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## Intrafamilial Child Sexual Abuse, Links to Subsequent Sexual Exploitation and Prevention/Treatment Programmes: a Literature Review

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# **Intrafamilial child sexual abuse, links to subsequent sexual exploitation and prevention/treatment programmes: a literature review<sup>1</sup>**

Kevin Lalor & Rosaleen McElvaney<sup>2</sup>

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## Introduction

The Stockholm (1996) and Yokohama (2001) World Congress against Commercial Sexual Exploitation of Children (CSEC) focused on commercial forms of child sexual exploitation, such as sex-tourism, prostitution, pornography and trafficking. There is a recognition that the much more pervasive sexual abuse of children in their own families and communities, by perpetrators trusted and known to them, needs to be addressed as part of the global initiative to tackle child sexual abuse.

The purpose of this review is to:

- Review the literature on the incidence of intrafamilial child sexual abuse.
- Explore the link between intrafamilial child sexual abuse and (later) exploitation outside the family.
- Review the literature on child sexual abuse prevention strategies and therapeutic interventions.

## **1. Overview of incidence of intrafamilial child sexual abuse**

Unfortunately, evidence worldwide indicates that children and adolescents are at risk from sexual predators, exploiters and opportunists. Incidence varies depending on individual, familial and societal circumstances, but the sexual exploitation of young people appears to be a universal phenomenon. The extant research also shows that family members, neighbours or those known and trusted by the child typically perpetrate abuse.

### International perspectives

The Foreword to Korbin's *Child abuse and neglect: Cross-cultural perspectives* (1981) states "child abuse ... has become a serious social problem in the United States and in some other industrialized countries, yet it occurs infrequently or not at all in many of the world's societies" (p. vii). We now know that this is not the case.

Finkelhor (1994) reviewed studies from 19 countries and noted findings similar to North American research (incidence rates ranging from 7-36 per cent for women and 3-29 per cent for men):

"Studies from a variety of countries suggest that sexual abuse [of children] is indeed an international problem. In every locale where it has been sought, researchers have demonstrated its existence" (1994, p. 412).

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Today, although many gaps remain, we have better information about the nature and incidence of child sexual abuse throughout the world. In the material below, selected studies are summarised.

Child sexual abuse prevalence worldwide

The methodological limitations of child abuse research have long been recognised (Briere, 1992; Runyan, 2000; Widom, 1988). Studies use different definitions of child abuse, select different age cut-off points and use different sampling procedures. This must be taken into consideration when interpreting study results.

**Table 1: ‘Headline’ findings on child sexual abuse\***

Country	Study	Incidence & Type of abuse	Perpetrators
UK	May-Chahal & Cawson (2005), n=2869 18-24 yr olds	10% (6% male; 15% female) reported a form of contact csa before <b>age 16</b>  2% (1% male; 3% female) reported sexual intercourse against their wishes before <b>age 16</b>	1% reported contact csa by parent/carer; 2% by relative; 8% by other known person; 2% by stranger/person just met
France	King et al. (2006), n=12,256 adults	1.3% (0.7% male; 2.1% female) reported a ‘forced sexual relationship’ (‘touching’ or ‘attempted rape’ or ‘rape’) before <b>age 18</b>	Not reported
Ireland	McGee et al. (2002), n=national sample of 3,118 adults	20.4%/16.2% of females/males reported contact sexual abuse before age 17. 5.6%/2.7% of females/males report penetrative abuse before <b>age 17</b>	Females/Males 24%/14% family members; 52%/66% known to victim; 24%/20% strangers
China	Chen et al. (2004), n=2,300 high school students	16.7% of females reported an ‘unwanted sexual experience’ before <b>age 16</b> (6.5% were touched or fondled; 0.3% had unwanted sexual intercourse)  10.5% of males reported an ‘unwanted sexual experience’ before <b>age 16</b> (2.8% were touched or fondled; 0.1% had unwanted sexual intercourse)	Not reported
Bedouin-Arabs in Southern Israel	Elbedour et al. (2006), n=217 female adolescents	31% reported some form of child sexual abuse <b>between the ages of 14 and 18</b>  13% reported being fondled; 4% reported penetrative abuse	Little data provided. 16% of perpetrators were strangers
New Zealand	Fanslow et al. (2007), n=2,855 females	23.5% in urban area, 28.2% in rural area, reported being ‘sexually touched or made to do something sexual they did not want to’ before <b>age 15</b>	86% male family members  1% ‘strangers’
US	Briere and Elliott (2003), n=national sample of 935 adults	32.3% of females and 14.2% of males reported at least one episode of childhood sexual abuse  52.8% of child abuse incidents involved penetrative abuse	Females/Males 93%/70% abused by at least one male  9%/39% abused by at least

			one female
Swaziland	CDCP & Unicef (2007), n=1,920 females aged 13-24 years	33.3% reported some form of sexual violence <b>before age 18</b> 9.1% reported 'coerced intercourse' (being persuaded/pressured) <b>before 18</b> 4.9% reported 'forced intercourse' (physically forced against her will) <b>before age 18</b>	husband or boyfriend (35.6%); a man/boy from the victim's neighbourhood (27.1%); male relative other than a father, stepfather or husband (15.7%); stranger (10.1%)
Ethiopia	Worku et al. (2006), n=323 female school students (age 12 to 20)	68.7% reported some form of sexual abuse ' <b>in their lifetime</b> ' (sample aged from 12 to 20) 18.1% reported unwanted sexual intercourse	strangers (36%); school mates (31.5%); family members (16.7%, including father, 1.4%; step father, 9.3%; brother, 2.3%; uncle, 0.9%; other, 5%); neighbours (15.8%)
Tanzania	McCann, Lator and Katabaro (2006), n=487 university students	27% (31% of females and 25% of males) had one or more unwanted sexual experience <b>before the age of 18</b>  Females reported unwanted fondling, 27.9%; sexual intercourse, 11.2%; oral sex, 5.6%  Males reported unwanted fondling, 13.4%; sexual intercourse, 8.8%; oral sex, 6.2%	Little data provided
South Africa	Jewkes et al. (2002), n=11735 women aged 15-49 years	1.6% of total sample reported being forced or persuaded to have sex against their will <b>before age 15</b>  3% of 15-19 year olds reported being forced or persuaded to have sex against their will before age 15	School teachers (33%); relatives (21%); strangers or recent acquaintances (21%); boyfriends (10%)

\*These findings should not be seen as comparisons in prevalence across countries, due to differences in study design, definitions and sampling.

As we can see, rates for penetrative child sexual abuse are higher for girls than for boys, ranging from a low of 0.3% (China) to a high of 18% reporting 'unwanted sexual intercourse' in one Ethiopian study.

Data on perpetrators are not always reported, but the studies above show that very high proportions of perpetrators were well known to the child; 86% were family members in the New Zealand study; 76% were family members or known to the child (Ireland); 78% were boyfriends, neighbours or male relatives (Swaziland); and in South Africa, 64% were teachers, relatives or boyfriends.

#### WHO multi-country study

In addition to the individual studies outlined above, a recent WHO multi-country study is important to note. García-Moreno et al. (2005) report on a study of women's health and domestic violence, including experiences of childhood sexual abuse amongst more than 24,000 respondents in 10 countries. The percentage of respondents reporting 'being

touched sexually or being made to do something sexual they did not want to do' before age 15 years varies widely, from a high of 21.3% in Namibia 'city'<sup>3</sup>, to a low of 1% in Bangladesh 'province'. More research is needed to determine the risk and protection factors at work here.

Also of note is the identity of perpetrators. In some regions, family members and acquaintances accounted for the bulk of the abuse (80.4% in Brazil 'province'; 84.7% in Brazil 'city'; 80.8% in Namibia). By comparison, in Thailand 'city', family and acquaintances only accounted for 19.7% of perpetrators. In some regions, 'strangers' are significant abusers (69.7% in Bangladesh 'city' and 69.5% in Japan 'city'). By contrast, strangers account for only 8.7% of abusers in Brazil 'city'.

#### A note on 'transactional sex' or 'exchange sex'

In the debate about where the correct balance of focus should lie between intrafamilial child sexual abuse and 'commercial sexual exploitation', the phenomenon of 'exchange sex' or 'transactional sex' must be considered. Sexual relations between younger adolescents and older boys or men ('sugar daddies'), with the exchange of small gifts, are frequently exploitative, but without perhaps qualifying as 'commercial exploitation'. This has long been a feature of sexual relations in parts of Africa, and is perhaps aggravated today due to widespread poverty, social upheaval and the dismantling of traditional coping mechanisms. García-Moreno & Watts (2000) refer to sexual relationships of this kind as "economically coerced sex" (p. 261).

## **2. The link between intrafamilial child sexual abuse and later sexual exploitation**

This section examines the link between intrafamilial child sexual abuse and later sexual exploitation, including high-risk sexual behaviour.

#### The negative sequelae of child sexual abuse

Child sexual abuse includes a broad range of behaviours, which can be perpetrated across a broad range of intrafamilial and extrafamilial relationships. There is also considerable variability in both duration and frequency of the abuse (Paine & Hansen, 2002). Briere and Elliott (2003) summarise two decades of research that:

"suggest with relative unanimity that childhood physical and sexual abuse have a wide number of psychological sequelae. Among these are low self-esteem, anxiety, depression, anger and aggression, post-traumatic stress, dissociation, substance abuse, sexual difficulties, somatic preoccupation and disorder, self-injurious or self-destructive behavior, and most of the various symptoms and behaviours seen in those diagnosed with borderline personality disorder" (p. 1207).

Dube et al. (2005) conclude that "exposure to CSA ... acts as a strong risk factor for multiple types of mental health, behavioural, and social outcomes similarly for adult men and women" (p. 434). It is important to note that the sequelae of child sexual abuse are not always negative. Many follow up studies show significant proportions of victims of sexual abuse reporting no psychopathology over their adult lives (Collishaw et al., 2007).

#### Link between child sexual abuse and sexual revictimization

In addition to negative socio-emotional and mental health outcomes, numerous studies have highlighted that child sexual abuse victims are vulnerable to later sexual revictimization.

An early study was conducted by Russell (1986) who found that 63% of a sample of women who experienced intrafamilial sexual abuse before age 14, also experienced rape or attempted rape after age 14 (compared to 35% of the sample who did not report childhood sexual abuse). Thus, childhood sexual abuse would appear to double the risk of sexual revictimization. More recent studies confirm this relationship. In Australia, Fleming et al. (1999) found victims of childhood abuse were significantly more likely to experience sexual violence as adults, compared to those

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<sup>3</sup> The cities and provinces surveyed were not specifically identified in the report.

who reported no childhood abuse (17% vs. 6%). The difference was even greater when the abuse reported involved intercourse (24% vs. 7%).

In an Irish study, McGee et al. (2002, n=3118) found a risk of 27% for penetrative sexual violence in adulthood among females who reported childhood sexual abuse, compared with a risk of 3% for those with no experience of abuse in childhood. For men, experiencing penetrative sexual abuse in childhood was associated with a sixteen-fold increase in the risk of adult penetrative sexual violence. Fanslow et al. (2007) interviewed 2,855 women in New Zealand regarding their experiences of unwanted sexual contact before the age of 15. Women who reported CSA were three and a half times more likely to report sexual violence by a non-partner in their lifetime (23.2% vs. 6.4%).

Humphrey & White (2000) report on a 5-year longitudinal study of sexual assault among a sample of 1569 female college students in the US. They found that victims of childhood assault were significantly more likely to experience either moderate ('unwanted or verbal coercion') or severe ('attempted or completed rape') adolescent victimization than non-victims. Also, experiencing sexual victimization in adolescence more than quadrupled the likelihood of sexual victimization in college. Respondents who were raped in their adolescent years were 13.7 times more likely to experience rape or attempted rape in their first year of college. Classen et al. (2005) reviewed 90 empirical studies on sexual revictimization and concluded that child sexual abuse is a significant risk factor for sexual revictimization. More severe forms of child sexual abuse, and the co-existence of physical abuse, increase the risk for later revictimization. Also, there appears to be a cumulative effect, whereby sexually abused children are more likely to be abused as adolescents; who are in turn more likely to be sexually revictimized as adults.

#### Link between child sexual abuse and prostitution

In addition to the literature on revictimization, numerous studies have also examined the link between child sexual abuse and later engagement in high-risk sexual behaviour, such as early age at first intercourse, drug use, prostitution, and multiple sexual partners (Finkelhor and Browne, 1985; Polusny & Follette, 1995). Early age at first intercourse has been associated with a history of child and adolescent sexual abuse (Lodico & DiClemente, 1994; Steel and Herlitz, 2005). Steel and Herlitz (2005, n=2810) explored the link between child and adolescent sexual abuse (CASA) and subsequent sexual risk behaviour among the general population in Sweden. In addition to early first intercourse, CASA victims were also at higher risk, relative to a control group, of: unintended pregnancy (28% vs. 17%), engagement in group sex (12% vs. 6%), sex work (1% vs. 0%), and adult sexual assault (8% vs. 1%). Some of these behaviours, such as prostitution, can be considered a form of revictimization.

Zierler, Feingold, Laufer, Velentgas, Kantrowitz-Gordon and Mayer (1991) studied a sample of 186 adults in New England, US, of whom 41 reported being raped or forced to have sex as a child or teenager. They found that this group were "four times more likely to report having worked as a prostitute ... two times more likely to have multiple sexual partners on an average yearly basis and 2.6 times more likely to become pregnant as a teenager" (p. 574). Spatz Widom and Kuhns (1996) conducted a prospective study to examine the effects of child abuse on subsequent risk for promiscuity, prostitution and teenage pregnancy. They followed 1196 subjects (676 abused and/or neglected and 520 control subjects) from childhood into early adulthood. They did not find significant differences in promiscuity ('having had sex with 10 or more people in a single year') between the abused/neglected group and the control group (17.79% vs. 16.99%). However, significant differences were found for prostitution, particularly for females (8.9% vs. 2.9%). They conclude, "childhood sexual abuse was a significant predictor of prostitution in female subjects" (Spatz Widom and Kuhns, 1996, p. 1609). They speculate that the effect may be mediated by running away and being alone on the streets and thus being more vulnerable to 'pimps'.

The literature on juvenile prostitution has long shown a link between child sexual abuse and engagement in prostitution. For example, Stoltz et al. (2007) found a significant relationship between child maltreatment (sexual, physical and emotional) and later involvement in sex work among a sample of 361 drug-using street-involved youth in Vancouver, Canada. They offer two hypotheses to explain this link. Firstly, those children who are sexually victimized "develop psychologically and emotionally in ways that make them vulnerable to continuing sexual predation". Secondly, they speculate that "childhood sexual abuse may create a propensity in the victim toward risk-

taking behaviors (substance abuse, running away from home) ... that in turn lead to situations in which survival sex work is one of few remaining options” (p. 1218).

Numerous studies report that juvenile prostitutes identify the sexual abuse they experienced as a child as a major factor in their decision to become involved in prostitution. For example, 70% of the subjects in Silbert and Pines’ (1983) US study felt that childhood sexual abuse affected their decision to become involved in prostitution.

However, only a small proportion of children who are sexually victimized subsequently become involved in trading sex for money or goods. While Flowers (1998) can maintain that “nearly all girl prostitutes have been sexually molested, assaulted, or physically abused before entering the profession” (p. 82), the reverse does not hold. In Sweden, Steel & Herlitz (2005) found that 1% of the sample of 268 CASA victims reported having engaged in ‘sex work’, compared to 0% of the sample of 2625 non-CASA victims.

Why are CSA victims vulnerable to sexual revictimization?

The studies above do not always speculate as to why CSA victims are vulnerable to revictimization and risky sexual behaviour. Grauerholz (2000) proposes an ecological model to explain the phenomenon. She notes that explanations frequently focus on individualistic factors, facilitating a ‘victim-blaming’ interpretation; she argues that a comprehensive explanation must incorporate interpersonal and socio-cultural factors. After Bronfenbrenner (1979) and Belsky (1980), she outlines an ecological perspective that incorporates ontogenic development (one’s individual personal history), the microsystem (eg, family relations), the exosystem (larger social systems in which the individual or family is located) and the macrosystem (cultural norms and institutions). Thus, a rich contextual understanding is gained of the individual, interpersonal, community and societal forces resulting in repeat sexual victimization.

**Table 2: Factors hypothesised to be related to sexual revictimization**

Ecological Level	Factor (or variable)
Ontogenic development	The initial victimisation experience (possible effects include traumatic sexualisation, alcohol and drug abuse, dissociative disorders, low self-esteem, powerlessness, stigmatization, learned expectancy for victimization, social isolation, running away, deviance, and early/pre-marital pregnancy) Early family experiences* (possible correlates include family breakdown, disorganization and dysfunction, marital dysfunction, unsupportive parents and patriarchal structure)
Microsystem	Exposure risk (factors increasing this risk include traumatic sexualisation, dissociative disorder, alcohol abuse, involvement with deviant activities, stigmatization, and low self esteem) Increased risk of perpetrator acting aggressively (due to: perception of victim as easy target; feeling justified in behaving aggressively; victim’s decreased ability to respond assertively and effectively to unwanted sexual advances)
Exosystem	Lack of resources (related factors include low socioeconomic status, unsafe living conditions, early childbearing, single motherhood, and divorce) Lack of alternatives (due to weak family ties or support and social isolation)
Macrosystem	Cultural tendency to blame victim Good girl/bad girl construction of femininity

\*As noted by Messman-Moore and Long (2003), the original ecological model proposed by Bronfenbrenner conceived the family environment as part of the microsystem.

Each of these levels, or layers, may contribute to sexual revictimization. Therefore, a proportion of victims of sexual abuse carry profound psychological distress into adulthood and this may create a vulnerability to revictimization and high-risk behaviour, such as prostitution. Secondary difficulties associated with the psychological impact of the abuse, such as substance abuse, may also contribute to this vulnerability and, in some situations, may remove barriers to involvement in sex work for some victims. Finally, societal factors such as social isolation, poverty and cultural attitudes may contribute to this vulnerability and facilitate revictimization.

Alternative theoretical frameworks are suggested by Polusny & Follette (1995) and Messman-Moore & Long (2003). Polusny & Follette proposed a model based on the theory of 'emotional avoidance' whereby the long term correlates of child sexual abuse are the individual's efforts to minimize negative emotional states such as guilt, shame, fear and rage, and associated thoughts and memories. Over time, emotional avoidance behaviours (such as dissociation, substance abuse and self-mutilation) "are negatively reinforced by the reduction or suppression of the intense affective responses associated with sexual abuse experiences" (p. 158). In this context, high-risk sexual behaviours (such as frequent, indiscriminate, compulsive sexual behaviours) serve to moderate painful internal experiences, "temporarily dispelling abuse-related emotional pain by providing more pleasurable, distress-incompatible input" (Briere and Runtz, 1993, cited in Polusny & Follette, 1995). This emotional avoidance may lead to revictimization. For example, chronic dissociative coping behaviours may lead survivors to ignore or minimize social cues in dangerous adult situations.

Messman-Moore & Long (2003) also espouse an ecological model to explain sexual revictimization. They argue for a shift of focus from the victim to interpersonal and societal levels:

"If we focus on the victim, we will find within her and her behavior explanations for revictimization. However, we must recognize the interpersonal context in which revictimization takes place, and choose to also focus on the perpetrator and cultural factors within our society. The study of revictimization should focus on the intersection between the victim and the perpetrator. We will never fully understand revictimization while the microscope remains focused solely on the victim" (p. 566).

Steel & Herlitz (2005) hypothesize a possible pathway from child and adolescent sexual abuse (CASA) to sexual risk behaviour, with psychological symptoms/disorders as a mediator. Psychological sequelae to CASA, such as depressive symptoms, poor self-esteem, lack of assertiveness, poor self-worth and PTSD, may lead to future risk behaviour due to "(1) feelings of unworthiness; (2) the inability to be assertive and prevent unwanted sexual advances; (3) avoidance or inability to comprehend emotionally laden information concerning sexuality; or (4) having competing needs for affection and acceptance" (p. 1150).

Is sexual revictimization of child sexual abuse victims universal?

A limitation of the above studies is the almost exclusive focus on the US, usually with samples of white women aged 18 to 60 (Polusny & Follette, 1995). Males and ethnic minorities have not been adequately studied. Classen et al. (2005) cite Urquiza & Goodlin-Jones (1994) as an exception; their study found rates of sexual revictimization were highest for African-American women (61.5%), followed by white women (44.2%), Latinas (40%), and Asian-American women (25%).

In Germany, Krahe et al. (1999) studied a sample of females. Those with histories of CSA and those 'not sure' whether they experienced CSA "were more likely than nonabused women to report unwanted intercourse. Those who reported child sexual abuse had a significantly higher number of partners (average of 5.6 vs. 2.9 reported by those without histories of CSA), which was in turn related to higher rates of later victimization".

In a Zambian study, Slonim-Nevo and Mukuka (2007) surveyed 10-19 year olds (n=3,360) regarding their experiences of physical and sexual abuse by family members and Aids related knowledge, attitudes and behaviour. They found that

“abuse by family members was a significant predictor of engagement in high-risk behaviours ... Specifically, the higher the level of sexual and physical abuse in the family, the higher the probability of engagement in any kind of high-risk behavior, controlling for various socio-demographic factors. For example, each unit of increase in the family abuse scale is about 1.5 in the likelihood of trading sex for food, money, gifts or a place to stay, of having sex with an unknown person, and of having sex while high on drugs” (p. 152).

Particularly in the sub-Saharan Africa context, the issue of child sexual abuse and later sexual revictimization and high-risk behaviour and exposure to HIV needs greater attention. They conclude, “Future studies should investigate which factors mediate between the experience of abuse and the tendency to engage in risky behaviours” (p. 143). As noted in Lalor (2008), child sexual abuse is an *indirect* predisposing factor to HIV exposure, through high-risk mediating behaviours such as transactional sex. Given the extent of violence/coercion in early sexual relationships and the extent of exchange sex in sub-Saharan Africa, it is important to know whether early abusive sexual experiences “increase the likelihood of girls and women engaging in, or being exposed to, high risk behaviours such as multiple partners, exchange sex, prostitution and repeat sexual assaults and rape.” (p. 105).

### **3. Overview of the literature on prevention and therapy**

The literature on prevention and therapy is examined below. As prevention strategies to date do not focus exclusively on intrafamilial abuse and few therapeutic efforts do so, this literature review pertains to child sexual abuse as perpetrated both within the family and by those outside the family.

#### Prevention

The literature on the prevention of sexual abuse advocates an ecological holistic approach which aims to address the various systemic levels that influence the child’s development (Browne, Hanks, Stratton, & Hamilton-Giachritsis, 2002) Save the Children Norway, 2005; WHO, 2002, 2004, 2006, 2007). For example, “a proper prevention policy needs to include co-operation between the educational, health, social, child protection, police and judicial sectors and target not only children at risk but also the potential offender. A successful strategy has to attack the problem on different fronts in a holistic manner” (Save the Children Norway, 2005, p.85).

Save the Children Norway (2005) describes several multi-sectoral initiatives from different continents and suggests that most governments have failed to take a central role in co-ordinating and implementing policies and services for prevention and child protection. WHO (2006) provides guidelines for implementing outcome evaluations of prevention programmes of child maltreatment. However, most efforts are directed at one level alone, for example media campaigns that target the general public, school programmes that target children and to a lesser extent parents and therapeutic services.

#### Media campaigns

Hoefnagels & Baartman (1997) and Hoefnagels and Mudde (2000) report on a multimedia campaign in the Netherlands in 1991-1992 that resulted in increased disclosure of sexual abuse as measured by calls to a children’s helpline before and after the campaign. Chalk & King (1998) evaluated a child sexual abuse media campaign using interviews with 200 parents from eight US sites and found it effective in terms of increased knowledge and appropriate responses to children reporting sexual abuse. No differences in attitudes towards victims or offenders were noted. The need for raising public awareness of sexual abuse is underscored by such studies as Chen, Dunne & Han (2007) who found significant proportions of parents in China who did not know that children most often are sexually abused by familiar people, that females can be the perpetrator, that boys can be sexually abused and that usually there are no obvious physical signs when sexual abuse has occurred. Rheingold and colleagues (2007), however, stress that media campaigns alone may not significantly affect primary prevention of child sexual abuse.

### School-based prevention programmes:

Studies of school-based child sexual abuse prevention programmes have repeatedly found improvements in the acquisition of knowledge and in some cases, evidence of safety skills; however, these improvements do not necessarily reduce the occurrence of sexual abuse.

Zwi, Woolfenden, O'Brien, Tait & Williams (2007) conducted a Cochrane Review of 15 school-based prevention programmes, predominantly conducted in the US. The majority of studies reported significant improvements in knowledge and protective behaviours in simulated at-risk situations. Only a few studies aimed to change actual behaviour, and these studies did find changes in demonstrating safe behaviours. Zwi et al. were concerned about both the methodologies employed and the analysis involved in the original studies, and the lack of follow-up to measure whether information was retained over time. Parents have expressed concern about the potential harm of such programmes, such as children knowing too much about sex (Chen et al., 2007) which may act as a potential barrier to introducing prevention programmes in schools (MacIntyre & Carr, 1999). Surprisingly few studies appear to have addressed parents' perceptions of school-based sexual abuse prevention programmes.

Outstanding issues highlighted by Zwi et al. requiring further exploration are the optimal age for interventions, whether knowledge gained is retained in the longer term, whether knowledge and skills learned transfer to real-life situations, and the optimal duration of such programmes. A criticism of such programmes by parents is that they inadequately address intrafamilial sexual abuse (McElvaney, 2008), and place an inappropriate burden on the child (Save the Children Norway, 2005). Teachers' attitudes to implementing such programmes are important as there is evidence to suggest significant variation in teacher comfort in dealing with sexuality issues in the classroom (Mayock, Kitching, & Morgan, 2007).

The scientific literature is conclusive that school prevention programmes are effective in dealing with other social issues such as bullying and drug use (see Durlak, 1995, cited in Finkelhor, 2007). However, one key distinction between child sexual abuse and bullying or drug use is that in sexual abuse, the child is most often the victim, rather than the perpetrator. Behaviour change is therefore an explicit goal of prevention programmes aimed at preventing bullying and drug use and is often measured in evaluations of such programmes. The consensus in the sexual abuse literature is that while school prevention programmes have been found to be effective in increasing children's knowledge and skills, there is no evidence from outcome evaluation studies to suggest that these skills are transferred to real life situations and therefore prevent sexual abuse from occurring in the first place. Such outcome measures would be difficult to obtain. Nevertheless, epidemiological studies are reflecting a decline in rates of substantiated child sexual abuse in the US, Canada and the UK (Finkelhor, 2008) and school-based prevention programmes have been cited as a possible explanation for this decline (Finkelhor & Jones, 2006; Jones, Finkelhor, & Halter, 2006).

### Prevention through therapy with abusers

WHO (2006) note the value of therapeutic intervention with various groups as part of a multi-pronged approach to prevention of child abuse. Secondary prevention is noted as the objective of many therapeutic programmes for offenders. Cognitive-behaviour therapy has been found to be effective, particularly those approaches that include relapse prevention. Hall (1995, cited in Craig, Browne, & Stringer, 2003) found a small but robust treatment effect in his meta-analysis. The research on outcomes for adolescent offenders also proves promising (O'Reilly, Carr, Marshall & Beckett, 2004).

### Key components of an effective preventive strategy

Save the Children Norway (2005) recommends that governments take a leading role in co-ordinating a child rights-based national policy to address child sexual abuse with enforceable agreements between governmental and nongovernmental agencies. Such a policy should include a strong monitoring and evaluation component, a multi-sectoral and multidisciplinary integrated response, an emphasis on children's consultation processes, a centralised data-gathering and research service, and integrated services for children, their families, and young and adult offenders

which provide immediate response in child protection, multi-level care and, finally, sufficient resources allocated to such measures. Butchart and colleagues (WHO, 2004) have described strategies for preventing child maltreatment, taking account of various developmental stages and levels of intervention at the individual, relationship, societal and community levels. An example of such a multi-level multi-sectoral approach to preventing child maltreatment in general (as opposed to child sexual abuse in particular) is that of The Triple P Positive Parenting Programme (Sanders, Markie-Dadds & Turner, 2003, cited in WHO, 2006). This programme, developed in Australia, involves provision of media messages on positive parenting and information resources such as advice sheets and videos, short interventions for children with specific behavioural problems, an intensive training programme for parents, and services to address broader family issues such as relationship conflict, parental depression, anger and stress. A number of independent outcome evaluations have shown it to improve family management techniques, parental confidence in effective child rearing, and behavioural outcomes including behaviour and aggression in many parts of Europe, including Germany, Switzerland and UK, China, Hong Kong, New Zealand and the US.

A difficulty with the literature on broad-based child maltreatment prevention studies is discerning the impact of such programmes on the prevention of sexual abuse as those risk factors specific to sexual abuse may be neglected in such programmes. However, these programmes may have the potential for adaptation to specifically target the prevention of child sexual abuse. The literature is not lacking in helpful models and guidelines to inform prevention. It is unfortunately lacking in evidence for implementation of such models and in efforts to robustly evaluate those that have been implemented.

#### Therapeutic Intervention

Therapeutic intervention is only part of the response needed for children and families when sexual abuse has occurred. How child protection systems and legal institutions need to respond is discussed in the WHO World Violence Report (WHO, 2002) and guidelines for best practice in investigating allegations of sexual abuse are available in the US (APSAC, 1999) and the UK (Home Office, 2002). There is a growing body of evidence to support the use of psychotherapy with children who have been sexually abused. However, children who have been sexually abused are a heterogeneous group, often with little in common other than their experience of sexual abuse. Significant proportions of young people do not appear to need therapeutic intervention following an experience of sexual abuse (Saywitz, Mannarino, Berliner, & Cohen, 2000; Edmond, Auslander, Elze & Bowland, 2006). Research on children who have been sexually abused is typically based on clinical and legal samples that are highly selective, based on therapeutic need or those willing to pursue for the most part a lengthy and potentially distressing legal process (McElvaney, 2008). Goodman-Brown, Edelstein, Goodman, Jones & Gordon (2003) found that families were less likely to agree to participate in research if the abuse experienced by the child was intrafamilial. Children abused by someone within the family may represent a distinctly different group from those abused outside the family. Such features as an increased reluctance to disclose abuse (DiPietro, Runyan, & Fredrickson, 1997; Hershkowitz, Horowitz, & Lamb, 2005), and a higher likelihood of recantation (Malloy, Lyon, & Quas, 2007), may militate against inclusion in therapy outcome studies. In addition, there is some evidence to suggest that those who have been abused within the family show less improvement following therapy (Hetzl-Riggin, Brausch, & Montgomery, 2007) and may be more subject to the cumulative impact of polyvictimization (Finkelhor, Ormrod, & Turner, 2007) due to exposure to sexual and emotional abuse.

#### Effectiveness of psychotherapy

Psychotherapy has been found to be effective with children and adolescents who have been sexually abused using different modalities of therapy such as cognitive-behavioural therapy and abuse-specific therapy (Saywitz, Mannarino, Berliner & Cohen, 2000; Saunders, Berliner & Hanson, 2003), art therapy (Kolko, 1987), family therapy (Silovsky & Hembree-Kigin, 1994) psychoanalytic group therapy and psychoeducational group work (Trowell et al., 2002), psychodrama (Avinger & Jones, 2007) and play therapy (Bratton, Ray, Rhine & Jones, 2005).

Outcomes in general for children who have been sexually abused are more optimistic for those who have parental support (Everson et al., 1989; Trickett, 1997). Chandy, Blum & Resnick (1997) surveyed adolescent boys who had been abused and found that one of the most powerful predictors of resilience was the perception that their parents

cared about them. Other researchers have found support for concurrent intervention with abused children and their non-abusing parents, in groups or individual sessions, with concurrent parent-child sessions (Cohen, Deblinger, Mannarino, & Steer, 2004; Putnam, 2003; Ramchandani & Jones, 2003; Reeker, Ensing, & Elliott, 1997).

### Generic psychotherapy literature

The known prevalence of sexual abuse among clinical populations and the underreporting of sexual abuse both underscore the relevance of the generic psychotherapy outcome literature to the field of child sexual abuse. This literature provides ample evidence of the effectiveness of psychotherapy as an intervention with children and adolescents with psychological difficulties that may arise from many sources, one of which is frequently child sexual abuse. Carr (2007) cites four broad meta-analyses of studies involving children with a broad range of psychological difficulties receiving a variety of different interventions, which included 350 treatment outcome studies. Effect sizes ranged from .71 to .79, indicating that the average child receiving therapy fared better than 76% to 81% of children in control groups (Casey & Berman, 1985; Kazdin, Bass, Ayers, & Rodgers, 1990; Weisz, Weiss, Alicke, & Klotz, 1987; Weisz, Weiss, Han, Granger, & Morton, 1995). Two of these studies found that effect sizes were maintained at six months' follow up (Weisz et al., 1987, Weisz et al., 1995). Carr also found a 'dose effect' relationship in psychotherapy, suggesting that 20-45 sessions are necessary for 50-75% of psychotherapy clients to benefit.

As with the literature on therapy with children who have been sexually abused, various therapeutic models have been found to be effective with clinical populations. Such findings emanate from reviews of meta-analyses on cognitive-behaviour therapy (Butler, Chapman, Forman & Beck, 2006), reviews of both controlled studies and those without control groups on psychoanalytic psychotherapy in Germany (Richter et al., 2002; Loew et al., 2002, respectively, cited in Carr, 2007) and in the UK (Fonagy et al., 2002; Kennedy, 2004) and a review of meta-analyses of family therapy studies (Shadish & Baldwin, 2003, cited in Carr, 2007). These findings support the use of psychotherapy as an empirically-based intervention with children and adolescents with psychological difficulties.

The ecological approach advocated in the area of prevention has equally valid application to the therapeutic response to sexual abuse but is rarely used to inform intervention. Levendosky & Bittenheim (2000) report on a single case study where the therapy was based on an integrated relational and trauma theory perspective through a systemic approach working directly within the family, school and social service agencies. Although examples of working with both the victim and the offender are not uncommon in clinical practice, the mutual benefits of such work to both victim and offender, particularly in cases of intrafamilial sexual abuse, have received little attention in the research literature.

### Which model?

Hetzel-Riggin et al. (2007) suggest that some therapy modalities may be more effective than others depending on the presenting secondary problems. In their review of therapy studies, Hetzel-Riggin et al. found that play therapy was more effective for social functioning, cognitive-behavioural, abuse-specific therapy, in either group or individual formats, was the most effective for behaviour problems, while cognitive-behavioural, family, and individual therapy (modality unspecified) was most effective for psychological distress. Abuse-specific, cognitive-behavioural, and group therapy was found to be most effective for low self-concept. The authors conclude that the choice of therapy modality should depend on the child's main presenting secondary problem.

Saunders et al. (2003) note that the interventions with the most empirical support tend to be based on behavioural or cognitive behavioural theoretical approaches, utilise behavioural and cognitive intervention procedures and techniques, and intervene at both the individual child and parent/family levels. Carr (2007) cautions against concluding that because cognitive behavioural therapy has been more frequently evaluated than other interventions, it is therefore more effective. Macdonald, Higgins & Ramchandani (2006)'s Cochrane Review confirmed the potential of CBT (particularly trauma-focussed approaches) for treating the adverse consequences of child sexual abuse, but highlighted the tenuousness of the evidence base and the need for more carefully conducted and better reported trials. Most of the programmes reviewed are based on a cognitive behavioural approach with little reference to other modalities (Saunders et al., 2003). The current thinking in psychotherapy is that common factors across

psychotherapy modalities have a greater impact on whether clients benefit from psychotherapy than specific factors (Carr, 2007). According to Carr, the single most important common factor in psychotherapy outcome is the therapeutic relationship, or working alliance, where the therapist is empathic and collaborative and the client is co-operative and committed to recovery.

#### The child's perspective

Recent developments in the field of sexual abuse research have emphasised the importance of involving children directly in the research process (McElvaney, 2008). According to Mudaly & Goddard (2006), young people's views about child protection and police intervention highlights the complexity of responding to young people's needs in ways that do not render them even more helpless following experiences of abuse. The use of qualitative methodologies can help identify themes or areas of investigation of importance to children themselves.

#### Cultural issues

Very little information is available on whether cultural differences exist in the relative efficacy of different therapeutic interventions (Cohen, Deblinger, Mannarino & de Arellano, 2001). Cohen et al. do suggest that certain cultural groups may have value systems that encourage them to engage with psychological services and influence expectations of therapy. In one US study conducted through telephone interviews with 157 parents whose children had suffered a serious sexual or physical assault in the previous year, only 22% had even considered getting mental health treatment for their victimized children (Kopiec, Finkelhor, & Wolak, 2004). According to Saunders et al. (2003), the role of cultural, racial, ethnic, and religious identification on treatment response is an important area for future research, and needs to be considered in all treatment planning decisions.

Reviews of the literature have pointed to the methodological difficulties associated with research studies – small samples with corresponding low predictive power, lack of detail in relation to study design and content of therapeutic intervention, and lack of control group. As with the ecological approach advocated in the prevention literature, a centrally co-ordinated, well-resourced holistic approach to therapeutic outcome evaluation is needed to ensure that limited resources are allocated to meeting the needs of children and families who have been affected by child sexual abuse. Saunders et al. (2003) offer 22 general principles of treatment for children that emphasise the importance of conducting comprehensive needs-based assessments, providing evidence based interventions, including parents and caregivers in the therapeutic work, offering support to other family members where indicated, including the offender, and matching the needs of clients to the intervention offered.

## **4. Conclusion**

Evidence that the sexual abuse of children is universally widespread, and is most frequently perpetrated by family members, neighbours and others known to the child or adolescent is indisputable.

Studies have consistently found that victims are vulnerable to subsequent sexual revictimization in adolescence and adulthood. They are also more likely than non-victims to engage in potentially harmful and damaging high-risk sexual behaviours, such as early age at first intercourse, multiple partners, low contraception use and prostitution. Ecological models, which incorporate explanations at the individual, family, community and societal level help explain this link.

Interventions in the area of prevention of child sexual abuse have not kept pace with international policy guidelines. Preliminary attempts at mass media campaigns and school-based prevention programmes have shown some improvements in the increase of knowledge and, to a more limited degree, the acquisition of skills. As yet, there is no evidence that such interventions have prevented sexual abuse from occurring in the first place. However, broad-based

prevention programmes aimed at preventing child maltreatment in general (as opposed to child sexual abuse in particular) may have something to offer in informing child sexual abuse prevention programmes. There is considerable evidence to support the use of various therapeutic modalities in intervening with children and families following the experience of child sexual abuse. However, researchers have identified significant methodological limitations in the extant research literature that impede the making of recommendations for implementing existing therapeutic programmes unreservedly.

We conclude by quoting CDCP & Unicef (2007), who state “[sexual] violence against children is both a public health problem and a human rights problem” (p. 28). The former because of the negative sequelae experienced in the population of victims (far too high a population in many societies), and the latter because of the infringement of the personal integrity of the victim.

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