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Original Article

Child Sexual Abuse- Clinical Challenges and Practical Recommendations

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ABSTRACT

Working with sexually abused children and their families carry intricate complexities because of the context in which abuse occurs. To unravel these complexities, it becomes imperative to recognize and document challenges that emerge during work with sexually abused children. Challenges that are commonly encountered in the clinical setting are discussed and suggestions to render assistance and services in an effective manner are provided.

KEYWORDS: child sexual abuse, child maltreatment, management, India.

INTRODUCTION

Child Sexual Abuse (CSA) is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared or that violate the laws or social taboos of society[1] .Systematic efforts to address CSA in India began about twenty years ago. Concerned

professionals then struggled not only with the culture of denial but also with difficulties of the language of trauma and sexuality. Much ground has apparently been covered since. The State has taken serious cognizance of the issue and has been involved in surveying the problem and studies on CSA have focussed on prevalence. This is understandable because prevalence data is needed to understand the magnitude of the problem and to consider appropriate policies and programmes. The Ministry of Women and Child Development initiated the National Study on Child Abuse covering 12447 children across 13 states in India. About 53.22% children reported having faced one or more forms of sexual abuse and 70% of children had not reported the matter to anyone[2]. Child protection systems are now in place and there are non-governmental agencies that work exclusively with this problem. The Protection of Children from Sexual Offences (POCSO) Act 2012 has been enacted. It is gender neutral and all acts of sexual nature - penetrative, non-penetrative, genital, non-genital, touch and non- touch based offences come under the purview of the act.

However, despite the progress in the last two decades, there are still huge gaps in providing assistance to affected children and families. Because there are multiple agencies involved, the gap is rendered even more complex. Individual cases carry their own complexities because of the context in which abuse occurs. To unravel these complexities, and render assistance and services in a more effective manner, it becomes imperative to recognize and document issues that emerge during work with sexually abused children.

CLINICAL CHALLENGES AND PRACTICAL RECOMMENDATIONS

In the article, we discuss some common clinical situations that are encountered and offer ways to negotiate these challenges. These are suggestions are based on our collective clinical experience considering the lack of clinical guidelines pertaining to management of CSA in the Indian Context.

ASKING ABOUT ABUSE

A 13 Year old girl presents with a history of episodes of unresponsiveness- characterised by falling on the floor, feeling sad, crying spells, declining school performance and decreased appetite. A diagnosis of Moderate Depressive Episode and comorbid Dissociative Disorder is made. The adolescent is started on an antidepressant.

When the adolescent has left the clinic, the clinician continues to wonder about the other symptoms that the parents reported: some vague fears and reluctance to be alone at times. Should one also ask about history of sexual abuse? If so, how to ask about the history of abuse? How distressing would it be for the child to talk about a traumatic incident? How to respond if the child reports such history? Would the parents take offence to this line of enquiry?

Child sexual abuse survivors are reluctant to talk about the abuse spontaneously to anyone. Given that there is a high prevalence of history of sexual abuse in all diagnostic categories and the low disclosure rates, it essential to ask ALL patients about abuse history[3]. Concerns about distressing children and their families are appropriate, questions must be asked in a sensitive manner and appropriate response should be provided. One may ask about abuse while taking personal history, i.e. in which parents/

children are asked for details about early childhood, schooling, family environment, adolescence, relationships and sexuality.

More specifically, the issue of abuse may be broached using a window approach by moving from general (less threatening/ more neutral) to specific questions such as:

- Can you tell me about your daily routine?
- Can you tell me about your best memory and the worst?
- Who are your favourite people? Tell me what you like about them and the activities you enjoy with them.
- Who are people you do not like? What are reasons you dislike them or why do they make you feel uncomfortable/ upset?
- Have you ever been upset or bothered by someone's behaviour towards you?
- Has anyone touched you in ways that you do not like?
- Has anyone touched your private parts and made you feel uncomfortable?

If the child reveals that s(he) has been sexually abused, the clinician should acknowledge that abuse can sometimes be difficult to talk about, but that it is a positive step to have told the clinician about it [3]. The clinician should then ask the child how s(he) feels having disclosed the abuse issue and if s(he) has told about it to anyone and what response was received. Then one must check for ongoing abuse. It is then vital to explain to the child what you plan to do next as this helps him/her from feeling powerless. The next appropriate step would be to inform the parents and then the concerned authorities.

ISSUES RELATED TO REVELATION OF ABUSE

In case the child tells us that she has been sexually abused and she does not want anyone to be told about this matter, it creates ethical dilemmas around maintaining the child's confidentiality versus protecting the child from further abuse. Not only is it the child's right to have her information kept confidential but it is also important to maintain confidentiality in order for the child to feel safe in sharing her experiences freely. But on the other hand, there is the issue of beneficence, which focuses on the clinician's obligation to promote the optimal well-being, functioning and development of the child and this entails cessation of or protection from abuse.

Often, confidentiality and beneficence are conflicting principles that require to be carefully balanced. In such instances, the clinician may explore with the child the reasons why she does not wish to reveal the abuse experience to the caregivers. Then, an attempt must be made to help them understand that disclosure is in her best interest, to ensure protection. To this end, the clinician must inform the child in the initial session that most of what is spoken is confidential but that there may be scenarios in which the clinician may need to set aside confidentiality, and inform the parents, such as in situations of personal neglect, imminent harm to self or others and high risk behaviour, ongoing physical/sexual abuse, all of which may harm or hurt the child. The clinician must also assure the child that as far as possible the nature of this disclosure to the parents will be discussed and agreed upon with the child and done in ways most comfortable to her. Such an approach that balances confidentiality and the child's well-being, presented from a

perspective of genuine concern that the clinician has for the child is likely to help the child move towards making decisions about disclosure.

Upon consent from the child, with clear discussions on plans on how and what to disclose, the clinician may then proceed to inform the parents; this is also best done in the presence of the child so that she is convinced that the disclosure process was conducted as per her permission and discussions with the clinician.

However, in cases where the child refuses to give consent for disclosure, the clinician might need to override confidentiality concerns and inform the parents in order to ensure the child's safety. Thus, although breaking confidentiality may disrupt the trust relationship between the child and clinician, this concern is outweighed by the responsibility of the clinician to prevent further harm and ensure the child's protection and best interests.

ISSUES WITH MANDATORY REPORTING OF ABUSE

A 15 year old girl diagnosed with Bipolar Affective Disorder- mixed affective state is admitted in the ward. After remission of the episode, during therapy, she reports that she has been sexually abused by their neighbour. She is hesitant to report this to her parents but then with the help of the therapist is able to reveal it to them. The parents and the client are quite certain that they do not wish that this is reported to the police.

The challenges:

- If child abuse is reported to the police, it will be a breach of confidentiality and the child's trust will be broken and the parents may also not be willing to bring the child for therapy.

- The steps taken by the police and the Child Welfare Committee (CWC) and may result in legal action against the neighbour (problematic for the family).
- In India, the need for mandatory reporting is mentioned in the Protection Of Children from Sexual Offences Act 2012 [4](See Appendix A).

The law implies that any person including the clinician is required to inform the police as soon as the incident comes to his/her notice even if the child and her family do not give consent to reporting the case. The dilemma for the clinician pertaining to mandatory reporting, especially when the perpetrator is related to the victim is: "what if I am doing more harm than good?"

Victims and families often report that following discovery and reporting of abuse, they experience additional trauma. This may be in the form of repeated interviews, frightening medical examinations, confrontation involving the victim and perpetrator's family[5]. Families also have to make multiple visits to the police station, CWC, the hospital and give legal testimony months or years later.

In the light of these difficult procedures, the clinician must take into account the overall needs of the family and realise that although reporting may cause disruption in the family in the short term, in the long term it is a step towards prevention of prolonged victimization of the child[6].In this vignette, the therapist will need to remind the adolescent about limits of confidentiality (discussed in the previous sub-section) and the need for mandatory reporting on the part of the clinician.

After the discussion with the child and the family regarding the need to report, the clinician needs to report the matter to the Special Juvenile Police Unit (SJPU). The

clinician must then work towards limiting harm due to reporting. It is the therapist's responsibility to prepare the child and the family for the various procedures that may take place after reporting. In the Indian setting, when the matter is reported to the SJPU, they file a First Information Report and then refer the child to a registered medical practitioner in a government hospital for a medical examination and for forensic evidence collection. The matter is also reported to the respective CWC which helps in ensuring safety of the child and provides legal help to the family. In each of these places, the child and the family may be asked to provide the details of the incident. The clinician could make the process less threatening by assigning a primary caseworker who could accompany the child in all referrals, procedures and enquiries and be a familiar, consistent figure in the process. In cases that need further clarification regarding the incident, the clinician may aid the police in conducting the forensic interview in order to prevent re-traumatisation and this interview can be embedded in the therapeutic process. Thus, the clinician must liaise with the CWC and the police and assist as much as possible in helping manage the pain and upheaval that follow reporting of abuse.

In case the clinician decides not to report due to ethical concerns, one must realise that currently it is against the law and take personal responsibility for the consequence of one's actions.

ISSUES IN FORENSIC INTERVIEWING

M is a 5 year old girl presenting with symptoms of fear, frequent nightmares, irritability, and decreased sleep following penetrative sexual abuse by a relative. The perpetrator was arrested and the family was pursuing legal action. The police and the parents

requested the clinician for help with forensic interviewing in order to obtain a statement from the child. The management plan was to use play therapy as the healing intervention and to conduct forensic interviewing during the play therapy sessions. Over the next few weeks, the child engaged in the sessions and there was improvement in the anxiety symptoms. The forensic interviewing was attempted over several sessions. But it was observed that the child would become extremely quiet and seemed reluctant to answer the questions and that her symptoms were exacerbated.

One wondered if the questioning was in fact re-traumatizing the child. The dilemma was whether evidence collection is to be continued in order to help bring the perpetrator to justice or be stopped considering the child's unease and deterioration. After a consultation among the treating team members, the parents and the police it was decided that forensic interviewing of the child would cease and therapeutic play sessions would continue.

This is the kind of challenge that a clinician may face when s (he) also takes on an investigative role, wherein the forensic interview is not a part of the treatment process. Such interviews are typically conducted by law enforcement officers, child protection services personnel, or forensic interviewers[7].It is usually not conducted by professionals who have a therapeutic relationship with the child [8].In India, however, the clinician may be asked to conduct the forensic interview. This creates a difficulty as there is no uniform forensic interview protocol and few persons are trained in interviewing children. Thus, in this context, the clinician may consider doing the forensic interview so further trauma to the child, through unskilled interviewing and multiple number of

interviews, is reduced. The Cornerhouse Forensic Interview Protocol [9] or National Institute of Child Health and Human Development protocol [10]may be adopted, to conduct forensic interviewing in a systematic manner.

The goal of a forensic interview is to obtain a statement from a child, in a developmentally-sensitive, unbiased and truth seeking manner that will support accurate and fair decision-making in the criminal justice and child welfare systems [8]. However, during the course of gathering information from the child, as in the vignette above, there is the dilemma of re-traumatizing the child versus bringing legal justice to her.

In such instances, the clinician may need to follow the principle of "Primum non nocere" – First, do no harm. The most important goal cannot be to obtain the all or accurate the details of the abuse but to understand the effects on the child and help in management of the consequences. Thus, even when the clinician does take on an investigator's role, in circumstances where the child responds to the investigation with extreme distress, the decision to continue with questioning should be guided by the child's best interests in terms of her psychosocial and mental health.

DEALING WITH INTRA-FAMILIAL ABUSE

R, a 7 year old girl was referred by the SJPU following a complaint made by a neighbour that the child was being sexually abused by the father. The family consists of 5 other children and their mother. The father is an immigrant labourer and is the only earning member in this family living in poverty. The mother believes that her husband could not have harmed the child and says that she needs him to stay with them as soon as he is released on bail so that they don't have to beg for basic sustenance.

In countries with strong child protection services, such a situation would evoke a detailed enquiry in order to evaluate whether it is safe for the child to stay with the family.

Complex decisions like separation of the child from the family are usually made based on the assessment of each parent. These decisions are made based on a number of factors. These are the extent of the offender's abusive behaviour, the severity of his/her other problems and the degree to which they take responsibility for the offence. The non-offending parent's reaction to the child abuse, level of dependency on the offender and quality of relationship to the victim are also important. Further, the victim's the level of comfort regarding the living arrangement is also checked and a decision is made weighing in all of the above mentioned factors.

In our country, in such cases, it may be vital to involve the local CWC so that joint decisions regarding ensuring the child's safety can be made. The intervention may involve removal of the child from home and placement of the child in NGOs or shelter homes. The consideration that abused children face difficulties adjusting to shelter homes and that government run homes can sometimes be worse than the child's own home further confounds the problem. Alternately, a decision facilitating family preservation with an order for compulsory treatment for the abusive caregiver may be made. Treatment of the adult abuser is paramount when children are closely related to the abuser and wish to have a close relationship with them. It focusses on reducing denial, accepting responsibility for the abuse and learning strategies to halt further abuse [11]. The clinician must make also efforts to empower and offer continued support for the non-

offending parent in order to ensure safety of the child. In such cases, it is therefore imperative to focus on the child, the non-abusive caregiver and the abuser.

ISSUES PERTAINING TO TREATMENT

Another challenge in CSA management is that it is an experience and not a disorder. About half to two thirds of the children who have been sexually abused may experience a wide variety of symptoms while the rest may have no apparent symptoms[12].Symptomatic children may be given specific pharmacological treatment depending on the disorder and psychotherapeutic interventions but the difficulty is that one cannot say which specific therapy or combination of therapies will be effective in an individual case as there are is paucity of treatment outcome studies. In general therapy involves encouraging expression of feelings about abuse, clarifying misconceptions, teaching prevention skills and diminishing the sense of stigma and isolation in victims[13] .

The greater dilemma is that of managing asymptomatic children who come into treatment as a result of discovery of the abuse and whose caregivers seek prophylaxis against future problems. The question is whether they need treatment at all and how much treatment they need as we do not have “symptom improvement” as a benchmark to guide us in that decision.

Certain recommendations state that clinicians should consider treatment only if there is demonstrable harm, i.e., the child/adolescent is symptomatic [14] while others argue that since CSA is a risk-factor for later psychopathology, treatment should be provided to prevent future pathology [15]. However, the argument in favour of treatment cannot be

limited to ‘demonstrable harm’ or ‘risk for future psychopathology’; it is sufficient that that the child has been sexually abused and this alone warrants action from a child rights’ perspective. While there may be no need to pathologize the issue if the child is asymptomatic, other interventions, involving the family and legal systems must still be implemented in the interests of protecting the child from further abuse.

Further, a brief intervention addressing personal safety issues with the child and psychoeducation to the parents must be done. It should be ascertained that the child is able to talk about his/her experience to the parents who believe the child and are supportive while ensuring that the abuse episode does not become the defining experience in the child’s life.

THERAPIST RELATED ISSUES

Working with sexually abused children and their families is stressful. Clinicians may feel uncertain about the occurrence of abuse, distressed about the terrible nature of these acts and the upheaval the families go through following the event. Therapists are often filled with self- doubt about the intervention, and wonder if it is causing more harm than good. They may also feel frustrated when their attempts to assist the child and family are unsuccessful. Such emotional turmoil can create feelings of helplessness and hopeless, even leading to ultimate disengagement with the concerned child and family.

These adverse consequences may be prevented by using team approaches to management in cases of CSA. They may range from sharing one’s feelings regarding the treatment of an incestuous family with a colleague to prevent the sense of isolation and overwhelming responsibility [5], to working as a part of a multidisciplinary team to deal with various

facets of management. Often a collaborative effort of two clinicians, one to work exclusively with the child and the other to address family concerns/ other systemic issue is helpful not only in reducing the burden of care on a single individual but also in providing more focussed and unbiased care to the child and a dedicated systemic response.

DISCUSSION AND FUTURE DIRECTIONS

Singh et al [16] provide an overview of the epidemiology of CSA in India and report that India has the largest number of CSA in the world and that several cases go unreported. Increasing awareness regarding mental health needs of children in general and regarding CSA in particular has led to an increase in the number of these children being seen by mental health professionals. Enquiry regarding sexual abuse is sensitive issue and this can seem especially difficult in young children and children with Intellectual Disability, age- appropriate techniques and use of art and play can facilitate disclosure in these populations. In case a child reveals abuse , then confidentiality may need to be set aside in order to ensure safety of the child and the child needs to be prepared for disclosure and procedures following it, namely mandatory reporting. The POCSO Act which mandates reporting is an important and comprehensive act but it may need to be reviewed based on the experience of its enactment over the past three years especially in its need for reporting of all cases to the SJPU. Instead, the cases could be mandatorily reported to the CWC and then after examining all the details of the case, the CWC could use its discretion to inform SJPU and initiate legal action. The medical evaluation that occurs following CSA must include testing for HIV, HbsAg and VDRL and in case abuse has

occurred within the last 72 hours, child must be referred for Post Exposure Prophylaxis to prevent sexually transmitted diseases. There is a need for a national guideline for management of CSA which incorporates a multidisciplinary approach and ensures effective liaison of medical, psychiatric, child protection and legal systems. This can effectively reduce the re-traumatisation while ensuring safety and justice for the children and their families.

CONCLUSION

Assessment, establishment and management of cases of CSA are filled with uncertainty. Clinicians get dragged in several directions while trying to satisfy the mandates of multiple parties, in working with sexually abused children and their families. While the primary aim is to assist the child, we are forced to take into consideration other issues such as the impact of sexual abuse on the non-offending parent and non-victim siblings, the limitations of confidentiality, the impact of reporting of abuse on the child, the social stigma faced by the family, a belief that the offender must be punished severely; all this, when we actually feel an overwhelming need to protect the child and enable her recovery and healing.

Therefore, in dealing with conflicting needs and goals, the clinician needs to maintain a continuous and unwavering focus on the child. Such a child-centric approach entails at a primary level, understanding the child's experience, her needs and desires and planning interventions from a rights-based perspective; at a deeper level, it entails examining all related decisions and interventions with regard to family, legal and other systems from

the perspective of the child's best interests, namely her safety and protection, and her immediate and future developmental trajectories and goals.

TABLE 1. CHALLENGES AND RECOMMENDATIONS.

Context	Challenges/Concerns	Strategies to address challenges
Asking about abuse	Risk of upsetting the child	Use of sensitive interviewing methods.
	Child's developmental level	Use appropriate methods for young children- art, play
Intra-Familial Abuse	Issues regarding confidentiality	Balance confidentiality and child's best interests. Persuade the child to disclose.
	Child's safety	Ensure child's safety in living arrangements with assistance of CWC
	Non offending caregiver/child wishes for family preservation	Management of the child, abuser and non-abusive caregiver.
Reporting of abuse	Family unwilling to report abuse	Follow mandatory reporting laws in India. Prepare the family for procedures following reporting.
Forensic Interviewing	Risk of re-traumatization Suggestibility of the child	Consider effects of forensic interviewing on child's well-being. Follow a standard protocol like RATAC or NICHD. Use of anatomically correct drawings if needed. Ideally to be performed by law enforcement or child protection services
Management Related Issues	Provision of treatment to asymptomatic children	Asymptomatic child: personal safety education for child, other legal and family interventions for abuse prevention.
	Treatment for symptomatic children	Symptomatic child: Encouraging expression of feelings about abuse, clarifying erroneous beliefs and disorder specific therapeutic interventions.
Therapist burn out	Feeling overwhelmed	Use of team approach to management. Supervision

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Appendix A

Section 19(1) of POCSO Act, 2012 states that "Notwithstanding anything contained in the Code of Criminal Procedure, 1973, any person (including child) who has apprehension that an offence under this Act is likely to be committed or has knowledge that such an offence has been committed, he shall provide such information to the Special Juvenile Police Unit; or the local police.

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