ENCYCLOPEDIA
on Early Childhood
Development

Child Sexual Abuse: An Overview

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May 2019, Éd. rév.

Introduction

Child sexual abuse (CSA) is a form of maltreatment that is recognized globally as a serious human rights violation and a major public health concern. This paper will provide an overview of the state of knowledge on CSA.

Subject

It is now recognized that the definition of CSA includes both contact and non-contact abuse. CSA comprises any sexual activity perpetrated against a minor by threat, force, intimidation or manipulation. The array of sexual activities includes fondling, inviting a child to touch or be touched sexually, intercourse, rape, incest, sodomy, exhibitionism, or involving a child in prostitution or pornography.[1] There is a general consensus that CSA is a complex phenomenon occurring for multiple reasons, in various ways, and in different relationships within families, peer groups, institutions, and communities.[2] Two important overlapping unresolved issues include the lack of a conceptual model of CSA and the absence of a shared definition or understanding of what constitutes CSA worldwide.

Scope of the Problem

Most studies emphasize that the full extent of CSA perpetration remains unknown.[1,3] It is difficult to determine given differences in the way data is collected,[4] as well as the reticence of most children to disclose the abuse.[5]

Disclosure of traumatic events such as CSA can often be a very complex, iterative life-long process.[6] Victims of CSA often delay reporting, or never tell.[5] For example, in a review by Finkelhor [7] only about half of survivors across all studies had disclosed the abuse to anyone. In another study, the vast majority of survivors (93%) did not report the abuse to authorities prior to the age of 15.[8]

In a 2013 systematic review and meta-analysis of recent studies worldwide, CSA prevalence rates were found to be 8 to 31% for girls and 3 to 17% for boys. Forced intercourse was self-reported by 9% of girls and 3% of boys.[9] In contrast, incidents of CSA reported annually to formal, official bodies such as child protection services is drastically lower (e.g., .43% in Canadian child protection systems;[10] 2.4% in U.S. child protection and community agencies).[11] Clearly, official reports to authorities underestimate the extent of CSA; in another worldwide CSA prevalence meta-analysis, rates were more than 30 times higher in self-report than official-report studies (12.7% versus 0.4%).[12]

Key Research Questions

For the past few decades, several questions have been central in guiding CSA research. These include: What are the risk factors for CSA? What are the mental health outcomes of CSA? What are the protective factors that make some children less likely to experience impairment following CSA exposure? What are the most effective prevention, assessment and treatment strategies?

Recent Research Results

Female children are about two times more likely to be victims of CSA than males.[12] There is a strong likelihood, however, that boys are more frequently abused than the ratio of reported cases would suggest given their probable reluctance to report the abuse.[13] Risk for CSA rises with age, with the highest number of victims in the 12 to 17-year age range. Girls are considered to be at high risk for CSA starting at an earlier age and of longer duration, while risk for boys peaks later and for a briefer period of time.[1]

CSA is a major risk factor for developing a host of negative consequences in both childhood and adulthood. Victims have been shown to experience more post-traumatic stress and dissociative symptoms than non-abused children,[14] as well as more depression and conduct problems.[15] They engage more often in at-risk sexual behaviours.[16] Victims are also more prone to abusing substances,[17] and to suicide attempts.[18] These mental health problems are likely to continue into adulthood.[19] CSA victims are also more at risk than non-CSA youth to experience violence in their early romantic relationships;[20] women exposed to CSA have a two to three-fold risk of being sexually revictimized in adulthood compared with women without a history of CSA exposure.[21]

However, about one third of victims may not manifest any clinical symptoms at the time the abuse is disclosed.[22] This can be explained, in part, by the extremely diverse characteristics of CSA which lead to a wide range of potential outcomes. Also, several factors influence the resilience of CSA victims; for example, children who receive support from their non-offending parents[23] and those who have not experienced prior abuse[24] seem to fare better. In all cases, however, early assessment and where indicated, intervention to address the negative outcomes, are important.

In the area of assessment, two forensic protocols have undergone considerable evaluation. These include the National Institute of Child Health and Human Development (NICHD) Structured Interview Protocol and the Sexual Assault Nurse Examiner (SANE) Model.

- The use of a structured investigative protocol, such as the NICHD model, specifies that police officers receive extensive training to elicit detailed information from CSA victims in a non-suggestive manner. This protocol clearly enhances the quality of interviews and facilitates the assessment of credibility by child investigators.[25]
- The SANE nurses provide, usually in the context of a hospital emergency unit, a first response that addresses victims' emotional and physical needs while gathering the forensic evidence that could potentially lead to prosecution of the person responsible for the abuse. The effectiveness of SANE in regard to forensic evidence collection and prosecution rates in CSA cases involving children has been demonstrated.[26]

In terms of interventions for reducing impairment associated with CSA, a recent meta-analysis found that treatment is effective in reducing PTSD symptoms as well as externalizing and internalizing problems.[27] Of the handful of evidence-based treatments, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is the most established treatment for children who have experienced CSA and present with post-traumatic stress disorder (PTSD) symptoms.[28] Randomized controlled

trials have shown this treatment to be effective in improving participant symptomatology as well as parenting skills and children's personal safety skills, even when the duration of the program was as short as eight weeks.[29] Sustained improvement following TF-CBT has been shown for anxiety, depression, sexual problems and dissociation at the 6-month follow-up and in PTSD and dissociation at the 12-month follow-up.[30,31]

Although school-based educational programs are widely disseminated and promoted as a primary prevention strategy, little evidence exists that they are effective in preventing actual exposure to CSA; they appear to improve children's knowledge and protective behaviours and may increase the likelihood of disclosure, but it is unknown whether they prevent the occurrence of CSA.[32]

Research Gaps

Two main gaps are worth highlighting: First, since most CSA victims remain unidentified, current knowledge is likely biased in its focus on information from victims where CSA has been detected; further investigation is needed to understand the variable ways in which children exposed to CSA present. Second, there is a need to identify additional evidence-based approaches for assessment, treatment and prevention of CSA.

Conclusions

While there is now a general consensus regarding the definition of CSA, the magnitude of the problem remains difficult to estimate given the differences in data collection systems. A 2011 meta-analysis on CSA prevalence showed that 12.7% of adults were sexually abused in their childhood or teenage years, with females and older children showing an increased risk. CSA is a major risk factor in the development of short- and long-term negative consequences, such as depression, PTSD, and substance abuse, although not all victims experience impairment. Two forensic protocols – the NICHD Structured Interview Protocol and the SANE Model – are well established in the field. The most effective treatment of children exposed to CSA and presenting with PTSD symptoms is TF-CBT. Future research should focus on developing strategies to facilitate the disclosure and reporting processes of CSA, to better identify the needs of CSA victims, and to develop prevention strategies.

Implications for Parents, Services and Policy

Beyond the broad range of deleterious health and social impacts of CSA, the lifetime economic costs have been estimated to be $9.3 billion.[33] To address this major public health problem, we should prioritize the development of strategies to prevent sexual abuse from happening in the first place and address the barriers to disclosure and reporting. Although the taboo of CSA might not be as prominent as a few decades ago, stigma as well as difficulty accessing services may still prevent victims from receiving necessary resources.

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