

## SEXUAL ABUSE IN CHILDHOOD : A REPORT OF FOUR CASES

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### ABSTRACT

*Sexual abuse of children and adolescents is prevalent across all cultures. Sexual abuse often begins in infancy or toddler stage for many children. A Child's developmental level influences the detection and disclosure of sexual abuse. Pre school children very rarely make verbal disclosures, but may present with behavioural and physical symptoms. Older children may make a conscious decision to reveal the abuse, but often feel that they risk their safety in making a disclosure. This paper reports four cases of sexual abuse detected in a clinic during a period of 12 months. The age group of these children ranged between 4 - 12 years.*

*Key words : Sexual abuse, Level of development*

### INTRODUCTION:

Sexual abuse of children became a topic of scientific enquiry at the end of the nineteenth century when Freud (1886) discovered that many of his patients had been molested or sexually victimized during childhood by adults or older siblings. The resulting seduction theory implicated sexual abuse in the aetiology of neuroses.

The abuse of children remained a relatively neglected subject until the production of Kempe et al's (1962) classic paper, "the battered child syndrome, ". This paper generated a public upheaval in the United States, which led to the enactment of child abuse reporting laws in every state. It was not until a decade later that child care and mental health professionals began to direct their attention to the problem of child sexual abuse. Prevalence rate of sexual abuse has been studied in the United States and Canada during the past decade and it has been quite alarming. Russell (1983) reported that 38% of a random sample of 930 adult women had experienced unwanted sexual contact before the age of 18. A Canadian survey, Badgley et al (1984), of 10006 females and 10003 males documented prevalence rates of 34% and 13% for the females and males respectively. In Russell's (1983) study, only 2% of the intra familial and 6% of the extra familial cases were reported to the police or child protective services.

Awareness of child abuse, especially sexual abuse as a frequently occurring problem in families has been given some recognition only in the last decade in India. Jain et al (1992) reported sexual abuse in childhood, associated with psychiatric morbidity in their patients. The lack of awareness and even the misconception that our cultural beliefs and joint family system, act as protective factors to our children have made us complacent and thus turn a blind eye towards this problem existing in our society. The paediatricians as well as the psychiatrists have not yet become proficient in addressing these issues. We are reporting four cases of sexual abuse in childhood which were seen in our clinic during the course of one year in order to draw the attention of the professionals to the existence of this problem in our culture also and to highlight some of the difficulties encountered in the psychiatric assessment and management of these cases.

### CASE SUMMARIES:

#### Case 1:

S.A. was a 4 years old female child, who was referred from the department of dermatology with history of suspected sexual abuse. She was originally seen in the department of child health with history of vaginal discharge and referred to dermatology after gonococcal vaginitis

was detected. S.A. lived with her family which consisted of her parents, younger brother, grand parents, uncle and a married aunt. Father reported that the child attended kindergarten and was always accompanied by an adult, when outside home. The child was previously assessed for developmental delay in our department and was found to be mildly retarded.

During the interview, her parents and aunt, who were the main caretakers of the child, denied any chance of the child having sexual contact with any of the family members. They felt that the child was indiscriminate at times in her behaviour towards strangers, but there was no chance of abuse according to them, since an adult was always with her.

The parents and aunt repeatedly denied any possibility of genital contact. She was referred for a genital examination and there was no evidence to suggest sexual penetration although copious discharge was present at the time of examination.

The family stayed in the centre of the town, where houses are crowded together and the boundaries of each house is undemarcated. The possibility that the child could have been abused by someone outside the family, who subscribed to the belief that sexual contact with a virgin would cure venereal disease was considered but could not be investigated further because the family stopped coming to the clinic.

#### **Case 2:**

CD was a 7 year old girl who was brought for psychiatric assessment by her parents. They reported that the child was having increased frequency of micturition. They were also concerned that she was over-familiar and seductive in her behavior towards strangers. Parents reported that the child was living with her father's sister while the rest of the family lived abroad. During the holidays, when the parents had come home, they noticed that she was frequently wetting herself and some times she was passing urine in different parts of the house. When the mother scolded her for her behaviour, the child

revealed to her that her aunt's brother-in-law had been sexually molesting her on many occasions. Child was examined for urinary tract infection and treated. Parents have taken her with them since this incident, but they find her seductive behaviour towards her father's male friends embarrassing. They are afraid to leave her younger sibling with her in case she shows any sexualized behaviour towards her.

During interview, CD was found to be a tall obese girl, who looked older than her chronological age. She was cheerful and friendly and communicated well during the interview. Since the family was going back to their place of work, only two sessions could be conducted. The child did not reveal anything about her experience of sexual abuse during these interviews.

#### **Case 3:**

R.J. was seven years old when she was brought by her mother to the clinic. Her mother reported that R.J. was noticed to be indulging in sexual play with her younger brother. When scolded, R.J. told her mother that her uncle (father's brother) had indulged in similar behaviour with her. This disclosure produced severe conflict in the family. The father accused the mother and child of lying about the incident. The father's family members do not visit them any more, and the mother blames R.J. for this conflictual situation in the family. She suspects that R.J. might have encouraged her uncle in some manner which made him make sexual advances towards her.

#### **Case 4 :**

S was a 10 years old girl, who was referred from department of child health with complaints of recurrent attacks of abdominal pain and deteriorating academic performance. Investigations revealed the presence of gonococcal infection of the urinary tract. She was referred to psychiatry as a case of probable sexual abuse. S was a thin quiet girl, small for her age. Father alone came with the patient. He reported that she was staying in her maternal grandfather's house along with her uncle and aunts, since it

was more convenient for her to go to school from there.

Father denied any chance of sexual abuse but he was not willing to bring any of the other family members for the interview. Mother attended one session but refused to consider any chance of the child having had sexual contact. During the session with the child, she was found to be withdrawn and uncommunicative. Both the parents were told about the definite chance of sexual contact. The child was removed from the grandparent's home. During the later sessions, she continued to remain withdrawn, but there were no reports of any physical symptoms.

### DISCUSSION:

The four children described came from different family backgrounds, and from different socio-economic strata. In all the four cases, after the initial contact, further investigations and follow up were difficult and almost made impossible because of the resistance on the part of those closely involved. They had difficulty in accepting the occurrence of sexual abuse in the family and used denial to reduce their anxiety. Fear of social stigma to the child and the family that might result from the disclosures also contributed to the families' reluctance to cooperate.

In the first case, the child is mildly retarded, living in a joint family setup, in a crowded environment where privacy of a family is often not well guarded. In the case of the second child, urinary symptoms, especially enuresis which is a common presenting symptom in children with history of sexual abuse brought her to medical attention. A victim of sexual abuse or molestation may behave in a seductive manner, which often results in the child being blamed as having provoked the perpetrator. In the case of the third child, the child's reported sexualized behavior towards the younger sibling led to her revealing the fact that she was sexually molested by a family member. This produced a conflictual situation in the family with the mother blaming the patient for this, which exemplifies why many

of the cases go unreported. Withdrawn, uncommunicative behavior with physical symptoms is often observed in children after sexual abuse as was seen in the child described in case 4.

Finkelhor and Browne (1986) described four traumatogenic factors-traumatic sexualisation, powerlessness, stigmatisation and betrayal. "Traumatic sexualization" happens as a result of sexual stimulation and there is a reinforcement of the child's sexual responses. The child learns to use sexual behaviour to gratify numerous non-sexual needs. This leads to inappropriate and premature sexual activity. There is a sense of "powerlessness" referring to helplessness during the sexual assault leading to fear and anxiety. "Stigmatization" describes the child's sense of being damaged and blamed for the molestation which may be reinforced by peers and family members. This leads to stigma, guilt and low self esteem. "Betrayal" refers to child's development of disillusionment when sexually assaulted by a trusted parent or care giver. Betrayal leads to generalized distrust of others, hostility and anger. These factors are found to be present in these four children also when their histories are taken together.

Green (1988) described a temporal and developmental perspective to account for the occurrence of immediate and long term sequelae. He described sexual abuse as the repeated infliction of aggressive and sexual stimulation superimposed on a chronic background of pathological family interaction. The acute sexual assault includes traumatic sexualization and powerlessness and produces fearfulness and anxiety-related symptoms and dissociative reaction that satisfy the criteria for post traumatic stress disorder. The underlying chronic family dysfunction results in feelings of stigmatization, betrayal, guilt, low self esteem, mistrust, depression and pathological defenses. The interaction between the acute and long term variables is likely to potentiate their pathological impact.

Although there is consensus in the field

regarding typical immediate and long term psychological sequelae in sexually abused children, such as PTSD, depression and conduct problems, they are not always present and these symptoms are frequently displayed by non-abused children also. Abnormal sexual behaviour, although quite common after asexual abuse, can also be caused by non-abusive events such as witnessing sexual activity or sexual over stimulation or may be a reflection of severe psychopathology. There are no behavioural patterns which are specific for child sexual abuse. Because of its heterogenous nature, sexual abuse may be defined as an event rather than as a psychiatric syndrome or disorder (Green 1993)

Because of the reluctance of the families to come for followup visits, the short or long term outcome of these cases could not be studied. However it is believed that in a given case of sexual abuse the nature and progression of symptoms will depend on the following variables.

1. Age and developmental level of the child.
2. The Child's pre existing personality and resiliency.
3. Onset, duration and frequency of molestation.
4. The degrees of coercion and physical trauma.
5. The closeness of relationship between the child and the perpetrator.
6. The degrees of the family's response to the disclosure.
7. The nature of institutional response to the abuse.
8. The availability and quality of therapist intervention.

In cases where the severity of the abuse is minimal and the child is resilient and supported by his or her own family, the child might not be

harmed or the impact would be slight and reversible. Follow up studies of sexually abused children would provide data regarding reversibility of the sequelae.

#### References:

**Badgley, R, Allard, H and McCormick** (1984). *Sexual Against Children*. Vol 1. Ottawa. Canadian Government Publishing Centre.

**Freud, S.** (1896). *The Etiology of Hysteria*. The standard edition of the Complete Psychological Works of Sigmund Freud. Vol: 3, 191-221 London : Hogarth

**Finkelhor, D and Browne, A.** (1986). *Initial and long term effects: A conceptual framework*. In *A Source book on Child Sexual Abuse - New Theory and Research*, (ed. D. Finkelhor) Beverly Hills, CA, Sage.

**Green, A.H.** (1988). *Child maltreatment and its victims. A comparison of physical and sexual abuse*. *Psychiatric Clinics of North America* 11, 591-610.

**Green, A.H.** (1993). *Child sexual abuse - Immediate and long term effects and intervention*. *Journal of the American Academy of Child and Adolescent Psychiatry* 32, 890-900.

**Jain, S; Vythilingam M; Eapen V and Reddy J.** (1992). *Psychotherapy and childhood sexual abuse*. *Indian Journal of Psychiatry* 1992, 34, 388-391.

**Kempe,C.H., Silverman, F.N; Steele, B.F., Droegemuller, W and Silver, H.K.** (1962) *The battered child syndrome*. *Journal of the American Medical Association*, 181, 17-24.

**Russel, D.E.** (1983). *The incidence and prevalence of intra familial and extra familial sexual abuse of female children*. *Child Abuse and Neglect* 7, 133-146.

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