CHILD SEXUAL ABUSE

Report on a consultation

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Contents

		Page
1.	Introduction	1
2.	Definition of CSA and Identification of Problems	1
3.	Incidence of CSA	2
4.	The setting and causes of CSA	3
5.	Consequences of CSA	4
6.	Disclosure and intervention	6
7.	Prevention	8
8.	Recommendations	8
	Annex 1: list of participants	11

1. Introduction

The consultation was convened by the Sexuality and Family Planning Unit of the World Health Organization Regional Office for Europe. Together with three WHO staff and one WHO consultant, five experts in the field of child sexual abuse were invited as temporary advisers. The training and professional backgrounds of the participants were in obstetrics/gynaecology, paediatrics, midwifery, psychiatry, psychology, sociology, education, sexology, and criminology.

The purpose of the meeting was to review reports on the incidence of child sexual abuse (CSA) in order to assess the magnitude of the problem; to identify situations and mechanisms conducive to CSA; to identify likely short and long term effects on the victim; to assess and propose means of early detection, intervention and prevention of CSA; and to propose programmes of research and education needed to improve understanding and coping with this problem.

In his welcoming speech, Dr P. Owe Petersson, Director, Health Promotion, stressed the importance of the Health for all by the year 2000 movement, and Ms Haddad, Regional Officer for Sexuality and Family Planning, in her opening address stressed the significance of sexual health in this connection.

The meeting was the first activity of the Regional Office for Europe of the World Health Organization in the specific area of CSA and was expected to provide guidance as to planning and future action on this issue.

2. Definition of CSA and Identification of Problems

CSA is the abuse of a child for the sexual gratification of an adult or a significantly older person[a]. A child is legally defined by the age of consent, which differs considerably from one country to another (in Europe from 14 to 18 years). In many countries, in addition to an unqualified (hetero)sexual age of consent, there are higher ages of consent pertaining to homosexual relationships and relations with dependents.

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[a] The requirement of a significant age difference does not apply to violent sex offences against children committed by other children.

Offenders as well as victims may be male or female, although male offenders and female victims are the most frequent in reported as well as clinical cases. The offender may be a stranger, an acquaintance, a relative or a closer family member. If the offender is a parent, or someone who is in the position of a parent (grandparent, step- or foster-parent, older sibling etc.) the sexual abuse is usually referred to as "incest"; however, the legal definition of incest differs from one country to another.

While all forcible sexual acts against children constitute CSA (e.g. rape of a 14 year old girl by a boy of the same age), consensual sexual acts between children will not usually be considered abusive unless they involve persons with a considerable age difference. For clinical purposes, however, each case must be considered individually. Consensuality is by no means a simple concept, and what appears to be a voluntary relationship may in fact be the result of abuse of power, knowledge, maturity and dependence.

3. *Incidence of CSA*

It is often thought that while older research reported very low figures for CSA, more recent studies have revealed a much higher incidence. This conception is wrong, at least in so far as CSA generally is concerned. Studies of several European countries show that in the past 15-20 years there has been a considerable decrease in reported sexual offences against small children. While this decrease appears largely to reflect a real reduction in the number of offences committed by strangers (and distant acquaintances), the number of offences committed by family members appears to have decreased less or not at all.

There is no indication of an increase in the actual number of cases of incest, although greater awareness of this type of CSA may have brought more cases to light.

Old as well as new studies on the incidence of CSA in <u>the general population</u> (as recorded later by adults in answers to questionnaires or interviews) show that between 10% and 40% of female and between 5% and 20% of male respondents have experienced at least one incident of CSA during childhood or adolescence. The frequencies obtained depend primarily on the definitions of CSA, the age limits used, and the methods applied.

In all studies most of the cases are single incidents of indecent exposure, propositions to do something sexual which are rejected by the child, and brief genital touching. Offences

involving some degree of force or prolonged or repeated abuse by the same person have been experienced by about one percent of the populations studied.

Physical sexual abuse by a close family member has been mentioned in all studies by 1-2% of female respondents. Recurrent acts or prolonged relationships of this nature (that is, the types of CSA that are usually seen in courts or clinics) occur more rarely and are not found in reliable numbers in general population studies, because of the limited number of respondents in these studies.

Serious and repeated sexual abuse is found more often in special groups such as the clientele of a psychiatric hospital or clinic. In such samples CSA, usually involving a family member or close acquaintance, is found quite frequently, even if the patient has been referred to treatment for other reasons.

Most cases of incest turning up in courts or clinics are committed by fathers or stepfathers, more rarely by grandfathers or older brothers. Very few known offenders of incest are female, and very few known victims are male.

While most cases of serious CSA committed by strangers are reported to the police, offences committed by friends or relatives are more rarely reported, either because the child does not tell anybody, or because the adults to whom the child mentions the offence will try to protect the offender. Most rarely reported are cases of incest, because the child is usually forced or persuaded to keep the occurrence as a secret. It is likely that the majority of incest cases are never revealed, although it appears that more cases are revealed now than earlier.

4. *The setting and causes of CSA*

Most sex offences against children are committed by sexually immature and socially inadequate persons who seek sexual gratification through contacting unsuspecting children. Many of these contacts are distant encounters (indecent exposure, showing pornography, indecent talk and suggestions, obscene phone calls) in which the child is involved briefly and purely at random. Also the majority of incidents in which some physical contact occurs are brief.

Some sex offences against children are committed by <u>pedophiles</u>, that is, persons who are sexually attracted to children rather than adults. Most child molestors, however, are <u>not</u> particularly

attracted to children, but merely seeking sexual stimulation through encounters with children to compensate for a preferred, but unobtainable or inadequate (sexual) relationship with adults. Pedophilia, i.e. the sexual attraction to children (which may or may not result in CSA), should therefore not be used synonymously with CSA.

More serious nonconsensual, close contact, sex offences against children, including incidents in which some degree of force is used, are also as a rule accidental in the sense that victimization may occur, under given circumstances, to any child.

Repeated or prolonged sexually abusive, close contacts with adults, including incest, on the other hand, is usually accompanied by a variety of other symptoms of abuse and psychological and social problems characterizing the child and the child's family. Under such circumstances the CSA is often one among several symptoms of a child with early narcissistic damage, growing up in a dysfunctional, incestogenic family. Typically, this family is socially isolated, the father is often depressive and possessive and tends to sexualize his own problems and his relations with the child or children; the mother often appears to be psychologically weak, submissive and unable to protect the children.

5. Consequences of CSA

The consequences of CSA for the victim depend on a wide variety of factors relating not only to the event and the persons involved, but also to circumstances preceding and following the event. To most children the event is unpleasant and may be frightening, but in the vast majority of cases, which are of a very brief and accidental nature and without any physical consequences, the reaction of the child depends entirely on the degree to which the child is prepared for such an event, and on the reactions of the surroundings if the child tells others about it.

If the child has received some sex education, is unfrightened about sex generally, and has basic knowledge of the nature of CSA, accidental and brief encounters with strangers are unlikely to produce any serious or lasting effects. Under such circumstances the child is likely to react appropriately to the situation, turning away from indecent exposures, rejecting propositions or attempts at physical contact. Furthermore, if the child tells about the event to an adult who reacts in a reassuring and undramatizing manner, any immediate shock will be diminished, and even relatively serious encounters will have no lasting effects in the normal child.

On the other hand, in a child who has received no sex education, to whom sexuality is frightening, tabooed and loaded with guilt, even relatively harmless encounters may elicit reactions of panic followed by more or less long lasting feelings of anxiety and guilt. Similar reactions may result if parents or educators to whom the child tells about the event react with fright or panic, dramatizing the event, implying that the child is lying, is somehow guilty of the event, or has in some way been "defiled" by it. Also reactions by the police and by the child's surroundings after the event have been known to cause considerably more distress than the event itself.

Children who are victims of forcible sex crimes may suffer psychological shock effects in the form of anxiety, depression, nightmares and insomnia for some time after the event and many need short term psychotherapy. Most normal children who have received adequate support from the surroundings will, however, have these symptoms only for a shorter period, and lasting ill-effects will be moderate or non-existing.

The most serious and lasting effects are seen in victims of incest. Consequences tend to be particularly serious if victimization begins at an early age and continues for a long time (up to several years), if the offender is a father or stepfather, if intercourse and similar practices are used, if some degree of force is applied, and if the event is kept secret for a long time. However, even single events where the offender is not a parent but a person of trust who abuses the child's dependence, may cause prolonged disturbances, especially if the child is unable to tell anyboby about it.

Since incest is one among several symptoms of a seriously dysfunctional family, the effects on the victim of the sexual abuse as such are difficult to separate from those stemming from growing up under generally abusive and despondent circumstances. This is true of a number of psychopathological symptoms and traits characterizing the (former) victim of incest. Typically difficulty is found in managing aggression, resulting in extreme sensitivity, low self-esteem, depression and self-destructive behaviour. The patient is usually ridden by strong feelings of guilt and shame, is prepared to sacrifice herself and therefore likely to bring herself into situations where she is eventually abused, sexually or otherwise. While these symptoms and traits appear to have been based in early preoedipal damage but consolidated and aggravated by the (later) incestuous event(s), serious sexual problems often found in adult former victims of incest, can be referred more directly to the sexual abuse. Such problems typically take the form of either extremely strong sexual inhibitions or, on the contrary, exceptionally low sexual inhibitions, in both cases associated with a general tendency to sexualize human relationships.

6. *Disclosure and intervention*

Disclosure of CSA usually occurs either because the victim tells somebody, or because some clue is observed which may point in the direction of sexual abuse (physical clues, change of behaviour or mood, excess of candy or money).

Victims of CSA often do not tell about the event to anybody, even if it has been unpleasant and frightening. Sometimes the child has been threatened to keep quiet; more often the offender has bribed or otherwise persuaded the child to "keep the secret". The latter situation is particularly common in cases of incest or if the offender is otherwise known to the child. Not infrequently, however, children will keep the experience a secret of their own accord, because they instinctively fear the reaction of the adults. All too often this judgement is sensible enough...

Although intervention is important in all serious cases of CSA to remedy harm and to avoid more harm being done, it is an extremely difficult and complex issue which should be approached with utmost care, both in the individual case and at policy level.

The basic problem of all intervention is the risk of aggravating harm that is already done, or even creating harm where none exists. This risk is imminent because of the specific social and psychological meaning of CSA which makes it unique in comparison with other forms of abuse or accidents that may happen to a child (such as battering, malnutrition or traffic accidents); namely the fact that CSA represents not only a serious criminal offence but also the breaking of one or more serious taboos.

Because a serious crime is committed, reporting a case of CSA to a person in authority will often release a complex routine of actions which are likely to create a host of additional problems. The child is questioned, examined and interrogated by social workers, psychologists, doctors and police officers. In cases of incest the utmost outcome of official action is a complete disruption of the family: the child is referred to an institution, the father is put to jail, and the mother and other family members, left in misery, feeling stigmatized and guilty, are often torn between loyalty to the child and to the father.

Because CSA means breaking at least one serious sexual taboo (in incest and homosexual CSA a double taboo is broken), the victim and, especially, the victim's surroundings tend to react with strong emotions - anger, fear, feelings of guilt, "hysterics".

Under these circumstances it is more than difficult to keep the child's best interests in mind, although everybody would agree that that ought to be the main issue.

To reduce these problems, it is recommendable that when a case of CSA is reported to the authorities, one (and only one) person, who is a specialist in child psychology and in handling CSA, be appointed to take charge of the case, coordinate all further action and represent the child - and the child's interests - in all contacts with the authorities. This system has worked successfully in Israel for many years and is being copied in other countries.

Furthermore, it is important that reporting a case of CSA to the authorities should not automatically release routine criminal investigation, arrest, court procedings etc., even if the police are informed. Such action should be implemented only after careful consideration of the individual case with special regard to the consequences of any action for the child. As a rule, arrest and court procedings against the offender should be considered only in more serious cases (e.g. when force has been used or the child has been abducted) or if deemed necessary in order to prevent continued or repeated abuse.

Particular care should be devoted to decisions about intervention following disclosure of incest. While intensive intervention of some form is usually necessary, any disruption of the family should be temporary, and efforts should be made to keep the family together in the long run. Intensive supervision and counselling of the family, perhaps combined with psychotherapy, may often redress the dysfunctions of the family and establish a sounder basis for its continued existence. In this connection it should be remembered that the costs of constructive intervention in the form of family supervision and therapy are far lower than those of the traditional, disruptive intervention.

In recent years crisis intervention offered on a private, voluntary basis to victims, offenders and families involved in CSA has appeared in some countries as an alternative to intervention by official bodies. In the United Kingdom such programmes include incest crisis lines providing 24 hour-a-day counselling for anyone involved in an incestuous relationship, including male victims and offenders, and family centres which provide support and parental education to families at risk. Although the quality of the help offered may be difficult to assess, such organizations have the advantage that advice is offered on an anonymous or discretionary basis without involving the authorities. It is likely that such programmes may reach cases of CSA which would otherwise have been left on their own. Besides, if the family decides afterwards to report the case to the authorities they may be better informed of and prepared for the consequences.

7. Prevention

Prevention of CSA is obviously more valuable than intervention after the facts.

Obviously the most effective form of prevention consists in eliminating or reducing the number of persons who would want to abuse children sexually. Since it is well known from research that child molesters have usually been brought up under generally as well as sexually restrictive and abusive conditions, improving such conditions should reduce the number of persons growing up to become child molesters.

A general improvment of the conditions of families with small children should not only reduce the number of dysfunctional families where incest and other sex offences against children are likely to occur, but also reduce the likelihood of CSA occurring in the next generation. Counselling and therapy offered to families at risk will have a similar double effect.

Sexual education which not only teaches the children about sexuality in general and about the risk and circumstances of sexual abuse, but also relieves some of the tension and excessive taboos surrounding sexuality, will serve the prevention of CSA in several ways: it may teach children to identify and handle potentially threatening situations so as to avoid or reject child molesters as far as possible. Further, it may reduce the harm resulting from unavoidable incidents of CSA, because the child is able to handle the situation without becoming excessively frightened or shocked, and is prepared to tell someone about it who will likewise react appropriately. Finally, sex education may lead to talking about feelings and sexuality in a way which is rare in the families where potential child molesters grow up, thus giving them a chance to learn that there is a difference between normal affectionate hugs and kisses and those sexual acts that are abusive.

8. Recommendations

8.1 All educational programmes for professions likely to handle cases of CSA (including the medical professions, social workers and the police) should include basic training on sexuality and the problems of sexual abuse.

8.2 Since serious cases of CSA require intersectorial cooperation, all such cases should be handled by multidisciplinary teams on the local level. A key person, who should be responsible for coordinating the approaches, should also be the link between the team and the victim.

8.3 In all decisions following CSA, the child's best interests should have the highest priority. Support for all those involved should come first with punishment as the last resort.

8.4 The public should be informed about CSA with special emphasis on prevention and early detection.

8.5 As part of the sexual education in schools, children should learn about CSA in a non-frightening and factual manner: how to avoid or reject potential abusers, how to react in the face of CSA, and where to turn afterwards.

8.6 Crisis centers and crisis intervention telephone services should be available to persons at risk and persons involved in CSA.

8.7 Research is needed on a variety of topics related to CSA, and especially incest, including:

(a) evaluative research on the functioning of the public services involved in handling cases of CSA;

(b) research on the effects of prevention and intervention programmes;

(c) research on the implementation and success of community support for families at risk;

Annex 1

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