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David J. Hansen
Univertsity of Nebraska-Lincoln, dhansen1@unl.edu

Kathryn R. Wilson

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Child Sexual Abuse

David J. Hansen and Kathryn R. Wilson

Although definitions can vary across legal, clinical, and research contexts, sexual abuse is commonly defined as sexual acts between a youth and an older person (e.g., by 5 years or more) in which the dominance of the older person is used to exploit or coerce the youth. Behaviors may include noncontact (e.g., exposure) and contact (e.g., intercourse) offenses.

The prevalence of sexual abuse is difficult to determine, but estimates suggest that as many as 20% of women and 5% to 10% of men report having been sexually abused as a child. The number of substantiated cases has dropped significantly in recent years, possibly due to a combination of factors, including changes in definitions and reporting and an actual decline in incidence. Sexual abuse occurs across all income levels and racial, cultural, and ethnic groups. Victims are identified via child self-disclosure, medical or physical evidence (e.g., trauma, sexually transmitted disease), behavioral and emotional changes that prompt inquiry, and investigations stemming from assault of other youths. Careful forensic interviews are often important for documenting abuse, protecting children, and successfully prosecuting perpetrators.

All states have mandatory reporting laws that require professionals to report suspected child maltreatment, including sexual abuse. Failure to report can lead to legal charges and ethical complaints. The statutes provide civil and criminal immunity from liabilities for reports made in good faith.

The impact of sexual abuse varies considerably, and there is no common symptom that is found in all victims. The possible consequences include internalizing (e.g., anxiety, depression, poor self-esteem) and externalizing (e.g., delinquency, substance abuse, sexual behavior) problems. Posttraumatic stress disorder (PTSD) is the most common clinical syndrome. A substantial number of young people do not show measurable clinical symptoms, although for some of them problems may appear later. Nonoffending parents and siblings may experience significant distress and may require treatment as well.

A variety of treatment approaches are used for reducing the consequences of abuse. Interventions may focus on the abused child, nonoffending parents, and nonabused siblings, in individual and group formats.

Only a small percentage of cases result in a sexually abused child testifying in court. Court preparation programs help make the experience less stressful and improve the child's participation.

Definitional Issues

Child sexual abuse is surprisingly difficult to define as no universally accepted criteria have been identified. Definitions generally consider the sexual behaviors involved and the ages of the victim and the perpetrator.

While force or coercion may occur, it is not always present. Younger children are not considered capable of consenting to sexual activities with older persons; thus, sexual acts between individuals with age differences of 5 years or more are generally seen as abusive. Legal definitions often emphasize that the perpetrator should be an adult in a position of dominance or authority over the youth for the behavior to be considered an act of abuse.

Noncontact offenses include genital exposure, voyeurism, showing a child pornographic material, or having a child undress or masturbate. Contact offenses include genital touching; oral sex; and digital, object, or penile penetration (vaginal or anal).

If the perpetrator is a family member, including distant relations, in-laws, and step-relations, then the abuse is considered "intrafamilial" sexual abuse. If the perpetrator is not a family member by marriage or blood, then it is usually considered "extrafamilial."

Child sexual abuse has been challenging to define as each word in the term has been operationalized differently across legal, clinical, and research contexts. While some behaviors are clearly sexual (e.g., intercourse), other behaviors (e.g., touching) can lie across a continuum, and the context can influence decisions regarding whether it is abusive. In clinical and research contexts, the term *sexual abuse* is sometimes used to describe the victimization of young people by similar-age peers, though in legal contexts this may be more likely to be viewed as "assault." Similarly, from a clinical and research standpoint, perpetration by an adult stranger or nonfamily member may be considered sexual abuse, but within the legal system it may be treated as sexual assault.

Incidence and Prevalence

Definitional challenges contribute to the difficulty in accurately identifying the incidence and prevalence of sexual abuse. Records from child protective services agencies in the United States in recent years indicate that approximately 1.2 children per 1,000 experience sexual abuse each year. This is an underestimate because it reflects only cases known to relevant agencies, and many instances of abuse are not identified or reported.

Overall, the number of cases of sexual abuse substantiated by child protective service agencies dropped by approximately 40% during the 1990s. This is likely due to a combination of factors, including increasing conservatism on what is substantiated as abuse, exclusion of cases that do not involve caretakers, changes in data collection methods, less reporting due to concerns about backlash, and possibly a real decline in incidence.

Although sexual abuse occurs across all income levels and racial, cultural, and ethnic groups, it is more commonly reported among families of lower socioeconomic status. Children of all ages are victimized, with risk of sexual abuse increasing around age 10. Girls are significantly more likely to experience sexual abuse than boys. In addition, children with physical or cognitive disabilities appear to be at increased risk.

Identification of Victims

Because of the covert and coercive nature of sexual abuse and the frequent absence of physical evidence, a child's self-disclosure is the primary means of identifying an abusive situation. When children do disclose sexual abuse, they are most likely to tell a parent, usually their mother.

Research has identified numerous factors that inhibit disclosure. Perpetrators often use manipulative and coercive methods to maintain their victim's compliance and silence. Children may be embarrassed, concerned about retaliation from the perpetrator or others, or worried about being blamed or punished. Unfortunately, such worries are often justified in that disclosures are sometimes met with disbelief and family upheaval. Boys are less likely to disclose due to concerns about being stigmatized if the abuse was perpetrated by a male, and they may not perceive sexual acts with older girls or women as abusive. Children are more likely to disclose if the abuse was perpetrated by a stranger. Older children are more likely to purposefully disclose (i.e., seek out someone to disclose to), while younger children may be more likely to disclose after questioning.

Medical or physical evidence sometimes leads to identification of sexual abuse. This may include trauma to the genitals or mouth, genital or rectal bleeding, sexually transmitted diseases, pregnancy, and complaints of discomfort in the genital or rectal area. In most cases, there are no physical indications of the abuse. However, positive medical findings are valuable for substantiation of an abusive act.

Sometimes there are significant behavioral or emotional changes that might provide an indication that something has happened. For example, a child might suddenly withdraw or act out, show signs of sexualized behavior, or avoid individuals or settings, and this might prompt questioning or investigation. At other times, abuse may be discovered as a result of an ongoing investigation of other victims, as perpetrators commonly have multiple victims.

Once abuse is suspected, it is common to conduct a forensic interview with the potential victim. These interviews are important for protecting children and successfully prosecuting perpetrators, and it is also important that falsely accused individuals are exonerated.

A number of techniques are used in forensic interviews, with varying degrees of documented support. It is considered acceptable to gather information about the allegation before a forensic interview, though knowledge of allegations can increase interviewer bias and result in leading questions, and allegation-blind interviews can lead to higher rates of disclosure than allegation-informed interviews. Assessing understanding of

the difference between the "truth" and a "lie," and the consequences of lying, is valuable before questioning. Open-ended questions increase the length and accuracy of responses with school-age children and adolescents. Cognitive interview techniques can also be useful, especially with older children, including recalling the event as a detailed narrative, reporting every detail of what happened, recalling the event in different sequences, and describing the event from other people's perspectives. The use of anatomically detailed dolls is controversial, with some reports of their being useful in helping children remember and describe their experience and other reports of their reducing the quality of responses and eliciting sexual play from nonabused children.

A relatively new approach to forensic interviews is the structured interview. The advantages of structured interviews are that they need limited training, use flexible and easy-to-follow protocols, and have been developed for alleged victims as well as their parents. Research has shown their utility in decreasing leading questions, increasing open-ended questions, and increasing the quality of the details elicited. Another new approach is extended forensic evaluation, in which multiple interviews are conducted to allow the child to disclose over time in a nonthreatening environment. It is recommended that interviewers be graduate-level mental health professionals with training in sexual abuse, child development, and court testimony. Stages of evaluation include gathering background information, rapport building, social and behavioral assessment, abuse-specific questioning, and review and clarification.

A promising development for improving child abuse investigations and substantiation rates is the Child Advocacy Center (CAC) model. CACs are child-friendly facilities staffed by professionals trained in forensic interviews, medical exams, and victim support and advocacy. The number of CACs has increased dramatically in recent years, with the majority of states having multiple centers.

Mandatory Reporting Statutes

All 50 states have laws that require certain professionals to report suspected child maltreatment. This commonly includes physicians, nurses, psychologists, social workers, teachers, day care workers, and law enforcement personnel. Any person may report, and many state statutes require "all persons" to report suspicions, though many individuals are unlikely to be aware of this responsibility.

Generally, mandatory reporting statutes indicate that a report is required when there is "reasonable cause" to believe that a child has been subjected to abuse or is being exposed to conditions that could result in abuse. Reports can be made via child protective services or law enforcement agencies, and 24-hour reporting is available in most states via a toll-free "hotline" phone number. Failing to report can lead to criminal penalties or civil liabilities, as well as professional ethical and malpractice complaints. The mandatory reporting requirement overrides professional confidentiality requirements.

Despite the mandatory reporting statutes, numerous studies indicate that many instances of abuse do not get reported by professionals, either because they do not recognize the situation as abusive or because they choose not to report. Research suggests that a variety of factors can influence reporting, including the perceived severity of the situation, prior success with reporting, and concerns about disrupting a therapeutic relationship.

Consequences of Sexual Abuse

A substantial amount of research has examined the potential consequences of sexual abuse. While there is no doubt that sexual abuse has serious consequences for many, the extent and nature of the impact vary considerably, and no symptom or disorder is found universally in all victims. In addition to the challenges of demonstrating experimental control, the research is faced with the presence of many potential confounding variables, such as the co-occurrence of other forms of maltreatment, domestic violence and marital dysfunction, and poverty.

Across the research on the short-term consequences, sexual abuse has been found to be associated with a number of internalizing behaviors, including anxiety, depression, suicidal ideation, problems with self-esteem, sleep disturbances, and somatic complaints. PTSD is the most commonly identified clinical syndrome found, including symptoms of reexperiencing the event, avoidance of reminders of the trauma, and arousal and hypervigilance.

Research has also demonstrated the presence of externalizing problems, including self-abusive behaviors, delinquency, and substance abuse problems. Difficulties with school performance and concentration, problems with interpersonal relationships and social competence, or increased body self-consciousness may also be found. Some children may be more interested and curious about sex and the genital areas, have heightened sexual activity, such as masturbation and precocious sexual play, or sexually act out toward adults and peers.

A substantial portion of youths may be asymptomatic following abuse. Research indicates that as many as 20% to 50% of victims do not show measurable clinical symptoms. Most of these children remain symptom

free, but there is evidence of a "sleeper effect," in which symptoms do not manifest until months or years after disclosure.

A substantial amount of research has identified potential long-term effects including anxiety, depression, self-mutilation, suicidal ideation and behavior, somatization, poor self-esteem, substance abuse, sexual dysfunction, sexual deviance, and posttraumatic stress. Research has also documented less satisfaction and comfort in relationships and more maladaptive interpersonal patterns. Increased risk of sexual assault revictimization is also a problem.

The substantial variability in consequences is not surprising given the variability in the nature and extent of sexually abusive acts and the contexts in which they occur. Research has shown that factors that may influence the impact of sexual abuse on children include characteristics of the abuse (e.g., type and severity, relationship with the perpetrator), premorbid child characteristics, family functioning, and school and community support and stressors. Research indicates that parental support after disclosure is a key factor in reducing the impact of sexual abuse.

Sexual abuse can affect the entire family system, and nonoffending parents and siblings may need support for dealing with the experience. Parents report increased strain on parent-child and spousal relationships, anger, depression, and posttraumatic stress. Siblings may experience emotional distress, including fear, helplessness, shame, guilt, anger, and resentment toward the victim.

Treatment for Victims and Families

Treatment for sexual abuse is unique in that children are generally referred for services because they have experienced the event of sexual abuse, not because of specific emotional or behavioral symptoms they are exhibiting. Many children receive services because of parental concerns about damage to their child and for prevention of future difficulties and revictimization. Thus, children in treatment are a very heterogeneous group.

Interventions range from brief psychoeducation and crisis intervention, to short-term abuse-focused treatments, to more comprehensive and longer-term interventions. The general findings are that the interventions, often based on research for treating other child difficulties, are effective for treating the symptoms exhibited by sexually abused youths.

Psychological assistance at the time of disclosure is designed to assess the child and its family's needs and to provide support, psychoeducation, and shortterm training in effective coping strategies. Crisis intervention services can improve parents' effectiveness in providing support and helping their child and family address the complex, abuse-related impacts and issues. Additionally, referrals for longer-term mental health services can be made if needed. It has been routine to provide asymptomatic children with treatment, especially psychoeducation, to prevent development of problems and reduce the risk of revictimization.

Abuse-specific therapy designed to decrease trauma-related symptomatology is the most extensively researched treatment and tends to use cognitivebehavioral procedures to target symptoms of posttraumatic distress. For example, anxiety and avoidance are targeted with relaxation training, desensitization and exposure, and cognitive restructuring. Behavior problems are addressed with behavior management techniques. Some young people also need intervention for sexual behavior problems to address parental supervision, education, communication, self-control, and sexual behavior rules.

Group therapy can offer opportunities not available in individual or family therapy. It provides the victims the opportunity to share experiences and feelings with other youths who have had similar experiences, helps them reduce their sense of isolation and stigma, and provides them with a safe setting to discuss and experiment with new behaviors, including social skills, and coping and problem-solving strategies. Research suggests that group interventions can be valuable for reducing problems of anxiety, depression, fear, and sexual behaviors and for increasing self-esteem.

Research indicates the importance of therapeutic services for nonoffending parents and nonabused siblings. Treatment for nonoffending parents is important to address parental distress, parental reactions, and supportive recovery of the abused child. Nonabused siblings may need services to address emotional distress involving feelings of relief, guilt, anger, and resentment, as well as for preventing future abuse and learning coping skills. Group treatments can be beneficial to parents and siblings by providing an atmosphere to give and receive support, share similar experiences, and resolve stressful issues.

Testifying in Court

Approximately half the substantiated cases result in criminal charges for the perpetrator, but only about half of those go through prosecution. Because only a small portion of cases actually proceed to trial, only a very small percentage of youths actually testify. The often long delays in court proceedings can be frustrating for families and delay recovery because of the continued need to face the situation in what can be challenging and stressful circumstances. Fortunately, participation

in such legal proceedings does not appear to regularly lead to longer-term adjustment problems, and for some children and families participation has positive benefits (e.g., feelings of closure).

In response to the stressors caused by the court process, as well as the need for child witnesses to participate appropriately during proceedings, court preparation programs are increasingly available for sexually abused youths. The goals of court preparation include making the experience less stressful, helping the child understand the proceedings, improving the child's ability to participate accurately and truthfully, and increasing the likelihood that the child will be seen as a credible witness. Court preparation procedures familiarize children with court participants, processes, and terms; inform children of their rights and obligations and the arrangements of the courtroom; and teach stress management strategies, such as deep breathing and desensitization. Although not well established by research, court preparation programs are believed by prosecutors to be effective, and families and professionals working with the children find them useful.

In addition to preparation programs, courts have implemented other practices to help protect children, including "vertical prosecution," where one prosecutor deals with the case from investigation through trial and keeps in regular contact with the child and its family. Victim advocates also provide support and information throughout the often long, complicated process.

Courts have allowed modifications to make testifying less stressful and aid in gaining attention and participation. For example, some courts allow a child to hold a teddy bear or a doll while testifying to help the child feel comfortable, seat the child in a less intimidating location within the courtroom, or allow the child to testify with a screen that blocks the child's view of the defendant or via closed-circuit television (CCTV) from an adjacent room. Although many states have enacted statutes to allow CCTV testimony, it has not been widely used because of the lack of availability of the equipment in court rooms, concerns about legal challenges, and beliefs about the value of in-person testimony.

Further Readings

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