, \text{Cramér's } V' = .16\). Indeed, 49.6% of respondents who reported exposure to the risk of a STI \((n = 125)\) had attempted suicide, in contrast to 33.1% of respondents who reported no such risk \((n = 160)\).

Moreover, 43.9% of suicide attempters reported exposure risk \((n = 125)\), in contrast to 28.2% of nonattempters \((n = 127)\). Inspection of standardised residuals (SRs) confirms that respondents who reported exposure to risk of a STI by the perpetrator/s were both significantly overrepresented amongst suicide attempters \((SR = 2.8)\) and underrepresented amongst nonattempters \((SR = -2.2)\). Conversely, respondents who reported no exposure to risk of a STI by the perpetrator/s were significantly underrepresented amongst suicide attempters \((SR = -2.0)\).

### 3.3.37 Contracting a Sexually Transmitted Infection: Comparison Between Suicide Attempters and Nonattempters

A small minority of CSA victims \((2.4\%)\) reported having contracted a STI as a consequence of CSA \((n = 18)\). A larger minority \((10.9\%)\) reported being unsure about whether they had contracted a STI in this manner \((n = 80)\). The majority of these respondents attempted suicide at some later time, in contrast to respondents who reported not contracting a STI from the perpetrator/s, \(\chi^2(1, N = 735) = 20.84, p < .0005, \text{Cramér's } V' = .17\). Specifically, 72.2% of respondents who reported contracting a
STI \((n = 13)\), and 56.3% of respondents who were unsure \((n = 45)\) had attempted suicide, in contrast to 35.9% of respondents who reported not contracting a STI \((n = 229)\).

Moreover, 4.5% of suicide attempters reported having contracted a STI \((n = 13)\), in contrast to only 1.1% of nonattempters \((n = 5)\). Similarly, 15.7% of attempters were unsure whether they had contracted a STI from the perpetrator/s \((n = 45)\), in contrast to only 7.8% of nonattempters \((n = 35)\). Inspection of standardised residuals \((\text{SRs})\) confirms that respondents who contracted a STI were significantly overrepresented amongst suicide attempters \((\text{SR} = 2.3)\), and that respondents who were unsure were both significantly overrepresented amongst attempters \((\text{SR} = 2.5)\) and significantly underrepresented amongst nonattempters \((\text{SR} = -2.0)\).
3.4 Discussion

3.4.1 Overview

This study was designed to examine, across multiple parameters, processes and artefacts of childhood sexual abuse (CSA), and the impact of such abuse on adult wellbeing, perturbation, and suicidality. It was sought to examine childhood sexual abuse experiences, and their impact, both from the perspective of the victim (now, an adult), and by delineating disparities in adult wellbeing between victims and nonvictims of CSA (or indeed, to identify a lack of such disparity). Given the persistent taboos and the resultant scarcity of accurate information regarding CSA, and the adverse outcomes that derive from inadequate understanding and silence, the need to both attain such information and break entrenched cycles of silence is clear. Information thus derived can be used to redress prevailing notions, myths, and knowledge deficits, both within child sexual abuse and adult mental health arenas, to the benefit of both victims and perpetrators. Specifically, identifying both disparities between victims and nonvictims, and perceptions and attributions unfavourable to wellbeing, can gainfully inform treatment protocols, and by offering apposite data, assist strategists for social reform, education, and service provision. Moreover, given that victims are ‘primary witnesses’ both to their own abuse, and to subsequent experiences and symptomology, the value in asking victims directly seems clear. The merit in so doing becomes clearer again when regard is given to the therapeutic potential of involving victims in positive actions against their own abuse experiences and those of others.

Yet surprisingly, no known research has similarly sought to ascertain such information in a detailed manner, nor used the specific strategy of asking victims to appraise salient aspects of their abuse; reporting practices; perpetrator and victim strategies; and subsequent attributions, beliefs, regrets, and sequelae. Instead, most of the extant data pertaining to psychological health focus on a limited field of psychological variables and derive from female samples and often nonrepresentative, narrow populations, such as university students or clinical subgroups, without the presence of appropriate nonvictim comparison groups (see Gold, Lucenko, Ehai, Swingle, & Sellers, 1999; Oddone-Paolucci, Genuis, & Violato, 2001; Roodman & Clum, 2001). Conversely, large scale
population surveys provide valuable information pertaining to prevalence, reported crime statistics, and sociodemographic factors (e.g., ABS, 2005b; AIC, 2008; Mouzos & Makkai, 2004) but fail to provide detailed data pertaining to psychological factors, and issues such as reporting practices, offender strategies, and victim appraisals and regrets. The many sizable difficulties and barriers inherent in researching areas subject to underreporting, underenumeration, taboo, stigma, and shame commonly also serve to undermine the utility of the extant data pertaining to sexual abuse. Accordingly, in this study, an online methodology and an inclusive and holistic approach were adopted to circumvent or minimise many of the methodological limitations pertaining to previous research. In seeking to address areas of high clinical and social relevance and those most neglected within the literature, particular emphasis was placed on examining victim perceptions, beliefs, and appraisals, with respect to offence and perpetrator typologies; perpetrator and victim strategies; victim experiences; physical and psychological abuse sequelae; patterns of disclosure; adulthood revictimisation; and suicidality subsequent to child sexual abuse. The inclusion of males in this study addressed a particular deficit in the literature, generating a sample more representative of the general community than is usual in research of this kind, and facilitating gender comparisons with respect to CSA and its aftermath.

Overall, the findings of Study 1 evidenced the almost universal experience, in the childhood period subsequent to CSA, of shame, ‘dirtiness’, ‘badness’, and guilt, and the ardent striving of child victims to ‘pretend nothing had happened’. Sadly, most individuals were alone with these feelings in childhood, as only a minority had disclosed the abuse as children. Aside from the plethora of negative psychological sequelae experienced in the direct aftermath of the abuse, and the suicidal ideation that was experienced by one in three children in the days or weeks following their abuse, similar proportions of CSA victims sustained physical injuries and exposure to risk of sexually transmitted infections (STIs) and pregnancy, and small minorities reported pregnancies and infections that had occurred as a consequence of CSA. The magnifying impact of secrecy and isolation on the pressures concomitant with such abuse aftermath is clear. Given that such pressures are sufficient to challenge the coping capacities of many adults, the immense threat to childhood wellbeing posed by sequelae of this nature (particularly in the absence of support) is similarly clear, and evidenced in multiple ways within this study. For instance, the horror and erosion of familial structures experienced by children
who become pregnant as a result of incestuous abuse and who are subsequently unsupported or disenfranchised from primary support figures can only be surmised. Yet, physical injuries, STIs, and pregnancy are aspects of CSA that are rarely if ever spoken about, acknowledged as possible ramifications of abuse, or examined.

It is of further concern to note the convergent evidence derived from the study that serious negative consequences extended into adulthood for many CSA victims, persisting commonly for multiple decades, to the present. Individuals who reported CSA had typically experienced this abuse many years previously. Indeed, as the mean age of female and male CSA victims was 36.1 and 41.2 years, respectively, at least two decades had elapsed since their childhood abuse. It is also noteworthy, that for some CSA survivors, at least six decades had passed since their childhood abuse. Yet, relative to nonvictims of CSA, individuals who had experienced CSA evidenced significantly poorer current psychological wellbeing (measured across multiple domains), as well as substantially higher rates of suicidal ideation and attempted suicide, and markedly higher rates of adulthood sexual abuse and intimate partner violence. Specifically, CSA survivors, relative to nonvictims, reported significantly higher current anxiety, stress, shame, guilt, aggression, and posttraumatic symptomotology, and lower general life satisfaction.

Moreover, high rates of nondisclosure continued into adulthood, with almost half of respondents reporting that they had never disclosed their CSA experience to a family member, and only a small minority having reported the matter to police. The unmitigated opportunities for repeat offending that are presented through victim nondisclosure are amid the many unwelcome corollaries of the silence surrounding sexual abuse. Notably, very little gender difference was found with respect to current psychological wellbeing amongst CSA survivors, and no significant gender difference was found with respect to lifetime occurrence of suicidal ideation or suicide attempt. However, relative to male CSA survivors, female survivors were almost twice as likely to report sexual revictimisation in adulthood, underscoring the need for consideration of gender-specific needs in service provision for victims of CSA and in violence prevention initiatives. In the discussion to follow, findings and implications arising from the current study are presented in the context of the extant literature.

### 3.4.2 Challenging Popular Conceptions Surrounding Child Sexual Abuse
Prevalence of male and female childhood sexual abuse

Females more commonly reported CSA, relative to males, consistent with well established findings in the literature that sexual abuse of all forms is more commonly perpetrated against females (e.g., ABS, 2005b; Finkelhor, 1994a, 1994b; Krug et al., 2002; Mouzos & Makkai, 2004). However, in this study, the proportion of males who reported CSA (31%) was 6-10 times higher than that found in Australian population studies (3-5%; ABS, 2005b; Mouzos & Makkai, 2004). In contrast, females in the study (48.8%) reported CSA at 2.7-5 times the rate reported in the same population studies (10-18%; ABS, 2005b; Mouzos & Makkai, 2004). This finding raises some interesting issues. Whilst there are clearly aspects of the TSP that attracted both male and female CSA victims in higher proportions than what is expected in the community, this effect was substantially more pronounced amongst male CSA victims.

Although the reasons for this difference remain largely open to conjecture, it seems likely that factors pertaining to differing gender roles and differing societal approaches to male and female sexual abuse victims contribute to this disparity. A possible explanation is that male CSA victims, relative to their female counterparts, are simply more often precluded from CSA research through internal, systemic, and societal barriers, and thus remain more invisible within conventional data collection approaches. If this were the case, one might expect a larger effect on male CSA victim reporting as a function of an inclusive and comparatively nonthreatening online data collection method, than found amongst females CSA victims. This is especially likely given that females are specifically targeted, and less constrained by, and hidden within existing approaches to sexual abuse research, and given that females generally experience fewer barriers to disclosure, communication of feelings, and help-seeking (Good et al., 2000; Kassing et al., 2005; Mittendorfer-Rutz, 2006; Möller-Leimkühler, 2003; Stewart & Smith, in press-a).

In terms of explaining the relatively high participation of male victims in this study, these comments remain speculative and should form the basis for future research. However, irrespective of the mechanisms by which male victims were moved to participate in the current study, the findings suggest that male CSA remains much more hidden and subject to far greater underenumeration within conventional research and intervention methodologies, than does CSA perpetrated against females. In short, findings deriving
from this study certainly challenge the notion that CSA perpetrated against males is a rarity. Rather, it is contended that rarity pertains to having male CSA reported and appropriately addressed. Indeed, it may simply be the case that the survey and recruitment methods, and the online methodology applied in the current study encouraged a level of disclosure and participation by male CSA victims that is precluded by conventional research and survey methods, and that the data thus derived more accurately reflect the level of CSA experienced by males. Such an explanation is consistent with documentation in the burgeoning literature pertaining to online research, intervention, and communication, that online modalities are able to foster favourable outcomes, including increased disclosure and disinhibition, especially in relation to sensitive issues (Hanna et al., 2005; Hiltz et al., 1986; Kalin & Schuldt, 1991; Kiesler et al., 1984; Reimers, 2007; Walther, 1996).

In contrast, it seems likely that conventional survey methods have contributed substantially to the persistent false impression that male CSA is a statistical rarity, and to a level of underenumeration of male sexual abuse that surpasses even the vast underenumeration that exists in relation to female sexual abuse. Several data deriving from the current study lend support to these speculations. Specifically, male CSA victims were almost twice as likely, relative to their female counterparts, to have never made a disclosure regarding their experience of CSA, and were significantly more likely to have never disclosed CSA to a family member. Indeed, in contrast to females, most male CSA victims had never disclosed CSA to a relative and were more resolute in their intention not to make a disclosure in the future. Such findings are consistent with those in the literature that males are more reluctant, relative to females, and find it more difficult to accept succour and communicate in regard to personal problems and sensitive issues; and are more prone to eschew assistance and proactive health behaviours (Good et al., 2000; Kassing et al., 2005; Mittendorfer-Rutz, 2006; Möller-Leimkühler, 2003; Stewart & Smith, in press-a).

These findings are concerning within the context of the earlier reported findings from this study that male CSA victims experienced very similar levels of current psychological distress to that of female victims. Whilst it is known from previous findings that CSA is associated with psychological maladjustment, both in childhood and in later life (e.g., Finkelhor, 2008; Nelson et al., 2002; Sanderson, 2004), such findings have been derived
largely from female samples. Thus, the current study extends the literature by demonstrating that, whilst male sexual abuse victims are more prone to nondetection and concomitant male psychopathology may be masked and mistaken for other ‘unrelated’ problems (e.g., aggression, substance use), males are no less vulnerable to psychopathology as a consequence of CSA. Indeed, this study suggests that male survivors experience comparable degrees of psychopathology, relative to their female counterparts, ostensibly with the additional burden of experiencing psychological distress and the aftermath of CSA in silence and isolation. Whilst cause for concern, this is not surprising given the stigma surrounding male sexual abuse (Crome, 2006; Hunter, 1990b), and the pressures on males to adhere and conform to stereotypic notions of masculinity (such as stoicism, invulnerability, and toughness) by repressing pain, emotions, or disclosures, and eschewing behaviours (such as help-seeking) that might connote vulnerability or other traits synonymous with ‘unmanliness’ (Good et al., 2000; Kassing et al., 2005; Mittendorfer-Rutz, 2006; Möller-Leimkühler, 2003; Stewart & Smith, in press-a).

It is salient and encouraging to note that the findings provide evidence that the male CSA victims in this study were nonetheless amenable to a level of nondisclosure (albeit, anonymous). This suggests that other males and individuals reticent to disclose sensitive information may be similarly amenable to disclosure, given the opportunity and the ‘right’ climate and approach. By extension, the findings from this study also indicate that male CSA victims may be amenable to help-seeking, given appropriate opportunity and climates conducive to such action. Indeed, email correspondence received by the thesis author (AS) from male CSA abuse victims and acutely distressed and suicidal males far outweighed that received from females. It appears from such correspondence that provision of opportunities for assistance without ‘threats’ attached is highly sought after by vulnerable males, and that such opportunities are readily accessed when available. As the many barriers that preclude male help-seeking render traditional health services more accessible for females, vulnerable females appear ostensibly better ‘catered for’ within existing practices, relative to their male counterparts. Under this model, vulnerable males (such as sexual abuse victims) are thus rendered additionally vulnerable, as a function of isolation and inadequate help-seeking. The higher suicide rates seen amongst males, relative to females, lend support to such models. Given the scarcity of literature pertaining to the sexual abuse of males, these findings may assist those who seek to understand male distress and provide services for male victims of childhood sexual and other abuses.
Child sex offenders: Notions of perpetrator gender

The finding in this study that most respondents identified a male perpetrator is consistent with the literature that males perpetrate the vast majority of sexual abuse (Finkelhor & Russell, 1984; Grayston & De Luca, 1999; Krug et al., 2002; SAC, 2007a, 2007b; Smith & Stewart, 2008; Ullman, 2004; Wakefield, Rogers, & Underwager, 1990). However, the finding that almost one in five male CSA victims and more than one in ten female CSA victims identified a female perpetrator certainly challenges the notion that female-perpetrated CSA is exceptionally rare. Rather, it is suggested that, whilst female-perpetrated CSA is statistically unusual, it is not as rare as popularly perceived. It is contended that such perceptions persist because female-perpetrated abuse remains underresearched and even more constrained by taboo, subject to even greater shame, and thus, even more likely to remain hidden than male-perpetrated CSA (Grayston & De Luca, 1999; Wakefield et al., 1990).

Whilst it has been speculated over recent years that female-perpetrated CSA is vastly underreported and not as rare as has been previously assumed, true prevalence remains unknown, and understanding of this type of offending remains sparse, given minimal available data, small sample sizes in relevant research, and serious methodological and definitional problems that have served to inflate statistics and call into question the validity of findings (Denov, 2004; Sanderson, 2004; Wakefield et al., 1990). Indeed, disagreement and confusion persists in relation to female-perpetrated CSA to the extent that studies have implicated female offenders as responsible for anywhere between 1.5% and 92% of victimisation cases (see Finkelhor, 1979; Grayston & De Luca, 1999; Wakefield et al., 1990). After analysing such widely disparate findings and attempting to exclude dubious data, Finkelhor and Russell (1984) suggest that female perpetrators are responsible for 14-20% of CSA against boys and 5-6% of CSA committed against girls. Other authors consider that females comprise less than 5% of those sexually offend against children and adolescents (e.g., Grayston & De Luca, 1999), whilst some contend that 20-25% of CSA is perpetrated by females (e.g., Sanderson, 2004).

Clearly, a need exists for more attention to be directed toward examining female-perpetrated CSA. The current study extends the literature in this domain by providing recent Australian data derived from a large, demographically and socially diverse sample
of both males and females, that may assist in raising awareness and understanding of female-perpetrated CSA and informing treatment protocols for both female perpetrators and their victims. Data of this type have not previously been available. Moreover, given the benefits of increased candour and disclosure facilitated by online methodology (as previously discussed; see for example, Hanna et al., 2005; Reimers, 2007), it is likely that data pertaining to such a highly stigmatising and sensitive issue would not have been forthcoming to the same degree using conventional research modalities.

The notion that women can (and do) perpetrate sexual abuse against adults is commonly trivialised or met with incredulity, and even mirth (Denov, 2004; Wakefield & Underwager, 1991). Indeed, despite a scarcity of empirical data pertaining to the impact of such abuse, research demonstrates the common attitude both amongst professionals (e.g., social workers, police working in child protection, psychiatrists) and the general community that female-perpetrated sexual abuse, where it occurs at all, is relatively insignificant and less harmful, relative to male-perpetrated abuse, and that social service and police involvement is less warranted (Denov, 2004; Finkelhor, 1984). Yet, the minimal research that has been conducted shows that female-perpetrated sexual abuse has a destructive impact for the vast majority of victims (Denov, 2004; Glasser et al., 2001; Lisak, 1994).

At the same time, the notion that women can (and do) perpetrate sexual abuse against children challenges notions of the female figure as a protector and nurturer of children, and as an offensive, shocking, or unbelievable concept to many, can be conceptualised as one of ‘last frontiers’ amongst topics of taboo (Denov, 2004; Sanderson, 2004; Wakefield & Underwager, 1991). The finding in the current study that one third of female-perpetrated CSA was perpetrated by relatives (predominantly mothers, followed by sisters) highlights not only the betrayal, the powerlessness, and the loss of maternal or familial protection experienced by children thus victimised, but also the degree to which such abuse transgresses and violates commonly held beliefs and social ‘rules’. The concomitant degree to which such abuse is likely to be hidden, denied, and minimised within the family unit raises the improbability that a child victim will gain access to supports or means to effect disclosure or halt the abuse. Finally, the notion that female-perpetrated sexual abuse against males is emasculating and thus, additionally shameful, ostensibly contributes further to the invisibility of female-perpetrated sexual abuse of
males. The forum conferred by the current research for anonymous online disclosure is the first of its kind in the area of female-perpetrated CSA.

Chronicity of child sexual abuse and the ‘stranger-danger’ fallacy

Findings that the vast majority of CSA victims had experienced more than one incident of sexual abuse, and a sizable minority had been perpetrated against by more than one person, highlight the high levels of vulnerability, exploitation, and repeated victimisation commonly experienced by victims of CSA. Indeed, both quantitative and qualitative data potently conveyed the chronicity of abuse encountered by many respondents, and the degree to which such abuse hallmarked their childhood experience. For many individuals, such experiences commenced in early childhood or prepubescence. Indeed, over half of CSA victims reported experiences of nonpenetrative sexual abuse and a quarter reported penetrative abuse prior to age 10. Such experiences were rarely isolated incidents. Experience of sexual abuse between the ages of 10 and 15 years was even more commonly reported, with more than two thirds of CSA victims reporting nonpenetrative abuse and almost half reporting penetrative abuse during these years. These findings are consistent with current Australian police statistics showing that, in 2006, the highest rate of sexual assault reported to police was recorded for females aged 10-14 years, and that amongst males, the highest rate of reported sexual abuse was also recorded for boys within this age group (AIC, 2008). Again, CSA experiences encountered during adolescence were isolated incidents in only the minority of cases. The repetitive and patterned nature of CSA is further evidenced by findings that, for many individuals, sexual abuse experiences spanned both early childhood and adolescence, with almost half reporting nonpenetrative abuse and more than one quarter reporting penetrative abuse experienced within both stages of childhood. Given that it is chronicity of CSA that is associated with more severe psychopathology (Bagley & Ramsey, 1986; Russell, 1986; Ullman, 2004), relative to isolated events, these findings attest to the severe nature of the abuse encountered by the majority of respondents.

In terms of abuse type, findings that, in addition to nonpenetrative abuse, more than half of CSA victims had experienced sexual intercourse, almost half had experienced oral sex, and almost one fifth had experienced anal intercourse, attest further to the severity of the abuse encountered. Whilst some exceptions occur in the literature (e.g., Anderson & Phelps, 2000; Finkelhor, 1979, Fromuth, 1985), and whilst factors such as the child’s age
and reaction, and the meaning attributed to the abuse, may be more predictive of impact than the nature of the sexual act (Sanderson, 2004), penetrative abuse (including intercourse, attempted intercourse, fellatio, cunnilingus, analingus, and anal intercourse), and particularly penile penetration, has repeatedly been associated with more severe traumatisation than digital exploration, unwanted kissing, and touching (Bagley & Ramsey, 1986; Landis, 1956; Russell, 1986; Sanderson, 2004; Tufts New England Medical Center, 1984).

The finding that nearly three quarters of CSA victims reported abuse that had been perpetrated by the same person on more than one occasion further challenges the popular notion of ‘stranger-danger’ as the prominent threat against children. Results of this study are consistent with the literature in demonstrating that, in reality, children face their greatest risk of sexual abuse at the hands of relatives and trusted figures, and current boyfriends (in the case of adolescent victims), and that such risk far outweighs that posed by strangers. Whilst such findings have been consistently reported in the literature (ABS, 2005b; Lievore, 2003; Mouzos & Makkai, 2004; Smith & Stewart, 2008; VLRC, 2003), few details have permeated sufficiently into the community and fewer have resulted in tangible changes in community awareness and prevention programs. Indeed, both victims and perpetrators remain ostensibly ‘faceless’, in the sense that, despite evidence to the contrary, stereotypic images prevail. Of the perpetrators identified as relatives, most were close family members, most commonly brothers, fathers, and uncles, and to a lesser degree, grandfathers, followed by mothers and sisters, as the predominant female familial perpetrators. In contrast to conceptualisations built on seemingly ‘faceless’ perpetrators, or alternatively, on stereotypic notions regarding the profile of child sex offenders, the current research project represents the first known study to provide such a profile of individuals who sexually offend against children in Australia. A more informed understanding of the reality that confronts many children can be used to evoke necessary changes that are tangible and equally ‘real’.

Promulgation of notions such as ‘stranger-danger’ may likely be explained in part by the fact that such notions are more ‘palatable’ than the perception of relatives and trusted figures as posing the greatest risk of sexual abuse against children. However, such inaccuracies are unhelpful to both preventive efforts and to victims directly, who on the basis of misinformation commonly conclude that they are unique and thus, alone in their
abuse experience (and sequelae), or that their assumed atypical abuse experience and subsequent reactions are somehow invalid. Specifically, victims who minimise or perceive their abuse to be ‘not as bad’ as what others have experienced are prone to self-rebuke for reacting in ways that, to their mind, may connote ‘weakness’, ‘sickness’, or ‘weirdness’. Further, the beliefs of many CSA victims that they are blameworthy and were somehow ‘flawed’ or ‘seductive’ children are often actively cultivated by perpetrators and function in powerful ways to instil guilt and shame, and effect silence. Unless challenged, such beliefs are often carried forth into adulthood, together with concomitant negative effects on wellbeing and future relationships.

High levels of adherence to myths and damaging beliefs surrounding CSA are evident also at the wider community level, such that victim blaming, and excusing or minimising the actions of the perpetrator occurs not only amongst victims themselves, but amongst those around them and at level of law enforcement and judiciary (Kassing et al., 2005; VLRC, 2004). Accessible, empirically derived information is needed in order to counter the many maladaptive beliefs and the prevailing misinformation surrounding CSA. Yet specific and empirically sound information of this nature is sparsely available. The current study provides many findings that are directly applicable to this task and assists in elucidating many of the issues in need of redress. These are discussed in turn under the forthcoming subheadings.

3.4.3 Processes and Sequelae of Sexual Abuse and Disclosure in Childhood

Findings with respect to perpetrator strategies show that ‘victim grooming’ and inveigling strategies were more commonly employed by perpetrators than physical force, violence, or overt aggression (although these strategies were also experienced by many victims). This is consistent with findings in the general sexual abuse literature that physical violence does not characterise the majority of abuses (Lievore, 2003), and that the majority of individuals who are sexually abused do not receive physical injuries (VLRC, 2001, 2004). Further, previous research demonstrates that sexual abuses not involving physical violence or resulting in visible injury are less likely than physically injurious and violent sexual attacks to be reported; far less likely to progress successfully through the judicial system (Lievore, 2003; Smith & Stewart, 2008; VLRC, 2001, 2004); and more likely to invoke self-blame, shame, and guilt (MacFarlane et al., 1986; Sanderson, 2004; Smith & Stewart, 2008). Thus, these findings are consistent with the high levels of secrecy and
psychopathology observed in relation to CSA, both in the current study and in the literature. Moreover, the findings offer material that can be used in therapy and victim education to assist in building insight; reducing guilt, shame, and self-blame; and normalising victim reactions. Specifically, the findings suggest that therapeutic outcomes can be facilitated and enhanced by exposing, identifying, and facilitating victim insight regarding perpetrator strategies; deliberate processes of manipulation and engineering of situations, emotions, and behaviours; and the efficiency of these methods in effecting and maintaining secrecy and achieving compliance by invoking fear, guilt, shame, and feelings in the child that he/she is complicit, flawed, and ‘bad’ as a function of involvement in his or her own abuse.

Indeed, it is significant that treating the child victim ‘nicely’ in order to gain compliance was the most commonly identified perpetrator strategy, followed by deception and instilling of guilt or sense of obligation. Given that such grooming practices and manipulation are commonly carried out in degrees and often over an extended period of time, these findings suggest that open dialogue with, and early disclosure to supportive adults would likely have proffered opportunities to circumvent many incidents of CSA, or at least, interrupted the progression of such abuses into chronicity.

Unfortunately however, two main barriers to such protective mechanisms (and subsequent positive outcomes) were highlighted by this study. First, only the minority of CSA victims disclosed their abuse during their childhood, and such disclosure was particularly unlikely amongst male CSA victims. This highlights the isolation experienced in childhood by the majority of individuals with respect to their CSA experiences, their concomitant vulnerability to revictimisation, the lack of targeted support and interventions available to them, and the invisibility of such abuse, even within close circles. The vulnerability of these individuals is further exacerbated, given that early intervention is known to be of pivotal importance in mitigating psychopathology in victims of sexual abuse and other traumas (Ullman, 2004). Similarly, in providing further evidence that CSA that comes to the attention of authorities represents a only small minority of the sexual abuses that are perpetrated against children (ABS, 1996, 2005a; Easteal, 1993; Fleming, 1997; Lievore, 2003; Sanderson, 2004; Stubbs, 2003; VLRC, 2004), these findings highlight the unfortunate situation that most CSA perpetrators do not receive the early intervention that is also recognised as critical in impeding sexual
recidivism and entrenchment of offending patterns (Abel et al., 1987; Boyd, 2006; Long & McLachlan, 2002; Nisbet et al., 2004, 2005; Sanderson, 2004; Tidmarsh, 1997).

Second, for the minority of children who made a disclosure of CSA, positive reactions from family or friends were substantially lacking. Indeed, the majority of these children encountered awkwardness, discomfort, avoidance, suspicion, challenging reactions, and lack of understanding, and half reported hostility, rejection, and blame. Not surprisingly, the minority of these individuals perceived such disclosure to have been helpful, half expressed a level of regret regarding the disclosure, and one in four expressed serious regrets in this regard. These findings are concerning given that previous research has demonstrated a mediating effect of disclosure reactions between CSA and adult psychopathology, such that individuals who received adverse reactions upon disclosure fared worse psychologically, relative to those who had received a supportive response, and those who had not disclosed their abuse (Everill & Waller, 1994; Roesler, 1994).

The level of negative reactions received by child survivors is additionally concerning given the dependency of children on the adults around them for support and protection; the limited alternative opportunities children have to access care and assistance; the potential for disclosure of CSA and other traumatic experiences to have significant beneficial health and safety outcomes (such as ending the abuse) (Arata, 1998; Pennebaker et al., 1988; Ullman, 1996); and conversely, that the alternative of failing to disclose traumatic events is related to poorer health outcomes (Pennebaker, 1985), and in the case of CSA, commonly allows the abuse to continue.

It is clear from the findings of the current study that, whilst the message of ‘telling an adult’ is widely promulgated (Sanderson, 2004), children who entrust adults with such information are commonly afforded a disservice, and encounter further betrayal of trust by the adults closest to them, and by adults on whom they depend. The finding that disclosure, a widely recommended and potentially effective strategy of self-protection, in itself commonly educes negative and painful outcomes for the individuals it is designed to assist, is a sad indictment of the position and powerlessness of child victims of sexual abuse within society. Clearly, such findings underscore the need for community education targeted towards adults (and specifically parents, teachers, judicial systems, and others who care for, and support the rights of children), to ensure a climate more conducive to
positive outcomes of CSA disclosure. Additionally, such findings underscore the salience of empowering children directly, such that their welfare is at least somewhat less than totally contingent on the adults around them. Specifically, such empowerment can be effected through appropriate education targeting specific vulnerabilities, confidence building, protective skills and behaviours, and risk awareness.

In the current study, the exercise of asking victims to identify and appraise both internal and external factors instrumental in facilitating their sexual abuse yielded information that is able to gainfully inform such educative initiatives. Notably, childhood obedience (i.e., ‘As a child, I did as I was told’) and perpetrator use of authority were identified as salient factors by the vast majority of respondents. This finding has clear implications for child-rearing practices and ideologies, given that vulnerability is conferred upon children by climates in which non-compliance is synonymous with ‘badness’ and conversely, unquestioning obedience, unwavering deference, and compliance toward all adults is rewarded and synonymous with being a ‘good’ child. Children that are taught to question, discern, evaluate, and respect and trust their own feelings and judgment are arguably less vulnerable, in a direct sense, to exploitation than those who unquestioningly comply. Indirectly, children with a healthy self-esteem, empowered to trust their instincts and judgments, and secure in the knowledge that their concerns will be heard and acted upon will similarly be less easily silenced and targeted by those with predatory intent. Moreover, the value of building and fostering protective behaviours and resilience to coercion clearly extends far beyond the realm of child sexual abuse. Such strengths are also important in buffering against peer pressure, and exploitation and abuses in other contexts (e.g., adulthood sexual abuse, intimate partner abuse).

Confident children are also those who have the unwavering support of the adults around them and who are able to express their concerns and voice opinions without fear of retribution or other negative repercussions. Indeed, factors such as parental warmth (Punamäki et al., 2001), and family support and low family conflict (Buka et al., 2001) have been shown to have mitigating effects on the impact of traumatic events and exposure to violence in children. It is salient to note that fear of being blamed or not believed was cited by CSA victims as a principal factor in facilitating their abuse. Thus, it is not sufficient that children have the unwavering support of adults. Rather, it is of pivotal importance that they also perceive themselves to have such support. As children, victims
were also highly fearful of the effects of disclosure on their family. The protective (and sometimes ‘adultified’ and ‘parental’) role often adopted by children in times of crisis commonly presents pressures that far exceed their emotional and functional capacities, and contributes to their potential for exploitation. Cognisance and appropriate actions amongst service providers and parents in relation to potentially unhealthy role adoption by children can gainfully assist in building their resilience and wellbeing.

Thus, in what might appear ostensibly paradoxical to sexual abuse victims who perceive themselves as blameworthy or intrinsically ‘bad’, it would seem that ingrained ‘obedience’, a strong sense of obligation and morality, and strong protective instincts toward family and others confer particular vulnerabilities to predation and exploitation of such traits. Instilling a sense of guilt and obligation and otherwise preying on children’s sense of morality are particularly insidious and effective perpetrator strategies given that ‘keeping’ promises and secrets, doing as adults wish, and not causing trouble for others are tantamount to being ‘good’ and comprise behaviours and qualities that are highly prized in children and subject to high praise and reward. The current study adds to a growing body of literature demonstrating that guilt, shame, and a sense of being complicit in their abuse are pervasive and destructive emotions and beliefs encountered amongst CSA survivors across their lifespan. Findings from this study strongly suggest that childhood obedience is not only an important facilitating factor in CSA, but also inextricably enmeshed with the destructive aftermath of self-blame, guilt, and sense of ‘badness’ that haunts many CSA survivors.

Emotional inability to stop the perpetrator, being rendered fearful, numb, ‘frozen’ or otherwise incapable of thwarting the abuse, and succumbing to various forms of manipulation and physical or psychological overpowering, were also commonly cited factors in facilitating CSA. Whilst inveigling and manipulative tactics appear more commonly applicable to the circumstances of the abuse, it must be noted nonetheless that use of physical force, violence, anger, humiliation, or spite was also commonly identified by CSA victims. Indeed, the force of such tactics was such that one in five CSA victims reported believing that they (or someone else) might be killed or seriously injured if they resisted. The presence of such a belief or fear is a key factor associated with risk for developing PTSD (Briere, 1997; Keane, Weathers, & Foa, 2000), and in general, physical force and violence concomitant with CSA appear to be associated with increased severity
of impact (Finkelhor, 1979, 1984, 2008; Friedrich, 1987, 1988; Friedrich, Beilke, & Urquiza, 1986; Fromuth, 1985; Russell, 1986; Tufts New England Medical Center, 1984), including an increased degree of behavioural disturbance in children (Tufts New England Medical Center, 1984), and increased externalising and internalising of symptoms (Friedrich, 1987, 1988; Friedrich et al., 1986).

However, it is also the case that physical force or violence is able to have a mitigating effect on traumatic impact (Anderson & Phelps, 2000; Bagley & Ramsey, 1986), likely because the presence of overt force or violence allows the child to more easily perceive the actions of the perpetrator as wrong; and thus, enabling the child to more easily attribute blame to the perpetrator, rather than to the self (MacFarlane et al., 1986; Sanderson, 2004). Conversely, the highly damaging effects of inveigling, manipulative perpetrator strategies can be heightened, and likely explained in part, through the absence of violence and aggression that allows the child to feel shame, guilt, and self-blame in the belief that they were ‘complicit’ or consenting to the abuse; and fosters feelings of confusion and betrayal surrounding love, affection, loyalty, and abuse (MacFarlane et al., 1986; Sanderson, 2004). These findings provide clear pathways by which, in therapeutic settings, CSA victims can be assisted to gain insight and address the appropriateness of ‘owning’ guilt, shame, and responsibility for their abuse.

Such factors highlight the extreme and debilitating power imbalance inherent in CSA, the powerlessness invoked by fear, and the vulnerability of children to exploitation, manipulation, and abuse. Whilst such factors are difficult to address directly, these findings underpin the importance of placing children within a supportive environment in which forces outside their control can be buffered by those with greater resources (i.e., adults). Whilst disclosure to appropriate adults does not retrospectively ‘prevent’ CSA, it can play a critical role in minimising the harmful effects of such abuse, and impeding patterns of chronic abuse, abuse escalation, and perpetration of sexual offences against others. However, as noted earlier, it is not sufficient for children to have access to supports. Rather, once placed within supportive environments, it is pivotally important that children also perceive themselves to be thus protected and well resourced (e.g., able to communicate concerns without fear of negative repercussions). Specifically, it is requisite that children perceive themselves as safe and are confident in the knowledge that responsibility for factors and problems beyond their control can (and should) be
delegated to adults, and that such delegation will effect appropriate protection and resolution of their concerns.

Whilst such security confers substantial resilience to repeated violation and exploitation, it remains elusive within climates where children fear blame, rejection, or other negative repercussions resulting from disclosure and help-seeking. Thus, it is important that parents and caregivers understand the need for children to feel unconditionally supported and secure in their care and the need to create a noncritical and nonpunitive climate conducive to open communication, especially in relation to difficult topics and personal problems. Specifically, it should not be expected or assumed that children necessarily understand that particular topics can be ‘safely’ broached and that they are unconditionally loved, accepted, and supported by their parent or significant others, even when such adults and other observers may perceive this to be abundantly obvious. Rather, it should be communicated to parents that children often require overt and repeated assurances and proactive approaches from adults in order to foster feelings of security and the belief that the support they receive is unwavering and cannot be threatened by any disclosure or behaviours manifested by the child or others.

If delegation and disclosure by the child effect positive outcomes such as abuse cessation, victim support, and appropriate action against the perpetrator, the child is empowered by his or her actions and able to move forward, at least to some degree, from the position of powerlessness experienced in the course of their victimisation. Conversely, if delegation to adults and disclosure are ineffective or even adverse in their effects, the position of powerlessness is intensified and reinforced and a form of revictimisation occurs. It is reasonable to speculate that protracted powerlessness and repeated failures to achieve control over their situation play a sizable role in explaining why a minority of CSA victims subsequently become sexual or other violent offenders who assume control and exert power and force over others.

Previous findings pertaining to CSA disclosure reactions have typically derived from North American exclusively female samples (e.g., Arata, 1998; Roesler & Wind, 1994) or predominantly female samples (e.g., Lamb & Edgar-Smith, 1994; Roesler, 1994). The current study provides the first known Australian data pertaining to CSA disclosure reactions encountered in childhood, and disclosure-related regret amongst male and
female CSA survivors. It is hoped these can be used to assist those who seek to educate parents, teachers, law enforcement agencies, and the wider community, as to the devastating effects of CSA (especially in the absence of appropriate supports); the importance of recognising and assisting children who have experienced such abuse; and the importance of ensuring that appropriate reactions are encountered by children who choose to make such a difficult disclosure. In raising awareness and support for children who are being sexually abused (or at risk thereof), climates in which protracted CSA is allowed to occur can be deconstructed and over time, become legacies of a less informed era.

3.4.4 Mechanisms of Childhood Sexual Abuse Disclosure in Adulthood

The acute difficulties and barriers inherent in disclosing CSA are evidenced by the findings that high rates of nondisclosure continued into adulthood. Almost half of CSA victims reported having never disclosed their experiences of CSA to a family member, and one in seven had never disclosed this abuse to anyone. This is not only consistent with the view in the literature that recorded sexual assaults vastly underrepresent the true level of sexual abuse in the community (ABS, 1996, 2005a; Lievore, 2003; London et al., 2005; Mouzos & Makkai, 2004; Sanderson, 2004; Smith & Stewart, 2008; VLRC, 2004), but highlights also the degree to which sexual abuse remains hidden at all levels, including at the level of families and in close relationships. Whilst it is known that survivors of CSA disproportionately experience adult sexual and relational discord, sexual revictimisation, and familial violence (Davis & Petretic-Jackson, 2000; DiLillo, 2001; Dorais, 2002; Lievore, 2003; Rumstein-McKean & Hunsley, 2001; Sanderson, 2004; Spataro et al., 2004), the full impact and pressure that such secrecy and victim isolation can place on individuals and relationships can only be surmised.

Indeed, it is salient to note that, for a sizable proportion of respondents in the current study, nondisclosure did not signify the absence of a need or desire for such disclosure. In fact, more than one third of individuals expressed the desire to tell someone, and more than one quarter expressed this desire but felt it was too difficult to do so, signifying both the ongoing and unresolved nature of the trauma, and the ongoing barriers to disclosure. Notably, as reported earlier, nondisclosure was more pronounced amongst males, relative to females. Indeed, males were twice as likely as females to have never disclosed their CSA experience/s, with almost one in four reporting lifetime nondisclosure. Moreover,
males were more resolute than females in their intention not to disclose in the future, and only a minority of male CSA victims had ever disclosed their abuse to a family member. Interestingly however, males were no less likely than females to express the desire for disclosure, and the view that whilst they would like to disclose, to do so would be too difficult. These findings highlight the additional isolation, vulnerability, and barriers faced by male victims of CSA, relative to their female counterparts, and are consistent with findings in the literature that males in general are more likely to eschew (and experience barriers to) help and succour; and less prone to confide, verbally communicate their negative feelings and problems, and adopt collective problem-solving approaches (Good et al., 2000; Kassing et al., 2005; Mittendorfer-Rutz, 2006; Möller-Leimkühler, 2003; Smith & Stewart, 2008; Stewart & Smith, in press-a).

Whilst it is concerning that CSA disclosure during childhood was hallmarked by negative reaction and characteristically perceived as unhelpful, it is an encouraging finding that disclosure of CSA in adulthood was perceived as more beneficial. This is consistent with earlier findings in the literature that childhood disclosure was perceived by victims as less helpful (Lamb & Edgar-Smith, 1994) and met with worse reactions, relative to CSA disclosures made in adulthood (Roesler, 1994; Roesler & Wind, 1994), and that females who disclosed incest during childhood more often encountered blame or disbelief, relative to those who made such disclosure as adults (Roesler & Wind, 1994). On a positive note, it can thus be argued that benefits of CSA disclosure are attainable, even if earlier disclosures were not well received, and even after protracted delay, and that it is ‘better late than never’. Given the size and diversity of the sample, it is argued that this message is able to be generalised and should be promulgated to the wider community to assist CSA victims (and their loved ones) across the lifespan. Further, the results provide additional evidence of the need for community education that can better equip adults in whom children confide to respond in supportive and helpful ways to disclosures of abuse.

3.4.5 Confidante Gender Preferences Amongst Adult Victims of Childhood Sexual Abuse
As in childhood, adulthood CSA disclosure toward a female was a much more common preference than disclosure toward a male. This is consistent with the common pre-treatment preference for female therapists evidenced both in the generalist and CSA-specific literatures (e.g., Dacy & Brodsky, 1992; Fowler & Wagner, 1993; Pikus & Heavey, 1996). However, it is also notable that one in four victims expressed no gender preference
with respect to their choice of confidante. As gender preferences with respect to
disclosure confidante have rarely, if ever, been examined in male and female sexual assault
victims, and given that disclosure is difficult and threatening for most victims of such
abuse, demanding a level of trust in the confidante, such information may be of use to
service providers and those who seek to facilitate disclosure and help-seeking in victims of
sexual assault. Moreover, given that most sexual abuse victims do not seek therapy,
examination of gender preferences in the current sample (comprising a non-therapy
seeking majority) may be particularly beneficial in highlighting ways in which climates
conducive to disclosure and help-seeking can be created.

Confidante gender preferences of female victims of childhood sexual abuse
Within gender analyses revealed that female victims showed a strong preference for
female confidantes, with two thirds of females reporting that conversing with a female
had been the most helpful to them. This finding is consistent with considerable research
evidence that female clients commonly express a preference for female therapists (e.g.,
Dacy & Brodsky, 1992; Fowler et al., 1992; Jones et al., 1987; Moon et al., 1993; Pikus &
Heavey, 1996), and a large body of literature indicating that gender impacts substantively
on therapeutic relationships and therapeutic gain (e.g., Adams-Tucker & Adams, 1984;
Howard et al., 1970; Lo Fo Wong et al., 2006; Orlinsky & Howard, 1976; Moon et al.,
2000; Wintersteen et al., 2005). Indeed, this finding supports the early view of Orlinksy
and others (subsequently mirrored by many authors and service providers, particularly in
the area of sexual abuse), that therapist ability and sensitivity may be less important than
therapist gender (Howard et al., 1970; Orlinsky & Howard, 1976).

Nonetheless, it is noteworthy that in the current study, a small minority of females found
a male confidante to have been the most beneficial, and almost one in four stated having
no gender preference. These findings mirror the equivocal and sometimes contradictory
results of previous research, suggesting that, at least for some individuals, practitioner
gender has minor or negligible impact on the therapeutic alliance (e.g., Cottone et al.,
Fowler & Wagner, 1993; Nelson, 1993; Wagner et al., 1993; Zlotnick et al., 1998) or
treatment retention (e.g., Sterling, Gottheil, Weinstein, & Serota, 1998). As such, these
findings are also consistent with the view of authors such as Blumenthal, Jones, and
Krupnick (1985), Fowler and Wagner (1993), Wagner et al. (1993), and Zlotnick et al.
(1998), that the equivocal nature of the evidence base precludes definitive conclusions to
be drawn regarding gender matching in therapeutic alliances, and that beliefs regarding the salient role of gender in therapeutic alliance may rest more so on theoretical and ideological biases and presumptions, than on empirical evidence (Blumenthal et al., 1985). The current findings suggest that, whilst gender may be an important consideration for some victims, factors other than gender match (e.g., therapist skill, personality, and experience; client personality style and developmental level) are pivotal in determining therapeutic alliance and outcome, and likely override the impact of gender match alone.

Confidante gender preferences of male victims of childhood sexual abuse

Whilst issues concerning female-female therapist-client dyads (versus female-male dyads) have been subject to considerable research attention, the male-male therapist-client match and male client preferences have received comparatively meagre attention (Blumenthal et al., 1985; Wintersteen et al., 2005). Even less is known of the preferences, views, and experiences of males who have experienced sexual abuse. The relative dearth of data, specifically with respect to male sexual abuse survivors, has led to confusion, and decisions related to service provision for male victims that ostensibly are built more on assumptions and extrapolation of findings related to females, than on male-specific empirical data. Specifically, considerable evidence suggesting that female survivors commonly prefer a gender-matched therapist (e.g., Dacy & Brodsky, 1992; Fowler et al., 1992; Jones et al., 1987; Moon et al., 1993; Pikus & Heavey, 1996), has led to the popular extrapolation that better therapeutic outcomes will derive from gender-matched therapeutic alliances, for both female and male survivors (Wintersteen et al., 2005). Accordingly, models of service delivery for male sexual abuse survivors have been underpinned traditionally by assumptions (in lieu of empirical evidence) that male victims would routinely require and prefer a male practitioner and that issues arising from cross-gender counselling are of central concern in providing services for male survivors (CASA, 2007). Yet findings supportive of such service provision models have not been forthcoming for males. Indeed, the sparse data available to date have suggested that males either show no gender preference (Pikus & Heavey, 1996), or like their female counterparts, tend toward a preference for female therapists (Dacy & Brodsky, 1992; Pikus & Heavey, 1996).

The findings of the current study, consistent with those of Dacy and Brodsky (1992) and Pikus and Heavey (1996), challenge the commonly espoused notion that better outcomes necessarily derive from gender-matched therapeutic alliances (Wintersteen et al., 2005),
particularly in the case of male survivors. Indeed in the current study, male CSA victims, similarly to their female counterparts, showed a preference for female confidantes. Notably however, this preference was less pronounced than that seen amongst female victims, such that males were more evenly divided in terms of gender preferences and such that sizable minorities either expressed the view that a male confidante had been most helpful, or stated having no gender preference with respect to confidante. These findings can assist in informing models of service delivery for male survivors by challenging assumptions that have played pivotal roles in the planning, development, and implementation of such services (e.g., see CASA, 2007) – specifically, assumptions made by service providers (in the absence of male-specific empirical data) that male sexual abuse victims would customarily prefer and require a male practitioner.

The results of this study highlight the variability amongst both male and female victims with respect to confidante gender preferences, and the fact that many issues other than simply gender may influence choices and preferences regarding confidantes and therapists. Accordingly, these findings underscore the importance of offering male and female sexual abuse victims choices with regard to treatment and therapist gender. However, whilst the existence of a range of treatment options represents the ideal situation, in practical terms, the ability of sexual abuse victims to choose what is appropriate for them is clearly contingent on the availability of resources and apposite treatment alternatives (Bavinton, 2003; Crome, 2006).

Unfortunately, treatment options for male survivors are still limited and not uniformly comprehensive or available across Australia (Bavinton, 2003; Griffiths, 2003; Worth, 2003). Moreover, limited attention has been directed toward how such services can be promoted so that male victims know of their existence and are assured that these are welcoming and appropriate for them (Bavinton, 2003; Crome, 2006). Whilst it has been argued that separate services designated for male victims achieve this simply as a function of their existence, arguments exist both for and against exclusive male treatment approaches (Bavinton, 2003) and debate persists regarding the optimal manner in which to meet the needs of male survivors (Crome, 2006). Limited data pertaining to male victims, uncertainties regarding existing data, male disclosure anxiety and reluctance, and male proclivity to eschew help-seeking and acceptance of succour (Crome, 2006; Griffiths, 2003; Stewart & Smith, in press-a; Worth, 2003) are amongst the sizable hindrances that exist with respect to effecting progress in this area.
Additional barriers to better and equitable service provision for male sexual abuse survivors derive from a number of ethical and sociopolitical issues (Crome, 2006). Males comprise a comparatively silent and marginalised minority group amongst sexual abuse victims whilst comprising the vast, well-recognised, and visible majority of sexual perpetrators. Accordingly, maleness in some contexts remains inextricably synonymous with perpetration of sexual violence rather than victimisation with the effect that some victim advocates and counsellors are unwilling to work with male victims and particular agencies similarly exclude male victims. Resentment has also been expressed by some that service provision for male victims (perceived as less worthy recipients) would encroach on the scarce funding and resources directed toward victims of sexual abuse (Crome, 2006).

The current findings extend the literature and can inform ongoing debates surrounding the specific needs and symptoms of male survivors; and more general debates around victim gender differences; treatment needs; confidante and therapist gender preferences (e.g., Cooper, 2006; Dacy & Brodsky, 1992; Fowler et al., 1992; Moon et al., 1993; Pikus & Heavey, 1996; Wintersteen et al., 2005; Zlotnick et al., 1998); and the importance (or lack thereof) of gender matching in the therapeutic alliance and treatment retention (e.g., Fowler & Wagner, 1993; Fowler et al., 1992; Howard et al., 1970; Moon et al., 2000; Okamoto, 2002; Orlinsky & Howard, 1976; Wagner et al., 1993; Wintersteen et al., 2005; Zlotnick et al., 1998).

The current finding that both males and females tended toward a preference for female confidantes is consistent with extant literature that males (including male therapists and health care professionals), relative to their female counterparts, demonstrate lower empathy, less patience, and more judgmental attitudes toward clients and others in distress (particularly males); exhibit less supportive responses to suicidal males than toward suicidal females; and more reticent and less empathic responses toward suicidal individuals than do females (Cato & Canetto, 2003; Good et al., 2000; Kassing et al., 2005; Maris et al., 2000b). Evidence also exists that males manifest a greater readiness to accept and concur with suicidal decisions of others as reasonable and viable options (Cato & Canetto, 2003). Similar data exist that male family doctors, relative to their female counterparts, have demonstrated more distancing, less emotional engagement, less active questioning, more negative views, greater suggestion of victim-deservedness, and more victim-blaming of partner-abused patients (Lo Fo Wong et al., 2006). Such findings
should be of interest to all professionals seeking to maximise their therapeutic potential and the tangible assistance they render their clients.

3.4.6 Victim Preferences for Confidante Type

In terms of confidante type, it is salient to note that a friend was the most popular choice of confidante, followed by a partner, family member, counsellor, psychologist, and psychiatrist. However, less than sixty percent of CSA victims had actually spoken with a partner about their CSA experience/s, only half had spoken with family, less than one third had spoken with a counsellor, and fewer had spoken with a psychologist or psychiatrist, or others. These findings highlight the continuation into adulthood of the secrecy, loneliness, and isolation which characterise the lives of many who experience sexual abuse in childhood. Further, they demonstrate the privileged position in which both health professionals and those close to victims of CSA, are placed, and concomitantly, the potentially critical implications of their response on victim wellbeing. The comparative rarity with which CSA victims confide in health professionals, relative to disclosure to friends, partners, and relatives, is also revealed. Thus, whilst the imperative of competent responses from health professionals is clear, these results underscore the need for empathic and appropriate responses from nonprofessionals, and by extension, the importance of public education to raise empathic awareness and understanding of the issues surrounding childhood sexual abuse.

The finding that friends were perceived by CSA victims as the most helpful of the confidante types, followed by partners, psychologists, family members, counsellors, and sexual assault counsellors, highlights not only the important role of psychologists and counsellors in assisting victims of such abuse, but also the critical role played by nonhealth professionals. These findings demonstrate further the need to disseminate accurate information and develop informed understanding of CSA at the community level. It is clear that many individuals without relevant training are entrusted by CSA victims and are thus presented with a unique opportunity to assist in meaningful and important ways, both directly and by encouraging victims to seek professional assistance as appropriate. Equally however, individuals thus entrusted are placed in a position of responsibility such that their responses hold the potential for both positive and negative repercussions for the person seeking their trust.
Regrettably, evidence from this study demonstrates powerfully the high rate with which CSA victims received suboptimal reactions from family and friends, and indeed, that such reactions were much more common than optimal reactions, particularly during childhood. Thus, the findings underscore yet again, the need to maximise (through public education) community awareness of the issues pertinent to CSA, and the importance of offering appropriate, nonjudgmental reactions to victims in response to disclosures of such abuse. It is of further concern to note that, of the small minority of CSA victims who received counselling in childhood, only one in three perceived this to have been helpful to some extent, and very few regarded such counselling to have been considerably helpful. Findings with respect to adulthood counselling for CSA were more optimistic, such that the large majority of persons undertaking counselling perceived this to have been helpful to some extent. Nonetheless, it remains of concern that less than half of these individuals found counselling very or extremely helpful, and close to half had had no counselling in adulthood in relation to CSA. Given the extent of protracted negative sequelae to such abuse, these findings highlight both the need for improved intervention approaches and the need to address the low rates at which CSA victims access appropriate therapy. Whilst it was beyond the scope of the current study to examine which aspects and types of intervention were perceived by CSA survivors as most beneficial, and how such perceptions might differ across gender and abuse type, such questions are important to address in future research.

### 3.4.7 Police Reporting of Childhood Sexual Abuse

Police reporting of childhood sexual abuse during the victim’s childhood

Similarly to the low rates of therapeutic help-seeking observed in the current study, low rates were found with respect to police reporting of CSA. Of the small minority of CSA victims (<7%) whose abuse was reported to police during their childhood, most perceived this to have been unhelpful and perceived the outcome as having been unfair. Specifically, less than half reported that the perpetrator was apprehended, and less than one in four reported that the person was charged or convicted. Considering that 93.1% of CSA was not reported to police during the victim’s childhood, these figures suggest that less than 3% of the total CSA perpetrators described by the sample were known to have been apprehended and less than 2% were known to have been charged or convicted. These figures are consistent with estimates in the literature that less than 10% of sexual
offence perpetrators come to the attention of criminal justice or health systems, far fewer are apprehended and prosecuted, and less than 2% of sexual assaults recorded in victimisation surveys result in convictions (ABS, 1996; Lievore, 2003; SAC, 2007a, 2007b; Sanderson, 2004; Stubbs, 2003; VLRC, 2003, 2004). These results contribute to findings in the literature demonstrating that engagement with the judicial system is commonly a harrowing experience for sexual abuse victims (Brereton, 1997; Taylor, 2001; VLRC, 2003), with outcomes often perceived as unfavourable, and that complainant challenges and distress are typically heightened for child victims (Cashmore, 1995; Cashmore & Bussey, 1994, 1996; SCLJ, 2002; VLRC, 2003).

Nonetheless it is salient to note that, notwithstanding their negative outcomes and perceptions, over half of individuals who reported CSA during childhood, expressed no regret in relation to initiating police involvement and only around one in four individuals expressed substantial regret. Indeed, almost half regretted not having made a police report sooner. These findings contribute to the literature that demonstrates a large division between victims in the extent to which they regret instigating, or alternatively, would opt to repeat, judicial proceedings in relation to CSA (Cashmore, 1995; Cashmore & Bussey, 1994, 1996; Eastwood & Patton, 2002; VLRC, 2003).

Evidence from this study, and that of Eastwood and Patton (2002), suggests that if a reporting process is implemented that is sensitive to the needs of CSA victims, then the ‘in principle’ preparedness of victims to repeat the reporting process (should such abuse reoccur) is enhanced. It is noteworthy that previous findings derive from children who have testified in court (e.g., Cashmore, 1995; Cashmore & Bussey, 1994, 1996; Eastwood & Patton, 2002; VLRC, 2003). The results from the current study extend the literature by examining victim perceptions and regrets in relation to both police reporting and nonreporting. Given the high rates of attrition that occur between initial reporting and ultimately providing court testimony in relation to CSA, this represents a sizable extension of the CSA victim sample under examination. Moreover, data in the current study were derived from child complainants in adulthood. Thus, it was possible to gauge CSA victim opinions related to childhood reporting experiences, albeit formed with the benefit of hindsight and from an adult perspective.
Police reporting of childhood sexual abuse during the victim's adulthood

In the current study, the low rates at which CSA was reported to police and indeed, the low rates at which perpetrators of CSA were confronted in relation to such violations, persisted into the victims’ adulthood and are similarly causes for concern. Findings from this study indicate that the vast majority of perpetrators were never confronted (either formally or informally) in relation to their offences, underscoring again the secrecy surrounding CSA, the relative rarity of perpetrator accountability, and the ensuing impunity with which perpetrators of this abuse form are commonly able to offend and reoffend. Police reports in relation to CSA were made rarely by adult victims. In turn, formal charges and convictions were rare amongst reported cases, even though evidence from this study suggests that police reporting of CSA was more likely for cases that involved perpetration of additional (nonsexual) crimes, and in instances when the victim was aware that crimes had also been perpetrated against others.

As with the findings relating to CSA police reporting in childhood (reported earlier), the current findings pertaining to reporting of CSA in adulthood are consistent with those in the literature that 90% of sexual abuses are never reported (ABS, 1996; de Visser et al., 2003; Lievore, 2003; Sanderson, 2004; Stubbs, 2003); that the vast majority of sex offenders are never held accountable for their offences (Sanderson, 2004; VLRC, 2004); and that even when such abuse is reported, rates of charges and convictions remain lower than for other crimes (ABS, 1996; Lievore, 2003; SAC, 2007a, 2007b; Sanderson, 2004; Stubbs, 2003; VLRC, 2003, 2004). Specifically, with respect to the minority of sexual offences that are reported, the attrition rate from reporting to prosecution remains extremely high, such that a large proportion of sexual assault complaints are withdrawn and rates of apprehension, prosecution, and conviction of sex offenders remain characteristically low, such that an estimated less than 2% of sexual assaults recorded in victimization surveys result in convictions (ABS, 1996; Lievore, 2003; SAC, 2007a, 2007b; Sanderson, 2004; Stubbs, 2003; VLRC, 2003, 2004).

Historically, within sex offence law, the evidence of children and minors as a class of witness have been regarded as inherently unreliable (VLRC, 2004). Notwithstanding the fact that such misconceptions have been disproved by empirical research (VLRC, 2004), sexual abuses against children and others within familial settings remain amongst those
most difficult to substantiate and least likely to result in convictions, hampered further by
the relative ease with which children can be intimidated and silenced (through fear or
loyalty) and the reality that sexual offences perpetrated by loved ones and significant
others are those least likely to be reported.

Findings from this study demonstrate that, notwithstanding the fact that police reporting
and ensuing judicial processes in relation to CSA are often distressing and perceived by
complainants as unhelpful and unfair in their outcome, undertaking such action is
nonetheless perceived by many victims as an important process and one that is not
subject to regret. Indeed, it was found that, despite the perception held by the majority of
individuals that the outcome of proceedings had been unfair, most expressed no regrets in
relation to having reported CSA to police in adulthood, and in fact, most expressed regret
in relation to not having reported sooner. Conversely, it is also notable that a significant
minority of adult complainants perceived the process as entirely unhelpful and regrettable.

Aside from highlighting the clear need for continued reforms to improve judicial
processes for complainants in sexual abuse matters (and particularly for child
complainants), these findings underscore the importance of supporting CSA survivors in
making carefully reasoned and informed decisions regarding whether or not to instigate
police action. Given that both courses of action (i.e., reporting and not reporting)
constitute sources of regret for sizable proportions of individuals in this study, these data
indicate that seeking either to dissuade or encourage survivors to make a police report
may be a disservice that, whilst well-intentioned, can serve to facilitate a form of
revictimisation or alternatively, perpetuate the disempowerment and silencing of CSA
survivors.

In the current study, the results obtained from adult complainants mirror those found in
relation to CSA reporting in childhood and in overall terms, juxtapose the view espoused
by some victims and reported in the literature (see for example, VLRC, 2004) that the
distress experienced by sexual abuse victims in the course of police reporting and judicial
processes in some cases outweighs any potential gains derived from such action. Given
that anticipatory fear and anxiety related to stressful court proceedings may inhibit police
reporting and perpetuate silencing of sexual crime victims, the current data showing a
relatively positive ‘net’ outcome provide an alternative perspective for victims of CSA
who must evaluate the advantages and disadvantages of initiating police investigations and possible court action. Accordingly, these findings, if disseminated, may assist CSA victims in making informed, educated, and carefully considered decisions in relation to providing a police report and proceeding with court processes.

3.4.8 Victim Attributions and Perceptions: Implications for Wellbeing

Given the clinical importance of identifying and addressing negative self-attributions and self-talk, it was particularly sought in this study to examine interplays between victim perceptions and attributions pertaining to childhood sexual abuse, adult wellbeing, and suicidality. Whilst most CSA victims reported negative feelings toward the perpetrator/s and almost half reported acute feelings of hate, it is notable that a sizable minority also reported some degree of positive feelings (such as liking, love, or trust) toward this person/s. Such findings proffer testimony to the conflictual nature of the relationship many child victims of sexual abuse have with the perpetrator, demonstrating the mix of emotions experienced by many sexual abuse victims, and the confusion, hurt, and cognitive dissonance surrounding betrayal and exploitation of trust, affection, and love felt toward the abuser. Particularly for child victims perpetrated against by their primary carers, such conflict is intensified due to their dependency for survival on these figures, and the implicit trust and love ordinarily held by children toward the central figures in their lives. These findings provide clear avenues for exploration within therapeutic settings and may assist in enabling victims of CSA to understand and process the impact and corollaries of their abuse.

The presence of residual trust, love, and affection for some perpetrators following abuse strongly underscores the vulnerability of victims for revictimisation, the difficulties many victims experience in distancing themselves from the perpetrator/s, and specifically, the potential for exploitation of such emotions by the original and subsequent perpetrators. Clearly, for children perpetrated against by primary carers and close relatives, distancing themselves is rarely viable or within their control, exacerbating not only their vulnerability for revictimisation, but also the perturbation and risk to wellbeing frequently concomitant with powerlessness to affect change in one’s circumstances and perceived hopelessness of one’s situation. Indeed, the strong relationship known to exist between hopelessness and suicidality (e.g., Beck, Brown, Berchick, Stewart, & Steer, 1990; Beck, Kovacs, & Weissman, 1975; Safren & Heimberg, 1999) may explain, at least in part, the
strong links also found between youth suicidality and child sexual abuse (e.g., Anda et al., 2006; Davis & Petretic-Jackson, 2000; Dong et al., 2004; Dorais, 2002; Fergusson et al., 1996; Finkelhor, 1981, 1984, 1986, 2008; Finkelhor et al., 1990; Friedrich, 1988; Fromuth, 1985; Herman, 1992; Kaplan, Pelcovitz, Salzinger, Mandel, & Weiner, 1997; Kaplan et al., 2001; Krug et al., 2002; Lievore, 2003; Maris et al., 2000a, 2000b; Nelson et al., 2002; Russell, 1986; Sanderson, 2004; Stephenson, Pena-Shaff, & Quirk, 2006; Tufts New England Medical Center, 1984; Ullman, 2004; Ullman & Brecklin, 2002, 2003; UN Secretary-General, 2006; van der Kolk, 2003; van der Kolk et al., 1991; van der Kolk, McFarlane, & Weisaeth, 1996; WHO & ISPCAN, 2006).

Whilst the vast majority of CSA victims strongly attributed responsibility for the abuse to the perpetrator, it is noteworthy that almost half also attributed some degree of responsibility to themselves, and a minority perceived themselves to be greatly responsible for their abuse. Such findings have direct implications for understanding child sexual assault trauma and guiding therapeutic intervention. The finding that most CSA victims reported experiencing great difficulty in talking about their abuse has further implications for victim wellbeing and therapeutic approaches.

Such difficulties clearly impede help-seeking and service provision and exacerbate isolation, and thereby, vulnerability to perturbation, revictimisation, and suicidality. Evidence from the current study suggests strongly that online methodologies have much to offer, not only for researching sensitive topics, but also in terms of therapeutic value, particularly for persons for whom the barriers to disclosure through conventional means are sufficient to preclude help-seeking. Indeed, the many and repeated email communications received from respondents indicate the popularity and level of acceptance of online methods both for research of this nature and as a mode of continued therapeutic interaction, information sharing, and referral to professional services.

Benefits of online interaction were particularly evident for respondents who reported never having disclosed their abuse, those who reported serious current suicidal ideation, and those living in remote and rural parts of Australia, who would not otherwise have disclosed their distress. In each case, an individualised approach was able to taken in communicating with the person whilst maintaining a high level of anonymity, privacy,
and confidentiality; and appropriate, personalised referral information and assistance was able to be offered. Many individuals reported therapeutic gains derived from this interaction. Others reported that simply the material presented in the survey and the level of introspection facilitated through the process of completing the survey had resulted in a range of positive outcomes (e.g., raising insight; enabling survivors to conceptualise their abuse in more adaptive ways; prompting individuals to revisit and seek to address unresolved issues; and prompting a number of individuals to engage in therapy).

Whilst not designed as, nor professing to be a therapeutic initiative, the positive outcomes of the current research reported by these individuals are clearly welcome corollaries of the research, and augur well for both similar modes of research, and online therapies in the future, particularly in relation to topics subject to stringent taboos and stigma, and especially for initiatives aiming to be inclusive of marginalised or hidden populations and those in remote geographical locations. Whilst it might be argued that online therapeutic interventions cannot compare favourably with the gains that can be afforded through conventionally conducted therapy and the concomitant value of human connection and therapeutic alliance that can derive from face-to-face interaction, findings from this study lend further support to the notion that online methods can tread where conventional approaches cannot. Further, it may be that online supports can offer a ‘stepping stone’ for persons who may progress, in time, to seek conventional therapy. It is pertinent to this argument that most individuals expressed some degree of regret, and over one third expressed strong regret in regard to not having spoken sooner or more about their CSA experience/s.

Overall, the current study provides ample evidence to support previous findings that online methodologies have many advantages over conventional approaches and are able to make valuable contributions to both research and service provision initiatives pertaining to broad ranging psychosocial and mental health concerns (Birnbaum, 2000, 2004; Daneback et al., 2005; DuRant et al., 2007; Feldman & Freedenthal, 2006; Fikar & Keith, 2004; Gosling et al., 2004; Hanna et al., 2005; Harding & Peel, 2006, 2007; Reimers, 2007; Reips, 2002; Shikiar et al., 2005). Importantly, the current study also provides encouraging findings consistent with those of others (see Hanna et al., 2005) that the benefits of online methods are particularly pronounced in initiatives addressing sensitive topics and targeting hidden, isolated, disenfranchised, and highly stigmatised
populations (e.g., Bowen, 2005; Boyle & Boekeloo, 2006; DuRant et al., 2007; Hanna et al., 2005; Oksuz & Malhan, 2005; Reimers, 2007; Ross et al., 2003).

3.4.9 Suicidality, Childhood Sexual Abuse, and Victim Attributions

As noted earlier, high levels of suicidality were found within this cohort, both in the immediate aftermath of the CSA and over the lifespan, attesting both to the high level of negative emotion experienced by many children following such abuse, and to the longterm negative impact of CSA. It is notable that suicidal ideation and suicide attempts were disproportionately high amongst CSA victims, relative to nonvictims of CSA, even though a large proportion of individuals in the latter group had experienced other abuses, such as sexual abuse in adulthood and intimate partner violence. These findings are consistent with the extant empirical literature in evidencing a robust correlational relationship between CSA and subsequent suicidality (e.g., Anda et al., 2006; Davis & Petretic-Jackson, 2000; Dong et al., 2004; Dorais, 2002; Fergusson et al., 1996; Finkelhor, 1981, 1984, 1986, 2008; Finkelhor et al., 1990; Friedrich, 1988; Fromuth, 1985; Herman, 1992; Kaplan et al., 1997, 2001; Krug et al., 2002; Lievore, 2003; Maris et al., 2000a, 2000b; Nelson et al., 2002; Russell, 1986; Sanderson, 2004; Stephenson et al., 2006; Tufts New England Medical Center, 1984; Ullman, 2004; Ullman & Brecklin, 2002, 2003; UN Secretary-General, 2006; van der Kolk, 2003; van der Kolk et al., 1991, 1996; WHO & ISPCAN, 2006).

The current study also contributes new findings by measuring victims’ subjective self-appraisal of suicidality causation. It is notable that the vast majority of CSA victims who had attempted suicide subsequently to experience/s of sexual abuse attributed the attempt/s to the CSA to some degree, and over half strongly attributed their attempt/s to this abuse. No known studies have previously examined CSA victims’ attributions regarding their suicidality, nor compared suicide attempters and nonattempters in terms of disclosure experiences, abuse-related self-blame, and abuse severity.

Further, salient points of difference were identified by this study between CSA victims who had attempted suicide and those who had not, extending both the suicidality literature and the literature pertaining to CSA. Whilst such findings are not intended as statements of causation, identification of attributions, perceptions, and sexual abuse sequelae that have significant relationships with suicidality is nonetheless able to gainfully
inform extant understanding of the complex interplays between sexual abuse and suicidality, and contribute in tangible ways to risk assessment and treatment approaches. Data of this type have not previously been forthcoming.

Specifically, from a therapeutic perspective, it is noteworthy that suicide attempters, relative to nonattempters, attributed greater responsibility for the CSA to themselves, and experienced greater difficulty in talking about their experience of CSA. Notably, suicide attempters were also more likely to express the desire for disclosure but perceive this to be ‘too difficult’, and expressed significantly greater regret in relation to not speaking more or sooner about their experience of CSA, relative to nonattempters. Moreover, individuals who expressed the desire to speak about their CSA experience more strongly attributed their suicide attempt/s to their abuse, relative to those who did not express such a desire. Similarly, those expressing the intention to disclose more strongly attributed their attempt/s to CSA, relative to those who had ‘no intention’ to disclose.

It appears that the desire and need for disclosure is commensurate with the level of perturbation. Yet this presents a circular problem in that it appears that the greater the level of shame, guilt, and perturbation, the greater the barriers to disclosure. The finding that only the minority of those who had attempted suicide had disclosed their experience of CSA during their childhood attests to this relationship. These findings lend further support to the notion that online therapeutic approaches are able to offer something of value to persons who find the concept of conventional therapy overly daunting or who through personal or external barriers are precluded from accessing therapy through conventional avenues.

Equally salient are the findings that suicide attempters, relative to nonattempters, had encountered more hostile, blaming, or rejecting reactions in childhood, and expressed greater regret regarding disclosure to family or friends in childhood. These data attest to the potentially pivotal impact on victim wellbeing of the reactions such individuals encounter upon CSA disclosure. The current finding that suicide attempters, relative to nonattempters, had received more counselling or services for CSA in both childhood and adulthood similarly raises interesting issues. Whilst this finding suggests that health professionals are often presented with opportunities for intervention pertaining to suicidality and sexual abuse and are potentially well placed for detection of risk, it also
raises questions as to how often professionals are unwittingly placed in such positions, and thus, how often vulnerabilities remain undetected.

Persons who had attempted suicide subsequent to CSA were also more likely, relative to CSA victims who had not attempted suicide, to perceive their CSA experience as very damaging, and more likely to conceptualise their CSA as a ‘crime’, as ‘sexual assault’, and as ‘rape’. The degree to which such perceptions reflect greater severity of abuse, relative to that sustained by nonattempters, or instead, reflect differences in cognitive appraisal of CSA experiences between attempters and nonattempters, remains somewhat open to conjecture. However, convergent evidence from this study suggests that severity of abuse is proportionately associated with suicidality. Indeed, relative to nonattempters, CSA victims who had attempted suicide subsequently to their abuse reported having sustained a significantly higher degree of physical injuries, were more likely to report exposure to risk of sexually transmitted infection (STI) as a result of CSA, and more likely to report having contracted a STI as a consequence of such abuse. Indeed, of the small minority of CSA victims who reported having contracted a STI as a consequence of CSA and the larger minority who expressed uncertainty about whether they had contracted a STI in this manner, the majority had attempted suicide at some later time, in contrast to the minority of suicide attempters amongst CSA victims who reported not having contracted a STI from the perpetrator/s.

Whilst infection with diseases such as human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) has been established as a factor that increases risk for suicidality (Cooperman & Simoni, 2005; Komiti et al., 2001), the impact of other STIs on suicidality risk has been sparsely investigated to date. Moreover, what data exist derive largely from adult males and females and particularly specific populations such as HIV-positive individuals, intravenous drug users, psychiatric patients, and gay men (Cooperman & Simoni, 2005; Komiti et al., 2001). In contrast, STI has rarely been considered either as a corollary of CSA or as a likely significant factor in CSA victim suicidality, and data pertaining to STI in children or related to CSA remain sparse and unreliable (Neinstein, 2008). The current research represents the first known study to examine STI more broadly and in the context of both CSA and suicidality. Given the heightened level of taboo that hampers discussion of, and attention to CSA, STI, and suicidality, limited opportunities to date to address these problems in
combination is not surprising. Given the health and social implications of neglecting to address STI in children and the powerlessness of children to self-manage such problems, such omission is concerning. Findings of the current study demonstrate that assessments of both CSA and suicidality (particularly where the possibility exists of a concomitant CSA history) should encompass consideration of possible STI and other physical impact.

In this study, individuals whose CSA experience was reported to police (either in childhood or in adulthood) represent only a small minority of CSA victims overall. As noted earlier, this is consistent with the literature in demonstrating that the vast majority of CSA is never formally reported or brought to the attention of law enforcement agencies (ABS, 1996; Lievore, 2003; SAC, 2007a, 2007b; Sanderson, 2004; Smith et al., 2002; Stubbs, 2003; VLRC, 2003, 2004). It is a notable and new finding however, that suicide attempters within the minority group of victims whose abuse was reported to police more strongly attributed their attempt/s to their CSA experience, than did attempters for whom no police report was made. Moreover, individuals whose matter was reported to police in childhood were more likely to have attempted suicide, relative to those for whom no police report was made. Again, whilst important implications for vulnerability and risk detection arise from these findings, it would be imprudent to draw causal connections from such data. Whilst it appears from the present findings, and seems intrinsically plausible, that police reporting signifies higher severity of abuse (in that the most overtly serious and physically injurious cases are those most likely reported) and that police reporting therefore serves as a marker of greater perturbation (and thus, possibly higher suicidality risk), other explanations are equally possible, and the veracity of such conjecture cannot be definitively ascertained from the current data. Further research is warranted in order to ascertain whether these results can be replicated in larger samples and are thus generalisable to wider populations.

Nonetheless, findings derived from this study strongly suggest that suicidality risk increased proportionately to the severity of CSA. Indeed, suicide attempters were substantially overrepresented amongst CSA victims who had had additional (nonsexual) crimes perpetrated against them by the sexual abuser, and similarly overrepresented amongst victims who reported an awareness that the perpetrator/s had also committed offences against another person/s. However, whilst severity of CSA and indeed, even the occurrence of CSA and other abuses are difficult to detect and often remain undetected,
concomitant suicidality if present, can similarly evade detection. Thus, a police report of
CSA may serve as a useful, tangible marker to alert practitioners and others to the need
to assess and consider the possibility of suicidality risk. Given the gravity and potential
for lethal outcome, it is contended that assessment of suicidality risk should be a standard
compontent of all assessments pertaining to CSA, and particularly so, in the presence of a
police report. Equally, it can be argued that assessments pertaining to suicidality should
routinely include screening for a history of sexual and other abuses.

3.4.10 Nomenclature: Implications for Research and Clinical Practice

Whilst the vast majority of CSA victims conceptualised their abuse as ‘sexual assault’ and
as a ‘crime’ to some extent, considerable variability was evident in the extent to which
victims endorsed such ‘labels’ with respect to their own experience/s. Similarly, whilst
more than half of CSA victims also conceptualised their abuse as ‘rape’, less than forty
percent strongly endorsed this perception, suggesting considerable ambivalence amongst
those who have experienced penetrative CSA regarding the use of this term to describe
their abuse. The finding that substantially fewer individuals perceived their abuse as
‘rape’, relative to the numbers who reported penetrative CSA, further suggests a lesser
inclination amongst penetrative CSA victims to identify themselves as a ‘rape’ victim or
to conceptualise their experience as ‘rape’, in comparison to ‘sexual assault’, ‘sexual
abuse’, or ‘crime’. These results are consistent with previous findings demonstrating the
underenumeration and misclassification that can result through the use of heavily laden
terminology and label descriptors. For example, research has found that around fifty
percent of women whose sexual abuse meets the legal definition of rape do not apply this
label to their experience (McMullin & White, 2006).

The current findings suggest substantial ambivalence overall with regard to the use of
such terms, and reveal the variation that exists amongst individuals firstly, with respect to
how terms of this nature are defined, and secondly, with regard to how such terms are
deemed applicable to personal experiences. Accordingly, these findings demonstrate the
importance of using behaviourally descriptive terminology in preference to label
descriptors such as ‘rape’ (Groth-Marnat, 2003). Further, these data support ‘best
practice’ recommendations made by Groth-Marnat, Kilpatrick, Tjaden, and Thoennes,
amongst others, to adopt a comprehensive approach; precise, unemotive, language; and a
multiple-definition and multiple-measurement research design (in lieu of a single
The definitional and single-measurement approach) when conducting psychological assessments and specifically when measuring violent victimisation (APA, 2001; Groth-Marnat, 2003; Kilpatrick, 2004; Tjaden, 2003, 2004; Tjaden & Thoennes, 2000a, 2000b, 2000c). Such measures are important in order to minimise ambiguity, effects of variations in definitions of terms such as ‘rape’ and ‘sexual abuse’, and possible (unwanted and unmeasured) effects of applying terminology with highly emotive and social overtones and widely variant nuance (e.g., reticence to self-identify with emotive and value-laden resulting in underenumeration).

3.4.11 Current Study: Strengths, Limitations, Outcomes, and Implications

The sexual abuse and suicidality literatures are replete with studies in which limitations derive from the use of ill-defined terms and constructs and those open to widely divergent interpretation and ambiguity (see Kilpatrick, 2004; O’Carroll et al., 1996; Tjaden, 2003, 2004; Tjaden & Thoennes, 2000a, 2000b, 2000c). Indeed, this literature is hallmarked by the considerable problems in comparing data from different sources that arise from the widely variant meanings ascribed across studies to terms such ‘sexual assault’ (Cupach & Spitzberg, 2003; Kilpatrick, 2004; McMullin & White, 2006; O’Carroll et al., 1996; Tjaden, 2003, 2004; Tjaden & Thoennes, 2000a, 2000b, 2000c). It is a particular strength of this study, that recommendations pertaining to issues of nomenclature, definitions, and wording were closely applied. Specifically, use of terms such as ‘rape’ was avoided, behavioural descriptors were used, and to ensure uniformity across respondents, definitions were provided for terms subject to ambiguity or varying interpretations (e.g., sexual intercourse). Further in accordance with recommendations, the method of seeking convergent evidence from multiple measures was applied in order to ascertain ‘victim status’, in lieu of reliance on a single-item screening question that is often used in sexual assault research to define victim and nonvictim status (Kilpatrick, 2004; Tjaden, 2003, 2004; Tjaden & Thoennes, 2000a, 2000b, 2000c).

A number of additional attributes contribute to the strength and uniqueness of this study. The inclusion of males contributes to the representative nature of the sample and the utility of the study (such that male CSA victims were able to be represented and compared both with female victims and male nonvictims), and constitutes a particular feature of the study, given that males are notably absent in much of the research pertaining to CSA.
Amongst other strengths are the generally inclusive nature of the research; inclusion of multiple comparison groups (e.g., victim/nonvictim, male/female, suicide attempter/nonattempter); examination of victim appraisal, attributions, and offence processes and outcomes; collection of both quantitative and qualitative data; examination of both childhood and adulthood sequelae of CSA; examination of a broad range of psychosocial domains including suicidality, adulthood sexual revictimisation, and intimate partner violence; and the use of a large and demographically diverse sample.

Indeed, experience of sexual abuse in childhood was reported by slightly less than half of respondents. Thus, the study utilised a CSA victim group of almost one thousand individuals and a nonvictim comparison group of over 1,500 males and females. Respondents derived from both urban and rural communities within each state of Australia, representing substantial heterogeneity with respect to age, socioeconomic status, cultural background, and demographic variables, and reflecting much of the diversity present in the general Australian population.

In terms of limitations, both the retrospective nature of this study and the limitations inherent in all self-report studies must be acknowledged (for discussion, see Belk, 2006; East & Uncles, 2008; Gearing et al., 2006; Gotlib & Hammen, 2009; Koop & Strang, 2002; Teitler et al., 2004; Sheinberg & Fraenkel, 2001; Sherer et al., 2001; Tomlinson, 1984). Nonetheless as discussed earlier, cogent arguments also exist that retrospective research methods constitute indispensable methodologies with distinct advantages and the potential to provide research opportunities and rich, unique, and in some cases, more valid, data that are not otherwise attainable (Belk, 2006; East & Uncles, 2008; Gearing et al., 2006; Gotlib & Hammen, 2009; Koop & Strang, 2002; Teitler et al., 2004; Sheinberg & Fraenkel, 2001; Sherer et al., 2001; Young, 1976).

Research has also shown that several concerns regarding memory reliability have been unsubstantiated by data, leading authors to conclude that retrospective methods have been unnecessarily underutilized and undervalued in many areas of mental health research including child, adolescent, and adult psychiatry (Brewin, Andrews, & Gotlib, 1993; Gearing et al., 2006; Gotlib & Hammen, 2009). Indeed, whilst typically underpinned by retrospective self-report and self-appraisal, clinical interviews and questionnaires are classical cornerstones of psychiatric and psychological research,
assessment, and interventions, and indispensable in many areas of human research (such as child abuse) in which a ‘gold-standard’ research design such as the randomised clinical trial cannot be ethically or feasibly applied (Lerner et al., 2002).

This study relies on the memory and subjective appraisal of abuses that occurred in some cases, decades previously. The literature pertaining to false memories, postevent suggestion, and memory failures in witnesses, particularly over time and in the presence of strong emotion cannot be discounted (see Bell & Loftus, 1989; Bjorklund, 2000; Brainerd & Reyna, 2005; Chaffin, Lawson, Selby, & Wherry, 1997; Garry, Manning, Loftus, & Sherman, 1996; Loftus, 2002, 2003; Stocks, 1998). However, such concerns must be countered against several main arguments. First, there are clear and substantial matters of feasibility and ethical considerations that preclude the conduct of this type of research with children directly, and historically, the judicial system has considered the ‘suggestibility’ of children as problematic and the testimony of child witnesses as unreliable (see Bala, Nicholas, Lee, Lindsay, & Talwar, 2001; Bruck, Ceci, & Hembrooke, 2002; Cashmore & Bussey, 1995; Ceci & Bruck, 1993, 1995, 1998; Ceci & Friedman, 2000; Ceci, Huffman, Smith, & Loftus, 1994; Ceci, Loftus, Leichtman, & Bruck, 1994; Flin, Kearney, & Murray, 1996; Goodman & Helgeson, 1985; Law Reform Commission of Western Australia [LRCWA], 1991; New Zealand Law Reform Commission [NZLRC], 1996; Saywitz, 1995; Spencer & Flin, 1993; Talwar, Lee, Bala, & Lindsay, 2006; VLRC, 2004; White, Leichtman, & Ceci, 1997). Thus, both ethical and practical barriers preclude the use of children in first-hand research examining CSA, particularly of such a detailed, introspective, and highly personal nature, with the result that research of this nature can only feasibly be conducted with adults, and thus, retrospectively.

Second, retrospective research has been vulnerable to criticism not only because of problems related to recall fallibility and biases, but also because of the subjective stance of self-reporters and a likely propensity to reconstruct histories based on personal experiences, cognitive stance, belief systems, and subjective appraisal of events. However, as noted above, an extensive review of research has revealed that several concerns regarding memory reliability have failed to be substantiated by data (Brewin et al., 1993; Gotlib & Hammen, 2009).
Third, given that a principal aim of the study was to examine impact of CSA in adulthood and over prolonged periods, it is therefore, by definition, necessary for such research to be conducted after significant time has elapsed since the experience of abuse. Fourth, whilst responses and accounts are indisputably subjective, it is, within the central tenets of cognitive behavioural theory, precisely the ‘subjective’ response to life events that dictates wellbeing, rather than events or absolute ‘truths’, per se. Thus, in order to advance extant understanding of traumatic sequelae and therapeutic needs pertaining to CSA, it is necessary to measure precisely those subjective appraisals, and beliefs rather than the events or ‘truths’ directly. Nonetheless, wherever possible, steps were taken to maximise the accuracy of responses. For example, careful attention was paid to avoid ambiguity of questions and terminology, opportunities were offered to respondents throughout the TSP to provide additional qualitative comment in order to elaborate or explain responses, and many domains were measured in multiple ways in order that convergent evidence was able to be obtained. Further, large victim and nonvictim samples were utilised to maximise power and validity of data, and to offset as far as practicable, the effects of limitations inherent in research of this nature.

In terms of possible benefits arising from participation in this research, a number of welcome and promising, albeit unexpected, findings became evident throughout the period of data collection. Given the importance ascribed, within a therapeutic perspective, to the development of insight, and the effective conceptualisation and processing of traumatic life events, it might be predicted that research examining how individuals perceive, appraise, and understand their abuse and concomitant factors can gainfully inform clinical practice. However, the processes invoked by participating in the research (i.e., processes of introspection and responding to the questions and issues raised by the TSP), ostensibly in themselves facilitated therapeutic gains for a sizable number of individuals. Indeed, the degree to which such gains were spontaneously reported by respondents was unanticipated.

Specifically, sentiments commonly expressed by respondents conveyed their beliefs that completing the survey had increased their insight; brought to the fore long buried emotions and memories; spawned the decision (and courage), and provided the impetus to seek therapy; and led to more adaptive perceptions of their abuse experience (i.e., less self-blaming and accordingly, less shameful). Many respondents reported on childhood
sexual abuse that had occurred decades previously. Many commented on the profound, negative impact of their childhood abuse on their adult lives, and the defining, deleterious influences of this abuse on intimate relationships, marriages, parenting, and mental health. Recurrent themes exemplifying the protracted, entrenched, and far-reaching nature of such corollaries were strongly evidenced by quantitative data, and powerfully elucidated by qualitative findings.

The findings of the current study underpin the pivotal importance of early intervention that is able to thwart the destructive, potentially life-altering, impact of CSA on individuals, families, and communities. The fact that therapeutic gains were reported from a relatively simple, short ‘nontherapeutic’ exercise is highly encouraging. Specifically, such outcomes raise implications and augur well for the development and delivery of cost effective, highly accessible, user-friendly, and relatively nonthreatening, non-invasive, and private, empirically-derived therapeutic modalities (e.g., self-help manualised intervention, online delivery, bibliotherapy).

The following explanatory model derives from the feedback received from participants, and is put forward as a possible conceptualisation of how therapeutic gains were derived from the process of reflection promulgated by participation in the TSP. It must be noted that this model, whilst seemingly plausible, remains a speculation. It is contended, on the basis of feedback received, that for some individuals, the perceptions formed in childhood (and thus, from the limited perspective of a child), about their abuse and themselves, remained ‘frozen in state’ throughout their adulthood, seemingly immutable to change. Likely, this effect was potentiated for the many individuals who had actively striven to bury their experiences, ‘forget about it’, and ‘pretend it never happened’.

Commonly, it seemed that the profound sense of dark secrecy, guilt, shame, impaired self-esteem, and ‘self-flagellation’ that had formed in childhood in response to their then perception of being a ‘dirty’ or ‘bad’ child, responsible and blameworthy for the abuse perpetrated against them, had not been subject to modification as might have arisen if viewed through the eyes of an adult. Induced by the process of participating in the TSP, processing and conceptualising the event from the perspective of an adult was able to engender feelings of protectiveness (as opposed to blame) toward the ‘child victim’ (i.e., themselves). A more ‘rational’ adult appraisal, rather than an emotive appraisal formed
from a child’s sensibility, facilitated a reconceptualisation of the abuse, such that the power imbalance between the adult perpetrator and child victim, and the powerlessness, vulnerability, and hence, blamelessness of the child was better able to be appreciated. Clearly, further research is needed to test such a model. However, if found to be of merit, such principles could be applied to gainfully inform current approaches to clinical practices relating to CSA and other childhood traumas.

It is important to note that the sizable minorities who respectively reported never having disclosed CSA to anyone; wishing to disclose but finding it too confronting; and having no intention of disclosing to anyone, nonetheless made an online disclosure through their participation in the TSP. This indicates the promise conferred by online methods of creating a less confronting climate, relative to conventional methods, and increasing disclosure and reducing inhibition. Whether such effects can be replicated in online therapeutic applications with similarly vulnerable populations and confronting subject matter remains a matter for future research. Specifically, it will be of importance to examine whether the promising outcomes evidenced to date in regard to cybertherapy for a variety of healthcare issues such anxiety, phobias, panic, eating and body dysmorphic disorders, depression, and smoking (e.g., Brendryen, Drozd, & Kraft, 2008; Christensen, Griffiths, & Jorm, 2004; Meyer et al., 2009; Wiederhold & Wiederhold, 2006) can be replicated for online treatment approaches specifically targeting problems such as childhood and adulthood sexual abuse and suicidality.

3.4.12 Summary and Conclusions
The current study highlights the vulnerability and isolation of victims of CSA both as children and continuing throughout adulthood. It demonstrates that CSA victims, relative to nonvictims, differ in adulthood on myriad measures of wellbeing. It demonstrates also that whilst male victims of CSA experience similar distress to that of their female counterparts, their lesser likelihood to disclose, and seek or accept succour renders them disproportionately vulnerable to negative corollaries and nondetection. Further, the findings deriving from this study underpin the inherent, multiple difficulties in recognising and addressing the needs of individual victims, and ascertaining and addressing the enormity of the problem at the societal level. Such findings emphasise the need to break taboos, facilitate disclosure, and offer timely, empirically validated intervention, in order
to thwart the chronicity of perturbation and patterns of revictimisation that hallmark the lives of many CSA victims who carry the burden of their abuse in silence and isolation.

A number of attributes contribute to the strength and utility of this study. Prominent amongst these is the broad, inclusive nature of the sampling and data collection methods, and the resultant diversity and size of the sample obtained. Utilisation of a nonclinical, nationwide sample of rural and urban Australians of diverse ages and sociodemographic profiles; inclusion of males and females, and victims and nonvictims; and application of multiple psychometric measures allowed thorough comparative analyses to be conducted across a wide range of variables. The utilisation of an online methodology contributed markedly to the success of the study both in terms of increased financial and logistic feasibility and in terms of facilitating recruitment, participation, and disclosure through enhanced access for diverse populations, user-friendliness, anonymity, and confidentiality.

The current study proffers many tangible data that can inform research and clinical practices, judicial processes, educators, and strategists for social and legal reform, and be applied in practical ways to guide therapeutic and preventive initiatives for both CSA victims and perpetrators. Further, as detailed throughout this discussion, it raises many new questions and implications, and highlights areas of need, both for social change and within research domains and clinical practice - areas in which knowledge deficits are at their greatest, and come at great potential human and social cost. Specifically, the many sparsely understood areas examined in this study in relation to CSA, remain equally poorly understood and underaddressed with respect to sexual abuse in adulthood. Moreover, many of the barriers to better understanding and redressing problems inherent to CSA pertain also to adulthood sexual abuse (ASA). How the findings derived from this study might parallel or deviate from those that could arise in relation to ASA remains open to conjecture in the absence of a parallel study. The data clearly show the multidimensionality of CSA and the far reach of CSA sequelae. The strong relationship found between CSA and suicidality shows the enormity of impact that can accompany such abuse and demands forays into literatures, research areas, and conceptualisations beyond those pertaining to sexual abuse. Thus, this study creates the platform for much further and extended research, and in so doing, creates the impetus for the next and subsequent studies in this thesis.
We owe our children – the most vulnerable citizens in any society – a life free from violence and fear. In order to ensure this, we must be tireless in our efforts not only to attain peace, justice and prosperity for countries, but also for communities and members of the same family.

- Nelson Mandela, 2002
CHAPTER 4

STUDY 2

ADULT SEXUAL ABUSE AND PERTURBATION

4.1 INTRODUCTION

_We must address the roots of violence. Only then will we transform the past century’s legacy from a crushing burden into a cautionary lesson._

- Nelson Mandela, 2002

4.1.1 Overview

Convergent evidence attests to the ubiquitous nature of sexual violence perpetration throughout the world, particularly against females. Estimates for the United States suggest that at least one in five females will experience sexual violence across the lifespan (e.g., Briere, 1992; Koss, Woodruff, & Koss, 1991). Similarly, one in five females and one in twenty males surveyed in Australia in recent years reported having experienced sexual violence since age 15 (ABS, 2005b; Lievore, 2003; Smith, Rissel, Richters, Grulich, & de Visser, 2003). Yet despite the global ubiquity of sexual abuse, such violation remains subject to stringent taboos, stigmatisation, and secrecy, ostensibly comprising the most underreported of all crimes (ABS, 1996, 2005a, 2005b, 2005c; AIC, 2008; DOJ, 1999; Lievore, 2003; Mouzos & Makkai, 2004; Smith & Stewart, 2008). Moreover, whilst it is recognised that sexual violence is also perpetrated against males, for reasons pertaining to heightened stigma, taboo, and patterns of male gender role socialisation, male sexual violation prevalence, processes, and aftermath remain even more sparsely enumerated, understood, and addressed, relative to the sexual abuse of females (Crome, 2006; Good et al., 2000; Griffiths, 2003; Hunter, 1990b; Mezey & King, 1989, 2000; Neame & Heenan, 2003; Stott, 2001; Walker et al., 2005; Worth, 2003).

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Abundant evidence has also been accumulated over recent decades that sexual violation is a pernicious, life-altering experience for many victims, and that the chaos and turmoil that commonly ensues in the aftermath of such abuse is not easily dissipated (Anda et al., 2006; Dong et al., 2004; Finkelhor et al., 1990; Golding, 1999b; Krug et al., 2002; Marx, 2005; Nelson et al., 2002; Russell & Bolen, 2000; United Nations Secretary-General, 2006; van der Kolk et al., 1991; WHO & ISPCAN, 2006). Indeed, myriad psychological, physical, and behavioural sequelae commonly persist long after the occurrence of sexual abuse, with unwelcome corollaries of such victimisation including depression, anxiety, substance misuse, sexual difficulties, interpersonal problems, sexually transmitted infections (STIs), chronic pain disorders, and other physical ailments (Acierno, Kilpatrick, & Resnick, 1999; Anda et al., 2006; Browne & Finkelhor, 1986; Golding, 1999b; Krug et al., 2002; Marx, 2005; Nelson et al., 2002; Resick, 1990; Russell & Bolen, 2000; United Nations Secretary-General, 2006; van der Kolk, 2003; van der Kolk et al., 1991, 1996; WHO & ISPCAN, 2006).

One of the most widespread effects of sexual abuse is posttraumatic stress disorder (PTSD), with estimated lifetime prevalence for PTSD ranging between 30% and 80% amongst survivors of sexual abuse (Acierno et al., 1999). However, it remains largely open to conjecture why some victims will develop serious and protracted symptomology including PTSD, whilst others will not, and indeed, why such extreme variance is seen amongst victims in relation to sexual abuse symptomology. The question of why divergent outcomes amongst individuals emanate from similar adverse events (the concept of multifinality) similarly remains an important area for investigation in the general trauma field, where it is recognised that only the minority of persons exposed to similarly traumatic events will develop PTSD (Breslau, 2002; Cicchetti & Rogosch, 1996, 1997; Flouri, 2005; McMahon, Grant, Compas, Thurm, & Ey, 2003), yet causative and inhibitory pathways for the development of this disorder remain to be adequately understood (Flouri, 2005; Luthar, Cicchetti, & Becker, 2000; McMahon et al., 2003).

Thus, in both the general field of trauma, psychopathology, and resilience; and in the specialist field of sexual abuse trauma, substantive further research is needed to properly understand how pathways and mechanisms by which widely divergent manifestations of psychopathology are formed can be interrupted and circumvented. Importantly, it needs
to be better understood how pathways to psychopathology and perturbation can be diverted instead toward wellness and resilience at the earliest stages of distress (Luthar et al., 2000; McMahon et al., 2003). The current study seeks to inform these literatures through detailed analysis of victim wellbeing and psychosocial variables in the context of sexual abuse sequelae, offence characteristics, and disclosure, help-seeking, and reporting patterns.

4.1.2 Implications and Corollaries of Disclosure and Nondisclosure

Unfortunately, the destructive effects of sexual victimisation are compounded by social conditions that foster stigma, shame, and self-blame in relation to such abuse (Marx, 2005). Disclosure of sexual abuse is frequently met with chastising, judgmental, victim-blaming responses and the validity of reports of sexual abuse is frequently called into question, causing further hurt to victims (for review see Herbert & Dunkel-Schetter, 1992; see also Anderson & Alexander, 1996; Arata, 1998; Armsworth, 1989; Buka et al., 2001; Everill & Waller, 1994; Frenken & Van Stolk, 1990; Gibbons, 1996; Lamb & Edgar-Smith, 1994; Punamäki et al., 2000; Regehr, 1990; Roesler, 1994; Roesler & Wind, 1994; Sanderson, 2004; Tufts New England Medical Center, 1984; Ullman, 1996). Additionally, sexual abuse and the corollaries of such violation are frequently trivialised or ignored by significant others, legal authorities, and even health professionals (Koss et al., 2004; Marx, 2005), and progress through the criminal justice system is recognised as more harrowing and less efficacious for sexual abuse victims than for victims of other crimes (ABS, 1996; Brereton, 1997; Koss et al., 2004; Lievore, 2003; Marx, 2005; SAC, 2007a, 2007b; Sanderson, 2004; Stubbs, 2003; Taylor, 2001; VLRC, 2003, 2004).

Not surprisingly, such circumstances complicate recovery, commonly causing further pain and inhibiting disclosure and help-seeking, to the extent that the minority of sexual abuse victims formally report or speak about their abuse or seek formal assistance (ABS, 1996; de Visser et al., 2003; Lievore, 2003; London et al., 2005; Sanderson, 2004; Smith et al., 2002; Stubbs, 2003; VLRC, 2004). This outcome is problematic given that early intervention is recommended and absence of apposite supports is associated with increased psychopathology in victims of sexual abuse (Ullman, 2004). Regrettably, whilst effective treatments are available to improve quality of life and alleviate distress experienced by survivors of sexual violence and other traumatic events (e.g., Foa, 2000;

High rates of nondisclosure and nonreported sexual abuses are additionally troubling given that, in the absence of police reporting, perpetrators of sexual violations are typically free to reoffend with expected impunity, against new or the same victims. As might be expected, strong cumulative trauma effects are found in relation to sexual victimisation, such that psychopathology severity generally increases proportionately to frequency of abuse. Whilst exceptions inevitably exist, convergent evidence reveals poorer psychosocial functioning in revictimised women, relative to nonrevictimised women (Breitenbecher, 2001; Miner, Klotz Flitter, & Robinson, 2006), and increased psychopathology concomitant with chronic sexual abuse relative to single events (Bagley & Ramsey, 1986; Russell, 1986; Ullman, 2004). It is noteworthy that the literature pertaining to sexual revictimisation is predicated predominantly on findings pertinent to females, to the relative exclusion of male victims, hence very little is known of revictimisation patterns and sequelae in male sexual abuse victims.

In combination, such conditions underscore the need to break cyclical patterns of victimisation and the corollaries of abuse by identifying and deconstructing barriers to disclosure and help-seeking. Yet at the same time, extant findings demonstrate that negative disclosure responses create further hurt for victims and in themselves constitute a form of revictimisation (for review see Herbert & Dunkel-Schetter, 1992; see also Anderson & Alexander, 1996; Arata, 1998; Armsworth, 1989; Brereton, 1997; Buka et al., 2001; Everill & Waller, 1994; Frenken & Van Stolk, 1990; Gibbons, 1996; Koss et al., 2004; Lamb & Edgar-Smith, 1994; Lievore, 2003; Marx, 2005; Punamäki et al., 2000; Regehr, 1990; Roesler, 1994; Roesler & Wind, 1994; SAC, 2007a, 2007b; Sanderson, 2004; Stubbs, 2003; Symonds, 1980; Taylor, 2001; Tufts New England Medical Center, 1984; Ullman, 1996; VLRC, 2003, 2004).

Clearly these are important matters to address, given that encouraging routine disclosure of sexual abuse without also fostering climates conducive to positive responses to such
disclosure may constitute a disservice to victims. Whilst anecdotal and incidental evidence abounds, few quantitative, systematic studies have examined reactions to sexual abuse disclosure in detail, and no known studies have examined victim regrets in regard to disclosure and police reporting, or lack thereof. The sparse existing data suggest that reactions from family and friends are more positive than those received from professionals such as physicians and police (Ullman, 1996). Such findings augur poorly for victims who wish to seek health services and judicial redress, and for those who recommend such actions to sexual abuse victims. Comparative analysis of disclosure responses by confidante type and gender has rarely been conducted, and no known studies of this kind have been undertaken in Australia or included the reactions encountered by male victims.

It is known from attitudinal research in the trauma literature that male victims of sexual abuse and domestic violence and other males in suicidal crises or other distress (relative to their female counterparts) are generally perceived more harshly and with less empathy both by the wider community and by professionals such as doctors, psychologists, and counsellors (Donnelly & Kenyon, 1996; Richey-Suttles & Remer, 1997; Washington, 1999), likely encountering less thorough support and services and heightened disbelief, minimisation, victim-blaming, and stigma, amid other disproportionate barriers to succour (Good et al., 2000; Kassing et al., 2005). It is known also from extant research that male therapists may react more reluctantly and with less empathy toward sexual assault victims and suicidal individuals (particularly males), relative to female therapists (Maris et al., 2000a, 2000b). However, few data derive from victims themselves regarding their predisclosure confidante choices and postdisclosure confidante preferences; and the differential confidante responses they encounter (e.g., by confidante type and gender).

Empirical data pertaining to these issues are needed so as to identify the persons in whom sexual abuse victims confide, factors conducive to favourable disclosure outcomes, and areas in need of change; and to ensure that accurately informed, qualified, and responsible recommendations are made to victims regarding disclosure and police reporting. Such data can also guide protocols for professional training of health and criminal justice professionals and inform strategies for effecting attitudinal shift in the broader community. Specifically, professional training and community education initiatives can be
targeted to confidante types who are remiss in offering optimal responses to sexual abuse disclosure, in order to assist and empower those entrusted by victims to better meet their needs. If available, confidante types such as partners, teachers, and emergency care workers may benefit from self-educative materials (e.g., tip sheets) detailing how best to respond to sexual abuse disclosure. Additionally, such data can be used in delivering parenting courses and professional training to those in whom victims confide (e.g., doctors, teachers, police, health care workers, counsellors), and to guide victims to confide in, and seek help from, those most likely to proffer supportive responses.

The current study examines victim preferences in regard to sexual abuse disclosure confidantes (both pre- and postdisclosure), and victim perceived helpfulness of confidantes, by gender and type (e.g., doctor, partner). Such research has not previously been systematically conducted in male and female adult sexual abuse survivors. Importantly, regrets in regard to disclosure and police reporting (or lack thereof) are also measured, as it is salient to differentiate for example, between what might be a harrowing, yet worthwhile, experience and an experience or action (such as police reporting) that one wishes in retrospective, never to have undertaken.

4.1.3 Treatments for Perpetrators of Sexual Abuse
Extant knowledge about sexual offence perpetrators derives largely from police data and from information divulged by offenders themselves, yet it is estimated that less than 10% of sexual offenders are reported or detected (ABS, 1996; Lievore, 2003; Sanderson, 2004; VLRC, 2004). Thus, comparatively little is known of the approximately 90% of sex offenders who are ‘successful’ in evading detection and never held accountable for their actions or provided with treatment (Sanderson, 2004; VLRC, 2004). Relying on information derived from the minority of sex offenders who are apprehended and then extrapolating from this and generalising to all sex offenders is clearly problematic in itself. However, additional flaws of relying on information divulged by the small subgroup of sex offenders who are apprehended are presented by the particular penchant of this offender cohort for offence minimisation, denial, and victim-blaming, amongst other cognitive distortions and manifestations of poor insight, faking good, socially desirable responding, and lack of candour (Abel et al., 1984; Andrews & Bonta, 2006; Gannon et al., 2007; Garland & Dougher, 1991; Kear-Colwell & Pollack, 1997; Kennedy & Grubin,
1992; Langevin & Lang, 1985; Marshall & Eccles, 1991; Marshall et al., 2006b; Salter, 1988; Sanderson, 2004). Although detailed information regarding offender modus operandi and offence characteristics is rarely sought from victims, it is contended in this thesis that victims comprise a rich and untapped repository of detail that can assist in offender detection and apprehension, and gainfully inform offender treatment protocols, victim treatment programs, and prevention initiatives.

Despite the persistence of the popular myth promulgated by researchers in past decades (e.g., Lipton, Martinson, & Wilks, 1975) that sex offenders are ‘untreatable’ (see Sanderson, 2004), convergent evidence from a growing number of studies undertaken over the last two decades demonstrates that many sex offenders can be effectively treated (e.g., Abel, Mittelman, Becker, Rathner, & Rouleau, 1988; Lee et al., 1996; Looman, Abracen, & Nicholaichuk, 2000; Looman et al., 2005b; Maletzky, 1980; Marshall & Barbaree, 1988; Nicholaichuk, Gordon, Gu, & Wong, 2000). Specifically, three meta-analyses (Gallagher, Wilson, Hirschfield, Coggeshall, & MacKenzie, 1999; Hall, 1995; Hanson et al., 2002) and a number of methodologically sound treatment outcome studies demonstrate that current initiatives in sex offender treatment result in significant reductions in sexual and general recidivism, with particularly favourable effects found in relation to cognitive-behavioral approaches and those that incorporate a relapse prevention component (Andrews & Bonta, 2006; Association for the Treatment of Sexual Abusers [ATSA], 2005; Bonta & Andrews, 2007; Gallagher et al., 1999; Hall, 1995; Hanson & Bourgon, 2008; Lee et al., 1996; Looman et al., 2000; Looman et al., 2005b; MacKenzie, 2006; Marshall & Barbaree, 1990b; Marshall, Hudson, & Ward, 1992; Marshall & Pithers, 1994; Nicholaichuk et al., 2000). Indeed, consistent with the now wide acknowledgement that cognitive-behavioral intervention is the treatment of choice with general correctional populations (Andrews & Bonta, 2006), the employment of this treatment modality has also been recommended as best practice in the treatment of sex offenders (ATSA, 2005).

Whilst such results and the existence of effective treatment modalities are clearly pleasing and augur well for the reduction of sexual offending in the future, it is important to view these relatively recent advances holistically, namely within the context of all sexual abuses that occur in society. To date, sex offender treatment can be effective for the minority of
offenders for whom, and from whose data, it was derived, and for the minority of offenders who are convicted and brought into contact with rehabilitative programs. Thus, the vast majority of sex offenders, their victims, and future victims derive no comfort or benefit from the availability of efficacious treatments, nor are they likely to in the future, in the absence of greater reporting and detection of sex offenders, and whilst treatment remains largely contingent on the tenuous conditions for obtaining convictions for sexual offences (Chung, O’Leary, & Hand, 2006). Enhanced understanding and strategies are needed to address extant barriers in order to facilitate wider and timely reporting, increased detection, and early intervention for those who sexually offend. Early detection is particularly important with this cohort of offenders given that early intervention has been identified as a critical factor in reducing recidivism and circumventing offence escalation and progression to entrenched offending patterns (Boyd, 2006; Nisbet et al., 2004, 2005; Salter, 2003; Sanderson, 2004; Tidmarsh, 1997). Moreover, little is known of the generalisability and efficacy of extant treatments if these were able to be applied to the majority of sex offenders who successfully evade detection and apprehension.

Learning about this hidden population from their victims is ostensibly an important strategy and one of few feasible methods available for gaining a holistic and realistic understanding of sex offenders that is not derived from the small minority who have been detected. Further, despite recent advances in evidence-based treatment, sex offenders continue to be regarded as an offender cohort that is particularly difficult to treat, commonly unmotivated for treatment and uninterested in changing deviant behaviour (Abel et al., 1984; Andrews & Bonta, 2006; ATSA, 2005; Bonta & Andrews, 2007; Garland & Dougher, 1991; Hanson & Bourgon, 2008; Kear-Colwell & Pollack, 1997; Langevin & Lang, 1985; Looman et al., 2005b; MacKenzie, 2006; Marshall & Barbaree, 1990b; Marshall & Pithers, 1994; Marshall et al., 1992; Salter, 1988; Sanderson, 2004).

Specifically, even amongst offenders who have access to best practice intervention, and notwithstanding advances in treatment modalities, high rates of drop-out and noncompletion, lack of engagement in the therapeutic process, persistent denial, and treatment resistance remain issues of concern, (Krug et al., 2002; Looman et al., 2005b; Salter, 2003). It is promising that evidence exists that intervention can reduce sexual recidivism by around half (Andrews & Bonta, 2006; Bonta & Andrews, 2007; Hanson &
Bourgon, 2008; Lee et al., 1996; MacKenzie, 2006; Marshall & Anderson, 2000; Marshall & Pithers, 1994; Marshall et al., 1992, 2006b; Nicholaichuk et al., 2000; Solicitor General of Canada, 1990). However, whilst this is clearly of substantive benefit to the community as a whole, it offers little solace to the victims of perpetrators who, despite all intervention efforts, persist as sexual recidivists. The challenge remains to further reduce recidivism rates in sex offenders.

Similarly, despite sizable advances in actuarial and nonactuarial measures for offender risk assessment (de Vogel et al., 2004; Boer & Hart, 2008; Hanson, 1997; Hanson & Bussière 1998; Hanson & Harris, 2000, 2001; Hanson & Thornton, 1999, 2000; Hare, 1998, 2003; Lund, 2000; Kemshall, 2001, 2003; Kemshall & McIvor, 2004; Serin et al., 2001; Thornton & Doren, 2002), inherent limitations remain, and prediction of sexual recidivism and risk to the community remains a challenging endeavour and an area of concern for those engaged in assessment and treatment of sex offenders and those who make recommendations and decisions regarding sentencing and release from custody and supervision orders. For instance, actuarial instruments for measuring the risk of sexual recidivism are of limited utility for determining specific risks, such as the level of risk posed to specific victim types (Proeve et al., 2006). Thus, from multiple perspectives, it is clear that substantive further work is needed in order to better understand and address sex offending amongst both detected and undetected perpetrators.

Specifically, the nature of what constitutes ‘best practice’ in the assessment and treatment of sex offenders continues to remain open to conjecture and testing, albeit to a far lesser degree than was the case prior to the emergence of recent studies and meta-analyses such as those cited above, by Hall (1995); Gallagher et al. (1999); and Hanson et al. (2002) (for discussion, see Looman et al., 2005b). Indeed, during the 1990s, the treatability of sex offenders and efficacy of treatment programs was the subject of sizable debate, with some researchers contending that sex offenders can be effectively treated (e.g., Marshall & Pithers, 1994; Marshall et al., 1991b, 2006a, 2006b), and others, in line with a controversial review published by Furby, Weinrott, and Blackshaw (1989), adopting the more pessimistic stance that little or no evidence existed to support the treatment efficacy of this offender group (e.g., Quinsey et al., 1993, 1998).
Contradictory findings arose in part from variation in treatment modalities (e.g., cognitive-behavioral, strictly behavioural, chemical, electronic monitoring), scientific rigour and research methodologies, and offender typology (e.g., paedophile, rapist), and because sex offender treatment outcome research is hampered by an array of factors (Looman et al., 2005b; Marshall & Pithers, 1994). Such complicating factors include low base rates, resulting in part from low rates of reporting by victims, low apprehension and conviction rates amongst sex offenders, near total absence of self-reported sex offending, and imprecision of sex offenders’ self-reports (Marshall & Pithers, 1994). However, recognition of the variance in treatment outcomes has in itself been useful in highlighting the heterogeneity that exists amongst sex offenders (e.g., child molesters, rapists, preferential versus opportunistic offenders, stranger versus date or intimate partner), the nature of their offences, motivations, and fantasies, and the way such fantasies are enacted. It was recognised that differential treatment outcomes were not precipitated simply by differences in individuals and treatment modalities, but also because varying offender types respond differently to treatment (Holmes & Holmes, 2002).

It follows therefore that broad, detailed understanding of offenders and offences and the inherent variants that exist in sex offending is necessary in order to effectively address this problem from both offender treatment and offence prevention perspectives. This view is consistent with evidence that sex offender treatments have become more effective as more has been learned about the variant and complex nature of sex offending (Alexander, 1999; Marshall & Pithers, 1994; Marshall et al., 1991a, 1992), and as it has come to light that some earlier conceptualisations and theories may have been inaccurate, overly simplistic, or misguided. For instance, on the widely held premise that many sex offenders are deficient in empathy for their victims, and that such a deficit represents one less barrier to be surpassed in order to engage in harming behaviours, it has been generally thought that assessment and enhancement of victim empathy is important for rehabilitation and should therefore form an integral part of sex offender treatment (e.g., Chaplin, Rice, & Harris, 1995; DeGue & DiLillo, 2005; Fernandez, Marshall, Lightbody, & O'Sullivan, 1999; Marshall, 1996a, 1996b; Marshall & Barbaree, 1990a; Marshall, Hudson, Jones, & Fernandez, 1995; Pithers, 1999; Rice, Chaplin, Harris, & Coutts, 1994; Roys, 1997).
However, this notion has latterly been challenged by the finding that child molesters exhibited no less empathy toward sexual abuse victims in a hypothetical context, than their nonoffending counterparts (Teuma, Smith, Stewart, & Lee, 2003). Such findings suggest that factors such as cognitive distortions, minimisation, and denial experienced in a sex offending context may negate or override the intrinsic empathy that might otherwise be felt toward one’s victim and serve to dissuade against sexual coercion or aggression. In other words, sex offenders who are able to justify their actions (e.g., perceived entitlement, victim deservedness, victim blaming) or perceive their actions as nonharmful to the victim are unlikely to experience cognitive dissonance related to victim empathy that might serve to inhibit offending. Indeed, such findings suggest that cognitive distortions, minimisation, and denial are necessary conditions for some sexual offending (particularly against children) given that in the absence of buffers of this kind, victim empathy can be an effective inhibitor against offending.

Findings of this nature suggest that addressing cognitive error, denial, and minimisation may be even more critical than formerly realised, and that such issues are important to address in the initial stages of treatment in order for constructs such as empathy and other treatment components to be meaningfully addressed. Of course, it should also be considered that findings of this type may reflect the ability of sex offenders to provide socially desirable responses and caution against unquestioningly accepting as truths the testimonies provided by individuals who seek to minimise their culpability. Again, such observations strengthen the argument for collecting information pertinent to sexual offending from multiple sources (including victims), rather than relying on that divulged by those with vested interests and inherent traits to minimise and distort their own behaviours. Moreover, such findings highlight the complexity of sex offending, the flaws in over simplifying such behaviours and concomitant treatment, the need to measure perpetrator strategies and offence characteristics in a much more detailed fashion than what has characteristically been undertaken, and the need to obtain such information from divergent sources (e.g., victims, workers engaged with offenders, offenders).

In the current study, perpetrator modus operandi are investigated from the perspective of the victim by asking both factual, behaviourally specific questions (e.g., Did the person use a weapon/find you when you were asleep/administer a substance without your knowledge?) and by
seeking the opinions of victims as to which perpetrator strategies were most influential in facilitating the abuse. Generally, the sexual abuse victim literature is quite distinct from the sex offender literature and offending patterns are rarely examined in the context of victim variables and even more rarely examined by seeking information from victims about offenders. Where examination of this nature has occurred, such as in the defining work of Koss, Ullman, and colleagues (e.g., Koss, 2000, 2005; Koss, & Cleveland, 1996; Koss & Oro, 1982; Rozee & Koss, 2001; Ullman, 1998), findings have been underutilised in practical settings and applications, and mostly restricted to considerations related to victims. It is contended in this thesis that to focus on either perpetrator factors or victim factors, to the exclusion of the other, is overly simplistic and precludes a holistic understanding of the synergy of the perpetrator-victim interaction, and that much can be gained by reducing the separation between victim and offender literatures. Thus, in recognition of the complex interplay between perpetrator and victim variables, the current study also encompasses examination of victims’ appraisals of their own behaviours, characteristics, and victim-centred variables (e.g., incapacitated by alcohol or drugs; feeling ‘frozen’; unable to assert).

Whilst certain victim traits that confer vulnerability and recognition as ‘easy prey’ are well known, easily recognised, and commonly exploited by those with predatory intent (e.g., victim intoxication, victim isolation), insufficient research attention and applied measures have been directed toward the examination of such and other traits and characteristics (e.g., submissiveness) and the manner in which these may be exploited by sex offenders. Moreover, whilst it is known that many perpetrators use coercive, non-violent strategies to facilitate sexual abuse and that most perpetrators are known to the victim, most research and criminal justice attention has been focused on violent attack, and prevention programs aimed at women have focused overarchingly on methods by which to thwart physically violent and stranger attacks (Fisher, Cullen, & Turner, 2000; Greenfield, 1997; Rozee & Koss, 2001; Tjaden & Thoennes, 2000b; Ullman, 2007). Consequently, far less is known, in both academic and practical senses, of non-violent coercive tactics employed by sexual predators, and these have rarely been addressed in programs endeavouring to empower women to avoid abuse (Ullman, 2007). Information gleaned from this study may assist victims (including males) and treating professionals in understanding what factors constitute the ‘ideal victim’, how perpetrators choose and exploit victim traits and
manipulate situations and individuals in order to facilitate sexual abuse, and how one might guard against falling prey to such individuals. Such information may similarly assist professionals who treat sex offenders by providing new insights into perpetrator cognitions, reasoning, and strategies.

4.1.4 Sexual Abuse Prevention Initiatives


However, conceptualising and implementing measures that can effectively prevent sexual abuse and redress the sweeping aftermath of this problem from victim, offender, and prevention perspectives remain challenging endeavours. Unfortunately, many important findings deriving from previous studies, including those that relate to perpetrator tactics (e.g., Koss & Oro, 1982; Koss et al., 1987), offender violence escalation (e.g., Ullman, 1998), victim resistance strategies (e.g., Ullman, 1998; Ullman & Knight, 1992, 1993, 1995), and sexual assault prevention initiatives (e.g., Breitenbecher, 2000b; Breitenbecher & Gidycz, 1998; Breitenbecher & Scarce, 1999), have been underutilised in practical applications to assist victims and potential victims; and sparsely incorporated into conceptualisations and management of offenders. Regrettably, to date, community prevention programs that effectively decrease either male sex offending or female risk of sexual victimisation have yet to be identified (Ullman, 2007).

As noted earlier, despite robust evidence that most sexual abuse is perpetrated by persons known to the victim and that few offences match the 'stranger danger' stereotype (Kilpatrick, Edmunds, & Seymour, 1992; Tjaden & Thoennes, 2000b; Ullman,
sexual abuse prevention programs have been grounded in averting stranger attacks (Greenfield, 1997). Such programs commonly advocate that women avoid risky behaviours (e.g., parking in dark alleys) in order to avoid attack, without due consideration of evidence that women are already familiar with such advice (Rozee, 1999, 2000; Stanko, 1998), and that such recommendations are largely inapplicable given that victims are most commonly sexually abused by someone they know, and indeed, often by intimate partners, dates, or other persons they trust, and in situations they believe to be safe (Fisher et al., 2000; Rozee & Koss, 2001; Tjaden & Thoennes, 2000b; Ullman, 2007). Accordingly, rape prevention programs have been described by numerous researchers as sporadic enterprises, largely devoid of scientific rigour, theoretical and empirical underpinnings, and evaluative components, and often unpublished (for reviews of rape prevention programs see Bachar & Koss, 2001; Berkowitz, 1992; Breitenbecher, 2000b; Lonsway, 1996; see also McCall, 1993; Rozee & Koss, 2001; Schewe & O’Donohue, 1996). Most evaluated programs have included content related to challenging rape myths, increasing self-efficacy, decreasing rape supportive attitudes, or increasing rape knowledge (Anderson & Whiston, 2005; Bachar & Koss, 2001; Brecklin & Forde, 2001; Breitenbecher, 2000b; Flores & Hartlaub, 1998; Ullman, 2007); and focused on victim behaviour, to the exclusion of factual information pertaining to perpetrator modus operandi, characteristics, and threat appraisal, such as victim selection strategies, ‘red-flag’ characteristics of aggressive males, and other factors that may warn of impending danger (Cleveland, Koss, & Lyons, 1999; Rozee, Bateman, & Gilmore, 1991; Rozee & Koss, 2001; Stevens, 1994). Moreover, most prevention programs devote sparse or no attention to specific victim resistance strategies (Rozee & Koss, 2001), even though empirical data suggest greater efficacy of some strategies over others and demonstrate that forceful physical and verbal resistance can be efficacious in lowering likelihood of completed rape (Bachar & Koss, 2001; Ullman, 1997).

Given such situations, it is not unsurprising that repeated studies have found no evidence of reduction in sexual victimisation after implementation of rape education and prevention programs (Breitenbecher, 2000b; Breitenbecher & Gidycz, 1998; Breitenbecher & Scarce, 1999; Kaniasty & Norris, 1992; Rozee & Koss, 2001); and that despite concerted and well-intentioned rape prevention efforts, rape prevalence statistics have remained largely unaltered over the past quarter century (Bachar & Koss, 2001;
Rozee & Koss, 2001). Given that the vast majority of prevention initiatives and related studies have excluded male victims, and in the absence of evidence that preventive approaches have been effective for females, the notion that such approaches might be able to be generalised to ameliorative efforts for male sexual abuse is even more tenuous.

New and extended research that is inclusive of male victims is clearly needed in order to inform current practices and guide prevention and intervention initiatives pertinent to both victims and perpetrators (Rozee & Koss, 2001; Ullman, 2007). Specifically, given that to date no rape prevention program targeted at community males has demonstrated a reduction in sexual offending (Ullman, 2007), a clear need exists for the development and evaluation of new initiatives to reduce sexual aggression. Similarly, whilst evidence exists that some resistance strategies can assist in thwarting rape completion, such information is limited in scope (e.g., male-to-female offending), and is yet to be conveyed to would-be victims through empirically derived risk reduction programs.

Importantly however, whilst information about effective resistance strategies is clearly valuable, such advances fail to address how victims can overcome barriers to implementing forceful resistance, such as ‘freezing’, immobility, and submission. This is a critical omission since it is known that only 20-25% of women in rape situations use strategies that have been identified as effective (e.g., forceful physical resistance or fighting) (Ullman, 2007), and that, according to most research, women are disposed to use substantively less resistance with known attackers, relative to strangers, and less against intimates, relative to acquaintances (Clay-Warner, 2002; Scott & Beaman, 2004; Ullman, 2007; Ullman & Siegel, 1993).

This is not surprising and may be an important survival strategy, given that (i) females commonly face their greatest risk for homicide at the hands of current or estranged intimate partners or other relative and in contexts of chronic abuse (Davies & Mouzos, 2007; Krug et al., 2002; Mouzos & Segrave, 2004); (ii) violence risk frequently escalates as women in intimate partnerships initiate protest actions such as attempts at separation and relationship dissolution (Browne & Williams, 1993; Campbell et al., 2003; Kellerman & Mercy, 1992; Mouzos & Makkai, 2004; Wilson & Daly, 1994); (iii) actions such as seeking Intervention Orders (IOs) frequently heighten their risk for harm (Cawood & Corcoran, 2009); (iv) fear of reprisal is a key reason for nonreporting of intimate partner violence.
(IPV) (Mouzos & Makkai, 2004); and (v) nonreporting is highest when the perpetrator is a current partner, in the presence of feared retaliation, and in the presence of a weapon (Krug et al., 2002; Mouzos & Makkai, 2004). Thus, the notion that blanket recommendations to resist forcefully can be made to those in assault situations is clearly fraught with complications and may well be dangerous (for discussion, caveats, and recommendations, see Cawood & Corcoran, 2009).

Indeed, the fear that forcefully resisting may escalate offender violence and cause victims to sustain more serious physical injury has prompted considerable debate and been the source of controversy and confusion in the literature (see Prentky, Burgess, & Carter, 1986; Ullman, 1998, 2007). Specifically, in contrast to the increased physical danger that can accompany forceful resistance by women in abusive intimate relationships, the notion that such resistance increases risk of physical harm to victims has not been empirically supported by studies measuring victim reactions in groups of female rape victims (Ullman, 2007). Instead, evidence exists that forceful resistance matched to the offender’s approach (i.e., physical resistance in response to physical attack, and forceful verbal resistance in response to verbal threats and non-physical coercion) can effectively avert rape or minimise the severity of the assault, without elevating risk of physical injury (see Ullman, 1997, for review; see also Clay-Warner, 2002; Ullman, 1998, 2007; Zoucha-Jensen & Coyne, 1993). In contrast, nonforceful verbal resistance (e.g., crying, pleading, reasoning) and lack of resistance (such as ‘immobility’ or freezing) have been related to higher odds of rape completion (Ullman, 1997, 2007). However, it is equally salient to note that such findings derive from a limited number of police-reported rapes (e.g., Zoucha-Jensen & Coyne, 1993) and unreported rapes documented in victimisation studies (e.g., Clay-Warner, 2002), with unknown generalisability to all sexual attacks, particularly those perpetrated within the most intimate and hidden of settings. It is important to note that some of the most severe intimate partner abuses are unlikely to be captured in such data due to nonreporting resultant from victim fear of offender retribution or indeed, because the victim is deceased.

Likely influenced by such caveats, a level of reticence sensibly remains in relation to advising women to respond forcefully to sexual attack, despite evidence supporting the use of strong resistance. To date, no consideration of this issue has emerged in the literature in relation to male victimisation. In the interests of furthering this debate, this
topic is addressed in the current study by asking victims to appraise the efficacy of specific resistance tactics. The inclusion of victims’ appraisal of the efficacy of the resistance strategies employed during their sexual assault (i.e., “Did this improve the outcome, worsen the outcome, or make no difference?”) comprises a unique feature of this study.

In addition to investigation of victim behaviours, reactions, and resistance tactics in the context of sexual abuse, victims are questioned across a broad range of domains in regard to perpetrator strategies and characteristics, yielding a breadth of data that has not previously been collected from male and female victims of sexual abuse.

4.1.5 The Phenomenon of Sexual Revictimisation

Amongst the many aspects of sexual abuse that remain to be appositely understood and addressed, the phenomenon of sexual revictimisation propensity amongst sexually violated individuals persists as one of the most difficult to elucidate (Breitenbecher, 2001; Kendall-Tackett, 2005; Marx, 2005). Research has identified childhood sexual victimisation as highly correlated with (Breitenbecher, 2001; Marx, 2005), and indeed one of the strongest predictors of, subsequent sexual victimisation in adulthood (Cloitre, 1998). Similarly, individuals sexually violated as adults are at heightened risk of future sexual abuse, relative to nonvictims (Beech, Craig, & Browne, 2009). Whilst multiple causative theories of sexual revictimisation have been postulated and examined, none have received unequivocal empirical support (see review by Breitenbecher, 2001). Specifically, individual differences in variables such as PTSD, chronic hyperarousal, coping strategies, affect regulation capacity, interpersonal behaviours, and threat perception and appraisal, have been implicated in explaining both the phenomenon of sexual revictimisation, and the reality that not all sexual abuse victims experience further abuses. However, relationships between such factors and revictimisation remain improperly understood (Breitenbecher, 2001; Marx, 2005).

Thus, whilst several decades of research have clearly yielded advanced conceptualisations of the prevalence and sequelae of sexual victimisation, patterns of revictimisation, alongside mechanisms, processes, and factors that generate wide variation with respect to responses to sexual abuse and responses to treatment, persist as pressing areas of concern and conjecture. Indeed, it is contended by many authors (e.g., Kendall-Tackett, 2005; Marx, 2005) that it is pathways and mechanisms such as these that require substantive
further research and clarification, as progress in these domains is contingent on enhanced, empirically derived knowledge and concomitant informed understanding amongst health and criminal justice professionals and the community. The issue of sexual revictimisation is measured, both in CSA victims and in victims of ASA, in the current study, and re-examined in the third study in the context of gender and psychopathology.

4.1.6 Current Study

This study investigates sexual abuse processes and aftermath using a methodology that affords victims the opportunity to disclose their abuse (and abuse aspects that may be sources of intense shame, guilt, or embarrassment) in a context far less threatening than that conferred by conventional research methodologies. It is contended (and supported by the literature pertaining to online communication and research (e.g., Hanna et al., 2005; Reimers, 2007; Shikiar et al., 2005) that such a methodology minimises self-censorship, restraint, and inhibitions, facilitating a level of candour and detailed disclosure that is unlikely to be attained through conventional methods of data collection. An additional feature of the online approach is the capacity to attract a large and diverse community sample to derive findings more representative of the broader community than many reported in the literature that derive from narrow convenience populations (e.g., clinical samples, university students, rape crisis centre clients). The methodology employed in this study addresses further limitations inherent in much of the sexual assault literature by including a nonvictim comparison group, and by including male victims and nonvictims.

To redress extant knowledge deficits and further current academic debate, information is sought from victims in relation to disclosure and police reporting practices, reactions, and outcomes; predisclosure confidante choices; postdisclosure confidante preferences; and help-seeking. In regard to both victim impact and offender profiling, information is sought in relation to victim psychological wellbeing, sexual and intimate partner violence revictimisation, perpetrator strategies, offence characteristics, and victim resistance tactics. In particular, it is of interest to examine the differential impact of varying resistance strategies on abuse outcome, so as to inform the debate as to effective modes of sexual attack resistance. The fact that the content, format, and methodology of this study in many ways mirrors those employed in Study 1 to examine CSA affords a unique opportunity to compare findings pertaining to sexual abuse experienced in childhood with those pertinent to sexual victimisation experienced in adulthood.
4.2 Method

4.2.1 Participants

The data presented in the current study derive from a sample of 1,683 individuals who participated in the TSP and completed the sections pertaining to ASA and wellbeing. Of these individuals, 33.3% \((n = 561)\) had experienced sexual abuse in adulthood and 66.7% identified as nonvictims \((n = 1,122)\). The sample comprised 495 female and 66 male victims of ASA, and 768 female and 354 male nonvictims. Thus, ASA victims comprised 39.2% of the female sample and 15.7% of the male sample. Further description of this sample of respondents is provided in the General Method in Chapter 2.

4.2.2 Definitions

Adulthood sexual abuse (ASA) was defined as sexual events experienced since the age of 16 that ‘you now consider to have been inappropriate, abusive, or damaging’. This definition was used given that sexual abuse definitions that rely on lack of consent fail to capture the many victims of ASA who believe themselves to have been complicit or consenting to their abuse, notwithstanding the fact that their ‘consent’ may have been invalid due to their mental status (e.g., incapacitated due to drug or alcohol intoxication) or due to its delivery under duress or coercion. Fuller discussion of issues relating to terminology and definitions of sexual abuse is provided in the General Method in Chapter 2.

The age of 16 was chosen as this is currently the age of consent for heterosexual and homosexual sex in most states and territories of Australia (i.e., Australian Capital Territory, New South Wales, Northern Territory, Victoria, and Western Australia), with the exception of South Australia and Tasmania, where the age of consent is 17 years (Australian Federation of AIDS Organisations [AFAO], 2006). Queensland is the only state to retain a disparate age of consent for vaginal and anal sex (i.e., 16 and 18 years, respectively) (AFAO, 2006), although until relatively recently, age of consent in Australia varied more broadly across states and territories, differing according to gender and to the nature of the sexual intercourse (e.g., heterosexual, gay male, lesbian) (Simpson & Figgis, 1997).
4.2.3 Procedure, Measures, and Data Analyses

Procedure and measures utilised in this study are detailed in the General Method presented in Chapter 2. A comprehensive battery of data analyses was applied; these analyses are similarly detailed in the General Method.
4.3 RESULTS

4.3.1 Overview

This study in many ways mirrors the previously reported study pertaining to CSA, albeit with a focus on sexual victimisation experienced in adulthood. Accordingly, very similar quantitative analyses were conducted to provide a holistic perspective and opportunities for integrated and parallel observations and comparative analyses.

Quantitative analyses were undertaken to measure a broad range of abuse-related experiences, perceptions, beliefs, and appraisals reported by victims of adult sexual abuse; and the relationship of such variables with current wellbeing, perturbation, suicidality, IPV, and CSA history. Emphasis was placed on measuring victim-reported offence typologies and processes (e.g., frequency; revictimisation); perpetrator characteristics and strategies (e.g., relationship to victim; use of physical force, coercion, inveigling, or substances to facilitate offending); and victim-related variables (e.g., fear of reprisal). Further emphasis was placed on delineating gender differences with respect to ASA aftermath and disparities in current wellbeing between victims and nonvictims of ASA.

The results of these analyses are presented in the forthcoming chapter under relevant headings. Where appropriate, excerpts of qualitative data (in the form of direct quotes from participants) have been used to augment statistical results. In all cases where such quotes are used, these have been reproduced faithfully, with the exception that spelling and typographical errors have been corrected. All quotations are presented in italics.

General descriptive statistics pertaining to adult sexual abuse prevalence within the sample are presented in Section 4.3.2, followed in Section 4.3.3 by qualitative data exemplifying the chronicity of ASA experienced by many respondents. Section 4.3.4 presents a quantitative analysis of child sexual abuse and sexual revictimisation in adulthood; and in Section 4.3.5, sample prevalence of ASA is presented by abuse typology. Perpetrator strategies and circumstances of abuse (with a focus on both perpetrator and victim variables) are examined in Sections 4.3.6 and 4.3.7, respectively. Disclosure of ASA is measured in
Section 4.3.8; followed by analyses of confidante gender preferences and confidante type choices of ASA victims, in Sections 4.3.9 and 4.3.10, respectively. Confidante types perceived most helpful by ASA victims are described in Section 4.3.11. Reactions received by victims upon disclosure of ASA are examined in Section 4.3.12. Confronting the perpetrator is examined in Section 4.3.13; and offence characteristics, victim perceptions, and outcomes related to police reporting and nonreporting of ASA are examined in Sections 4.3.14 and 4.3.15, respectively. Additional crimes against victims of adult sexual abuse are examined in Section 4.3.16; followed by examination of IPV in the context of adult sexual victimisation in Section 4.3.17. Physical injury, exposure to risk of STI, and exposure to possible pregnancy resultant from ASA are examined in Sections 4.3.18 – 4.3.20. Section 4.3.21 details relationships between ASA and measures of psychological wellbeing. Feelings experienced subsequently to ASA, and victim perceptions regarding their abuse are measured and reported in Sections 4.3.22 and 4.3.23, respectively. Finally, suicide attempt and suicidal ideation are examined in the context of ASA, and results of these analyses are presented in Sections 4.3.24 and 4.3.25, respectively.

4.3.2 General Sample Characteristics Pertaining to Adult Sexual Abuse Prevalence

Experience of adult sexual abuse within the sample

Experience of sexual abuse in adulthood was reported by 33.3% of respondents (n = 561). – defined as ‘sexual experiences since the age of 16, that you now consider to have been inappropriate, abusive, or damaging’.

Adult sexual assault across gender

Males and females differed significantly with respect to reported experience of ASA, $\chi^2(1, N = 1683) = 78.76, p < .0005$, Cramér’s $V = .22$. In contrast to 15.7% of male respondents (n = 66), 39.2% of females (n = 495) reported experience of sexual abuse in adulthood. Inspection of standardised residuals (SRs) reveals that males were the most disproportionately represented, being most significantly underrepresented amongst ASA victims (SR = -6.3), and very significantly overrepresented amongst nonvictims (SR = 4.4). Conversely, females were significantly overrepresented amongst ASA victims (SR = 3.6), and significantly underrepresented amongst nonvictims (SR = -2.6).
Whilst most respondents (90.02%, $n = 505$) identified the perpetrator/s as male, it is pertinent to note that a sizable minority (10.16%, $n = 57$) identified a female perpetrator. Note: These percentages sum to greater than 100% because one respondent identified both a male and female perpetrator/s. Within male ASA victims, 72.73% reported a male perpetrator/s ($n = 48$) and 27.27% reported a female perpetrator ($n = 18$). Amongst females, 92.32% of ASA victims identified a male perpetrator ($n = 457$), and 7.88% identified a female/s perpetrator ($n = 39$), with one respondent reporting both a female and male perpetrator/s.

Most respondents reported that the ASA was perpetrated by one person (most commonly male). However, a significant/large minority of respondents reported ASA perpetrated against them by more than one person. Indeed, 35.84% of respondents perpetrated against by males ($n = 181$), and 23.21% of respondents perpetrated against by females ($n = 13$) reported more than one perpetrator.

Within male ASA victims, 29.17% of those who reported male-perpetrated abuse identified more than one male perpetrator ($n = 14$) and 23.53% of those reporting female-perpetrated ASA reported more than one female perpetrator ($n = 4$). Similarly, within female ASA victims, 36.54% of those who reported male-perpetrated abuse identified more than one male perpetrator ($n = 167$) and 25.64% of those reporting female-perpetrated ASA reported more than one female perpetrator ($n = 10$).

**Number of incidents of adult sexual abuse**
The minority of ASA victims (36.5%, $n = 198$) reported experiencing only a single incident of unwanted sexual activity. Indeed, over one third of respondents identifying as ASA victims reported at least five separate incidents of unwanted sexual activity (35.0%; $n = 190$). Specifically, 12.7% of victims reported 5-10 separate incidents ($n = 69$), and 22.3% reported more than 10 separate incidents ($n = 121$). Whilst concerning, such statistics alone fail to properly convey the chronicity of ASA experienced by many respondents. Qualitative responses however, potently demonstrate the repetitive nature of much of the experiences reported by many respondents; the dominant theme of chronic abuse occurring within relationships, and the relative absence of stranger assaults; and the strong pattern of repeated revictimisation across adult relationships following experience of sexual
4.3.3 Qualitative Data Exemplifying Experience of Chronic Adult Sexual Abuse

Respondents for whom the chronicity of their ASA experiences was unable to be conveyed accurately by a numeric Likert scale (with highest points of 5-10 and 11+), were invited to provide a qualitative response to the question ‘How many separate incidents of unwanted sexual events have you experienced since age 16?’. The following response examples demonstrate the repetitive and extreme nature of ASA for many respondents. Themes evident in the qualitative responses to this question are illustrated by further examples presented in forthcoming section.

- Around twenty
- At least 20
- Hundreds
- Lost count
- Countless
- Gang raped so was at the one time just lots of guys.

Chronic ASA was found overwhelmingly amongst respondents who had also experienced sexual abuse in childhood, particularly abuse of a similarly chronic nature. The following examples of respondents who had also reported CSA are illustrative of the progression from childhood to adulthood victimisation:

- With my father, be raped my anally night after night until I left home at 17. Then at uni I was raped vaginally once.
- Have been coerced into sexual relations by men on numerous occasions throughout late teens early 20's. On discovering I had the right to say no, and did not have to go along with anything I felt uncomfortable about, I found myself physically forced into having sex.
- From 16-19 there was a continuation of some of the assaults from childhood. Also a family friend, a friend’s boyfriend, and a stranger at a pub (for the other ages mentioned).
- I was the subject of sustained sexual abuse from the age of five years until I left home. There were too many incidences to numerate.
- Continuation of sexual abuse from uncle from 16-19, (indecent assaults only) but difficult to quantify, perhaps 150. Others were either single incidents or a couple of times.
- Constant by stepfather and 2 other separate events
* Continuation of repeated abuse from childhood.

* Many acts of coercion in my marriage by my husband and then 2 minor date rapes since. I also had an attempt by a boyfriend when I was young that I stopped and wasn't traumatic to me and was trapped in a house by an acquaintance with the purpose of sex but managed to get away, also not traumatic probably due to the perspective I had already. As an adult I was spoken to sexually inappropriately by my father which has affected me.

Some respondents overtly linked their adult sexual experiences to their earlier and childhood experiences, as exemplified by the following responses:

* I was a "slut" and had sex with everybody and anybody - whether I wanted it or not - it was a way to validate myself. I can't answer the following questions because I have seriously had sex with hundreds of people and I can't be specific like you want me to. Even when sex was unwanted, I did it anyway. Even being thrashed and forced to have sex was better than being alone. And no, I was never a prostitute - I never sold myself to anyone for money - maybe self-esteem and pride, but not money.

* I became promiscuous myself, initiating sex with a stranger in one instance on a tram, at other times, men I picked up in clubs. It gave me a sense of having power over my body. I behaved robotically [sic] throughout these sexual experiences, behaved like a femma fatale [sic] but basically I was faking it. The men, particularly the ones who remained as strangers to me, were happy to oblige. I do not hold them responsible but I now consider the experiences were abusive, as much on my part as on theirs.

* This experience was not as an unwilling participant but as I had already been sexually violated and I believed the way to relate to boys was by having sex with them. I had sex with 5 boys at a party. I was drunk and now view this experience as very humiliating and degrading.

However, not all respondents who had experienced CSA articulated the notion that their experiences of ASA may be linked to their childhood experiences. Indeed, comments by some respondents suggest instead, a self-attributing style, possibly in lieu of such insight:

* I was involved in a group sex party at aged 17, another couple & my boyfriend. Couple were much older, say 25 years older. I was very young & naive.

* Too many to count. I was homeless and would sleep with men to have a place to stay the night. [Respondent for whom chronic CSA commenced at age 5]

* I have never been physically forced but persuaded to have sex when I did not want to have sex.

* This includes times where I was drunk, and not wanting to have sex, but allowed it to occur after some coercion.

Indeed, it was common for respondents, particularly those that had also experienced CSA, to provide victim-centred responses in regard to ASA rather than perpetrator-centred responses. Such responses included succumbing to coercion and ‘consenting’ to unwanted
sexual activity through fear of negative repercussions or self-identifying inability to ‘say no’, prevent, or end the abuse. For example:

- I have had so many sexual events that I didn’t want but didn’t know how to stop.
- I guess in retrospect I didn’t want to be with this person at all, ever, but didn’t know how to say so.

The use of present tense in this context of abuse is additionally concerning:

- It is something that is on-going, and I don’t know how to stop it...
  [34 year old female victim of chronic CSA commencing at age 12]

Respondents who reported ‘giving in’ to coercion commonly described the event/s as ‘unwanted sex’ but not ‘rape’. Some overtly expressed their ambivalence pertaining to the definition of abuse in the context of them having ‘consented’ or ‘allowed it to happen’. For example:

- This is difficult to answer. On reflection because of my childhood experiences I do not make ‘good’ choices in sexual partners or activities. Is it abuse if I willingly participate in an activity but chose to do so from a flawed knowledge of what is appropriate?
- What is the difference when they are drunk and abusive and you were either bashed or forced into unwanted sex?

Further responses elude to the variation in common parlance and discourse pertaining to definitions of sexual abuse. For example:

- In my case it was Attempted Rape so I don’t count it as a sexual experience/event. When I was down on the pavement for the third time I had a vision (of me floating in the nearby Yarra when people were walking to work the next morning) and I allowed hysteria to take over because I was fighting for my life. It did not ruin my relations with men but it ruined my nights. I have seldom been able to walk alone in the dark since then for more than 100 yards.

Stranger attacks such the one described by this respondent were relatively rare in this set of responses. However, this is somewhat to be expected given that the survey question from which this response set derives pertained to a high number of separate incidents (i.e., chronic ASA), which is more usual in the context of abusive relationships. Indeed, responses to this question typically referred to ASA occurring in the context of such
relationships, such that most respondents described sexual abuse perpetrated by well-known and trusted figures – predominantly, intimate partners. Similarly, coercive and implicitly threatening perpetrator tactics, moreso than the use of physical force, were reported in most responses referring to chronic abuse. Specifically, predominant themes emerged illustrating the common usage by perpetrators of coercion, psychological strategies, and implicit threat of danger and other negative repercussions to resistance. Succumbing to sexual activity due to fear of harm and other negative sequelaes was particularly common, especially in the context of chronic abuse within long-term intimate relationships. Examples include:

- After about 2 years with my abusive partner I no longer wanted to have sex so it was mostly the case of giving in to his demands or there would be an argument with the potential for physical assault.
- I experienced an indecent exposure in frightening circumstances when 19, and during my marriage it was safer to have marital sex when I didn’t want to than express my feelings.
- Unwanted sex with my husband. Not forced as such but I was afraid to say no when I didn’t feel like it.
- De facto partner constantly forcing himself on me (in the end it was easier to give in than fight), arranging for me to have sex with someone else for money, and for someone else to watch us have sex for money.

The dominant theme of chronic abuse occurring within marriage and other long-term relationships is also exemplified by the following responses. Such responses were particularly typical among individuals who had also experienced sexual abuse in childhood.

- My husband believed it was his right to have sex when ever he wanted. NO meant nothing to him.
- Continual abuse and rape throughout a marriage of 30yrs.
- I was in a relationship where it occurred hundreds of times.
- I was in a nine month relationship when i was 20 where sex was forceful and not my choice.
- I was sexually abused through the most of my relationship
- In 18month relationship, boyfriend was constantly verbally abusive when having sexual encounters, used emotional manipulation to get sex and oral sex.
- Forced sexual intercourse within marriage. Could be many, many times.
- Frequently towards the latter part of my marriage

Other responses illustrate the common continuation and progression of revictimisation from one relationship to another:

- A boyfriend of age 18, then continuously for 31 years of marriage
- At least 5 separate incidents of rape, the rest my husband of 6 years. He had to have sex every night, often many times a night and whether or not I wanted it was of no consequence as far as he was concerned
- About 3 as a teenager [unwanted sex] but many during marriage by husband
- 1 rape at 19, many instances of unwanted sex within marriage

Although females were more than twice as likely to report chronic ASA, relative to males, such abuse was also reported by a substantial minority of males. Whilst most male ASA victims identified a male perpetrator, the following responses show similar use of threat and psychological abuse in instances where female-perpetrated chronic abuse occurred within marriage:

- Sexual demands from my wife when I was tired or otherwise busy. Often these were accompanied by threats of removing our child from my life if I did not comply.
- During the course of my marriage breakup, my wife was probably bipolar. She was very predatory sexually and would have up to 10 men a night, but would still be unsatisfied. She would come home and be physically violent to me wanting more sex. She would abuse me and tell me about all the weak men she had bad that night and how they couldn’t satisfy her.

As with CSA, sexual abuse by professionals was also reported by victims of ASA. The following responses are examples of the violations of professional boundaries reported by respondents:

- One time each for friend and date. Many times with bereavement counsellor.
- As the original assault occurred under hypnosis, I cannot say how many times she did things at that point. There was also unwanted hugging and cuddling. I do not believe consent was possible during the time I was engaged, and as my mental health and cognitive function were both seriously compromised by the abuse by my rapist of her professional skills, I consider every act of sexual relations between us to have been non-consensual and therefore unwanted.

4.3.4 Quantitative Analysis of Child Sexual Abuse and Sexual Revictimisation in Adulthood

The qualitative data suggested a strong relationship between CSA and later experience of ASA. Evidence of the statistical significance of this relationship was provided through chi-square analysis. Respondents reporting ASA were significantly more likely than non-ASA victims to have experienced CSA, \( \chi^2(1, N = 1663) = 50.73, p < .0005, \) Cramér’s \( V = .18. \) Specifically, 53.3% of ASA victims (\( n = 294 \)) had also experienced CSA, in contrast to only 35.0% of non-ASA victims (\( n = 389 \)). Moreover, 43.0% of CSA victims (\( n = 294 \)) reported experience of ASA, in contrast to only 26.3% of non-CSA victims (\( n = 258 \)).
Inspection of standardised residuals (SRs) reveals that victims of ASA were the most disproportionately represented, being most significantly overrepresented amongst CSA victims (SR = 4.5), and significantly underrepresented amongst non-CSA victims (SR = -3.7). Conversely, respondents who had not experienced ASA were significantly underrepresented amongst CSA victims (SR = -3.2).

4.3.5 Sample Prevalence of Adult Sexual Abuse by Abuse Typology

Respondents were asked questions pertaining to six types of ASA, phrased as unwanted sexual activities 'since the age of 16': (i) nonpenetrative sexual experiences, (ii) oral sex, (iii) sexual intercourse, (iv) anal sex, (v) other unwanted sexual experience, and (vi) attempted CSA (a) attempted oral sex, b) attempted sexual intercourse, c) attempted anal sex). Definitions used for these sexual activity types were the same as those employed in the examination of child sexual abuse, and are described in Study 1.

Nonpenetrative sexual experiences

Experience of nonpenetrative ASA was reported by 22.4% of the entire sample (n = 371). This figure represents over half of respondents (59.4%) who identified as having experienced ASA.

Oral sex

Unwanted oral sex in adulthood was reported by 11.9% of the entire sample (n = 193). This figure represents one third of respondents (33.5%) who reported experience of ASA.

Sexual intercourse

More than one fifth of the entire sample reported experience of unwanted sexual intercourse since age 16 (21.5%; n = 347). This figure represents 61.9% of respondents who identified as having experienced ASA.

Anal sex

Seven percent of the entire sample reported experience of unwanted anal sex in adulthood (7.0%; n = 114). This figure represents almost one fifth of respondents (19.8%) who identified as having experienced ASA.
Other unwanted sexual experience

Almost one tenth of the entire sample reported experience of some other type of unwanted sexual activity since age 16 (9.2%; \( n = 147 \)). This figure represents almost one quarter of respondents (24.0%) who identified as having experienced ASA. Under this category, respondents included experiences such as non-consensual pornographic photographing; involvement in ‘bestiality pornography’; ‘breast mauling’; ‘cutting of skin in a sexual manner’; sadistic physical injury to genitals (e.g., rape with objects; ‘scrubbing my breasts and genitalia with a floor scrubbing brush and kitchen scourer’; forced watching of sexual activity; frottage; forced engagement in gang sexual activity; forced involvement in ‘fetish sex’; forced role of ‘aggressor in S & M situation’; forced ‘wife swapping’; and non-consensual engagement in group sexual activity.

Attempted ASA:

i) Attempted oral sex

Of the entire sample, 6.5% of respondents reported experience of attempted oral sex in adulthood (\( n = 104 \)). This figure represents 15.5% of respondents who reported experience of ASA.

ii) Attempted sexual intercourse

Of the entire sample, 10.6% of respondents reported experience of attempted sexual intercourse in adulthood (\( n = 165 \)). This figure represents more than one quarter of respondents (28.5%) who identified as having experienced ASA.

iii) Attempted anal sex

Of the entire sample, 3.7% of respondents reported experience of attempted anal sex in adulthood (\( n = 58 \)). This figure represents 10.1% of respondents who reported ASA.

As sexual intercourse was most commonly reported by respondents, this category of ASA is described in more detail in terms of the following analyses.
Sexual intercourse

As noted earlier, unwanted sexual intercourse since age 16 (hereafter referred to as penetrative ASA) was reported by more than one fifth of the entire sample and more than half of respondents who identified as having experienced ASA ($n = 347$). Notably, this form of sexual abuse was reported by more than one in four females across the entire sample (27.3%; $n = 330$), and by two thirds of females (66.7%) who reported experiencing any form of ASA.

Amongst respondents reporting penetrative ASA, almost one in five reported experiencing this abuse form within the past year (respondents: 18.4%, $n = 64$; females: 18.5%, $n = 61$). Overall since age 16, less than half of victims of penetrative ASA reported experiencing this abuse form on only one occasion (respondents: 41.6%, $n = 142$; females: 42.1%, $n = 136$). Indeed, more than one third reported having experienced penetrative ASA on five or more occasions (respondents: 35.9%, $n = 122$; females: 35.9%, $n = 116$).

Consistent with themes emerging from the qualitative data, the recurrent nature of ASA is further evidenced by the finding that 58.0% of victims of penetrative ASA reported that the abuse was perpetrated by the same person on more than one occasion ($n = 182$; female penetrative ASA victims: 58.4%, $n = 174$). Notably, the pattern of repeated offending is also consistent with, albeit less pronounced than, that found in Study 1 with respect to perpetrators of CSA, in which 74.0% of penetrative CSA victims reported repeated perpetration of this abuse form by the same person. This disparity is consistent with findings from the literature and from Study 1 in the current thesis, that children are most vulnerable to sexual victimisation by trusted figures and relatives, and that abuse from strangers and a wider range of perpetrator types becomes more likely as independence is gained and movement outside the home and supervised environments increases with age (Krug et al., 2002).

4.3.6 Perpetrator Strategies

Respondents were asked to indicate which of a range of perpetrator strategies were applied in order to engage them in unwanted sexual activity. As evident in Table 4.1, coercion, manipulation, and disregard for victims’ wishes were dominant themes reported by the majority of ASA victims. Physical force or restraint and verbal aggression were also
reported by more than half of respondents. Using alcohol effects to facilitate sexual assault was reported by almost half of ASA victims. Similarly, using substance effects to facilitate ASA was reported by almost one in five ASA victims. Being found by the perpetrator/s whilst asleep was reported by one third of victims. Similarly, threats of physical force or violence were reported by almost one third of victims, and use of physical violence or aggression was reported by more than one quarter of victims.

<table>
<thead>
<tr>
<th>Abuse-facilitating perpetrator strategy</th>
<th>To some degree</th>
<th>Very or extremely</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>By somehow manipulating the situation (e.g., so that we were alone, or that I had no way to get home)</td>
<td>76.0</td>
<td>352</td>
<td>54.8</td>
</tr>
<tr>
<td>Ignoring my protests and statements that I wished him to stop</td>
<td>73.1</td>
<td>337</td>
<td>52.0</td>
</tr>
<tr>
<td>Making me feel guilty or somehow obliged to do it</td>
<td>67.8</td>
<td>318</td>
<td>45.4</td>
</tr>
<tr>
<td><strong>Using</strong> some degree of physical force or restraint (e.g., holding me down with his or her body weight, or pinning my arms)</td>
<td>59.6</td>
<td>279</td>
<td>42.3</td>
</tr>
<tr>
<td>Using strong arguments or continual verbal pressure or showing displeasure (getting angry)</td>
<td>59.6</td>
<td>272</td>
<td>42.3</td>
</tr>
<tr>
<td>By telling me lies, or tricking me in some way</td>
<td>51.3</td>
<td>233</td>
<td>33.0</td>
</tr>
<tr>
<td>Using emotional blackmail or tactics (e.g., ‘If you really loved me…’ or making false promises about the future, threatening to end the relationship or spread rumours about me)</td>
<td>47.3</td>
<td>217</td>
<td>31.8</td>
</tr>
<tr>
<td>Encouraging me to use alcohol or finding me when I was alcohol affected</td>
<td>47.0</td>
<td>217</td>
<td>32.5</td>
</tr>
<tr>
<td>Verbally ordering me</td>
<td>44.0</td>
<td>200</td>
<td>26.8</td>
</tr>
<tr>
<td>Finding me when I was asleep</td>
<td>34.4</td>
<td>158</td>
<td>22.0</td>
</tr>
<tr>
<td>Harming me in a <strong>non-physical</strong> way</td>
<td>33.0</td>
<td>103</td>
<td>15.0</td>
</tr>
<tr>
<td><strong>Threatening</strong> to use some degree of <strong>physical</strong> force, restraint, or violence on me (or someone else)</td>
<td>31.5</td>
<td>143</td>
<td>21.1</td>
</tr>
<tr>
<td><strong>Using</strong> some degree of physical violence or aggression (e.g., hitting, punching, biting, choking)</td>
<td>27.0</td>
<td>122</td>
<td>16.8</td>
</tr>
<tr>
<td><strong>Threatening</strong> some sort of <strong>non-physical</strong> harm against me (or against someone else)</td>
<td>19.6</td>
<td>88</td>
<td>10.7</td>
</tr>
<tr>
<td>Encouraging me to use drugs or finding me when I was drug affected</td>
<td>17.4</td>
<td>80</td>
<td>11.6</td>
</tr>
<tr>
<td>Serving me high alcohol content drinks when they appeared to be regular strength drinks</td>
<td>15.7</td>
<td>71</td>
<td>9.7</td>
</tr>
</tbody>
</table>
Respondents were also asked to indicate which of these strategies ‘best describes what happened in [your] case’. As evident in Table 4.2, perpetrator use of physical force or restraint was rated by the highest proportion of ASA victims as the single strategy that best described their abuse circumstance/s. In order of next highest rated strategies, the following perpetrator tactics were identified as the single best descriptors of abuse circumstances: manipulating the situation (e.g., isolating the victim, or ensuring she/he had no way of getting home); instilling guilt or sense of obligation to comply; disregarding victim protests and requests to stop; and encouraging alcohol use or taking advantage of victim’s alcohol-affected state.

Table 4.2

*Perpetrator Strategy Identified by Victims as Most Instrumental in Facilitating Their Sexual Abuse*

<table>
<thead>
<tr>
<th>Principal abuse-facilitating strategy</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using some degree of physical force or restraint (e.g., holding me down with his or her body weight, or pinning my arms)</td>
<td>68</td>
<td>14.7</td>
</tr>
<tr>
<td>Somehow manipulating the situation (e.g., so that we were alone, or that I had no way to get home)</td>
<td>64</td>
<td>13.8</td>
</tr>
<tr>
<td>Making me feel guilty or somehow obliged to do it.</td>
<td>55</td>
<td>11.9</td>
</tr>
<tr>
<td>Ignoring my protests and statements that I wished him to stop</td>
<td>47</td>
<td>10.1</td>
</tr>
<tr>
<td>Encouraging me to use alcohol or finding me when I was alcohol affected</td>
<td>35</td>
<td>7.5</td>
</tr>
<tr>
<td>Using emotional blackmail or tactics (e.g., &quot;If you really loved me… “ or making false promises about the future, threatening to end the relationship or spread rumours about me)</td>
<td>28</td>
<td>6.0</td>
</tr>
<tr>
<td>Finding me when I was asleep</td>
<td>27</td>
<td>5.8</td>
</tr>
<tr>
<td>Using strong arguments or continual verbal pressure or showing displeasure (getting angry)</td>
<td>26</td>
<td>5.6</td>
</tr>
<tr>
<td><strong>Using</strong> some degree of physical violence or aggression (e.g., hitting, punching, biting, choking)</td>
<td>21</td>
<td>4.5</td>
</tr>
</tbody>
</table>
Other
Telling me lies, or tricking me in some way 18 3.9
Encouraging me to use drugs or finding me when I was drug affected 14 3.0
Harming me in a non-physical way 12 2.6
Giving me drugs without my knowledge 11 2.4
Verbally ordering me 10 2.2

Threatening to use some degree of physical force, restraint, or violence on me (or someone else) 7 1.5
Threatening some sort of non-physical harm against me (or against someone else) 4 0.9
Using a weapon 4 0.9
Threatening to use a weapon or implying or indicating that a weapon was present 3 0.7
Serving me high alcohol content drinks when they appeared to be regular strength drinks 1 0.2

TOTAL
N = 464 100.00

4.3.7 Circumstances of Abuse: Perpetrator and Victim Variables
Respondents were also asked to indicate which of a range of internal and external factors (i.e., situations, victim variables, and perpetrator strategies) were applicable in their situation – either actively applied to advantage by the perpetrator in order to engage them in unwanted sexual activity, or otherwise serving (indirectly) to facilitate their abuse. As evident in Table 4.3, this list included both victim-centred variables (e.g., ‘I was unable to say no because I was scared, numb, or “frozen”.’), and perpetrator-centred variables (e.g., ‘The person used physical force or violence.’) in order to gauge victims’ opinions regarding both internal and external factors that may have assisted in facilitating their abuse. Being unable to assert oneself in the situation was ranked as applicable by the highest proportion of respondents, followed by perpetrators’ disregard for victim protests and statements; feeling emotionally unable to stop the person; guilty or obliged to comply; and scared, numb, or ‘frozen’; and being overpowered physically by the perpetrator. Over half of victims thought to some degree that it was safer to not to try to fight in the situation, and over one third held this belief ‘very much’ or ‘extremely’.
<table>
<thead>
<tr>
<th>Factor</th>
<th>To some degree</th>
<th>Very or extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was unable to be assertive in the situation</td>
<td>78.3 376</td>
<td>58.8 282</td>
</tr>
<tr>
<td>The person ignored my protests and statements</td>
<td>78.1 375</td>
<td>56.0 269</td>
</tr>
<tr>
<td>I was emotionally unable to stop the person</td>
<td>72.5 351</td>
<td>51.7 250</td>
</tr>
<tr>
<td>I felt guilty or somehow obliged to do it</td>
<td>69.6 334</td>
<td>43.1 207</td>
</tr>
<tr>
<td>The person overpowered me physically</td>
<td>61.9 296</td>
<td>39.8 190</td>
</tr>
<tr>
<td>Person used emotional blackmail or psychological tactics</td>
<td>60.6 288</td>
<td>39.0 185</td>
</tr>
<tr>
<td>I thought it was safer for me not to try to fight</td>
<td>59.7 283</td>
<td>37.6 178</td>
</tr>
<tr>
<td>I feared I would be blamed or not believed</td>
<td>56.6 267</td>
<td>38.6 182</td>
</tr>
<tr>
<td>I was unable to say no because I was scared, numb, or “frozen”</td>
<td>56.2 268</td>
<td>34.8 166</td>
</tr>
<tr>
<td>I was too worried about the consequences of trying to stop them</td>
<td>55.1 259</td>
<td>26.8 126</td>
</tr>
<tr>
<td>The person did not know or understand that it was against my wishes</td>
<td>52.4 249</td>
<td>21.9 104</td>
</tr>
<tr>
<td>The person was angry, nasty or humiliating</td>
<td>50.2 240</td>
<td>31.4 150</td>
</tr>
<tr>
<td>I was unable to say no because I was embarrassed or shy</td>
<td>48.0 227</td>
<td>21.4 101</td>
</tr>
<tr>
<td>I feared rejection if I didn’t do it</td>
<td>45.4 207</td>
<td>23.6 112</td>
</tr>
<tr>
<td>The person used physical force or violence</td>
<td>44.8 212</td>
<td>30.2 143</td>
</tr>
<tr>
<td>The person used his or her authority</td>
<td>42.8 203</td>
<td>24.7 117</td>
</tr>
<tr>
<td>The person was being apologetic or somehow making me feel sorry for him/her</td>
<td>41.5 197</td>
<td>17.7 84</td>
</tr>
<tr>
<td>I feared the effects on my family if I told someone</td>
<td>38.8 183</td>
<td>26.5 125</td>
</tr>
<tr>
<td>I was unable to say no (under influence of alcohol)</td>
<td>32.1 152</td>
<td>17.1 81</td>
</tr>
<tr>
<td>The person threatened to physically hurt or punish me</td>
<td>28.0 130</td>
<td>18.3 85</td>
</tr>
<tr>
<td>The person threatened to hurt or punish me in some non-physical way</td>
<td>24.2 113</td>
<td>12.8 60</td>
</tr>
<tr>
<td>I thought I (or someone else) might be killed or seriously injured if I resisted</td>
<td>21.4 101</td>
<td>13.6 64</td>
</tr>
<tr>
<td>I was unable to say no (under influence of drugs)</td>
<td>14.1 67</td>
<td>9.3 44</td>
</tr>
<tr>
<td>The person threatened to hurt or punish someone else</td>
<td>11.4 54</td>
<td>7.2 34</td>
</tr>
<tr>
<td>Other</td>
<td>9.5 45</td>
<td>8.6 41</td>
</tr>
</tbody>
</table>

Respondents were also asked to indicate which of these factors was ‘most true for [you]’. As evident in Table 4.4, inability to assert oneself in the situation; being overpowered physically; and perpetrator disregard of victim protests and statements emerged as the most
dominant factors, followed by feelings of guilt and obligation to comply; fear of blame and disbelief; and perpetrator use of physical force or violence.

Table 4.4

<table>
<thead>
<tr>
<th>Victim-Perceived Factor Most Applicable to Their Abuse Circumstances</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was unable to be assertive in the situation</td>
<td>61</td>
<td>12.5</td>
</tr>
<tr>
<td>The person overpowered me physically</td>
<td>42</td>
<td>8.6</td>
</tr>
<tr>
<td>The person ignored my protests and statements</td>
<td>42</td>
<td>8.6</td>
</tr>
<tr>
<td>I felt guilty or somehow obliged to do it</td>
<td>37</td>
<td>7.6</td>
</tr>
<tr>
<td>I feared I would be blamed or not believed</td>
<td>29</td>
<td>5.9</td>
</tr>
<tr>
<td>The person used physical force or violence</td>
<td>28</td>
<td>5.7</td>
</tr>
<tr>
<td>Other</td>
<td>28</td>
<td>5.7</td>
</tr>
<tr>
<td>I was unable to say no because I was scared, numb, or “frozen”</td>
<td>27</td>
<td>5.5</td>
</tr>
<tr>
<td>Person used emotional blackmail or psychological tactics</td>
<td>24</td>
<td>4.9</td>
</tr>
<tr>
<td>I was emotionally unable to stop the person</td>
<td>22</td>
<td>4.5</td>
</tr>
<tr>
<td>I was unable to say no (under influence of alcohol)</td>
<td>19</td>
<td>3.9</td>
</tr>
<tr>
<td>I feared the effects on my family if I told someone</td>
<td>16</td>
<td>3.3</td>
</tr>
<tr>
<td>The person did not know or understand that it was against my wishes</td>
<td>15</td>
<td>3.1</td>
</tr>
<tr>
<td>I feared rejection if I didn’t do it</td>
<td>13</td>
<td>2.7</td>
</tr>
<tr>
<td>I was unable to say no (under influence of drugs)</td>
<td>13</td>
<td>2.7</td>
</tr>
<tr>
<td>I was unable to say no because I was embarrassed or shy</td>
<td>12</td>
<td>2.5</td>
</tr>
<tr>
<td>The person was being apologetic or somehow making me feel sorry for him/her</td>
<td>10</td>
<td>2.1</td>
</tr>
<tr>
<td>I thought I (or someone else) might be killed or seriously injured if I resisted</td>
<td>8</td>
<td>1.6</td>
</tr>
<tr>
<td>I thought it was safer for me not to try to fight</td>
<td>8</td>
<td>1.6</td>
</tr>
<tr>
<td>I was too worried about the consequences of trying to stop them</td>
<td>8</td>
<td>1.6</td>
</tr>
<tr>
<td>The person used his or her authority</td>
<td>8</td>
<td>1.6</td>
</tr>
<tr>
<td>The person was angry, nasty or humiliating</td>
<td>7</td>
<td>1.4</td>
</tr>
<tr>
<td>The person threatened to physically hurt or punish me</td>
<td>6</td>
<td>1.2</td>
</tr>
<tr>
<td>The person threatened to hurt or punish someone else</td>
<td>3</td>
<td>0.6</td>
</tr>
<tr>
<td>The person threatened to hurt or punish me in some non-physical way</td>
<td>3</td>
<td>0.6</td>
</tr>
</tbody>
</table>

TOTAL                                                                 N = 489  100.00
4.3.8 Disclosure of Adult Sexual Abuse

As evident in Table 4.5, almost two thirds of ASA victims reported never having disclosed their experience/s of ASA to a family member, and one in five reported never having disclosed this abuse to anyone. Respondents were more likely to have disclosed to a female, than to a male. More than one third expressed the desire to tell someone, more than one quarter expressed this desire but felt it was too difficult to do so, and almost one third expressed having ‘no intentions of telling anyone’.

Table 4.5
Disclosure of Adult Sexual Abuse

<table>
<thead>
<tr>
<th>Victim disclosure statement</th>
<th>True</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
</tr>
<tr>
<td>I have never told a family member about it</td>
<td>62.8</td>
</tr>
<tr>
<td>I told a female about it</td>
<td>69.1</td>
</tr>
<tr>
<td>I told a male about it</td>
<td>55.7</td>
</tr>
<tr>
<td>I have never told anyone about it</td>
<td>20.0</td>
</tr>
<tr>
<td>I would like to tell someone</td>
<td>35.2</td>
</tr>
<tr>
<td>I would like to tell someone but it is too difficult</td>
<td>27.7</td>
</tr>
<tr>
<td>I have no intentions of telling anyone</td>
<td>31.4</td>
</tr>
</tbody>
</table>

Gender differences were found with respect to certain elements of disclosure. Indeed, males were significantly less likely than females to have disclosed their experience of ASA to a family member, $\chi^2(1, N = 484) = 6.28, p = .012$, Cramér’s $V = .11$. In contrast to 39.2% of females ($n = 168$), only 21.8% of males ($n = 12$) reported having disclosed ASA to a family member.

Males were also significantly less likely than females to have disclosed ASA to a female, $\chi^2(1, N = 485) = 12.89, p < .0005$, Cramér’s $V = .16$. In contrast to 71.8% of females ($n = 308$), only 48.2% of males ($n = 27$) reported having disclosed ASA to a female. Inspection of standardised residuals (SRs) reveals that males were significantly overrepresented amongst respondents who not disclosed ASA to a female (SR = 2.8). Additionally, males
were significantly more likely than females to have never disclosed their experience of ASA to anyone, $\chi^2(1, N = 480) = 6.29, p = .012$, Cramér's $V = .11$. In contrast to only 18.4% of females ($n = 78$), 32.7% of males ($n = 18$) reported having never told anyone about their ASA. Inspection of standardised residuals (SRs) reveals that males were significantly overrepresented amongst respondents who had never disclosed their experience of ASA ($SR = 2.1$).

In contrast, no significant gender differences were found with respect to: i) disclosure of ASA towards a male, $\chi^2(1, N = 481) = 0.64, p = .42$, Cramér's $V = .04$; ii) desire to disclose, $\chi^2(1, N = 471) = 0.62, p = .43$, Cramér's $V = .04$; iii) a wish to disclose but finding it too difficult to do so, $\chi^2(1, N = 476) = 0.06, p = .81$, Cramér's $V = .01$; or iv) having no intention to disclose in the future, $\chi^2(1, N = 471) = 1.58, p = .21$, Cramér's $V = .06$. Specifically, 60.7% of males ($n = 34$) and 55.1% of females ($n = 234$) reported having disclosed ASA to a male. The wish to disclose ASA was expressed by 40.0% of males ($n = 22$) and 34.6% of females ($n = 144$) who endorsed the statement ‘I would like to tell someone’, whilst almost equal proportions of males (29.1%; $n = 16$) and females (27.6%; $n = 116$) endorsed the statement ‘I would like to tell someone, but it is too difficult’. Moreover, a sizable minority of males (38.9%; $n = 21$) and females (30.5%; $n = 127$) endorsed the statement, ‘I have no intentions of telling anyone.’

### 4.3.9 Confidante Gender Preferences of Adulthood Sexual Abuse Victims

Respondents were asked to specify the gender type they had found it most helpful to converse with in relation to their experience of ASA. As evident in Table 4.6, the majority of respondents reported finding it most helpful to speak with a female, although almost one fifth of respondents stated no gender preference, and a sizable minority identified speaking with a male as most helpful. Respondents who endorsed ‘Other’ were asked to specify. Their responses reflect the importance of factors other than gender (such as sexual orientation, personality type, and individual differences) in forming their preference, and also the perceived futility or negative outcomes of disclosure. Examples include:

- *As a lesbian, naturally a lesbian had a far better idea*
- *Partner, gay male, believed he would relate/understand more*
- *Depends on the personality type, rather than their gender*
- *Different ways of understanding, all are helpful*
Honestly, I wish I hadn’t said anything – it’s just too much.

It made very little difference. I was rarely believed.

Table 4.6
Confidante Gender Preferences of Adulthood Sexual Abuse Victims

<table>
<thead>
<tr>
<th>Confidante gender</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>47.62</td>
<td>200</td>
</tr>
<tr>
<td>No preference</td>
<td>19.05</td>
<td>80</td>
</tr>
<tr>
<td>Not applicable as I told no one or only one person</td>
<td>17.86</td>
<td>75</td>
</tr>
<tr>
<td>Males</td>
<td>13.10</td>
<td>55</td>
</tr>
<tr>
<td>Other</td>
<td>2.38</td>
<td>10</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0</td>
<td>N = 420</td>
</tr>
</tbody>
</table>

Given that such gender preferences may well vary as a function of victim gender and that these results may have been, at least to some extent, an artefact of a predominance of females within the victim sample, it was important to also examine confidante gender preferences within victim gender groups. As expected on the basis of the previous (whole sample) results, female victims showed a strong preference for female confidantes, such that 61.3% of female victims for whom this question was applicable stated a preference for female confidantes (n = 185), and only 13.6% stated a preference for male confidantes (n = 41). It is notable however, that 25.2% of female victims stated having no gender preference (n = 76).

In contrast, male victims showed only a minimal preference for female confidantes and indeed, were quite evenly divided in their preference for either males or females. Interestingly, males were also more likely than females to have a definite preference for either gender, with only a small minority having no gender preference. However, it should also be noted that this question was not applicable to the sizable portion of male victims (27.1%; n = 18) who had not disclosed to anyone or who had only disclosed to confidantes of one gender and hence, were not in a position to make a comparison. Thus, the following percentages pertain to the reduced sample of male victims for whom this question was
applicable. Of those, 45.5% of males preferred a female confidante \((n = 15)\), 42.4% preferred a male confidante \((n = 14)\), and only 12.1% stated having no gender preference \((n = 4)\). Importantly, these results highlight the comparatively low level of disclosure amongst male victims, relative to female disclosure.

4.3.10 Confidante Type Choices of Adulthood Sexual Abuse Victims

Respondents were asked to indicate with whom they had spoken about their ASA experience/s, in terms of confidante type. As shown in Table 4.7, a friend was the most popular choice of confidante, with almost two thirds of respondents reporting that they had spoken with a friend/s regarding about their ASA. Whilst partners were the next most popular choice of confidante, followed by family, counsellor, and psychologist, reported figures suggest that less than half of respondents had actually spoken with a partner about ASA, only thirty percent had spoken with family, one quarter had spoken with a counsellor, and only one in five had spoken with a psychologist.

Table 4.7

<table>
<thead>
<tr>
<th>Confidante Type</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friend</td>
<td>64.11</td>
<td>309</td>
</tr>
<tr>
<td>Partner</td>
<td>43.15</td>
<td>208</td>
</tr>
<tr>
<td>Family</td>
<td>29.46</td>
<td>142</td>
</tr>
<tr>
<td>Counsellor</td>
<td>24.69</td>
<td>119</td>
</tr>
<tr>
<td>Psychologist</td>
<td>21.37</td>
<td>103</td>
</tr>
<tr>
<td>No one</td>
<td>18.67</td>
<td>90</td>
</tr>
<tr>
<td>Sexual assault counsellor</td>
<td>17.84</td>
<td>86</td>
</tr>
<tr>
<td>Doctor/nurse</td>
<td>17.01</td>
<td>82</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>17.01</td>
<td>82</td>
</tr>
<tr>
<td>Police</td>
<td>11.62</td>
<td>56</td>
</tr>
<tr>
<td>Colleague</td>
<td>8.09</td>
<td>39</td>
</tr>
<tr>
<td>Stranger</td>
<td>5.39</td>
<td>26</td>
</tr>
<tr>
<td>Religious figure</td>
<td>4.15</td>
<td>20</td>
</tr>
<tr>
<td>Other</td>
<td>3.94</td>
<td>19</td>
</tr>
<tr>
<td>Teacher</td>
<td>1.66</td>
<td>8</td>
</tr>
<tr>
<td>Friend’s parent</td>
<td>1.45</td>
<td>7</td>
</tr>
</tbody>
</table>

4.3.11 Confidante Type Perceived Most Helpful by Adulthood Sexual Abuse Victims

Respondents who had disclosed their ASA experience/s were asked to indicate with which confidante type they had found it most helpful to converse. As seen in Table 4.8, friends were rated by far the most helpful of the confidante types, with over one third of respondents ranking a friend/s as the most helpful to have spoken with in regard to their ASA experience/s. Partners were ranked as most helpful by almost one in five respondents, followed by counsellors, psychologists, and sexual assault counsellors. Together, these confidante types accounted for 82.6% of respondents’ preferences ($n = 289$), with over half accounted for by friends and partners alone (53.15%; $n = 186$). It is of concern to note that five percent of respondents found that ‘no one’ was of help to them in regard to speaking about ASA ($n = 18$).

Table 4.8

<table>
<thead>
<tr>
<th>Confidante type</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friend</td>
<td>34.29</td>
<td>120</td>
</tr>
<tr>
<td>Partner</td>
<td>18.68</td>
<td>66</td>
</tr>
<tr>
<td>Counsellor</td>
<td>11.14</td>
<td>39</td>
</tr>
<tr>
<td>Psychologist</td>
<td>9.43</td>
<td>33</td>
</tr>
<tr>
<td>Sexual assault counsellor</td>
<td>8.86</td>
<td>31</td>
</tr>
<tr>
<td>No one</td>
<td>5.14</td>
<td>18</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>3.71</td>
<td>13</td>
</tr>
<tr>
<td>Family</td>
<td>3.14</td>
<td>11</td>
</tr>
<tr>
<td>Other</td>
<td>1.71</td>
<td>6</td>
</tr>
<tr>
<td>Religious figure</td>
<td>1.14</td>
<td>4</td>
</tr>
<tr>
<td>Doctor/nurse</td>
<td>0.86</td>
<td>3</td>
</tr>
<tr>
<td>Teacher</td>
<td>0.57</td>
<td>2</td>
</tr>
<tr>
<td>Stranger</td>
<td>0.57</td>
<td>2</td>
</tr>
<tr>
<td>Colleague</td>
<td>0.29</td>
<td>1</td>
</tr>
<tr>
<td>Police</td>
<td>0.29</td>
<td>1</td>
</tr>
<tr>
<td>Friend’s parent</td>
<td>0.00</td>
<td>0</td>
</tr>
</tbody>
</table>
Overall, 39.2% of ASA victims (n = 159) reported receiving some degree of counselling in relation to this abuse, however a minority reported receiving counselling ‘very much’ or ‘extremely’ (13.3%; n = 54). Whilst the vast majority of those who received counselling found this helpful to some degree (86.1%; n = 136), less than half found it ‘very’ or ‘extremely’ helpful (43.0%; n = 68).

4.3.12 Reactions to Disclosure of Adult Sexual Abuse

As evident in Table 4.9, more than half of respondents reported to some extent having discussed their experience/s of ASA with a friend/s or relative/s (54.3%; n = 219), although less than one in five reported doing so ‘very much’ or ‘extremely’ (17.1%; n = 69). Whilst most respondents reported to some extent receiving ‘positive, supportive, understanding, and protective’ reactions from family or friends (84.6%; n = 203), less than half reported receiving such reactions ‘very much’ or ‘extremely’ (42.1%; n = 101). Unfortunately, two thirds of respondents also reported encountering awkwardness, discomfort, and avoidance; almost half reported suspiciousness, challenging reactions, and lack of understanding; and one third reported encountering hostility, rejection, and blame.

Table 4.9
Reactions to Disclosure of Adult Sexual Abuse

<table>
<thead>
<tr>
<th>Victim statement</th>
<th>To some degree</th>
<th>Very or Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>I discussed this with a friend(s) or family member(s).</td>
<td>54.3</td>
<td>219</td>
</tr>
<tr>
<td>The reactions I received at that time from family or friends were mainly:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive, supportive, understanding, protective</td>
<td>84.6</td>
<td>203</td>
</tr>
<tr>
<td>Awkwardness, discomfort, we avoided it</td>
<td>68.1</td>
<td>158</td>
</tr>
<tr>
<td>Suspicious, challenging, didn’t understand</td>
<td>47.0</td>
<td>108</td>
</tr>
<tr>
<td>Hostility, rejection, blaming</td>
<td>33.2</td>
<td>76</td>
</tr>
<tr>
<td>Overall, talking to family or friends was helpful to me</td>
<td>80.6</td>
<td>191</td>
</tr>
<tr>
<td>Overall, I regret talking to family or friends about this</td>
<td>45.0</td>
<td>107</td>
</tr>
</tbody>
</table>
Notwithstanding these reactions, eighty percent of respondents reported that overall, speaking with family or friends had been to some degree helpful to them (80.6%; \( n = 191 \)), and more than one third had found this very or extremely helpful (38.4%; \( n = 91 \)). Conversely, almost half of respondents also expressed some degree of regret overall, with respect to talking with friends or family about their ASA experience/s (45.0%; \( n = 107 \)), and almost one in five expressed very much or extreme regret (17.2%; \( n = 41 \)).

4.3.13 Confronting the Perpetrator

Only 21.4% of ASA victims \( (n = 72) \) reported confronting the perpetrator/s about the event/s at the time, and 5.6% reported doing so many years later \( (n = 19) \). Thus, almost three in four perpetrators of ASA were never confronted by their victim (73.0%; \( n = 246 \)). Similarly, a minority of perpetrators were known by the victim to have been confronted by a third party regarding the event/s, either at the time (10.4%; \( n = 34 \)), or many years later (2.8%; \( n = 9 \)). Over half of ASA victims (67.2%; \( n = 219 \)) reported that the perpetrator/s was never confronted by a third party, and 19.6% were unsure \( (n = 64) \).

4.3.14 Police Reporting of Adult Sexual Abuse: Offence Characteristics, Victim Perceptions, and Outcomes

Victim perceptions regarding police reporting

A minority of ASA victims reported the matter to police (11.8%; \( n = 57 \)). Of those, 44.6% perceived doing so as having been ‘Not at all’ helpful \( (n = 25) \). A further 37.5% of respondents found reporting to police to have been ‘A little’ or ‘Moderately’ helpful \( (n = 21) \), and only 17.9% of respondents found reporting to be ‘Very’ or ‘Extremely’ helpful \( (n = 10) \). Eighty percent of respondents perceived that overall, the outcome had been ‘Not at all fair’ \( (n = 40) \), 16% perceived the outcome to have been a little or moderately fair \( (n = 8) \), and only 4% perceived there to have been a very or extremely fair outcome \( (n = 2) \).

Notwithstanding such perceptions, it is salient to note that, with respect to the question ‘Do you regret reporting to the police?’, half of respondents responded ‘Not at all’ (50.9%; \( n = 27 \)). A further 22.6% reported ‘A little’ or ‘Moderate’ regret \( (n = 12) \), and more than one in four respondents reported ‘Very much’ or ‘Extremely’ regretting that they had reported the matter (26.4%; \( n = 14 \)). Moreover, almost half of these respondents reported some regret over not having reported sooner to police (48.9%; \( n = 21 \)), with one in four
expressing very much or extreme regret (25.6%; \( n = 11 \)), and almost one in four expressing a little or moderate regret (23.3%; \( n = 10 \)).

**Offence and offender characteristics**

Of the respondents who had reported ASA to the police, more than one in three had had additional (nonsexual) crimes (e.g., violent physical assault, theft) perpetrated against them by the perpetrator of their sexual abuse (36.5%; \( n = 19 \)). Thirty percent of ASA victims who had made a police report were also aware of offences that the perpetrator had committed against another person (30.2%; \( n = 16 \)).

**Perpetrator outcomes of police reporting**

Of the respondents who had reported the matter to police, half reported that the person was caught (50.9%; \( n = 27 \)), 47.2% reported that the person was not caught (\( n = 25 \)), and 1.9% reported not having this information (\( n = 1 \)). Most respondents reported that the person was not charged (69.8%, \( n = 37 \)), with 24.5% of respondents reporting that the person was charged (\( n = 13 \)), and 5.7% reporting not being privy to this information (\( n = 3 \)). Similarly, the majority reported that the person was not convicted (69.6%; \( n = 32 \)), 8.7% reported not having this information (\( n = 4 \)), and 21.7% reported that a conviction was made against the person (\( n = 10 \)).

Given that only a small minority of ASA victims had made a police report, these percentages represent a small proportion of actual perpetrators. Indeed, given that 482 ASA victims responded to the questions regarding police reporting (but of those, 88.2% had not made a police report), the low levels at which perpetrators are apprehended, charged, and convicted is clear. Specifically, when one considers the perpetrators pertaining to both the ASA victims who reported to police and those who did not, only 11.8% were reported to police (\( n = 57 \)), 5.6% were known to have been caught (\( n = 27 \)), 2.7% were reported as having been charged (\( n = 13 \)), and 2.1% were reported to have been convicted (\( n = 10 \)).
4.3.15 Nonreporting of Adult Sexual Abuse to Police: Offence Characteristics, Victim Perceptions, and Outcomes

Victim perceptions in relation to nonreporting of adult sexual abuse
As noted earlier, the vast majority of ASA victims reported not having made a police report (88.2%; n = 425). The divided response regarding regrets over not having reported is notable. Whilst over half of respondents reported having no regrets regarding their decision not to report to police (52.4%; n = 156), almost as many respondents expressed some level of regret regarding this decision (47.7%; n = 142). Specifically, 32.9% expressed a little or moderate regret (n = 98), and 14.8% expressed very much or extreme regret over not having made a police report (n = 44).

Offence and offender characteristics
Of the respondents who had not reported ASA to the police, 17.1% had had additional (nonsexual) crimes (e.g., violent physical assault, theft) perpetrated against them by the perpetrator of their sexual abuse (n = 57), and 19.2% were aware of offences that the perpetrator had committed against another person (n = 70). Comparison of these findings with those reported above in relation to police-reported ASA suggests that police reporting was more likely when additional crimes were perpetrated and when the victim was aware that crimes had also been perpetrated against others.

4.3.16 Additional Crimes Against Victims of Adult Sexual Abuse
Crimes committed by the perpetrator/s were not limited to those of a sexual nature. Indeed, one in five ASA victims reported that the perpetrator/s had committed additional (nonsexual) crimes against them (19.7%; n = 76). Predominantly, such crimes included physical assaults, described by respondents in terms such as bashing, biting, cutting, beating, choking, domestic violence, ‘choking and banging my head on wall trying to kill me’, assaults with weapons, hair-pulling, punching, and attempted murder. Other crimes included abductions and attempted abductions; holding against will; physical restraining; stabbings and attempted stabbings; intentional burn injuries to body; stalking; stealing; robbery; car theft; arson; placing ‘homemade bombs on driveway’; assorted forms of property damage; and animal cruelty, including mutilation or killing of pets.
Moreover, one in five ASA victims were aware that the perpetrator/s had also committed
criminal offences against at least one other person (20.6%; n = 86). Such crimes comprised
a similar (though less extensive) range to those perpetrated against respondents (as
reported above).

4.3.17 Violence in Intimate Relationships

Intimate partner violence (IPV) within heterosexual relationships was examined in all
respondents who had ever had a partner of the opposite sex (including a casual dating
partner). Similarly, examination of IPV within same-sex relationships was conducted.
Discussion of both same-sex IPV and heterosexual IPV within the context of sexual
orientation is presented in Study 6: Wellness, Perturbation, and Vulnerability Across Sexual
Orientation, whilst the following discussion pertains to IPV within heterosexual
relationships, hereafter referred to simply as IPV.

Gender differences in experience of intimate partner violence

Across the entire sample, one in five respondents identified themselves as a victim of IPV
(20.3%; n = 227). The proportion of respondents who identified as victims of this form of
violence differed significantly across gender, \( \chi^2(1, N = 1119) = 13.44, p < .0005, \) Cramér's
\( V = .11. \) Indeed, relative to males (12.0%; n = 30), females were almost twice as likely to
self-identify as victims of IPV (22.6%; n = 197). Moreover, females comprised 86.8% of
the total number of IPV victims in the sample, whilst comprising only 75.4% of nonvictims
(n = 673). In contrast, males comprised only 13.2% of IPV victims (n = 30), whilst
comprising 24.6% of non-IPV victims (n = 219). Inspection of the standardised residuals
(SRs) showed that males were significantly underrepresented amongst IPV victims (SR = -
2.9).

Intimate partner violence concomitant with adulthood sexual abuse

As with victims of CSA, respondents who had experienced adulthood sexual assault (ASA)
were significantly more likely to have also identified as victims of IPV, \( \chi^2(1, N = 1077) = 71.98, p < .0005, \) Cramér's
\( V = .259. \) Indeed, victims of ASA were almost three times as
likely to have experienced IPV in adulthood (35.2%, n = 123), relative to respondents who
had not experienced ASA (13.0%, n = 95). Moreover, IPV victims were more than twice as
likely to have experienced ASA (56.4%; n = 123), relative to non-victims of IPV (26.3%; n
= 226).
Inspection of the standardised residuals (SRs) showed that victims of ASA were most disproportionately represented, being both very significantly overrepresented amongst IPV victims (SR = 6.2), and significantly underrepresented amongst non-victims of IPV (SR = -3.1). Conversely, respondents who had not experienced ASA were significantly underrepresented amongst victims of IPV (SR = -4.3) and significantly overrepresented amongst non-victims of IPV (SR = 2.2).

4.3.18 Physical Injury Resultant from Adult Sexual Abuse

More than one third of ASA victims (38.4%; n = 182) reported sustaining some level of physical injury as a result of ASA. Moreover, 8.2% of victims reported Extremely (2.8%; n = 13) or Very Much (5.5%; n = 26) sustaining such injury. In terms of qualitative data, most commonly reported were genital injuries such as vaginal and anal bleeding, tearing, bruising, and soreness; and bruising, lacerations, and bite injuries to other areas, particularly the breast, face, throat, wrists, and thigh. Specific other injuries included a broken cheek bone, thumb, and ribs; fractured skull; other head injuries; bite injury to penis; ‘love’ bites; rope burns; stab injuries; split lip; black eye; severe internal injuries and ruptures; and a deliberate burn from a cigarette lighter. One respondent noted that with respect to bruising, ‘he was always careful not to leave marks where anyone would see them’. Conversely, another respondent noted that ‘sometimes there were obvious marks and bruises that people would comment upon.’ One respondent noted that she was seven months pregnant at the time of injury; another respondent reported injuries that required four operations; and numerous others reported injuries requiring surgery or hospitalization.

4.3.19 Exposure to Risk of Sexually Transmitted Infection

More than one half of ASA victims reported having been exposed to the risk of a sexually transmitted infection (STI) as a consequence of ASA (52.7%; n = 253). However, only 38.8% of ASA victims reported having been tested for any infection possibly contracted from the perpetrator/s (n = 186). Given that respondents may have undergone testing after some (but not all) exposure to risk of STI, the option to respond both Yes and No to this question was provided. Notably, 64.4% of ASA victims reported not having undergone testing for STI contracted from an ASA perpetrator/s (n = 309), indicating that 3.1% of respondents were, in fact, tested after some (but not all) exposure (n = 15).
Notably, only 10.8% of respondents reported that the perpetrator/s ‘used a condom on every occasion of unwanted penile penetration’ \( (n = 32) \), suggesting that respondents’ own summation of their exposure to risk of STI represents a substantial underestimation.

A sexually transmitted infection contracted following ASA was reported by 6.1% of ASA victims \( (n = 29) \); and a further 13.5% of respondents reported being Unsure as to whether they had contracted a STI from the perpetrator \( (n = 64) \).

4.3.20 Exposure to Possibility of Pregnancy

Amongst female victims of all forms of ASA, 50.8% reported having been exposed to the possibility of a pregnancy in the course of ASA \( (n = 214) \). A further 14.3% reported that this question was not applicable \( (n = 60) \), and 34.9% reported no such exposure \( (n = 147) \). Thus, this figure represents 59.3% of female victims for whom this question was applicable (i.e., because penile-vaginal penetrative ASA had occurred).

However, with respect to condom use, only 11.1% of female victims reported that a condom had been used on every occasion of penile penetration \( (n = 30) \), suggesting, as with risk perception regarding STI, that respondents’ appraisal of risk represents an underestimation of actual risk. (Notably, male ASA victims responded similarly to this question, in that only 8.0% reported condom use on every occasion of unwanted penile penetration \( [n = 2] \)).

Forty-eight females reported that such exposure within the context of ASA resulted in a pregnancy. This represents 9.7% of female respondents who reported any form of ASA (i.e., including nonpenetrative ASA). However, this figure also represents 22.4% of the females who reported exposure to the possibility of pregnancy in the course of ASA.

4.3.21 Relationships Between Adult Sexual Abuse and Current Psychological Wellbeing

A one-way between-groups multivariate analysis of variance was performed to examine the relationship between ASA and psychological wellbeing. Nine parameters of psychological health were measured in the current study and used as dependent variables to assess overall wellbeing: (i) depression; (ii) anxiety; (iii) stress; (iv) self-esteem; (v) shame; (vi) guilt; (vii) aggression; and (viii) posttraumatic symptomotology; and (ix) life satisfaction. A statistically
significant difference was found between nonvictims and victims of ASA on the combined dependent variables, $F(9, 854) = 10.37, p < .0005$, Wilks’ $\Lambda = .90$, partial $\eta^2 = .10$. When the results for the dependent variables were considered separately, significant differences were found for seven of the nine variables, using a Bonferroni adjusted alpha level of .006. Specifically, differences between victims and nonvictims were found with respect to anxiety, $F(1, 862) = 12.26, p < .0005$, partial $\eta^2 = .01$; stress, $F(1, 862) = 19.94, p < .0005$, partial $\eta^2 = .02$; shame, $F(1, 862) = 12.08, p = .001$, partial $\eta^2 = .01$; guilt, $F(1, 862) = 16.53, p < .0005$, partial $\eta^2 = .02$; aggression, $F(1, 862) = 9.95, p = .002$, partial $\eta^2 = .01$; posttraumatic symptomatology, $F(1, 862) = 79.47, p < .0005$, partial $\eta^2 = .08$; and life satisfaction, $F(1, 862) = 8.00, p = .005$, partial $\eta^2 = .01$. No significant difference was found with respect to depression, $F(1, 862) = 6.99, p = .008$, partial $\eta^2 = .01$; or self-esteem, $F(1, 862) = 2.61, p = .11$, partial $\eta^2 = .003$.

Inspection of the mean scores indicated that victims reported greater anxiety ($M = 11.37, SD = 11.03$), relative to nonvictims ($M = 8.71, SD = 9.89$); more stress ($M = 18.73, SD = 11.32$) than nonvictims ($M = 15.04, SD = 11.07$); more shame ($M = 15.95, SD = 8.39$) than nonvictims ($M = 13.95, SD = 7.46$); more guilt ($M = 9.99, SD = 5.04$) than nonvictims ($M = 8.51, SD = 4.87$); higher aggression ($M = 67.43, SD = 20.09$) than nonvictims ($M = 62.86, SD = 19.31$); greater posttraumatic symptomatology ($M = 55.82, SD = 15.47$) than nonvictims ($M = 44.66, SD = 17.44$); and lower life satisfaction ($M = 22.73, SD = 9.59$) than nonvictims ($M = 24.88, SD = 10.51$).

4.3.22 Feelings Experienced Subsequently to Adult Sexual Abuse

Respondents were asked to describe the feelings they experienced following the sexual abuse event/s, by rating a range of both positive and negative statements (listed in Table 4.10). As evident in this table, negative feelings predominated, with all respondents reporting guilt feelings to some degree, and two thirds reporting Very much or Extreme guilt. Similarly, feelings of upset; anger; sadness; shame; and hurt, rejection, or betrayal; and feeling ‘dirty’ or bad were reported by 80-94% of respondents and acutely present in over half to two thirds of respondents. These results are consistent with the finding that only one quarter of respondents reported ‘feeling good about [themselves]’ to some degree, and only four percent reported feeling Very or Extremely good about themselves. Most
respondents also reported trying to ‘pretend that nothing had happened’ and over half reported doing so ‘Very much’ or ‘Extremely’.

Interestingly, half of respondents to some degree endorsed the statement “My life was fine”, yet less than one in ten endorsed this statement ‘Very much’ or ‘Extremely’. Juxtaposed with these results is the finding that forty percent of ASA victims reported having seriously contemplated suicide in the days or weeks following the sexual abuse event/s, and more than one in five reported ‘Very much’ or ‘Extreme’ suicidal ideation (SI) within this timeframe. Moreover, over half of respondents reported such SI at some later point in their lives, and almost forty percent reported contemplating suicide ‘Very much’ or ‘Extremely’ at some time subsequent to the event/s. More than one in four ASA victims reported having attempted suicide since the event/s. More than three quarters of ASA victims who had attempted suicide subsequently to experience of sexual abuse attributed the attempt/s to the ASA to some degree, and almost half did so ‘Very much’ or ‘Extremely’ (see note in Table 4.10). These figures demonstrate that suicide attempts attributed to ASA occurred across a wider timeframe than that immediately following the abuse, and that in fact, likelihood of lifetime occurrence of suicide attempt attributable to ASA increased markedly with time.

This finding counters the notion that suicide risk is necessarily confined by temporal proximity to precipitating factors; and therefore, that suicide risk is necessarily greatest in the period closely aligned what might be considered a precipitating factor and subsequently subsides with the passing of time. Whilst such a finding might not be surprising, it provides evidence that current models of mental health care practice that deliver crisis intervention followed by rapid withdrawal of services (particularly in climates of inadequate resources coupled with high case load demands) may overlook individuals who experience high suicidality risk or mental deterioration at times not overtly linked to external stressors or traumatic events. Given that such phenomena and concomitant underrecognised risks are clearly important to uncover, these findings indicate that more research is warranted to further examine factors and processes that precipitate suicidal behaviour over the long term.
Whilst almost three quarters of respondents reported feeling some degree of hate towards the perpetrator/s and almost half reported very much or extreme feelings of hate, it is also notable that a sizable minority of respondents reported retaining some degree of positive feelings toward the perpetrator/s. Specifically, around one third of respondents reported liking, trusting, or loving the person/s to some degree, and around one in ten reported strongly experiencing such feelings. Moreover, to some extent, more than one in four respondents felt loved by the person and more than one in five felt special because of the person, although less than one in ten felt this way strongly. These findings demonstrate the mix of emotions experienced by many victims of sexual abuse, and the confusion, hurt, and cognitive dissonance surrounding betrayal and abuse of trust, affection, and love felt toward the perpetrator. The presence of residual trust, love, and affection for some perpetrators following abuse also highlights the vulnerability of victims for revictimisation, the difficulties many victims experience in distancing themselves from the perpetrator/s, and specifically, the potential for exploitation of such emotions by the original and subsequent perpetrators.

Table 4.10
Feeling Experienced Subsequently to Adult Sexual Abuse

<table>
<thead>
<tr>
<th>Victim feeling</th>
<th>To some degree</th>
<th>Very much or Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>I felt guilty</td>
<td>100.0</td>
<td>382</td>
</tr>
<tr>
<td>I was upset</td>
<td>93.6</td>
<td>450</td>
</tr>
<tr>
<td>I felt angry</td>
<td>90.0</td>
<td>430</td>
</tr>
<tr>
<td>I felt sad</td>
<td>87.6</td>
<td>418</td>
</tr>
<tr>
<td>I felt ashamed</td>
<td>84.4</td>
<td>406</td>
</tr>
<tr>
<td>I tried to pretend nothing had happened</td>
<td>82.0</td>
<td>392</td>
</tr>
<tr>
<td>I felt hurt or rejected or betrayed</td>
<td>79.7</td>
<td>381</td>
</tr>
<tr>
<td>I felt ‘dirty’ or like I was bad</td>
<td>78.5</td>
<td>377</td>
</tr>
<tr>
<td>I hated the person</td>
<td>73.4</td>
<td>354</td>
</tr>
<tr>
<td>At some later point in my life I thought seriously about killing myself</td>
<td>53.3</td>
<td>256</td>
</tr>
<tr>
<td>My life was fine</td>
<td>51.1</td>
<td>243</td>
</tr>
</tbody>
</table>
In the days or weeks after the event(s), I thought seriously about killing myself  
I liked the person  
I trusted the person  
I loved the person  
I felt loved by the person  
I felt good about myself  
I felt special because of the person

<table>
<thead>
<tr>
<th></th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have attempted suicide since the event(s)</td>
<td>26.8</td>
<td>129</td>
</tr>
<tr>
<td>If true, how much do you believe your attempt(s) was due to the event(s)?</td>
<td>77.9*</td>
<td>113</td>
</tr>
</tbody>
</table>

* Note that these percentages sum to > 100, because some respondents described more than one suicide attempt, and attributed some attempts more strongly to ASA than others.

4.3.23 Victim Perceptions Regarding Adult Sexual Abuse

As evident in Table 4.11, the overwhelming majority of ASA victims considered the event/s to have been damaging to some degree, and almost half rated the event/s as very or extremely damaging to themselves. Similarly, over ninety percent of victims conceptualised the event/s as sexual assault to some extent, and two thirds endorsed this perception ‘very much’ or ‘extremely’. Whilst respondents were slightly less inclined to view the event/s as a crime, the vast majority nonetheless endorsed this perception to some degree, and over half endorsed this view ‘very much’ or ‘extremely’. Respondents were less inclined again to view the event/s as ‘rape’, with only two thirds endorsing the statement “What happened to me was rape”, and less than half of respondents endorsing this view ‘very much’ or ‘extremely’. This finding demonstrates the importance of using behavioural in preference to label descriptors of sexual assault in order to minimise ambiguity, effects of variations in definitions of terms such as ‘rape’, and possible effects of applying terminology with highly emotive and social overtones and widely variant nuance.

Whilst the overwhelming majority of ASA victims strongly attributed responsibility for the event/s to the perpetrator/s, it is noteworthy that almost two thirds of victims also
perceived themselves to some degree responsible for the event/s, and almost one in five perceived themselves ‘very much’ or ‘extremely’ responsible. Such findings have clear implications for understanding sexual assault trauma and guiding therapeutic intervention.

Most respondents reported some degree of difficulty in talking about their experience/s of ASA, and forty percent reported finding this very or extremely difficult. Such difficulties clearly impede help-seeking and service provision and exacerbate isolation, and thereby, vulnerability to perturbation, revictimisation, and suicidality. Indeed, implications for victim needs and wellbeing arise also from the finding that sixty percent of respondents expressed some degree of regret, and thirty percent expressed very much or extreme regret about not having spoken sooner or more about their ASA experience/s.

Table 4.11

<table>
<thead>
<tr>
<th>Victim Perceptions Regarding Adult Sexual Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Perception</td>
</tr>
<tr>
<td>What happened was damaging to me.</td>
</tr>
<tr>
<td>What happened to me was a crime.</td>
</tr>
<tr>
<td>What happened to me was sexual assault.</td>
</tr>
<tr>
<td>What happened to me was rape.</td>
</tr>
<tr>
<td>I was responsible for what happened.</td>
</tr>
<tr>
<td>The other person was responsible for what happened</td>
</tr>
<tr>
<td>I regret not talking sooner or more about what happened</td>
</tr>
<tr>
<td>How difficult has it been to talk about the event(s)?</td>
</tr>
</tbody>
</table>

4.3.24 Adult Sexual Abuse and Suicide Attempt

Suicide attempt occurrence

Respondents who had experienced ASA were proportionately more likely to have attempted suicide, $\chi^2(1, N = 1148) = 22.23, p < .0005$, Cramér’s $V = .14$. Indeed, 38.1% of
victims of ASA ($n = 138$) had attempted suicide, in contrast to 24.6% of respondents who had not experienced ASA ($n = 193$). Moreover, 41.7% of suicide attempters had experienced ASA ($n = 138$), compared with 27.4% of nonattempters ($n = 224$). Inspection of standardised residuals (SRs) reveals that victims of ASA were the most disproportionately represented, being most significantly overrepresented amongst suicide attempters ($SR = 3.3$), and significantly underrepresented amongst nonattempters ($SR = -2.1$). Conversely, respondents who had not experienced ASA were significantly underrepresented amongst suicide attempters ($SR = -2.2$).

**Suicide attempts before and after adult sexual abuse**

Of the respondents who reported ASA, 24.4% had attempted suicide on at least one occasion prior to their experience of adult sexual assault ($n = 117$), and 26.8% of ASA victims attempted suicide at least once subsequently to their sexual victimisation ($n = 129$). (It should be noted that these periods might represent quite unequal timeframes). Of the respondents who had attempted suicide since their experience/s of ASA, only 22.1% believed their suicide attempt/s to be ‘Not at all’ related to their experience of sexual victimisation in adulthood ($n = 32$). In contrast, 87.9% believed their suicide attempt/s to be related to their experience of ASA to some degree ($n = 113$). Specifically, 13.8% of respondents believed the attempt/s to be due to the ASA to a small degree ($n = 20$); 17.9% attributed the attempt/s ‘Moderately’ to the ASA ($n = 26$); 19.3% believed the attempt/s to be ‘Very much’ due to the ASA ($n = 28$); whilst the largest proportion of respondents (26.9%) believed the attempt/s to be ‘Extremely’ due to the ASA ($n = 39$).

**Sexual abuse-related perceptions**

Within respondents who had experienced ASA, a one-way between-groups multivariate analysis of variance was performed to examine differences in perceptions regarding the sexual abuse between respondents who had attempted suicide subsequently to ASA, and those who had not. Six dependent variables were used to assess overall perception: (i) ‘What happened was damaging to me’; (ii) ‘What happened to me was a crime’; (iii) ‘What happened to me was sexual assault’; (iv) ‘What happened to me was rape’; (v) ‘I was responsible for what happened’; and (vi) ‘The other person was responsible for what happened’. A statistically significant difference was found between suicide attempters and nonattempters on the combined dependent variables, $F(6, 347) = 7.44, p < .0005$, Wilks’ $\Lambda$.
= .89, partial $\eta^2 = .11$. When the results for the dependent variables were considered separately, significant differences were found for three of the six variables, using a Bonferroni adjusted alpha level of .008. Specifically, differences were found in the degree to which the ASA was regarded as damaging, $F(1, 352) = 33.05, p < .0005$, partial $\eta^2 = .09$, and in the degree to which the ASA was identified as rape, $F(1, 352) = 8.69, p = .003$, partial $\eta^2 = .02$. Moreover, attempters and nonattempters varied in the degree to which they attributed responsibility for the ASA to themselves, $F(1, 352) = 9.09, p = .003$, partial $\eta^2 = .03$.

Inspection of the mean scores indicated that suicide attempters were more likely to regard the ASA as very damaging ($M = 3.92, SD = 1.14$) compared with nonattempters ($M = 3.10, SD = 1.36$); more likely to classify the ASA as rape ($M = 3.40, SD = 1.68$) than nonattempters ($M = 2.85, SD = 1.71$); and likely to attribute more responsibility for the ASA to themselves ($M = 2.46, SD = 1.42$) than nonattempters ($M = 2.06, SD = 1.06$).

**Adult sexual abuse disclosure effects**

Within ASA victims, a one-way between-groups multivariate analysis of variance was performed to examine differences in disclosure and its effects between respondents who had attempted suicide subsequently to ASA, and those who had not. Six dependent variables were used to assess CSA disclosure and its effects: (i) helpfulness of talking to friends or family; (ii) regrets regarding talking to friends or family; (iii) hostile, rejecting, or blaming reactions from family or friends; (iv) suspicious, challenging, or lack of understanding reactions from family or friends; (v) receiving counselling or services for ASA; and (vi) degree of difficulty experienced in talking about ASA.

A statistically significant difference was found between suicide attempters and nonattempters on the combined dependent variables, $F(6, 196) = 6.56, p < .0005$, Wilks’ $\Lambda = .83$, partial $\eta^2 = .17$. When the results for the dependent variables were considered separately, significant differences were found for five of the six variables, using a Bonferroni adjusted alpha level of .008. Specifically, differences were found in the regrets experienced in regard to discussing ASA with family/friends, $F(1, 201) = 8.59, p = .004$, partial $\eta^2 = .04$; the level of hostile, blaming, or rejecting reactions experienced, $F(1, 201) = 10.50, p = .001$, partial $\eta^2 = .05$; the level of suspicious, challenge, or lack of understanding
reactions experienced, $F(1, 201) = 18.11, p < .0005$, partial $\eta^2 = .08$; the extent of
counselling or services for received for ASA, $F(1, 201) = 12.50, p = .001$, partial $\eta^2 = .06$;
and in the degree of difficulty experienced in talking about the ASA, $F(1, 201) = 15.33, p <
.0005$, partial $\eta^2 = .07$.

Inspection of the mean scores indicated that suicide attempters experienced more regrets
regarding disclosure to family/friends ($M = 2.46, SD = 1.49$) compared with
nonattempters ($M = 1.83, SD = 1.26$); more hostile, blaming, or rejecting reactions ($M =
2.30, SD = 1.49$) than nonattempters ($M = 1.63, SD = 1.18$); more suspicious, challenging,
or lack of understanding reactions ($M = 2.86, SD = 1.60$) than nonattempters ($M = 1.91,
SD = 1.29$); more counselling or services for ASA ($M = 2.56, SD = 1.45$) than
nonattempters ($M = 1.82, SD = 1.22$); and more difficulty in talking about the ASA ($M =
3.90, SD = 1.11$) than nonattempters ($M = 3.08, SD = 1.34$).

An independent-samples $t$-test, with a Bonferroni adjustment for multiple comparisons,
was conducted to compare ASA victims who had subsequently attempted suicide with
those who had not, in terms of regret related to not talking more or sooner about their
experience/s of ASA. Respondents who had attempted suicide since experiencing ASA
reported significantly more regrets with respect to insufficient or delayed disclosure ($M =
2.97, SD = 1.61$), than ASA victims who had not subsequently attempted suicide ($M =
2.33, SD = 1.52$), $t(474) = -3.999, p < .0005, \eta^2 = .03$.

Sexual abuse-related physical injury
An independent-samples $t$-test, with a Bonferroni adjustment for multiple comparisons,
was conducted to compare ASA victims who had subsequently attempted suicide with
those who had not, in terms of physical injuries sustained as a result of the sexual assault/s.
Respondents who had attempted suicide since experiencing ASA reported significantly
more physical injury ($M = 2.08, SD = 1.19$), than ASA victims who had not subsequently
attempted suicide ($M = 1.54, SD = .95$), $t(181.25) = -4.60, p < .0005, \eta^2 = .04$.

Police reporting of adult sexual abuse
Only 11.7% of ASA victims reported having referred the matter to police ($n = 56$).
These respondents were proportionately more likely to have attempted suicide at some
later time, χ²(1, N = 477) = 6.78, p = .009, Cramér’s V = .12. Indeed, 41.1% of respondents who had made a police report (n = 23) had attempted suicide, in contrast to 24.7% of respondents who had not reported the ASA to the police (n = 104). Moreover, 18.1% of suicide attempters had made a police report (n = 23), in contrast to only 9.4% of nonattempters (n = 33). Inspection of standardised residuals (SRs) reveals that respondents who reported the ASA to police were significantly overrepresented amongst suicide attempters (SR = 2.1).

Additional crimes against the victim

One in five victims of ASA reported that the perpetrator/s had committed additional (nonsexual) crimes against them (19.9%; n = 76). These respondents were around twice as likely to have attempted suicide at some later time, χ²(1, N = 382) = 14.07, p < .0005, Cramér’s V = .19. Indeed, 43.4% of respondents who reported additional crimes against them (n = 33) had attempted suicide, in contrast to 22.2% of respondents who reported no additional victimisation by the perpetrator/s (n = 68). Moreover, 32.7% of suicide attempters reported additional victimisation (n = 33), in contrast to only 15.3% of nonattempters (n = 43). Inspection of standardised residuals (SRs) reveals that respondents who reported additional victimisation by the perpetrator/s were significantly overrepresented amongst suicide attempters (SR = 2.9).

Crimes against others

Approximately twenty percent (20.7%) of ASA victims reported an awareness that the perpetrator/s had also committed an offence/s against another person/s (n = 86). These respondents were more likely to have attempted suicide at some later time, χ²(1, N = 415) = 5.17, p = .02, Cramér’s V = .11. Indeed, 37.2% of respondents who reported offences against another person/s (n = 32) had attempted suicide, in contrast to 24.9% of respondents who reported no victimisation by the perpetrator/s against others (n = 82). Moreover, 28.1% of suicide attempters reported victimisation against another (n = 32), in contrast to 17.9% of nonattempters (n = 54).

Exposure to risk of sexually transmitted infection

Over fifty percent (53.0%) of ASA victims reported having been exposed to the risk of a sexually transmitted infection (STI) by the perpetrator/s (n = 251). These respondents
were more likely to have attempted suicide at some later time, \( \chi^2(1, N = 474) = 10.71, p = .001 \), Cramér’s \( V = .15 \). Indeed, 33.1% of respondents who reported exposure to the risk of a STI \( (n = 83) \) had attempted suicide, in contrast to 19.7% of respondents who reported no such risk \( (n = 44) \). Moreover, 65.4% of suicide attempters reported exposure risk \( (n = 83) \), in contrast to 48.4% of nonattempters \( (n = 168) \). Inspection of standardised residuals (SRs) reveals that respondents who reported no exposure to risk of a STI by the perpetrator/s were significantly underrepresented amongst suicide attempters \( (SR = -2.0) \).

**Desire for disclosure**

Thirty-five percent (35.0%) of ASA victims expressed a desire to tell someone about their experience of ASA \( (n = 163) \). These respondents were more likely to have attempted suicide at some later time, \( \chi^2(1, N = 466) = 4.71, p = .03 \), Cramér’s \( V = .10 \). Indeed, 33.1% of respondents who expressed a wish to tell someone \( (n = 54) \) had attempted suicide, in contrast to 23.8% of respondents who reported no such desire \( (n = 72) \). Moreover, 42.9% of suicide attempters expressed a desire to tell someone \( (n = 54) \), in contrast to 32.1% of nonattempters \( (n = 109) \).

**Barriers to disclosure**

Over one quarter of ASA victims (27.6%) endorsed the statement that ‘I would like to tell someone but it is too difficult’ \( (n = 130) \). These respondents were more likely to have attempted suicide at some later time, \( \chi^2(1, N = 471) = 14.84, p < .0005 \), Cramér’s \( V = .18 \). Indeed, 39.2% of respondents who endorsed this statement \( (n = 51) \) had attempted suicide, in contrast to 21.7% of respondents who disagreed with this statement \( (n = 74) \). Moreover, 40.8% of suicide attempters endorsed this statement \( (n = 51) \), in contrast to only 22.8% of nonattempters \( (n = 79) \). Inspection of standardised residuals (SRs) reveals that respondents who endorsed this statement were significantly overrepresented amongst suicide attempters \( (SR = 2.8) \).

4.3.25 Adult Sexual Abuse and Suicidal Ideation

**Suicidal ideation occurrence and frequency**

Respondents who had experienced ASA were also proportionately more likely to have seriously contemplated suicide, \( \chi^2(1, N = 1174) = 8.12, p = .004 \), Cramér’s \( V = .083 \). Indeed, 72.8% of ASA victims \( (n = 267) \) had contemplated suicide, in contrast to 64.3% of
respondents who had not experienced ASA ($n = 519$). Moreover, 34.0% of suicide contemplators had experienced ASA ($n = 267$), compared with 25.8% of noncontemplators ($n = 100$).

An independent-samples $t$-test was also conducted to compare individuals who experienced ASA with those who had not, in terms of frequency of suicidal ideation. Victims of ASA reported a significantly higher frequency of SI ($M = 3.15, SD = 1.75$), than nonvictims ($M = 2.69, SD = 1.63$), $t(1172) = -4.40, p < .0005, \eta^2 = .02$.

A one-way repeated measures ANOVA was conducted amongst ASA victims only to ascertain whether a temporal relationship existed between SI and ASA. Suicidal ideation was compared across four time-points: (i) in the days or weeks preceding ASA (Shortly Before: SB); (ii) some earlier time preceding ASA (Earlier Time: ET); (iii) in the days or weeks following ASA (Shortly After: SA); and (iv) at some later time following ASA (Later Time: LT). The means and standard deviations are presented in Table 4.12. There was a significant effect for time, $F(3, 431) = 90.62, p < .0005, \text{Wilks' } \Lambda = .61, \text{ multivariate partial } \eta^2 = .39$. Repeated measures $t$-tests were conducted to examine where significant differences occur. Statistically significant differences, using a Bonferroni adjusted alpha level of .008 for six comparisons, were found between all time periods. Specifically, there was a significant increase in SI between Shortly Before ASA and Shortly After ASA, $t(464) = -8.68, p < .0005, \eta^2 = .14$ (a large effect size); and a larger significant increase between Shortly Before and a Later Time, $t(465) = -15.18, p < .0005, \eta^2 = .33$ (signifying a very large effect size). A significant increase was also found between an Earlier Time before ASA and a Later Time after ASA, $t(447) = -3.66, p < .0005, \eta^2 = .03$. Each of these tests indicate that SI increased following ASA. Conversely, a significant decrease in SI was found between an Earlier Time before ASA and Shortly After ASA, $t(447) = 4.84, p < .0005, \eta^2 = .05$. This result is not surprising given that Shortly After refers to a short time-limited period, compared with the Earlier Time period which can potentially encompass multiple decades.

The two time periods before ASA (Shortly Before and Earlier Time) were also examined for differences in SI frequency using a repeated measures $t$-test. A statistically significant lower frequency of SI was noted, using a Bonferroni adjustment for multiple comparisons,
between the time period Shortly Before, and an Earlier Time, $t(443) = -12.64, p < .0005, \eta^2 = .27$ (a very large effect). Again, this result is to be expected given that Shortly Before refers to a short time period, whereas Earlier Time refers to an entire adult lifetime prior to ASA. Similarly, upon examination of the two time periods following ASA (Shortly After and Later Time), a significantly higher frequency of SI was found in the Later Time period compared with the time period Shortly After, $t(472) = -10.70, p < .0005, \eta^2 = .20$ (a large effect size). Once again, this is not so surprising given that ‘Shortly After’ represents a short time frame and ‘Later Time’ encompasses all time elapsed since ASA, and given the fact that these respondents include adults of all ages. Further, the difference between Earlier and Later Time is not altogether surprising given that ‘Earlier’ is a time-limited period (limited by younger age at one end and the occurrence of ASA at the other). In contrast, ‘Later Time’ encompasses the period from occurrence of ASA until completion of the survey – potentially decades.

In summary, the most telling finding is the difference between Shortly Before and Shortly After (equivalent time periods), even though the found effects are not as large as those found when comparing ET and LT, and SB and LT. Taken together, these findings show strong temporal relationships between ASA experience and heightened suicidality when measured in terms of SI across time periods prior and subsequent to ASA.

### Table 4.12

**Suicidal Ideation Prior and Subsequently to Adult Sexual Abuse (N = 434)**

<table>
<thead>
<tr>
<th>Time period</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earlier in life (ET)</td>
<td>2.37</td>
<td>1.66</td>
</tr>
<tr>
<td>Shortly before ASA (SB)</td>
<td>1.50</td>
<td>1.14</td>
</tr>
<tr>
<td>Shortly after ASA (SA)</td>
<td>2.00</td>
<td>1.46</td>
</tr>
<tr>
<td>Later in life (LT)</td>
<td>2.66</td>
<td>1.76</td>
</tr>
</tbody>
</table>

Therefore, it may be more meaningful to examine changes in SI in terms of percentages of respondents who experienced SI at different time points (See Table 4.13). Inspection of
Table 4.13 reveals that, of the respondents who identified as ASA victims, 53.0% had never seriously contemplated suicide prior to their experience of ASA (n = 241), and 80.5% had not contemplated suicide in the days or weeks preceding the assault (n = 379). Yet, within the days or weeks after the ASA, the proportion of respondents who had not contemplated suicide at all within this timeframe had fallen to 60.9% (n = 291), and indeed, only 46.7% of ASA victims reported having never subsequently contemplated suicide (n = 224). Instead, the proportion of respondents reporting ever contemplating suicide ‘extremely’ increased from 19.6% prior to ASA (n = 89) to 30.0% post-ASA (n = 144). Shortly before the ASA, only 5.9% of respondents had ‘extremely’ contemplated suicide (n = 28). Within the days and weeks following the ASA, this proportion had risen to 13.8% (n = 66).

Table 4.13

<table>
<thead>
<tr>
<th>Time period</th>
<th>% Not at all</th>
<th>% A little</th>
<th>% Moderately</th>
<th>% Very much</th>
<th>% Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earlier in life</td>
<td>53.0 (241)</td>
<td>7.3 (33)</td>
<td>7.9 (36)</td>
<td>12.3 (56)</td>
<td>19.6 (89)</td>
</tr>
<tr>
<td>Shortly before</td>
<td>80.5 (379)</td>
<td>5.5 (26)</td>
<td>3.6 (17)</td>
<td>4.5 (21)</td>
<td>5.9 (28)</td>
</tr>
<tr>
<td>Shortly after</td>
<td>60.9 (291)</td>
<td>10.7 (51)</td>
<td>7.3 (35)</td>
<td>7.3 (35)</td>
<td>13.8 (66)</td>
</tr>
<tr>
<td>Later in life</td>
<td>46.7 (224)</td>
<td>6.5 (31)</td>
<td>7.9 (38)</td>
<td>9.0 (43)</td>
<td>30.0 (144)</td>
</tr>
</tbody>
</table>

Suicidal Ideation at Time Periods Before and After Adult Sexual Abuse
CHAPTER 5

STUDY 3

VICTIM APPRAISAL OF SEXUAL OFFENCE TYPOLGY, MECHANISMS, AND SEQUELAE

5.1 INTRODUCTION

Many who live with violence day in and day out assume that it is an intrinsic part of the human condition. But this is not so. Violence can be prevented. Violent cultures can be turned around. In my own country and around the world, we have shining examples of how violence has been countered. Governments, communities and individuals can make a difference.

- Nelson Mandela, 2002

5.1.1 Overview

The current study addresses artefacts of sexual and familial abuse that remain inadequately understood, enumerated, and addressed within current research, judicial, and clinical arenas. Extending the examinations reported in Study 1 and Study 2, this third study comprises quantitative and qualitative analyses of sexual abuse processes and corollaries, examined from the victim’s perspective. Specifically, victim appraisals are sought with respect to the nature of the abuse itself; abuse impact and sequelae; perpetrator modus operandi; and victim resistance strategies. Focus is also directed to measurement of victim disclosure and reporting practices; and victim regrets.

Given the pivotal impact of personal perceptions and appraisals of events in determining psychological outcome, measurement and understanding of such perceptions is important, in order to best meet the therapeutic needs of sexual abuse survivors. Moreover, such unique insights are potentially useful in informing both educative community-directed prevention protocols, and treatment protocols for sexual offenders. Yet no known research has similarly examined the opinions, appraisals, and reflections of sexual abuse survivors on issues pertaining to victim-related variables (such as wellbeing,
distress, behaviours, offence impact, and regrets) or perpetrator-related variables (such as characteristics and modus operandi). Examining for the possible presence of ‘positive’ outcomes of abuse contributes further to the uniqueness of the study. If found, such outcomes can be of potential benefit in informing treatment protocols that emphasise strength-building and resilience, and foster the re-framing of adversity in terms of finding meaning and opportunities for positive outcome and personal growth. The inclusion of a male sample and gender comparisons contributes additionally to the potential applications of the current study.

In the following discussion, attention is directed to current knowledge and practice deficits in a number of areas pertaining to sexual and familial violence. The discussion is focussed in turn to each of the broad areas subject to consideration in the current study. These areas include sexual revictimisation, intimate partner and familial abuse, health outcomes of sexual and familial abuse, victim resistance, and therapeutic treatment approaches.

5.1.2 Sexual Revictimisation

Multiple causative theories have been put forward and tested in order to explain the phenomenon of sexual revictimisation in women. Yet, whilst the phenomenon itself has been widely observed, documented, and considered an issue of sizable concern by both researchers and clinicians, generating and applying effective explanatory, inhibitory, and recovery pathways remains elusive. In a review of empirical investigations examining female sexual revictimisation, Breitenbecher (2001) categorised causative theories into eight major areas (i.e., situational or environmental factors, cognitive attributions, self-blame and self-esteem, damaged interpersonal relationships, coping skills, perception of threat and trauma-related symptomology, and general psychological adjustment). Whilst modest support exists for situational variables and general psychological adjustment as factors that differentiate victimised and revictimised women, none of the theories postulated to date have received unequivocal empirical support (Breitenbecher, 2001). As with general sexual abuse research, it also salient to consider that male victims have rarely been appropriately represented in considerations of sexual revictimisation; thus, very little is known of revictimisation patterns and corollaries amongst male victims of sexual abuse (Arata, 1998; Crome, 2006; Good et al., 2000; Griffiths, 2003; Hunter, 1990b; Lamb &
Further, whilst sequelae of child and adult sexual abuse have been thoroughly examined within distinct and separate arenas, until recently, spare research attention has been directed to the differential impact of child and adult sexual victimisation, and the effects on wellbeing of experiencing both forms of abuse (Miner, Klotz Flitter, & Robinson, 2006). Instead, most research examining sexual revictimisation has been directed toward elucidating the factors that heighten the vulnerability of CSA victims to further sexual abuse, and of the studies that have been conducted (e.g., Miner et al., 2006), few have included male victims.

The importance of addressing the pernicious problem of cyclical violence patterns is further underscored both by the dire, chronic, and far-reaching consequences and potential lethality of familial violence; and by the associations found between childhood exposure to adverse experiences (such as IPV, sexual abuse, and other forms of child abuse and neglect) and a vast array of negative health outcomes in adulthood. Such outcomes include suicide, psychopathology, alcohol and substance abuse, smoking, unwanted and early pregnancies, HIV and sexually transmitted infections, promiscuity, revictimisation, relationship instability, diminished work performance; increased risk for heart, chronic lung, and liver diseases, other leading causes of death, premature mortality, and injuries (Anda et al., 1999, 2001, 2006a, 2006b; Dietz et al., 1999; Dube, Felitti, et al., 2003; Dube, Miller, et al., 2006).

Adoption of behavioural patterns that confer health risks (e.g., smoking, substance and alcohol use, poor diet, lack of exercise) has been conceptualised as a mechanism for explaining such negative physical health outcomes in victims of child abuse (Krug et al., 2002). Indeed, a large body of evidence demonstrates that impaired wellbeing as a function of child abuse comprises a sizable proportion of the global burden of disease (Krug et al., 2002). However, compared with other health consequences of child abuse (e.g., child mortality), relationships between child abuse and psychiatric illness and suicidality have been inadequately considered within conceptualisations of wellbeing until
relatively recently, and have only latterly received concerted research attention and wider recognition (Fergusson et al., 1996; Krug et al., 2002; Trowell et al., 1999; Wolfe, 1999).

In determining the influence of abuse on long-term wellbeing, the importance of examining the cumulative effects of multiple categories of abuse has been emphasised repeatedly by researchers (Felitti et al., 1998). Indeed, many have concluded that research focusing on single abuse forms may overlook the cumulative effects of contextual factors and multiple forms of abuse, and thereby erroneously attribute long-term negative health effects solely to a particular form of victimisation (Humphreys, Sharps, & Campbell, 2005). For instance, the cumulative nature of negative health effects arising from sexual and physical abuse has been demonstrated with respect to both childhood abuses (Wind & Silvern, 1992) and those experienced in adulthood (Green, Flowe-Valencia, Rosenblum, & Tait, 1999), such that individuals who had experienced both abuse forms fared worse than those reporting either abuse form alone.

Such findings underscore not only the need for holistic research practices, but also the importance of holistic screening, and treatment approaches, given the heightened vulnerability of persons who have endured multiple adversities, and the additional vulnerabilities conferred through nondetection of victimisation and concomitant psychopathology and susceptibility to perturbation. Moreover, such data raise implications for preventive strategies and underscore the importance of community education and professional training that highlights risks of revictimisation in abuse victims and serves to mitigate vulnerabilities and minimise the occurrence of such revictimisation. Broad-based Australian research that is inclusive of males and examines the differential and cumulative impact of CSA and ASA has been lacking to date. The current study adopts a holistic perspective to examine child and adult sexual abuse impact and corollaries from both differential and cumulative perspectives.

5.1.3 Intimate Partner and Familial Violence

Research in trauma and violence over the last quarter century has revealed the ubiquity of IPV on global and community levels (Janssen et al., 2005). Indeed, a lifetime history of physical or sexual abuse by an intimate partner has commonly been reported by between 25% and 41% of females (Johnson, 1998; Mouzos & Makkai, 2004; Richardson et al.,
with population surveys worldwide revealing physical assault by an intimate partner in 10-69% of women (Krug et al., 2002). Amongst an Australian cohort, Mouzos and Makkai (2004) found that 34% of ever-partnered women had experienced IPV. Whilst it is recognised that IPV is bidirectional, it is acknowledged that male-perpetrated violence against women is more dangerous and persistent than that perpetrated by women against their male partners (Janssen et al., 2005). Indeed, women face their greatest risk for assault and femicide at the hands of their current or estranged intimate partner or other family member (Browne & Williams, 1993; Campbell et al., 2003; Davies & Mouzos, 2007; Kellerman & Mercy, 1992; Mouzos & Segrave, 2004; Wilson & Daly, 1994).

There is general agreement amongst authors that diverse and serious, negative psychological, physical, and financial sequelae are common amongst those who experience intimate partner abuse (Mullen, Pathé, & Purcell, 2000; Pathé & Mullen, 1997; Rhodes & Levinson, 2003). Indeed, meta-analysis results indicate that depression and PTSD rates amongst IPV victims are respectively, two-fold and four-fold those of the general population (Golding, 1999a). High levels of utilization of the health care system amongst IPV victims are consistent with these findings (Zink & Putnam, 2005). Specifically, several studies have shown that abuse survivors, relative to their nonabused counterparts, more often attend general practitioners, specialists, and emergency departments, and more frequently utilise pharmaceutical services and undergo surgery (Campbell & Kendall-Tackett, 2005; Hulme, 2000; Kendall-Tackett, 2003, 2005; Kendall-Tackett, Marshall, & Ness, 2000). Such findings are consistent with those demonstrating that abuse survivors experience higher incidence of both functional illnesses, such as irritable bowel syndrome and generalised pain syndromes, (Drossman et al., 2000; Kendall-Tackett et al., 2003) and organic illnesses (such as diabetes, cancer, ischemic heart disease, and stroke) (Dallam, 2005; Felliti et al., 2001; Kendall-Tackett, 2005).

However, research demonstrates that whilst victims of IPV present frequently to health professionals with myriad health problems, the presence of abuse frequently remains inadequately addressed or even undetected in many cases. Indeed, evidence exists that many potential opportunities are missed by health professionals to render support and possibly prevent continued, escalating, and extreme violence including femicide (Sharps et
al., 2001). For example, research reveals that 50% of IPV victims who were killed by the perpetrator had sought health care services in the year preceding their homicide (Sharps et al., 2001). Accordingly, best practice health care requires that IPV is detected through overt questioning and appropriate assistance rendered, given that failure to detect and respond to such victimisation has clear potential for dangerous and lethal outcomes. Moreover, nondetection of abuse likely results in management of individuals and their health problems that ranges from nonoptimal to grossly inappropriate, such that individuals are subjected to unnecessary or inappropriate expenses, procedures, case formulations, testing, or treatments, whilst the source of their distress or pain remains unaddressed (Zink & Putnam, 2005).

The pervasive nature of female victimisation by intimate partners is exemplified by the fact that departure from the relationship frequently offers little reduction in risk. Indeed, women’s actions toward ending such relationships are frequently met with an escalation of violence (Coleman, 1997; Janssen et al., 2005; La Violette & Barnett, 2000; Logan & Walker, 2004). Specifically, some women first encounter abuse following dissolution of an intimate partnership (Fleury, Sullivan, & Bybee, 2000; Kurcz, 1996) and risk of lethal violence is reportedly highest in this period (Campbell, 1992; Coleman, 1997; McFarlane et al., 1999; Meloy, 1998). Yet separation is inadequately recognised as a potential risk factor in itself, and indeed is often erroneously and overly simplistically conceptualised as the ‘first-line’ objective (Logan & Walker, 2004). Clearly, due caution and informed practice are necessary to ensure professional service provision that empowers victims; enhances safety and wellbeing; and avoids approaches that can inadvertently elevate risk.

Yet, despite several decades of research and clinical attention to IPV and evaluations of intervention initiatives, factors and processes that foster desistance from violent behaviours remain sparsely understood (Haggard, Gumpert, & Grann, 2001), efforts directed at treatment of male perpetrators have been mostly ineffective, and evaluations of female-focused preventive strategies remain in their infancy (Janssen et al., 2005). The extant difficulties in the field of IPV prevention are exemplified by the conflicting results proffered by prevention initiatives (Schwartz, 2005). Whilst in general, preventive strategies that reduce exposure of female victims to physically abusive partners have been found highly effective in reducing future homicide, other intervention initiatives have
appeared to generate retaliatory effects that heightened risk of femicide in some cases (Dugan, Nagin, & Rosenfeld, 2003), leading the authors of this study to conclude that some interventions are worse than implementing no intervention.

Clearly, such mixed outcomes underscore the need for immediate and concerted attention to be directed toward gaining better understanding of both precipitating and inhibitory factors surrounding perpetration of IPV. Moreover, whilst some important inroads have been made in recent years (Kendall-Tackett, 2005), the important matter of explaining and addressing disparate susceptibility to negative health outcomes for IPV remains to be adequately tackled. Such evidence suggests the need for multifaceted approaches that improve current practices for detection, prevention, and treatment of familial violence and the many manifestations of distress that can accompany such abuse. Specifically, improved understanding and treatment approaches are needed to address both precipitating and maintaining factors underlying negative health behaviours. Concerted efforts are needed that de-stigmatise and foster help-seeking for mental (and not just physical) distress. Improved understanding is also needed in relation to perpetrator strategies and factors that precipitate initial and repeated victimisation. For example, as with sex offenders, in both public discourse and scientific rhetoric, individuals who perpetrate IPV are commonly conceptualised on the basis of stereotyped notions as a homogeneous cohort; yet research demonstrates that males who are violent within intimate relationships are a heterogeneous population (Cavenaugh & Gelles, 2005; Gondolf, 1988; Gottman et al., 1995; Hamberger, Lohr, Bonge, & Tolin, 1996; Holtzworth-Munroe, 2000; Holtzworth-Munroe & Stuart, 1994; Johnson, 1995). Thus, it can reasonably be expected that differing perpetrator variables (such as strategies and contexts) impact differentially on victims, who in turn, require differing treatment protocols.

However to date, relatively sparse attention has been directed toward victim-focused perspectives of their sexual abuse, even though, as primary witnesses, victims appear well-placed to inform research, judicial, and clinical practices. Moreover, evidence for the efficacy of educational and preventive programs in reducing the incidence of sexual assault remains sparse (Breitenbecher & Scarce, 1999). Thus, focused attention to sexual abuse processes is needed in order to better address the issues of both primary and secondary sexual abuse prevention.
The relatively few studies that have examined offender and offence-oriented variables from the perspective of victims have been limited to examination of sexual abuse experienced in adulthood by females; and been constrained by a focus on a limited range of factors (e.g., perpetrator use of alcohol as a tactic; physical force versus coercion), or narrow sampling (e.g., only in context of dating couples) (Ullman, 1997, 1998, 2007). Similarly, studies of victim resistance strategies have typically been limited by small, exclusively female samples and a narrow range of questions; and data thus derived have not been analysed in the context of broader victim variables (Clay-Werner, 2002; Ullman, 1997, 1998, 2007; Zoucha-Jensen & Coyne, 1993). Importantly, the fact that opinions and perspectives of victims have rarely been sought with respect to these or other factors (e.g., “what helped?” and “what didn’t?”) ostensibly signifies multiple significant omissions. As discussed in the following section, amongst other data, the current study seeks victim-based appraisals and opinions with respect to resistance strategies and their relative, perceived effectiveness; disclosure and reporting practices; and later regrets. No known study has previously sought, nor collected, such data.

5.1.4 Victim Strategies

The issue of whether or not to advocate forceful resistance by sexual offence victims has been the subject of controversy in the literature as it has been feared by some that forcefully resisting may escalate offender violence and cause victims to sustain more serious physical injury (see Prentky, Burgess, & Carter, 1986; Ullman, 1998, 2007). This theory has not been empirically supported. Instead, limited evidence exists that forceful resistance matched to the offender’s approach (i.e., physical resistance in response to physical attack, and forceful verbal resistance in response to verbal threats and non-physical coercion) can effectively avert rape or minimise the severity of the assault, without elevating risk of physical injury (see Ullman, 1997, for review; see also Clay-Warner, 2002; Ullman, 1998, 2007; Zoucha-Jensen & Coyne, 1993). In contrast, nonforceful verbal resistance (e.g., crying, pleading, reasoning) and lack of resistance (such as ‘immobility’ or freezing) have been related to higher odds of rape completion (Ullman, 1997, 2007).
Despite such evidence, a level of reticence sensibly remains in relation to advising women to respond forcefully to sexual attack, given the potential risk that such action can nonetheless increase danger for the victim. To date, no consideration of this issue has emerged in the literature in relation to male victimisation. In the interests of furthering this debate, this topic is addressed in the current study by asking victims to appraise the efficacy of specific resistance tactics. The inclusion of victims’ appraisal of the efficacy of the resistance strategies employed during their sexual assault (i.e., “Did this improve the outcome, worsen the outcome, or make no difference?”) comprises a unique feature of this study.

5.1.5 Sexual and Familial Abuse: Victim Treatment Approaches

Robust empirical evidence exists that effective treatments (such as behavioural and cognitive behavioural interventions, including exposure, stress management or stress inoculation training [SIT]) are available for those who experience posttraumatic stress following violent acts such as rape and sexual assault and exposure to other forms of violence and traumatic events (e.g., war trauma, acts of terrorism) (Kamphuis & Emmelkamp, 2005; Foa et al., 1999; Foa, Keane, & Friedman, 2000). Specifically, empirical evidence attests to the efficacy of therapeutic interventions such as prolonged exposure (Foa & Rothbaum, 1998; Foa et al., 1999, 2000) and cognitive processing therapy (Resick & Schnicke, 1992, 1996) in dramatically alleviating distress and improving quality of life in survivors of rape. Whilst more research is needed to demonstrate efficacy, preliminary studies also yield promising findings for more recently developed interventions, such as the intervention developed by Cloitre, Koenen, Cohen, and Han (2002) comprising skills training in affect and interpersonal regulation-modified prolonged exposure (STAIR-modified PE) specifically to address affect regulation, interpersonal deficits, and pathological fear in survivors of CSA.

However, whilst interventions for PTSD are able to play a critical role in ameliorating trauma impact and improving the wellbeing of persons with this disorder, such treatments address only a portion of the problems concomitant with sexual abuse. As with other trauma survivors, most victims of sexual abuse will not develop PTSD, however, may nonetheless experience debilitating and protracted negative effects as a consequence of their abuse (Breslau, 2002; Cichetti & Rogosch, 1996, 1997; Flouri, 2005; Foa &
Indeed, lifetime prevalence of PTSD amongst trauma survivors has been estimated at 24%, with females showing higher susceptibility to developing PTSD following trauma (10%), relative to males (5%) (Breslau, 2002; Breslau, Davis, Andreski, & Peterson, 1991; Foa & Rothbaum, 1998; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

Despite the development of promising treatments, both causative and inhibitory pathways for the development of PTSD remain to be adequately explained. Further, sizable knowledge deficits exist with regard to how to best assist the large proportion of abuse survivors who experience symptoms additional to, or in lieu of those that sum to meet the diagnostic criteria for this disorder. For instance, comparatively little is known about optimal treatment and supportive interventions for victims of chronic abuse, and specifically, sexual and other abuses perpetrated by intimate partners. Yet it is known that mistakes in this field can have lethal consequences. For example, as addressed earlier, encouragement of victims to leave abusive partners can be a gross disservice since it is known that violence frequently escalates following departure from abusive relationships and indeed, that a sizable proportion of female murder victims meet their demise at the hands of ex-partners whilst attempting to depart or in the period shortly after the dissolution of the relationship (Campbell, 1992; Coleman, 1997; Davies & Mouzos, 2007; Janssen et al., 2005; Krug et al., 2002; La Violette & Barnett, 2000; Logan & Walker, 2004; McFarlane, 2004; McFarlane et al., 1995, 1999, 2000, 2002a, 2002b, Mechanic et al., 2008; Meloy, 1998, 2000; Mouzos & Makkai, 2004; Mouzos & Segrave, 2004).

Further, focusing on trauma impact to the neglect of other factors concomitant with abuse can similarly provide ineffective treatment. For example, such a focus may overlook the reality that many other factors that frequently coexist with traumatic symptomology can complicate and preclude treatment or relationship departure for many victims of IPV and familial abuse. Such factors may include acute fear of reprisal; residual loyalty, trust, and affection toward the perpetrator; abiding hope for positive change; ambivalence and fear of change; cognitive dissonance; grief and loss; lack of perceived alternative options and resources; confusion; emotional and fiscal dependencies; fear for children’s physical safety or future) (Mouzos & Makkai, 2004; Krug et al., 2002).
In order to best serve the needs of individuals who experience intimate partner or familial violence, it is important to identify and understand factors such as these that can serve as barriers to both psychological recovery and abuse cessation. Moreover, empirical evidence identifies CBT-based approaches as the most promising for treating abuse-related trauma. As addressing beliefs and thought patterns are pivotal components of this treatment, it is important to identify these accurately in order for treatment to progress effectively. Identifying both adaptive and maladaptive cognitions through the current study can potentially assist in developing improved protocols for sexual and familial abuse. This study includes examination of appraisals and opinions on a range of topics not previously measured (e.g., victim regret, self-blame, notions of causality, shame). Examination of possible ‘positive’ outcomes of abuse (e.g., ‘becoming a stronger person’) contributes further to the uniqueness of the current study. If found, such data can potentially inform treatment protocols fostering strength-building, resilience, and conceptualisations through which to find meaning and opportunities for positive outcomes and growth through adversity.

A number of additional factors exist that can complicate and inhibit recovery for victims of intimate and familial abuses. It is known that disclosure and help-seeking become less likely the closer the relationship to the perpetrator, with the result that familial violence is often the hardest of all abuse forms to detect. Further, PTSD commonly coexists with at least one other comorbid psychiatric condition (Foa et al., 2000). Thus, even when PTSD is present, it may be masked by other disorders and frequently overlooked when individuals present with issues such as depression, substance abuse, anger, aggressive behaviours, intimacy deficits, or relationship dysfunction.

Males are particularly prone to such nondetection, given the propensity for males to externalise their distress and for such distress to manifest in ways that are more ‘socially acceptable’ within stereotyped notions of masculinity and gender role expectations (e.g., heavy drinking, risk-taking, anger, aggression, nondisclosure as a marker of stoicism) (Good et al., 2000; Laslett et al., 2006; Möller-Leimkühler, 2003; Smith & Stewart, 2008; Stewart & Smith, in press-a; WHO, 2004). In the absence of accurate identification of underlying causes, it is probable that, at best, treatment will address symptoms of distress, rather than the distress itself. Given evidence that male sexual and familial abuse victims
are further disadvantaged by more stigmatisation, negative attitudes, rape myth adherence, and notions of victim deservedness held toward males, relative to female victims, sizable improvements in current ideologies and practices are needed (Crome, 2006; Donnelly & Kenyon, 1996; Good et al., 2000; Hunter, 1990b; Kassing & Prieto, 2003; Kassing et al., 2005; Richey-Suttles & Remer, 1997; Washington, 1999).

For both male and female victims, deficits in current awareness and ability to detect, prevent, and treat abuse symptomology limit the resources available to this cohort. Specifically, multiple and often chronic abuse experiences are common for those who have been subjected to sexual or familial abuse. Yet, empirically sound studies are lacking for interventions for victims of multiple and enduring violence and chronic abuse, such as those that commonly hallmark the lives of many victims of IPV and CSA (Kamphuis & Emmelkamp, 2005).

It can be postulated that holistic and proactive treatments are needed that encompass elements such as empowerment; insight-building; self-protective regulatory and self-determining capacity; self-esteem and personal growth; problem solving; and adaptive coping techniques, in addition to elements that address trauma symptomology directly. However, new data are needed in order to support such a model and to derive evidence-based treatment protocols with which to effectively address such complex problems as are precipitated by chronic and severe abuse. Moreover, new holistically-derived broad-based evidence is needed with which to effect attitudinal shifts, and inform funding and resource allocation decisions, judicial processes, in addition to current clinical and social work practices. Multifaceted treatment approaches are also needed in order to effectively address the comorbid and socially complex presentations frequently concomitant with sexual and other abuses.

Research examining other psychotherapeutic intervention techniques, such as the written disclosure procedure pioneered by Pennebaker and colleagues (Pennebaker, 1997), has yielded mixed findings (Marx, 2005). Whilst earlier evaluations of this procedure were not supportive (see Sloan & Marx, 2004b, for a review), later research suggests that the written disclosure procedure can be useful in assuaging moderate levels of psychopathology, and may thus hold promise as a cost-effective adjunctive or stand alone
intervention for victims of sexual abuse (Sloan & Marx, 2004a; Sloan, Marx, & Epstein, 2005). Specifically, it appears from the most recent research that specific written disclosure instructions that foster expression of emotions in relation to traumatic experiences (rather than insight and cognitive assimilation) may be pivotal in effecting reduction in psychopathology (Sloan, Marx, Epstein, & Lexington, 2007).

Whilst clearly more research is needed to establish the true efficacy and necessary conditions for this technique, such findings have implications not only for written and spoken therapy, but also for the wording and content domains of sexual assault surveys. If established through further research as a useful procedure, this approach could also be of benefit to survivors of sexual assault who access online psychotherapeutic resources. Thus, some promising prospects exist for individuals affected by sexual violence and for the researchers, clinicians, advocates, and others concerned with their wellbeing. With the exception of bibliotherapy and self-help programs, the benefits of therapeutic interventions targeting sexual abuse trauma are largely unattainable for individuals who do not wish to disclose their abuse history. Online psychoeducative and psychotherapeutic resources would likely hold particular appeal for such persons (amongst others), given that accessing electronic resources does not necessitate disclosure, forfeiture of anonymity, or other similar ‘costs’, but may nevertheless be therapeutic in its own right. Additionally, such action may be a ‘stepping stone’ in providing the impetus, emotional fortitude, or motivation to engage in conventional therapy. This alone would be an important advance, given that sexual abuse victims relatively rarely seek professional assistance yet commonly suffer severe and protracted trauma effects. The current study builds on the previous two studies reported in this thesis by continuing to test the feasibility and benefits of online methods for assessment and potentially treatment of sexual abuses and other violations subject to stringent taboos and therapeutic barriers.

5.1.6 Current Study
In the current study, the opinions and appraisals of sexual abuse victims are sought with respect to a broad range of victim and perpetrator variables. Specifically, data are collected in relation to both perpetrator strategies and characteristics; and victim-centred variables, including victim behaviours, reactions, resistance tactics, regrets, post-assault events (including police reporting and barriers to reporting), and sexual abuse impact;
yielding a breadth of data that has not previously been collected from male and female victims. Since this study is the first of this type, an inclusive, nondirectional research approach has been chosen in favour of a model that would test directional hypotheses, in order to facilitate a broader, more ‘natural’, respondent-driven, and more revealing research outcome.

It is recognised in research, judicial, and clinical arenas that sexual violence is also perpetrated against males. However, for reasons pertaining to heightened stigma, taboo, and patterns of male gender role socialisation, male sexual victimisation prevalence, processes, and aftermath remain sparsely enumerated, understood, and addressed, relative to sexual abuse of females. The current study seeks to address this deficit by including a male sample and by conducting comparative gender analyses for the topics under examination.

This study builds upon and extends the examination of CSA and ASA presented in Study 1 and Study 2, respectively, by examining sexual revictimisation and cumulative impact; sexual abuse within the context of intimate or familial relationships; differential influences of victim gender; disclosure and reporting practices; and victim regrets. A focus on ‘positive’ outcomes of abuse contributes further to the uniqueness of the study, offering a potential avenue for informing intervention approaches that focus on strength-building, resilience, and finding meaning and opportunities for positive growth in adversity.
5.2 Method

5.2.1 Participants
The data presented in the current chapter derive from a sample of 1,663 individuals who participated in the Tellsomeone Project (TSP) and completed the both the section pertaining to CSA, and that pertaining to ASA. The sample, comprising 1,247 females (75.0%) and 416 males (25.0%), was divided and examined across four victim groups: (i) not sexually victimised (NSA); (ii) victim of SA in childhood only (CSA); (iii) victim of SA in adulthood only (ASA); and (iv) victim of both CSA and ASA (CSA-ASA). Within this sample, 43.4% of individuals reported no experience of sexual victimisation ($n = 722$); and 66.6% reported experience of sexual abuse in either childhood, adulthood, or in both life stages ($n = 941$). In terms of gender, 37.0% of females ($n = 461$) and 62.7% of males ($n = 261$) identified as nonvictims; and 63.0% of females ($n = 786$) and 37.3% of males ($n = 155$) reported sexual abuse. Sexual abuse in childhood only was reported by 23.4% of the sample ($n = 389$); this subgroup comprised 24.0% of females ($n = 299$) and 21.6% of males ($n = 90$). Sexual abuse in adulthood only was reported by 15.5% of the sample ($n = 258$); this subgroup comprised 17.8% of females ($n = 222$) and 8.7% of males ($n = 36$). Experience of sexual abuse both in childhood and in adulthood was reported by 17.1% of the sample ($n = 284$); this subgroup comprised 21.3% of females ($n = 265$) and 7.0% of males ($n = 29$). Additional details relating to these sample groups are provided in the Results section of the current study (Section 5.3); in Studies 1 and 2, the studies presented earlier in this thesis; and in the General Method in Chapter 2.

5.2.2 Definitions, Procedure, Measures, and Data Analyses
Definitions of CSA and ASA were identical to those applied in Studies 1 and 2, and these have been discussed and presented in relevant earlier sections of this thesis (see Method Sections 3.2 and 4.2; and the General Method in Chapter 2, for fuller discussion). Procedure and measures utilised in this study are detailed in the General Method presented in Chapter 2. A comprehensive battery of data analyses was applied; these analyses are similarly detailed in the General Method.
5.3 RESULTS

5.3.1 Overview
Quantitative and qualitative analyses were conducted in the current study to augment the findings reported in Study 1 and Study 2, pertaining to CSA and ASA, respectively. It was of interest to examine differences among four victim groups (nonvictims, victims of CSA only, victims of ASA only, victims of both CSA and ASA), in order to derive comparative data and measure cumulative effects. Amongst other domains, comparative data were examined with respect to gender, experience of IPV, psychological wellbeing, sexual assault distress symptomology, and suicidality. Further, it was of interest to measure specific aspects of sexual abuse, such as victim regret, victim resistance strategies (in terms of application and efficacy), victim-perceived sexual abuse outcomes and commonalities between assaults, additional crimes perpetrated against victims, and barriers to police reporting of sexual abuse.

The results of these analyses are presented in the forthcoming chapter under relevant headings, as summarised below. Qualitative data, in the form of participant quotations, are presented where appropriate to extend statistical findings. As noted earlier, quotations have been reproduced faithfully, with the exception that spelling and typographical errors have been corrected. All quotations are presented in italics.

Gender differences in lifetime sexual abuse occurrence were measured by comparing nonvictims, victims of CSA only, victims of ASA only, and victims of both CSA and ASA. Results of these analyses are presented in Section 5.3.2. Relationships between sexual abuse and IPV were also examined by comparing these four victim groups, and these results are presented in Section 5.3.3. Victim-identified characteristics of the ‘most serious sexual assault’ are presented in Section 5.3.4; and in Section 5.3.5, this assault is described in terms of abuse typology.

Sexual assault-related distress and victim-perceived sequelae of the most serious assault are examined in Section 5.3.6 and 5.3.7, respectively. Victim-perceived commonalities between
sexual assaults are presented in Section 5.3.8; followed by examination of the use and outcome of victim sexual assault avoidance strategies in Section 5.3.9. Victim-perceived most beneficial resistance strategies are discussed in Section 5.3.10; and the notion of ‘potentially helpful’ resistance strategies is addressed in Section 5.3.11. Sexual assault-related victim regrets are reported in Section 5.3.12; followed in Section 5.3.13 by examination of additional crimes perpetrated against victims of sexual assault.

Barriers to police reporting of sexual abuse are measured and presented in Section 5.3.14. Section 5.3.15 presents data pertaining to relationships between sexual victimisation and nine measures of psychological wellbeing. Sexual distress symptomology was assessed specifically using four distress subscales and compared across victim groups. Results for these analyses are presented in Section 5.3.16. Sexual assault distress symptomology was also compared across gender, and these results are presented in Section 5.3.17. Sexual assault occurrence and distress symptomology were further examined in the context of suicidality. Section 5.3.18 presents data relating to lifetime occurrence of suicide attempt and suicidal ideation, each compared across four victim groups; and Section 5.3.19 provides data relating to suicide attempt and suicidal ideation in the context of four sexual assault distress subscales.

5.3.2 Gender Differences in Lifetime Sexual Abuse Occurrence

The impact of gender on sexual victimisation was examined across four victim groups: (i) not sexually victimised (NSA); (ii) victim of SA in childhood only (CSA); (iii) victim of SA in adulthood only (ASA); and (iv) victim of both CSA and ASA (CSA-ASA). Males and females differed significantly in terms of sexual victimisation across the lifespan, \( \chi^2(3, N = 1663) = 101.26, p < .0005, \) Cramér’s \( V = .25. \) Overall, males were substantially less likely to report having been sexually victimised, with 62.7% of males reporting no sexual abuse across the lifespan (\( n = 261 \)), in contrast to only 37.0% of females (\( n = 461 \)). Females reported sexual abuse experienced in adulthood only, at twice the rate reported by males, and were three times more likely to report sexual victimisation in both childhood and adulthood, relative to males.

Interestingly however, only minimal gender difference was evident with respect to sexual abuse experienced only in childhood. Specifically, 17.8% of females reported sexual abuse
in adulthood only ($n = 222$), in contrast to 8.7% of males ($n = 36$). Moreover, in contrast to only 7.0% of males ($n = 29$), 21.3% of females reported sexual victimisation in both childhood and adulthood ($n = 265$). By comparison, little difference was evident with respect to sexual victimisation in childhood only, such that 24.0% of females ($n = 299$) and 21.6% of males ($n = 90$) reported experiencing this form of abuse.

Inspection of the standardised residuals ($SR$s) revealed that males were most disproportionately represented, being most significantly overrepresented amongst nonvictims ($SR = 6.0$), and significantly underrepresented both amongst victims of SA in adulthood only ($SR = -3.6$) and amongst persons who had experienced both CSA and ASA ($SR = -5.2$). Conversely, females were significantly underrepresented amongst respondents who had never been sexually abused ($SR = -3.5$), and significantly overrepresented amongst persons who had experienced sexual abuse in adulthood only ($SR = 2.1$), and amongst those who had experienced both CSA and ASA ($SR = 3.0$).

5.3.3 Relationships Between Sexual Abuse and Intimate Partner Violence

Respondents who had experienced either child or adult sexual assault (or both) were proportionately more likely to have also identified as victims of IPV, $\chi^2(3, N = 1065) = 88.30, p < .0005$, Cramér’s $V = .29$. Specifically, in contrast to 9.6% of persons who had never been sexually abused ($n = 45$), 19.4% of persons abused in childhood alone ($n = 49$), 26.4% of persons abused in adulthood alone ($n = 38$), and 40.6% of persons abused in both childhood and adulthood ($n = 82$) had experienced IPV.

Moreover, amongst persons who had experienced IPV, only 21.0% reported no history of sexual victimisation across the lifespan ($n = 45$), in contrast to 49.6% of persons who had not experienced IPV ($n = 422$). Conversely, IPV victims were more than twice as likely to report both CSA and ASA, relative to nonvictims of IPV, with 38.3% of IPV victims reporting sexual victimisation in both childhood and adulthood ($n = 82$), in contrast to only 14.1% of nonvictims of IPV ($n = 120$).

Inspection of the standardised residuals ($SR$s) confirmed that persons who had experienced both CSA and ASA were most disproportionately represented, being both significantly overrepresented amongst IPV victims ($SR = 6.5$), and significantly underrepresented
amongst non-IPV victims ($SR = -3.3$). Conversely, respondents who had never been sexually assaulted were most significantly underrepresented amongst IPV victims ($SR = -5.0$), and significantly overrepresented amongst non-IPV victims ($SR = 2.5$).

5.3.4 Victim-Identified Characteristics of the ‘Most Serious Sexual Assault’

Specific examination was conducted in respect to the incident perceived by respondents as the ‘most serious sexual assault’ they had experienced.

How long ago did this happen?

Qualitative responses to this question revealed that for the vast majority of respondents this incident occurred more than one year ago, and commonly, many years ago. Indeed, whilst timeframes ranged from ‘last month’ to ‘64 years ago’, only 2.6% of respondents indicated that their most serious sexual assault had occurred within the last year ($n = 19$). However, it is of concern that within this minority were respondents who described their most serious sexual assault as ongoing (e.g., ‘47 years ongoing’; ‘years - still happening’). More commonly however, respondents described as their most serious sexual assault an event that had happened one to several decades ago.

How old were you?

Respondents’ most serious sexual assault occurred at a median age of 16 years and a mean age of 16.82 years, with a standard deviation of 9.10 years. Ages ranged from infancy (0 years) to 57 years of age, with the highest frequencies of most serious sexual assaults occurring between the ages of 5 and 25 years, with intensified vulnerability evident between the ages of 8 and 22 years. Indeed, 68.1% of most serious sexual assaults occurred between 8 and 22 years ($n = 474$), and 81.2% occurred between 5 and 25 years ($n = 565$). In terms of modal age, the most serious sexual assault occurred most commonly at age 17, followed by age 13, and age 18.

Whilst abuse identified as the most serious sexual assault lessened in frequency as age increased, it is notable that, for sizable minorities, this event occurred at an older age. Indeed, 9.6% of respondents reported experiencing their most serious sexual assault between the ages of 26 and 35 years ($n = 67$), and 4.0% reported this experience whilst aged between 36 and 57 years ($n = 28$).
Although mean age at most serious sexual assault did not differ significantly between males and females, \( t(694) = -1.32, p = .19, \eta^2 = .003 \), a trend suggests that males experienced this event at a younger age (\( M = 15.77 \) years, \( SD = 9.01 \)), than did females (\( M = 17.02 \) years, \( SD = 9.11 \)).

5.3.5 Victim-Identified ‘Most Serious Assault’ by Abuse Typology

Respondents were asked to specify what type of sexual abuse comprised their most serious sexual assault. As evident in Table 5.1, vaginal penetration was the most commonly identified abuse form, followed by nonpenetrative sexual contact, and oral-genital contact. For most respondents, their most serious sexual assault entailed more than one type of abuse, evidenced by the fact that percentages for individual abuse forms sum to 165%.

Table 5.1

<table>
<thead>
<tr>
<th>Sexual abuse type</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal penetration</td>
<td>46.3</td>
<td>342</td>
</tr>
<tr>
<td>Nonpenetrative sexual contact</td>
<td>42.9</td>
<td>317</td>
</tr>
<tr>
<td>Oral-genital contact</td>
<td>25.3</td>
<td>187</td>
</tr>
<tr>
<td>Attempted vaginal penetration</td>
<td>13.3</td>
<td>98</td>
</tr>
<tr>
<td>Anal penetration</td>
<td>13.0</td>
<td>96</td>
</tr>
<tr>
<td>Other</td>
<td>11.2</td>
<td>83</td>
</tr>
<tr>
<td>Attempted oral-genital contact</td>
<td>7.0</td>
<td>52</td>
</tr>
<tr>
<td>Attempted anal penetration</td>
<td>6.0</td>
<td>44</td>
</tr>
</tbody>
</table>

Abuse forms listed in the ‘Other’ category include: beating, whipping, and other forms of sadism; attempted kidnapping; bestiality; exposure to pornography; forced participation in pornographic filming and photography; digital penetration; genital exposure; voyeurism; forced masturbation; forced witnessing of sexual acts; frottage; forcible kissing; forced removal of clothing; and gang attack.
Qualitative responses include:

- abuse of genitalia
- aggressive sex
- bestiality pornography
- breast mauling
- bruised my breasts
- cutting of skin in a sexual manner
- digital penetration
- domestic violence- choking & banging my head on wall trying to kill me
- fetish sex
- filmed by teacher for child porn
- forced to be aggressor in S&M situation
- genital exposure and ejaculation onto my clothing
- husband made me "wife swap"
- kissing and groping at breasts, broken bra.
- me being forced to penetrate assailants
- oral-anal contact
- photographs were taken by onlookers and handed round to friends
- spying on me while in the bathroom/shower/bedroom
- threatened sexual assault/ rape and forced entry into bedroom
- torture
- violence (bashing)
- witnessing my mother being sexually assaulted

Whilst the large majority of perpetrators of the most serious sexual assault were male (92.1%; \( n = 685 \)), it is also notable a female perpetrator was identified by 7.9% of respondents (\( n = 59 \)). Amongst cases in which the perpetrator was a current partner (e.g., spouse, de facto, lover), 5.5% of respondents reported that they were still with this person (\( n = 22 \)).

Overall, many respondents reported leaving the perpetrator within minutes or hours of the assault. However, it was also very commonly reported that respondents remained with the perpetrator for many years, sometimes decades (as long as 41 years, in one case).
Particularly in cases of CSA perpetrated by a family member, distancing oneself from the perpetrator was rarely a tenable option.

5.3.6 Sexual Assault-Related Distress

How distressing was the assault?

Only a small minority of respondents reported the assault as ‘Not at all’ distressing (2.7%; n = 20). Conversely, one in four respondents rated the assault as ‘Extremely’ distressing (25.2%; n = 186), and the majority of respondents (60.6%; n = 448) rated the assault as ‘Very’ (21.9%; n = 162), ‘Severely’ (13.5%; n = 100), or ‘Extremely’ distressing. A further 17.5% of respondents reported the assault as ‘Moderately’ distressing (n = 129) and a minority rated the assault as ‘Mildly’ (8.9%; n = 66) or ‘A little’ distressing (10.3%; n = 76).

An independent-samples t-test, with Bonferroni adjustment for multiple comparisons, found a significant gender difference with respect to mean perceived distress associated with the sexual assault, $t(156.43) = -4.19$, $p < .0005$, $\eta^2 = .03$. Females reported the sexual assault as more distressing ($M = 4.99$, $SD = 1.68$), than did males ($M = 4.22$, $SD = 1.88$).

Distress experienced since the assault

Similarly, the smallest proportion of respondents reported having experienced ‘No distress’ since the assault (8.9%; n = 65). Conversely, more than one in four respondents reported experiencing ‘Severe’ (11.5%; n = 84) or ‘Extreme’ distress (15.2%; n = 111). One third reported ‘Moderate’ (20.4%; n = 149) or ‘Very much’ distress (14.0%; n = 102), and 29.9% reported ‘Mild’ (13.3%; n = 97) or ‘Little’ distress (16.6%; n = 121).

An independent-samples t-test, with Bonferroni adjustment for multiple comparisons, found a significant gender difference with respect to mean severity of distress experienced since the assault, $t(727) = -3.77$, $p < .0005$, $\eta^2 = .02$. Females reported having experienced more severe distress since the sexual assault ($M = 4.21$, $SD = 1.88$), relative to males ($M = 3.50$, $SD = 1.85$).
5.3.7 Victim-Perceived Sequelae of the ‘Most Serious Sexual Assault’

It was of interest to examine victim-perceived consequences of the most serious sexual assault. Respondents were asked to rate the applicability of a series of statements pertaining to negative, positive, and ‘nondirectional’ consequences of the assault. These statements are presented in Table 5.2; marked ‘N’, ‘P’, and ‘ND’, respectively. In particular, respondents were presented with twelve negative consequences, four positive consequences, and three statements conceptualized as nondirectional (or ambiguous) because, whilst these might appear to be positive outcomes, endorsement of such statements may also reflect denial, suppression, or minimization in relation to the effects of the sexual abuse.

As evident in Table 5.2, the majority of respondents perceived that, to some extent, their ability to trust others and have a successful intimate relationship; the quality of their relationships with intimate partners and loved ones; their body image; and their quality of life, had deteriorated as a consequence of the assault, and 28-49% held these views strongly. Almost half of respondents reported some degree of suicidal ideation as a consequence of this assault, and one quarter strongly endorsed this statement. Indeed, one in five reported having made a suicide attempt as a consequence of the assault. More than one third also reported increased food consumption and weight gain as a consequence of the assault, with one in five respondents endorsing these statements strongly. Moreover, increased alcohol intake, increased smoking, and increased drug intake was reported by 29.8%, 23.6%, and 17.3% of respondents respectively, with around half of these respondents strongly endorsing these statements.

In terms of positive consequences of the most serious sexual assault, it is pleasing to note that 78.4% of respondents endorsed, to some extent, the statement that they had ‘learned a lot as a consequence of the assault’, with 41.6% strongly endorsing this statement. Additionally, most respondents perceived to some degree that their understanding of people had increased and that they had become stronger a person as a result of the assault, and almost one third strongly held this belief. Less than one third perceived that they had become closer to loved ones as a consequence, and a small minority held this view strongly.

As noted above, three nondirectional statements were also examined. The overwhelming majority of respondents reported to some degree trying to ‘go on as though nothing had
happened’, with almost two thirds strongly endorsing this statement. Almost two thirds endorsed, to some degree, the statement that their life ‘went on just as before’, and more than one quarter strongly held this view. Moreover, almost half of respondents contended to some degree that the assault had ‘not really affected [them]’, although less than one in five strongly endorsed this perception.

Table 5.2
Victim-Perceived Sequelae of the ‘Most Serious Sexual Assault’

<table>
<thead>
<tr>
<th>Perceived sequelae of sexual assault</th>
<th>True to some extent</th>
<th>Very or Extremely true</th>
</tr>
</thead>
<tbody>
<tr>
<td>My ability to trust others has suffered as a consequence of the assault (N)</td>
<td>71.7 597</td>
<td>48.7 356</td>
</tr>
<tr>
<td>The quality of my intimate relationship/s has suffered as a consequence of the assault (N)</td>
<td>68.3 492</td>
<td>42.1 303</td>
</tr>
<tr>
<td>The assault has lowered my ability to have a successful intimate relationship (N)</td>
<td>68.3 499</td>
<td>40.6 297</td>
</tr>
<tr>
<td>The assault has negatively affected my relationships with loved ones (N)</td>
<td>67.9 492</td>
<td>34.8 252</td>
</tr>
<tr>
<td>My body image is poorer as a consequence of the assault (N)</td>
<td>59.2 429</td>
<td>35.4 256</td>
</tr>
<tr>
<td>My quality of life has deteriorated as a consequence of the assault (N)</td>
<td>56.8 411</td>
<td>28.4 205</td>
</tr>
<tr>
<td>Have you ever had suicidal thoughts as a consequence of the assault? (N)</td>
<td>44.0 318</td>
<td>25.2 182</td>
</tr>
<tr>
<td>I have increased my food consumption as a consequence of the assault (N)</td>
<td>38.3 279</td>
<td>19.7 143</td>
</tr>
<tr>
<td>I have gained weight as a consequence of the assault (N)</td>
<td>35.7 259</td>
<td>19.7 143</td>
</tr>
<tr>
<td>I have increased my alcohol intake as a consequence of the assault (N)</td>
<td>29.8 217</td>
<td>12.5 91</td>
</tr>
<tr>
<td>I have increased my smoking [nicotine] as a consequence of the assault (N)</td>
<td>23.6 172</td>
<td>12.7 93</td>
</tr>
<tr>
<td>I have increased my drug intake as a consequence of the assault (N)</td>
<td>17.3 126</td>
<td>8.6 63</td>
</tr>
<tr>
<td>I feel I have learned a lot as a consequence of the assault (P)</td>
<td>78.4 573</td>
<td>41.6 304</td>
</tr>
<tr>
<td>I feel my understanding of people has increased as a consequence of the assault (P)</td>
<td>70.0 512</td>
<td>32.4 237</td>
</tr>
<tr>
<td>I am a stronger person as a consequence of the assault (P)</td>
<td>62.5 456</td>
<td>29.2 213</td>
</tr>
<tr>
<td>I am closer to loved ones as a consequence of the assault (P)</td>
<td>31.3 227</td>
<td>11.3 82</td>
</tr>
<tr>
<td>After the assault, I tried to go on as though nothing had happened (ND)</td>
<td>91.4 662</td>
<td>64.0 464</td>
</tr>
<tr>
<td>After the assault, my life went on just as before (ND)</td>
<td>63.2 458</td>
<td>27.1 196</td>
</tr>
<tr>
<td>The assault did not really affect me (ND)</td>
<td>46.9 338</td>
<td>16.8 121</td>
</tr>
</tbody>
</table>
Independent-samples $t$-tests, with Bonferroni adjustments for multiple comparisons, were conducted to compare males and females with respect to victim-perceived negative, positive, and ‘nondirectional’ consequences of the most serious sexual assault. Mean scores on four of the twelve negative perceived consequences differed significantly across gender (with a Bonferroni adjustment of .004), with three of these pertaining to eating, weight, and body image, and the fourth pertaining to ability to trust. Specifically, females reported (as a perceived consequence of the assault) a greater extent of increased food consumption ($M = 2.04, SD = 1.44$), relative to males ($M = 1.64, SD = 1.25$), $t(180.31) = -3.09, p = .002, \eta^2 = .01$; a higher degree of weight gain ($M = 2.01, SD = 1.45$), compared with males, ($M = 1.58, SD = 1.22$), $t(184.73) = -3.35, p = .001, \eta^2 = .02$; poorer body image ($M = 2.74, SD = 1.63$), relative to males ($M = 2.13, SD = 1.45$), $t(179.98) = -4.12, p < .0005, \eta^2 = .02$; and a greater lowering of their ability to trust others ($M = 3.34, SD = 1.47$), relative to males ($M = 2.83, SD = 1.45$), $t(729) = -3.48, p = .001, \eta^2 = .02$.

Mean scores of three of the four positive perceived consequences also differed significantly across gender (with a Bonferroni adjustment of .013). Specifically, females more strongly than males endorsed the statements ‘I am a stronger person as a consequence of the assault’ (Females: $M = 2.64, SD = 1.49$; Males: $M = 2.07, SD = 1.31$), $t(177.82) = -4.21, p < .0005, \eta^2 = .02$; ‘I feel I have learned a lot as a consequence of the assault’ (Females: $M = 3.08, SD = 1.44$; Males: $M = 2.53, SD = 1.36$), $t(729) = -3.85, p < .0005, \eta^2 = .02$; and ‘I feel my understanding of people has increased as a consequence of the assault’ (Females: $M = 2.75, SD = 1.43$; Males: $M = 2.33, SD = 1.29$), $t(729) = -2.92, p = .004, \eta^2 = .01$. Nondirectional perceived consequences did not differ significantly across gender.
5.3.8 Victim-Perceived Commonalities Between Sexual Assaults

Amongst victims who had experienced more than one sexual assault, it was of interest to examine victim-perceived commonalities between sexual assaults. As evident in Table 5.3, almost three quarters of victims reported that during two or more of the events, verbal coercion had been applied in order to facilitate the assault, and more than two thirds reported having on two or more occasions felt ‘too embarrassed or shy to stop the person’. Over half of respondents had feared physical harm on more than two occasions, and almost half reported the use of physical force on two or more occasions and experience of repeated sexual assault in the same location. Less frequently identified commonalities between sexual assaults included perpetrator use of alcohol or drugs; victim concern that non-compliance might threaten the relationship; victim use of alcohol; and for a small minority of respondents, victim use of drugs. The following excerpt exemplifies the complex interplays between CSA, revictimisation, and heightened vulnerability concomitant with alcohol use and placement in high risk situations.

*At this time in my life I drank a lot and had various encounters. Sometimes I didn’t know where I was or what their names were. Often I would have ‘blackouts’. The first time was with someone I trusted wholly and was shattered. I also came from a very strict upbringing and experienced some freedom which led to a total disregard for my mother’s laws, which often put me in risky situations.*

Table 5.3

<table>
<thead>
<tr>
<th>Victim-Perceived Commonalities Between Sexual Assaults</th>
</tr>
</thead>
<tbody>
<tr>
<td>True</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>‘During two or more of the events…’</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>The person used verbal pressure to engage me in the event.</td>
<td>71.0</td>
<td>369</td>
</tr>
<tr>
<td>I felt too embarrassed or shy to stop the person.</td>
<td>68.6</td>
<td>356</td>
</tr>
<tr>
<td>I was afraid the person would physically hurt me.</td>
<td>54.4</td>
<td>284</td>
</tr>
<tr>
<td>The person used physical force to engage me in the event.</td>
<td>48.3</td>
<td>247</td>
</tr>
<tr>
<td>The experience happened in the same location.</td>
<td>46.4</td>
<td>240</td>
</tr>
<tr>
<td>The person had consumed alcohol or drugs.</td>
<td>39.4</td>
<td>199</td>
</tr>
<tr>
<td>I was concerned the person would end our relationship if I didn’t do it.</td>
<td>27.2</td>
<td>137</td>
</tr>
<tr>
<td>I had consumed alcohol.</td>
<td>25.7</td>
<td>132</td>
</tr>
<tr>
<td>I had consumed drugs.</td>
<td>10.4</td>
<td>53</td>
</tr>
</tbody>
</table>

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Of these commonalities across sexual assault incidents, only one differed significantly by gender. Specifically, males (79.2%; $n = 57$) were significantly more likely than females (66.9%; $n = 299$) to endorse the statement that ‘During two or more of the events... I felt too embarrassed or shy to stop the person’, $\chi^2(1, N = 519) = 4.34, p = .04$, Cramér’s $V = .09$.

5.3.9 Use and Outcome of Victim Sexual Assault Avoidance Strategies

It was of interest to examine the strategies victims had employed in attempts to prevent, halt, or minimise the extent of sexual assault. Further, it was of interest to measure victim perceptions with regard to whether such strategies had bettered or worsened the outcome of their circumstances, or whether they perceived the strategy to have made no difference. (Note: Given that some respondents used the strategy repeatedly and it sometimes bettered, sometimes worsened, and sometimes made no difference to the situation, percentages for each strategy may sum to greater than 100%). As evident in Table 5.4, the majority of respondents reported having tried to distance themselves physically from the perpetrator and convey their lack of consent nonverbally, by stiffening, moving or turning away, or pushing the perpetrator away. Similarly, most respondents reporting having ‘nicely’ asked the perpetrator to stop and making it ‘completely clear to the person that it was against [their] wishes’. The majority of respondents using these strategies perceived them to have made no difference to the situation, less than one quarter considered them to have improved the outcome, and a similar or greater proportion of respondents considered these strategies to have worsened the outcome. Indeed, one third considered pushing the person away to have impacted negatively on the situation.

Almost two thirds of respondents described feeling as though ‘frozen’ in the situation/s. Whilst almost two thirds of these respondents perceived this to have had no bearing on the outcome of the situation, one quarter felt this had worsened the outcome, and only one in ten felt this to have positively affected the situation.

Half of respondents reported making the decision that it was safer for them not to try to resist physically, and 38% decided it was safer not to try to resist verbally. However, only 29% of these respondents felt these approaches had improved this situation, almost one in
five felt they had worsened the event/s, and most felt they had made no difference to the outcome.

More than one third of respondents reported using strategies such as persuasion, reasoning, or negotiation; delay or distraction; pleading, crying, or trying to appease the person; or trying to escape or hide. Whilst escape or hiding was identified as a helpful strategy by one third of respondents, a higher proportion of respondents found this strategy worsened the situation or made no difference. Pleading, crying, or trying to appease the person were seen as helpful by only one in ten respondents who applied these strategies, and were perceived as having a negative impact or negligible impact by 32% and 70% of respondents, respectively. Equal minorities of respondents found persuasion, reasoning, or negotiation to be either helpful or detrimental to the situation; the large majority found these approaches made no difference.

On balance, tactics of delay or distraction appear to have been one of the more successful strategies, in that 29% of respondents reported an improved outcome, whilst only 12% reported a negative effect from using such an approach.

Conversely, the lesser used approaches of becoming angry with the person; screaming; or using physical defence (e.g., hitting, punching), whilst perceived helpful to the situation by 26%, 24%, and 32% of respondents, respectively, were proportionately much more likely to be perceived as having negative repercussions, by the respondents who used these strategies.

Obtaining help or raising alarm, and verbally threatening, scaring, or warning the person, whilst relatively rarely applied, were the strategies ranked as helpful by the highest proportion of respondents who used any particular strategy. However, it is noteworthy that similar proportions of respondents rated threatening, scaring, or warning the person as unhelpful to the situation or perceived this approach to make no difference. In contrast, obtaining help or raising alarm was much more likely to be perceived as a successful (rather than a negative) approach, with only 22% reporting a negative outcome from this approach.
Overall, these findings reflect substantial ambivalence and diversity of opinion amongst victims of sexual abuse, with respect to perceived utility of resistance strategies. Such mixed findings preclude the drawing of definitive conclusions. Indeed, it would be unsafe to make strong recommendations on basis of these outcomes, since the most evident and consistent finding is that most, if not all of the examined strategies appear to have the potential for both positive and negative outcomes. Despite such a caveat, a number of themes are suggested by the findings. Specifically, with respect to perpetrator-targeted approaches, findings suggest that nonconfrontational, calm approaches that can be implemented without risk of escalating violence and assault (e.g., delay and distraction) likely have the greatest potential for beneficial outcome, without adding undue risk of further harm to the victim.

Conversely, strong, overtly confrontational approaches such as the use of physical defence; screaming; and verbal threats, and warnings, whilst beneficial for a sizable minority of respondents, should be employed with caution, given the potential for such tactics to escalate violence and aggression and increase harm to the victim. Such risk is evidenced by findings that respondents were almost twice as likely to report a negative, rather than a positive, outcome from screaming; that over half of respondents who used physical defence reported a negative outcome, in contrast to one third who reported a positive outcome; and that respondents were fairly evenly divided in their appraisal of the use of threats and warnings.

In terms of strategies external to the perpetrator, getting help or raising alarm shows the most promise for improved outcome with comparatively low risk of adverse effects. Whilst escaping or hiding was also beneficial for one third of respondents, it must be noted that a larger proportion of respondents reported adverse effects from the use of such an approach.

Finally, the finding that all but three of the strategies were perceived as having made no difference by at least half of the respondents who had used them, reflects the perceived futility of resistance, powerlessness, and low locus of control experienced commonly by many respondents in regard to sexual abuse.
Nonetheless, it is also salient to consider that these responses reflect the experiences and perceptions of victims. It would be of value to also examine the use and value of these strategies amongst persons who had averted sexual attacks, and to compare the perceptions and outcomes of victims and ‘would-be’ victims (i.e., victims of completed and noncompleted or attempted sexual abuse).

Use of ‘other’ strategies to prevent sexual abuse

Almost three quarters of respondents who reported an ‘other’ strategy perceived this approach to have improved the situation. Whilst few found it detrimental, 41% perceived it to have made no difference. Qualitative responses reflected a wide range of situations and approaches used in contexts of both childhood and adulthood sexual abuse, and reflected also the divided opinion seen earlier with respect to utility of resistance strategies, and the futility perceived by many victims in relation to any efforts to prevent their abuse. The following examples of qualitative responses are illustrative of such themes.

These responses reflect both relative successes and childhood ingenuity in relation to the attempts made by children to counter and prevent sexual abuse.

- In the child rape, when things got really bad, for some reason I suddenly said, ‘I’ll tell Jesus on you’, and he stopped. Crazy! He was a minister and it was in a church, but he was violent and who would have ever thought those words would have stopped him. But he had already done what he wanted. I thought his assistant was also going to do something but when I said ‘I’ll tell Jesus on you’, he let go of me and I ran out of the church and home.
- I put drawing pins on the floor next to my bed where he would stand. (Commencing at age 2, this respondent experienced regular sexual abuse perpetrated by her father. She reported this strategy as having improved her situation.)
- I didn’t know anything was wrong. I pushed him off because he was heavy on top of me.
- Something I did, I remember my uncle putting me in his bed to sleep while my cousins slept in the other room. My auntie and uncle had visitors and I knew something was going to happen once they left. So I made myself have an asthma attack so they could take me to the hospital. I did spend the night in hospital and I believe that is what kept me safe from harm. I was 8 years old at the time.
- I managed to get away whilst the man had his pants down around his ankles.
- Not enough privacy and once I got away by threatening to wet myself.
- Making myself vomit.
- Someone else interrupted, I would become ill and vomit, or I was able to yell and cry out.
I kept telling him I was a boy.

Other responses reflect the strong, physical, and sometimes violent forms of resistance employed by some child victims:

- *I PUSHED HIM REALLY HARD AND HIT MY HEAD ON HIS NOSE REALLY HARD.*
- *I fought him off and attempted to stab him.*
- *I fought off the key attacker (slamming their head into a wall), and the others backed off.*
- *I had passed out and was woken by the attempt. Once I woke and asked what did he think he was doing and where were my friends the attempt stopped.*
- *I injured him.*
- *I refused and was physically strong enough to intimidate him [grandfather]*
- *Something I said - I was locked in the car with him, it had central locking and I didn’t know what that was at the time. I tried to get the door open. Then he pinned me down fully so I screamed and screamed and he finally let me out. We were parked at the front of my house at the time.*

The following responses reflect the ability of some respondents to end or change the course of their abuse, often after chronic sexual abuse in childhood.

- *As I grew up I became more able to assert my overall independence. For example, I remember being 17 and him investing an entire night and lots of dope in trying to convince me of the absolute lack of value in the rock band I was passionate about at that time.*
- *I fought him off and acted determined and did not believe the nonsense he told me, and was really angry. The other times I had believed him and felt sorry for him and was isolated and helpless. I think that I was starting to grow up and realise that I had some degree of power and that perhaps it was wrong.*
- *At 17 years, said no firmly. Successful.*
- *Defending myself - shocked attacker*
- *Continuing to try moving, making insertion/penetration difficult.*
- *Curling up in a ball kicking and biting*
- *Discussion after the fact that I didn’t like it and didn’t want to continue...*
- *Asking for it to be quick.*
Table 5.4

*Use and Outcome of Victim Sexual Assault Avoidance Strategies*

<table>
<thead>
<tr>
<th>Strategy</th>
<th>N</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stiffening, turning away or moving away from the person.</td>
<td>697</td>
<td>71.5</td>
<td>498</td>
<td>20.5</td>
<td>102</td>
<td>25.7</td>
<td>128</td>
<td>62.3</td>
<td>310</td>
<td></td>
</tr>
<tr>
<td>I felt as if I were ‘frozen’.</td>
<td>700</td>
<td>63.6</td>
<td>445</td>
<td>10.3</td>
<td>46</td>
<td>25.8</td>
<td>115</td>
<td>64.1</td>
<td>285</td>
<td></td>
</tr>
<tr>
<td>Asking the person “nicely” to stop (or using apologies or excuses).</td>
<td>704</td>
<td>63.5</td>
<td>447</td>
<td>15.9</td>
<td>71</td>
<td>15.7</td>
<td>70</td>
<td>79.2</td>
<td>354</td>
<td></td>
</tr>
<tr>
<td>Making it completely clear to the person that it was against my wishes.</td>
<td>704</td>
<td>63.4</td>
<td>446</td>
<td>24.4</td>
<td>109</td>
<td>22.4</td>
<td>100</td>
<td>65.0</td>
<td>290</td>
<td></td>
</tr>
<tr>
<td>Pushing the person away.</td>
<td>697</td>
<td>57.3</td>
<td>399</td>
<td>23.3</td>
<td>93</td>
<td>32.6</td>
<td>130</td>
<td>52.9</td>
<td>211</td>
<td></td>
</tr>
<tr>
<td>Deciding that it would be safer for me not to try to resist physically</td>
<td>687</td>
<td>49.6</td>
<td>341</td>
<td>29.0</td>
<td>99</td>
<td>18.8</td>
<td>64</td>
<td>61.6</td>
<td>210</td>
<td></td>
</tr>
<tr>
<td>Escaping or trying to escape, run away or hide.</td>
<td>700</td>
<td>43.7</td>
<td>306</td>
<td>33.3</td>
<td>102</td>
<td>41.5</td>
<td>127</td>
<td>37.6</td>
<td>115</td>
<td></td>
</tr>
<tr>
<td>Persuading, explaining, reasoning, negotiating or bargaining with the person.</td>
<td>705</td>
<td>42.7</td>
<td>301</td>
<td>18.9</td>
<td>57</td>
<td>21.3</td>
<td>64</td>
<td>78.1</td>
<td>235</td>
<td></td>
</tr>
<tr>
<td>Trying to delay or distract the person</td>
<td>694</td>
<td>39.6</td>
<td>275</td>
<td>28.7</td>
<td>79</td>
<td>12.0</td>
<td>88</td>
<td>70.2</td>
<td>193</td>
<td></td>
</tr>
<tr>
<td>Pleading, crying, or trying to please the person.</td>
<td>699</td>
<td>39.3</td>
<td>275</td>
<td>28.9</td>
<td>75</td>
<td>19.2</td>
<td>87</td>
<td>70.2</td>
<td>193</td>
<td></td>
</tr>
<tr>
<td>Deciding that it would be safer for me not to try to resist verbally</td>
<td>687</td>
<td>37.9</td>
<td>260</td>
<td>28.9</td>
<td>75</td>
<td>19.2</td>
<td>87</td>
<td>70.2</td>
<td>193</td>
<td></td>
</tr>
<tr>
<td>Becoming angry with the person.</td>
<td>697</td>
<td>32.1</td>
<td>224</td>
<td>25.9</td>
<td>58</td>
<td>39.7</td>
<td>89</td>
<td>50.0</td>
<td>112</td>
<td></td>
</tr>
<tr>
<td>Using physical defence (e.g., hitting, punching, scratching, kicking, biting, etc).</td>
<td>692</td>
<td>18.4</td>
<td>127</td>
<td>32.3</td>
<td>41</td>
<td>57.5</td>
<td>73</td>
<td>41.0</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>Screaming</td>
<td>692</td>
<td>16.5</td>
<td>114</td>
<td>23.7</td>
<td>27</td>
<td>46.6</td>
<td>53</td>
<td>53.5</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>Verbally threatening, scaring or warning the person.</td>
<td>698</td>
<td>15.2</td>
<td>106</td>
<td>45.3</td>
<td>48</td>
<td>41.5</td>
<td>44</td>
<td>45.3</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>Getting help or raising alarm</td>
<td>693</td>
<td>11.3</td>
<td>78</td>
<td>46.2</td>
<td>36</td>
<td>21.8</td>
<td>17</td>
<td>59.0</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>Capturing or detaining the person.</td>
<td>693</td>
<td>0.4</td>
<td>3</td>
<td>100</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>150</td>
<td>24.7</td>
<td>37</td>
<td>73.0</td>
<td>27</td>
<td>10.8</td>
<td>4</td>
<td>40.5</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

Note: Given that some respondents used the strategy repeatedly and it sometimes bettered, sometimes worsened, and sometimes made no difference to the situation, percentages for each strategy may sum to greater than 100%.
Asking very clearly to stop, saying it hurt.

Threatening someone was about to arrive.

Trading - offering oral to avoid anal.

These responses illustrate the value, for some respondents, of passive avoidance strategies, nonconfrontational deterrence, and delay and distraction tactics:

- During one pack-rape, I persuaded one guy that he didn't want to share me; he locked the other guys out & I encouraged him to drink between assaults. After a while he passed out & I escaped.
- Perhaps father decided not to. The male friends my father brought home were usually too drunk to stand up and perhaps could not manage penetration.
- Delaying them by staying in the shop until he lost interest.
- Avoiding contact – e.g., making sure there was a separate bed.
- No eye contact.
- Not answering phone/front door when it was him.
- Dissociating; pretending to still be asleep.
- Pretended I was asleep.

Other excerpts allude to the role of perpetrator fear of discovery as a mitigating factor:

- I don't think he wanted to cause any damage or mark me in any way in case it would result in mother finding out.
- I was not the only cousin he tried it with. He was frightened I'd tell.
- I was trapped in my room and my mother called out to say dinner was ready from down the hallway - to avoid being caught the person left the room - I consider myself lucky in this instance - I believe that it occurred from them being exposed to pornography at an early age by my father's lack of discretion and failure to teach any moral values in the home.

Many responses reflected the utterly powerless position of child sexual abuse victims, and illustrated the absence of any factors other than ‘luck’ or sheer physical difficulties experienced by the perpetrator in achieving penetration that might have served to mitigate against penetrative abuse.

- I was a virgin and he couldn’t get his dick properly in. I guess I had a strong hymen.
- I was too young and it was physically difficult for them to penetrate.
I was not ready for sexual intercourse, they were too big & unable to fit or penetrate, more good luck on my part being quite strong, unwilling to open my legs fully, difficult manoeuvre with not a fully consenting individual, scared & frightened, not conducive to having a good time, my wishes & feelings were not considered.

Equally, the futility of resistance attempts and the powerlessness of many respondents to alter the course of their abuse are reflected in many responses, including the following:

- Every day I tried to please my mother and father so that they would not hurt me that night. I looked after my brother and sister and did all the chores. It never worked.
- Anything I did to resist merely upped the ante.
- I was very debilitated by the drugs and could just barely get some physical slurs out.
- I could not fight as it would have made it worse for me, so I would not have tried. In deterring, I believe it added to their control.
- I was so scared and although I was screaming inside my head, I could not get the words and sound out of my mouth.
- I became immobilised/ frozen/ couldn’t speak.

Finally, the value of proximity to others or summoning external assistance is demonstrated by the following responses, identified as successfully impacting on the outcome.

- Help came when I called.
- Looking for help from witnesses.
- My brother would punch my cousin to make him stop.
- I was rescued by the brother of one of the attackers.
- Someone else around

5.3.10 Victim-Perceived Most Beneficial Resistance Strategy

It was of interest to examine which one of the resistance strategies applied by victims was perceived by them to have been the most helpful in their circumstances. As evident in Table 5.5, widely divergent opinions were expressed in regard to this question. Most commonly, respondents reported as most helpful, their decision to desist from attempting to resist physically. Other strategies commonly regarded as the single most helpful approach included clearly conveying lack of consent to the person; escaping or hiding; experiencing a state as if ‘frozen’; asking the person ‘nicely’ to desist; and stiffening or physically distancing oneself from the person. Interestingly, these results are
consistent with earlier observed trends that nonconfrontational strategies hold the most promise for favourable outcomes. Although feeling ‘frozen’ is not a deliberate strategy, it may be that victims perceive this state as having been helpful in some way by inhibiting an aggressive, confrontational, or in other ways, unhelpful approach or chain of events that might have unfolded in the absence of such a state.

Table 5.5
Victim-Perceived Most Beneficial Resistance Strategy

<table>
<thead>
<tr>
<th>“Of the strategies you used, which one do you believe was the most helpful?”</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deciding that it would be safer for me not to try to resist physically</td>
<td>15.2</td>
<td>82</td>
</tr>
<tr>
<td>Making it completely clear to the person that it was against my wishes.</td>
<td>11.5</td>
<td>62</td>
</tr>
<tr>
<td>Escaping or trying to escape, run away or hide.</td>
<td>9.2</td>
<td>50</td>
</tr>
<tr>
<td>I felt as if I were ‘frozen’</td>
<td>8.9</td>
<td>48</td>
</tr>
<tr>
<td>Asking the person “nicely” to stop (or using apologies or excuses).</td>
<td>6.8</td>
<td>37</td>
</tr>
<tr>
<td>Other</td>
<td>6.7</td>
<td>36</td>
</tr>
<tr>
<td>Stiffening, turning away or moving away from the person.</td>
<td>6.1</td>
<td>33</td>
</tr>
<tr>
<td>Using physical defence (e.g., hitting, punching, scratching, kicking, biting, etc).</td>
<td>5.0</td>
<td>27</td>
</tr>
<tr>
<td>Pushing the person away.</td>
<td>4.4</td>
<td>24</td>
</tr>
<tr>
<td>Trying to delay or distract the person</td>
<td>4.3</td>
<td>23</td>
</tr>
<tr>
<td>Persuading, explaining, reasoning, negotiating or bargaining with the person.</td>
<td>4.1</td>
<td>22</td>
</tr>
<tr>
<td>Getting help or raising alarm</td>
<td>4.1</td>
<td>22</td>
</tr>
<tr>
<td>Verbally threatening, scaring or warning the person.</td>
<td>3.7</td>
<td>20</td>
</tr>
<tr>
<td>Deciding that it would be safer for me not to try to resist verbally</td>
<td>3.5</td>
<td>19</td>
</tr>
<tr>
<td>Pleading, crying, or trying to please the person.</td>
<td>3.0</td>
<td>16</td>
</tr>
<tr>
<td>Becoming angry with the person.</td>
<td>2.6</td>
<td>14</td>
</tr>
<tr>
<td>Screaming</td>
<td>1.1</td>
<td>6</td>
</tr>
<tr>
<td>Capturing or detaining the person.</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Total 100 N = 541

5.3.11 Potentially Helpful Resistance Strategies?
Respondents were asked to nominate which strategy (if any), in retrospect, would have been most helpful in their situation. One third of respondents indicated that ‘Nothing’ would have helped their situation (32.8%; n = 242). However, a large number of qualitative responses in answer to the question ‘Which would have been most helpful?’ reflected widely
divergent and strongly held beliefs surrounding this topic. Many respondents expressed
the view that certain strategies listed in Table Victim strategies to avoid sexual assault would
have been particularly useful, if applied in their situation/s. Prominent themes emerged
centric on the perceived protective and preventive effects of assertive responses to the
perpetrator; clear and firm communication; disclosure and help-seeking (especially in
relation to childhood sexual abuse); leaving an abusive relationship; avoiding vulnerable
situations (especially intoxication and being alone with a potential perpetrator); attracting
attention and raising the alarm; and ‘fighting back’ more strongly.

However, the powerlessness of many victims to prevent their abuse was also evocatively
conveyed through many responses pertaining to both childhood and adulthood sexual
abuse. Responses referring to childhood abuse include:

- There was nothing I could do, as I was only 6 years old and physically incapable of fighting back against a
30 year old man. A strategy I could have used would have been to tell someone about the abuse, but he had
threatened in vivid detail that he would kill me or my mother if I did that.

- Compliance kept me alive. Active participation got me rewards and kindness (if you could call it that).

- I didn’t have any strategies. I turned away in passive resistance for myself, for my own self respect. I was a
little child and he was 6’2” man. Strategies are a victim blaming nonsense.

- I don’t think I could have done any more than hide, because my family was out and they would not have
protected me or believed me anyway - there was no one to help or talk to.

- As a 10 year old I didn’t have the capacity to negotiate, however I think that would have been more useful.

- I wish I had run away when I was a child, and not just when I was 17.

- If I had realised that it was wrong I don’t think I would have done anything. I would have been afraid my
father would have injured him.

Responses pertaining to sexual abuse in adulthood include:

- He would have shot or hit me if I had have retaliated.

- Physically resisting was not possible given the lack of physical strength I had because of the unknown drugs
he had given me (I think it might have been Ketamine).

- Crap situation. Nothing would have made it any ‘better’. I did the best I could.

Other responses reflected victim beliefs that their own internal states heightened their
vulnerability to sexual predation and impeded their capacity for resistance tactics.
Examples include:

- I'm not sure if any would have been helpful. I was being emotionally manipulated and I didn't believe myself to be worthwhile enough to stop him doing these things to me.

- I was dominated by my sense of inadequacy as a human being despite in all other respects having good self-esteem. Nothing made a difference - although I could change and did, but not by my wilful action.

- I was incapable of using strategies as I blamed myself and felt powerless.

- Getting out of the relationship but due to depression I had nowhere to go.

Conversely, other responses reflected internal thought processes and strategies through which victims were able to gain a level of control, at least in some situations. Also strongly conveyed through the following responses is the value of approaches that diffuse, or avoid the escalation of, violence and anger:

- Persuading, explaining, and comforting my kidnapper really calmed him down. I told him EVERYTHING that he wanted to hear, even saying I would get back with him!!! Even though I had no intention of doing so... I wanted to do anything that would get me out alive. With my rapist, being submissive would have let me get out with a lot less bruises!

- If I shut up and turned over and lay there he would penetrate me, have sex, ejaculate only once or twice and go to sleep. If I objected/cried/begged/became angry he would keep using me all night and I would be unable to operate effectively in the daytime.

- Persuading him to stop was done by me offering to do something else.

- Agreeing etc so I could try to get away. Eventually I bit/ kicked or something and did get away.

- Find an excuse to leave (i.e., pretend to have lost something valuable to get out so it doesn’t get their back up), listening to gut instincts better, and getting out much quicker.

A number of responses pertained to abuse within care settings and client-therapist relationships. Examples include:

- Clearly telling the person that it was against my wishes, and making it clearer to the Department of Human Services that I needed to be moved from that placement.

- Depends which situation we’re talking about. Going into a house stopped the youths when I was 12. In the end I just stopped attending the therapy sessions and that worked too. Would have been good if I could have said No from the start in that situation.

The importance of being with other people, particularly when alcohol affected, was reflected in the responses of numerous victims:

- Being vocal about my objection. I would have then given an impetus to the witnesses to back me up, maybe.
Always making sure that there was another woman present with me in the room I was working in, leaving the room if I was alone.

I was lucky someone was around. I don't think I would have got away as he had a car and my house was 500 m away.

I think especially when you have been drinking your ability to be physical and to reason is so diminished so that your only real protection is to be with other people.

Escaping the situation, which was very difficult because of the circumstances (alone in a locked office building after hours, severely affected by alcohol).

Heightened emotions in relation to sexual abuse, a strong sense of animosity and enmity toward the perpetrator (sometimes generalised to all men), and a belief in the merit of strong, physical defence were reflected in the violent and highly ‘physical’ sentiments expressed by numerous victims. Examples include:

- A bloody great plank to the back of the head.
- A good kick to the groin.
- A kick in the testicles.
- Beating the shit out of him with a weapon.
- Depending on strength differences, fighting back as much as possible and hurting the assailant particularly in the genital area.
- Having mace or mobile phone or knife.
- Going to the police, running away from home, physically injuring the doctor (I thought about stabbing him once).
- I wished that I’d been physically violent with him. I had items with me that could have been helpful (a thick coffee mug and a sharp pointed umbrella).
- Confidence and making sure the person knows I am no longer a walkover, if they want to take anything they had better be prepared for one hell of a fight.
- Call for help. I later learned self defence.
- Just kill them.
- Killing all men.
- Not being born a girl in a male world.

In some cases, violent sentiments were also directed to the self, as exemplified by this response:
• I wish I’d killed myself before it happened so it never happened.

Finally, the elusive nature of seeking to combat sexual abuse, and the implicit threat of such abuse acutely perceived by many victims as omnipresent and transcending generational and situational boundaries, is summarised by this comment made by a 63 year old female who, after experiencing chronic sexual abuse between the ages of 3 and 9 years, experienced sustained intimate partner violence throughout a long marriage.

• I wish I knew. I would teach them to my grandchildren.

5.3.12 Sexual Assault-Related Victim Regrets

Over half of SA victims (54.6%; n = 382) reported having regrets in relation to the action(s) they took, or wishing that they had taken different actions. Amongst a multitude of regrets, dominant themes were evident, centering most strongly on wishes to have been more assertive; had a healthier conceptualisation of self; told someone (particularly, with regard to childhood sexual abuse); left abusive partners; and to have been less trusting; fought back more strongly; consumed less alcohol; reported to police; not left venues alone; and on less tangible and more global regrets such as having ‘gotten into the situation in the first place’.

Expressions of regrets pertaining to childhood sexual abuse poignantly reflect the damaging ramifications of secrecy and taboo. Moreover, recurrent sentiments reflect the power of perpetrators to silence their victims through lies, threats, manipulation, and inducement of guilt and fears, and their adept exploitation of childhood sensibilities of trust, ‘goodness’, and concern for the welfare of others (including often for the perpetrator themselves). Such themes are exemplified by the following responses:

• If I had realised how much it hinged on my silence/fear/cooperation etc, I would have raised the alarm about the early abuse from the family friend. That would have prevented 80% of my abuse. For the later events with my uncle, my mum was in denial. The whole family knew about that already. It was allowed. But, I do realise that I didn’t know any better, so I don’t "regret" my choices in that sense.

• With my father I wish that I had told grownups but given my impressionable nature this was not possible. Even if I told Mum it might have helped but Dad swore me to secrecy and told me Mum didn’t want me, so that was not an option either.
I wish I had have called out to my dad who I could hear calling for me, and not bothered by what the person had said about them getting into trouble if I called out.

I wish I hadn't agreed to it, and bad realised be would have been in far more trouble than me if he told my father.

The family held him in such high esteem I knew they would never believe me so I couldn't DO anything to make a difference. I'd been brought up to accept adults as having full power & authority.

I wish I'd fought back on both occasions but a kid doesn't hit their mum do they? And I was too drunk to do much as an adult.

He continued to control my life, psychologically, not sexually, until as an adult I told him to get his own cup of tea, I was not his servant, and he never ordered me around again. I stood up to him once and his attitude to me changed. If only I had known that as a child. I should have just said 'No, bugger off I don't like this, and I will tell on you'. But I was 8 years old and he made me feel I must protect my mother.

I wish I had been clearer about not wanting it. I wish I had told my mother (who, ironically, worked in child protection).

I wish I'd spoken out, but I could not. There was a conspiracy of silence, or so it seemed and I was only young.

Sentiments not dissimilar to these were expressed in relation to abuse within intimate relationships. Indeed, commonly expressed sentiments reflect the power of the perpetrator to exploit qualities (e.g., trust, loyalty, nurturing, forgiveness, maternal instincts), needs (e.g., love, affection, security, belonging), and weaknesses (e.g., dependency, low self esteem, insecurity, lack of assertiveness) of the victim, and the concomitant difficulties experienced by many victims in distancing themselves from abusive relationships. Not surprisingly, threats to harm or remove children are cited as immensely powerful inhibitors of proactive behaviours and departure from such relationships. Many regrets pertaining to abuse within relationships reflect the perceived powerlessness of victims to effect positive change; the impeding effects of personal attributes in victims’ capacity to leave abusive relationships; and ultimately, the fact that departure from the relationship was not effected sooner. The following comments are illustrative of such themes:

To this day, I do not have any idea what I could have done differently as I am not an unintelligent person. The only thing that now makes sense would have been to have left, a lot sooner. But, bad children to worry about. He always threatened to take the children, and nothing I could have said would have made any difference, legally speaking. I fear that I would not have been left alone. As was proven, even when I left the country to try make a life here in Australia.
I wish I hadn’t put up with his shit, that I’d left earlier, been stronger and not let him play on all my fears and insecurities. I don’t think I knew how well I could survive in Sydney on my own, so I felt like I needed him. I was very wrong!

I wish that I didn’t need his attention, good or bad and therefore could have been much clearer about him never to do that to me again.

I wish I was more forceful instead of believing that he wouldn’t want to hurt or upset me. I shouldn’t have trusted that he would actually care.

I wish I had left after the first time.

I wish I had left him years earlier.

Many regrets pertaining to both childhood and adulthood sexual abuse centred on perceived personal shortcomings (and concomitantly, falling prey to perpetrator tactics), the wish for a healthier self-concept, and the attribution of sexual abuse to varying degrees on negative conceptualisations of self, as exemplified by these responses:

I regret being manipulated. He would never have killed himself as be threatened, but I couldn't think quickly enough.

Just wish I’d had more self worth & strength as a young teen to not allow myself to be abused. I wish that every boy that abused me I reported them & had the strength to just tell everyone.

Would like to have been more sure of myself as a person and know that I may have had feelings which were just as valid as anyone else.

Wanted company, sometimes affection. Trust people, take them at their word and literally get f**ked for it.

I wish I had had better self-esteem.

I wish I had had the emotional strength to say no.

I wished I had been confident enough to make a better life for myself.

It was common also for respondents to express regrets in relation to tangible and specific actions and inactions. Many comments reflected self-criticism, self-blame, guilt, and self-admonishment for actions and inactions retrospectively perceived as ‘stupid’, unsafe, overly trusting, or naive. However, regrets were also expressed in relation to ‘neutral’ actions (e.g., going to TAFE) and those considered intrinsically ‘good’ (e.g., rendering assistance to another). Such themes are exemplified by these comments:

I wish I had not been so stupid - not a very valid response but that is how I feel.

I wish I could have stopped myself being so stupid and cheap.
That I had agreed to go for "fresh air". If I had stayed in the club, friends would have noticed the rapid change in me because of the drugs. The bartender (a friend of the stranger) spiked my drink unbeknownst to me.

I wish I had never walked out of the party alone.

I wish I hadn't taken so many of the drinks he offered me. They rendered me helpless.

I wish I had been watching over my shoulder when they were following me so I knew they were there.

I wish I hadn't given him permission to share my bed.

I wish I had never gotten in his truck because I didn't know him well enough.

I wish I had gone through with reporting it to the police, even though they were so unhelpful and unsupportive when I attempted to.

I should have told a nurse or doctor. I should have gone to a medical centre as I bled quite a lot. I would not go to the police as I think that most male police would dismiss me.

I wish I had never gone to TAFE.

I wish I had never gone to help.

It was very common for victims to express regret that they had not ‘tried harder’ to resist the abuse. Whilst it was acknowledged by some that such an approach may have been ineffective in changing the course of the abuse, or even escalated the violence and increased harm to the victim, the close relationship between the victim’s appraisal of their own behaviours and their later attribution of self-blame and subsequent feelings of guilt, shame, and perturbation was clearly articulated by some respondents. Indeed, the notion expressed in the following comment that, even at the expense of ‘more pain’, having ‘fought harder’ would have been preferable in the interests of ‘peace of mind’ conveys the integral relationship between victim attributions and their later wellbeing.

I wish I had fought harder even if it meant more pain...just for peace of mind that I tried as hard as I could.

I wish I were emotionally stronger and resisted more - it may not have changed anything but I would feel better about myself.

I wish I had fought harder somehow or resisted more strongly. May have made me feel less guilty or responsible about what happened.

I wish that I had tried so hard to stop them, I really wish I had.
Regrets were also directed towards external factors, such as potential negative outcomes for third parties. Specifically, the commonly expressed regret of not reporting the abuse to police was often founded in guilt or fear that the perpetrator may have continued to act with impunity and caused harm to other persons as a consequence of the victim’s inaction and in the absence of police intervention. Evidence of negative outcomes for others is cited in the following responses:

- I wish I had enough confidence to tell my mother, and the maturity to tell the police, through my mother or by myself. I very much regret that nothing was done about it, and then finding out when my daughter was 18 years that he had attempted the same thing with her, and she acted in precisely the same manner as I did.

- I did not take any action over the incident straight away, and did not do anything until months later when I heard he had done the same thing to someone else. I wonder if I had confronted him earlier it might have saved her from the incident.

- Trying to raise alarm resulted in another person being bashed, although it meant neither me or my mate were receiving those punches.

As previously cited, the level of malice felt by some victims of sexual abuse toward their assailant is illustrated by the chilling and graphic nature of the following sentiments and expressions of regret:

- Murder of the rapist at the time of the assault is the only opportunity a victim will ever get for justice. Just make sure there are no witnesses.

- Wish I had kicked him the in the balls, broken his nose, gauged his eyes out.

- I wish I had’ve grabbed his trophy and hit him with it, repeatedly.

- I should have killed them.

In sharp contrast to these statements are the uplifting sentiments expressed in the following comment:

- It was not my behaviour to regret. I am so proud that I prevailed and came out of it a good, decent authentic person who only adds love and kindness to the world.

Finally, both the enormous, often cross-generational, toll of sexual abuse, and the potential for positive growth in the aftermath of such abuse are articulated in the following comment:
I have a lot of positive self-narrative as a result of my survival of these experiences. In a way I have a sense of reading the world through the negative aspect of a photograph. I didn’t get what you need for setting out into healthy relationships, but I know something of how to measure the distance back from the undesirable. My regret is that the distance I placed between myself and the events has had profound and terrible effects for my son; I am troubled by the sense of how people can get on with apparently pretty normal lives but catastrophe is just under the surface due to unconscious material that has not been dealt with. I wish that somewhere along the line I had become aware of this possibility, and I wish more education was going on of people along these lines. I think child sexual assault is a hidden epidemic and we have so very much to learn about the ways we protect and also harm ourselves through placing distance between events and ourselves (much much unconsciousness). In brief, my regret is not having done therapy about it, but this never occurred to me.

5.3.13 Additional Crimes Against Victims of Sexual Assault

Almost one in five victims of sexual assault reported that the perpetrator/s had committed additional crimes against them (17.3%; n = 122). Such crimes, whilst also comprising various forms of theft, were overwhelmingly violent crimes against the person. Moreover, particularly with regard to sexual abuse in childhood and within intimate partnerships, it was common for sexual violence to coexist with other abuse forms. Notably however, as this question referred to ‘crimes’, emotional and psychological abuses were ostensibly excluded, or at least substantially underenumerated, by this question. Similarly, it is commonly observed that assaults and other abuses (both sexual and nonsexual) popularly subsumed under the heading of ‘domestic’ violence are underclassified as ‘crimes’, often minimised by both perpetrators and victims and conceptualised as not ‘real’ crimes. Hence, it is considered that the findings deriving from this question similarly understate the true level of coexistence between sexual and other violence, particularly within intimate partnerships. Moreover, numerous qualitative responses attest to the misconceptions, ambivalence, and generalised reluctance of victims to define events as ‘crimes’ such as rape or assault. For example:

I should have gone to the police but at the time did not recognise that I had been raped - I was married but I had said NO. I felt assaulted but didn’t realise that non-penile penetration was classed as rape.

The following responses attest to the physical violence that frequently accompanies childhood experiences of sexual abuse within the family. Notably, frequent references were made to violence directed toward multiple family members, offering powerful images of the daily realities of childhood for these respondents and of the contextual settings in which their sexual abuse occurred.
Attempted murder when I was 7. Hitting me a lot too.

Bashing, neglect, etc etc etc

Regular beatings.

He beat my mother every day.

Physical abuse (belt/jug cord) when my sisters and I misbehaved/ didn’t do chores.

Physical and emotional abuse throughout my childhood and teenage years.

Whipping with sticks, hitting.

Scrubbing my breasts and genitalia with a floor scrubbing brush and kitchen scourer.

Threw me across the room when I intervened during a torture session being directed at my brother.

Crimes perpetrated against children in the context of extrafamilial sexual abuse were also reported, as evidenced by the following examples:

Abduction and tying up when I was a child.

No, but he did to other children.

Pornography, giving drugs to a minor.

The frequent chronicity and multifaceted nature of intimate partner violence, and the erosion of spirit and wellbeing that frequently accompanies such abuse are poignantly conveyed in the following comments. Many others document chronic physical, psychological, and emotional abuse, property damage, and financial abuse, including theft of property and from joint bank accounts. References to ex-partners also document the reality that exists for many victims of IPV that departure from abusive relationships does not always end the abuse, and indeed, not infrequently effects an escalation of abuse, enmity, and risk of harm to the victim.

He regularly beat me. Anything that was mine was his. I had no private property, not even my body or my thoughts.

Numerous mental and physical assaults throughout the marriage

Regular physical assaults with fists and improvised weapons. Theft and damage of my property.

Various forms of domestic abuse, although I don’t think they are all technically crimes, and even if they are, the legal system usually doesn’t help.
Yes, she had just beaten me up very badly, split lip, black eye, knocked unconscious. I thought she was going to kill me. (Female victim of intimate partner violence within a same-sex relationship)

My ex-husband continues to harass me. He has vandalised my car, stalked me etc and he does it in a way that I cannot prove it is him so he is never prosecuted. But I no longer put myself in a situation where he is ever alone with me, so there is less chance of him physically harming me anymore.

The following example illustrates the added vulnerability often incurred in states of crisis, and the cumulative nature of risk encountered by many victims of abuse.

Ex-boyfriend, drove me home to Melbourne (2 hours in car) under the influence of alcohol. I just wanted to go home, I didn’t know anyone else.

This response exemplifies the pattern of revictimisation in adulthood, and the multiple abuse forms, experienced by many victims of childhood abuse.

My mother hit me often and my partner stole from me and physically kept me in the house.

Overall, a wide range of crimes were perpetrated by those who committed sexual abuses. Most commonly reported were violent physical assaults described as bashings, beatings, battering, and physical violence. Abduction and instances of extreme violence, including attempted murder, choking, and assaults resulting in serious injury, were reported by numerous respondents. Additionally, respondents reported crimes such as stalking, drink spiking, harassment, property damage (including vandalism and arson), and theft (e.g., handbag, money, mobile phone, car).

The following are examples of responses in which victims reported abduction in conjunction with sexual abuse. However, the hesitancy of some victims to classify their experience as abduction is evident in their responses.

Abduction and assault

Bashing, abduction

Bashing, removal from my home when I was too bashed to know or consent.

Abduction/kidnapping. When the vehicle stopped, placing the car against a fence so I couldn’t open the door and had nowhere to go.

A qualified yes to abduction I suppose because he wouldn’t let me out of the car and took a different direction to the one I was heading towards.
The taxi driver in Thailand - abducted me in a sense. I was on the back of his bike and he took me to a
dirt track and assaulted me there - alone and in the middle of nowhere. I didn't know where I was, I
didn't speak the language and knew only one other person in the country - my boyfriend who was
working at the time.

Other victims described various forms of physical restraint and being held against their
will, as evident in the following examples:

- Holding me by forcing my head onto a wall and holding it there
- Hitting, holding, forcing, pushing, tying up, restraining
- During the rape - assault (punching and hitting) and physical restraint
- Holding me against my will
- Trying to lock me in a pantry

The extreme violence experienced by some victims in the context of sexual abuse is
evidenced by the following responses:

- Well, not that he bashed me as such, but he attempted to choke me when I attempted to push him off me.
- Once I put up a fight he started to choke me and I started to black out.
- Bashing, attempted murder
- Bashing, cutting, hostage (held at knife point)

- Physical abuse - broken jaw, broken collar bone
- Psychological damage, theft, bashing, black eye
- Threw things at me, had a lump on the bone in my leg from a bowl he threw.
- Criminal sexual assault with nun in 1966 and assault causing grievous bodily harm with the woman in
1986
- Beat me up sometime later to prove he was not really gay.

Thefts, threats, and intention to harm or intimidate described in the following responses:

- Assault when I threatened to go to family, friends or authorities.
- Threats of physical actions against myself and family members.
- Verbally abused me and threatened to come back.
- Damaged my front door and fence, verbally abusive.
- Stole handbag, placed homemade bombs on driveway.
- Car theft, mobile theft, stole money from my mother.
- Theft, arson. They stole my watch & money from my bag.
- Stole money and possessions.

5.3.14 Barriers to Police Reporting of Sexual Abuse

It was of interest to investigate barriers to reporting sexual abuse to the police. Examination was conducted of factors that influenced victim decisions with respect to reporting or not reporting their experience/s of sexual abuse. Specifically, both victims who reported and those who did not were asked to rate a series of statements with respect to how much these reflected their thinking at the time they were making their decision regarding whether or not to report. Given that the majority of victims had not made a police report in relation to their sexual abuse, and in this respect mirrored reporting patterns commonly seen in other populations of sexual abuse victims, examination of inhibiting factors within the current sample was of particular interest.

As evident in Table 5.6, the majority of victims identified multiple concerns and beliefs as influential in their decision-making process. Predominant amongst these was the belief that their abuse was a personal matter; the concern that they might be blamed or judged; the belief that it would be impossible to prove; and the perception that it was too shameful, with almost two thirds of victims influenced to some extent, and around one third strongly influenced by these views. More than half of victims to some extent feared the social consequences of identifying as a sexual assault victim; thought they would not be believed; were anxious or fearful about what the perpetrator might do if reported; and did not want to become involved in what they perceived would be a protracted and complicated legal process, with 22-35% of victims strongly influenced by these concerns.

Almost half of victims endorsed, to some extent, the view that they had simply had a bad sexual experience, but that no crime had been committed; and that police investigation would be ineffectual, with around one in four victims strongly influenced by these
beliefs. Moreover, more than one third of victims were influenced to some extent by their concerns about negative consequences for the perpetrator as a result of a police report, and for almost one in five, this concern strongly influenced their decision. Finally, one in five victims were influenced by concerns that they would be identified as homosexual and a smaller minority identified concerns that they would be identified as transgender or intersex.

Table 5.6

Barriers to Police Reporting of Sexual Abuse

<table>
<thead>
<tr>
<th>Victim-identified reporting barriers</th>
<th>Agree to some extent</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I considered it to be a personal matter.</td>
<td>67.5 467</td>
<td>35.2 247</td>
</tr>
<tr>
<td>I was concerned that I might be blamed or judged.</td>
<td>64.6 449</td>
<td>36.4 253</td>
</tr>
<tr>
<td>I thought it would be impossible to prove.</td>
<td>63.8 450</td>
<td>42.1 297</td>
</tr>
<tr>
<td>It was too shameful.</td>
<td>61.7 428</td>
<td>32.3 224</td>
</tr>
<tr>
<td>I was afraid of the social consequences of identifying myself as victim of sexual assault or rape.</td>
<td>56.6 395</td>
<td>31.8 222</td>
</tr>
<tr>
<td>I thought I would not be believed.</td>
<td>55.3 389</td>
<td>35.4 249</td>
</tr>
<tr>
<td>I believed that I was responsible for the assault.</td>
<td>52.7 369</td>
<td>22.4 157</td>
</tr>
<tr>
<td>I was afraid or worried about what the person might do if I reported it.</td>
<td>51.7 360</td>
<td>29.4 205</td>
</tr>
<tr>
<td>I did not want to become involved in what I believed would be a long and complicated legal process.</td>
<td>50.8 352</td>
<td>29.3 203</td>
</tr>
<tr>
<td>I believed that I simply had a bad sexual experience, but that no crime had been committed.</td>
<td>45.8 321</td>
<td>22.5 158</td>
</tr>
<tr>
<td>I believed that the police would be ineffectual in investigating the crime.</td>
<td>43.6 305</td>
<td>25.9 181</td>
</tr>
<tr>
<td>I was concerned about what might happen to the person if I reported it [or felt sorry for him].</td>
<td>38.8 270</td>
<td>18.5 129</td>
</tr>
<tr>
<td>I was worried I would be identified as gay/lesbian.</td>
<td>20.5 142</td>
<td>15.9 110</td>
</tr>
<tr>
<td>I was worried I would be identified as transgender or intersex.</td>
<td>13.8 95</td>
<td>13.1 90</td>
</tr>
</tbody>
</table>
5.3.15 Relationships Between Sexual Victimisation and Psychological Wellbeing

Impact of lifetime experience of sexual victimisation on psychological wellbeing

It was of interest to examine the relationship between lifetime experience of sexual victimisation and psychological wellbeing. Accordingly, a one-way between-groups multivariate analysis of variance was performed to compare victims and nonvictims of sexual abuse in terms of psychological wellbeing. Nine parameters of psychological health were used as dependent variables to assess overall wellbeing: (i) depression; (ii) anxiety; (iii) stress; (iv) self-esteem; (v) shame; (vi) guilt; (vii) aggression; and (viii) posttraumatic symptomatology; and (ix) life satisfaction.

A statistically significant difference was found between nonvictims and victims of SA on the combined dependent variables, $F(9, 846) = 12.27, p < .0005$, Wilks' $\Lambda = .92$, partial $\eta^2 = .12$. When the results for the dependent variables were considered separately, significant differences were found for seven of the nine variables, using a Bonferroni adjusted alpha level of .006. Specifically, differences between victims and nonvictims were found with respect to anxiety, $F(1, 854) = 14.06, p < .0005$, partial $\eta^2 = .02$; stress, $F(1, 854) = 13.43, p < .0005$, partial $\eta^2 = .02$; shame, $F(1, 854) = 15.87, p < .0005$, partial $\eta^2 = .02$; guilt, $F(1, 854) = 16.59, p < .0005$, partial $\eta^2 = .02$; aggression, $F(1, 854) = 12.87, p < .0005$, partial $\eta^2 = .02$; posttraumatic symptomatology, $F(1, 854) = 91.43, p < .0005$, partial $\eta^2 = .10$; and life satisfaction, $F(1, 854) = 10.35, p = .001$, partial $\eta^2 = .01$.

No significant difference was found with respect to depression, $F(1, 854) = 5.09, p = .02$, partial $\eta^2 = .01$; or self-esteem, $F(1, 854) = 2.93, p = .09$, partial $\eta^2 = .003$.

Inspection of the mean scores indicated that victims reported greater anxiety ($M = 10.67$, $SD = 10.85$), relative to nonvictims ($M = 8.04$, $SD = 9.39$); more stress ($M = 17.44$, $SD = 11.60$) than nonvictims ($M = 14.63$, $SD = 10.64$); more shame ($M = 15.48$, $SD = 8.07$) than nonvictims ($M = 13.37$, $SD = 7.28$); more guilt ($M = 9.57$, $SD = 5.01$) than nonvictims ($M = 8.20$, $SD = 4.77$); higher aggression ($M = 66.31$, $SD = 20.10$) than nonvictims ($M = 61.55$, $SD = 18.43$); greater posttraumatic symptomatology ($M = 53.02$, $SD = 16.45$) than nonvictims ($M = 42.06$, $SD = 17.03$); and lower life satisfaction ($M = 23.19$, $SD = 9.96$) than nonvictims ($M = 25.45$, $SD = 10.56$).
Comparison of psychological wellbeing across four victim groups

It was also of interest to compare the wellbeing of persons who had experienced differing forms of sexual abuse. Accordingly, a one-way between-groups multivariate analysis of variance was performed to examine psychological wellbeing across four victim groups: (i) not sexually victimised (NSA); (ii) victim of SA in childhood only (CSA); (iii) victim of SA in adulthood only (ASA); and (iv) victim of both CSA and ASA (CSA-ASA). Nine parameters of psychological health were used as dependent variables to assess overall wellbeing: (i) depression; (ii) anxiety; (iii) stress; (iv) self-esteem; (v) shame; (vi) guilt; (vii) aggression; and (viii) posttraumatic symptomatology; and (ix) life satisfaction.

A statistically significant difference was found on the combined dependent variables as a function of victim group, $F(27, 2465.56) = 5.47$, $p < .0005$, Wilks’ $\Lambda = .84$, partial $\eta^2 = .06$. When the results for the dependent variables were considered separately, significant differences were found for eight of the nine variables, using a Bonferroni adjusted alpha level of .006. Specifically, differences across victim type were found with respect to depression, $F(3, 852) = 5.10$, $p = .002$, partial $\eta^2 = .02$; anxiety, $F(3, 852) = 8.05$, $p < .0005$, partial $\eta^2 = .03$; stress, $F(3, 852) = 8.13$, $p < .0005$, partial $\eta^2 = .03$; shame, $F(3, 852) = 9.45$, $p < .0005$, partial $\eta^2 = .03$; guilt, $F(3, 852) = 10.13$, $p < .0005$, partial $\eta^2 = .03$; aggression, $F(3, 852) = 7.03$, $p < .0005$, partial $\eta^2 = .02$; posttraumatic symptomatology, $F(3, 852) = 40.55$, $p < .0005$, partial $\eta^2 = .13$; and life satisfaction, $F(3, 852) = 6.27$, $p < .0005$, partial $\eta^2 = .02$. No significant difference was found with respect to self-esteem, $F(3, 852) = 3.23$, $p = .02$, partial $\eta^2 = .01$.

Posthoc comparisons, using Hochberg’s GT2 test for unequal sample sizes, revealed that, with respect to depression, anxiety, shame, guilt, and posttraumatic symptomatology, the CSA-ASA group differed significantly from each of the other groups. Specifically, the CSA-ASA group ($M = 17.92$, $SD = 13.30$), reported higher depression than the NSA group ($M = 13.16$, $SD = 12.74$), the CSA group ($M = 14.15$, $SD = 13.23$), and the ASA group ($M = 13.37$, $SD = 12.12$). Similarly, the CSA-ASA group ($M = 12.82$, $SD = 11.08$) reported higher anxiety than the NSA group ($M = 8.04$, $SD = 9.39$), the CSA group ($M = 9.89$, $SD = 10.65$), and the ASA group ($M = 9.24$, $SD = 10.59$).
The CSA-ASA group \((M = 17.24, SD = 8.33)\) also reported more shame than the NSA group \((M = 13.37, SD = 7.28)\), the CSA group \((M = 14.97, SD = 7.64)\), and the ASA group \((M = 14.09, SD = 8.15)\); and more guilt \((M = 10.79, SD = 4.96)\) than the NSA group \((M = 8.20, SD = 4.77)\), the CSA group \((M = 9.00, SD = 4.94)\), and the ASA group \((M = 9.00, SD = 4.98)\). Finally, the CSA-ASA group \((M = 58.80, SD = 14.15)\) also reported greater posttraumatic symptomology than the NSA group \((M = 42.06, SD = 17.03)\), the CSA group \((M = 49.66, SD = 17.05)\), and the ASA group \((M = 51.58, SD = 16.21)\). With respect to posttraumatic symptomology, the levels reported by the CSA group and the ASA group were also significantly higher than those reported by the NSA group.

With respect to stress, the CSA-ASA group \((M = 19.82, SD = 11.19)\) differed significantly from two of the other groups, reporting higher stress than the NSA group \((M = 14.63, SD = 10.64)\) and the CSA group \((M = 15.89, SD = 11.77)\). With respect to life satisfaction, the CSA-ASA group \((M = 21.27, SD = 9.25)\) differed significantly from two of the groups, reporting lower life satisfaction than the NSA group \((M = 25.45, SD = 10.56)\) and the ASA group \((M = 24.73, SD = 9.79)\). Finally, in relation to aggression, the CSA-ASA group \((M = 69.93, SD = 18.52)\) differed significantly from one group only, reporting higher aggression than the NSA group \((M = 61.55, SD = 18.43)\).

### 5.3.16 Sexual Assault Distress Symptomology Across Victim Groups

It was of interest to examine sexual assault distress symptomology across victim groups. Hence, a one-way between-groups multivariate analysis of variance was performed to examine differences in sexual assault distress symptoms among respondents who had experienced CSA only (CSA), ASA only (ASA), and both CSA and ASA (CSA-ASA). Four subscales of the Sexual Assault Symptom Scale (SASS) were used as dependent variables to assess sexual assault distress: (i) safety fears; (ii) self-blame; (iii) disclosure shame; and (iv) depression subsequent to sexual assault.

A statistically significant difference was found among victim groups with respect to the combined dependent variables, \(F(8, 1238) = 10.56, p < .0005\), Wilks’ \(\Lambda = .88\), partial \(\eta^2 = .06\). When the results for the dependent variables were considered separately, significant differences were found for each of the four variables, using a Bonferroni adjusted alpha
level of .013. Thus, differences among groups were found with respect to safety fears, $F(2, 622) = 9.07, p < .0005$, partial $\eta^2 = .03$; self-blame, $F(2, 622) = 14.94, p < .0005$, partial $\eta^2 = .05$; disclosure shame, $F(2, 622) = 7.72, p < .0005$, partial $\eta^2 = .02$; and depression following sexual assault, $F(2, 622) = 16.58, p < .0005$, partial $\eta^2 = .05$.

Posthoc comparisons, using Hochberg’s GT2 test for unequal sample sizes, revealed that, with respect to disclosure shame, safety fears, and depression subsequent to sexual assault, the CSA-ASA group differed significantly from the each of the other groups. Specifically, the CSA-ASA group ($M = 12.26, SD = 6.76$) reported greater disclosure shame than the CSA group ($M = 10.55, SD = 7.17$), and the ASA group ($M = 9.43, SD = 6.97$); greater safety fears ($M = 7.23, SD = 4.83$), relative to the CSA group ($M = 5.49, SD = 5.11$) and the ASA group ($M = 5.43, SD = 4.64$); and more depressive symptoms subsequent to sexual assault ($M = 5.39, SD = 4.22$), relative to the CSA group ($M = 4.04, SD = 4.08$) and the ASA group ($M = 2.98, SD = 3.60$). The CSA-ASA group ($M = 12.82, SD = 11.08$) also reported significantly greater self-blame ($M = 10.42, SD = 4.37$), relative to the CSA group ($M = 8.00, SD = 5.25$), but did not differ significantly from the ASA group in this respect, ($M = 9.54, SD = 4.84$).

Additionally, significant differences were found between the CSA group and the ASA group with respect to self-blame and depression subsequent to sexual assault. Respondents who had experienced sexual assault in childhood alone reported significantly higher depression subsequent to sexual assault ($M = 4.04, SD = 4.08$), but significantly less self-blame ($M = 8.00, SD = 5.25$), relative to those who had experienced sexual assault only in adulthood (Depression: $M = 2.98, SD = 3.60$; Self-blame: $M = 9.54, SD = 4.84$).

5.3.17 Sexual Assault Distress Symptomology Across Gender

It was of interest to also examine the impact of gender on the experience of sexual assault distress symptomology. Hence, a one-way between-groups multivariate analysis of variance was performed to examine differences in sexual assault distress symptoms between male and female victims of sexual assault. Four subscales of the Sexual Assault Symptom Scale (SASS) were used as dependent variables to assess sexual assault distress:
(i) safety fears; (ii) self-blame; (iii) disclosure shame; and (iv) depression subsequent to sexual assault.

A statistically significant difference was found between male and female victims on the combined dependent variables, $F(4, 684) = 10.26, p < .0005$, Wilks’ $\Lambda = .94$, partial $\eta^2 = .06$. When the results for the dependent variables were considered separately, significant differences were found for two of the four variables, using a Bonferroni adjusted alpha level of .013. Specifically, gender differences were found with respect to safety fears, $F(1, 687) = 17.78, p < .0005$, partial $\eta^2 = .03$; and self-blame, $F(1, 687) = 14.25, p < .0005$, partial $\eta^2 = .02$. No significant gender difference was found with respect to disclosure shame, $F(1, 687) = 2.07, p = .15$, partial $\eta^2 = .003$; or depression following sexual assault, $F(1, 687) = 0.19, p = .66$, partial $\eta^2 < .0005$.

Inspection of the mean scores indicated that female victims reported greater safety fears ($M = 6.18, SD = 4.91$), relative to males ($M = 4.04, SD = 4.59$); and more self-blame ($M = 9.19, SD = 5.05$), than did males ($M = 7.21, SD = 4.82$).

### 5.3.18 Sexual Assault Occurrence and Suicidality

**Lifetime occurrence of suicide attempt**

The relationship between sexual assault and suicidality was examined by comparing four victim groups: (i) not sexually victimised (NSA); (ii) victim of SA in childhood only (CSA); (iii) victim of SA in adulthood only (ASA); and (iv) victim of both CSA and ASA (CSA-ASA). Respondents who had experienced either child or adult sexual assault (or both) were proportionately more likely to have attempted suicide, $\chi^2(3, N = 1136) = 55.21, p < .0005$, Cramér’s $V = .22$, with the highest vulnerability evident in victims of both CSA and ASA, followed by victims of CSA only, and a less elevated risk evident in victims of ASA, relative to nonvictims. Indeed, victims of both CSA and ASA were more than twice as likely to have attempted suicide, relative to nonvictims. Specifically, in contrast to 19.5% of nonvictims ($n = 99$), 45.7% of respondents who had experienced both CSA and ASA ($n = 95$), 34.8% of respondents who had experienced CSA only ($n = 94$), and 26.5% of those who had experienced ASA only ($n = 40$) had attempted suicide.
Moreover, respondents who had experienced both CSA and ASA comprised 29.0% of suicide attempters \((n = 95)\), whilst comprising only 14.0% of nonattempters \((n = 113)\). Overall, respondents who had experienced either CSA or ASA, or both, comprised 69.9% of suicide attempters \((n = 229)\), whilst comprising only 49.5% of nonattempters \((n = 400)\). In contrast, respondents who had never experienced sexual assault comprised only 30.2% of suicide attempters \((n = 99)\), whilst comprising 50.5% of nonattempters \((n = 408)\). Inspection of the standardised residuals (SRs) showed that respondents who had experienced both CSA and ASA were most significantly overrepresented amongst suicide attempters \((SR = 4.5)\), and significantly underrepresented amongst nonattempters \((SR = -2.9)\). Conversely, respondents who had never been sexually assaulted were most significantly underrepresented amongst suicide attempters \((SR = -3.9)\), and overrepresented amongst nonattempters \((SR = 2.5)\).

**Lifetime occurrence of suicidal ideation**

Respondents who had experienced either CSA only, or both CSA and ASA, were also proportionately more likely to have seriously contemplated suicide, relative to nonvictims, although the effect was less pronounced than that seen with suicide attempt, \(\chi^2(3, N = 1162) = 24.34, p < .0005\), Cramér’s \(V = .15\). Specifically, in contrast to 61.2% of respondents who not been sexually assaulted \((n = 319)\), 79.2% of respondents who had experienced both CSA and ASA \((n = 168)\), and 70.0% of respondents who had experienced CSA only \((n = 194)\) had contemplated suicide, but little difference was found between nonvictims and those who had experienced sexual abuse only in adulthood (63.2%; \(n = 96\)).

Moreover, respondents who had experienced both CSA and ASA comprised 21.6% of suicide contemplators \((n = 168)\), whilst comprising only 11.4% of noncontemplators \((n = 44)\). Respondents who had either experienced CSA or ASA, or both, together comprised 59.0% of suicide contemplators \((n = 458)\), whilst comprising only 47.5% of noncontemplators \((n = 183)\). In contrast, respondents who had never experienced sexual assault comprised only 41.1% of suicide contemplators \((n = 319)\), whilst comprising 52.5% of noncontemplators \((n = 202)\). Inspection of the standardised residuals (SRs) showed that respondents who had experienced both CSA and ASA were significantly overrepresented amongst suicide contemplators \((SR = 2.2)\), and underrepresented
amongst noncontemplators (SR = -3.1). Conversely, respondents who had never been sexually assaulted were significantly overrepresented amongst noncontemplators (SR = 2.2).

**Frequency of suicidal ideation across the lifespan**

A one-way between-groups analysis of variance was conducted to examine the impact on frequency of suicide contemplation of sexual abuse that had occurred either in childhood or adulthood, in both life periods, or never. Four victim groups were compared: (i) not sexually victimised (NSA); (ii) victim of SA in childhood only (CSA); (iii) victim of SA in adulthood only (ASA); and (iv) victim of both CSA and ASA (CSA-ASA).

Mean suicidal ideation frequency differed significantly as a function of sexual victimisation, $F(3, 1158) = 17.06, p < .0005$, partial $\eta^2 = .04$. Post-hoc comparisons, using Hochberg’s GT2 test for unequal sample sizes, revealed a number of significant differences between groups. Specifically, the CSA-ASA group reported significantly higher mean frequency of suicidal ideation ($M = 3.48, SD = 1.75$), relative to each of the other groups (NSA: $M = 2.55, SD = 1.59$; CSA: $2.96, SD = 1.67$; ASA: $M = 2.67, SD = 1.63$). Additionally, the CSA group reported significantly higher mean frequency of suicidal ideation, relative to the NSA group.

**5.3.19 Sexual Assault Distress Symptomology and Suicidality**

**Suicide attempt and sexual assault distress**

A one-way between-groups multivariate analysis of variance was performed to examine differences in sexual assault symptoms between respondents who had attempted suicide and those who had not. Four subscales of the Sexual Assault Symptom Scale (SASS) formed the dependent variables used to assess sexual assault distress: (i) safety fears; (ii) self-blame; (iii) disclosure shame; and (iv) depression subsequent to sexual assault.

A statistically significant difference was found between suicide attempters and nonattempters on the combined dependent variables, $F(4, 562) = 39.53, p < .0005$, Wilks’ $\Lambda = .78$, partial $\eta^2 = .22$. When the results for the dependent variables were considered separately, significant differences were found in each of the four dependent variables, using a Bonferroni adjusted alpha level of .01: depression subsequent to sexual
assault, $F(1, 565) = 157.40, p < .0005$, partial $\eta^2 = .22$; disclosure shame, $F(1, 565) = 47.23, p < .0005$, partial $\eta^2 = .08$; safety fears, $F(1, 565) = 44.47, p < .0005$, partial $\eta^2 = .07$; and self-blame, $F(1, 565) = 32.08, p < .0005$, partial $\eta^2 = .05$.

Inspection of the mean scores indicated that suicide attempters reported greater depression subsequent to sexual assault ($M = 6.82, SD = 4.14$) than nonattempters ($M = 2.76, SD = 3.41$), greater disclosure shame ($M = 12.93, SD = 6.71$) than nonattempters ($M = 8.88, SD = 6.71$), more safety fears ($M = 7.60, SD = 4.91$) than nonattempters ($M = 4.84, SD = 4.60$), and higher levels of self-blame ($M = 10.47, SD = 4.64$) than nonattempters ($M = 8.01, SD = 5.12$).

**Suicidal ideation occurrence and sexual assault distress**

A one-way between-groups multivariate analysis of variance was also performed to examine differences in sexual assault distress symptoms between respondents who had seriously contemplated suicide and those who had not. A statistically significant difference was found between suicide contemplators and noncontemplators in overall sexual assault distress, $F(4, 575) = 31.48, p < .0005$, Wilks’ $\Lambda = .82$, partial $\eta^2 = .18$. When the results for the SASS subscales were considered separately, significant differences were found in each of the four dependent variables, using a Bonferroni adjusted alpha level of .01: depression subsequent to sexual assault, $F(1, 578) = 124.34, p < .0005$, partial $\eta^2 = .18$; disclosure shame, $F(1, 578) = 29.46, p < .0005$, partial $\eta^2 = .05$; safety fears, $F(1, 578) = 19.74, p < .0005$, partial $\eta^2 = .03$; and self-blame, $F(1, 578) = 23.99, p < .0005$, partial $\eta^2 = .04$. Inspection of the mean scores indicated that suicide contemplators reported greater depression subsequent to sexual assault ($M = 5.27, SD = 4.20$) than noncontemplators ($M = 1.47, SD = 2.38$), greater disclosure shame ($M = 11.20, SD = 7.01$) than noncontemplators ($M = 7.81, SD = 6.45$), more safety fears ($M = 6.37, SD = 4.86$) than noncontemplators ($M = 4.42, SD = 4.70$), and higher levels of self-blame ($M = 9.51, SD = 4.85$) than noncontemplators ($M = 7.29, SD = 5.31$).

**Suicidal ideation frequency and sexual assault distress symptomatology**

The relationship between current overall sexual assault distress symptomatology and frequency of suicidal ideation over the lifespan was examined using Pearson product-moment correlation coefficient. A moderate, positive correlation existed between the two
variables, \( r = .48, \ n = 564, \ p < .0005 \), with higher lifetime frequency of serious suicidal ideology associated with greater sexual assault distress symptomatology. Calculating the coefficient of determination \( (r^2) \) revealed 22.85% shared variance between lifetime suicidal ideation and overall symptomatology.

Relationships between individual sexual assault distress subscales and suicidal ideation frequency were also examined. A strong, positive correlation existed between depression subsequent to sexual assault and frequency of suicidal ideation, \( r = .62, \ n = 612, \ p < .0005 \), with higher frequency of serious suicidal ideation over the lifespan associated with greater depression. Moderate, positive correlations existed between disclosure shame and suicidal ideation frequency, \( r = .33, \ n = 593, \ p < .0005 \); and safety fears and suicidal ideation frequency, \( r = .30, \ n = 612, \ p < .0005 \); with higher frequency of lifetime suicidal ideation associated with greater disclosure shame and safety fears. A small, positive correlation existed between self-blame and suicidal ideation, \( r = .29, \ n = 607, \ p < .0005 \), with higher frequency of serious suicidal ideation over the lifespan associated with greater self-blame.
5.4 Discussion

5.4.1 Overview

Building on Studies 1 and 2, it was the purpose of the third study to extend the examination of sexual abuse across a number of domains. Victim appraisals were sought with respect to sexual offence typology, perpetrator modus operandi, offence processes and impact, and victim resistance strategies. The study comprised both quantitative and qualitative analyses pertaining to these domains and to characteristics of the incident identified by victims as their ‘most serious sexual assault’. Given the salience of perceptions of events in determining wellbeing, investigation of such perceptions is important. Specifically, analyses of both victim perceptions and offender practices can afford potentially valuable data that are able to inform both prevention and intervention initiatives directed toward sexual violence and broader issues of mental health and suicidality. Surprisingly, to date, no known research has similarly concentrated on overt self-appraisal or introspection in relation to wellness, perturbation, resistance strategies, and sexual abuse impact, nor sought the opinion and perceptions of victims in relation to offender and offence variables. This discussion presents an integrated examination of the findings of the third study, such that results are considered within the context of those deriving from the previous studies (Studies 1 and 2), to enable holistic conceptualisation and comparative comment.

Findings from this study consolidated and extended many of the findings of the first and second studies, evidencing the profound, negative health effects concomitant with sexual violence, the often protracted nature of such effects, and the starkly apparent patterns of revictimisation frequently coexistent with sexual abuse. Specifically, strong associations found in Studies 1 and 2 between CSA histories and sexual victimisation in adulthood were found to exist also with respect to intimate partner violence (IPV), with elevated experience of IPV found amongst CSA victims and ASA victims, and highest occurrence of IPV found in individuals who had experienced both childhood and adulthood sexual abuse.
5.4.2 Gender Differences in Sexual Victimisation and Offending Propensity

With respect to gender disparity in relation to sexual victimisation, the current findings are broadly consistent with a large body of literature that demonstrates much lower rates of sexual abuse amongst males, relative to females (e.g., ABS, 2005b; AIC, 2008; Boudreaux & Lord, 2005; Finkelhor, 1994a, 1994b; Krug et al., 2002; Lievore, 2003; Mouzos & Makkai, 2004; Smith et al., 2003). In overall terms, sexual abuse appeared markedly less common amongst males, with females reporting twice the level of sexual abuse confined to adulthood, and three times the level of sexual victimisation experienced in both childhood and adulthood. Further, findings deriving from the current sample suggest a lower propensity for male CSA victims to be sexually revictimized in adulthood, relative to female CSA victims. Notably however, this pattern was not evident with respect to CSA per se, such that little gender difference was found in relation to sexual abuse confined to childhood.

Whilst these findings appear to reflect important gender differences with implications for treatment and prevention of sexual abuse and revictimisation, cautious interpretation of such figures is warranted. Consideration should also be given to the extent to which such findings may reflect (i) artefacts of sampling; (ii) relatively greater willingness of females to disclose and participate in research; and conversely, (iii) a greater reluctance amongst males to acknowledge or disclose sexual abuse (particularly that which is experienced in adulthood) (Crome, 2006; Good et al., 2000; Griffiths, 2003; Hunter, 1990b; Mezey & King, 1989, 2000; Neame & Heenan, 2003; Stott, 2001; Walker et al., 2005; Worth, 2003); (iv) additional rape myths, stereotyped notions, misconceptions, and systemic challenges facing male sexual abuse victims; and (iv) the more generable extant barriers encountered by males with respect to help-seeking and disclosure that may connote weakness, emasculation, or other traits incongruent with stoicism and other perceived-desirable attributes of masculinity (Good et al., 2000; Möller-Leimkuhler, 2003; Smith & Stewart, 2008; Stewart & Smith, in press-a).

In relation to sexual offence perpetrators, the findings are also consistent with the literature, such that the overwhelming majority of sexual abuses reported by individuals in the current studies were perpetrated by males (Denov, 2004; Finkelhor & Russell, 1984; Grayston & De Luca, 1999; Krug et al., 2002; SAC, 2007a, 2007b; Sanderson,
2004; Smith & Stewart, 2008; Ullman, 2004; Wakefield & Underwager, 1991; Wakefield et al., 1990). Nonetheless, the findings equally attest to the occurrence of female-perpetrated sexual abuse amongst sizable minorities of victims, suggesting that such abuse is not as statistically rare as continues to be popularly believed, particularly amongst male children and adults, but also amongst females. Indeed, more than one in four male ASA victims, almost one in five male victims of CSA, and around one in ten female victims of sexual abuse identified a female perpetrator. These findings support recent research demonstrating that, whilst female-perpetrated sexual abuse is even more likely subject to taboo and under-reporting than male-perpetrated violence, females are capable of, and responsible for, appreciable numbers of sexual abuses (Denov, 2004; Finkelhor, 1979; Finkelhor & Russell, 1984; Glasser et al., 2001; Grayston & De Luca, 1999; Lisak, 1994; Sanderson, 2004; Smith & Stewart, 2008; Wakefield & Underwager, 1991; Wakefield et al., 1990). Notably, some victims identified both a male and a female perpetrator, and sadly, qualitative data indicated that for some child victims, this signified sexual abuse jointly perpetrated against them by both parents. The reality that the minority of victims experience female-perpetrated sexual abuse should not overshadow nor minimise the experience and impact of such abuse. Indeed, attention should be directed to the specific and additional sequelae that can ensue from female-perpetrated sexual abuse, and the pressures to hide such abuse, such as emasculation, ridicule, and shame, stigma, disbelief, and taboo compounding that which commonly accompanies other sexual abuse forms.

5.4.3 Chronicity of Abuse

Both quantitative and qualitative findings from the current study acutely underpinned the entrapment and chronicity of abuse experienced by many victims of sexual violence, particularly those incestuously perpetrated against in childhood, and those for whom abuse occurred within the context of intimate partnerships. Whilst many individuals reported leaving the perpetrator within minutes or hours of the assault, findings demonstrated the degree to which distancing oneself from the perpetrator is frequently fraught with difficulties, and often rendered untenable, particularly in cases where abuse occurs in childhood or in the context of intimate or dependent relationships and families.

Indeed, in cases of CSA perpetrated within families, distancing from the perpetrator/s is rarely a tenable option for the child. Such entrapment was repeatedly evidenced in the
findings, with many victims of CSA describing a chronicity of abuse that hallmarked their childhood and ceased only when they were able to extricate themselves from the family home. Sadly however, for such individuals, it was common to encounter further multiple abuses in adulthood. These findings are consistent with previous research relating to female revictimisation, in demonstrating a higher propensity for experiencing sexual and intimate partner violence in adulthood amongst victims of CSA, relative to nonvictims (Beech et al., 2009; Breitenbecher, 2001; Cloitre, 1998; Kendall-Tackett, 2005; Marx, 2005). Further, the current findings extend the revictimisation literature through the inclusion of a male sample. Notably, whilst males and females reported similar rates of CSA, females were three times more likely to report sexual revictimisation in adulthood. This phenomenon can likely be explained by the fact that adult males are ostensibly less vulnerable relative to adult females, to fall prey to male perpetrators through factors of proximity (such as heterosexual dating relationships and intimate partnerships) or overt power imbalance (such as gender-based physical strength and size differences). In contrast, male children are as vulnerable as are female children to sexual predation and other abuses. Nonetheless, whether revictimisation in adulthood truly occurs to far lesser degrees amongst males relative to females, or rather, whether these findings reflect artefacts of sampling or male reticence to report ASA remains to be clarified by future research.

Notable also within the data, were the many individuals (predominantly, but not exclusively females) who remained for many years, and often decades, in relationships with sexually abusive partners. It was particularly concerning to note the use of the present tense by some individuals in describing their abuse circumstances and to note that, amongst those who had identified the perpetrator as having been a current partner, a minority of respondents reported still being in a relationship with this person. Whilst it was beyond the scope of the present study to elucidate the reasons why some respondents remain in the present in an abusive relationship, it is known from the extant literature that fear of reprisal, impoverished self-esteem and sense of self-worth, self-blame, shame and pride, partner domination, and enduring partner loyalty and hope for positive change are commonly instrumental in inhibiting disclosure and departure from violent or otherwise abusive partnerships (Smith & Stewart, 2008; WHO, 2001, 2005b).
5.4.4 Disclosure, Help-Seeking, and Sexual Abuse Impact

The findings of this study lend further credence to those deriving from Studies 1 and 2, demonstrating that persons experiencing sexual abuse commonly perceive multiple barriers to police reporting; rarely report their abuse; and rarely receive adequate professional support; yet commonly experience extreme distress and far-reaching problems that they attribute to their sexual abuse, and often experience additional (nonsexual) violence and crimes perpetrated by the abuser. Specifically, it was found that self-reproach, shame, guilt, and the experience of multiple regrets, commonly related to the victim’s own actions or inactions or negative attributions of self, were almost ubiquitous amongst victims of sexual abuse. Moreover, markedly greater sexual assault trauma was found amongst persons who had reported suicidality, relative to sexual abuse victims who had not experienced suicidal ideation nor made a suicide attempt. In particular, relative to nonattempters, individuals who had attempted suicide expressed greater depression subsequent to sexual assault, greater disclosure shame, more safety fears, and greater self-blame. It is salient to note these differences existed also between suicide ideators and nonideators. Indeed, a strong, positive correlation was found between depression subsequent to sexual assault and lifetime frequency of suicidal ideation, and moderate associations were found between ideation frequency over the lifespan and sexual assault distress, disclosure shame, and safety fears. Whilst the notion that sexual assault victims ‘should’ and do recover from the acute impact of their trauma in a ‘timely’ fashion (‘get over it and move on’) might represent a desirable response and a ‘convenient truth’, evidence from this study demonstrates that for many victims such recovery does not represent the truth of their experience. Instead, findings from the current study indicate that for many victims, the impact of their abuse has been profound and long lasting. The findings demonstrate that the true aftermath commonly remains unrecognised and under acknowledged in terms of severity, persistence, and breadth of impact, spanning more widely across arenas of wellbeing and functioning and persisting more widely across the lifespan than is commonly understood.

Victim-perceived causality

Whilst the current findings mirror those of Studies 1 and 2 and earlier findings in the literature in demonstrating significant associations between sexual abuse and negative health symptoms (Acierno et al., 1999; Anda et al., 2006; Browne & Finkelhor, 1986;
Dong et al., 2004; Finkelhor et al., 1990; Golding, 1999b; Krug et al., 2002; Marx, 2005; Nelson et al., 2002; Resick, 1990; Russell & Bolen, 2000; United Nations Secretary-General, 2006; van der Kolk et al., 1991, 1996; WHO & ISPCAN, 2006), the current study also extends these findings by comparing childhood and adulthood sexual abuse effects and by examining the notion of victim-perceived causality. That is, data were collected with respect to how much victims themselves attributed particular health-related variables to their experience of sexual abuse. The majority of sexual abuse victims perceived their quality of life and interpersonal relationships, their ability to trust others and conduct successful intimate relationships, and their body image, to have suffered as a function of their sexual victimisation. Almost half reported suicidal ideation, and one in five reported attempting suicide, self-attributed to their sexual abuse. Sizable minorities also attributed increased use of tobacco, alcohol, and drugs, and increased food consumption and weight gain to sexual abuse, with many respondents acutely perceiving such causal connections.

Although it is clear that statements of actual causation cannot be drawn from these data, the findings pertaining to self-attribution are important in their own right and have clear implications for victim wellbeing, autonomy, self-efficacy, and treatment needs. Entrenched core beliefs pertaining to the sense of self (e.g., perceptions of an impaired self; perceiving oneself as ‘damaged goods’) create potential pathways to self-fulfilling prophecies related to maladaptive coping responses, and potentially counterproductive fatalistic views of the self and future that in turn, fuel an impaired sense of self-efficacy and self-determination, and self-defeating behaviours. As adherence to such beliefs can maintain and foster a position of disempowerment and maladaptive identification with a ‘victim’ role, the current findings have identified areas that are potentially important to address in treatment in order to increase the individual’s sense of autonomy and control over their present and future functioning and wellbeing. Equally of course, it may be that the individual has correctly and insightfully identified causal relationships between their sexual abuse experience and particular health-related variables. These are equally important to identify both for the individual and for victim populations, in order to facilitate appropriate service provision, education, and positive management and change. Further research is warranted to ascertain whether true causal relationships can be identified, and how these, if found, can be best addressed to effect positive change.
Gender differences

Notably, impaired ability to trust others, impaired body image, and increased food consumption and body weight attributed to sexual abuse were reported more strongly by females, than males. These findings are consistent with the literature, that females, relative to males, are more prone to body image and food-related disturbances (Feldman & Meyer, 2007a, 2007b; Striegal-Moore, Wilfley, Pike, Dohm, & Fairburn, 2000). Further, the findings support previous research outcomes demonstrating an association between CSA and eating pathology (Sanci et al., 2008). Whilst in clinical settings, a causal relationship between CSA and disordered eating has long been suspected, convincing epidemiological and empirical evidence for this relationship has been sparse to date, with discrepant findings (likely the product of methodological flaws) emanating from early reviews (Sanci et al., 2008; Smolak & Murnen, 2002; Stice, 2002). The current findings (whilst not permitting a statement of causation) contribute to mounting evidence deriving from more recent and robust research (including a longitudinal cohort study) that CSA comprises a risk factor for bulimic disorders in young females (Sanci et al., 2008).

In the current study, the gender disparities found in relation to food consumption, body image, and weight are consistent with the overall findings that males, relative to females, reported less distress generally, both during their most serious sexual assault, and subsequently to their abuse (including less self-blame and fewer safety fears). Interestingly however, whilst males reported less overt distress related to sexual abuse, relative to females, no significant differences were found between male and female sexual abuse victims with respect to disclosure shame or depression subsequent to sexual abuse. These findings raise a number of questions. It may be that depressive symptoms in males were coincidental to their sexual abuse but derived from other factors. Of course, it could also be the case that males simply experienced lesser distress, relative to females in the current study.

However, evidence from Study 2 demonstrates that, although males made fewer sexual abuse disclosures than females, their expressed desire and apparent need for such disclosure was commensurate with that reported by female victims. Thus, an alternative explanation may be that males appraised their abuse as less distressing in part because they were less likely or willing to attribute negative health symptoms to sexual abuse; less
attuned to, and less able to identify and articulate their feelings and mental health status; and less prepared to recognise and admit symptomology that might connote to themselves or others signs of weakness or emasculation. Such an explanation would be consistent with previous research findings in reflecting the lower propensity amongst males, relative to females, for verbal communication of personal problems and sensitive topics, confiding, help seeking, and acceptance of succour and help services (Good et al., 2000; Möller-Leimkühler, 2003; Stewart & Smith, in press-a); and the relatively greater predilection of males, compared to females, to express distress through externalised behavioural manifestations (e.g., aggression, violence, substance abuse, risk-taking) (ABS, 2003b, 2005a, 2005b, 2005c, 2007b; Giancola, 2002; Godbout et al., 2006; Good et al., 2000; Laslett et al., 2006; Möller-Leimkühler, 2003; Stewart & Smith, in press-a; Smith & Stewart, 2008; DHS, 2007; WHO, 2004).

The current findings that males expressed no greater disclosure shame and no lesser desire and apparent need for disclosure, relative to females, and yet less frequently made disclosures of sexual abuse, suggest the presence of additional factors acting to impede such disclosure amongst males. In particular, evidence from the current and previous research supports the contention that fear of displaying emotions that might be construed as signs of weakness or unmanliness can actively and frequently inhibit male disclosure of sensitive material or engagement in therapy. Such findings have practical applicability to clinical practice and are able to gainfully inform therapeutic protocols. Specifically, in therapeutic contexts, mindful consideration should be given to the likely reality that pressures faced by males to adhere to gender role expectations will compound presenting problems and pressures emanating from the presenting problem itself, potentially impeding or thwarting therapeutic engagement, development of the therapeutic relationship, and progress in treatment.

Cumulative effects of sexual abuse

It is known from the extant literature that revictimisation is frequently experienced by victims of sexual abuse, particularly by those who experience such abuse in childhood (Beech et al., 2009; Breitenbecher, 2001; Cloitre, 1998; Kendall-Tackett, 2005; Marx, 2005; Sanderson, 2004; VLRC, 2003, 2004). This study showed that the psychological damage experienced through repeated victimisation is cumulative in nature. Specifically,
current findings evidenced strong cumulative effects, such that individuals sexually violated in both childhood and adulthood fared significantly worse in terms of psychological wellbeing, sexual assault distress, and suicidality, relative to those whose abuse was confined to either childhood or adulthood. Indeed, relative to individuals who had experienced either CSA or ASA, those who had experienced both childhood and adulthood sexual abuse evidenced higher disclosure shame, safety fears, and depressive symptomology subsequent to sexual abuse. Moreover, such individuals reported significantly greater stress and sexual abuse-related self-blame than individuals sexually abused in childhood only, and lower general life satisfaction than those whose sexual abuse was confined to adulthood. In turn, individuals who had experienced sexual abuse only in adulthood expressed higher sexual abuse-related self-blame, relative to those who had experienced sexual abuse only in childhood.

Further, relative to both nonvictims of sexual abuse and individuals who had experienced either CSA or ASA, those who had experienced both childhood and adulthood sexual abuse evidenced higher current depression, anxiety, shame, guilt, and posttraumatic symptomology. Yet, it is pertinent to note that when individuals who had experienced both childhood and adulthood sexual abuse were removed both from the group of CSA victims and the group of ASA victims, these groups no longer differed significantly from nonvictims with respect to current depression, anxiety, shame, guilt, stress, aggression, or life satisfaction. This finding extends those of Studies 1 and 2 that showed pervasive health differences between CSA victims and nonvictims, and ASA victims and nonvictims, respectively. Importantly, this finding appears to signify not only the strong, cumulative negative impact of repeated sexual victimisation, but conversely, also a substantially healthier prognosis for both victims of childhood sexual abuse for whom adulthood revictimisation does not occur, and for victims of ASA without histories of childhood sexual victimisation. Such findings augur well for victims of sexual abuse who are well supported and receive appropriate and timely intervention and for whom revictimisation does not occur. Moreover, these findings proffer sound indications of the importance of educative prevention and intervention approaches that focus on insight development, risk perception, and education surrounding cycles of victimisation and revictimisation vulnerabilities as strategies for ‘revictimisation inoculation’ and empowerment of victims and would-be victims.
Nonetheless, these findings are tempered by data pertaining to suicidality and sexual abuse. A clear hierarchical pattern was evident such that highest suicidality (measured in terms of attempt, ideation occurrence, and ideation frequency) was found amongst individuals who had experienced both childhood and adulthood sexual abuse, followed by those who had experienced sexual abuse in childhood only. Whilst suicidality amongst individuals who had experienced sexual abuse in adulthood only was also elevated, relative to nonvictims, this disparity was less pronounced. The finding that individuals who had experienced sexual abuse only in childhood reported higher depressive symptomology subsequent to sexual assault, relative to those who had experienced sexual abuse only in adulthood, is consistent with these results. In combination, these results represent important findings demonstrating that early sexual boundary violation places individuals at increased risk of vulnerability across multiple psychological domains, including suicidality. This is consistent with extant knowledge in the field of developmental psychology that identity and self-esteem are not fully formed in childhood and hence, more vulnerable to damage in early life, and similarly, that resources for resilience remain underdeveloped and thus, more easily exhausted in the context of early trauma (Cicchetti & Rogosh, 1997; Dayton, 2007; Luthar, 2003; Luthar et al., 2000; van der Kolk, 2003; van der Kolk et al., 1991, 1996; Yawkey & Johnson, 1988).

Presence of ‘positive’ sexual abuse sequelae
Within the context of overwhelmingly negative sequelae to sexual abuse, it was evident from the findings of this study that many individuals were also able to acknowledge the presence of limited ‘positive’ sequelae. Most respondents perceived they had become a stronger person, increased their understanding of others, and ‘learned a lot’, as a consequence of their abuse. Interestingly, females more strongly endorsed these perceptions, relative to males. Similarly to the issues raised concerning the gender differences reported earlier, the degree to which these findings signify gender differences with respect to victim reactions and impact of sexual abuse per se, or rather, differences in how males and females appraise sexual abuse and related outcomes, remains open to conjecture, and may be useful to investigate in future research.

Further, it remains to be determined whether such differences may signify more general gender differences, with respect to adaptive coping mechanisms and variables such as
cognitive appraisal, reframing, introspection and reflection (or equally, denial and repression). If this were the case, these findings would be consistent with those in the literature (and cited earlier) that males, relative to females, exhibit lower proclivity for adaptive coping mechanisms (such as personal disclosure and communication; help-seeking; and help-acceptance) that likely engender positive outcomes; and higher propensity for denial, repression, and maladaptive coping strategies (Good et al., 2000; Möller-Leimkühler, 2003; Stewart & Smith, in press-a). Given that such differences may explain, at least in part, the higher vulnerability of males for completed suicide, substance abuse, and other high-risk behaviours, and the higher propensity for males to externalise their perturbation by acting out violently toward the self and others (ABS, 2003b, 2005a, 2005b, 2005c, 2007b; Giancola, 2002; Godbout et al., 2006; Good et al., 2000; Laslett et al., 2006; Möller-Leimkühler, 2003; Stewart & Smith, in press-a; Smith & Stewart, 2008; Victorian Department of Human Services, 2007; WHO, 2004), further research in this area is warranted.

Irrespective of such considerations and apparent differences across gender, it remains that findings pertaining to ‘positive’ outcomes of sexual abuse (and indeed, other traumatic events) are relatively scarce in the literature, and yet, are able to gainfully inform therapeutic protocols, particularly those concerned with redressing negative emotions, shame, self-deprecation, and maladaptive perceptions pertaining to the event, the self, and the future. Specifically, such findings are relevant to interventions directed toward adaptive reframing and challenging of negative self-dialogue, therapeutic processing of the abuse (or other traumatic event) and its impact, finding ‘meaning’, development of insight, inoculation training against revictimisation, and rebuilding of self-esteem, self-efficacy, dignity, and confidence. The current findings contribute new information to the sexual abuse and trauma literatures by documenting self-reported ‘positive’ outcomes of sexual abuse trauma not previously collated from male and female victims of CSA and ASA.

5.4.5 Commonalities Among Incidents of Sexual Abuse

It was equally informative to examine victim perceptions with regard to commonalities between separate sexual assaults. Perpetrator use of verbal coercion and victims having felt ‘too embarrassed or shy to stop the person’ were the most frequently cited commonalities, reported by the majority of respondents. Clearly, it would be simplistic
and erroneous to assume that such factors alone were instrumental in allowing the abuse to occur, and that therefore, to address these would proffer protection against all sexual abuse.

Countless abuses occur, and will continue to occur, irrespective of any action or inaction taken by the victim. The topic of rape preventive education and advice remains, despite repeated investigation and consideration, to be controversial, dichotomous, and subject to sizable academic and community debate and confusion (Bachar & Koss, 2001; Breitenbecher, 2000b; Breitenbecher & Gidycz, 1998; Breitenbecher & Scarce, 1999; Prentky et al., 1986; Rozee & Koss, 2001; Ullman, 1998, 2007). For example, it is known from the literature, and confirmed by the findings of this study, that victim passivity and ‘compliance’ in many cases of sexual abuse and intimate partner violence comprise a critically important survival strategy, proffering protection against an escalation of violence and potentially lethal outcome (Davies & Mouzos, 2007; Krug et al., 2002; Mouzos & Makkai, 2004; Mouzos & Segrave, 2004).

Conversely, empirical evidence exists that forceful physical and verbal victim resistance matched to the approach of the perpetrator does not escalate perpetrator violence and instead, can be efficacious in lowering the probability of rape completion (Bachar & Koss, 2001; Clay-Warner, 2002; Ullman, 1997, 1998, 2007; Ullman & Knight, 1991, 1992, 1993, 1995; Zoucha-Jensen & Coyne, 1993). However, other research and crime statistics demonstrate that aggression, active resistance, or initiation of protest actions by victims (e.g., attempted relationship departure and dissolution; instigation of legal pathways such as seeking AVOs or Intervention Orders [IOs]) can markedly escalate violence and increase the danger and potential for lethality to which they are exposed (Campbell, 1992; Coleman, 1997; Davies & Mouzos, 2007; Janssen et al., 2005; Krug et al., 2002; La Violette & Barnett, 2000; Logan & Walker, 2004; McFarlane, 2004; McFarlane et al., 1995, 1999, 2000, 2002a, 2002b, , Mechanic et al., 2008; Meloy, 1998, 2000; Mouzos & Makkai, 2004; Mouzos & Segrave, 2004). Thus, to advocate aggressive, active resistance (or any other ‘blanket’ response) by all victims is clearly fraught with complications, potentially dangerous, and certainly counter to the intention of the author. Further, to assume the ‘victim-blaming’ approach of suggesting that victims are responsible for, or even ‘deserving’ of, their abuse as a function of their action or specific inaction is similarly diametrically opposed to the intention of the author.
Within the context of such caveats however, it is contended that empowering of victims and potential victims of sexual and intimate partner violence is an important goal, with the potential to effect pivotal positive change. Thus, in alignment with the credo that knowledge affords power, it is important that prevention approaches impart empirically derived information and incorporate such information in initiatives to maximise awareness and insight surrounding sexual abuse processes and risk, and abilities to perceive and minimise risk in ‘real life’ settings. Findings such as those deriving from this study with respect to commonalities across abuse settings (e.g., alcohol fuelled) and perpetrator strategies (e.g., coercive, inveigling, manipulative, forceful) can assist in providing information to achieve this end. Amongst victims themselves, the process of identifying patterns and commonalities can in itself foster insight, feelings of empowerment, and increased understanding of offending processes and possible ways of circumventing further abuses. Feedback received from some respondents reflected such beneficial outcomes. For example, raised awareness of the multiple strategies that can be employed in the process of sexual predation allowed some victims to reconceptualise their own abuse objectively in terms of the overt and deliberate strategies used against them. In turn, increased awareness of offending processes and strategies (including specific understanding of how they had fallen prey to particular strategies) led such respondents to appraise their abuse in less personalised, self-denunciating, and self-blaming ways.

In seeking to assist sexual abuse victims and minimise risk of revictimisation, victim-centred variables (e.g., fear, embarrassment, unassertiveness) are clearly more easily addressed and amenable to direct change than external factors such as perpetrator-centred variables and seemingly immutable offence characteristics (e.g., perpetrator use of physical force, perpetrator alcohol and drug use). Nonetheless, victim awareness and understanding of common offender practices and risk factors is necessary in order to optimise skills in the perception, assessment, and minimisation of risks (e.g., propensity for alcohol to fuel violence; alcohol-induced victim vulnerability), risky behaviours (e.g., accepting lifts), and risky settings (e.g., isolation; aloneness with potential perpetrators). Of the respondents who had experienced more than one incident of sexual abuse, almost half reported that physical force had been used on more than one occasion, and that the incident had occurred repeatedly in the same location. One in three respondents cited
repeated perpetrator alcohol or drug use, and one in four reported their own use of alcohol on more than one occasion.

These findings are consistent with the literature in evidencing the robust associations between alcohol and violence of all forms, the strong relationship between perpetrator alcohol use and sexual violence proclivity, and the acutely heightened vulnerability for sexual victimisation conferred by victim alcohol and substance use. Interestingly, of the commonalities across multiple sexual abuse incidents cited by victims, only one differed significantly by gender. Males, relative to females, were significantly more likely to report on more than one occasion feeling ‘too embarrassed or shy to stop the person’. This finding exemplifies the acute conflict and perturbation commonly experienced by male victims in reconciling notions of masculinity and gender role expectations and stereotypes with sexual abuse and subjugation (Good et al., 2000; Möller-Leimkühler, 2003; Stewart & Smith, in press-a).

5.4.6 Victim Resistance Strategies

Wide divergence of opinion was evident amongst respondents with respect to perceived utility of victim resistance strategies. Many responses were illustrative of the value, for some individuals, of passive avoidance strategies, nonconfrontational deterrence, delay and distraction tactics, and summoning of external assistance, and thus, encouraging of the notion that victims can, at least sometimes, achieve a level of control over the outcome of their abuse. Yet, such notions are tempered by the many responses that equally attested to the futility of resistance attempts and the powerlessness of many individuals to alter the course of their victimisation. Moreover, salutary messages of caution are also conveyed by findings that many actions taken by individuals in their attempts to counter and thwart sexual abuses had the potential to effect both positive and negative outcomes, minimising harm for some victims, yet worsening the abuse for others (e.g., violence escalation). Such findings highlight and exemplify the inherent difficulties and potential risks attached to presenting generic ‘advice’ or preventive guidelines in relation to sexual abuse.

Indeed, the substantial ambivalence and diversity of opinion reflected in victim appraisals pertaining to resistance strategies preclude the drawing of definitive conclusions. Accordingly, it would be imprudent to offer strong directional comment or
recommendations formed on the basis of such mixed findings, since the most prominent and consistent finding is that most, if not all, of the examined strategies appear to have the potential for both positive and negative outcomes. Notwithstanding such caveats, a number of themes are suggested by the current findings. With respect to perpetrator-targeted approaches, findings suggest that nonconfrontational, calm approaches that are able to be implemented safely, that is, without risk of escalating violence and assault, likely have the greatest potential for beneficial outcome. Specifically, strategies such as delay and distraction appear to have had beneficial effects for many victims without adding undue risk of further harm. This is encouraging given that other nonforceful resistance (e.g., crying, pleading) and lack of resistance (e.g., immobility or ‘freezing’) have been related to higher odds of rape completion (Ullman, 1997, 2007).

Conversely, strong, overtly confrontational approaches such as the use of physical defence; screaming; and verbal threats, and warnings, whilst beneficial for a sizable minority of respondents, should be employed with caution, given evidence from the current study that such tactics more often resulted in negative (rather than positive) outcomes, and specifically, given the potential for such tactics to escalate violence and aggression and thereby increase harm to the victim. Such risk is evidenced by findings that respondents were almost twice as likely to report a negative, rather than a positive, outcome from screaming; that over half of respondents who used physical defence reported a negative outcome, in contrast to only one third who reported a positive outcome; and that respondents were fairly evenly divided in their appraisal of the use of threats and warnings.

These results challenge earlier findings in the literature that forceful resistance matched to the offender’s approach can effectively avert rape or minimise assault severity without elevating risk of physical injury or negative outcome (see Ullman, 1997, for review; see also Clay-Werner, 2002; Ullman, 1998, 2007; Zoucha-Jensen & Coyne, 1993). It is salient to note that such findings have commonly derived from a limited number of police-reported rapes (e.g., Zoucha-Jensen & Coyne, 1993) and unreported rapes documented in victimisation studies (e.g., Clay-Werner, 2002), with unknown generalisability to all sexual attacks, particularly those perpetrated within the most intimate and hidden of settings. Importantly, it should be noted that some of the most severe intimate partner abuses will unlikely be captured in such data due to nonreporting resultant from fear of
perpetrator reprisal or indeed, because the victim is deceased. The current findings contribute to the literature by capturing data from a broad range of male and female sexual abuse victims, varying widely in terms of abuse severity and type (e.g., penetrative, nonpenetrative, CSA, ASA, IPV), and perpetrator typology and modus operandi.

In terms of strategies external to the perpetrator, getting help or raising alarm shows the most promise for improved outcome with comparatively low risk of adverse effects. Whilst escaping or hiding was also beneficial for one third of respondents, it must be noted that a larger proportion of respondents reported adverse effects from the use of such an approach. Finally, the finding that all but three of the strategies were perceived, by at least half of the respondents who had utilised them, as having made no difference, reflects the perceived futility of resistance, powerlessness, and low locus of control experienced by many individuals in regard to sexual abuse.

Qualitative responses mirrored the divided opinion expressed through the quantitative data with respect to utility of resistance strategies, evidencing both the relative successes experienced by children and adults in their attempts to counter and thwart sexual abuses, and the futility perceived by many victims in relation to any efforts to prevent their abuse. Many qualitative responses attested to the value of various manifestations of passive avoidance, nonconfrontational deterrence, delay, and distraction, and to the notion that many victims are able to assume at least some degree of control in the course of their abuse, effecting some degree of harm minimisation.

However, tempering these optimistic responses were the many evocatively conveyed messages describing the powerlessness experienced by many victims of CSA and ASA to avert the course of their abuse. Amongst such responses were those that overtly expressed the sense of being internally hampered in thwarting sexual abuse, through a profound sense of inadequacy, worthlessness, depression, or other ‘internal’ vulnerabilities. In the context of these findings, it is salient to note that many victims also expressed the strong view that passivity, compliance, and overt and total lack of resistance or retaliation were critical to their survival. Thus, it is precisely through ostensibly assuming a position of ‘powerlessness’, passivity, and inaction, that victims assumed pivotal power and control over their destiny and survival. Far from defeat, weakness, and grounds for shame and blame, such stances of ‘inaction’ signify successful
application of survival ‘tactics’ on many levels. Yet, many victims are plagued by self-reproach, shame, and guilt in relation to their apparent inaction and compliance.

Such perceptions are particularly common and entrenched for victims of CSA, given that many child victims are actively shamed, blamed, and besmirched by perpetrators for purposes of ensuring secrecy and preserving the clandestine nature of the abuse. It follows that victim appraisals of apparent ‘inaction’ (and actions) can gainfully be used in therapeutic settings to challenge and assist in reframing notions of self-blame, shame, and guilt pertaining to both CSA and ASA. Similarly within research arenas, measurement of victim appraisals, perceptions, and attributions are a potentially rich source of information that to date, remain underexamined and incompletely understood, particularly in the context of wellbeing, interpersonal functioning, intimate relationships, sexual functioning, and risk for future victimisation. Such areas can be further fruitfully examined through future research. For example, it may be beneficial, both within academic and therapeutic settings, to explore the extent to which guilt and self-reproach in relation to self-appraised ‘wrong’ or incompetent resistance efforts impacts on victim wellbeing.

It was also illuminating to ask victims to nominate retrospectively which single strategy (if any) they believed would have bettered the outcome of their sexual abuse. Notably, one in three victims perceived that ‘nothing’ would have aided their situation. However, the views of the majority reflected widely divergent and strongly held beliefs regarding this topic. Prominent themes emerged centring on the perceived benefits of assertive responses toward the perpetrator; clear and firm communication; disclosure and help-seeking (particularly in relation to CSA); departure from abusive relationships; avoiding positions and situations of vulnerability (particularly intoxication and being alone with a potential perpetrator); attracting attention and raising alarm; and ‘fighting back’ more strongly.

Whilst some of these retrospective considerations appear to reflect increased insight and adaptive, rational, and reasoned thought surrounding harm minimisation (e.g., help-seeking, disclosure, leaving abusive relationships), others (such as ‘fighting back more strongly’) may reflect less adaptive thinking and guilt or shame regarding ‘inaction’ and ‘compliance’. Indeed, some individuals overtly expressed the view that ‘fighting back’,
even at the risk of escalating violence and incurring additional physical harm, would have been preferable to the guilt and shame ensuing from their belief that they had ‘consented’ to, or ‘complied’ with their abuse and were thus, complicit and blameworthy. Such responses exemplify the integral connection between victim attributions (particularly in relation to the self) and subsequent wellbeing. For others, expressed wishes to have reacted aggressively and with physical violence reflected a strong sense of enmity and animosity toward the perpetrator (generalised in some cases, to all males). Clearly, the high level of violent sentiment conveyed by numerous responses in regard to the perpetrator and in some cases, also toward the self, and the beliefs and perceptions underlying such sentiments, have important implications for clinical practice and both victim and perpetrator wellbeing. The level of shame, guilt, and anger carried and expressed by many respondents at palpable levels provides an index of the ongoing distress and debilitation commonly experienced by victims, that for many is unlikely to resolve without professional assistance. In terms of implications for perpetrator and victim wellbeing, it is clear that victim enmity, animosity, and wish for violent and severe retribution toward perpetrators carries potential for serious negative consequences for both parties.

Finally, it is noteworthy that the responses gleaned in relation to resistance strategies, by definition, reflect the experiences and perceptions of victims. It would be of value to also examine in future research the use and value of resistance strategies amongst persons who have averted sexual attacks, and to compare the perceptions and outcomes of victims and ‘would-be’ victims (i.e., victims of attempted and thwarted sexual abuse). It would also be of interest to compare the perceptions of victims and would-be victims with those of their perpetrators to examine the degree to which they concur. Further, it would be useful to ask perpetrators themselves what victim strategies and other factors would have averted or changed the course of their assaultive behaviours. Such research would likely proffer information of practical value to clinical practice and prevention initiatives.

5.4.7 Victim Regrets

More than half of sexually victimised respondents expressed regrets in relation to their actions or inactions surrounding their abuse. Amongst myriad regrets, dominant themes emerged, identifying areas of regret that were common to many victims. Amongst the
most commonly recurring themes were those pertaining to internal, rather than external, factors. Common victim regrets pertained to perceived ‘flaws’ and personal traits such as perceived unassertiveness, ‘stupidity’, and naïveté, unhealthy conceptualisations of self, and being overly trusting.

In terms of victim behaviours and inactions (both at the time of the abuse, and subsequently), common regrets pertained to victim alcohol consumption, engagement in risk behaviours (e.g., accepting lifts), failure to have ‘fought back’ more strongly, failure to leave abusive relationships, failure to disclose (particularly in relation to childhood sexual abuse), failure to report to police, and failure to seek therapy. Specifically, the commonly expressed regrets of nondisclosure, and of not reporting the abuse to police, were often founded in guilt or fear that, in the absence of police or other intervention, such inaction may have allowed the perpetrator to continue to offend with impunity, and thus, caused harm to others. Notably, myriad expressed regrets (particularly pertaining to childhood sexual victimisation) similarly and poignantly convey the harmful corollaries of secrecy and taboo. Recurrent sentiments were equally powerful in conveying the power and adeptness of perpetrators to silence their victims and exploit childhood qualities, vulnerabilities, and sensibilities of trust, ‘goodness’, and concern for others. As noted previously, ongoing programs to educate parents, caregivers, and children regarding the need for disclosure and supportive responses toward victims are necessary in order to evoke positive changes to the culture awaiting future generations. Similarly, for victims of past abuses, a culture that is permissive and supportive in relation to disclosure and breaking of taboos creates opportunities for discourse that is both empowering and therapeutic for victims and able to circumvent further abuses and interrupt cycles of violence.

Whilst the majority of regrets pertaining to sexual abuse were grounded on perceived personal shortcomings (both traits and behaviours), some individuals also expressed regrets in relation to innocuous or ‘neutral’ actions (e.g., ‘If I hadn’t gone to TAFE, it wouldn’t have happened’) and those considered intrinsically ‘good’ (e.g., rendering assistance to another).

Many regrets pertaining to abuse within intimate relationships reflected the perceived powerlessness of victims to effect positive change; the impeding effects of personal
attributes in victims’ capacity to leave abusive relationships; and ultimately, the fact that
departure from the relationship was not effected sooner. Specifically, commonly
expressed sentiments in regard to intimate relationships reflected the power of the
perpetrator to exploit victim qualities (e.g., trust, loyalty, nurturing, forgiveness, maternal
instincts), needs (e.g., love, affection, security, belonging), and weaknesses (e.g.,
dependency, low self esteem, insecurity, lack of assertiveness), and the concomitant
difficulties experienced by many victims in distancing themselves from abusive
relationships. Not surprisingly, threats to harm or remove children were cited as
immensely powerful inhibitors of proactive behaviours and dissolution or departure from
such relationships.

5.4.8 Additional Crimes Against Victims of Sexual Abuse
Almost one in five victims reported that additional (nonsexual) crimes had been
committed against them by the perpetrator/s of their sexual abuse. Such crimes, whilst
also comprising various forms of theft, property damage (including vandalism and arson),
stalking, drink spiking, threats, and intention to harm or intimidate, were overwhelmingly
violent crimes against the person. Whilst violent physical assaults described by victims as
bashings, beatings, battering, and ‘physical violence’ were most commonly reported,
abduction and instances of extreme violence, including attempted murder, choking, and
assaults resulting in serious injury were also reported by numerous individuals.

These findings highlight the strong relationship between sexual violence and other forms
of violence and demonstrate that for many victims, sexual abuse occurs within contextual
settings characterised by overt physical violence or within climates of globalised
aggression and fear, abusive power relations, and generalised disregard for basic human
rights and boundaries. Indeed, particularly with regard to sexual abuse in childhood and
within intimate partnerships, it was common for sexual violence to coexist with other
abuse forms. Specifically, many responses attested to the physical violence that
accompanied childhood sexual abuse experiences, predominantly in the case of familial
abuse, but also in the context of extrafamilial sexual abuse. Frequent references to
violence directed toward multiple family members offered strong and poignant images of
the daily realities of childhood for many individuals and of the contextual backdrops
against which their sexual abuse occurred. Further, frequent responses exemplified the
pattern of revictimisation in adulthood commonly seen in victims of CSA, and more generally, the added vulnerability often incurred in states of crisis, and thus, the cumulative nature of risk encountered by many victims of abuse.

Similarly, the responses of many individuals powerfully articulated the frequent chronicity and multifaceted nature of intimate partner violence, and the erosive power of such abuse on the human psyche. Responses made in reference to expartners further exemplified the reality that departure from abusive relationships does not always effect the cessation of abuse, and indeed, not infrequently effects an escalation of abuses, enmity, and risk of harm to the victim.

It is noteworthy that, since emotional and psychological abuses are not commonly conceptualised as ‘crimes’, such abuses were ostensibly excluded or at least substantially underenumerated in the data pertaining to ‘additional crimes’. Similarly, assaults and other abuses (both sexual and nonsexual) popularly subsumed under the rubric of ‘domestic’ violence are typically underclassified as crimes, often minimised by both perpetrators and victims and conceptualised as something other than ‘real’ crimes. Hence, it is expected that the findings deriving from these data similarly understate the true level of coexistence between sexual and other violence, particularly within intimate partnerships. More generally, myriad responses in this study attest to the misconceptions, ambivalence, and reluctance of victims to define specific events as ‘crimes’ such as rape, assault, or abduction. Thus, it is contended that, grave as these data appear, these signify an underenumeration of actual abuses.

Amongst the many aspects of sexual violence that remain to be appositely understood and addressed, the phenomenon of heightened revictimisation propensity amongst sexually violated populations persists as one of the most pressing areas of concern and conjecture (Breitenbecher, 2001; Breitenbecher & Gidycz, 1998; Cloitre, 1998; Kendall-Tackett, 2005; Krug et al., 2002; Marx, 2005). The findings of the current study contribute to the revictimisation literature by demonstrating the chronicity and pervasiveness of abuse, the globalised violation of human rights, and the profound resultant attack on the human psyche that hallmarks the reality of many victims of sexual and familial abuse.
5.4.9 Summary and Conclusions

In the present study, victim appraisals of perpetrator modus operandi and their own responses during the course of sexual abuse educed valuable insights into common perpetrator practices, predatory behaviours, and the exploitative powers of those with predatory intent. Such findings have multiple applications in addressing areas such as recidivism, revictimisation, abuse trauma, preventive and community education, and victim empowerment, risk perception, and resilience. Specifically, the findings pertinent to commonalities, use of coercive and other offender tactics, and offender exploitation of victim embarrassment and other emotions, perceptions, and characteristics can be of benefit in informing prevention and treatment initiatives, and potentially curbing current high rates of revictimisation. This is important given that, despite concerted and well-intentioned rape prevention efforts, rape prevalence statistics have remained largely unaltered over the past quarter century (Bachar & Koss, 2001; Rozee & Koss, 2001).

The findings deriving from this study in relation to common offender modus operandi and repeated victimisation highlight the importance of empowering, educative, and skill-building approaches to prevention and treatment, and inoculation approaches particularly aimed at decreasing the risk of revictimisation. This is of pivotal importance given the sizable deficits that persist in current academic understanding and practical initiatives to reduce revictimisation (Breitenbecher, 2001; Breitenbecher & Gidycz, 1998; Cloitre, 1998; Kendall-Tackett, 2005; Krug et al., 2002; Marx, 2005). Specifically, the need for building protective behaviours, assertiveness skills, confidence, awareness, and risk perception in those vulnerable to abuse is clear.

Victim appraisals of their own actions and inactions elicited multiple insights regarding perceived efficacy of specific resistance strategies; formation of regret, self-admonishment, self-attributions, and self-blaming conceptualisations of the abuse; and presence of concomitant shame and guilt. To date, no known research has similarly sought appraisals from victims regarding their own strategies to avoid or minimise sexual assault. Information thus derived in the current study can be meaningfully applied in sexual assault awareness and treatment initiatives, and assist in therapeutic settings in challenging and reframing maladaptive cognitions and self-attributions commonly endorsed by sexual abuse victims.
In summary, findings deriving from the current and earlier studies (Studies 1 and 2) underscore myriad threats to wellness that are strongly associated with experiences of sexual abuse encountered in the contexts of childhood, adulthood, and intimate partnership. Whilst pervasive psychological concerns and negative corollaries were found in relation to both childhood and adulthood sexual abuse, more severe negative impact was associated with sexual abuse in childhood. However, a high rate of sexual revictimisation in adulthood was found amongst individuals who had experienced CSA, and it was amongst individuals who had experienced sexual abuse in both childhood and adulthood that the most profound psychopathology was evident. Such cumulative effects were exemplified by the findings pertaining to suicidality, such that, whilst suicidality was significantly associated with both childhood and adulthood sexual abuse, it was most strongly evident amongst individuals who had experienced both forms of sexual violation.
6.1 BACKGROUND AND RESEARCH RATIONALE

OVERVIEW

This suffering….is a legacy that reproduces itself, as new generations learn from the violence of generations past, as victims learn from victimizers, and as the social conditions that nurture violence are allowed to continue. No country, no city, no community is immune. But neither are we powerless against it.

- Nelson Mandela, 2002

6.1.1 Statement of the Problem: An Overview

causative and inhibitory pathways for the development of PTSD and other psychopathology remain to be adequately understood (Flouri, 2005; Luther et al., 2000; McMahon et al., 2003).

The minority of individuals exposed to traumatic events will develop PTSD (Breslau, 2002; Cichetti & Rogosch, 1996; Flouri, 2005; Foa & Rothbaum, 1998; Foa et al., 2000; Keane et al., 2000; Kilpatrick et al., 1992; McMahon et al., 2003). However, evidence from the current research supports previous findings that severe, diverse, and complex manifestations of trauma impact, including frequent comorbidities, are commonly seen in traumatised individuals, such as victims of violence and abuse. Moreover, the current findings support the abundant evidence that, amongst individuals who develop PTSD, many continue to manifest the disorder and associated symptomology indefinitely (Foa et al., 2000). Thus, concepts such as multifinality, equifinality, resilience, and susceptibility (Flouri, 2005; Luther, 2003; Luther et al., 2000; McMahon et al., 2003) must be better understood in order to identify and match the diversity of trauma responses evidenced across populations, individuals, and settings, with diverse, flexible, and customised trauma interventions, so as to minimise harm, foster resilience, and optimise recovery for all traumatised individuals.

Strong evidence exists from the current research that intervention for sexual and familial violence is further complicated and impeded through the secrecy, silence, and stigma surrounding such violence forms. Indeed, the current outcomes are consistent with literature findings that sexual and familial violence frequently remains hidden, to the extent that most victims of these abuse types (including an estimated 80% of Australian sexual assault victims) desist from formal disclosure and professional help-seeking (ABS, 1996; de Visser et al., 2003; Lievore, 2003; London et al., 2005; Sanderson, 2004; Smith et al., 2002; Stubbs, 2003; VLRC, 2004); an estimated over 90% of sexual abuse is never officially reported; and many victims have never disclosed their abuse to another person (ABS, 1996; de Visser et al., 2003; Lievore, 2003; Sanderson, 2004; Stubbs, 2003; VLRC, 2004). This is not surprising given the level of stigmatisation, shame, and victim-blaming that continues to surround sexual abuse and often accompanies disclosure (for review see Herbert & Dunkel-Schetter, 1992; see also Anderson & Alexander, 1996; Arata, 1998; Armsworth, 1989; Buka et al., 2001; Everill & Waller, 1994; Frenken & Van Stolk, 1990;
As corroborated by the current research, unhelpful, avoidant, or victim-blaming responses are commonplace, extending such that sexual abuse and the corollaries of such violation are frequently trivialised or ignored by significant others, legal authorities, and even health professionals (Koss et al., 2004; Marx, 2005). Further, engagement with the judicial system is commonly regarded as more harrowing and less efficacious for sexual crime victims than for victims of other crimes (ABS, 1996; Brereton, 1997; Koss et al., 2004; Lievore, 2003; Marx, 2005; SAC, 2007a, 2007b; Sanderson, 2004; Stubbs, 2003; Taylor, 2001; VLRC, 2003, 2004); and complainant challenges and distress are typically exacerbated for child victims (Cashmore, 1995; Cashmore & Bussey, 1994, 1996; SCIJ, 2002; VLRC, 2003). Indeed, the marginalised role of victims in prosecutorial proceedings and sentencing, and the often traumatic and revictimising judicial processes encountered by victims has engendered widespread criticism and calls for reform (VLRC, 2003, 2004).

Similarly, whilst violence perpetrated by intimate partners is ubiquitous at global and local levels (Janssen et al., 2005; Johnson, 1998; Krug et al., 2002; Mouzos & Makkai, 2004; Richardson et al., 2002; Straus & Gelles, 1986; Tjaden & Thoennes, 2000a, 2000b, 2000c; Wilt & Olson, 1996), victims of IPV often desist both reporting such crime and departing from abusive relationships (Sharps et al., 2001). Although many reasons exist, paramount amongst these is a fear of reprisal (Mouzos & Makkai, 2004). Such fears are often grounded in fact, given that escalation of violence commonly ensues following attempts to leave abusive relationships, and that women face their greatest risk for assault and femicide at the hands of a current or estranged partner or other relative, particularly during the period of relationship dissolution or attempted departure (Browne & Williams, 1993; Campbell, 1992; Campbell et al., 2003; Cawood & Corcoran, 2009; Coleman, 1997; Davies & Mouzos, 2007; Fleury et al., 2000; Janssen et al., 2005; Kellerman & Mercy, 1992; Krug et al., 2002; Kurcz, 1996; La Violette & Barnett, 2000; Logan & Walker, 2004; McFarlane et al., 1999; Meloy, 1998; Mouzos & Makkai, 2004; Mouzos & Segrave, 2004; Wilson & Daly, 1994).
However, nonreporting is equally problematic for victims, given that silence frequently allows abuse to continue, and that protracted negative sequelae are most likely experienced in the context of chronic victimisation and in absence of disclosure and apposite support (Golding et al., 1989, 2002; Ullman, 2004). Indeed, evidence exists that many potential opportunities are missed by health professionals to render assistance and possibly avert continuing, escalating, and extreme violence including femicide (Sharps et al., 2001). For example, data indicate that 50% of IPV victims who were killed by the perpetrator had accessed health services in the year preceding their homicide (Sharps et al., 2001). Haplessly, victims of sexual, familial, and chronic abuse thus commonly experience the entrapment of a seemingly ‘no win’ situation in which it appears ‘too dangerous to stay and too dangerous to go’.

Notwithstanding the exigency surrounding the problem of IPV, factors and processes that foster desistance from violent behaviours within intimate partnerships remain sparsely understood (Haggard, Gumpert, & Grann, 2001), efforts directed at treatment of perpetrators have been mostly ineffective, and evaluations of victim-focused preventive strategies remain in their infancy, despite several decades of research and clinical attention to IPV and evaluations of intervention initiatives (Janssen et al., 2005). Extant difficulties in the field of IPV prevention are exemplified by conflicting results proffered by prevention initiatives (Schwartz, 2005). Whilst in general, preventive strategies that reduce exposure of female victims to physically abusive partners have been found highly effective in reducing future homicide, other intervention initiatives have appeared to generate retaliatory effects that (in some cases) heightened risk of femicide (Dugan et al., 2003), leading the study authors to conclude that some interventions are worse than implementing no intervention. Clearly, such results underscore the need for concerted efforts to improve understanding of both precipitating and inhibitory factors for IPV perpetration. Moreover, academic, socio-political, community, and clinical attention has focussed overwhelmingly on IPV from a heterosexual perspective that presumes male perpetration and female victimisation. Whilst such a focus caters to the majority, minority groups such as male victims, female perpetrators, and individuals who perpetrate and experience same-sex IPV remain marginalised, invisible, and inadequately supported in the absence of more inclusive and holistic approaches.
From forensic perspectives, nondisclosure and nonreporting is also problematic, given evidence that offenders who are granted impunity as a function of nondetection are unlikely to desist from further offending. Indeed, in the absence of legal sanctions or other deterrence or interruption to offending cycles, individuals are likely to commit offences that escalate in severity over time (Boyd, 2006; Nisbet et al., 2004, 2005; Salter, 2003; Sanderson, 2004; Tidmarsh, 1997). Apart from the obvious impact of creating more victims and revictimisation, added costs for society arise through delayed apprehension of offenders, given that early intervention has optimal outcomes and prognoses for rehabilitation become less favourable as criminal careers and procriminal cognitions and behavioural pathways become increasingly entrenched (Boyd, 2006; Nisbet et al., 2004, 2005; Salter, 2003; Sanderson, 2004; Tidmarsh, 1997). Recidivism risk is additionally heightened for sexual offenders given that (i) only the minority are reported; (ii) a further minority of reported sexual offences result in charges; (iii) sexual offence charges less often result in convictions, relative to other criminal charges; and (iv) sex offender treatment is highly unlikely in the absence of apprehension and conviction (ABS, 1996; Chung et al., 2006; de Visser et al., 2003; Lievore, 2003; Sanderson, 2004; Stubbs, 2003; VLRC, 2004). The current study confirms the extremely low rates at which sexual offenders are reported, apprehended, charged, and convicted.

Thus, through multiple pathways, whilst effective programs exist for both sexual and nonsexual violent offending (e.g., Abel et al., 1988; Andrews & Bonta, 2006; ATSA, 2005; Bonta & Andrews, 2007; Gallagher et al., 1999; Grant, 2000; Hall, 1995; Hanson & Bourgon, 2008; Hanson et al., 2002; Lee et al., 1996; Looman et al., 2000, 2005b; Maletzky, 1980; Marshall & Barbarée, 1988, 1990b; Marshall & Pithers, 1994; Marshall et al., 1992; Nicholaichuk et al., 2000; VLRC, 2004), these remain insufficiently accessible to those in need of such intervention; violence continues to be perpetrated at high ostensibly unabated rates despite all efforts; and pervasive negative impact is felt by societies, families, and individuals (ABS, 1996, 2005a, 2005b, 2005c; Krug et al., 2002; Sanderson, 2004; WHO, 2004, 2005b).

Self-directed violence manifesting in suicide similarly continues to occur, despite concerted prevention initiatives in Australia and globally, at rates that ostensibly surpass the incidence of mortality attributable to any other cause of preventable, premature death;
claiming more lives worldwide than homicide or war (De Leo & Evans, 2003; Krug et al., 2002; Oquendo & Mann, 2003; WHO, 2001, 2002, 2004, 2005a); and in Australia, accounting for most firearm deaths and claiming more lives annually than all transport-related accidents (ABS, 2003a, 2003b, 2004, 2006b, 2006c, 2007b, 2007c, 2008, 2008, 2009; Henley et al., 2007; Mouzos & Rushforth, 2003). As with sexual and familial violence, enumerating and addressing suicidality within societies is complicated by the extant taboos and stigma surrounding suicide and mental illness. The current research attests both to the ubiquity of suicidality and to the hidden, and often undetected, nature of the turmoil and precipitators underlying lethal and nonlethal suicide attempts.

6.1.2 Influences on Thesis Formulation and Construction

As noted earlier, the initial conceptualisations and subsequent construction and focus of this thesis on human rights violations and interpersonal and self-directed violence were informed and directed by several seminal initiatives and reports issued by the WHO over the last decade (see Krug et al., 2002; WHO, 1999, 2000, 2001, 2002, 2004a, 2004b, 2005; WHO & IPSCAN, 2006). Amongst those issued in recognition of the ubiquity of interpersonal and self-directed violence, the enormity of its aftermath, and the need to strive for betterment, two WHO initiatives (and the recommendations contained therein) have been particularly instrumental in forming the aims and foci of the current research series (De Leo et al., 2002; Krug et al., 2002; WHO, 2004).

The World Report on Violence and Health, released by the WHO in 2002, was the first comprehensive summation of the problem of violence on a global scale (Krug et al., 2002). This report demonstrated not only the enormous human cost of violence and its many manifestations and corollaries, but also (as with other health concerns) the uneven distribution of this problem across populations and settings. Importantly, it was articulated by Nelson Mandela and others in the report that (despite the apparent evidence to the contrary in the lives of many individuals and communities) violence is not an immutable factor intrinsic to the human condition, but rather, that violence in all manifestations is preventable and able to be countered, given appropriate individual and collective consensus and investment (Krug et al., 2002).
Many factors that heighten risk of receiving and perpetrating violence are not only common across different violence and abuse forms, but also modifiable, such that both proactive and reparative measures can be implemented at many levels to effect broad-reaching social change and interruption of intergenerational, systemic, and situational cycles of violence and vulnerability (Krug et al., 2002). On a global scale, advances in public health have been remarkable over recent decades, particularly with respect to the reduction of physical illnesses, many childhood diseases, and related infant, child, and adult mortality (Krug et al., 2002). Such advances bear testimony to what can be achieved with concerted and strategic attention. Efforts commensurate with those directed toward amelioration of physical health concerns are needed in relation to mental health and violence, in order to make comparable and necessary advances in these realms and create safer and healthier environments at individual, community, and global levels.

Recommendations and commentary contained in the World Report on Violence and Health and related subsequent initiatives and publications closely informed the aims, objectives, and content of the current research series. These recommendations included, but were not limited to, calls for (i) enhanced capacity for violence data collection; (ii) research examining causal factors and impact of violence; (ii) initiatives able to foster, promote, and inform primary prevention and social change strategies (e.g., parenting programs; prenatal and perinatal maternal health care; preschool enrichment and social development programs for children and adolescents; media campaigns to address problematic social norms, attitudes, and behaviours; restriction of firearms and other lethal means); (iii) strengthening of responses to victims of violence; (iv) integration of violence prevention strategies into social and educational policies, to promote gender and social equality; and (v) promotion and monitoring of adherence to mechanisms for protecting human rights (Krug et al., 2002).

The current research agenda was constructed to obtain a wide array of data that could potentially contribute to enactment of each of these recommendations; and be used in practical ways to inform a range of primary and reparative initiatives aimed at ameliorating violence perpetration and victimisation impact.
Further impact on the current research program arose from a global initiative for the prevention of suicide prevention, launched in 1999 by the WHO. This initiative encompassed the following objectives: (i) to effect a lasting reduction in the frequency of suicidal behaviours, with emphasis on developing countries and countries in transition; (ii) to identify, assess, and eliminate at an early stage, as far as possible, factors that may result in youth suicide; and (iii) to raise general awareness about suicide and provide psychosocial support to people with suicidal ideation or behaviours, as well as to the friends and relatives of those who have attempted or completed suicide (De Leo et al., 2002). Information gleaned from this research is potentially useful in direct service and treatment protocols for suicidal persons and their significant others; and for informing proactive initiatives to prevent suicide and lower precursory distress. Information from this thesis can also be applied to raise awareness of suicide and mental illness amongst general communities and targeted cohorts (e.g., parents, educators, health and judicial professionals, custodial institutions, residential care facilities).

In terms of specific content and construction, the current research program was conceived and conducted in recognition of, and as a response to, theory and practice deficits in the field of violence amelioration and specifically, in the fields of child and adult sexual abuse, IPV, and suicidality. Concerted measures were taken at each level of project design and implementation to circumvent extant taboos and minimise barriers to effective research and limitations identified in previous studies.

Measures taken to address previous limitations include: (i) the use of multiple comparison groups (e.g., victim/nonvictim; suicidal/nonsuicidal; male/female); (ii) inclusion of male sexual abuse victims; (iii) use of an online, anonymous, and nonthreatening survey mode; (iv) broad, inclusive, nationwide recruitment enabling a large, diverse sample and representation from rural and marginalised cohorts; (v) additional overt invitation and targeted recruitment campaign specific to males; (vi) formulation of new measures and questions and adaptation of existing measures to eliminate gendered and directional biases in language and content (e.g., gender neutral and nondirectional language to avoid presumption that perpetrators are males and victims are female and that IPV is unidirectional); and (vii) the use of a comprehensive and holistic assessment battery enabling extensive examination of effects and relationships among variables.
6.2 Summary of Findings

Summaries of findings for each study are presented under relevant headings in the forthcoming section, followed by discussions pertaining to needs, implications, and future directions.

6.2.1 Study 1. Child Sexual Abuse and Adult Perturbation

The findings of Study 1 evidenced the almost universal experience, in the childhood period subsequent to CSA, of shame, ‘dirtiness’, ‘badness’, and guilt, and the ardent striving of child victims to ‘pretend nothing had happened’. Sadly, most individuals were alone with these feelings in childhood, as only a minority had disclosed the abuse as children. Moreover, the minority of individuals who had made such disclosure reported receiving more negative reactions from family or friends, than positive, to the extent that the minority of this group regarded the disclosure as having been helpful overall, and half regretted having spoken to family or friends about their abuse. Of the few CSA victims who received counselling during childhood, only a third perceived this to have been at all helpful and only a small minority found this to have been very or extremely helpful.

Even more concerning are the findings that serious negative consequences extended into adulthood for many CSA victims, persisting commonly for multiple decades, to the present. Indeed, relative to nonvictims of CSA, those respondents who had experienced CSA evidenced significantly poorer current psychological wellbeing (measured across multiple domains), higher rates of SI and attempted suicide, and higher rates of ASA and IPV. Moreover, high rates of nondisclosure continued into adulthood, with almost half of respondents reporting that they have never disclosed their CSA experience to a family member; 42% never having disclosed CSA to their partner; fewer than one third disclosing to a counsellor or other health professional; and only a small minority having reported the matter to police. Friends, followed by partners, were both the most commonly chosen confidantes and perceived to be the most helpful; and female confidantes were the most popular preference for both female and male CSA victims, albeit this gender preference was less pronounced amongst males. In contrast to
counselling received in childhood, the large majority of individuals who, as adults, received counselling for CSA perceived this as helpful, and almost half reported this to have been very or extremely beneficial.

Revealing data were also gleaned with respect to perpetrator identity and modus operandi, and victim attributes, reporting practices, offence appraisals, attitudes, and regrets. For example, trusted figures and relatives were identified most commonly as the perpetrators of CSA, and most victims reported multiple abuses by the same perpetrator, highlighting the entrapment and vulnerability concomitant with childhood and the dependence of children on adult care-givers. Exploitation of childhood obedience, loyalty, trust, power imbalance and associated child powerlessness, and fear of being blamed or not believed, was manifest in perpetrator tactics, both those centred on grooming and inveigling approaches and those grounded in overt force, aggression, threat, intimidation, and inducement of fear. Most CSA perpetrators were never confronted regarding the abuse and the vast majority were never brought to the attention of police.

It is salient to note that, whilst males were more reticent than females with regard to CSA disclosure and help-seeking, few gender differences were found with respect to psychopathology subsequent to such abuse. In contrast to females, only the minority of males reported ever having disclosed CSA to a family member; and male victims exhibited twice the propensity never to have disclosed their abuse to another person, and greater propensity for future nondisclosure. It is important to note however, that the ‘wish to disclose CSA, but finding it too difficult’ was expressed as commonly amongst males as amongst females.

Recurrent themes illustrative of the protracted and entrenched nature of deleterious effects of CSA were both strongly evidenced by the quantitative findings, and powerfully elucidated by qualitative data. From both victim and offender perspectives, these findings underpin the critical importance of early intervention that is able to circumvent the potentially life-altering, harmful, impact of CSA on victims and the communities in which they live.
Suicidality (in terms of both ideation and attempt) was significantly overrepresented in victims of CSA; and within this cohort, no gender difference was found with respect to ideation or attempted suicide. Suicide attempts were attributed to the experience of CSA to some degree by the vast majority of victims; and over half strongly attributed their attempt/s to their childhood experience of sexual abuse. Survivors of CSA who had attempted suicide differed from non-suicidal CSA survivors in a number of ways. With regard to victim perceptions, relative to non-attempters, persons with a history of suicide attempt attributed greater responsibility for their CSA to themselves; and were more likely to perceive the CSA as very damaging; and more likely to conceptualise the CSA as a crime, and as ‘sexual assault’ and ‘rape’. Relative to non-attempters, attempters reported greater difficulty talking about their abuse; greater barriers counteracting their desire for disclosure; greater regrets regarding CSA non-disclosure or delayed disclosure; more hostile, blaming, or rejecting reactions upon disclosure in childhood; and greater regrets regarding disclosure to family or friends during childhood. Persons expressing a desire and intention to speak about their abuse more strongly attributed their past suicidality to their CSA. Similarly, persons whose CSA experience was reported to the police, either during their childhood or in adulthood, more strongly attributed their suicide attempt to their abuse, relative to respondents for whom no police report was made.

Whilst only a small minority of CSA cases were reported to police during the victim’s childhood, it is salient to note that over half of victims in this category attempted suicide at some later time, evidencing significantly higher suicidality relative to victims whose CSA was not reported during childhood. It was also found that sustaining greater physical injuries as a result of CSA; contracting an STI as a consequence of CSA; experiencing additional crimes committed by the perpetrator; and victim awareness of crimes committed by the perpetrator against others were associated with higher suicidality. Nonetheless, whether heightened suicidality was causally related to greater severity of abuse (which in turn led to police reporting) or rather to other factors (such as stressors connected with proceeding through the police and judicial systems) cannot be determined from the current data; and further research is warranted to examine this relationship.

Regardless of causation, however, it is important to note the disproportionately high suicide vulnerability found in this study amongst individuals involved as children in police
or judicial processes for CSA. This finding suggests that police-reported CSA and other visible factors (e.g., physical injury, STI) can act as important markers for potentially elevated suicide vulnerability that should be appropriately recognised and managed in the community. Taken together, the findings from the current study highlight the complex and variable relationships between disclosure and vulnerability, such that both the absence of disclosure and the processes of disclosure and police reporting can potentially impact on suicide vulnerability; and underscore the need for mindfulness to be brought to the manner in which CSA victims are identified and best supported.

In summary, findings from Study 1 highlight the vulnerability and isolation of victims of CSA both as children and continuing throughout adulthood. Further, they underpin the inherent, multiple difficulties in recognising and addressing the needs of individual victims, and ascertaining and addressing the enormity of the problem at the societal level. Finally, these findings emphasise the need to break taboos, facilitate disclosure and help-seeking, and offer timely, empirically validated intervention, in order to thwart the chronicity of perturbation and revictimisation patterns that hallmark the lives of many CSA victims who carry the burden of their abuse in silence and isolation, and to break offending patterns through timely detection and intervention. It is clear that proactive and sensitive action and interventions are needed to identify and assist victims of CSA, given ample evidence from this research of the passivity and difficulty experienced by many CSA victims in being forthcoming and open about their needs and distress.

6.2.2 Study 2. Adult Sexual Abuse and Perturbation

In broad terms, many of the observations reported in Study 1, in relation to CSA, applied also to the findings for ASA, albeit, to less extreme degrees. Reported perpetrator strategies were remarkably similar for CSA and ASA, with manipulative and inveigling tactics, perpetrator disregard for victim protestations and statements, and use of physical force or restraint most commonly reported and identified as pivotal strategies in facilitating the abuse. However, fewer respondents reported having experienced ASA, relative to CSA. This difference was most noticeable amongst males, with CSA reported within the research at double the rate of ASA. Moreover, whilst repeated incidents of sexual abuse were reported by the majority of both CSA and ASA victims, experience of multiple incidents was, nevertheless, less commonly reported by ASA victims.
Overall, a strong pattern of sexual revictimisation in adulthood was evident amongst CSA victims, and indeed, chronic ASA (predominantly perpetrated by intimate partners or other well known or trusted figure) was found overwhelmingly amongst respondents who had also experienced CSA, particularly of a similarly chronic nature. Whilst overt links were drawn by some respondents between their ASA experiences and their sexual abuse in childhood, such insight was by no means universal. Indeed, other responses were notable for the absence of such expressed notions, suggesting instead, a self-attributing and blaming style.

Rates of nondisclosure of ASA were even higher than those found with respect to CSA, and higher amongst males, relative to females. Moreover, most perpetrators of ASA, and an even larger majority of CSA perpetrators, were never confronted in relation to their perpetration of abuse. Police reports were made in relation to only a minority of ASA incidents, and rarely in relation to CSA. These findings further underpin the secrecy surrounding sexual abuse (particularly that perpetrated against children), the relative rarity with which perpetrators are held accountable, and thus, the rampant impunity that exists to allow many to offend and reoffend. Similarly, such findings highlight the high level of invisibility of sexual abuse in the community, even within close circles, and the concomitant isolation experienced by victims in relation to their abuse, especially given the low levels at which victims report accessing professional support services.

Sadly however, it appears that disclosure itself often proffers suboptimal relief or support and indeed, educes negative and painful outcomes for many sexual abuse victims. Indeed, findings from both Study 1 and Study 2 attest to the high levels of suboptimal reactions received by victims (particularly in relation to child sexual abuse), ranging from minimally supportive to overtly hostile, rejecting, and blaming. Given the innate vulnerability of children, and their limited access to resources and alternative means of support, the finding that disclosures made by children were even more harshly received than those made in relation to ASA is particularly disconcerting. This finding alone is a sad indictment on the position of child victims of sexual abuse within society. Whilst the message of ‘telling an adult’ is widely promulgated, it would appear from the findings that adults thus entrusted by children commonly afford these children a disservice,
constituting a further betrayal of trust by the adults closest to them, and by adults on
whom they must depend. Notably, the physical or emotional dependency of many victims
on the perpetrator of their abuse, and the presence of residual victim trust, loyalty, love,
or affection for some perpetrators following abuse, underscores the vulnerability of
victims for revictimisation, the difficulties frequently experienced by victims in distancing
themselves from the perpetrator, and the opportunities for exploitation of such emotions
and situations that exist for the original and subsequent perpetrators, and others with
predatory intent.

The findings of Study 2 closely mirror those of Study 1, in evidencing the pervasive, far-
reaching, and insidious nature of sexual abuse sequelae. Convergent evidence indicates
that such effects are commonly experienced in the absence of professional assistance.
Comparison of findings from these studies reveals that, in broad terms, negative effects
of sexual abuse were most pronounced in relation to sexual abuse experienced in
childhood, however exceptions to this pattern were also noted and discussed.

A strong association between suicidality and sexual abuse was evidenced in both studies,
in relation to both CSA and ASA. As found in Study 1 in relation to CSA, ASA victims
evidenced significantly greater SI and suicidal behaviours, relative to their non-victim
counterparts. Four in ten ASA victims reported experiencing SI in the days or weeks
following their abuse, and more than one in five victims reported severe SI within this
timeframe. Over half of ASA victims reported SI at some later time point, with almost
one in four reporting severe SI. More than one in four ASA victims reported having
attempted suicide since the abuse, with more than eight in ten victims within this cohort
attributing their attempt/s to their ASA to some degree, and almost half strongly
attributing their attempt/s to their abuse. These data demonstrate that ASA-attributable
suicide attempts occur over a far wider time frame than that immediately following the
abuse; and that, in fact, in the current cohort, likelihood of lifetime occurrence of suicide
attempts attributable to ASA increased markedly over time.

Importantly, multiple delineating factors were identified by which to differentiate sexual
abuse victims who had attempted suicide subsequently to their abuse from those who had
not. As found in Study 1 in relation to CSA, victims of ASA who had attempted suicide
subsequently to their abuse were more likely than victim non-attempters to regard their
abuse as very damaging; more likely to classify the assault as ‘rape’; and likely to attribute greater responsibility for the ASA to themselves.

Similarly to Study 1 results, relative to non-suicidal ASA victims, persons who had attempted suicide subsequent to ASA also experienced more physical injuries; greater regret regarding insufficient or delayed disclosure; greater regrets regarding disclosure to family/friends; more hostile, blaming, rejecting, suspicious, or challenging reactions or lack of understanding; and greater difficulty speaking about their ASA. Attempters reported accessing more counselling or services for ASA; and expressed both greater desire for disclosure and greater personal barriers to such disclosure, relative to non-attempters. Subsequent suicide attempts were significantly more common in persons who had reported their ASA to police and in victims who were aware of crimes committed against others by the perpetrator; and around twice as likely in ASA victims who had experienced additional crimes committed against them by the perpetrator. Over half of ASA victims reported exposure to risk of sexually transmitted infection (STI) as a consequence of their abuse; and this cohort was significantly overrepresented amongst subsequent suicide attempters, relative to victims who reported no exposure risk.

Many implications arise from these findings with respect to community education, prevention, and interventions surrounding sexual abuse, mental illness, and suicidality. It is clear that many victims of sexual abuse and many suicidal individuals ‘suffer in silence’, in the absence of detection, intervention, and supports – both formal and informal. Evidence from these studies also shows clearly that many individuals have a strong desire for disclosure and yet experience personal barriers that preclude ‘speaking out’ and help-seeking into the long-term.

Further, findings from both studies counter the notion that suicidality risk is defined or necessarily confined by temporal proximity to precipitating factors and observable stressors. Rather, it is suggested that vulnerability can be highest when the immediate observable crisis appears to have passed and services and supports are duly withdrawn. Even greater risk can be present when the crisis or persisting stressors remain hidden and escalate over time in the absence of improvement and with a concomitant loss of hope and resilience. It is proposed that the current findings offer a range of markers of
potential suicide vulnerability that can be used as ‘alert flags’ or conceptualised as static risk factors that are able to effect early identification and assistance for persons at risk before an acute stage is reached. Such a model of proactive early detection and intervention would offer an improvement over current practices in which suicidality often remains hidden until extreme risk and behavioural markers are manifest. Given that suicide attempts increase in lethality over time and remain the strongest known predictor of a subsequent attempt, it is important to intervene at the earliest stage of suicidal ideation, and before behavioural manifestations of suicidality appear and risk of lethal outcome elevates. Given that ideation is not intrinsically observable, encouraging disclosure and developing methods for proactive detection are imperatives. Study 3 was designed to augment findings stemming from Studies 1 and 2, and to address many of the new and existing questions prompted by these data. Implications for practice and future research are discussed further in subsequent sections of the thesis.

6.2.3 Study 3. Victim Appraisal of Sexual Offence Typology, Mechanisms, and Sequelae
Findings from Study 3 consolidated and extended many of the findings from the first and second studies, evidencing the profound, negative impact of sexual abuse, the often protracted nature of such impact, and the strong patterns of revictimisation frequently concomitant with sexual abuse. Indeed, strong associations found earlier between CSA histories and sexual victimisation in adulthood were found also with respect to IPV, with elevated reporting of IPV found amongst CSA victims and ASA victims, and highest occurrence of IPV reported by individuals who had experienced both CSA and ASA. Findings suggesting greater propensity for female CSA victims to be sexually revictimised in adulthood, relative to male CSA victims, are consistent with previous findings that males generally experience less ASA, although male reluctance to report sexual abuse should also be considered as a likely factor in explaining this apparent gender disparity.

Both quantitative and qualitative findings acutely underpinned the entrapment and chronicity of abuse experienced by many sexual abuse victims, particularly those incestuously perpetrated against in childhood, and those for whom abuse occurs in the context of intimate partnerships. Whilst many respondents reported leaving the perpetrator within minutes or hours of the assault, findings demonstrated the degree to which distancing oneself from the perpetrator is frequently fraught with difficulties, and often rendered untenable, particularly in cases where abuse occurs in the context of
intimate or dependent relationships and families. Indeed, it was particularly concerning to note the use of the present tense adopted by some individuals, signifying the ongoing nature of their abuse.

Convergent evidence from Studies 1, 2, and 3 shows that sexual abuse victims commonly perceive multiple barriers to police reporting; rarely report their abuse; and rarely receive adequate professional assistance; yet commonly experience extreme distress and far-reaching problems that they attribute to their sexual abuse, and often experience additional (nonsexual) violence and crimes perpetrated by the abuser. It was also found that self-reproach, shame, guilt, and the experience of multiple regrets, often related to the victim's own actions or inactions, were almost ubiquitous amongst sexual abuse victims. Findings from Study 3 evidenced strong cumulative effects, such that persons abused in both childhood and adulthood fared significantly worse in terms of psychological functioning and suicidality, relative to persons whose abuse was confined to either childhood or adulthood. Indeed, individuals who had experienced both CSA and ASA were more than twice as likely to have attempted suicide, relative to nonvictims. In turn, CSA victims exhibited greater experience of suicide attempt, relative to ASA victims. A similar (albeit, less pronounced) pattern was found with respect to suicidal ideation, such that ideation was greatest in persons who had experienced sexual abuse in both childhood and adulthood, followed by persons who had experienced CSA only. Moreover, persons reporting suicidality evidenced markedly greater sexual assault trauma, relative to sexual abuse victims who had not experienced suicidality. Specifically, suicide attempters reported greater depression subsequent to sexual assault, greater disclosure shame, more safety fears, and higher levels of self-blame, relative to non-attempters. Given the importance of developing models that can facilitate early detection and intervention, it is salient to note that the same pattern was found with respect to suicidal ideation, such that ideators exhibited greater depression subsequent to sexual assault, disclosure shame, safety fears, and self-blame, relative to non-ideators.

Within the context of overwhelmingly negative sequelae to sexual abuse, it was evident that many respondents were nevertheless able to acknowledge the presence of ‘positive’ sequelae (e.g., having become a stronger person; increased understanding of others). Findings pertaining to ‘positive’ outcomes of sexual abuse (and indeed, other traumatic
events) are relatively rare in the literature, and yet, are able to gainfully inform treatment protocols, particularly those concerned with redressing negative emotions, shame, self-deprecation, and maladaptive perceptions pertaining to the event, the self, and the future.

In this thesis, victim appraisals of perpetrator modus operandi and their own reactions during the course of the abuse proffered valuable insights into common offender practices, predatory behaviours, and the exploitative powers of those with predatory intent. Such findings have multiple applications for addressing areas such as recidivism, revictimisation, abuse trauma, prevention and community education, and victim empowerment, perception of risk, and resilience. Moreover, victim appraisals of their own actions and inactions offered multiple insights related to both the perceived efficacy of specific resistance strategies, and the formation of regret, self-admonishment, self-attributions, self-blaming conceptualisations of the abuse, and concomitant shame and guilt. The research approach undertaken in this thesis of seeking appraisals by victims of their own strategies to avoid or minimise sexual assault appears not to have been undertaken in any previous studies. Information thus derived can be meaningfully applied in sexual assault awareness and treatment initiatives, and assist in therapeutic settings in challenging and reframing maladaptive cognitions and self-attributions commonly endorsed by sexual abuse victims.

Wide divergence of opinion was evident with respect to utility of resistance strategies. Many responses were illustrative of the value, for some individuals, of passive avoidance strategies, nonconfrontational deterrence, delay and distraction tactics, and summoning of external assistance, and thus, encouraging of the notion that victims can, at least sometimes, achieve a level of control over the outcome of their abuse. Yet, such notions are tempered by the many responses that equally attested to the futility of resistance attempts and the powerlessness of many respondents to alter the course of their abuse. Salutary messages of caution are also conveyed by the current findings that many actions taken by victims in their attempts to counter and thwart sexual abuses had the potential to effect both positive and negative outcomes, minimising harm for some victims, yet worsening the abuse for others (e.g., escalating violence). These findings highlight the inherent difficulties and potential risks attached to presenting generic ‘advice’ or
preventive guidelines in relation to sexual abuse, and should be disseminated to relevant service providers.

In summary, Studies 1, 2, and 3 identified multiple threats to longterm wellbeing that were strongly associated with sexual abuse experiences. Whilst pervasive psychological distress and ill effects were evident in relation to both CSA and ASA experiences, more extreme negative impact was noted in relation to CSA. However, a high rate of sexual revictimisation in adulthood was evident amongst CSA victims, and it was amongst individuals who had experienced both childhood and adulthood sexual abuse that the most profound negative impact was evident. Such cumulative effect was exemplified by the findings pertaining to suicidality, such that, whilst suicidality was significantly associated with both CSA and ASA, it was most strongly evident in persons who had experienced both forms of sexual abuse.
6.3 Research, Practice, and Societal Change: Needs, Implications, and Future Directions

6.3.1 Creation of Victims and Perpetrators: The Importance of Interrupting Cyclical Transmission of Violence

Breaking cycles: A holistic, developmental, and whole-community approach

As supported by the current thesis outcomes, it is recognised that children who live in a maelstrom hallmarked by violence, abuse, and neglect are highly challenged in extricating themselves from cycles of violence that continue to adulthood (Anda et al., 1999, 2001, 2006a, 2006b; Bannister & Gallagher, 1995; Beech et al., 2009; Breitenbecher, 2001; Cloitre, 1998; Davis & Petretic-Jackson, 2000; Dietz et al., 1999; DiLillo, 2001; Dorais, 2002; Dube et al., 2003, 2006; Finkelhor, 2008; Kendall-Tackett, 2005; Lievore, 2003; Lovell, 2002; Marx, 2005; O’Callaghan & Print, 1994; Proeve et al., 2006; Proeve & Reilly, 2007; Rasmussen et al., 1992; Rumstein-McKean & Hunsley, 2001; Sanderson, 2004; Skuse et al., 1998; Spataro et al., 2004; van der Kolk et al., 1991; WHO & IPSCAN, 2006).

Within theoretical frameworks of social learning and child development, it is not difficult to understand the potent negative impact of abusive childhood experiences and inadequate nurturing and protection on future psychosocial functioning, cognitive schemata, and wellbeing (Bandura, 1973, 1977; Bandura, Caprara, Barbaranelli, Pastorelli, & Regalia, 2001; Benson, Donahue, & Erikson, 1989; O’Bryan, Fishbein, & Ritchey, 2004; Steinberg, 2001, 2007). Research evidences that parents and families comprise the principal social influences through which values are modelled and communicated to children, and constitute pivotal roles in facilitating intergenerational transmission of gender role stereotyping, prejudice, and intolerance (Benson et al., 1989; O’Bryan et al., 2004; Steinberg, 2001, 2007). Thus, particularly in a climate in which abusive, exploitive, procriminal, or otherwise antisocial values and belief systems are privileged and enacted by primary attachment figures, role-models, and peers, children are at high risk of internalising self-damaging or antisocial belief systems, that commonly
find expression in self-defeating, antisocial, and other problematic behavioural patterns (Bandura, 1973, 1977; Bandura et al., 2001; Catalano, Oxford, Harachi, Abbott, & Haggerty, 1999; Gannon et al., 2007; Loeber, 1990; Lyddon & Sherry, 2001; Sperry, 2003; Sperry & Mosak, 1996; Sukhodolsky & Ruchkin, 2004). Through such pathways, toxic childhood environments are potent facilitators of the transition both from child victim to adult perpetrator, and from child victim to adult victim (Bandura, 1973, 1977; Bandura et al., 2001; Catalano et al., 1999; Loeber, 1990; Lyddon & Sherry, 2001; Sukhodolsky & Ruchkin, 2004). Nonetheless, whilst certain factors have been identified and theories abound to explain the disproportionately high vulnerability of sexual abuse victims to further victimisation, definitive causative models and effective practice pathways for inhibiting this phenomenon remain elusive (Breitenbecher, 2001); and male sexual revictimisation remains particularly poorly examined and understood (Arata, 1998; Crome, 2006; Good et al., 2000; Griffiths, 2003; Hunter, 1990b; Lamb & Edgar-Smith, 1994; Mezey & King, 1989, 2000; Neame & Heenan, 2003; Roesler, 1994; Roesler & Wind, 1994; Stott, 2001; Walker et al., 2005; Worth, 2003).

Concerted research and practice efforts, sustained influx of funding and resources, and initiatives underpinned by sound evidence-based principles and practices, are needed to interrupt cyclical violence and abuse patterns and their insidious impact. A particular and holistic focus must be directed toward delivery of evidence-based practice for amelioration of child abuse and neglect. Such initiatives must encompass parenting education, support and skills-based training for disadvantaged families, and provision of best-practice community education, services, and resources (such as accessible quality childcare; re-entry education opportunities for early school leavers and teenage parents; and accessible professional counselling for children and adults, irrespective of financial means).

Child-directed approaches

Aside from proactive and reparative parenting, community, and family-strengthening initiatives, intensive approaches are needed to assist children directly, in order to subvert progression from childhood victimisation, psychopathology, disadvantage, and neglect to adulthood revictimisation, offending, substance misuse, and other self-defeating behaviours and psychopathology. Such approaches should be both proactive and holistic, flexibly delivered and client-focused, professionally orchestrated and
administered, and driven by sound empirical evidence. For young children, such approaches should encompass initiatives to foster enriched and safe early childhood experiences and education and ensure access to best-practice childcare and preschool environments for all children.

For school-aged children, both proactive and reparative initiatives are needed to counter negative educational, social, and psychological effects of trauma and disadvantage. These should include provision of easy and equitable access to school-based and other professional counselling, well-developed programs to prevent and address substance abuse, remedial education opportunities, and quality schooling for all children. Such outcomes could be delivered through increased funding for teaching, pastoral, welfare, and psychological services and community resources available to children and could include initiatives such as mentoring, reading recovery, and social skills training programs; remedial tutoring and homework clubs; and social and community initiatives that foster connectedness, prosocial cognitions and behaviours, and formation and adherence to positive peer groups.

For ‘at-risk’ children and young people, it is particularly important that initiatives and supports are in place to avert and minimise risks for abuse and neglect, academic failure, truancy, and premature school departure as such problems are recognised risk factors for delinquency, social disadvantage, substance use, and later antisocial behaviours including adulthood criminality (Colten & Gore, 1991; Lerner & Steinberg, 2004; Loeber, 1990; McNamara, 2000; Widom, 1991). Accordingly, within at-risk and adolescent forensic populations, it is of pivotal importance that timely and concerted efforts, appropriate funding, and best-practice principles are applied in order to minimise the transition from juvenile delinquency, substance abuse, and offending, to antisocial, self-injurious, and procriminal behaviours in adulthood.

Children and youth who have experienced abuse and trauma require best-practice intervention and holistic support to ensure that reparative opportunities are maximised and risks for further harm are optimally managed. Under current settings and practices, children who are amongst the most vulnerable within society and who fall under the auspices of welfare and protective agencies commonly, and notwithstanding well-
intentioned efforts from service providers, encounter profound disservices and endure further harm as a result of resource limitations and systemic obstacles.

Concerted reform efforts are needed to improve many aspects of practice standards, resource availability and accessibility, and the legal protection afforded to this needy and under-served client population. For example, the ease with which a parent or guardian can withdraw consent for the child or children under his or her care to receive counselling and other important services is acutely problematic in cases where the parent/guardian and the perpetrator of child abuse are the same person. In such situations, it is common and simple for adults to withdraw consent upon having been identified as alleged perpetrators and after having become disgruntled with service providers and with the notion that the children under their care have a ‘voice’. Under these circumstances, withdrawal of consent for counselling renders the child isolated and unsupported at a highly critical time and amplifies the risk that further abuse of the child remains undetected and unalleviated. One approach toward addressing this problem would be to implement mandated counselling for any child that comes to the notice of protective services. Whilst, under current practices, Magistrates are able to issue such mandates, many cases do not proceed to Court (particularly if the child has reduced avenues for disclosure), and inadequate policing of Court-ordered directives often undermines those that are made.

The current findings provide strong evidence of the barriers and reluctance experienced by child victims in regard to CSA disclosure; and of the very low rates at which victims make such disclosures during childhood. Regrettably, the current research also shows the high frequency with which overtly negative, damaging, or at best, suboptimal reactions are received when children do make a disclosure of sexual or other abuse. Risk of negative outcomes and an escalation of risk to the child are extremely high when the perpetrator is also the parent or a person with a significant carer role and position of power over the child. Upon a formal notification of child abuse, the confidentiality of the child is frequently betrayed through systemic and judicial processes. Aside from damaging the child’s trust and therapeutic alliances and lessening the likelihood of honest disclosure and help-seeking in the future, such breaches render the child highly
vulnerable to punitive, retaliatory, and silencing measures at the hands of perpetrators/care-givers.

For child protection cases that proceed to the Children’s Court, over-worked and under-resourced child protection workers and legal aid lawyers are commonly compromised in their ability to render thorough timely attention to the child and relevant others, including informants and those who have close working knowledge and relationships with the child. In practice, such constraints can result in rushed and insufficiently prepared cases that are conducted often without consulting with, and receiving input from, relevant others, such as teachers, counsellors, and other professionals who hold valuable information about the child and the predicaments to which he or she is exposed. Court-related conversations, interviews, and briefings occurring between the child and an array of adults (typically strangers) are, not surprisingly, unfamiliar experiences for the child that are commonly perceived as uncomfortable, anxiety-provoking encounters in which the child is concerned and conflicted regarding issues such as loyalty to alleged perpetrators; fear of reprisal; guilt regarding disclosure and impact on family; and confusion and anxiety regarding what to disclose and whom to trust.

Such pressures are taxing for any adult and far surpass what is appropriate to placed on the shoulders of children. The Court environment, even at designated Children’s Courts, is typically alien to children and perceived as a sterile, ‘adult’ domain that is unfriendly, chaotic, confusing, and threatening. Aside from the negative impact on children of such experiences, a climate of this nature is unlikely to elicit open and accurate responses from a child. Careful and considered planning and strategies should be implemented to ensure that lawyers and other professionals engaged to represent the best interests of children have relevant specialist training and interest in this field, including understanding of developmental stages, age-appropriate language and concepts, and awareness of the emotional and psychological aspects of the child’s experience. Designated ‘child-friendly’ areas and staff within the Court environs would be highly beneficial, particularly as it is not uncommon for children to spend many hours waiting for Court proceedings. Appointed child advocates or ‘buddies’ would be welcome, especially given that children are often attending Court in the sole care of the alleged
perpetrator and called upon to provide briefings to their lawyer that further compromise their relationship with their carer/s, and potentially, their safety.

As discussed in Section 3.1.9, notwithstanding recent reforms, in matters of sexual abuse particularly, proceeding through the judicial system as a victim continues to be widely cited as a harrowing experience for adults (with often unsatisfying outcomes, relative to other crimes) (ABS, 1996; Brereton, 1997; Koss et al., 2004; Lievore, 2003; Marx, 2005; SAC, 2007a, 2007b; Sanderson, 2004; Stubbs, 2003; Taylor, 2001; VLRC, 2003, 2004), and one that is heightened for child complainants (Cashmore, 1995; Cashmore & Bussey, 1994, 1996; Eastwood & Patton, 2002; SCIJ, 2002; VLRC, 2003, 2004). Continued efforts are needed to address the ongoing needs for reform in order to better outcomes and experiences of adult and child complainants who proceed through judicial systems as victims of sexual abuse.

Addressing offending patterns and offence-precipitating factors

Sound evidence exists in the forensic and psychology literatures that offending behaviours and offence-precipitating factors (such as substance misuse; mental illness; and deficits in emotional regulation, impulsivity control, anger management, coping, and problem-solving) are unlikely to spontaneously remit and typically escalate in the absence of appropriate intervention (Abel et al., 1987; Boyd, 2006; Cullen et al., 1998; Loeber, Farrington, & Petechuk, 2003; Long & McLachlan, 2002; Nisbet et al., 2004, 2005; Salter, 2003; Sanderson, 2004; Stewart et al., 2005; Tidmarsh, 1997). Indeed, offence severity typically increases over time, in the absence of external interruptions, such as offence-specific treatment; rehabilitation or other intervention for offence-facilitating and offence-related factors (e.g., anger, substance misuse, psychopathology); detection; apprehension; legal sanctions; or incarceration (Abel et al., 1987; Boyd, 2006; Cullen et al., 1998; Loeber et al., 2003; Long & McLachlan, 2002; Nisbet et al., 2004, 2005; Salter, 2003; Sanderson, 2004; Stewart et al., 2005; Tidmarsh, 1997). Such evidence is consistent with findings from the current research that many victims experienced chronic abuses at the hands of the same person. Thus, abundant convergent evidence exists that early intervention is critically important, not only to minimise progression from juvenile to adult offending, but also in order to minimise recidivism, escalation of offence severity, and intractability of behavioural patterns,
related psychopathology, and procriminal cognitions in all forensic populations (Abel et al., 1987; Boyd, 2006; Cullen et al., 1998; Loeber et al., 2003; Long & McLachlan, 2002; Nisbet et al., 2004, 2005; Salter, 2003; Sanderson, 2004; Stewart et al., 2005; Tidmarsh, 1997).

Clearly, broad-based and holistic whole-community and individual approaches are needed to address sexual and nonsexual violence as well as non-violent offending. Such approaches must be both preventive and reparatory in nature, addressing childhood, adolescent, and adulthood precipitating risk and maintaining factors; as well as extant needs for societal, attitudinal, legislative, and systemic change.

To meaningfully effect such change, funding and resources should be directed to delivery of best-practice interventions in juvenile justice and residential care settings, and to broader preemptive initiatives that minimise probability that young people will become enmeshed in, and dependent on, such systems. Similarly in adult forensic populations, in order to optimise rehabilitative potential and minimise risk severity and recidivism, a strong rehabilitative focus must be enacted at all levels within judicial, custodial, and noncustodial settings, with due attention to both criminogenic and noncriminogenic needs of persons placed in the care of such systems.

Broad evidence demonstrates that prisoners and ex-prisoners are representative of groups that are amongst the most socially disadvantaged and disenfranchised within society (ABS, 2009b; Johnston, 1991; Kappus, 1988; Kivivuori & Linderborg, 2009; Loh, Maller, Fernandez, Ferrante, & Walsh, 2007; Muñoz, 2009; Standing Committee on Law and Justice, 1999, 2000; Woodward, 2003). Thus, provision of psychotherapeutic interventions and counselling (both offence-specific and nonoffence-specific), psychoeducative and life skills training programs, parenting programs, employment training, and education (particularly literacy) to incarcerated populations and sound professional support for prisoners on release (e.g., access to, and encouragement to engage with, counselling, drug and alcohol rehabilitation, parenting support services, mentoring, accommodation services, and supported transition into employment) are amongst the proactive approaches that are of pivotal importance if
cyclical and interrelated problems of interpersonal and familial violence, child abuse, and substance misuse are to be effectively addressed.

Effective treatments exist for both violent and sexual offending (Abel et al., 1988; Andrews & Bonta, 2006; ATSA, 2005; Bonta & Andrews, 2007; Gallagher et al., 1999; Gannon et al., 2007; Hall, 1995; Hanson & Bourgon, 2008; Hanson et al., 2002; Lee et al., 1996; Looman et al., 2000, 2005b; MacKenzie, 2006; Maletzky, 1980; Marshall & Barbaree, 1988, 1990b; Marshall & Pithers, 1994; Marshall et al., 1991b, 1992, 2006a, 2006b; Nicholaichuk et al., 2000). Yet frequently, these remain inaccessible to those in dire need of such intervention, both in adult and juvenile incarcerated and community settings, where insufficient programs may be available or because exclusion criteria preclude participation. Moreover, sex offender programs are largely inaccessible in the absence of apprehension and prosecution and whilst treatment remains largely contingent on the tenuous conditions for obtaining convictions for sexual offences (Chung et al., 2006). Thus, concerted efforts are needed to increase accessibility of therapeutic programs for both incarcerated offenders and for such individuals who are predisposed to offending or whose offending behaviours have not resulted in formal detection, prosecution, and incarceration.

In practical terms, more offence-specific programs (e.g., sex offender and violent offender programs) and offence-related programs and education (e.g., drug and alcohol; anger management; problem-solving; conflict resolution; parenting and relationships) are needed, so that these can be accessed by all incarcerated and nonincarcerated offenders. Other areas for urgent reform within custodial and noncustodial settings include insufficient availability and accessibility of individual and group psychotherapeutic interventions for psychopathology and problems in addition to, and often comorbid with substance misuse, and typically highly related to offending (e.g., anxiety, depression, PTSD, grief, trauma, childhood and adulthood victimisation). Given the important role of such problems and distress in heightening recidivism risk, such areas warrant concerted attention and influx of appropriate resources.

Many opportunities exist for improvement to current practices. One example is that, under current practices, remand prisoners and offenders with short sentences are often
precluded from participation in programs because their early or unspecified discharge date renders uncertain their ability to complete a specific course within the timeframe of their incarceration. Whilst, at face value, shorter sentences are generally received favourably by offenders and seen as appropriate to lesser crimes by sentencing judges, in practical terms, creating conditions that preclude access to rehabilitation opportunities manifests as a disservice to offenders and the communities in which they reside, and runs counter to evidence-based practice models emphasising the important role of program participation in lowering recidivism. Moreover, given that shorter sentences correlate with less serious offending, precluding shorter-stay offenders from program participation also runs counter to practice evidence that early intervention is optimal, and specifically, that it is preferable to intervene at the earliest possible stage of a criminal career in order to maximise success.

Thus, it is recommended strongly in the current thesis that rehabilitative programs and interventions should be accessible to all prisoners. Specifically, it is contended that incarcerated individuals should not be precluded from participation in such programs on the basis of sentence duration or release dates, as a punitive measure, or because of systemic factors such as prison requirements to undertake non-skill building employment or other duties during program or class times. Rather, it is recommended that flexible delivery of therapy be implemented to ensure that all prisoners and their families and communities have equitable and real opportunities to benefit from rehabilitative and therapeutic services. As presented in the first three studies, the current research offers new information regarding offender strategies and victim responses and resistance strategies that may assist both offender and victim treatment protocols and prevention initiatives. As outlined in later sections of this thesis, further research would be beneficial in order to expand this information and determine the extent to which it can be gainfully applied.

*Childhood victims: Facilitating a voice and appropriate response*

Evidence from the current research demonstrates extremely high rates of nondisclosure of CSA during childhood and experiences of negative reactions from primary carers for the minority of children who disclosed their abuse. While the negative consequences of nondisclosure can be severe and pervasive, to promulgate the message to children and
their care-givers that abuse must be disclosed, without first ensuring that such disclosures are met with favourable outcomes, is also fraught. Indeed, facilitating disclosure that results in further harm and revictimisation constitutes further betrayal of the trust and confidence that children can, and must, place in adults to ensure their survival.

At community, legislative, systemic, and individual levels, concerted and strategic efforts must be taken to ensure that processes and sequelae of disclosure occur in a climate of safety, to serve the best interests of the child. Regrettably, under current practices, children who disclose abuse frequently encounter punitive outcomes at the hands of perpetrators and at familial and systemic levels, including blame and chastisement for family breakdown and perturbation, separation and disenfranchisement from primary figures, or disbelief at individual and systemic levels resulting in non-intervention and return to abusive environments and into the custody of angered and vengeful care-givers.

Current results show that few children received counselling for CSA, and in cases where this was provided, the experience was commonly perceived by now-adult recipients as having been unhelpful. At levels of funding, professional training, and service provision and accessibility, efforts must be made to ensure that child victims of abuse are able to access best-practice models of therapeutic intervention, regardless of economic or other obstacles. Aside from increased service availability, education of parents and care-givers is needed to convey the importance of providing traumatised children with apposite support, intervention, and physical and psychological safety from further abuse.

Strong evidence was obtained from the current research that the silence, taboos, and resultant isolation surrounding CSA commonly persist into adulthood and that such abuse is concomitant with long lasting and insidious psychopathology and other negative corollaries, including suicidality, IPV, and sexual revictimisation. Further evidence was gleaned that adulthood counselling for CSA was received favourably by most individuals. Yet current findings also demonstrate that therapeutic services are received by only the minority of those who experience sexual abuse as children or adults.
Despite community education strategies to assuage stigma and nondisclosure of sexual abuse, progress in this area remains insufficient. Continued efforts are needed at community, systemic, and individual levels, to facilitate dismantling of taboos, stigma, and victim-blaming responses surrounding sexual abuse that, in turn, inhibit disclosure, help-seeking, and access to succour for victims of abuse and other secret trauma. Similarly, the persistent stigma surrounding help-seeking itself, and particularly psychological counselling and mental illness, continues to warrant attention, given the reluctance and omission of many perturbed individuals to access psychotherapeutic services or even disclose their distress. In terms of providing a sound help-seeking rationale, evidence should also be made more accessible to the general public that successful outcomes can be achieved through engagement in empirically validated treatments, countering commonly held beliefs that particular perturbations are immutable and that ‘counselling wouldn’t help’.

**The burden of maleness**

Targeted initiatives to break taboos and prohibitions surrounding communication and help-seeking are particularly needed to assist males who experience psychological distress, both related and unrelated to victimisation. Given the identification in the current research, and in the literature (Good et al., 2000), of similar levels of psychopathology in male and female victims of CSA, the added vulnerability, isolation, and lack of support and intervention experienced by male victims in a context of silence and secrecy cannot be ignored. The current finding that male CSA victims were significantly more likely than females to maintain silence surrounding their abuse is consistent with literature findings that males experience major additional barriers to disclosure and that male sexual abuse is perceived commonly as particularly shameful and emasculating (Crome, 2006; Donnelly & Kenyon, 1996; Good et al., 2000; Hunter, 1990b; Kassing et al., 2005; Kassing & Prieto, 2003; Richey-Suttles & Remer, 1997; Washington, 1999). Concerted efforts are clearly needed to counter the strong reticence evidenced amongst males in regard to help-seeking and discussion of sensitive topics. The wish of male victims themselves to be able to overcome such reticence is indicated by the current finding that ‘wishing to disclose CSA but finding it too difficult’ was expressed by males as commonly as by females. However, such reticence and resultant
lack of support and intervention is not specific to males who have been sexually victimised.

Substantive evidence exists from the current research and the extant literature that males in general experience acute barriers, relative to females, with respect to disclosure and discussion of sensitive topics, overt expression of difficult emotions and perturbation, help-seeking, and adoption of proactive health behaviours (Crome, 2006; Good et al., 2000; Hunter, 1990b; Kassing et al., 2005; Mittendorfer-Rutz, 2006; Möller-Leimkühler, 2003; Stewart & Smith, in press-a). Given the disproportionately strong proclivity of males, relative to females, to eschew adaptive communication and assistance and instead, externalise and manifest their distress in maladaptive behaviours (e.g., substance abuse, aggression, impulsivity, suicide, high-risk behaviours, earlier death, higher trauma-related death rate) (ABS, 2003b, 2005a, 2005b, 2005c, 2007b; DHS, 2007; Giancola, 2002; Godbout et al., 2006; Good et al., 2000; Laslett et al., 2006; Möller-Leimkühler, 2003; Smith & Stewart, 2008; Stewart & Smith, in press-a; WHO, 2004), designing and implementing initiatives to facilitate open, adaptive expressions of distress and help-seeking amongst males should be the subject of concerted efforts at clinical, social, and research levels. Addressing aspects of male gender role expectations (e.g., toughness, stoicism, suppression of emotions that might connote ‘weakness’) and socialisation patterns that can serve to undermine male wellbeing would be useful in programs delivered to males and male children of all ages.

Similarly, useful inclusions in education programs for both male and female primary and secondary school children would incorporate modules that prevent or replace maladaptive expressions of emotions and address specific skills and awareness deficits related to psychological wellbeing. Amongst such modules would be those that teach adaptive coping and communication strategies and skills such as anger management, conflict resolution, problem solving, assertiveness, and respectful relational styles; build resilience, strengths, and self esteem; and enhance understanding of healthy sexuality, relationships, and unacceptability of violence and abusive interaction within a human rights framework.
6.3.2 Suicide: Hidden Grief and Avoidable Mortality

Treating the problem or reacting to crises: The treatment of choice

Suicide can be usefully conceptualised as avoidable mortality, given that suicidality (particularly among adolescents and young adults) is commonly associated with treatable problems, such as clinical depression, posttraumatic symptomology, substance misuse, or other mental illness (AISRP, 2003; Appleby et al., 1999; Caldwell & Gottesman, 1992; Cavanagh et al., 1999, 2003; Clark & Fawcett, 1992; Harris & Barraclough, 1997; Henriksson et al., 1993, 2001; Kovacs et al., 1993; Lönnqvist, 2000; Mann et al., 2005; Maris et al., 2000a, 2000b, 2000c; Moscicki, 1999; Page et al., 2006; Pearson et al., 2001b).

Regrettably however, the majority of mental illnesses detected in suicide decedents remain untreated at death (Henriksson et al., 2001; Mann et al., 2005). Such findings are supported by strong evidence from the current research that timely detection and treatment of psychological distress are of integral importance in addressing suicidality.

In preference to crisis intervention approaches, holistic practice models are needed with which to proactively address suicidality at the level of contributing and precipitating factors such as substance misuse and mental illness. Approaches for better addressing alcohol misuse and depression are particularly important, given the high level of alcohol involvement in suicide deaths and the very strong evidence of elevated suicide risk in the presence of alcohol use, especially when concomitant with depressive or other affective disorder (Abel & Zeidenberg, 1985; AISRP, 2003; Andreasson et al., 1988; Bovasso, 2001; Brener et al., 1999; Brent et al., 1993; Flavin et al., 1990; Harris & Barraclough, 1997; Hawton et al., 1989; King, 1997; Kovacs et al., 1993; Maris et al., 2000a, 2000b; McKenry et al., 1982; Murphy & Wetzel, 1990; Rich et al., 1986; Schernhammer, 2005; Schukit et al., 1997; Shafii et al., 1985, 1988; Stephenson et al., 2006; Wasserman et al., 1994, 1998).

Given that effective treatments exist for such problems, many precipitating factors for suicide can be ameliorated at the individual level, if funding bodies and youth and other community health services are able to overcome access barriers and provide proactive and appropriate case management, counselling, and other social and medical support.
services, in a manner commensurate with need (Page et al., 2006). Proactive and creative measures are also needed to address suicide risk factors at population levels, with focussed attention directed to problems such as child abuse and neglect, sexual and familial abuse, poverty, unemployment, mental illness, substance misuse, and aspects of socialisation (such as bigotry, stigmatisation, disenfranchisement of marginalised populations, bullying, and social isolation) (Page et al., 2006). Concerted and improved efforts to address suicidality and perturbation at individual and population levels are particularly important given that sparse evidence exists for the effectiveness of current policies, prevention initiatives, and treatment services (AISRP, 2003; Mann et al., 2005; Page et al., 2006).

Suicide prevention initiatives: Implementing effective practices?

National suicide prevention initiatives have been implemented by a number of developed nations over recent years (see review by Mann et al., 2005; see also AISRP, 2003). Unfortunately however, the introduction of such initiatives has failed to significantly impact national suicide rates or trends (with the possible exception of Finland) (AISRP, 2003). Although declines in suicide mortality have been observed in countries where initiatives have been launched (e.g., Australia, Finland), simultaneous declines have occurred in countries without national initiatives (e.g., United States, Ireland, Netherlands) (AISRP, 2003). This is not so surprising given that, whilst such prevention programs are typically comprised of multiple intervention strategies, the effectiveness of individual components has rarely been subject to evaluation (Mann et al., 2005). For example, evidence exists that physician education in depression recognition and treatment lowers suicide rates (Mann et al., 2005); and that GP education and training in suicide prevention can have multiple positive outcomes, including improved detection of suicidal ideation; increased competency in depression treatment and prevention; and reduced suicide rates (Mann et al., 2005; Pfaff, Acres, & McKelvey, 2001; Pfaff & Almeida, 2005; Pfaff & Osvaldo, 2004; Rihmer, Belso, & Kalmar, 2001; Rutz, 2001; Smith & Stewart, in press; Verger et al, 2007).

Similarly, restricting access to high-lethality methods (e.g., restricting access to firearms and pesticides; detoxification of domestic gas in 1963) has been shown to reduce suicide mortality (AISRP, 2003; Farberow & Simon, 1969; Mann et al., 2005; Murphy et al.,
1986; Whitlock, 1975). However, other modes of intervention, including public education, media education, and screening programs, require more evidence of efficacy (Mann et al., 2005). Similarly, implementation of mental health plans and substance abuse policies has not demonstrated a consistent effect on suicide deaths (AISRP, 2003). Delineating which components of suicide prevention initiatives are effective in lowering suicide mortality and attempts and applying evidence-based best practices are important to ensure optimization of precious and limited resources (Mann et al., 2005). Data arising from the current research can be used in a number of practical ways to inform current prevention and treatment initiatives. For instance, findings from this thesis should be used to inform current screening, assessment, and treatment practices such that suicidality becomes much more widely and openly discussed and routinely included in protocols of mental health assessment and treatment. This is particularly indicated where childhood or adulthood sexual abuse is suspected and within other high-risk cohorts, such as young people, depressed and otherwise distressed individuals, and those subject to marginalisation or social disenfranchisement.

**A special case for GP training**

As previously noted, extant evidence identifies that physician education in depression recognition and treatment lowers suicide mortality (Mann et al., 2005); and that GP education and training in suicide prevention can result in improved detection of suicidal ideation, increased competency in depression treatment and prevention, and lowered suicide mortality, amongst other positive outcomes (Mann et al., 2005; Pfaff & Almeida, 2005; Pfaff & Osvaldo, 2004; Pfaff et al., 2001; Rihmer et al., 2001; Rutz, 2001; Scoullar & Smith, 2002; Smith & Scoullar, 2001; Smith & Stewart, in press; Verger et al, 2007). Suicide prevention is contingent in part, on the ability to identify individuals and populations at high risk and offer effective interventions. Current findings extend previous evidence that, regrettably, suicidal individuals commonly remain undetected, to the extent that whilst psychiatric disorders can be diagnosed in at least 90% of suicides, over 80% remain untreated at death (Henriksson et al., 2001; Mann et al., 2005); and underdetection, nontreatment, and undertreatment of depression are commonplace (Coyle et al., 2003), persisting even after attempted suicide (Oquendo et al., 2002).
As discussed earlier, ample evidence exists that GPs are optimally positioned to play a significant role in suicidality detection across age-cohorts, and therefore to assist in preventing suicide by offering appropriate intervention and referral options (Pirkis & Burgess, 1998; Walker & Townsend, 1998; Scouller & Smith, 2002; Smith & Scouller, 2001; Smith & Stewart, in press). Moreover, in many communities (e.g., rural), the GP is the primary service provider for mental as well as physical health issues, and thus carries the burden of detection and treatment for suicidality amid other health concerns, in contexts of limited resources and specialist referral options. Data demonstrate that half to three-quarters of suicide decedents consulted a GP in the weeks or months prior to death (e.g., Hirschfeld & Russell, 1997; Schulberg et al., 2004); up to 66% of individuals contacted a GP in the month preceding death (Pirkis & Burgess, 1998); and most individuals in psychological distress, and those who seek assistance prior to imminent suicide, consult a GP rather than mental health professionals (Bancroft, Skrimshire, Casson, Harvard-Watts, & Reynolds, 1977; Paykel et al., 2005). Indeed, research has shown that 75% of suicide decedents contacted primary care providers in the year of their death in contrast to only 33% of decedents who accessed mental health services within that year (Luoma et al., 2002).

Further, notwithstanding the perception that young people underutilise health services and that suicidal youth are therefore difficult to detect by health professionals, data indicate that the average adolescent consults a doctor two to three times annually per year; 50% of adolescents sought medical services in the month prior to suicide, up to 80% did so within their final six months (Haste et al., 1998; Pirkis & Burgess, 1998), and 78% did so in their final year (Farand et al., 2004). Moreover, suicide decedents under 35 increased their GP visits in the 3 months prior to death; rates of GP consultations increased further in the final week (especially for females); and for both genders, psychological issues constituted the presenting problem in most final consultations (Appleby et al., 1999). Amongst the elderly, GP consultations were sought by 70% of individuals in the month prior to (Pfaff & Osvaldo, 2004; Luoma et al., 2002; Vassilas & Morgan, 1994). Similarly, around 50% of suicide attempters consulted a GP within one month of their attempt; and of those who repeated an attempt within 1-4 weeks, 50% had consulted their GP prior to repetition (Gunnell, Bennewith, Peters, Stocks, & Sharp, 2002).
However, whilst an extensive empirical literature detailing risk factors, warning signs, and precipitating factors for suicide has developed in recent decades (Rudd et al., 2006), the level of suicide knowledge held by GPs has been shown to be lacking in key areas and highly variable across individuals (e.g., Pfaff & Almeida, 2004; Scoullar & Smith, 2002; Smith & Scoullar, 2001; Smith & Stewart, in press). Australian adolescent suicide research indicates that, whilst GPs are generally well-informed in relation to precipitating factors and to a lesser extent about warning signs, they are significantly less informed regarding risk factors, demographics, and implications for treatment and prevention; and to varying degrees endorse erroneous beliefs relating to suicide (Smith & Scoullar, 2001). These outcomes are consistent with convergent evidence that GPs detect suicidal intent with relative infrequency (Verger et al., 2007). Similarly, a wealth of evidence exists that depression and other psychopathologies are inadequately recognised and undertreated within primary care settings (Tylee & Jones, 2005); and whilst GPs are more likely to detect suicidality in the presence of recognised depression (Verger et al., 2007), suicidality is more likely to be overlooked in the presence of moderate depressive symptoms and other forms of psychopathology that are nonetheless associated with heightened suicide risk (e.g., psychosis, anxiety) (Smith & Stewart, in press).

Evaluations of suicide awareness, education, and training programs developed for GPs show that their implementation is associated with reduced suicide rates and improvements in recognition of suicidal ideation, mental health assessment, and general patient management (Scoullar & Smith, 2002; Smith & Scoullar, 2001; Smith & Stewart, in press). However, to assume homogeneity across populations, and accordingly prescribe a single model for suicide prevention, would be simplistic and inappropriate. Instead, programs are needed that reflect and are sensitive to both the commonalities and heterogeneity existing across communities, cultures, and contexts. Given that sensitivity towards diversity and minority group stressors can gainfully inform and refine generalist models for training programs, GP education and training should be extended to enhance understanding of, and responses to, the differential needs of minority populations and particular cohorts at disproportionately high suicide risk (e.g., same-sex attracted; abuse victims). The value of incorporating new empirical findings into existing suicide prevention training programs is also evident.
The current research provides a broad array of recent Australian data (both general and cohort-specific) that can be used to inform and create education and training materials, practice guidelines, and screening tools for physicians and other health professionals. Outcomes of the current research indicate strongly that screening for past suicidality is an important, potentially life-saving, addition to any thorough mental health assessment and should be routinely included rather than only in cases where suicidality is suspected or identified as an issue of particular concern. Additionally, the current research has produced a large volume of data relating to suicidality in specific populations (e.g., victims of CSA and ASA; revictimised adults; males; male victims). These findings should be used to provide specialised information to assist GPs and others to identify and accommodate the needs of individuals who may experience disparate stressors and disproportionate vulnerability to suicidality and other concerns.

The current data can similarly be applied to create education and training materials for dissemination to other professionals such as educators, school welfare coordinators, counsellors, and psychologists, and others concerned with the welfare of adolescents and young adults. To address current knowledge and practice deficits, such materials should comprise practical information based on empirically derived and best practice principles in areas such as timely identification and intervention for suicidality; warning signs and risk factors; modes of risk assessment; and ways of speaking with suicidal or perhaps suicidal individuals, including discussion of ‘myths and facts’. Given that intervention modes such as public and media education require more evidence of efficacy (Mann et al., 2005), careful attention should also be applied to delineating how the current research findings and extant literature can be used in the future to achieve beneficial outcomes via these additional interventions.

6.3.4 Strengths, Limitations, and Nomenclature

Overview
The current research program comprises an integrated examination of sexual violation, perturbation, and suicidality. To date, no known research has similarly examined these domains in combination, nor taken a similar approach in terms of the detail explored
within each of these areas. Specifically, with respect to sexual abuse, no known studies have previously sought to ascertain information pertaining to CSA and ASA in a similarly detailed manner, nor used the specific strategy of asking victims to appraise salient aspects of their abuse; reporting practices; perpetrator and victim strategies; and subsequent attributions, beliefs, regrets, and sequelae. Instead, most extant data pertaining to psychological health of sexual abuse victims pertain to a limited field of psychological variables and derive from female samples and often nonrepresentative, narrow populations (e.g., university students, clinical subgroups), without the presence of appropriate nonvictim comparison groups (see Gold et al., 1999; Oddone-Paolucci et al., 2001; Roodman & Clum, 2001). Conversely, large scale population surveys provide valuable data regarding prevalence, reported crime statistics, and sociodemographic factors (e.g., ABS, 2005b; AIC, 2008; Mouzos & Makkai, 2004) but fail to provide detailed information regarding psychological factors, and issues such as reporting practices, offender strategies, and victim appraisals and regrets. The many practical and psychological barriers and difficulties inherent in researching areas subject to underreporting, underenumeration, taboo, stigma, and shame commonly also serve to undermine the utility of extant data relating to sexual abuse.

Addressing limitations: Identification, prevention, and management

In terms of study design, content, and implementation, concerted efforts have been made, within each subject domain and in the integration of these domains, to address and circumvent limitations identified in earlier research and to minimise inherent and unavoidable limitations and potential weaknesses. At both theoretical and practical levels, discussion of strengths and limitations has been presented in relevant sections throughout this thesis. However, additional focussed attention to the identification, consideration, and management of limitations is warranted, and this forms the basis of the forthcoming discussion. Strengths and attributes of the current research will be further discussed in the subsequent sections.

In terms of limitations, both the retrospective nature of some components of the current research and the limitations inherent in all self-report studies must be acknowledged (for discussion, see Belk, 2006; East & Uncles, 2008; Gearing et al., 2006; Gotlib & Hammen, 2009; Koop & Strang, 2002; Teitler et al., 2004; Sheinberg &
Research has demonstrated that several concerns regarding memory reliability have been unsubstantiated by data, leading authors to conclude that retrospective methods have been unnecessarly underutilized and undervalued in many areas of mental health research including child, adolescent, and adult psychiatry (Brewin et al., 1993; Gearing et al., 2006; Gotlib & Hammen, 2009). Indeed, whilst typically underpinned by retrospective self-report and self-appraisal, clinical interviews and questionnaires are classical cornerstones of psychiatric and psychological research, assessment, and interventions, and indispensable in many areas of human research (such as child abuse) in which a ‘gold-standard’ research design such as the RCT is not ethically or feasibly able to be applied (Lerner et al., 2002).

The current research examining CSA relies on recall and subjective appraisal of events that occurred in some cases, decades previously. Whilst the literature pertaining to false memories, postevent suggestion, and memory failures in witnesses, particularly over time and in the presence of strong emotion cannot be discounted (see Bell & Loftus, 1989; Bjorklund, 2000; Brainerd & Reyna, 2005; Chaffin et al., 1997; Garry et al., 1996; Loftus, 2002, 2003; Stocks, 1998), such concerns must be countered against several main arguments. First, clear and substantial matters of feasibility and ethical considerations exist to preclude the conduct of this type of research with children directly; and historically, judicial systems have considered the ‘suggestibility’ of children as problematic and child witness testimonies as unreliable (see Bala et al., 2001; Bruck et al., 2002; Cashmore & Bussey, 1995; Ceci & Bruck, 1993, 1995, 1998; Ceci & Friedman, 2000; Ceci, Huffman, et al., 1994; Ceci, Loftus, et al., 1994; Flin et al., 1996; Goodman & Helgeson, 1985; LRCWA, 1991; NZLRC, 1996; Saywitz, 1995; Spencer & Flin, 1993; Talwar et al., 2006; VI.RC, 2004; White et al., 1997). Given the presence of both ethical
and practical barriers precluding the use of children in first-hand research examining CSA, particularly of such a detailed, introspective, and highly personal nature, such research can only feasibly be conducted with adults, and thus, retrospectively.

Second, retrospective research has been criticised not only because of problems related to recall fallibility and biases, but also in relation to the subjective stance of self-reporters and a likely propensity to reconstruct histories based on personal experiences, cognitive stance, belief systems, and subjective event appraisal. However, as noted earlier, extensive literature reviews have revealed that several concerns regarding memory reliability are not substantiated by data (Brewin et al., 1993; Gotlib & Hammen, 2009).

Third, given that a principal aim of the current CSA research was to measure impact of CSA in adulthood and over prolonged periods, it is necessary, by definition, that such research be conducted after significant time has elapsed since the experience of abuse. Fourth, whilst perceptions, thoughts, and related affective responses to events are indisputably subjective and highly variable across individuals, it is, within the central tenets of cognitive behavioural theory, precisely the ‘subjective’ response to life events that dictates wellbeing, rather than events or absolute ‘truths’, per se (Beck, 1972, 1976, 1991; Dattilio & Freeman, 2007; Dobson, 2010; Franklin et al., 2008; Leahy & Holland, 2000). Thus, it is necessary and desirable to measure precisely those subjective appraisals and beliefs, rather than the events or ‘truths’ directly, in order to advance extant understanding of traumatic sequelae and therapeutic needs pertaining to childhood abuse and other traumatic events. Nonetheless, as far as possible, steps were also taken to maximise response accuracy. For example, careful attention was paid to avoid ambiguity of questions and terminology, opportunities were offered throughout the survey for respondents to provide additional qualitative comment in order to elaborate or explain responses, and many domains were measured in multiple formats in order to collect convergent evidence. Further, large victim and nonvictim samples were utilised to maximise power and validity of data, and to offset as far as practicable, the effects of limitations inherent in human research of this nature.
A number of other potential limitations should also be considered. For example, deliberate efforts were made to recruit broadly, and evidence exists that the sample comprises individuals from diverse socioeconomic and geographical backgrounds across Australia. Nonetheless, by definition, it remains an artefact of the research design that the sample is limited to a self-selected group of English-speaking individuals who possess reasonably high standards of literacy and computer literacy and have access to, and familiarity with, the Internet.

Notwithstanding high levels of Internet connectivity across Australia, it must be noted that socioeconomic characteristics of households continue to impact both computer and Internet access (ABS, 2007a). Specifically, households with no children aged under 15 years, those located outside metropolitan or in remote areas, and those with lower incomes remain less likely to have computer and/or Internet access within the home; and Internet access from any location remains significantly lower than average for unemployed and older Australians, and those with below median household income (ABS, 2007a). Conversely, significantly higher than average levels of Internet access have been registered for Australians aged 15 to 17 years, and amongst Australians with high income, higher educational attainment, and current employment (ABS, 2007a). Such potential sampling biases and limitations must be balanced against evidence of the many advantages conferred by online research methods, including the enhanced recruitment that can be achieved by offering online versions of surveys in preference to printed booklets (Hanna et al., 2005; Hickson et al., 2003, 2007; Hillier et al., 2005; Pitts et al., 2006; Reid et al., 2002, 2004; Reimers, 2007). Notably, enhanced effects have been particularly evident within marginalised and otherwise difficult-to-recruit populations, including ethnic minority groups, behaviourally bisexual males, and those aged under 20 and over 50 years (Hickson et al., 2003; Reid et al., 2002, 2004). The interested reader is directed to Section 2.3.2 of the General Method for a detailed discussion related to online research methodology.

In terms of sampling, it should also be considered that, within the subsample of sexual abuse victims, the cohort is clearly confined to individuals who are prepared, at least within the anonymous and relatively non-threatening forum of an online survey, to disclose and detail their abuse. Similarly, within the subsample of individuals with a
history of suicidal behaviours, the cohort is obviously confined to individuals who have made non-lethal suicide attempts. However, given posthumous interviews with suicide decedents are not possible and that information able to be derived via psychological autopsies is often sparse and limited to what can be provided by third parties, interviewing surviving suicide attempters directly appears to be amongst the most reliable approaches available.

With respect to gender, it should be noted that males in all categories (e.g., victim/nonvictim; heterosexual/nonheterosexual; urban/rural) were more difficult to recruit relative to females, such that despite targeted campaigns directed at males, male subsamples remained smaller than their corresponding female groups. It remains a challenge for future researchers to overcome the evident reticence of males to participate in research involving disclosure of sensitive information, even when efforts are made to provide conducive conditions. Future researchers should also anticipate that extra recruitment efforts are needed to counteract small sample sizes in rural and remote areas and the further reducing effects on sample size of disaggregation into subgroups (e.g., disaggregation by SO, gender, and victim status groupings).

**Nomenclature: Implications for research and clinical practice**

As discussed in relevant sections of this thesis, the sexual abuse, suicidality, and SO-related literatures are replete with studies in which limitations derive from the use of ill-defined terms and constructs and those subject to divergent interpretation and ambiguity (see Kilpatrick, 2004; O'Carroll et al., 1996; Tjaden, 2003, 2004; Tjaden & Thoennes, 2000a, 2000b, 2000c). Indeed, these literatures are hallmarked by the considerable limitations inherent in comparing data from different sources that arise from the varying meanings ascribed across studies to terms such ‘sexual assault’, ‘suicidal’, ‘suicide’, and ‘suicide attempt’ (ABS, 2008; AIHW, 2009; AISRP, 2003; Cupach & Spitzberg, 2003; Henley et al., 2007; Jobes et al., 1987; Kilpatrick, 2004; Krug et al., 2002; Maris, 1991, 1993; Maris et al., 2000a, 2000b; McMullin & White, 2006; NHMRC & DoHAC, 1999; Nygh & Butt, 2004; O'Carroll et al., 1996; Rosenberg et al., 1988; Tjaden, 2003, 2004; Tjaden & Thoennes, 2000a, 2000b, 2000c). It is a particular strength of the current research program, that recommendations relating to issues of nomenclature, definitions, and wording were closely applied. Specifically, use of terms such as ‘rape’ was avoided, behavioural descriptors were used, and to ensure uniformity
across respondents, definitions were provided for terms subject to ambiguity or varying interpretations (e.g., sexual intercourse).

Results from the current research are consistent with previous findings demonstrating the underenumeration and misclassification that can result through the use of emotive or value-laden terminology and label descriptors. For example, research has found that around fifty percent of women whose sexual abuse meets the legal definition of rape do not apply this label to their experience (McMullin & White, 2006). The current findings suggest substantial ambivalence regarding the use of such terminology, and reveal variation amongst individuals, both with regard to how such terms are defined, and with how these are deemed applicable to personal experiences.

Accordingly, the current findings reinforce the importance of using behaviourally descriptive terminology in preference to label descriptors such as ‘rape’ (Groth-Marnat, 2003); and support ‘best practice’ recommendations to adopt a comprehensive approach; precise, non-emotive, language; and a multiple-definition and multiple-measurement research design (in lieu of a single definitional and single-measurement approach) when conducting psychological assessments and particularly when measuring violent victimisation (APA, 2001; Groth-Marnat, 2003; Kilpatrick, 2004; Tjaden, 2003, 2004; Tjaden & Thoennes, 2000a, 2000b, 2000c). Such steps are important in order to minimise ambiguity, effects of variations in definitions of terms such as ‘rape’ and ‘sexual abuse’, and possible (unwanted and unmeasured) effects of applying terminology with highly emotive and social overtones and widely variant nuance (e.g., reticence to self-identify with emotive and value-laden resulting in underenumeration). In accordance with recommendations, the method of seeking convergent evidence from multiple measures was applied in order to ascertain ‘victim status’, in lieu of reliance on a single-item screening question that is often used in sexual assault research to define victim and nonvictim status (Kilpatrick, 2004; Tjaden, 2003, 2004; Tjaden & Thoennes, 2000a, 2000b, 2000c).

Attention was also applied to the use of language to ensure non-directionality and gender-neutrality. Specifically, to avoid gender-stereotyped notions that assume male perpetration and female victimisation, terms such as ‘person’, ‘partner’, and ‘individual’ were used in lieu of gender-directional terms such as ‘he’ and ‘she’. Where gender-
directional terms appeared in published measures, these were replaced with gender-neutral label descriptors such as ‘person’, ‘perpetrator’, or ‘victim’. Achieving gender neutrality through appropriate nomenclature was similarly important in order to avoid heterosexist biases that imply heterosexual relationships and interactions, to the exclusion and marginalisation of same-sex relationships. Thus, terms such as ‘partner’ and ‘other person’ were used in lieu of gendered terms such as ‘boyfriend’, ‘girlfriend’, ‘husband’, and ‘wife’. It is hoped that researchers and others consider the impact of nomenclature in creating either inclusive or exclusive, and optimal or nonoptimal, environments for data collection and service provision, to ensure accessibility and delivery of equitable outcomes for all members of society.

Current research strengths and attributes and future directions

Particular strengths of the current thesis lie in the emphasis placed on examining areas of high clinical and social relevance and those most neglected within the literature. With respect to sexual abuse, strengths of the research include the focus placed on examining victim perceptions, attributions, and appraisals, with respect to offence and perpetrator typologies, processes, and outcomes; perpetrator and victim strategies; victim experiences of abuse, physical and psychological abuse sequelae, and police reporting; patterns and characteristics of disclosure and disclosure responses; and sexual revictimisation. Further strengths lie in the collection of both quantitative and qualitative data; examination of both childhood and adulthood sequelae of CSA; comparative and cumulative examination of CSA and ASA; integrated examination between sexual abuse and a broad range of psychosocial domains including mental health, suicidality, sexual revictimisation, and IPV; and the use of a large and demographically diverse sample.

Particularly in relation to the study of sexual abuse, the inclusion of males and nonvictims addressed sizable deficits in the literature, generating samples more representative of the general community than is usual in research in this area, and enabling gender and victim status comparisons with respect to child and adult sexual abuse and long term corollaries and sexual abuse aftermath that have not previously been conducted. Given the notable absence of males and nonvictim comparison groups in much of the sexual abuse literature, these inclusions contribute markedly to the utility of the research (such that male CSA and ASA victims were able to be represented and
compared with female counterparts, and that victim/nonvictim comparisons were able to be conducted), and constitute amongst the most salient strengths of the research.

In terms of possible benefits arising for survey participants through their engagement with the TSP, a number of welcome and promising, albeit unexpected, findings became evident throughout the data collection period. Given the importance ascribed, within a therapeutic perspective, to the development of insight, and the effective conceptualisation and processing of traumatic life events, it might be predicted that research examining how individuals perceive, appraise, and understand their abuse and concomitant factors can gainfully inform clinical practice. However, participant feedback indicates that the processes invoked by participating in the research (i.e., processes of introspection and responding to the questions and issues raised by the TSP), in themselves facilitated therapeutic gains for a sizable number of individuals. Indeed, the degree to which such gains were spontaneously reported by participants (via email, other direct contact, and survey entries) was unanticipated.

Specifically, commonly expressed sentiments conveyed respondents’ beliefs that completing the survey had increased their insight; brought to the fore long buried emotions and memories; spawned the decision (and courage), and provided the impetus to seek therapy; and led to more adaptive perceptions of their abuse experience (i.e., less self-blaming and accordingly, less shameful). The fact that therapeutic gains were reported from a relatively simple, short ‘nontherapeutic’ exercise is highly encouraging. Specifically, such outcomes raise implications and augur well for the development and delivery of cost effective, highly accessible, user-friendly, and relatively nonthreatening, non-invasive, and private, empirically-derived therapeutic modalities (e.g., self-help manualised intervention, online delivery, bibliotherapy).

It is important to note that the sizable minorities who respectively reported never having disclosed CSA to anyone; wishing to disclose but finding it too confronting; and having no intention of disclosing to anyone, nonetheless made an online disclosure through their participation in the TSP. Whilst this shift is likely attributable to a combination of factors, both person-specific and specific to the nature of the research content and design, participant feedback and survey results suggest that the online format played an important part in facilitating participation and disclosure. Overall, the
survey results clearly indicate the success of the online method for the current research purposes, and specifically, in procuring a large national sample from urban and remote locations and a large volume of detailed information. In terms of person-centred factors, the apparent success of the online method in facilitating participation and disclosure is consistent with previous evidence demonstrating the ability of online modalities to reduce inhibition, social anxiety, and socially desirable responding; increase disclosure, self-awareness, and self-reflection; and create a less confronting climate, relative to conventional methods (for reviews, see Birnbaum, 2000, 2004; Gosling et al., 2004; Hanna et al., 2005; Reips, 2002; see also Archer et al., 1982; Hiltz et al., 1986; Joinson, 1999; Kalin & Schuldt, 1991; Kiesler & Sproull, 1986; Kiesler et al., 1984; Matheson & Zanna, 1988; Reimers, 2007; Walther, 1996).

As mentioned earlier, feedback from participants in the current research suggests that positive results may also be attainable for online psychotherapeutic interventions targeting sexual abuse and other taboo topics. Whether such effects can be replicated in online therapeutic applications with similarly vulnerable populations and confronting subject matter remains a matter for future research. Specifically, it will be of importance to examine whether the promising outcomes evidenced to date in regard to cybertherapy for a variety of healthcare issues such as anxiety, phobias, panic, eating and body dysmorphic disorders, depression, and smoking (e.g., Brendryen et al., 2008; Christensen et al., 2004; Meyer et al., 2009; Wiederhold & Wiederhold, 2006) can be replicated for online treatment approaches specifically targeting problems such as childhood and adulthood sexual abuse and suicidality.

It is contended in the current research that much can be gained by conceptualising victims as the ‘expert witness’ to their own abuse rather than to relegate and constrain such individuals to the position of passivity such as is promulgated and imposed by the classic ‘victim’ role. In the traditional conceptualisation of victims in the judicial system, rhetoric occurs around the victim, whilst their own voice and opinion is rarely heard. Nowhere is such marginalisation of victims in prosecutorial proceedings more pronounced than in relation to child victims of sexual abuse (VLRC, 2003, 2004). Within the Australian judicial systems, the inclusion of Victim Impact Statements (VIS) reflects the relatively recent recognition that the opportunity for victims to communicate to the judiciary the impact of their victimisation is critical to psychological
healing and restoration (Smith & Stewart, 2008). However, it is argued in the current research that victims have more to offer than simply a narrative depicting victimisation impact.

Instead, it is contended that victims are equally well placed to elucidate issues such as perpetrator modus operandi, offence precipitating and inhibiting factors, and thus, areas to be targeted in rehabilitation, prevention, and treatment initiatives. Additionally, if asked, victims can elucidate and identify hindrances they have encountered in regard to disclosure and police reporting and provide feedback that can be used to improve current practices. These contentions are strongly supported by the results of the current research, such that a large number of findings were obtained that contribute new and important information to extant literatures. Such information should be of interest to all persons committed to reform of extant policies and practices, and specifically, to judiciary, law and policy makers, clinicians, victim advocates, and others concerned with issues of human rights, equity, violence reduction, offender rehabilitation, and victim wellbeing. Moreover, to ask the opinion of victims is in itself an action that is empowering of victims, reducing the powerlessness traditionally and by definition ascribed to the ‘victim’ role. Thus, conceptually, further significant strengths of the current research design and content lie in the extent to which the TSP has provided a ‘voice’ for victims and a vehicle through which disclosure and dissemination of previously unavailable ‘expert’ information can be facilitated and used to effect positive change.

The current studies proffer many tangible data that can inform research and clinical practices, judicial processes, educators, and strategists for social and legal reform, and be applied in practical ways to guide therapeutic and preventive initiatives for both sexual abuse victims and perpetrators. Further, as detailed in the relevant chapters of this thesis, these raise many new questions and implications, and highlight areas of need, both for social change and within research domains and clinical practice - areas in which knowledge and practice deficits can attract great human and social costs. The strong relationships found between suicidality and child and adult sexual abuse demonstrate the enormity of impact that can accompany abuse of this nature; and demand forays into literatures, research arenas, clinical practices, and conceptualisations beyond those
pertaining to sexual abuse. Thus, these studies create impetus and serve as creative platforms for many research endeavours in the future.

Like sexual abuse, suicidality is a topic fraught by taboo, misinformation, underdetection, and undertreatment (ABS, 2006b, 2007a, 2007b, 2008; AIHW, 2009; AISRP, 2003; Baume et al., 1998; Beautrais, 2006; Cooper & Milroy, 1995; Henley et al., 2007; Henriksson et al., 2001; Krug et al., 2002; Mann et al., 2005; Maris et al., 2000a, 2000b; McCarthy & Walsh, 1975; Mittendorfer-Rutz, 2006; NHMRC & DoHAC, 1999; O'Donnell & Farmer, 1995; Russell, 2003; Sainsbury & Jenkins, 1982). Given the heightened vulnerability for psychopathology and suicidality concomitant with sexual abuse history and particularly CSA (Fergusson et al., 1996; Kaplan et al., 1997, 2001; Kernic et al., 2000; Smith & Stewart, 2008; Stark & Flitcroft, 1995; Steenkamp & Harrison, 2000; Stephenson et al., 2006; Ullman, 2004; Ullman & Brecklin, 2002, 2003), examination of suicidality in the context of sexual victimisation and differentiation by victim status contribute markedly to the clinical relevance and utility of the current studies. Strengths of the research components examining suicidality within this context lie also in the breadth and quantity of data collected and in the capacity of the TSP to offer a nonthreatening forum conducive to disclosure and accessible to diverse, isolated, and marginalised communities traditionally underrepresented, unheard, or undifferentiated within research samples.

The parallel design of examining both suicide attempt and ideation have added significant value to the study, widening the sample and resultant findings substantially beyond what would have been achievable by measuring suicide attempt only. This is particularly the case, given that suicidal ideation has been sparsely examined to date, relative to the research attention directed toward suicide attempts. Given that proactive and early intervention is desirable, learning to better identify, understand, and address suicidality before behavioural manifestations occur should be important goals at community and individual levels. The current research provides findings that can be applied in practical ways to further professional, community, and individual understanding and clinical practice.

As discussed earlier, welcome, albeit unexpected, outcomes were reported by a number of survey participants who had experienced sexual abuse. Similarly welcome outcomes
developed amongst a group of participants who reported current suicidality to varying degrees of severity. Specifically, email communication was received by the principal researcher from a number of TSP participants during the period of data collection, detailing high, and in some cases, imminent risk of suicide. In all cases, at the point of initial contact, the individual manifested either reticence or unwillingness to disclose their suicidal intent in person and had received no appropriate intervention or support. A number of individuals were located in rural or remote areas and cited lack of anonymity, confidentiality, and appropriate service options; and fear of negative appraisal as inhibitors to help-seeking. Non-empathic, judgmental, or otherwise countertherapeutic responses from GPs were reported by a number of respondents who had started to raise the topic of depression; and cited as the reasons why they did not proceed to disclose their suicidal intent. Conversely, a number of participants commented that the mode of communication via email conferred a sense of safety and anonymity that facilitated disclosure; and that help-seeking was encouraged by the nature and content of the TSP. Examples of comments include:

- 'I figured that if you’d put that much trouble into studying this and seem to know this much about it, you must care and you wouldn’t judge me’
- ‘Somehow you seemed like you’d be easy to talk to and you’d understand…’

Via return email communications, it was possible to take appropriate measures, including the organisation of referrals and facilitation of engagement in treatment. Given the geographical and social isolation, secrecy, and barriers to help-seeking reported by this group of participants, the online format of the TSP and the availability of email communication were pivotal factors in facilitating these outcomes. As discussed in relation to sexual abuse and other topics of taboo, these results suggest that positive outcomes may also be attainable for online psychoeducative and psychotherapeutic interventions targeting depression and suicidality; and provide opportunities that could be explored and extended by future researchers.

Given the demonstrated advantages and success of online research methods for examining sensitive topics and marginalised populations (Archer, 1980; Archer et al., 1982; Bachmann et al., 1996; Bowen, 2005; Boyle & Boekeloo, 2006; Daneback et al., 2005; Derlega et al., 1993; DuRant et al., 2007; Feldman & Freedenthal, 2006; Fikar &
Keith, 2004; Hanna et al., 2005; Harding & Peel, 2006, 2007; Hillier, Turner, & Mitchell, 2005; Hillier et al., 1998; Hiltz et al., 1986; Joinson, 1999; Kalin & Schuldt, 1991; Kelly & McKillop, 1996; Kiesler & Sproull, 1986; Kiesler et al., 1984; Matheson & Zanna, 1988; McDaniel, Purcell, & D’Augelli, 2001; Mehta & Sivadas, 1995; Molloy & McLaren, 2004; Moon, 2000; Oksuz & Malhan, 2005; Pitts, Smith, Mitchell, & Patel, 2006; Reimers, 2007; Ross et al., 2003; Walther, 1996; Turner et al., 1998) the suitability of an online survey for the current research seemed apparent at the design stages. Nonetheless, the extent to which the research was embraced and supported by both sexual abuse victims and the general community was an unexpected, albeit pleasing, outcome. Both the favourable feedback, expressed appreciation, and active support received from groups, organisations, and individuals; and the success of the current research in reaching large numbers of urban and rural Australians attests to the value of the online approach and the research design in examining and identifying hidden disparities in wellbeing.

The current findings can be used to gainfully inform a number of literatures and associated research applications. These include the expanding generic literature pertaining to online research methodologies and computer-mediated communication (Birnbaum, 2000, 2004; Englis & Solomon, 2000; Gosling et al., 2004; Joinson, 1999; Kiesler et al., 1984; Kiesler & Sproull, 1986; Mehta & Sivadas, 1995; Nosek et al., 2002; Reimers, 2007; Reips, 2002; Rhodes et al., 2003; Stern, 2003; Strickland et al., 2003; Thomas et al., 2000); and the literature pertaining to research methods within specialist areas of psychology (Fish, 2000; Meezan & Martin, 2003; Morris & Rothblum, 1999; Mustanski, 2001) and taboo areas such as suicide and sexual assault (Bowen, 2005; Hanna et al., 2005; Moon, 2000; Ochs et al., 2002; Stern, 2003; Turner et al., 1998).

In terms of specific areas for future research, the current findings provide multiple platforms for new investigations. Given the many differences found in the current research between suicide attempters/ideators and non-suicidal individuals, further investigation of concomitant vulnerabilities is warranted. With respect to suicide attempt, it could be argued that, since it is already well-established that a previous attempt is predictive of future suicidality, it is therefore also already known that attempters differ in the long term from nonattempters. However, whilst this finding indicates the presence of disparate vulnerability, it proffers little explanation for such
difference, nor substantive information about possible broader mental health differences, except by implication. For example, it remains poorly understood whether heightened suicide vulnerability amongst previous attempters is conferred by differences in factors such as cognitive stance, coping strategies, problem solving approaches, and perturbation thresholds, or rather by heightened distress per se (e.g., depression, anxiety, shame), as might easily be presumed.

Second, it remains unknown whether suicidal ideation has similar predictive qualities to suicide attempt. This would be important to know, given the sizable benefits of identifying and intervening at an earlier (pre-behavioural) stage. Further research should be conducted to extend current understanding of vulnerabilities concomitant with suicidality, and to determine how vulnerabilities that persist into the future can best be identified and mitigated. Given that far more people experience suicidal ideation than attempt suicide, earlier identification and intervention for a larger proportion of suicidal individuals could be facilitated if delineating factors could be identified with respect to ideators and non-ideators. Hence, it should be examined through future research whether long term differences exist between individuals who have ever seriously contemplated suicide, and those who have not, and further, whether previous ideation holds similar predictive merit to that of a previous suicide attempt. Given the salient role of alcohol and drug use in facilitating self-directed and externalised violence, incorporation of variables that examine substance use patterns and sequelae should be given careful consideration.

The current research shows clearly elevated suicidality vulnerability amongst adult CSA survivors, relative to their non-victim counterparts. Principles of early intervention suggest therefore that both preventive and therapeutic approaches and research endeavours should be targeted toward populations of highest vulnerability, including children and young people with recent or current experiences of abuse. Before this can be achieved however, researchers wishing to target such populations and topics must navigate and address the extremely sensitive and important ethical and safety issues inherent in research of this kind. A more feasible approach may continue to be that of addressing adult populations and extrapolating from resultant findings to derive implications for best practice in supporting children and young people.
The important issue of suicidality contagion effects (particularly amongst young people and those with a mental illness) constitutes another priority area for suicide research. Whilst media reporting of suicide is currently strictly limited and controlled in Australia, it has been argued, for example, by 2010 Australian of the Year, Professor Pat McGorry (Metherell, 2010), that reporting guidelines should be eased, given the premise that suicide taboos perpetuate stigma, inadequate attention and investment, and lack of awareness. This view is juxtaposed by the need for due caution given valid concerns that media coverage can increase suicide deaths amongst vulnerable cohorts (Blood & Pirkis, 2010; Hassan, 1995; O’Carroll & Potter, 1994; WHO, 2008). Empirical research is needed to guide this debate, and similarly, to measure the still unknown impact on suicide of the Internet and social networking sites such as Facebook (Biddle, Donovan, Hawton, Kapur, & Gunnell, 2008). The challenge remains for researchers to accurately gauge both the positive and potentially negative impact of the Internet upon suicide risk at individual and population levels to allow more evidence-based debating on important issues that remain uncertain to date (Biddle et al., 2008).

With respect to the demonstrated reticence with which individuals (particularly males) discuss sensitive information and seek psychological services, it would be useful for future researchers to identify and examine help-seeking, and disclosure-inhibiting and disclosure-facilitating factors amongst sexual abuse victims and other distressed cohorts. Specifically, it would be useful to determine what has previously inhibited help-seeking; and if counselling has been sought, ‘what worked’ and ‘what didn’t’. Possible points of delineation could include both client-centred, problem-centred, and therapist-centred variables; and factors such as therapist-client dyads, therapeutic alliance, and therapeutic frameworks and session content.

Further, the current findings prompt research agendas pertaining to violent and sexual offending, recidivism, victimisation, and revictimisation. It would be useful to extend the current findings relating to victim resistance strategies and offender modus operandi by gaining offender perspectives on these topics. Specifically, future research could target offending patterns, and offender cognitions and attitudes with respect to victim selection and victim responses, with a particular focus on potential deterrents and offence-facilitating and offence-escalating factors. The anonymity conferred by online
methods would allow responses to be gained from undetected and unconvicted offenders and allow comparative studies to be conducted between offending and non-offending individuals. In general, the anonymity and conduciveness to open disclosure created through cyber-research methods provides opportunities for research examining many illegal and socially unacceptable behaviours and attitudes, as well as topics subject to shame, guilt, or embarrassment.

Given the known negative impact of minority group stress (Smedley et al., 2003) and the higher vulnerability to suicide present amongst sexual minority groups (Cochran et al., 2003; D’Augelli & Grossman, 2001; Fergusson et al., 1999; Gold et al., 2007; McDaniel et al., 2001; Mills et al., 2004; Paul et al., 2002; Pitts et al., 2006; Russell, 2003; Saewyc et al., 2006; Savin-Williams, & Ream, 2003; Stewart & Smith, in press-b; Warner et al., 2004; Welch et al., 2000), further research should also examine the topics explored in this thesis in the context of sexual orientation. Further online research can be usefully conducted to examine victim mental health and wellbeing in the context of homophobic prejudice and discrimination; as well as other forms of bigotry (e.g., racism) from both victim and perpetrator perspectives. Given the challenges demonstrated in the current research in recruiting male respondents relative to females, targeted and considered efforts should be directed at male recruitment in order to obtain an accurate representation of male experiences.

Summary A number of attributes contribute to the strength and utility of the current research program. Prominent amongst these are the broad, inclusive nature of the sampling and data collection methods, and the resultant diversity and size of the sample obtained. Utilisation of a nonclinical, nationwide sample of rural and urban Australians of diverse ages and sociodemographic profiles; inclusion of males and females, victims and nonvictims, and suicidality comparison groups; and the application of an inclusive battery of both psychometrically sound measures and item sets constructed by the researcher allowed thorough and scientifically rigorous comparative analyses to be conducted across a wide range of variables. The utilisation of an online methodology contributed markedly to the strength and success of the study both in terms of increased financial and logistic feasibility and in terms of facilitating recruitment, participation, and disclosure. For the purposes of the current research, the enhanced anonymity, confidentiality, and user-friendliness; the relatively nonterrorizing forum for disclosure;
and the increased accessibility for diverse, remote, and hidden populations conferred by the online method were amongst the most salient advantages of using this mode of research. It is hoped that future research can be conducted that utilises, extends, and builds upon the methods and findings of this research in order to advance problem-solving at individual and population levels.

6.3.5 Concluding Comments
At theoretical levels, interpersonal and self-directed violence and abuse are entirely preventable, by definition (Krug et al., 2002; Page et al., 2006). However, in practice, a complex interplay of contributing factors must be addressed at individual and societal levels and from criminal justice, health care, social, and welfare perspectives. Interventions for alcohol and drug misuse are amongst those warranting prioritised attention. Particular cohorts within society are clearly more vulnerable to perturbation, violence, and victimisation than others; and such disparate vulnerabilities similarly demand close attention. Policies and social structures that engender social cohesion, belonging, and meaning, in a climate of safety and respect are likely to facilitate lower manifestations of anger and aggression. Specific foci for attention include initiatives that foster peaceful co-existence within a framework of equality; tolerance; respect; and acceptance of difference (Page et al., 2006). Initiatives are also required to address social welfare disparities, particularly those that adversely impact children and their opportunities for nurturing, safety, and learning. To this end, it is important that efforts to minimise violence, abuse, and harm from substance misuse extend beyond the primary targets of such interventions, to include also the families and communities who witness and bear the brunt of such problems and, in turn, manifest distress that bears testimony to the broad-reaching harmful corollaries of such experience.

Enacting the current research agenda resulted in a breadth and quantity of interrelated data not previously collected in any known study. Combination of research domains allowed myriad analyses and potential topics and variables to be analysed. In particular, data collected enabled focussed examination in topics ordinarily hampered by taboo or previously underresearched and neglected in mainstream research. Such areas include child and adult sexual abuse processes and corollaries, male sexual victimisation, and suicidality. This research has drawn heavily on a number of distinct mainstream and specialist literatures that have been able to inform and extend each other to afford
unique perspectives and allow new relationships to be explored in ways that have not previously been undertaken. Such literatures include those pertaining to forensic issues (e.g., sexual and violent offending, legal and psycho-legal, child and adult victimisation); suicidology; trauma, substance use, and other areas of clinical psychology and psychiatry; and computer-mediated communication.

Unique combinations of variables and comparisons have yielded findings, both of a broad nature and at the level of minutiae, that have been unavailable to date. For example, broad-natured findings include those that individuals were able to be differentiated in terms of long-term psychosocial wellbeing and suicidality on the basis of past child and adult sexual victimisation. At the level of fine detail, examples include data that quantify and describe sexual abuse victim regrets related to police reporting and non-reporting; sexual abuse victim counselling experiences, confidante choices and preferences; victim patterns of disclosure and nondisclosure; and long-term impact of CSA. It is hoped that the integrated and holistic methodology applied in the current research has produced findings that are of interest and utility to readers in a range of disciplines and literatures, and that these will be gainfully applied in the future in diverse research and practice applications, to effect meaningful positive change.

No one is born hating another person because of the colour of his skin, or his background, or his religion. People must learn to hate, and if they can learn to hate, they can be taught to love, for love comes more naturally to the human heart than its opposite.

- Nelson Mandela


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