ARTICLE

Child Sexual Abuse

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Introduction

Child sexual abuse (CSA) is an umbrella term describing criminal and civil offences in which an adult engages in activity with a minor or exploits a minor for the purpose of sexual gratification. This term includes sexual assault, sexual molestation and sexual exploitation. The legal term child sexual offender refers to a person who has been convicted for one or more child abuse offences. The term 'paedophile' is used to refer to child sexual offenders. Intrafamilial sexual abuse refers to a CSA offense where the perpetrator is related to minor, either by blood or marriage. Its deleterious consequences are primarily psychological in nature. It is therefore a significant risk factor for the development of psychopathology at various stages of life.

History

CSA is not a new phenomenon. The laws of Moses (3000 BC) describe incest as a sin. Freud (1896) in his lecture on "aetiology of hysteria" has proposed link between CSA and hysteria. CSA first came to the forefront of public attention after laws that protected against cruelty to children were established in the late 1800s. First national estimate of number of CSA cases was published in 1948. The literature on CSA was sparse till the early 1980s. Since 1985, however there has been an explosion in the number of studies that concentrated specifically on CSA.

Definition

The most influential and time honoured definition of CSA is by Schechter and Roberge (1976): "Sexual abuse is defined as the involvement of dependent, developmentally immature children and adolescent in sexual activities they do not truly comprehend to which they are unable to give informed consent or that violates the social taboos of family roles." Most comprehensive definition is given by the Standing Committee On Sexually Abused Children (SCOSAC 1984) which states that: "Any child below the age of consent may be deemed to have been sexually abused when sexually matured person has engaged or permitted the engagement of that child in any activity of a sexual nature which is intended to lead to sexual gratification of sexually matured person." The South Australian Government Task Force defined sexual activity of a child who lacks the power and authority to prevent being coerced into compliance. Such abuse includes exposure, voyeurism, exhibitionism, to oral sex, sexual intercourse, and involvement with pornography, or child prostitution.

Intrafamilial sexual abuse - Sexual abuse that occurs over a period of time evolves through five phases –

Engagement phase: The perpetrator induces the child into a special relationship.

Sexual interaction: The sexual behaviours progress from less to more intrusive forms of abuse. As the behaviour continues the abused daughter becomes confused and frightened, because she never knows whether her father will be parental or sexual.

Secrecy phase: The perpetrator threatens the victim not to tell. Here the perpetrator is often jealously possessive of her, interferes with girl's development of normal peer relationship.

Disclosure phase: The abuse is discovered accidentally through the child's reporting it to a responsible adult when the child is brought to medical attention.

Suppression phase: The child often retracts the statements of the disclosure because of family pressure or because of child's own mental process.

Extrafamilial sexual abuse - Sexual abuse by strangers, teachers, counselors, family friends, clergy.

Prevalence

In Europe, 10-20% of women and 3-10% of men had childhood sexual abuse before 18 years of age (Svedin et al. 2002). In US, prevalence of sexual abuse of male child is 3-31% and female child is 6-62%.

Indian scene - The World Health Organization (WHO) puts the prevalence figure at around 10% (Malhotra and Gupta 2005). National Human Rights Commission conducting research on child trafficking in India stated that in 2004 January on average 30,133 children disappear every year. 27% were never found. India is estimated to have between 3,00,000 and 5,00,000 child victims of commercial sexual exploitation. According to a survey conducted by the

Union Ministry of Women and Child Development, in age between 5 to 18 years across the country 50% of children of 13 states are sexually abused in school.

State wise analysis of severe form of sexual abuse of children revealed –

Assam	57.27%
Delhi	41%
Andhra Pradesh	33.87%
Bihar	33.27%
Goa	2.38%
Uttar Pradesh	5.98%
Gujrat	7.34%

Within the walls of their own homes, children are at risk for sexual abuse. 30-40% of victims are abused by family members. Another 50% are abused by someone outside of the family whom they trust. Approximately 40% are abused by older children whom they trust. Therefore only 10% are abused by strangers.

Theories

Biological theory - Physiological factors are hormone levels (androgenes and androgen releasing hormone) and chromosomal makeup. Androgen promotes sexual arousal, orgasm, ejaculation, as well as regulates sexuality, aggression, cognition, emotion, and personality (Marques et al. 2002). Biological theories about deviant sexual behavior usually pertain to rape because it is considered to be an act of violence. There is also correlation between aggression and high testosterone levels (Money 1970; Rada, Laws and Kellner 1976). These theories address paedophilia most often looking at abnormal hormonal and androgenic levels in the brain. Testosterone is the primary biological factor responsible for normal and abnormal sexual behaviour. From chromosomal perspective, Klinefelter's syndrome predisposes a male toward sexually abusive behaviour. A review of the literature suggests that the prevalence of sexual deviations among individuals who are diagnosed with Klinefelter's syndrome may be higher than among individuals who have not been diagnosed with Klinefelter's syndrome.

Psychodynamic theory - Psychoanalytic explanation of deviant sexual behaviour was initially attributed to Freud, who proposed four states. According to Freud, failure to resolve the conflict, boy may develop a permanent aversion to females as an adult if their appearance brings back this fear of castration. Human psyche is in a constant struggle to fulfill the primal desires of the id and moral authority of the superego. Sexual aggression is lacking in a strong superego and has become overwhelmed by their primal id.

Behavioural theory - Deviant sexual behaviour as a learned condition. According to behavioural theory, deviant sexual preferences and cognitions are acquired by the same mechanisms by which other individuals learn more conventionally accepted modes of sexual expression.

Attachment theory - Research indicates that there is relationship between poor quality attachment and sexual offending. Marshall (1989) found that men who sexually abuse children often have not developed the social skills and self-confidence necessary for them to form effective intimate relationship with peers.

Cognitive-behavioural theory - It addresses the way in which offenders' thought affect their behaviour, focuses on the way in which sex offenders diminish their feelings of guilt by excuses and justifications. When individuals commit deviant sexual acts, they often try to diminish their feelings of guilt and shame through "neutralizations." This neutralization generally takes the forms of excuses and justifications with the offenders rationalizing their behaviour (Scott and Lyman 1968, Scully 1990). These neutralizations are cognitive distortions or distorted thinking patterns that allow the offenders to remove from themselves any responsibility, shame or guilt for their actions (Abel et al. 1984). Sykes and Matza (1957) list five primary neutralization techniques: (1) Denial of responsibility, (2) Denial of injury, (3) Denial of the victim, (4) Condemnation of accusers, and (5) Appeal to higher loyalties.

Implicit theory - Ward and Keenay (1999) claim that cognitive distortions of child sexual offenders emerge from five underlying implicit theories that they have themselves, their victims and their environment. Implicit theory consider following factors: (1) Children as sexual objects, (2) Entitlement, (3) Dangerous world, (4) Uncontrollability, and (5) Nature of harm.

Integrated theory - Finkelhor (1984) proposed a four-factor model of the preconditions to CSA, which integrate the various theories about why individual begin to participate in sexually deviant behaviour. These factors include: (1) Emotional congruence, (2) Sexual arousal, (3) Blockage, and (4) Disinhibition.

Risk factors

Age - Incidence of child sexual abuse increases with age.

0-3 years of age - 10% of victims.
4-7 years of age - 28.4% of victims.
8-11 years of age - 25% of victims.
12 years and older - 35.9% of victims.

The median age for reported abuse is 9 years old.

Gender - 2.5 to 3:1 female predominance. 25% of victims are male.

Disabilities - Risk increased for those with physical disabilities, especially those that impair the child perceived credibility – blindness, deafness, mental retardation. Research at international level shows that children with disabilities are 3.4 times more likely to be abused compared with nondisabled children.

Family constellation - Absence of one or both parent is a factor. Presence of stepfather in home doubles the risk for girls. Parental impairments are also associated with increased risk.

Socioeconomic status - More important for physical abuse and neglect. Much less impact on CSA.

Race and ethnicity - May influence symptom expression. Do not seem to be risk factor for CSA.

Childhood sexual abuse as the prototypical trauma: An event that overwhelms resources.

Resource limitations - The internal or personal resources with which children can protect themselves are limited by the simple fact of their life stage. Their external resources are far more limited than those of adult. Children have little choice about where they live or on whom they depend. Their home, the traditional source of safety, is also very often source of injury.

Resource loss - CSA is a trauma perpetrated by an adult, usually important caretaker upon whom a child depends significantly for psychological and material resources. During the recovery from trauma, investments of additional 'repairing' resources are required. If the caretaker is perpetrator of trauma, child is motivated to ignore, hide or deny of abuse. Silence and stigma, associated with it, adds to further resource loss. As a result, substantial functional impairment occurs amongst adult survivors of CSA. They include: loss of healthy attachment, loss of effective guidance in the development of emotional and social competencies, loss of support and connection to larger social community.

Sequelae of child sexual abuse

Outcome in childhood - Disturbances in the form of fear, anxiety, depression, anger, hostility, low self esteem; poor academic, scholastic performances; various anxiety disorders like fearfulness, nightmares, phobias; posttraumatic stress disorder (PTSD) (20 to 70% CSA) (Wolfeetal 1991, Melee et al. 1992); hysterical reaction; suicidal behaviour, substance abuse. Boys are likely to use alcohol (Garnefski and Arends 1998), drugs, display aggression, truancy, suicidal attempt, and criminal behaviour.

Dysfunctional behaviours - Increased arrest rate for sex crimes and prostitution irrespective of gender. Sexually abused adolescents are at increased risk for earlier pregnancy. CSA is a predictor of human immunodeficiency virus (HIV) risk related behaviour.

Neurobiological effect - Deleterious effect on the hypothalamic-pituitary-adrenal axis and the sympathetic nervous system. Sexually abused females demonstrate increased morning cortisol levels and decreased evening basal level of cortisol. Sexually abused had increased 24 hours urinary catecholamine levels. Magnetic resonance imaging (MRI) scans of children suffering from PTSD following serious sexual abuse showed a 7% smaller cerebral volume and increased cortical cerebrospinal fluid volume in comparison to non-abused children (De Bellis et al. 1994). Deficits in verbal short-term memory have been found in men and women with history of CSA (Bremner et al. 1995).

Adult sequelae of child sexual abuse

Studies suggest that the ongoing problem areas include -

Emotional and psychological problems: Depression – It may present as sadness, inability to experience pleasure, sleep and appetite disturbances and it may persist for many years.

Low self esteem – They may feel unworthy of love or happiness and feel they deserve abusive relationship with unhealthy lifestyles.

Dissociative symptoms – This is psychological defence against overwhelming emotions, a child's defence system carried on into adulthood. This disorder is seen most commonly among the CSA. It may present as suppressed memory, denial of self or feeling of being outside self.

Flashback and nightmares – Suppressed memories are experienced in sleep as nightmares (particularly as a sexual nature) or as flashback when awake causing fear and anxiety in response to trigger events.

Physical symptoms – Somatisation may present as headaches, dermatological disorders or pelvic pain. Survivors have a higher incidence of gynaecological problems.

Self destructive behaviour – This may present as substance abuse (a history of childhood abuse is more commonly reported amongst survivors than other groups) or suicide attempts.

Eating disorders – Survivors are more likely to have body image problems leading to eating disorder particularly bulimia.

Borderline personality disorder.

Defects in interpersonal relationship: Impaired ability to form intimate and trusting relationship with men or women. Since the mother figure may be seen by the child as collaboration or at least failing to protect, survivors may feel anger towards both parents and may have difficulty relating to other women. Women victimised as children are more likely to become victims as adults and are more likely to be physically or sexually abused. Men who have been abused as children are more likely to become the perpetrators of abuse and this may be so of a small number of women survivors.

Sexual maladjustment: Low levels of sexual esteem may lead to inappropriate sexual behaviour, promiscuity, or prostitution. Retreat from all sexual activities, particularly fear of men. Physical sexual problems like vaginismus, failure to obtain pleasure from sex, dyspareunia. Flashbacks during sexual activity. Fear of medical examination of genitalia or breasts.

Social function: Children may leave home early to escape from abuse. This may lead to them using anti-social survival techniques such a criminality or prostitution and expose them to exploitation by other adults. Use of alcohol and other drugs is common. Feelings of isolation prevent socialisation.

Assessment

The following are the common means by which sexual abuse comes to the attention of professionals: The child report, behavioural disturbance or inexplicable changes in behaviour, physical signs or symptoms, other types of maltreatment, accusations made by parents, relatives or other concerned adults.

A careful assessment of these issues is required: Age-inappropriate sexual behaviour or inappropriate knowledge in the child, the child's report of sexual abuse or incest, physical finding suggestive of sexual abuse, the report of a sibling or other informant that sexual abuse has occurred.

In the course of assessment, the following general principles need to be taken into account: The way in which assessment is undertaken and its thoroughness needs to be in proportion to the degree of suspicion, additional traumatisation of the patient during physical examination should be avoided, multiple tests and examinations should be avoided, external sources of information should be used when available, the credibility of the child's or adolescent's statements needs to be assessed.

Intervention

Therapeutic steps when treating the CSA are: (1) Further sexual abuse must be prevented, (2) The offender or child's father is expected to accept total responsibility for the abuse, thus abusing his responsibility as parent, (3) Both parents should accept equal responsibility for the child's general well being, (4) The relationship between the child and mother is strengthened, (5) The parental emotional and sexual conflicts must be addressed, (6) The relationship between the child and father is addressed.

The role of courts - Two or three courts are potentially involved in a sexual abuse case. The Juvenile Court is responsible for child protection. The Criminal Court is for offender prosecution. The Divorce Court, if either parents decides, to pursue divorce. The court can be helpful in compelling family members, especially offenders, into treatment, in protecting victims and families from offenders, and in effecting alternative living situations for offenders (or victims if necessary). Testifying in court may have a positive and negative effect on the child. Victim may gain sense of mastery over the sexual abuse from testifying, on the other hand, victims may experience court testimony as additional trauma.

Visitation: Many professionals recommend no contact between the victim and offenders; if the child is to appear in court, until after her/his testimony. If the child genuinely does not wish visitation there should be none.

Individual therapy - Psychotherapy with the sexually abused individual include: (1) Reduction of guilt, (2) Separation of victim and perpetrator, (3) Development of an empathic therapeutic relationship, (4) Sex education, (5) Issue of autonomy.

Group therapy - Groups are appropriate for victims, siblings of victims, mothers of victims, offenders and adult survivors of sexual abuse. Therapies are time-limited, long-term or open-ended. They may deal with relapse prevention, sex education, or protection from future abuse. Group therapy has advantages over individual approach. It helps to counteract isolation, raise low self esteem. There are three studies on group cognitive behavior therapy (CBT) in CSA (Burke 1988, Berliner and Saunders 1996, Deblinger et al. 2001); all of which show effectiveness of group CBT in reducing psychopathology.

Dyadic treatment - It is used to enhance and/or repair damage to the mother-daughter relationship, husband-wife relationship, father-daughter relationship.

Family therapy - Family therapy is used to bring about modification in the style of family communication: (1) Dissolution of rigid boundary between family and its environment, (2) Improvement

of the independence and self determination of individual family members, (3) Provision of an explanation of the sexually abused child's situation, (4) Discussion of the appropriateness of individual treatment for the child and/or perpetrator, (5) Assessing the likelihood of treatment being successful in reconstructing family relationship.

Cognitive behavioural therapy for child sexual abuse - CBT-CSA is designed to for children and adolescents, three through 18 years old, who have experienced CSA and are exhibiting PTSD, depression, and other abuse related difficulties. Benefits: In the aftermath of CSA, CBT-CSA helps children talk about their experiences and cope with their feelings and concern, assists parents in coping with abuse specific distress and responding effectively to their children's emotional and behavioural problems, improves parent-child communication and interactions.

The specific components of treatment for both the child and parent are: Education about CSA and healthy sexuality; coping skills training, including relaxation, emotional expression and cognitive coping; gradual exposure and processing of traumatic memories and reminders; personal body safety skills training.

Prevention

Two major categories of program include – (1) Perinatal and early childhood programs: Preventing sexual abuse amongst high risk individuals and families, nurse/social worker home visit programs, identification of high risk families and regular visits made for at least two years. (2) Education programs: Sexual abuse education programs may be more useful as secondary preventive interventions, school based education programs.

Primary prevention of child sexual abuse: alternative, non-child directed approach - These approaches are based upon the aetiology and sustaining and maintaining factors for the conditions to be prevented (Bickman 1983, Morell 1981, Rappaport 1987). David Finkelhor (1984) suggested that CSA may be prevented by intervening any one of the four preconditions.

Alternative approaches to enhancement of internal inhibitors - Internal inhibitors relate to the individuals' personal awareness of the inappropriateness of the sexual contact and their willingness or ability to control their impulses towards children. By publicizing the use of sexual abuse prevention programs in schools. Parent education forums on CSA may also increase internal inhibitors if any perpetrators or potential perpetrators are in the audience. Public advertising may serve an important role. Public campaign ads designed to educate perpetrators and potential perpetrators about the effect of CSA.

Alternative approaches to enhancement of external inhibitors - External inhibitors stop sexual abuse through environmental constraints upon the act (Finkelhor 1984): (1) Presence of another person who might witness the act, (2) Lack of private time with the child,(3) Likelihood of discovery.

Alternative approaches to increasing children's resistance - Parents may increase their child's resistance to abuse by developing a relationship with their child which would encourage disclosure of abuse.

Parent education - Parents training would help parents recognize situation which require further investigations.

Alternative approaches to reduction of motivation to sexually abuse - (1) Intervention with adults who are currently manifesting sexual arousal patterns towards children. Numerous approaches to the treatment of paedophilia had been attempted. (2) Efforts may be directed at children to prevent the later development of abnormal sexual arousal patterns.

Conclusion

CSA is not a rare phenomenon. It results from the complex interplay of individual, familial and social factors. CSA is associated with high degree of psychological and physical consequences. But because of the overlap between sexual abuse, physical abuse, emotional neglect and conditions like poverty, it is difficult to ascertain how much CSA contributed to the psychological consequences. Establishment of a sound therapist-patient relationship and individualized treatment remains the cornerstone for management of CSA. There is an urgent need to develop a database in our country so that appropriate intervention can be planned and implemented.

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