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Child Sexual Abuse in Clinical Practice: Identification and Management

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Introduction

Child Sexual Abuse (CSA) is not a new phenomenon. The incest taboo has been in existence for over 4000 years. The laws of Moses (~3000 BC) describe incest as a sin. Freud (1896) in his lecture on 'etiology of hysteria' has proposed a link between CSA and hysteria. The literature on CSA was sparse till the early 1980's. Since 1985, however, there has been an explosion in the number of studies that have concentrated specifically on sexually abused children. Its conceptualization is complex involving several dimensions from medical, social, psychological, legal, ethical and moral aspects. Increasing recognition came with the women's movement and reports by adult women survivors of CSA (Sariola & Uuteta, 1996; Luo, 1998; Rhind et al, 1999). However, CSA has been a taboo and societies have often reacted with a so-called "Ostrich psychology". This attitude of the society has resulted in the reluctance of the affected individuals to share their traumatic/ painful experiences with health professionals, thus hindering the process of research and understanding of the phenomenon (Malhotra & Gupta, 2005).

Though CSA is a physical act, 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 i.e. childhood, adolescence and adulthood (Kendall-Tackett et al, 1993; Bulik et al, 2001; Berliner & Elliot, 2002; Putnam, 2003). Thorough knowledge about this phenomenon is of paramount importance for the psychiatrist as well as for primary care physicians. This article reviews definitions, incidence, prevalence, psychological and physical consequences of CSA and the physician's role in its recognition, reporting and prevention.

Child maltreatment is often classified into 4 major categories: physical abuse, neglect, sexual abuse and emotional abuse. Most research to date has focused on physical and sexual abuse.

Definition

Definition of what act constitutes CSA has been a point of debate for several years. Most definitions have been fraught with conceptual issues. The most influential and time honoured definition of CSA is by Schechter & Roberge (1976): *"Sexual abuse is defined as the involvement of dependent, developmentally immature children and adolescents in sexual activities they do not truly comprehend to which they are unable to give informed*

consent, or that violate the social taboos of family roles". Inherent, although not specifically stated in this definition, is the notion of coercion or a power differential between the perpetrator and the child. It is also important to note that the abuser's intentions or motivations are not considered necessary to be included in many definitions. Finkelhor (1984) defined 'sexual victimization' as sexual encounters of children under age 13 years with persons at least 5 years older than themselves, and encounters of children 13-16 years with persons at least 10 years older. This definition is highly unsatisfactory in terms of not only absence of the concept of 'sexual' and 'abuse', but also by the age criteria used. What if the child of age 12 is subjected to sexual victimization by adolescent of 16 years? What if an adolescent girl of 14 years is subjected to sexual assault by a male of twenty years?

The 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 a 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 the sexually mature person"*.

CSA activities include oral-genital, genital – genital, genital – rectal, hand-genital, hand-rectal or hand-breast contact; exposure of sexual anatomy; forced viewing of sexual anatomy and showing of pornographic material to a child or using a child in production of pornography, viewing or touching of genitals etc. Sexual activities by preadolescent children of same or opposite sex, separated by no more than 4 years of age, in which there has been no force or coercion, is termed as sexual play *(Johnson, 2001)*.

Incidence and Prevalence

The prevalence of CSA can be ascertained from 2 major sources:

a) Data from studies of children who have been sexually abused and referred to various agencies like police, social services and doctors.
b) Studies on adult population exploring into their sexual experiences as children.

In Europe 10-20% of women and 3-10% of men had experienced sexual abuse before 18 years of age (Svedin et al, 2002). In a study of 930 women in San Francisco, 54% reported being sexually abused before 18 years (Russell, 1983). The prevalence rates for women from an US sample ranged 15-32% depending upon definitions (Vogeltanz et al, 1999). In a South African study of adult rape, sexual coercion and forced sexual initiation were reported in almost 1/3rd of adolescent girls (Jewkes & Abrahams, 2002).

It may be mentioned that the exact numbers of children who are sexually abused are unlikely to be ever known. There are several reasons why all instances of abuse are not recognized or reported.

1. Inadequate communication skills of young or handicapped children to report such events or provide details.
2. Lack of judgment of a child to recognize such an action as improper; more so if the perpetrator is a female caretaker (Kaufman et al, 1995; Kelly et al, 2002).
3. Children and adults may forget unpleasant memories or cooperate with demands for secrecy (Wilsnack et al, 2001; Svedin et al, 2002).

4. Developing countries like India with limited economic resources may not be able to manage all reports of suspected child sexual abuse or to collect and report the data (Malhotra & Gupta, 2005).
5. Adult rape, non-consensual sex in marriage and dating, and CSA may mingle with the CSA data.

The prevalence of children involved in child prostitution is unknown (Walker, 2002). It is estimated that 1-10 million children are involved (Willis & Levy, 2002).

Table 1**:**

Incidence rates of CSA

Greenland (Curtis et al, 2002)	8% women; 3% men
Copenhagen, Denmark (Klit et al, 2002)	0.7/ 1000 children
Europe (Lampe, 2002)	3-36 % girls; 1-15% boys (<16 years)
USA (US Deptt. of Health and Human Services, 2002)	10.1% were sexually abused (1.7/ 1000 girls; 0.4/ 1000 boys)
Australia (Mazza et al, 2001)	42.3% non-contact CSA 33.7% contact CSA

The wide range in incidence rates (Table 1) could be due to the differences in: 1) definitions 2) data – gathering techniques & 3) age of individuals in the studies.

Population based studies in UK and in US have demonstrated that there are no ethnic differences in the rates of CSA (Kelly et al, 1991; Priest, 1992; Korbin, 1997). CSA has been reported in minority communities living in USA e.g. Filipino, Cambodian and Asian communities (Rao et al, 1992; Okamura et al, 1995; Scully et al, 1995). However, the exact incidence rates are difficult to estimate in these communities partly due to lack of consensus on data collecting criteria in classifying ethnicity/ racial backgrounds and partly due to shame and denial of reporting CSA in these cultures (Glaser, 1999).

CSA has been predominately reported from lower and middle social class groups (Haugaard & Reppucci, 1988). It has been argued that this phenomenon is not uncommon amongst the higher social class; it is just unreported (Bentovim et al, 1988). The probable reason could be that underprivileged groups are more likely to attract attention of child protective agencies than affluent societies who find ways of hiding the abuse or avoiding reporting (Gomez-Schwartz et al, 1990).

Etiology of Child Sexual Abuse

Child sexual abuse has often been viewed as a social phenomenon which is linked to general attitudes and practices towards children, and ways in which social relationships are organized and regulated in a particular society (Glaser & Frosh, 1993). Greater permissiveness in a society increases the chances of CSA due to increased frequency and intimacy of contact between adult and child coupled with decreased vigil by caretakers. It has been suggested that four factors influence the occurrence of sexual abuse (Finkelhor, 1984).

1. Motivation, which includes the abuser's sexuality.

2. Absence of internal inhibitors (Moral values of the adult)

3. Absence of external inhibitors (Supervision of child by others)

4. Child's own resistance towards the adult.

Motivation refers to the abuser's sexuality and sexual development. This includes paedophilia, fear or avoidance of peer sexual relationship, sadism and interpersonal motivators such as need to overpower more vulnerable persons, arising as a result of one's past abuse and low self-esteem. In a survey of male undergraduates it was found that 5-9% expressed sexual interest in children. However, the fact that the rates of CSA is lower than rates of expressed sexual interest meant that the inhibiting factors need to be overcome for CSA to occur. Occasions where perpetrator's internal inhibitions (e.g. moral values) may be overcome are use of alcohol and presence of stress. Cognitive distortions including rationalization, minimization of harmful effect of abuse and conceptualization of abuse as 'love' or 'education' may be motivators for abuse. On the other hand, a protective family, secure attachment to the primary care giver, good monitoring of child's whereabouts and a confiding relationship with the child prevent or decrease the chances of abuse (Budin & Johnson, 1989; Conte et al, 1989).

Another influential theory is the 'Family Systems Theory' (Furniss, 1984; 1991). This theory postulates that the basic problem is that of a father-daughter incestuous relationship due to dysfunctional family arrangement where parents suffer from an 'emotio-sexual' conflict. CSA occurs when the child comes to the parent(s) seeking emotional relief / care and child gets a sexual response. There are two forms of family pathology viz. conflict avoidance and conflict regulation. In the former type the family is too insecure to cope with acknowledging the abuse and in the later though they hide the abuse from the outside world, they openly recognize the abuse, which leads to frequent arguments amongst the members.

a) Characteristics of abusers:

An attempt should be made to characterize and understand juvenile sexual abusers / offenders. A sexual offender is one who has committed an act of sexual aggression breaching societal norms and moral codes and violated law (National Task Force on Juvenile Sexual Offending, 1993). He/she can be either preadolescent or an adolescent

person. A paedophile is a person who is at least 16 years of age (and at least 5 years older than the child) and indulges in a child younger than 13 years (APA, 1994). However, research on juvenile sexual abusers is difficult due to the disgust of the perpetrators and the 'Ostrich Psychology' of the society to such acts (and the perpetrators themselves) (McConaghy, 1998).

Following characteristics of juvenile sexual abusers have been described:

1. Most of them have poor control over impulsivity and impaired social skills such as difficulty in interacting with other persons. Some paedophiles view children as objects of sexual gratification, while others report feelings of affection towards children (Conte et al, 1989).

2. Biological studies on incarcerated paedophiles suggest that they have high plasma levels of epinephrine and norepinephrine, and reduced cortisol responses to meta-chlorophenylpiperazine challenges (Maes et al 2001, 2001).

3. 60-90% of juvenile sex offenders have some form of psychiatric illness (Raymond et al, 1999). Paedophiles have a 93.9% lifetime and 75% current prevalence for co-morbid psychiatric disorders e.g. conduct disorder, mood disorders, anxiety disorders and drug abuse. Sixty percent of the male paedophiles meet criteria for personality disorders, primarily obsessive-compulsive (25%), antisocial (22.5%), narcissistic (20%), and anxious-avoidant (20%) (Raymond et al, 1999).

Several predisposing factors have been implicated in the etiology of paedophilia. Family environment (Becker et al, 1993), social isolation and lack to make friends (Becker et al, 1993; Smith & Monastresky, 1986), academic and scholastic problems (Shaw et al, 1993) and developmental disabilities (McCurry et al, 1998) are some of such factors.

Incarcerated perpetrators reported that they sought for children, who were available, could be easily manipulated and had desirable attributes. Perpetrators usually target pretty, young or small, innocent and trusting children who lack confidence and self esteem. These children are likely to be found in single parent homes and to be alone and lonely. Perpetrators find vulnerable children in public places frequented by children, in playgrounds, at family events, in the child's home or in / or near the perpetrator's home. They claim to prefer seduction and gaining trust over coercion, by becoming the child's friend, playing games with them, and offering them gifts ranging from money and toys to beer and cigarettes. They use play, babysitting, bribes, affection and understanding and love to gain trust. The most common threats include hitting and hurting loved objects. Less common threats involve the use of guns or hurting loved ones. Murder of the child is, however, rare. Sexual abuse usually begins with genital touching and kissing, asking children to undress or lie down or sex talk. Drugs, alcohol or pornography are techniques used to maintain the relationship (Elliott et al, 1995).

b) Who is likely to sexually abuse the child?

Table 2: **National USA statistics (US, 2002)**	
Perpetrators responsible for CSA	% of cases of CSA
"Father only"	21.5
Other relatives	19.4
Others	24.9
Either of the parents	5.3
"Mother only"	3.9
Both parents	8.1
Day care providers	2.7

45.2% of the sex abusers were in age group of 20-29; only 6.6% and 7.2% of the sex abusers were in the age group <20 years and > 50 years respectively.

Consequences of Child Sexual Abuse

The consequences of child sexual abuse are both psychological and physical. Damaged tissue is likely to heal without scarring but psychological consequences may persist (McCann & Kerns, 1998). Pregnancy and sexually transmitted diseases may result in lifelong effects, some of which can be life threatening. Psychological consequences such as suicide attempts and posttraumatic stress disorder may be just as serious. Also, a wide range of serious long and short-term consequences of CSA, include reactive abuse (abuse of other children by a victim). Thus all children with suspicion of being sexually abused should be referred for psychological testing and treatment (Glasser et al, 2001; Johnson, 2004).

a) *Psychological consequences*

Child sexual abuse can have both immediate and long-term psychological effects that carry over into adulthood (Wyatt & Powell, 1988).

Outcome in Childhood:
The immediate psychological consequences in an abused child may include emotional disturbances in the form of fear, anxiety, depression, anger, hostility and low self-esteem (Browne & Finkelhor, 1986; Bentovim et al, 1988; Kendall-Tackett et al, 1993). Poor academic and scholastic performances have usually been seen in sexually abused children. These children can also present with various anxiety disorders (fearfulness, nightmares, phobias), post-traumatic stress disorder (PTSD), hysterical reactions, depression, suicidal behaviour, substance abuse etc. Research reports have shown that 20-70% of children with substantiated CSA suffer from PTSD (Wolfe et al, 1991; McLeer et al 1992). PTSD is a serious psychiatric illness developing in reaction to a major, unpleasant stressful event and manifests with repeated nightmares, vivid 'flashbacks' (memories of the event in the awake state) and marked anxiety leading to considerable suffering and dysfunction (Green, 1993). It has been estimated that 1/3rd of the abused children show no psychological symptoms or only non-specific symptoms. This allows the abuse to go undetected over prolonged periods (Kendall-Tackett, et al 1993). This is more in children than in adolescents (McLeer et al, 1998).

Browne & Finkelhor (1986) did an extensive review of earlier research on the impact of sexual abuse. Initial effects of abuse noted were fear, anger, hostility, guilt, shame, sleep disturbances, eating disorders and an array of sexualized behavior from genital manipulation to pregnancy, 'mummy/daddy' and 'nurses/doctors' related themes in their play. Sexually inappropriate behaviors have been linked to early onset of sexual abuse (McClellan et al, 1996). Later effects included depression, anxiety, negative self-concepts, interpersonal problems, a tendency towards re-victimization and self-destructive behaviors.

In a study comparing parents' reports of definitely abused, allegedly abuse, and non-abused pre-pubescent females using Structured Interview for Signs Associated with Sexual Abuse, researchers found significant differences between the three groups (Wells et al 1995). The symptoms that did not seem to be related to abuse included nightmares, crying easily, fears of being left alone, bedwetting, headaches, and stomach aches. The symptoms that were significantly different between the girls who were definitely sexually abused and those who were allegedly abused were difficulty getting to sleep, noticeable changes in behavior, fear of being left with a particular person, fear of males, becoming withdrawn, unusual interest or curiosity about sexual matters. It was concluded by the researchers that a report from the parent can be a useful part of the assessment regarding the likelihood of sexual abuse.

Studies of psychological consequences of sexually abused boys are very far and few (Gurshurst, 2003). In a study of a large group of 12,599 secondary school children in Netherlands it was found that boys were more likely to use alcohol, drugs, display aggressive and criminal behavior, truancy and suicidal attempts after sexual abuse than girls (Garnefski & Arends, 1998). The behavioral effects on boys who reported a positive

response to sexual abuse were greater than those noted in girls who had been abused. 43% of the boys who had been sexually abused (versus 2.6% of those who were not abused) and 26% of the girls who were abused (versus 5.1% who were not abused) reported suicide (Garnefski & Arends, 1998). Self-injurious and suicidal behavior as adults has therefore been linked to childhood sexual abuse (King et al, 2002). ______

Outcome in Adulthood:

Although is has been mentioned that some children do not manifest with any psychiatric illness in the period immediately following sexual abuse, yet this does not support the fact that all is well in these children. The effects of CSA can have their ramifications into adulthood. Even in adults, varied emotional and psychological reactions occur. Low self esteem, sense of helplessness and self-hatred and disturbed interpersonal relationships in the form of marital discord and divorce are seen. Psychiatric illnesses like depression, anxiety, suicidal tendencies, hysterical reactions, sexual problems and borderline personality disorder have been reported in adults with history of sexual abuse in childhood (Cotgrove & Kolvin, 1996). The behavioral consequences of sexual abuse are affected by the child's age, development, physical acts performed, threats and bribes, fear of retribution, fear of culpability, chronicity of acts, child's resilience and relationship to the perpetrator (Haj-Yahi & Tamish, 2001; Macfie et al 2001;Molnar et al 2001;Hanson et al 2001) and effective treatment.

Apart from the psychological aspects of CSA, there is enough evidence that neurophysiological and neuroanatomical changes in brain do occur as a result of early trauma (Glaser, 2000). In sexually abused girls there was dysregulation of HPA axis with blunting of ACTH response to CRH, but without increase in cortisol secretion even after 5 years of the abuse suggesting a downregulation of the HPA axis following abuse (De Bellis et al, 1994a). The 24-hours urinary cortisol secretion was found to be increased in children still suffering from PTSD following serious abuse (De Bellis et al, 1994a). Magnetic resonance Imaging (MRI) scans of children suffering from PTSD following serious abuse showed a 7% smaller cerebral volume and increased cortical cerebrospinal fluid volume in comparison to non-abused children (De Bellis et al, 1994b). Deficits in verbal short-term memory have been found in men and women with history of CSA (Bremner et al, 1995).

b) Physical consequences

HIV and other sexually transmitted diseases are seen in children with CSA that can have its own ramifications in adulthood. In addition, CSA may lead to unwanted pregnancies and rarely genital injuries (Willis & Levy, 2002). It is noteworthy that even in documented cases of CSA, only 50% of cases show physical findings (Muram, 1989). A careful or experienced perpetrator is unlikely to perform an act that will result in his or her detection. Intense and persistent pain, obvious tissue injury, or bleeding can lead to immediate suspicion or detection unless the perpetrator is able to keep the trauma from being discovered. A child who is injured may be kept away from pre-school or school or other adult caretakers until healing occurs. Some types of abuse, such as exhibitionism, voyeurism, viewing or creating pornography, touching and licking may not result in physical findings. Reddening of the skin caused by rubbing resolves in minutes to hours unless the skin is excoriated. Minor scratches may not be detectable (Johnson, 2004). Great concern has been expressed about the fact that physicians have shown persistent

lack of knowledge about normal and abnormal female genitalia. Emergency room physicians should not misinterpret findings that can lead to a mistaken report of physical trauma, or to failure to recognize trauma (Johnson, 2004).

Physician's Role (Recognizing behavioural and psychological consequences)

Goethe said, *"We see what we look for; we look for what we know".* Therefore, identifying subtle signs of psychological and physical consequences requires thorough knowledge.

The primary care physician is often the first professional from whom a concerned caretaker requests consultation about possible child sexual abuse. Disclosure of abuse requires access to a trusted adult (Johnson, 2004). Some children who are abused do not disclose it to anyone until much later when they feel much safer and protected. This delay, along with healing, accounts for the absence of physical findings (Lauritsen & Charles, 2001). Therefore, a specialized interviewing skill is a must to ensure that the abused child feels protected and receives treatment. Repeated interviews should be avoided. As far as possible there should be a multidisciplinary diagnostic clinic where children's' services, mental health professionals, law enforcers and prosecutors are present. In private practice, doctors don't get enough time for such an assessment. The abused child should be seen as quickly as possible (within 72 hours) to avoid further abuse and reduce chances of threats and bribery and detecting the injuries before they heal (Gosset & Hedouin, 2002).

Since eliciting history of CSA can make both the physicians as well as the victim uncomfortable, a step-wise interview (Yuillie et al 1993) is recommended. It includes rapport building → asking open – ended questions → telling the truth → introducing the topic of concern → free narration after topic has been introduced → general questions → lastly specific questions. Associated psychological aids like drawings (Burgess & Hartman, 1993), anatomical dolls, projective tests (Rorschach, Child Apperception Test) have been found useful (Leifer et al, 1991). Behavioural checklists (Freidrich et al, 1991, Chantler et al, 1993) have also been used. Mental State Examination (MSE) is an integral part of the whole process of reaching a diagnosis. Establishing a good rapport, keeping the interviews to a minimum and use of open-ended questions are important aspects of MSE. In addition, play observation may be a useful mode of examination.

Any statement made by the child should be recorded. Questions regarding who, when, how often, threats and bribes must be open-ended. All information gathered about abuse should be legibly recorded and should be complete. Detailed physical examination including genital and rectal examination is also mandatory in such cases. As far as possible an examiner who is familiar to the child should do the genital examination, as it would help in better cooperation from the abused child. Additionally, a child may be entertained or distracted by the television or any other means. Colposcopy, Foley catheter Technique, Wood Lamp Examination can be useful to get forensic evidences (Atabaki & Paradise, 1999).

According to emergency room physicians and specialists in the field court appearances are the most stressful aspect of abuse assessments, (Johnson, 1990; 1999). However, one must prepare to testify as a content expert and a teacher to lay audiences. Meeting with

the prosecutor before appearance in court is of value. The physician should educate the prosecutor regarding the medical evidence. A physician may testify for the child. This is based on the assumption that children do not lie to physicians. This is particularly relevant when the children cannot or will not testify on their own behalf (Peters, 2001).

Intervention Evaluation: What Works?

A public health approach typically focuses on prevention; however, this discussion of intervention has been expanded to include both prevention and treatment. Intervention includes firstly risk factor identification, educational programs and treatment of both physical and psychological consequences.

Risk factor identification:

This is the first step in the public health approach and it involves identifying factors that increase the likelihood or risk of CSA. The term "risk factor" is any factor associated with an increased likelihood of CSA (Conte & Schuerman, 1988; Mullen et al, 1993; 1996).

Prevention:

Prevention of CSA includes 2 major categories of programs: 1) perinatal and early childhood programs and 2) education programs. The first category includes programs that are generally aimed at preventing sexual abuse amongst high-risk individuals and families. The second group of interventions, most often focus on preventing sexual abuse or abduction in the general population. The perinatal and early childhood programs include the nurse / social worker home visit program. High-risk families are identified and regular visits are made for at least 2 years. Several researches have shown that this can considerably reduce the rates of CSA and also decrease the burden on the society by decrease in expenditures of health care costs on abused children.

Most sexual abuse education programs are aimed at teaching children to avoid sexual victimization or abduction. Some investigators suggest that sexual abuse education programs may be more useful as secondary preventive interventions i.e. once sexual abuse has already occurred. Children exposed to school-based education programs were more likely to disclose an incident of victimization. In most of these programs the onus of responsibility is placed on the children to avoid sexual abuse, rather than on the persons committing the abuse (Finkelhor & Berliner, 1995).

Treatment:

The focus of treatment has been not only on the issues directly related to the abuse, but also on the dysfunctional and problematic relationships associated with it. Numerous practical problems come into play during the course of treatment viz. the component of confidentiality, secrecy, denial on part of the part of the family members, and liaison with various agencies working with the family.

Treatment can be carried out in different settings i.e. individual, group, and family. Individual approach aims at enabling the children to describe their abuse and the feelings

regarding the same. This form of treatment aims at developing a one-to-one relationship, reversing the sense of isolation and resolution of the guilt in a facilitative atmosphere (Hunter, 1986). Individual Cognitive Behavior Therapy, which is a form of individual psychotherapy, focuses on safety education, assertiveness training, fear, anxiety and inappropriate behaviors (Ramchandani & Jones, 2003).

In a multi-centre psychotherapy outcome study (Trowell et al, 2002) of sexually abused girls (aged 6-14 years), who were randomly assigned to either focused individual psychotherapy (upto 30 sessions) or psychoeducational group therapy (upto 18 sessions), it was found that both therapies were equally effective in substantially reducing psychopathology; with individual psychotherapy being most effective in PTSD. Till date six studies involving individual Cognitive Behavior Therapy (CBT) have found this approach to be effective in reducing psychopathology in sexually abused children (Celano et al, 1996; Cohen & Mannarino, 1996; 1998a; Deblinger et al, 1996; King et al, 2000; Dominguez, 2002). These interventions were mostly short term. Children who are severely abused or those who experience greater magnitude of maladaptive behaviour may require longer periods of interventions.

Group therapy has been used widely in recent years (Prior et al, 1994). Its advantages over individual approach are: it helps to counteract isolation, raise low self-esteem, and provide a common language for communication. There are 3 studies on Group CBT in CSA (Burke, 1988; Berliner & Saunders, 1996; Deblinger et al, 2001), all of which shown effectiveness of Group CBT in reducing psychopathology.

It has been found that the disclosure of CSA and subsequent events like the investigative process, a breakdown of trust and relationship with the perpetrator and family disruption usually result in psychopathological symptoms. High prevalence of psychopathological symptoms has been found not only in the victims of CSA, but also in their non-abusing parents (Forbes et al, 2003). Therefore, family interventions are important as they help the therapist to involve the siblings in treatment, the family to talk about the abuse and the therapist to assess family functioning (Finkelhor & Berliner, 1995; Nurcombe et al, 2000). CBT sessions of parents of CSA victims include cognitive reframing, thought stopping, positive imagery, contingency reinforcement programs, parent management training and problem solving. Empathy and education about CSA, information about investigative process, reinforcement of competent parenting, teaching coping strategies have been found to cause reduction in parental distress and degree of psychopathology (Forbes et al, 2003). Of all the non-pharmacological treatment modalities available, CBT is the one, which is most widely studied and argued to have the strongest research evidence on efficacy to reduce psychopathology in CSA victims (Ramchandani & Jones, 2003).

Drug treatment is warranted for diagnosable psychiatric illnesses e.g. depression. Various psychological interventions can provide the child a platform to talk about the abuse and the associated feelings. Various specialized form of psychological interventions like identifying and modifying negative / maladaptive thoughts, teaching ways to handle stress and non-directive supportive therapy have been tried in these patients. However, despite treatment some abused children don’t improve and can even worsen. Also, there is a high rate of dropouts. Boys are harder to treat and it is unclear whether one kind of treatment could suit all children.

Indian Scene

Considerable amount of data is available to suggest that the phenomenon of CSA is prevalent in India. The World Health Organization puts the prevalence figures at around 10% (Malhotra & Gupta, 2005). A study conducted by Virani and coworkers (1985) in Mumbai found that 30% of females and 10% of male adults had childhood history of CSA. Nambiar (1994) reported that 54% of the rape victims in New Delhi were below 15 years of age. Additionally, a significant percentage of these children were abused either by family members or by relatives (Virani, 1994; Davar, 1999).

Very few studies have been conducted to study the psychological and physical outcomes of CSA. Almost 2/3rd of CSA cases have some psychological problems with depression being the most common (Patel et al, 1997). Interpersonal problems with family, conduct problems and sexualized behavior was seen in a case series of CSA patients (Kohli, 2004). However, there are no available studies to highlight whether any intervention strategies have been developed or implemented for CSA (Jain et al, 1992). This is rather surprising and disappointing as CSA is not a rare phenomenon. There is an urgent need to develop a database in our country so that appropriate interventions can be planned and implemented.

Conclusions

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 physical and psychological consequences. Assessment of CSA is a tedious task with legal and social issues complicating the matter. 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. Interviewers must identify suspected victims and maintain objectivity. The ability of children to recall information and / or be prompted should be researched thoroughly. There is also need for further research on normal sexual behavior of children. Establishment of a sound therapist-patient relationship and individualized treatment remains the corner stone for management of CSA. Despite the plethora of research from the West, India has lagged behind in documenting, reporting and carrying out interventional studies. Various professionals from the medical, social and psychological fields have not understood and learnt to properly handle the issue in a holistic manner. Needless to say, sexual abuse in children is an area where questions definitely outnumber the answers.

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