Child sexual abuse

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Child sexual abuse (CSA), an historical phenomenon which can be found in many different culture and society. Nowadays the sensibility of public opinion and the legal framework changed. However, the available statistics gathered by various national and international organizations (WHO, UNICEF, INTERPOL, EUROPOL, etc.) do not represent the true extent of the phenomenon which is often underestimated, primarily because many cases of CSA are not reported. In fact, 1 out of 3 tell no one (THORN, 2017).

Research conducted by UNICEF in 30 countries confirms this fact. A small percentage of victims said that they asked for help. Behind this reluctance could be the fear of vendetta, feelings of guilt, shame, confusion, distrust in institutions, cultural and social conditioning, but also misinformation regarding the services and structures that can help. The one thing that is certain is that millions of children in the world are victims of exploitation and sexual abuse.
Definition

• It is very difficult to define the term “CSA” ...
• It’s also very hard to make a certain diagnosis based on clear criteria.
• CSA survivors show different kind of symptoms: dissociative disorders, posttraumatic stress symptoms, depression, etc.
• But some victims are also asymptomatic.
• Sexual abuse contravenes Article 19 of the Convention on the Rights of the Child, which states that “children have the right to be protected from being hurt and mistreated, physically or mentally”.

• CSA encompasses any sexual act involving a child that is intended to provide sexual gratification to a parent, caregiver or other individual who has responsibility for the child.

• Sexual abuse includes activities such as fondling a child’s genitals, penetration, incest, rape, sodomy and indecent exposure.

• Sexual abuse also includes noncontact exploitation of a child by a parent or caregiver—for example, forcing, tricking, enticing, threatening, or pressuring a child to participate in acts for the sexual gratification of others, without direct physical contact between child and abuser (APA, 2013, p. 718)
“Sexual violence against children encompasses both sexual exploitation and sexual abuse of children and can be used as an umbrella term to refer jointly to these phenomena, both with regard to acts of commission and omission and associated to physical and psychological violence” Interagency Working Group on Sexual Exploitation of Children, *Terminology Guidelines for the Protection of Children from Sexual Exploitation and Sexual Abuse*, ECPAT International and ECPAT Luxembourg, Rachathewi, Bangkok, June 2016, p. 16.
Global level:

In 2017, the WHO estimated that up to 1 billion minors between the ages of 2 and 17 years of age have endured violence either physical, emotional, or sexual. Sexual abuse (from groping to rape), according to some UNICEF estimates from 2014, affected over 120 million children, representing the highest number of victims.

In 2017, the same UN organization reported that in 38 low and middle income countries, almost 17 million adult women admitted having a forced sexual relationship during their childhood.
Europe:

In 2013, the WHO estimated that **almost 18 million children** had been victims of sexual abuse in Europe: 13.4% of all girls and 5.7% of all boys.

According to UNICEF, in 28 European countries, about 2.5 million young women have reported sexual abuse, with or without physical contact, before the age of 15 years (data published in 2017).

In addition, 44 million (about 22.9%) have been victims of physical violence, while 55 million (29.6%) have been victims of psychological violence.

And this is not all: in 2017, an INTERPOL report on the sexual exploitation of minors led to the identification of 14,289 victims in 54 European countries.
Types of CSA

MALTREATMENT
• Physical abuse
• Psychological abuse

SEXUAL ABUSE
• intra and extra family
• Sexual exploitation (pornography, prostitution, sex tourism)

PATHOLOGY OF CARE
• Lack of care (physical, emotional)
• Neglect

(Montecchi, 1998)
Psychological abuse can be defined as the systematic use of malicious manipulation through nonphysical acts against someone.

These actions can include threatening the physical health of the victim or the victim's loved ones, purposely controlling the victim's freedom, and/or acting to undermine or isolate the victim.
and may not become, Sir Knight, thy gentle Ecclesiastica, thy narrow-mindedness take the mind of our high privilege. Marry, I say, I shall be absolved from the part of a Templar; but I shall not be absolved from my duty to our Order. Not the wisest of men need all absolution, whose examples you must follow. I have won wider privileges than we poor sol- diers. The Temple may claim license by the fire at this reproach. I have spoken mildly of a conqueror's object to my will, but of my right, I will not consent to establish.
Lack of care and neglect

The signs of physical negligence are very precise and referable to omissions in providing the basic needs of the child (food, housing, clothing, health), as well as the lack of necessary protection conditions to prevent the child from incurring accidents.

In some extreme cases, due to food shortages or lack or excess of medical care, neglect can lead to the death of the child.

Emotional neglect, more difficult to document, can be defined as a lack of emotional contact, inattention and unavailability towards the child in his/her life context.
In 1975, Edward Tronick and colleagues first presented the "still face experiment". He described a phenomenon in which an infant, after three minutes of "interaction" with a non-responsive expressionless mother, "rapidly sobers and grows wary. He makes repeated attempts to get the interaction into its usual reciprocal pattern. When these attempts fail, the infant withdraws and orient his face and body away from his mother with a withdrawn, hopeless facial expression”.

“What’s really striking about the still face experiment is that the infants don’t stop trying to get the parents’ attention back,” Tronick said. “They’ll go through repeated cycles where they try to elicit attention, fail, turn away, sad and disengaged, then they turn back and try again.”
Sexual abuse

Constriction to perform or suffer sexual acts through:
- Violence
- Threat
- Abuse of authority

Induction to perform or suffer sexual acts through:
- Abuse of physical or mental inferiority condition
- Deception for having replaced another person

• What is it?
• Who is usually the abuser?
• Author of sexual abuse of a minor = pedophile?
• Legal model = psychological model?
• Who during childhood was a victim of sexual abuse by will a sex abuse author be great?
• There are psychological indicators of sexual abuse on victims? What?
Sexual abuse indicators

Indicators of sexual abuse are those atypical behaviors common to a wide one percentage of victims of sexual abuse.

- **Physical**: delay or stop in growth, reflex of abnorme anal expansion, injuries traumatics of the genital or anal apparatus
- **Cognitives**: inessive sexual knowledge for age, defective attention, confusion in the memory of the facts and overlay of times.
- **Behavioral and emotional**: sleep disorders, acute crisis of anxiety, disorders of the language, depression, stress, behavior regressive
Sexual abuse indicators

Most of them are common to many other problematic situations, therefore a definition does NOT exist to date of a standard and incontrovertible symptom picture (Petruccelli, 2002)

It should be emphasized as such indicators to be considered "Non-specific", ie non-indicative necessarily the abuse occurred; the at the same time, their absence did not occur necessarily translates into denial of abuse (Castellazzi, 2007).
Hagen (2003) after proposing a review of twenty years of research claims as the greatest part of the abused children is completely asymptomatic.

Indicators, in fact, will have to be collected, compared and inserted in an overall picture that has one given consistency (Castellazzi, 2007).
Also family conditions must be analyzed.

Possible indicators of **family distress** (Petruccelli, 2002):

- dysfunctional family organization (characterized by closed borders, rigid roles and rigid distribution of power);
- family isolation;
- "secret atmosphere";
- maintenance of the dysfunctional family system;
- presence of inadequate parental figures;
- constant use of defense mechanisms such as denial and splitting.
Attachment and abuse

John Bowby
Strange Situation

At first, 3 organized patterns: sale, insecure and avoiding, insecure-ambivalent.

The inability to classify abused children has stimulated Main and Solomon (1986, 1990) to identify their characteristic and to codify one’s own child behavior as disorganized/disoriented attachment.

Children develop different attachment styles/strategies, dependent upon their care giving experience. These can be classified as:

• Type A - Anxious avoidant
• Type B - Secure
• Type C - Anxious ambivalent
• Type D - Disorganised

Children with disorganized attachment (“type D”): disoriented and/or conflictual behaviors
Victims: the impact of CSA

• In specialized literature multiple models explaining the formation of symptoms following CSA were suggested; however, after effects can greatly vary among individuals.

• In addition, it must be considered that in many cases minors are abused for years but growing up they develop their awareness that there must be something wrong and may realize all of a sudden what has been going on or what has happened.
• Victims abused by a caregiver have greater perceptions of betrayal and greater disturbances in memory than victims abused by nonparental figures. Perceptions of betrayal by the nonabusing parental figure were also found to be associated with dissociation.

• Survivors of CSA may be at higher risk for depression, anxiety, substance abuse, posttraumatic stress disorder, anger, low self-esteem, behavior problems, physical symptoms, and medical diagnoses.

• Depression in adulthood is one of the most commonly reported aftereffects of CSA, with some estimates indicating that CSA victims have a lifetime risk for adult depression as much as four times greater than non-CSA survivors.
• CSA has been linked to poor social adjustment and
general relationship problems, to negative intimate relationship outcomes, including decreased satisfaction in romantic relationships, intimate partner violence, and sexual assault in adulthood, to risky sexual behaviors.

• Among psychiatric patients, reported rates of childhood physical abuse (CPA) are up to 82%, while CSA are up to 54%, and co-occurring CSA/CPA are up to 60%. In particular, from 30% to 90% of patients diagnosed with borderline personality disorder (BPD) report childhood sexual, physical, or emotional abuse.
Assessment and evaluation procedures: children’s testimony and interviewing practice

• Children’s ability to demonstrate such an early understanding has been found to be influenced by the types of questions asked.

• Preschool-aged children successfully accepted true statements and rejected false statements before they were able to label true and false statements as “truth” and “lie” or as “good” and “bad”.

• Interviewed children would be more inclined to provide evaluative content when asked questions that specifically referred to evaluation through *How* questions and *Wh-* questions rather than option-posing questions.

• The term *disinformation effect* (or *suggestibility effect*) indicates that a witness easily accepts a suggested piece of information; when this phenomenon takes place, the witness is not always aware of it.
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Treatment: Intervention approaches

• Types of intervention go from individual psychotherapy, to participation in groups of victims of abuse, to family therapy.

• Therapeutic work must lead to the recognition of what really happened and allow the victim to rediscover the course of his/her psychic internal evolution.

• Family therapy in these cases has as objectives: social skills building, psychoeducation about CSA, personal safety skills training and exposure treatment with play therapy interventions (Mohl, 2010).
A series of crucial therapeutic steps can be identified:
• a definition of the problem and its redefinition in more correct terms
• becoming aware of the profound emotions linked to the trauma and managing such emotions the working through of denial processes
• reviewing the traumatic experience and the new attribution of blames and responsibilities
• the building up of a new relational balance and the assumption of new roles
• reparation
Madanes’ strategic model in family therapy

1. Obtain an account of the sexual offense(s) moving from parents, to siblings, to offender, to victim
2. Ask each family member why it was wrong beginning with the offender
3. Therapist adds that it was also wrong because it caused the victim spiritual pain or “pain in the heart”
4. Therapist adds that it also causes a spiritual pain in the victimizer
5. Discuss other sexual victimization that has gone on in the family
6. Therapist adds that these behaviors also cause a spiritual pain in the family
7. The Apology – offender gets on knees in front of the victim and repents
8. The Apology II – other family members get down on their knees and repent for not having protected the victim
9. Discussing the consequences of any future abuse
10. Find a protector for the victim (e.g. responsible uncle, two grandmothers, etc.)
11. Individually with victim – work to place the abuse in context and orient victim to positive things in his/her life
12. Reparation – an act of long-term sacrifice for the offender that is beneficial to the victim
13. Reconnecting the offender to peers and appropriate social and sexual activities
14. Restoration of the parent’s love for the offender
15. Restoration of the offender’s role as protective of younger sibling
16. Help offender to forgive him/herself
Prevention programs

• Cowen outlined two levels of prevention:
  Primary and secondary prevention

Barron and Topping (2010) suggest that recommendations for policy and practice should be fitted into eight categories:
• evaluation,
• training,
• school context,
• programme presenter,
• planning for disclosure,
• length of programmes,
• effective teaching and learning
• partnership with parents.
THANK YOU FOR YOUR ATTENTION! ANY QUESTIONS?