Child Sexual Abuse: A Public Health Perspective
Symposium Hosted by the Moore Center for the Prevention of Child Sexual Abuse

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Note of Appreciation
We sincerely appreciate the time and talent dedicated by each of our speakers, which
included Dr. James Mercy, Dr. Derek Brown, Ms. Karen Baker, and Mr. Scott Matson
(morning speakers); panellists Mr. James Clemente, Mr. Scott Paterno, Mr. Adam
Rosenberg; and Ms. Maia Christopher (afternoon speakers). In this document, we
summarize the morning presentations. Any discrepancies between information
presented by our speakers and this summary are due entirely to our own errors of recall.

Symposium Co-Chairs Drs. Elizabeth Letourneau and Fred Berlin
Child Sexual Abuse: A Public Health Perspective

Introduction

**Speakers**

Prof. Daniele Fallin, Chair, Department of Mental Health, Johns Hopkins Bloomberg School of Public Health

Prof. Elizabeth J. Letourneau, Ph.D., Director, Moore Center for the Prevention of Child Sexual Abuse

In her welcoming remarks, **Prof. Daniele Fallin** said the Bloomberg School sees the mission of the Moore Center “as a school-wide and even a university-wide initiative.” Based on her own work in autism spectrum disorder, she said she was particularly pleased with the Center’s focus on prevention.

In both child sexual abuse (CSA) and autism, “if only we looked at the causes and did something about risk factors, we might be able to target primary prevention and stem that tide,” so that future generations see less impact. That’s why it’s important to address child sexual abuse from a prevention perspective, and not only by focusing on criminal justice and victim treatment and recovery.

**Dr. Elizabeth Letourneau** welcomed participants to the Center’s largest symposium ever. “We hope you will leave here today with a better appreciation of the scope and consequences of child sexual abuse, and the promise of preventing both victimization and perpetration,” she said.

“Prevention is possible. This is the message of the Moore Center, and it’s a message we hope you will come to believe if you don’t already.”

Child sexual abuse is one of 24 risk factors that contribute substantively to the global burden of disease, and just one of a handful that are preventable, according to the World Health Organization. It also has a direct and indirect effect on other risk factors, including sexual risk behaviors and substance abuse.

For the last 30 years, CSA prevention programs have typically targeted young children at school and focused on three R’s: recognizing potentially abusive situations, resisting abusive overtures, and reporting previous or ongoing abuse. Dr. Letourneau said high-quality programs do increase knowledge and self-protection skills and encourage disclosure, “and these are all very important goals. But so far, no research has indicated that training young children to protect themselves reduces their likelihood of victimization. And part of the issue is that the children should not be responsible for their protection—we are responsible, the adults in their lives.”

She said several strands of research support the view that prevention is possible.

- Children who present with serious sexual behavior problems that don’t stop with simple interventions are not sex offenders, but they’re a high-risk group. A 10-year study found
that appropriate intervention reduced the likelihood that they would go on to perpetrate to the same incidence as children who entered the same clinic for anxiety disorders. “That’s the functional equivalent of a cure,” she said.

• Three randomized control trials showed that appropriate intervention can reduce the likelihood that adolescents who have sexually offended will reoffend. The largest of the studies, led by Dr. Letourneau, had 127 participants and demonstrated the effectiveness of a community-based, family focused intervention. “We have to focus on the adults who are responsible for keeping kids safe, not just from victimization, but also keeping kids safe from perpetration.”

• There is a vast body of research on high-quality prevention programs for other forms of child maltreatment, including effective programs that reduced bullying by 20 to 23%. The Moore Center is now developing a project that would link bullying prevention and CSA prevention.

• From 2003-2008, when anti-bullying programs were being widely adopted, peer sexual violence fell by 50%. All forms of child maltreatment share common characteristics, Dr. Letourneau said, “so it stands to reason that if you have an effective program dealing with any one of them, we’ll see positive effects” on others.

• Research supports the potential to reduce the incidence of child physical abuse in high-risk families through Positive Parenting Practices (Triple-P) programs. “This is the only intervention for child maltreatment that has shown community-wide effect.”

Given the breadth of the available evidence, Dr. Letourneau said the question is not whether prevention is possible, but why more isn’t being done. The reasons begin with the tendency to treat child sexual abuse as a “special problem that happens to some kids, not our kids,” where the societal response is to rehabilitate victims and hold offenders accountable. That response has achieved a great deal, she said. The criminal justice system now recognizes that adult sexual interactions with children are illegal behavior, not a “family problem”. There is greater likelihood that a convicted sex offender will serve time, and the criminal justice perspective “has also spawned a really close look at evaluating the risk of offender recidivism.” Tools are available to accurately identify men who are at higher risk of offending because “as taxpayers, we want our money going to the highest-risk people, where we’re going to get the biggest bang for our buck,” in the form of the greatest reduction in harm.

Along with increased knowledge about the effects of CSA, criminal justice strategies in the United States likely contributed to the 62% reduction in the rate of child sexual abuse from 1992 to 2010, but most of that decline occurred in the early period, up to 1999 or 2000. “We’ve gotten as far as we can go with these criminal justice- and victim-oriented interventions,” Dr. Letourneau said, so “we have to develop, implement, and disseminate some truly effective primary prevention interventions. Addressing the needs of victims and perpetrators after the fact has got us a long way, but the effects are starting to slow down.”
So far, prevention has not been as effective with CSA as with other forms of violence, partly because not all of the underlying causes are well understood. A coordinated research effort will be needed to understand the causes of adult preferential sexual interest in children.

Dr. Letourneau also pointed to the “dual frame” through which society views sex offenders. According to the prevailing view, “they’re monsters. And if they’re not monsters, they’re not sex offenders,” she said. “This does us all real harm. We know that the people in our lives are not monsters, our parents, our dads, our brothers, our sons. And if we think that to commit a sex offence you have to be a monster, we’re not going to see alarm signals or red flags that may be exhibited by the people we love, care about, or respect, who may be engaging in these behaviors.” Without that attention, it’ll be impossible to intervene and prevent both the abuse and the perpetration.

“So we really have got to understand that, under some conditions, people with no attraction to children might still sexually abuse children,” and that many people who are sexually attracted to children want to seek help, rather than doing harm. One part of the solution is to bridge the gap between the professional groups that deal with victims and offenders. “It’s going to take all of us working together to push effective prevention policy and intervention.”

She said an effective prevention focus will depend on:

- A national research agenda that brings agencies and resources together to build an understanding of key risk and causal factors
- A focus on primary prevention
- A high-level champion to help advance the issue, as did President Obama for domestic child sex trafficking and Vice President Biden for domestic violence
- A public health approach grounded in science, with adequate funding for research
- More effective dissemination of knowledge.

**Sexual Violence Against Children in Low- and Middle-Income Countries**

**Speaker**

James Mercy, Ph.D., Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC)

**Dr. James Mercy** invited participants to imagine hearing the news that scientists had just discovered a new disease, to which 250 to 300 million around the world had been exposed. The disease increased the incidence of post-traumatic stress disorder (PTSD), anxiety and depression disorders, and sexually transmitted diseases, especially HIV. It placed survivors at higher risk of diabetes, heart disease, cancer, and substance abuse, of offending violently later in life or becoming victims of violence.
“The truth is that we do have such a disease,” in the form of sexual violence against children. “One of the first things we would do is measure the problem and use those measurements to propel action.”

Around the world, about 18% of females and 8% of males have been exposed to child sexual abuse, a large enough number that if those children constituted a country, they would be the fourth- or fifth-largest in the world. “This is a huge number,” Dr. Mercy said. “This is a large, immense public health issue.”

Data from various Latin American studies show that CSA survivors are more likely to experience partner violence as adults, either as victims or perpetrators. From other studies, “we know pretty conclusively that exposure to sexual violence can lead to direct transmission of HIV,” while “exposure to sexual and physical violence can affect children’s ability to negotiate safe sexual practices,” which can also increase the risk of HIV. As well, children exposed to sexual abuse often end up on the streets, where they are vulnerable to HIV and a variety of other problems.

Recent research points to a biological basis for the impacts of sexual violence against children. Dr. Mercy said sexual violence “can actually create a toxic type of stress that can change brain architecture. It can affect the endocrine system, the immune system, the stress regulation system,” contributing to risk behaviors that lead to a variety of negative health outcomes. It can even change survivors’ DNA.

Since 2006, the CDC has carried out a series of Violence Against Children Surveys (VACS), with two primary objectives: To measure violence and its impacts, and to foster political engagement and action. “We don’t just want these data sitting on a shelf,” Dr. Mercy said. “We want them to be meaningful and make a difference.”

The research series began with a national household survey in Swaziland, with an initial focus on the connection between sexual violence and HIV for young adolescent girls. The model has been extended to several other countries, and Swaziland is planning to repeat its survey. The surveys describe the magnitude and nature of the problem, assess health consequences, identify potential risk and protective factors, assess the utilization of services, and provide guidance for prevention programs and policies.

The first five surveys—from Swaziland, Tanzania, Kenya, Zimbabwe, and Haiti—determined that:

- 25.7% to 37.8% of females and 8.9% to 21.2% of males aged 18 to 24 said they had experienced some form of sexual violence by age 18.
- The respondents aged 18 to 24 showed a substantial increase in prevalence, for both genders, compared to a separate group aged 13 to 17.
- The results for Haiti suggested that sexual violence may have increased after the catastrophic earthquake that hit the country in 2010.
• Boyfriends and male neighbors were among the most common perpetrators in Swaziland and these data helped counter the false perception that teachers were frequent perpetrators. In Tanzania strangers played an important role.

• Boyfriends who commit sexual violence are often much older than the victims: 60% of them by five or more years in Swaziland, 40% of them by 10 or more years in Tanzania.

• Of the women aged 18 to 24 who had experienced sexual violence, 82% had also been subject to physical or emotional violence, or both, at some point in their lives. “You’re often not dealing with just the issue of sexual violence when you intervene with this population,” Dr. Mercy said.

• In Swaziland, girls who had experienced sexual violence faced almost four times the risk of HIV and other STDs, three times the risk of unwanted pregnancy, and twice the risk of attempted suicide. The other country surveys showed similar results.

• In Tanzania, both boys and girls exposed to sexual violence were twice as likely to use condoms infrequently, or not at all, as young adults.

• In Kenya, only about half of the girls and one-third of the boys who had experienced sexual violence ever told anyone, supporting the importance household surveys rather than relying on official data sources.

With each survey, the CDC works in partnership with a task force of national government agencies, non-government organizations (NGOs), universities, UNICEF and United Nations offices, and U.S. government offices in-country, to build local ownership and ensure that the data are used. In Swaziland, the deputy prime minister took on the task of developing a national education campaign to address sexual violence. Key elements included a weekly children’s radio program, training for police officers, establishment of the country’s first sexual violence counselling center and family court, and adoption of a sexual offence bill with legal protection for children.

While it’s too soon to say whether these data-driven measures have reduced sexual violence in Swaziland, the country moved from 45th to ninth in the African Child Policy Forum’s index of African countries between 2008 and 2013.

Dr. Mercy said a key gap in the household survey is its failure to reach children outside family units, including street kids and children in institutions who are very vulnerable to sexual violence. The CDC is working with India to adapt the methodology to include street children.

He listed a series of key actions for preventing and responding to sexual violence against children, beginning with increasing safe, stable, and nurturing relationships with caretakers, protecting vulnerable children, and promoting gender equality. “We do have an evidence base we can draw on, and we have many possibilities,” he said. “We can learn from what’s going on in other countries, and they can learn from us. This is truly a global problem, and we’re not without ideas and good intentions.”
The Cost of Child Sexual Abuse

Derek S. Brown, Ph.D., Center for Violence and Injury Prevention (CVIP), Washington University in St. Louis

Child sexual abuse “affects not just children and families, but society at large, and has a burden that spreads across taxpayers and the entire society,” said Dr. Derek Brown. Those wider costs are important to understand because policy-makers and NGOs “need some kind of information about the burden in dollar costs, to help think about resource allocation” across competing health and social problems.

In addition to direct costs like medical expenditures and lost earnings, Dr. Brown stressed the opportunity costs associated with child sexual abuse, “the drain and the burden on our real societal resources that can’t be used in other ways to help families and children.” Dollar costs are only part of the impact, and “the tools we have are useful when used across conditions” to compare the societal costs and benefits of prevention. The most recent publications in the World Health Organization’s Global Burden of Disease series support the effective allocation of scarce prevention resources by breaking down public health problems by risk factor.

In a measurement of 17 leading risk factors based on disability-adjusted life years (DALYs), child sexual abuse comes in eleventh, accounting for about 1% of the global burden of disease. But with a closer look at the budgets of U.S. public agencies, Dr. Brown said child maltreatment would actually account for about 6% of the global burden. He said a more complete economic analysis would focus on the net impact on total societal resources, including:

- Direct and short-term costs, including medical care for victims, social services, and criminal justice
- Indirect and long-term costs, including adult impacts, quality of life, effects on families, education, earnings, productivity, criminal justice, delinquency, risky behaviors, mortality, and suicide.

“The larger burden actually comes through the more difficult to pinpoint, indirect costs,” he said. Over a lifetime of cumulative impacts, sexual abuse can lead to poorer educational outcomes, which in turn have an impact on a survivor’s labor force participation and income.

“The argument for public health and prevention is in part that there’s a large externality here. That means costs are not borne strictly by those affected,” as perpetrators, children, and families. “The burden ends up being spread across society, and it affects all kinds of resources.”

When the Center for Violence and Injury Prevention set out to quantify the total burden in 2008, its conservative estimate was $124 billion, compared to $210 billion for obesity and $193 billion for smoking. Based on child protective services (CPS) case counts, the lifetime cost of CSA
exceeds $210,000 per case, and “I think those numbers are probably larger in several cases,” Dr. Brown said. Specific costs include:

- $32,600 for child health care
- $10,500 for adult health care
- $144,400 in lost productivity over 40 years or more
- $7,700 for child welfare
- $6,700 in criminal justice costs
- $8,000 for special education.

He said it’s a mistake to base the estimates in the assumption that 10% of CPS cases involve some form of abuse, since the actual count is probably much higher. The best analysis would capture and characterize the full range of cases, recognizing that “different types of abuse and neglect have different impacts.” CPS cases linked to Medicaid claims show $2,800 in additional expenditures—a doubling from the norm—for children suffering from any kind of abuse or neglect. But health care costs are twice as high for sexual abuse compared to physical abuse, and three times as high compared to neglect. Poly-victimization is the costliest scenario of all.

Children with health problems become adults with lingering health conditions and stresses, but “unfortunately it takes a fairly intensive set of data to capture this well,” Dr. Brown said. The best estimate is that an average $800 per year in lifelong medical expenditures can be attributed to child maltreatment. Connecting the data to child sexual abuse will be a challenge, but an Australian study found that CSA “has a particularly strong and more costly impact.”

Beyond DALYs, the Center has focused some of its work on health-related quality of life, measured in Quality-Adjusted Life Years (QALYs). In addition to treatment costs, QALYs take into account what it’s like to live with a chronic condition, from day-to-day stress to the impact on activities and relationships. In the detailed calculation, a year of life in perfect health is considered equal to two years at 50% quality of life.

Emerging evidence from a couple of studies suggests that adult survivors aged 18 to 25 lose two to eight QALYs to child sexual abuse, representing three to 12% of their quality of life. Child victims lose 30%, teen victims 50%. The total—seven to 13 fewer years relative to perfect health—exceeds the impacts of many major diseases.

He said research is still needed to quantify the impact of child sexual abuse on survivors’ families and relationships.

Increased mortality is another important concern, given the association between child sexual abuse and the heightened risk of suicide or death from other risk factors. The economic value of premature death can be captured in QALYs, as a measure of foregone life years, or in lost productivity over the years of life lost.

While economists have only a limited range of tools for assessing the impact of child sexual abuse, there is still “a strong economic argument for prevention,” Dr. Brown said. “To me, this is another part of building the case for why we should consider doing this, in addition to it just being the right thing for children and families.”
Primary Prevention of Child Sexual Abuse from Various Perspectives

Speaker
Karen Baker, MSW, Director, National Sexual Violence Resource Center (NSVRC)

The solutions a group comes up with depend on the way it defines a particular problem. With that in mind, Karen Baker said her group includes child sexual abuse under the umbrella of sexual violence, which it defines as actual or potential harm or non-consensual activity of a sexual nature.

A few years ago, the NSVRC participated in a study of community perceptions of sexual violence. The research team “came back with a very strong portrayal that the public thinks of it as an individual problem: that there are some bad people out there, they might have mental health issues, they might have character flaws, but for whatever reason, they’re bad people and there’s nothing we can do about it.” The solutions were defined mainly as punishment or isolation. While there was public support for intervention “anywhere and everywhere we can” along the continuum from primary through tertiary responses, she said more energy must be devoted to primary prevention, “so that we don’t have the victims and perpetrators.”

Once the focus turns to primary prevention, “I really don’t think there’s a difference in those perspectives,” she said.

She presented an ecological model of public health intervention that “really expands our thinking about who’s impacted and where we can intervene,” capturing the continuum from individuals, to relationships, to community and societal factors. The approach “puts that individual in the context of the people they work with and interact with on a day-to-day basis, the neighborhoods and organizations they’re involved with and, indeed, our entire societal context that influences all of us.”

Ms. Baker said the ecological model provides many more strategies for preventing CSA, pointing to opportunities for a wider conversation with parents, teachers, coaches, and faith communities. The approach can address everything from sports club policies that may have been adopted but not implemented, to the ease with which child pornography is available in hotel rooms.

In addition to the public health model, the NSVRC factors in racism, sexism, heterosexism, and other forms of oppression by viewing sexual violence through a social justice lens. “It certainly is true that anyone can be sexually violated, but it happens more often to certain groups,” including children, women of color, members of the LGBT community, and others who are marginalized or vulnerable.

One result of this work has been a conscious decision among victim advocates to stop referring to “prevention” when the focus is on reducing a specific person’s risk. With personal safety advice, “we weren’t talking about prevention. We were taking about risk reduction or risk shifting,” she said. “I might be able to prevent myself from being raped or harassed in some
way, but if someone is really intent on doing that they’ll do it to someone else, and that’s not acceptable to me.”

The language of risk-shifting also contributed to victim-blaming, when people were abused after being told how they might prevent sexual violence. Victims were left feeling responsible, “which they’re not. No one is responsible for their own abuse.”

The larger public health frame for sexual violence involves defining the problem, identifying risk and protective factors, developing and testing prevention strategies, and assuring widespread adoption of strategies that are effective. With research showing that the burden of sexual violence falls disproportionately on children and young adults, the ecological model becomes a useful tool for identifying risk and protective factors:

- At the individual level, risks include childhood neglect, exposure to violence or pornography, substance abuse, a sense of entitlement or sexual interest in younger children, and limited ability to interact with age peers. Protective factors include a safe, stable, nurturing family environment, communication and conflict resolution skills, positive hobbies, and pro-social behaviors, all of which “strengthen the person at the individual level.”

- At the relationship or family level, risks include a parent or caregiver who doesn’t understand normal child development, lack of supervision of older children in the home, or a chaotic or over-controlled family environment with insufficient privacy or respect for boundaries. Protective factors include parents who understand healthy child and sexual development, model good boundaries, and respect the child’s boundaries. She stressed that it’s the job of all adults “to be role modelling, looking out for children, and nurturing the children we come in contact with.”

- Risk factors at the community level include bullying in schools or day care settings where staff are improperly screened, educated, trained, or supervised. Too often, Ms. Baker said, parents are hyper-attentive about their children’s safety at the mall, but think nothing of leaving them with a neighbor for three or four hours. Protective factors include good access to health and mental health care, services for victims when they’re needed, and effective treatment for abusers. These factors are all protective “because they signal that this is a problem we care about, we know how to address it, we are addressing it, and we’re not afraid to talk about it.”

- Societal risk factors include the norms and attitudes of a society that “sometimes objectifies and sexualizes our children in weird ways,” while encouraging people to think it’s none of their business if they see something that might be wrong. Protective factors include a strong economy, high employment rates, and changing social norms to make it a priority to nurture and protect children.

Ms. Baker pointed to the public health response to smoking as a successful example of changing social norms. “What really shifted things was when public health got involved, and they didn’t just talk about smokers,” she said. “They talked about the tobacco industry. There’s a whole other set of solutions.” Over time, second-hand smoke became a hot topic, cigarette vending
machines were removed from public places, tobacco ads directed at children were eliminated, and smoking was banned on aircraft, in restaurants, and in government buildings. “That’s a change that is due to public health, and that’s what I want to see for child sexual abuse, as well.” She suggested a series of focal points for strategy, including:

- Training parents
- Engaging bystanders
- Enacting laws and policy
- Conducting organizational safety assessments
- Engaging media
- Delivering healthy sexuality education.

**Sex Offender Assessment and Management**

**Speaker**
Scott Matson, Senior Policy Advisor, Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART), U.S. Department of Justice

Scott Matson said the SMART Office’s primary responsibility is to implement the federal Sex Offender Registration and Notification Act (SORNA), and to provide technical assistance and training to participating entities and jurisdictions.

A few years ago, the office launched the Sex Offender Management Assessment and Planning Initiative (SOMAPI) to review the state of research and practice in sex offender management. While “everyone has the same goal, which is to prevent sexual violence,” Mr. Matson said law enforcement, prosecutors, policy developers, and victim advocates had very little information on effective strategies. SOMAPI was set up to identify evidence-based practices and find gaps in knowledge on the best ways to prevent sexual violence. The research determined that:

- Across at least 15 data sources on the incidence and prevalence of sexual violence, there is no single definition of sexual offending. Accurate reporting is also much more difficult because offenders often lie, and victims often decline to report.
- The etiology of sexual violence is too complex to associate with any one theory or factor, but research confirms that it’s a learned behavior associated with adverse conditions in early development, and with repeated exposure to violent pornography.
- Although sex offenders are believed to specialize by victim type or victimization strategy, they are often involved with other types of criminal behavior. This broader picture supports a focus on risk factors and offence pathways that lead to sexually abusive behaviors, providing a wider range of treatment and intervention targets for therapists.
- Internet offending is “gaining a lot of momentum” as a new type of crime, usually involving sexual solicitations as well as possession, production, and distribution of child pornography. One in eight Internet offenders have had some official history of a contact sexual offence.
• Recidivism rates are higher than reported data, but “lower than most people think,” with less than 25% of perpetrators reoffending after 15 years. But the results vary by type of sex offence, and sex offenders can also have higher rates of general criminal recidivism.

• The literature on risk assessment identifies no single risk factor as the best predictor of sexually violent behavior. The field is moving toward measures of risk that incorporate static as well as dynamic factors and point to a range of targets for intervention.

• Recent research has identified treatment methods that are effective, especially with moderate- and high-risk offenders. Treatment can reduce sexual recidivism by 5% to 8% over five years. There is empirical support for intensive supervision with rehabilitative treatment, and some support for Circles of Support and Accountability (COSA), a Canadian program where volunteers work with offenders in a community setting.

• The research on juvenile strategies shows lower rates of sexual recidivism than with adult sexual offenders, but higher rates of general recidivism than sexual recidivism. Assessment of juvenile offenders should include a wide range of individual, social, interactional, and contextual factors, but no known instrument has consistent predictive validity. The research reinforces the effectiveness of juvenile interventions.

The second phase of the SOMAPI project was a February 2012 expert forum, where 60 participants from a variety of disciplines reviewed the research to date. The group delivered a series of recommendations on prevention and education, research and evaluation, Internet offending, juveniles, and the specific needs of the field. The final SOMAPI report will be released later in 2014, and will be a reference point for the SMART Symposium in 2015.

Concluding Remarks

After 25 years in the field, Dr. Elizabeth Letourneau said it was remarkable to see a strong research agenda taking shape in support of a scientific approach to prevention. She recapped key comments from the morning, beginning with Dr. Mercy’s data on the global prevalence of child sexual abuse.

“The hopeful message from Jim is that governments can own this issue, and that they can make meaningful policy changes to improve the lives of children,” she said. Swaziland is a success story to build on, and the CDC’s Violence Against Children Surveys will continue to deliver valuable results in the years ahead.

Dr. Brown’s research shows that child sexual abuse appears to confer higher costs than other forms of violence. “I don’t want this to devolve into [a claim that] we deserve more resources than the child physical abuse people,” she stressed. But the economic impact data are “relevant to our message about salience” of a child sexual abuse prevention framework.
From Ms. Baker and Mr. Matson, participants heard how important it is to frame messages and deliver information in a way that all stakeholders can hear it. “Researchers are often accused of being a little dense and obtuse,” Dr. Letourneau said, and “we could all do a better job of making sure we reach everybody. Child sexual abuse is not an ivory tower phenomenon. It touches every single one of us, and we’ve got to be able to speak to it in a way that people hear us.”

She added that Ms. Baker’s distinction between individual risk reduction and primary prevention had helped shift the focus to identifying and altering the vectors associated with perpetration. Offenders “are people in our lives, and they’re influenced by things that are changeable.” Mr. Matson’s work highlighted the promising evidence on effective treatment, while pointing to the need for separate policies and practices for youth and adult perpetrators.

Preventing child sexual abuse is a worthwhile and achievable goal. Steps towards achieving this goal include developing a national research agenda, enlisting the support of a high-level policy “champion”, and grounding the science of primary prevention within the broader public health model of violence prevention. We hope that you will join the Moore Center for the Prevention of Child Sexual Abuse in support of this goal.