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Research Paper

Child Sexual Abuse: Analysis of its Aetiology, Models and Consequences; Breaking the Conspiracy of Silence

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ABSTRACT

Sexual abuse of children has become a subject of great community and a serious global issue. It has become the focus of many legislative and professional initiatives. There is enough evidence to show that those who have faced abuse in their childhood continue to deal with its consequences well into their adulthood, suffering physical, psychological and emotional problems. Children find difficulty disclosing abuse and they are left to suffer in silence. This paper discusses various aetiology, theories and models relating to child sexual abuse and the role of preventive education in children to combat sexual abuse. This paper also presents an overview of research findings and attempts to draw attention to highlight the consequences of child sexual abuse, and break the conspiracy of silence surrounding it.

Keywords: *Child Sexual Abuse, Aetiology, Theory, Models, Consequences, Combating through Preventive Education*

The World health organization (WHO,1999) defines child sexual abuse as "the involvement of a child or an adolescent in sexual activity that he or she does not fully comprehend and is unable to give informed consent to, or for which the child or adolescent is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society." Children can be sexually abused by both adults and other children who are – by virtue of their age or stage of development – in a position of responsibility or trust or power over the victim. It includes incest, which involves abuse by a family member or close relative. Sexual abuse involves the intent to gratify or satisfy the needs of the perpetrator or another third party, including that of seeking power over the child. Adolescents may also experience sexual abuse at the hands of their peers, including in the context of dating or intimate relationships. Child sexual abuse circles a broad range of sexual behaviors, including vaginal or anus penetration (using a finger, penis, or any other object), oral sex, touching genitals and other body parts, masturbation, exhibitionism (exposing genitals), voyeurism (watching), exposing a child to pornography, and directing a child to engage in sexual activities (Christensen, 2017).

Browne and Finkelhor (1986) found little clear relation between the age of onset and trauma; but if a trend could be discerned, it was that younger age was associated with greater trauma.

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There have been several reports showing a relationship between the history of child sexual abuse and later homosexual behavior. Fromuth (1986), for instance, found a weak but significant relation between child sexual abuse and homosexual-experiences (r = .12). Runtz and Briere (1986) reported a significantly higher incidence of homosexual contact among 39 sexually abused women compared with 11 non-abused controls.

A variety of adult psychiatric conditions have been clinically associated with child sexual abuse. These include the disorders of major depression, borderline personality disorder, somatization disorder, substance abuse disorders, post-traumatic stress disorder (PTSD), dissociative identity disorder, and bulimia nervosa (Putnam, 2003).

Finkelhor (1979) suggested that the association between childhood sexual abuse and re-victimization may be due to factors that force victimized children out of the family and into high-risk situations for wife abuse or rape. Childhood sexual abuse may also have a corrosive effect on self-esteem, therefore making these women conspicuous targets for sexually exploitative men. Sexual victimization can result in a broad array of problems, including emotional disorders (e.g., depression, anxiety), cognitive disturbances (e.g., poor concentration, dissociation), academic problems, physical problems (e.g., sexually transmitted diseases, teenage pregnancy), acting-out behaviors (e.g., prostitution, running away from home), and interpersonal difficulties (Berliner & Elliott, 2002).

The 20-year retrospective study by Laila et al (2014) of 311 child sexual abuse victims consulting at the department of pediatric medical emergencies of Rabat Children's Hospital, revealed that there were behavioral disorders with different degrees, including fear, anxiety, irritability, regression in school performance, sleep disturbances, eating disorders, social problems as well as poor self-esteem. Incest victims had particularly severe problems such as depression and attempted suicide.

A cross-sectional survey of 7353 adult household population of England (Adult Psychiatric Morbidity Survey 2007) by Bebbing et al (2007) to study the linkage of childhood sexual abuse to psychosis revealed that sexual abuse before the age of 16 was strongly associated with psychosis, particularly if it involved non-consensual sexual intercourse. There was evidence of partial mediation by anxiety and depression, but not by heavy cannabis use nor re-victimisation in adulthood and concluded that the association between childhood sexual abuse and psychosis was large, and may be causal. These results have important implications for nature and the aetiology of psychosis, for its treatment and for primary prevention.

Etiology of sexual offending

The etiology of adult sexual offending refers to the origins or causes of sexually abusive behavior, including the pathways that are associated with the behavior's development, onset and maintenance. There is no single answer to the question of why people engage in this behavior. The problem of sexual offending is too complex to attribute solely to a single theory.

Research shows that child sexual offenders may exhibit a variety of characteristics. They may be more likely to: • experience depression or low self-esteem. • Struggle with loneliness, social anxiety, or poor social skills. • Experience feelings of powerlessness. • Struggle with alcoholism. • Lack empathy. • Have a passive personality. • Have a fear of

intimacy • Have strained, poor, or lack meaningful relationships with adults. • Move or relocate frequently. • Have a history of poor parent-child relationships. • Have a history of being sexually abused as a child or having experienced other forms of abuse or neglect. (However, not everyone who has been sexually abused will abuse other people.) • Often not have a criminal background. • Relate or feel they relate better to children than adults. • Seek out multiple opportunities to engage with youth. • Rationalize their abuse as actually helping or protecting a child. • Put themselves in places and situations where youth are present (Arévalo et al., 2014).

Biological Influences

The endocrine system basic to these behaviors is quite complex and involves a number of biochemical mediators. Aggression and sex appear to be mediated by the same neural substrates (Adams, 1968; MacLean, 1962), which predominately involve mid brain structures such as the hypothalamus, septum, hippocampus, amygdala and pre-optic area. In addition, the neural networks within these areas appear to be remarkably similar to sex and aggression (Valzelli, 1981). Perhaps more importantly, however, is the fact that the same endocrines, namely the sex steroids, activate both sex and aggression (Moyer, 1976). The sex steroids have two major functions in both sexual and aggressive behavior: organizational and activational (Bronson& Desjardin, 1969; Money,1965). Puberty, therefore, appears to be a crucial period for the development of enduring sexual propensities and, given that the same biochemical activators underlie aggression, we may reasonably assume that the same is true of aggressive behavior. Hays (1981) suggest that developmental and environmental factors are the major determinants of these behaviors, with the endocrines playing a facilitating or contributory role.

Childhood experiences

Poor socialization, particularly a violent parenting style, will both facilitate the use of aggression as well as cut the youth off from access to more appropriate socio sexual interactions. Exposure to these unfortunate influences is also expected to instill a serious lack of confidence in the growing boy as well as strong feelings of resentment and hostility. These feelings and ineptitude will certainly not help the pubescent male acquire appropriate inhibitory controls over sex and aggression; indeed, they may serve to entrench quite the opposite dispositions.to secure an intimate relationship, the growing boy need the interpersonal skills necessary to interact effectively with females of his own age. A failure to effectively interact with others during adolescence, particularly within a socio sexual context, will lead to anxiety about such interactions, feelings of masculine inadequacy, and possibly anger toward those (particularly females) who are seen as the source of these problems. Social inadequacy, therefore, will not only increase stress and anxiety, which, tend to dis-inhibit sexual aggression, it will also produce attitudes (hostility toward females and feelings of inadequacy) which facilitate sexual offending. Consistent with this expectation, (Marshall & Barbaree 1989). Childhood social incompetence not only predicted adult social incompetence, it also predicted adult sexual pathology, including a proclivity to rape (Knight et al.,1983)

Socio cultural factors in child sexual abuse

Socio-cultural factor in child sexual abuse is family secrecy. In India, the business of the family stays in the family, especially with regard to any actions that are considered inappropriate or taboo (Choudhury 2006). This is because in India there are cultural elements of blame and shame (including in family systems), and families will go to great

lengths to protect the reputation of the family in the community (Baradha 2006; Choudhury 2006). It is also not unusual for children to be blamed for their own abuse, because the rights and statements of adults tend to trump those of children (Baradha 2006; Priyabadini 2007). Moreover, since the child's identity is rooted in the family's identity and standing in the community, anything that would embarrassment the family or tarnish their good name is kept private – in some cases even from, other immediate or extended family members (Patnaik 2007; Priyabadini 2007). This practice of secrecy only serves to protect the sexual perpetrator and allows the cycle of abuse to continue (Baradha 2006; Patnaik 2007). In addition, the parents or caregivers' refusal to believe the child is a victim of the sexual abuse or covering it up further exacerbates the child's distress (i.e., betrayal trauma) and prevents her or him from getting therapeutic help when needed (Priyabadini 2007).

According to Kacker and Kumar (2008), traditionally the care and protection of children in India has been the responsibility of families and communities. They may be correct in their observation that a strongly-knit patriarchal family system has seldom held the belief that children are individuals with their own rights. These authors note that, even though the Constitution of India guarantees many fundamental rights to children, these rights are more need-based than rights based, and the government has the challenging task of implementing constitutional and statutory provisions for children. Henceforth an increasing incidence of child abuse, India needs both legislation and large-scale interventions to address this problem". Widespread public education about child sexual abuse and exploitation is also sorely needed, especially in Indian schools and families (Deb and Mukherjee 2009; Priyabadini 2007).

Theory of sexual offending

Psychological approaches to what cause sexual assault have focused on the abuser rather than on the victim or the family. Psychologists have focused their attention on two levels: identifying a personality profile of sex offenders and on isolating the motivations of abusers. The search for a personality profile of sex offenders has focused on establishing the existence of fixed and stable personality traits that are predictive of sex offenders.

There have been four main multi-factorial theories of child sexual abuse,

1. Finkelhor's Four Precondition Theory (Finkelhor, 1984)
2. Marshall and Barbaree's Etiology and Risk Integrated Theory (Marshall & Barbaree, 1991).
3. Hall and Hirschman's Quadripartite Model of child molestation (Hall & Hirschman, 1992).
4. Ward and Siegert's Pathways models of child sexual abuse (Ward &Siegert 2002)

Child sexual abuse models

Finkelhor's Four Preconditions Model (1984)

The Four Preconditions Model asserted that four preconditions needed to be met in order for child sexual abuse to occur: (1) an offender with a predisposition to sexually abuse a child; (2) the ability to overcome any internal inhibitions against acting on that predisposition; (3) the ability to overcome external barriers, such as lack of access to the child or supervision of the child by others; and (4) the ability to overcome any resistance or reluctance on the part of the child. The offender predisposition was itself conceptualized as comprising three components, which were also to some extent preconditions: some emotional congruence to the act of sexual abuse with this particular child, the capacity for sexual arousal to this child

and this activity, and some blockage of his ability to get his emotional and sexual needs met in another way that would not involve a criminal activity.

Hall and Hirschman's quadripartite model of sexual aggression against children (1991)

This model is based on four components: physiological sexual arousal, cognitions justifying sexual aggression, affective dyscontrol, and personality problems. These serve both as motivational precursors that increases the probability of sexual aggressive behaviour occurring, and define offender and offence subtypes based on the relative prominence of each factor. Hall and Hirschrnan suggest that physiological, affective, and cognitive factors are all primarily state and situation dependent (state factors) while personality problems represent enduring vulnerability factors (a trait factor). This implies that they occur as a consequence of personality deficits, which are hypothesised to function as the source of offenders' vulnerability to sexually abusing children.

Marshall and Barbaree's Etiology and Risk Integrated Theory (1992)

This model states that, since, self-esteem appears to be largely determined in males, and particularly in young males, by their sense of their sexual ability, the young boy who cannot develop a relationship with a female may turn to aggressive sex or sex with children as a way of proving to himself that he is masculine.Biological inheritance confers upon males a ready capacity to sexually aggress which must be overcome by appropriate training to instill social inhibitions toward such behavior. Variations in hormonal functioning may make this task more or less difficult. Poor parenting, particularly the use of inconsistent and harsh discipline in the absence of love, typically fails to instill these constraints and may even serve to facilitate the fusion of sex and aggression rather than separate these two tendencies. Sociocultural attitudes may negatively interact with poor parenting to enhance the likelihood of sexual offending, if these cultural beliefs express traditional patriarchal views. The young male whose childhood experiences have ill-prepared him for a prosocial life may readily accept these views to bolster his sense of masculinity. If such a male gets intoxicated or angry or feels stressed, and he finds himself in circumstances where he is not known or thinks he can get away with offending, then such a male is likely to sexually offend depending upon whether he is aroused at the time or not. All of these factors must be taken into account when planning treatment of these men.

Ward and Siegert's Pathways model of child sexual abuse (2002)

The Pathways Model suggests that there are multiple pathways leading to sexual abuse of a child; it does not attempt to explain why child molestation may continue. Each pathway involves a core set of dysfunctional psychological mechanisms. In this sense, mechanisms are psychological processes that cause specific outcomes, effects or clinical phenomena. These mechanisms constitute vulnerability factors and are influenced by distal and proximal factors, including learning events, biological, cultural and environmental factors. In line with the previous three theories, the Pathways Model suggests that the clinical phenomena evident among child molesters are generated by four distinct and interacting psychological mechanisms: intimacy and social skill deficits; distorted sexual scripts; emotional dysregulation; and cognitive distortions. Each mechanism depicts a specific offense pathway with different psychological and behavioral profiles, and separate etiologies and underlying deficits. The number and type of etiologies will vary depending on a pathway's particular developmental trajectory. Although each pathway is hypothesized to be associated with a unique set of primary mechanisms and cluster of symptoms or problems, the mechanisms always interact to cause a sexual crime. That is, every sexual offense involves emotional,

intimacy, cognitive, and arousal components, However, each distinct pathway will have at its center a set of primary dysfunctional mechanisms that impact on the others. The primary causal mechanisms involve other types of mechanisms in order to generate the range of symptoms typically seen in child molesters. But these additional causal mechanisms may be functioning normally and only exert a dysfunctional effect because of the driving force of the primary set of mechanisms.

Consequences of child sexual abuse

The effects of child sexual abuse are wide ranging, including physical effects, psychological effects, sexual effects and interpersonal effects.

physical effects

According to Leserman (2005) physical effects include chronic and diffuse pain, especially abdominal or pelvic pain. Adults abused as children are four to five times more likely to have abused alcohol, illicit drugs, twice as likely to smoke, be physically inactive, be severely obese, experience self-neglect and eating disorders. (Felliti et al.,1998)

Psychological effects

Child sexual abuse has a definite effect on the victim's mental health in their late adulthood. The trauma is thought to be reflected not only in sexual distress as an adult, but in difficulties with trust, feelings of stigmatization, and powerlessness (Finkelhor & Browne, 1985).

Child sexual abuse (CSA) may hinder proper growth and development (Cicchetti and Toth 2006; Goodman et al. 2010) and place children at risk for a host of mental health disorders, including but not limited to: anxiety, depression, anger, cognitive distortions, posttraumatic stress, dissociation, identity disturbance, affect dysregulation, interpersonal problems, substance abuse, self-mutilation, bulimia, unsafe or dysfunctional sexual behavior, somatization, aggression, suicidality, and personality disorders (Briere and Lanktree 2008; Deb and Mukherjee 2009, 2011; Goodyear-Brown 2011)

Coffey et al (1996) studied the relation between methods of coping during adulthood with a history of childhood sexual abuse and current psychological adjustment" with 192 women who had been sexually abused during childhood, and revealed that disengagement methods of coping were used more often to deal with the stressful aspects of having been sexually abused than to deal with other stressful events. In contrast, engagement methods of coping were used more often to deal with the other stressors than with sexual abuse.

Turner et al (2005) studied 14564 participants drawn from the National Epidemiological Survey on Alcohol and Related Conditions (NESARC) with the participants limiting to males aged 20 years and older on the relationship between childhood sexual abuse and mental health outcomes among males from a nationally representative United States sample revealed emotional abuse, physical abuse, and exposure to intimate partner violence were the most common forms of maltreatment that co-occurred with child sexual abuse among males. Child sexual abuse among males commonly co-occurs with other types of maltreatment, which is important knowledge for health care providers and to inform effective intervention strategies.

Canton-Cortes D, Canton J (2010) studied 138 victims of child sexual abuse and another 138 participants selected as a comparison group on the role of continuity of abuse and relationship with the perpetrator to examine the effects of child sexual abuse (CSA) on the use of coping strategies and post-traumatic stress disorder (PTSD) scores in young adults, as well as the role of avoidance and approach coping strategies in those PTSD scores in child sexual abuse victims .The study revealed that child sexual abuse is a high-risk experience that can affect the victim's coping strategies and lead to PTSD to a lesser or greater extent depending on the coping strategy used. Moreover, the role of these strategies varies depending on whether or not the participant is a victim of child sexual abuse and on the characteristics of abuse (continuity and relationship with the perpetrator).

Sexual effects

It includes early adolescent or unwanted pregnancy and prostitution. Gynecologic problems including chronic pelvic pain, dyspareunia, vaginismus and non-specific vaginitis (Noll et al 2005; Wilson & Widom, 2010)

Interpersonal effects

The American College of Obstetricians and Gynecologists (1999) states that survivors of child sexual abuse may be unable to trust or establish rapport with adults. Some women blame themselves for the abuse and come to believe that they are not entitled to assistance from others. Thus, they risk continuing to enter abusive relationships.

Role of preventive interventions to combat child sexual abuse

A public health model portrays sexual abuse as a "disease" and attempts to alter the interaction between the agent (perpetrator), host (victim), and the environment (community, society). The public health approach also advocates a focus on primary prevention strategies directed toward the public at large. The goal of primary prevention is to prevent a problem from ever occurring, and services are offered to everyone, regardless of risk status. One way to prevent the occurrence of sexual victimization is by educating parents, children, schools, and the community at large about child sexual abuse (Anderson et al.,2004).In the field of child maltreatment, the goals of preventive interventions are to reduce risk factors associated with the child and neglect, to improve the outcomes of individuals or families exposed to such risk factors, to enhance compensatory or protective factors that could mitigate or protect the child from the effects of victimization. Understanding the magnitude of the problem of sexual abuse, the legislative bodies of various countries have passed many ordinances, stringent laws to prevent children becoming victims of sexual abuse. Research driven approach is essential to combat the problem of sexual abuse. Various organizations and NGO's engage in research work, prepare prevention strategies, and have given powerful intervention models to prevent child sexual abuse. They work with the communities, governments and the public health system to improve health outcomes of vulnerable children.

CONCLUSION

It is important to work with growing children and adolescence to impart knowledge on sexual, reproductive and mental health. Prevention strategies would help children help themselves to protect them from sexual abuse. Prevention strategies against sexual abuse would involve children's knowledge, awareness and early developmental experiences. Imparting clear knowledge in children about prevention strategies for sexual abuse will give them insights to act in an informed way to protect themselves from sexual abuse.

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