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Child Sexual Abuse Risk Factors, Outcomes, and Protective Factors in India: A Conceptual and framework model.

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Abstract

Until recently, academic research in India was primarily concerned with crimes against females of reproductive age, such as rape or sex trafficking, while downplaying sexual abuse of pre-pubertal or adolescent boys and girls. However, in recent years, child sexual abuse has been recognised and reported as a criminal justice issue, with an increasing number of such incidents being published in the country. This article proposes a conceptual framework delineating the risk factors, outcomes, and protective factors of child sexual abuse in India based on a systematic review of the existing literature. The paper concludes with policy and research implications.

Key words: Child Sexual abuse, Disclosure, Perpetrator characteristics, Systematic review

Introduction

Child sexual abuse (CSA) is one of the most common, yet under-reported, forms of violence against children worldwide (Pellai & Caranzano, 2015). Pereda, Guilera, Forns, and Gomez-Benito conducted a worldwide study among students and the community in 2009 to determine the prevalence of child sexual abuse. The analysis of data from 22 countries revealed that CSA is a serious problem all over the world. According to the data, nearly 7.9 percent of men and 19.7 percent of women have experienced some form of sexual abuse before the age of eighteen. The problem of CSA, which is widely underreported, has global prevalence, regardless of socioeconomic difference among various nations. Every year, millions of children are subjected to various types of sexual abuse without ever entering the criminal court system. Until recently, academic study had been focused with crime against females of reproductive age (mostly rape or prostitution), dismissing sexual abuse of pre-pubertal or adolescent boys and girls. However, CSA is now being acknowledged as a criminal justice concern, with more occurrences being discovered and recorded. In light of this, this systematic study aims to identify the risk factors for CSA in India and offers a conceptual framework emphasising CSA preventive strategies.

What is Sexual Abuse?

According to World Health Organization's Violence and Health in the WHO African Region Report (2010), 'sexual abuse is the involvement of a child in any kind of sexual liaison that he/she is unable to comprehend fully, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society'. Broadly, sexual abuse is classified into four categories: non-contact, non-penetrative contact, penetrative contact, and internet-based sexual abuse (Figure 1). Non-contact sexual abuse includes any verbal or non-verbal references to sexual matters such as implicit or explicit invitations for sexual liaisons, being exposed to genitals, sexual acts, or sexually explicit materials, or being asked to reveal own genitals to someone else. Non-

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penetrative contact abuse comprises of being kissed or fondled sexually, caressing others' genitals or masturbating someone else or watching somebody masturbate, while attempting intercourse, oral intercourse, anal intercourse, and genital intercourse come under the preview of penetrative contact abuse (Elklit, 2015). The growth of the world wide web has exposed children to a new hazard of internet-based CSA comprising of creating, depicting or distributing sexual images of children online, stalking, grooming and engaging in sexually explicit behaviour with children through the internet (Pellai

Caranzano, 2015). Sexual abuse may be a single sporadic incident or multiple episodes occurring in succession (Behere, Rao, & Mulmule, 2013). Similarly, a child may be exposed to repeated abuses by different individuals during his/her childhood. Bhaskaran & Sheshadri (2016) rightly pointed out that CSA is an experience and not a disorder. Hence, it is challenging to detect CSA as some of the victims may manifest a wide variety of symptoms while the others may be asymptomatic (Bhaskaran & Sheshadri, 2016; Cromer & Goldsmith, 2010). Research suggests that sometimes initially asymptomatic sexually abused children may develop severe psychiatric disorders years after the trauma (Aydin, Akbas, Turla, Dundar, Yuce & Karabekiroglu, 2015). Any sudden change in the behavior of a healthy child may be suggestive of a probable abuse, and the parents must look out for following verbal, bodily, emotional, and sexual symptoms among the children (Jensen, 2005). The presence of any one or more traits may indicate a probable incident of sexual abuse. The self-disclosure of CSA is the best diagnostic tool to report a CSA. However, an explicit verbal disclosure of abuse is quite rare and may be quite indirect, which the caregivers may find difficult to decipher. Further, sudden changes in child's stimuli may also hint at the probable incidents of sexual abuse such as the presence of enuresis, encopresis, stomach aches, headaches, and so on. Sometime, sudden aversion towards certain food items such as yogurt or milk also may be suggestive of CSA (Jensen, 2005). Similarly, parents must watch out for any abrupt behavioural changes in their children, such as mood swings, frightening or anxiety reactions, bizarre behaviour, or refusal to meet or visit any specific individual as these may be indicative of probable CSA. Other subtle signs of a likely CSA are masturbation in children, sexualised play with dolls, sexual experimenting with other children, or drawing pictures or images of sexual acts.

Child Sexual Abuse in India

India has the world's most significant number of CSA cases every year. One out of every ten children is a victim of CSA in India at any given point of time (Virani, 2000). Behere et al. (2013) found that every second child is prone to one or the other forms of sexual abuse such as eve-teasing, molestation, sexual violence, etc. and every fifth child faces critical forms of CSA in the country. According to the Childline India (2014), every 155th minute a child less than 16 years of age is raped, for every 13th hour child below 10, and one in every ten children is a victim of CSA. Tata Institute of Social Sciences undertook the first ever study on child sexual abuse in Mumbai in 1985 among the adults aged twenty and twenty-four (Virani, 2000). The results of the survey revealed that one out of three girls and one out of every ten boys had been victims of CSA and half of these abuses happened at home. Later in the year 1996, a group of medical practitioners carried out a research study to find the prevalence of CSA among 348 girl students from eleven schools and colleges in Bangalore. The results revealed that 15 percent of the sample was sexually abused as children inclusive of being subjected to rape, forced into oral sex or penetrated with foreign objects, and so on. The family members or relatives inside the

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households were the most common perpetrators. In the year 1998, Recovery and Healing from Incest (RAHI) conducted a nationwide survey among 600 English speaking middle and upper-class women to find the prevalence of CSA. Around 76 percent of these women revealed being sexually abused in their childhood. In more than fifty percent of the cases, the perpetrator was a familiar person including family members or relatives. The Tulir-Centre for Prevention and Healing of Child Sexual Abuse (CPHCSA) also carried out a large-scale survey to find the prevalence of CSA among 2211 school going children in Chennai in the year 2006. The study revealed that, irrespective of their socioeconomic backgrounds, around 42 percent of the children had been sexually abused.

Outcomes of Child Sexual Abuse

CSA is one of the most heinous forms of crime against children prevalent worldwide. CSA has been found to be detrimental for the affected children and leads to severe dysfunction among the victims. Although it is quite difficult to estimate the damages cost to the children, the socioeconomic prices are profound. Some of the common physical outcomes of CSA include, but are not limited to, pain, discoloration, sores, cuts, bleeding or discharges in the genitals, anus or mouth, persistent or recurring pain during urination and bowel movements, gynecologic conditions, gastrointestinal problems, and so on. For many children wetting and soiling accidents are the allusive outcome of CSA (GHPPHS, 2012; Seth, 2015). CSA is also associated with subsequent sexual victimisation, unwanted pregnancy and HIV transmission (Meinck et al., 2015). Further, CSA also results in a range of long-term adverse sexual outcomes for the victims such as sexual inhibition, sexual avoidance or aversion, and vaginal or pelvic pain to sexual dis-inhibition, compulsive or impulsive sex, risk-taking sexual behaviours, and numerous sequential or simultaneous sexual partners. The experiences of CSA lead to multiple adverse outcomes for children, paralysing the victims' minds more than their bodies (Berkowitz, 1998; Cromer & Goldsmith, 2010; Elklit, 2015; Johnson, 2004; Matiyani, 2011; Meinck et al.,
2015). Post-traumatic stress disorder, delinquency, academic difficulties, low self-esteem, withdrawal, conduct disorders, substance abuse, depression, anxiety, suicidal ideation and personality disorders are not uncommon among the victims. Victims of CSA may experience avoidance, dissociation or denial which could have initially developed as adaptations to the abuse. The severity of the mental health outcome is dependent upon the age of the onset, the duration of the abuse, relationship with the perpetrator, as well as the kind of abuse – penetrative or non-penetrative (National Child Traumatic Stress Network Child Sexual Abuse Committee, 2009; Ventus, Antfolk, & Salo, 2017). The outcomes of incest or abuse perpetrated by close kin are more devastating as victims may find it difficult to trust others in their social network forever which in turn jeopardizes their recovery post abuse. Research suggests in cases of violence by the known person, the dilemma to report or not to communicate further aggravates the trauma (Durham, 2003). The experience of CSA is often emotionally paralysing for the victims and many victims fail to recover throughout their life. Unfortunately, CSA has a cyclical effect, and CSA victimisation does appear to be a risk factor for future perpetration (Becker & Murphy, 1988; Bhaskaran & Sheshadri, 2016). In their study of 224 male victims of CSA, Salter et al. (2003) found that around 12 percent had official records of perpetrating a sexual offense against children (cited in Cromer & Goldsmith, 2010). However, the model of a victim-perpetrator cycle has been found to be relevant for the males, but not for the females (Glasser, Kolvin, Campbell, Glasser, Leitch, & Farrelly, 2001; Virani, 2001).

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Laws and Legislation concerning Children in India

Before 1986, each state in India had its enactment of juvenile justice with children being treated differently by the respective state legal systems. The Juvenile Justice (JJ) Act of 1986 was the first central legislation concerning juveniles passed by the Union Parliament of India in the year 1986. With the inception of the JJ Act in the year 1986, India became the first country in the world to have introduced a universal juvenile justice, the law that covered both children in need of care and protection, and children who come in conflict with the law under its preview. The JJ Act ensured protection for children in difficult circumstances. In the history of legal jurisprudence in the country, protection of children came to be viewed as an integral part of social justice as well as the justice delivery system. The JJ Act 1986 however, was discriminating in nature. It was applicable for girls till they attained majority, i.e., up to eighteen years of age, while for boys the age limit was only sixteen years. In the year 2000, the JJ Act (1986) was repealed and the Juvenile Justice (Care and Protection of Children) Act, 2000 came into being. It was later amended in 2006 to build on minimum standards of care and protection as part of justice delivery and to strengthen the existing child protection mechanisms. The Act underwent further amendment in 2010 to end the segregation of disease-hit children from other occupants within child care institutions. This JJ Act of 2000, with modifications made in 2006 and 2010 is followed till date. The JJ (C & CP) Act 2000, amended in 2006 and 2010, internalises the Constitution of India (as prescribed in Article 15 (3), Article 39 (e) and (f), Articles 45 and 47); the United 18 Nations Convention on the Rights of the Child, 1989; the UN Standard Minimum Rules for the Administration of Juvenile Justice, 1985 ('the Beijing Rules'); the UN Rules for the Protection of Juveniles Deprived of their Liberty, 1990; the UN Guidelines for the Prevention of Juvenile Delinquency, 1990 ('The Riyadh Guidelines'); the UN Standard Minimum Rules for Non-custodial Measures, 1990 ('The Tokyo Rules'); and many other international conventions/treaties and instruments. The current JJ Act is highly progressive legislation that has as its primary focus the protection of the best interests of the child. This law covers all children less than eighteen years of age. It provides for appropriate care and protection of the children by catering to the child's needs and rights by adopting a child-friendly approach in the adjudication and disposition of the cases relevant to the children. The focus of the Juvenile Justice Law in India, as it currently stands, centres on the protection of the dignity of the child and ensuring their access to their rights, security, and rehabilitation through State responsibility and action.

Protection of Children from Sexual Offenses (POCSO) Act, 2012

Until 2012, the only sexual offenses against children recognised by the law were covered by three sections of the Indian Penal Code (IPC) not specific to children. Only three kinds of crimes viz., rape (sexual intercourse without consent – section 376), outraging modesty of a woman (unspecified acts – section 354) and unnatural acts defined as 'carnal intercourse against the order of nature with any man, woman or animal' (anal sex, homosexuality or bestiality – section 377) were treated as severe and registered and reported in the annals of the law enforcement. Other forms of non-penetrative sexual assaults, harassment and exploitation were not explicitly recognised as crimes and therefore not recorded (assuming if they were reported). The 2007 National Study on Child Sexual Abuse highlighted the wide prevalence of child sexual abuse in the country and the dire need of specific legislation to deal with these abuses. After years of deliberation, the Government of India passed the first ever specialised legislation on the 'Protection of Children against Sexual Offenses

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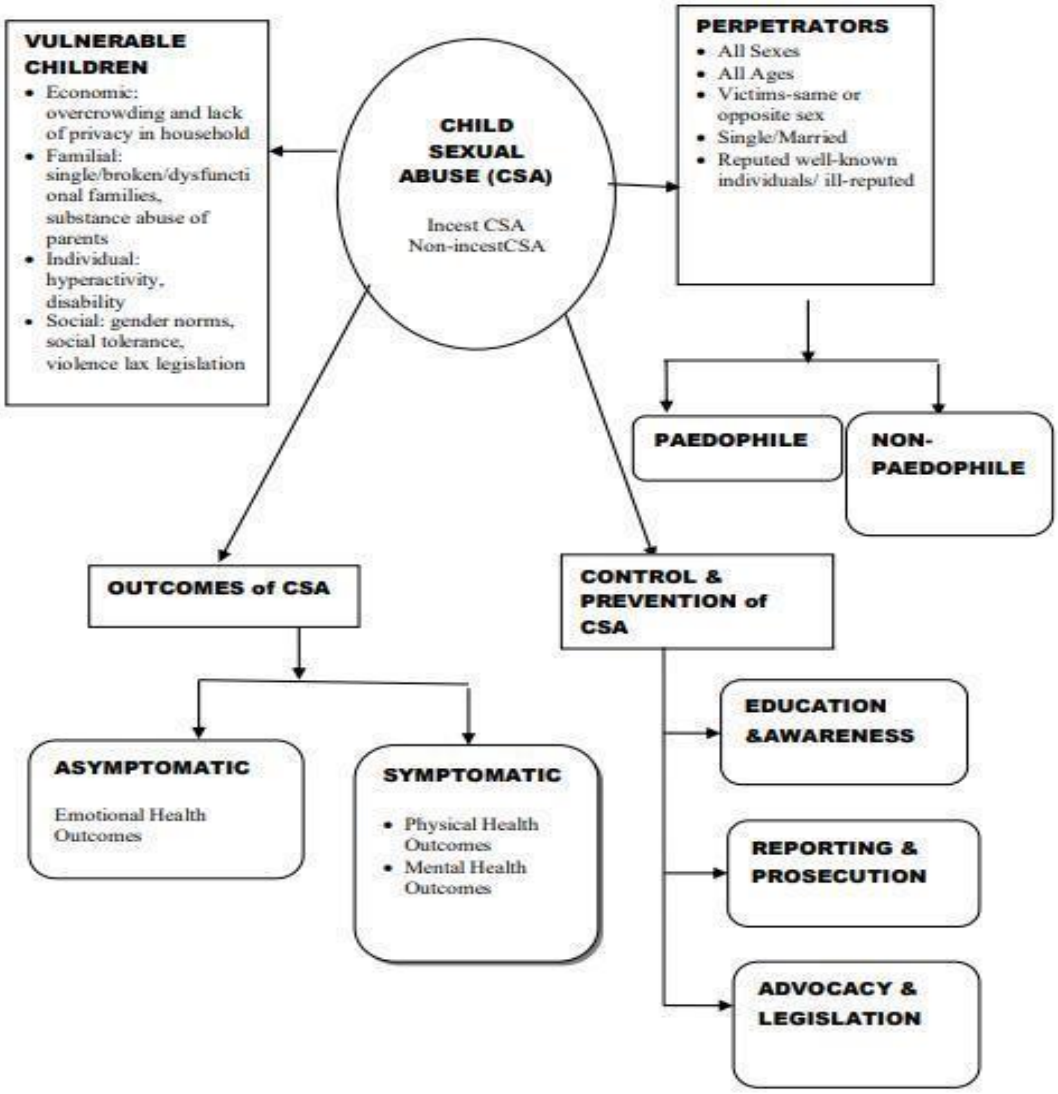

Figure 1. The conceptual framework representing risk factors, outcomes, and protective factors of child sexual abuse.

(POCSO) Act' in the year 2012. The POCSO Act criminalises all sexual offenses against a child (under 18 years of age) namely penetrative, non-penetrative, genital, non-genital, touch and non-touch based including internet-based abuses and is gender neutral (The POCSO Act, 2012). The Act requires mandatory reporting of child sexual abuse by doctors and other professionals. The POCSO Act emphasises incorporating child-friendly mechanisms for reporting and recording of evidence. It also attempts to safeguard the interests of the child at every stage of the judicial process of investigation such as the speedy disposal of trials through the designated Special Courts. The law is very stringent and comprehensive as even the intent to abetment is punishable under the POCSO Act and the onus of the acquittal rests with the accused and not on the victim.

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Conclusion

Child sexual abuse is a serious form of violence against children which has several detrimental outcomes on the growth and development of the child victims. Besides the physical violation of the genitals, the victims of CSA are found to suffer from severe emotional and psychological outcomes. The victims of CSA need rigorous medical and psychological assistance for recovery and reconstruction. Sometimes, the trauma of CSA may last forever. However, CSA is not taken as a serious health hazard violating the rights of the children. The exposure to CSA strongly interferes with the growth and well-being of children, hence, this review strongly advocates in favor of strict intervention measures for the prevention of CSA. The results of the review reveal that research in the Indian context on CSA are in nascent stage; hence, the review recommends undertaking research on different aspects of CSA such as victim or perpetrator characteristics, disclosure of CSA, effective prevention and intervention measures for CSA, and so on. The review further suggests that children from dysfunctional or broken families are quite susceptible to CSA; hence, the sensitisation material on CSA must include the probable role of dysfunctional or broken families in aggravating vulnerability to CSA. It is found that the current research is basically victim-centric, i.e., the popular subjects of research are charactertics of the victims of CSA, outcomes of CSA, disclosure pattern of CSA and so on. The perpetrator-centric studies are virtaully absent; hence, the review advocates for more research centering around perpetrators in order to design suitable intervention and sensitisation material for CSA prevention. Further, the perpetrators are often related to the victims and incidents take place in and around the homes of the victims; hence, sensitisation programmes for the public regarding this may come in handy in preventing a potential episode of CSA. Little sensibility and insight can help an individual detect a prospective victim and save many lives from the scourge of CSA. Further, the government must promote research prima facie on crime sites, context, space/location, information on the background of the victims and the perpetrators to generate more data which will aid in policy formation and development.

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