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Child Sexual Abuse: Prevention and Processes of Resilience

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ABSTRACT

Child sexual abuse (CSA) is a major global public health concern causing negative health effects that go beyond physical and emotional trauma. Effects can include long-term adverse outcomes such as personality disorders, depression, anxiety, substance abuse, sexual promiscuity, eating disorders, post-traumatic stress disorder, suicidality, unwanted pregnancy, and STIs. Several interventions including Trauma Systems Therapy (TST) and Trauma-focused cognitive-behavioral therapy (TF-CBT) have proven to be effective. However, in minimizing the long-term negative effects of CSA, the areas of prevention and early recognition are critical.

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Overview

Child sexual abuse (CSA) includes many types of sexually abusive acts toward children, including sexual assault, rape, incest, and the commercial sexual exploitation of children [1]. According to the US Centers for Disease Control and Prevention (CDC), child sexual abuse is "any completed or attempted (noncompleted) sexual act, sexual contact with, or exploitation (ie, noncontact sexual interaction) of a child by a caregiver" [2]. The CDC defines "sexual acts" as those involving penetration, "sexual contact" as intentional touching with no penetration, and "noncontact" as exposing a child to sexual activity, taking sexual photographs or videos of a child, sexual harassment, prostitution, or trafficking [3]. The World Health Organization (WHO) defines CSA as:

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 and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to: the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of child in prostitution or other unlawful sexual practices; the exploitative use of children in pornographic performances and materials [4].

The 2006 World Report on Violence against Children states that in 2002 approximately 150 million girls and 73 million boys were subject to contact CSA worldwide, including 1.2 million trafficked children and 1.8 million exploited through prostitution or pornography [5]. In the United States, a study on 34,000 adults found that 10% reported experiencing contact CSA before age 18, 25% of whom were men [6]. Another study of 4549 children and their caregivers reported that 6.1% of children had been victims of CSA (contact and noncontact) in the past year and 9.8% in their lifetime [7]. However, it is difficult to obtain accurate estimates because CSA is widely underreported to legal authorities [8]. Research has suggested that all forms of child maltreatment are not recognized or reported nearly enough in the United States, Canada, United Kingdom, and Australia [9].

Child sexual abuse is a major global public health concern, affecting one in eight children and causing enormous costs including depression, unwanted pregnancy, and HIV [10]. In the U.S., the socioeconomic costs are vast, with the average cost for each victim estimated at $210,000 [11]. Health consequences include anxiety, depression, post-traumatic stress disorder (PTSD), and suicidality [12].

Developmental Issues and Consequences

Bowlby's (1988) attachment theory suggests that children seek protection and care from their parents or caregivers when threatened or distressed. Parents' availability and responsiveness mold children's perception of their own self-worth and importance. When attachment figures are responsible for perpetrating abuse, competing desires to flee from and seek proximity to these figures compromises children's abilities to fully organize and competently respond to harmful or risky situations [13]. Bowlby (1988) also theorized that children develop enduring internal working models of the self, others, and relationships. These models are shaped by the nature of early attachment experiences and influence adult relationship functioning. CSA may result in working models that evoke passive acquiescence to risky sexual demands and limited sexual/intimacy boundaries [14].

The effects of CSA go beyond physical and emotional trauma. Researchers have linked CSA with many long-term adverse outcomes, such as personality disorders, psychosis, depression, anxiety, substance abuse, sexual promiscuity, eating disorders, behavior problems, post-traumatic stress disorder, adult revictimization, and adverse effects on parenting behaviors

as adults [15-17]. CSA has serious implications for children's mental and physical health. Problems may include changes in behavior, such as sexualized behaviors, additional consequences of pregnancy, exposure to sexually transmitted diseases, changes in self-esteem, and effects on social and emotional development that influence adult relationships and parenting skills [18].

Community-based studies on children, youth, and adult populations have consistently found a strong relationship between depressive symptoms and reported histories of CSA [19, 20]. Also, many population and clinical studies on youth and adults suggest a strong relationship between CSA and PTSD [21]. CSA is 1.3–4.3 times greater in those with an anxiety disorder [22]. Population-based studies have also demonstrated higher frequencies of CSA among adolescents and adults with alcohol and/or drug related disorders compared to non-abused adolescents and adults [23]. CSA and borderline and antisocial personality disorders are also associated [24]. Several population-based studies on youth and adults have demonstrated an association between sexual trauma and psychotic symptoms in general [25].

Interventions

Awareness of CSA and the development of reporting suspected CSA have increased over the past few decades. However, there is still a gap in the knowledge base needed to prevent child maltreatment and to recognize signs of maltreatment early so that appropriate and timely interventions can be implemented to reduce the long-term effects associated with CSA [26]. More focus is needed on prevention.

In minimizing the long-term negative effects of CSA, the areas of prevention, early recognition, and treatment are very important [27]. The primary preventative message that has been widely used is teaching children to avoid "stranger danger" [28, 29]. However, it is important to recognize that the largest proportion of CSA perpetrators are not strangers but are individuals known to the child and family [30, 31].

Research has suggested that the focus of CSA prevention should be parents, professionals, and the public and, to a lesser degree, children themselves. However, children most likely are not at a developmental level to be able to understand the issues nor are they empowered to act against inappropriate adult behavior [32]. Education is key to building safe environments by helping adults recognize high-risk situations in which abuse is more likely to occur and warning signs that suggest CSA may have occurred. Furthermore, education is important to help parents identify the availability of resources in the community to assess and treat potential victims [33, 34].

Trauma Systems Therapy

Trauma Systems Therapy (TST) is both a clinical model for the treatment of child traumatic stress as well as a framework for appropriate services [35]. The primary innovation in TST is the concept of the trauma system. The trauma system is bound by a traumatized child's emotion regulation capacity and his/her social environment. The trauma system is defined as a traumatized child who has difficulty regulating emotional states and a social environment and/or system of care that is not able to help the child regulate these emotional states [36].

An accurate evaluation of the trauma system consists of assessing a youth's emotion regulation capacity and assessing the functioning of the social environment in which the youth lives. This dual assessment determines the treatment phase that, in turn, determines the most appropriate course of treatment [37]. Treatment modalities are designed to help the youth become better regulated as well as to help stabilize the social environment that is contributing to this dysregulation. This assessment is repeated frequently to accurately assess the youth's current phase of treatment [38].

A second key innovation of TST is that it describes how to integrate different clinical interventions so that children receive the right level of care. TST provides a framework for identifying and coordinating the different service elements as well as a clinical model that describes what providers do once they are together. The four primary service modules within TST include: 1) home- and community-based care; 2) outpatient, skills-based psychotherapy; 3) psychopharmacology; and 4) services advocacy [39]. Each service is provided by separate clinicians who serve on a multi-specialty TST team [40].

TST has been implemented in 26 programs within 17 agencies across 10 states in the U.S. [41]. Such programs include community-based outpatient programs, child welfare/mental health collaborations, foster care/mental health collaborations, school-based mental health programs, shelters for unaccompanied alien minors, residential programs, pediatric hospital- based programs, and substance abuse/mental health collaborations. TST has been shown to be effective in several clinical trials and successfully disseminated in a variety of settings [42, 43].

Trauma-Focused Cognitive-Behavioral Therapy

Trauma-focused cognitive-behavioral therapy (TF-CBT) is one of the most rigorously evaluated treatments for CSA [44, 45]. TF-CBT is a hybrid model that integrates elements of exposure-based, cognitive-behavioral, affective, humanistic, attachment, family, and empowerment therapies into a treatment designed to address the unique needs of children with problems related to traumatic life experiences such as sexual abuse [46]. This treatment was developed to include both the child and a supportive caregiver, in weekly parallel sessions.

Eight components are delivered and practiced over a period of approximately 12 to 16 weeks. The components of TF-CBT include: (1) psychoeducation; (2) relaxation; (3) affective modulation; (4) cognitive processing; (5) trauma narrative (gradual exposure) and cognitive restructuring of the trauma; (6) in vivo desensitization; (7) conjoint parent/child session; and (8) enhancing safety skills [47]. Although the treatment is designed with specific components, each with a set of goals, TF-CBT is highly flexible in meeting the individual presentation of symptoms and the needs of different children and families [48].

TF-CBT is a highly effective treatment for child trauma exposure, including depression, anxiety, and PTSD symptoms [49]. TF-CBT has been adapted and used effectively with a variety of populations including Latino youth, Native American youth, and orphans and vulnerable children in Zambia [50]. Research suggests broad applicability and acceptability among ethnically diverse therapists, children, and parents [51, 52].

Stop It Now! Helplines in Europe

Stop It Now! aims to prevent child sexual abuse by using a free anonymous helpline. It provides information, advice, and guidance to anyone concerned about child sexual abuse [53]. It targets people who have sexually abused children or who are worried that they might do so. Stop It Now! is a model of sexual abuse prevention developed in the United States in 1992 by a survivor of CSA, Fran Henry. The original program seeks to mobilize

"adults, families, and communities to take actions that protect children before they are harmed [54]. The concept was developed and implemented in the United Kingdom and Ireland in 2002 (Stop It Now! UK) and in the Netherlands (NL) in 2012 (Stop It Now! NL) [55].

The two European Stop It Now! programs take a public health approach to the prevention of CSA [56]. The helpline's activities include providing information, advice, and guidance to professionals, parents, and people who pose a sexual risk to children and people who have committed child sexual offenses. Through support and advice to a wider audience than people concerned about their own behavior, Stop It Now! also aims to raise awareness of CSA among the community [57]. Benefits reported by helpline users are shown to correspond with the aims of the helplines. Many factors were reported by users that helped them modify their own or others' actions to minimize risk of abuse [58].

Conclusion

CSA is a global problem and it does not appear to be decreasing over time. Across the planet, new advances to better prevent and respond to child sexual abuse are needed. Developing awareness about child sexual abuse and empathy towards victims is necessary to enhance healthy behavior, responses, and societal change. This needs to be done at the individual, institutional, and societal levels. Enhanced awareness and empathy are key to facilitate advantageous outcomes in violence prevention, humane responses, policy reform, and development of healthy social norms and communities.

In order to provide the best support for victims of CSA, guidelines for CSA treatment and management, such as those suggested by the World Health Organization [59] should be developed for all regions of the world. Since the cultural context might build an obstacle in implementing successful interventions, the implementation should be tailored to each country. This is the case for cultural differences in disclosing CSA to others, which is necessary to implement interventions for victims.

CSA is associated with the risk of negative psychosocial and health outcomes, but processes of resilience have also identified several protective factors such as family support, parent-child relationships, social support that could be strengthened through prevention and early intervention efforts. Several therapies have been shown to be successful in treating CSA. A wide range of symptoms are decreased, including individual symptoms of PTSD, depression, anxiety, and behavioral problems, as well as family and relationship problems. Future research must examine the limitations and barriers of interventions and focus on screening and prevention strategies.

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