

The Zurich Study

XVII. Sexual Abuse in Childhood. Frequency and Relevance for Adult Morbidity Data of a Longitudinal Epidemiological Study*

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Summary. In the course of a 10-year longitudinal investigation of young Swiss adults, childhood sexual abuse was assessed at the age of 30 years. It was reported by 11.5% of women and by 3.5% of men; 56% of the females had been abused by relatives (none of the males), 20% by fathers. Abuse cases tended to be more depressed and anxious; they reported more suicide attempts and more sexual problems than controls and also slightly more psychiatric symptoms and neuroticism. Childhood familial risk factors were more frequent for abuse cases than for controls. Depression at adult age was more strongly connected with early familial risk factors than with early sexual abuse.

Key words: Child sexual abuse – Adult age – Family risk factors – Anxiety – Depression – Personality

Introduction

Since the 1970s childhood sexual abuse (CSA) has, for several reasons, received increasing attention in the media and in psychiatric and psychological research. A discussion of child/adult sexual contacts arose with the “coming-out” of a paedophilic movement, which maintained that children’s voluntary sexual contact with adults was not damaging and even helped to develop a normal sexual life. The contrary position was taken up by the feminist movement. It focused on father-daughter incest, as the symbol and culmination of male dominance and violence, which was supposed to leave the child psychologically crippled (Lachmann 1988). In

Switzerland, at the end of the 1980s several cases of child rape and murder turned public opinion in favour of the feminist stance. Presently the conventional media wisdom concerning CSA holds that a large number of children, mainly girls, are affected (rates of 25–50% are given); that father-daughter incest is the most frequent type of abuse; that CSA mainly occurs in seemingly intact, closely knit families; and that it regularly, severely and permanently impairs the mental health of the child (Bifulco et al. 1991; Elliger and Schötensack 1991; West 1988). The finding of large rates of women with clinical eating disorders reporting CSA (Bulik et al. 1989; Hall et al. 1989; Oppenheimer et al. 1985; Palmer et al. 1990; Kinzl and Biebl 1991) confirmed this view from a scientific perspective.

The response of psychiatric epidemiology to public opinion, on the other hand, is equivocal. Whereas there is a consensus in the epidemiological literature that among abuse cases father-daughter incest is relatively rare, data on lifetime prevalence in the general population vary widely, and the familial antecedents and concomitants of CSA as well as its consequences for mental health in the general population have been infrequently investigated (Bifulco et al. 1991; Beitchman et al. 1992).

Tables 1 and 2 show epidemiological data of lifetime prevalence and frequencies of CSA according to strict and wide definitions. Rates vary from 1% to 51%, and it is immediately evident that two factors determine the variation: the age limit the authors set to childhood and whether sexual encounters with peers of approximately the same age are excluded or not. By including peer contacts Elliger and Schötensack (1991) arrived at a prevalence rate of 21.1% for Würzburg students; by including encounters with exhibitionists, non-contact molestation and being confronted with pornography they obtained a rate of 33.5%. The inclusion of contacts between older adolescents (16–18 years of age) and of at least 16-year-old girls with adults seems to overstretch the concept of

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Table 1. Narrow definition of childhood sexual abuse (CSA)

	Sample	Definition	Age limit	Prevalence	Thereof abuse by relatives
Finkelhor and Hotelling 1984	521 parents; Boston general population	Sexual contact (5 years +) ^a or use deceit/force	17	6% m	n.d.
Sapp and Carter 1978 (questionnaire)	1339 Texas driving licence holders	"abuse" by parent/adult	18	5.3%	
Kerchner and McShane 1984 (questionnaire)	1056 Texas driving licence holders	being used for sexual stimulation by adult/older peer	"child" 9.8% f	7.4% 3.4% m	n.d.
Baker and Duncan 1985 (interview)	2160 UK general population	being used for sexual stimulation by adult/older peer (including porno, exhibitionist)	16	10% 8% m 12% f	14%
Bagley and Ramsay 1985	377 women; general population Canadian city	sexual contact (3 years +) or pressure	16	22% f	n.d.
Briere and Runtz 1988 (questionnaire)	278 female undergraduates	sexual contact (5 years +) ^a	15	14.7% f	12%
British Broadcasting Research (cited in Markowe 1989) 1988 (interview)	UK general population	used by adult or older peer for sexual gratification	15	1% m 4% f	
Burnham et al. 1988 (ECA, interview) Siegel et al. 1987	3132 Los Angeles general population	sexual contact under pressure	16	5.3% 3.8% m 6.8% f	20%
Mullen et al. 1988 (interview)	2000 New Zealand women general population	"sexual abuse"	13	9.9% f	39%
Ellinger and Schötensack 1991 (questionnaire)	1018 Würzburg students	sexual contact (5 years +) ^a	14	6.9% 4.3% m 10.0% f	50%
Bifulco et al. 1991 (interview)	395 London housewives with children	any sexual contact with non-peer	17	9%	56%

n.d., Not determined

^a5 years +: contact with a person at least 5 years older**Table 2.** Wide definition of CSA

	Sample	Definition	Age limit	Prevalence
Russell 1983	930 San Francisco women	any contact in family	18	16%
Herman et al. 1986 (interview)		any contact outside family	18	31%
Committee 1984 (interview)	2000 Canada general population	unwanted sexual contact	16 16	47.5% f 12.5% m
Sedney and Brooks 1984 (questionnaire)	301 College women (volunteers)	sexual contact	"grow-ing up"	16%
Wyatt 1985	Los Angeles county random digit sample, 395 females (45% refused) 248 interviews	contact with adult older peer (unwilling)	18	40% black 51% white

child abuse. In 1992 in Switzerland the criminal law was changed by public vote, and peer contacts even in early adolescence today are no longer punishable.

The median of lifetime prevalences of frequencies for females resulting from Table 1 is of 11%; that resulting from Table 2 is of 20%. In Table 1 the median of prevalence or frequencies of strictly defined CSA obtained by interviews and questionnaires are not strikingly different, though Finkelhor (1986) expressed the opinion that interviews lead to higher frequencies.

The following data are based on four interviews of a representative young adult swiss population, which we use to discuss the frequency of CSA in the general population and its relevance for later psychiatric and psychosomatic disorders.

Materials and Methods

The subjects investigated were those of the Zurich Study, which was extensively described in Angst et al. (1984). In 1978 a representative sample of 19-year-old conscripts and 20-year-old female first-time voters were screened with the SCL-90R (Derogatis 1977) and a longitudinal sample was followed up ($n = 591$). In order to obtained a group with a relative high risk for later disorder, this sample consisted of two-thirds of subjects with an SCL-90R score above percentile 85. Personal interviews were obtained in 1979, 1981, 1986 and most recently in 1988, when the subjects were 29 and 30 years old. We used the SPIKE interview, which is highly structured and assesses psychiatric and psychosomatic symptoms and syndromes and among other variables also social relationships, coping and life events. In 1988 the response rate was of 72% (197 males, 224 females, including 3 males and 6 females who were given a short version of the interview).

For dependent variables besides DSM-III diagnoses of depression and anxiety we introduced the concept of recurrent brief depression (Angst et al. 1990) and of minor depression (Angst, in press).

In 1986, at age 27–28 years, we obtained a description of the subject as a child mainly in regard to emotional and behavioural problems. In 1988 we investigated family stress in childhood, such as a broken home, and other familial risk factors. In this context we asked the question: "When you were a child or adolescent, did you ever have a sexual experience that you found distressing?" Then a short narrative description of these experiences was obtained.

This method of asking an incidental question among a wealth of other assessments had the advantage of a minimum irradiation from the subject of CSA to other topics, e.g. to the reporting of familial risk factors or childhood problems or to reporting later psychiatric disorders or difficulties in emotional or sexual relationships. All data examined for an association with CSA were either repeatedly collected over 10 years (diagnoses, suicidal behaviour, quality of partner relationships) or in a previous interview (childhood problems) or before, in the 1988 interview, the question on abuse was posed (familial risk factors).

In comparison with an interview or questionnaire focused specifically on CSA, the one question we asked is relatively superficial. The interviewers wrote down the spontaneous descriptions of distressing experiences without further inquiries. A counterweight to this somewhat perfunctory treatment of CSA consists in its psychiatric associations having a greater chance of being assessed with four than with one single interview.

In the same interview in 1988 (at age 30), which contained a question on CSA, the following childhood risk factors for later psychiatric disorder were also assessed: chronic somatic illness or disability in parents/sibs; psychiatric disorder in parents/sibs; not having lived with both natural parents up to age 16; parental dis-

cord; severe conflicts of self or sibs with parents; lack of care; overly severe punishments; financial problems; family not highly regarded in the community. From this variable a weighted index of family strain (0–100) was calculated where a "broken home" had twice the value of the other factors and where the single variables were weighted reciprocally to frequency.

Forty-one females and 11 males gave a positive answer to the question about early stressful sexual experiences. Two independent assessors differentiated sexual abuse from other unpleasant experiences by the following criteria:

1. With the intention of obtaining sexual satisfaction an adult tried to initiate or initiated physical contact with the subject when a child under age 16.
2. The same definition was applied to adolescents if there was an age difference of more than 3 years, if threats were used or if the adolescent was a relative.

Results

Frequencies and Prevalences

These criteria defined 25 women (11.2%) and 6 men (3.0%) who had suffered CSA, e.g. sexual molestation by a teacher, being assaulted by a stranger, having a sexual relationship with his/her father. Two of these experiences may have included intercourse. Of the women 14 had been molested by family members, while all sexual contacts or molestations of men were initiated by homosexual, non-related adults, of whom were a teacher, a camp-counsellor, and an older adolescent. The others were strangers (Table 3).

With the small numbers involved, the weighting back from the longitudinal sample to the 4547 original subjects is fraught with some uncertainty. The prevalence – weighted for the selection of the longitudinal sample by SCL-90R – of CSA was 4.9% for girls and 1.8% for boys (sex ratio 2.7); the unweighted frequencies were 11.2% for girls and 3.0% for boys (sex ratio 3.8). Girls were abused at a higher rate than boys, and 56% of the females but none of the males reported sexual molestation or contacts within the family. All perpetrators were male. The involved relatives were fathers (5 cases = 20%), brothers (2 cases), unspecified relatives (2 cases), uncles (2 cases), grandfathers (3 cases).

Because of the small number of males who reported CSA the following analyses are restricted to the 25 females who reported any abuse and the subgroup of 14 females who reported abuse within the family. The con-

Table 3. Frequencies and prevalences of CSA reported at age 30

	Women		Men		Sex ratio
	<i>n</i>	%	<i>n</i>	%	
Frequencies					
Any abuse	25	11.5	6	3.0	3.8
Abuse by relatives (subgroup)	14	6.5	—	—	
Weighted prevalence					
Any abuse		4.9		1.8	2.7
Abuse by relatives		2.6		—	

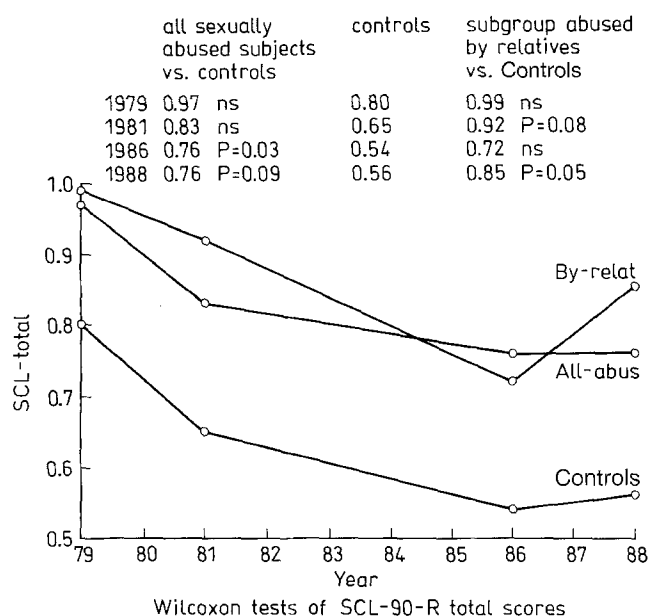


Fig. 1. SCL-90 total score and childhood sexual abuse over 10 years (age 20/21–29/30)

trol group consisted of 199 non-abused females. We give those data for descriptive purposes. Statistical tests are usually not significant even if the differences are robust (small numbers) and may be of clinical significance.

The Familial Context of Child Abuse

Abused women and controls did not differ in social class of origin. The whole abused group and the subgroup that suffered familial abuse did not differ from controls in regard to chronic illness of father or sibs, financial stress or the family being held in low esteem. The groups differed as regards the presence of a broken home (40% and 50% vs 13%), mother being chronically ill (20% and 35% vs 12%), psychiatric disorder of father (28% and 36% vs 21%), psychiatric disorder of mother (20% and 36% vs 24%), parental discord (36% and 43% vs 27%), and severe conflict with parents (48% and 50% vs 33%). The whole abused group and the subgroup that suffered familial abuse more often reported low level of care (47% and 42% vs 9%) and severe punishment (37% and 29% vs 37%). None of the differences reached statistical significance. The rates contain an allusion to the association of familial abuse with chronic illness of the mother and psychiatric disorder of the father.

The whole CSA group and the subgroup that suffered familial abuse differed from controls in a higher reported level of the family strain index (Table 4). The abused group reported an average of 3.8 strain factors; the subgroup with familial abuse 4.6 factors and controls 2.8 factors ($P = 0.08$ and 0.03).

Emotional and Behavioural Childhood Problems

How did these childhood conditions reflect on the self-reported personality of the child? The 1986 interview

Table 4. Child abuse and family strain reported in 1988

	Cases	Controls
All childhood abuse (n)	25	199
Index value (x)	27.8	16.0
Wilcoxon	P = 0.03	
Subgroup with abuse by relatives (n)	14	199
Index value (x)	34.6	16.0
Wilcoxon	P = 0.01	

contained 12 items on childhood anxiety such as fear of teacher, gymnastics, swimming, and on behavioral difficulties such as truancy, stealing, fighting, and running away from home. Females who reported any CSA described themselves as more unpopular and more behaviourally disturbed than controls (small differences on six questions). The largest deviation from controls was in being unpopular (32% of cases vs 17.3% of controls) and stealing (24% vs 6.8% of controls). The subgroup that had been abused by relatives also reported feeling more unpopular (42.9% vs 17.3% of controls) and, whereas this group appeared more anxious on two items, behavioural disturbances were not reported. Because of small numbers none of the differences mentioned above were statistically significant.

Association of CSA with Later Psychopathology

We investigated the association of early sexual abuse with adult depression by comparing the rate of cases with controls by diagnoses of depression over 10 years (1979–1988). There was only a slight association with major depressive disorder DSM-III, and none with recurrent brief depression, minor depression or dysthymia. There was also no association with panic. There was a trend to increased agoraphobia and social phobia among cases. Lifetime suicide attempts were five times more frequent among CSA cases than among controls (difference not significant) (Table 5).

Binge eating was not associated with CSA, nor was cigarette smoking or regular cannabis use.

At each interview sexual problems and disturbances were assessed. Half of the women with any CSA (48%) reported persisting sexual problems as compared with 28% of controls ($P = 0.02$). Among the subgroup of 14 women who were abused by relatives 71.4% reported problems (difference from controls not significant because of small numbers). Psychological or somatic difficulties at menstruation, on the other hand, were not more frequent among CSA cases than among controls.

Psychiatric and Psychosomatic Symptoms

The Symptom Checklist SCL-90R was given at each interview (Fig. 1).

The subjects' SCL-90R total score was consistently higher than that of controls, but differences were small. Those between women abused in childhood and controls

Table 5. CSA and later psychopathology

	Cases <i>n</i> = 25 %	<i>P</i> *	Controls <i>n</i> = 199 %	Familial abuse ^a subgroup <i>n</i> = 14 %
<i>Depression</i>				
DSM-III-R MDD 1979–1988	52	0.08	34	43
Recurrent brief depression 1979–1988	44	n.s.	33	43
Dysthymia ^b 1986–1988	4	n.s.	5	7
Minor depression 1979–1988	12	n.s.	12	7
<i>Suicide attempts</i>	20	n.s.	4	21
<i>Anxiety</i>				
Panic ^b 1986–1988	8	n.s.	9	7
Generalized anxiety ^b 1986–1988	4	n.s.	7	7
Agoraphobia ^b 1986–1988	12	n.s.	4	12
Social phobia ^b 1986–1988	24	n.s.	11	21
Simple phobia 1979–1988	16	n.s.	21	7
Persisting sexual problems 1979–1988	48	0.02	28	71

^aStatistics: all chi square of cases of “familial abuse” vs controls are not significant (small numbers)

^bThese diagnoses only fulfilled DSM criteria at the 1986/88 interview

were most consistent over time on the scales “paranoid ideation”, “psychoticism” and “somatization”, and for the subgroup abused by relatives also on “interpersonal sensitivity”. “Paranoid ideation” contains items detecting mistrust, diffidence, readiness to feel slighted; “psychoticism” contains items on loneliness, isolation, and not feeling allright. The scales of depression and anxiety, on the other hand, showed few consistent differences in comparison with controls.

Personality and Early Sexual Abuse

In 1988 the Freiburg Personality Inventory (Fahrenberg et al. 1978) was given. A comparison of all 25 cases of sexual abuse with controls led to a difference on one of nine primary scales (cases appearing more depressed: 17.5 vs 14.1, $P = 0.02$) and on one of the secondary scales (cases appearing more extraverted: 21.1 vs 19.4, $P = 0.03$). The subgroup of 14 cases that experienced abuse by relatives described themselves as more depressed (18.8 vs 14.2, $P = 0.02$), and in regard to the secondary scale of neuroticism tended to be more neurotic (19.4 vs 16.4, $P = 0.10$).

As regards the factor “neuroticism” (obtained by factor-analysing FPI results) (Angst and Clayton 1986), both the whole group and the subgroup abused by relatives were slightly higher than controls (20.3 vs 17.3, $P = 0.05$; 21.3 vs 17.4 $P = 0.06$).

Table 6. Log-linear analysis of CSA and family strain as precursors of depression in young adult age

	<i>df</i>	Chi square	<i>P</i>
Intercept	1	0.02	0.8867
Sex abuse	1	1.14	0.2855
Scale family strain	1	6.43	0.0112

Pearlin and Schooler's (1978) scales of self-esteem and mastery were part of the first three interviews. Notwithstanding the trend to an association of CSA with social phobia and agoraphobia, cases did not deviate from controls on these variables at any time over 8 years.

Relationship to the Other Sex

At each interview, in another context, marital status was assessed and subjects were asked whether they were cohabiting or had a lover or partner and if so, about the quality of the relationship. Parts of the life-event scale (Holmes and Rahe 1967) were interspersed with the interview and some of the items concerned problems connected with lover or partner, such as abortion, miscarriage, pregnancy, separation, or divorce. In 1979 the whole risk group reported an average of one partner-related event per person (vs 0.5 events for controls, $P = 0.03$) and in 1988 an average of 0.76 events per person (vs 0.19 events for controls, $P = 0.0001$). For the familial subgroup the values were the same as for the whole group. There was no significant difference in marital status or presence of a partner or in the quality of the relationship.

Logistic Regression Analysis

A log-linear analysis for the whole group of 25 CSA cases showed that abuse per se was not independently connected with later depression (DSM-III MDD and/or recurrent brief depression and/or dysthymia and/or minor depression diagnosed over a period of 10 years, 1979–1988) but that reported family strain was significantly associated with later depression (Table 6).

Discussion

Frequencies of CSA found among a stratified 30-year-old Swiss sample were of 3% for men and 11.2% for women. The latter rate is in accordance with the literature in so far as strict definitions for CSA are used: female Würzburg students, London housewives and New Zealand women reported approximately the same frequencies of CAS (Bifulco et al. 1991; Elliger and Schötensack 1991; Mullen et al. 1988). Weighting back from frequency to prevalence resulted in 4.9% for 30-year-old Zurich women. This value is lower than the prevalence of 6.8% given by the ECA Study, which was based on 3000 subjects and regarded sexual contacts obtained by pressure

or force (Burnham et al. 1988; Siegel et al. 1987). The frequency of CSA we obtained among females may be looked at with some confidence. Frequency and prevalence among men (3% and 1.8%), on the other hand, are at the lower end of the range reported in Tables 1 and 2, and the prevalence is about half of the ECA prevalence (3.8%). As Finkelhor and Hotaling (1984) estimated the lifetime prevalence of CSA up to age 13 for men at 2.5–5% and culled from eight studies a sex ratio of 2.5 – the sex ratio in our sample was of 3.8 – it is possible that in our study men were less ready than women to discuss the subject with our female interviewers in 1988. All our male cases of serious abuse were involved with or molested by extrafamilial males. This fact is in accordance with the literature, where females appear as aiders and abettors but not as perpetrators (Finkelhor 1984).

There are other characteristics of our group of 25 young women who reported CSA which fit well with previous descriptions. As shown in Tables 1 and 2 the rate of familial abuse of all abuses is approximately 50% at the most and often much lower. The rate of abuse by relatives of all abuse in our study was 56%, and of abuse by the father was 20%; the ECA study gives a rate of 26.2% of all abuse for sexual contact with any relative and of 13.1% for contact with a parent. Bifulco et al. (1991) found in their study that 56% of all abuse cases had been abused by a relative and 28% by the father. In none of the epidemiological studies on CSA which have come to our notice does father-daughter incest appear as the dominant situation in abuse.

Several authors were of the opinion that alcoholism, parental discord, a broken home, presence of a stepfather and low income were risk factors for both familial and non-familial CSA (Finkelhor 1987; Sheldrick 1991; Van der May 1988) and that CSA victims from disrupted families were particularly beset with adult pathology (Conte and Schuerman 1987). Fromuth (1986) showed for a female student sample, Bagley and Ramsay (1985) for Canadian females, and Bifulco et al. (1991) for a London working class sample of housewives that familial and non-familial abuse were strongly connected with familial risk factors in childhood, such as low support, punitiveness, having to stay at an institution, and parental violence. (The last-mentioned authors took care to ascertain that these factors were present before abuse set in. Our Swiss data confirm this view.) Familial and non-familial CSA was significantly related to a weighted scale of family strain. The connection was stronger for the subgroup of subjects abused by relatives than for the whole group. Thus the view that CSA is connected with family disruption, low level of support, and particularly with separation from parents is fully confirmed and the view that familial CSA is the feature of a seemingly intact family is contradicted.

As regards the impact of CSA on later caseness or psychiatric diagnoses opinions are divided. Over a period of 3 years, Bifulco et al. (1991) found among their London working class CSA cases 64% who fulfilled at least one Bedford College criterion (controls 26%) and 36% with chronic episodes lasting 12 months or more (controls

10%). These criteria are similar to those of the PSE-ID system. On the other hand, in a representative sample of New Zealand women with CSA Mullen et al. (1988) diagnosed 31% GHQ cases and 20.7% PSE-ID cases (vs 20% and 10.2% among controls). Being a CSA victim increased the risk by a factor 1.5–3.6. Browne and Finkelhor (1986) maintained in a survey that most victims are “slightly impaired or normal”, and that only about one-fifth, i.e. twice the rate of controls, have evidence of serious psychopathology. The difference between the strength of the association of CSA and later pathology in the London and the New Zealand sample may be connected with differences in the subjects’ socioeconomic status.

Differing from both studies we found, over a period of 8 years, a trend of CSA to be associated with later major depression, suicide attempts, and social phobia: being a CSA case increased the risk by a factor 1.5, 5 and 2.2 respectively. There was also a strong significant association with persistent sexual disturbances and problems, which reached 71% in the subgroup with familial abuse. In a survey of long-term effects of CSA, sexual difficulties are quoted as the most striking finding (Beitchman et al. 1992). An association of CSA with later binge eating was not confirmed by our data.

At the level of *psychiatric and psychosomatic symptoms* Brière and Runtz (1988), using the Hopkins Symptom Check List (a precursor of SCL-90R), found by discriminant analysis in victims of CSA among female undergraduates mainly higher values on scales of somatization and dissociation. The not very striking differences of our subjects on the SCL-90R over 10 years were most consistent on the scales of somatization, and those of paranoid ideation and psychoticism, which seem to detect the feeling of being slighted and inadequate. This finding goes well with that of a higher frequency of social phobia and agoraphobia, but not so well with our cases’ report of an unimpaired sense of self-esteem and mastery. Our data correspond closely to those reported by Fromuth (1986) in a sample of female undergraduates.

If repeated application of scales that measure short-term symptoms is considered as an equivalent to giving a personality test (Duncan-Jones et al. 1990), then the agreement of the SCL-90R with the FPI in degree of deviation will not come as a surprise. On the latter our CSA cases were different from controls regarding depressivity and factor neuroticism, but differences were not large.

Bagley and Ramsay (1985), Mullen et al. (1988), and Bifulco et al. (1991) tested the quality of partnerships of CSA victims. The subjects of the latter groups did not differ from controls in frequency of marriage and number of children, but had a greater risk of their marriage ending in divorce or separation. Bagley and Ramsay (1985) found more marital dissatisfaction in CSA subjects. Our Swiss females, on the other hand, did not deviate from controls as regards marital status, or partnership variables. If at all, differences may appear at a later age. Both groups, however, reported slightly more partner-connected life-events than controls, i.e. possibly a more stormy course of the relationships.

Thus the main findings over 10 years in our sample of CSA cases at age 30 are those of slight deviations of mood and personality, of a propensity to major depression and to anxiety disorders (mostly to those connected with being evaluated by others), and of reporting many more lifetime suicide attempts and many more sexual problems and disturbances than controls. Only the latter difference was statistically significant. A log-linear analysis showed that CSA by itself was not connected with depression in early adulthood but that family strain (as defined by the classical risk factors for psychiatric childhood disorders) was associated with later depression. This is in accordance with the careful analysis by Bifulco et al. (1991), who concluded that CSA led to later depression only in the context of a neglectful and violent childhood environment.

In accordance with the epidemiological literature our study thus refutes conventional wisdom regarding: the prevalence of CSA, which is more likely around 10–15% for women than 20–50%; the rate of familial abuse and particularly of father-daughter incest, which amounts to a small fraction of all CSA cases; the impact on later mental health, which – with the exception of sexual problems – appears limited; the families, where CSA – whether familial or not – occurs: cases reported more intrafamilial strain and disruption than controls.

The relative inoffensiveness of CSA for later mental health may be a consequence of the rarity of severe abuse among our subjects. Tsai et al. (1979) compared two groups of adult female victims of familial CSA: one strongly deviating from non-abused controls in the MMPI, the other similar to controls. The former group had more often been molested by the father, at an earlier age, for longer periods, more frequently and more often by intercourse. Women who have experienced such severe abuse – with concomitant familial risk factors – will cluster in clinical samples (Herman et al. 1986), but they seem to constitute a small minority of the general population.

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