IntechOpen

Sexual Abuse

An Interdisciplinary Approach

Edited by Ersi Kalfoğlu and Sotirios Kalfoglou

Sexual Abuse - An Interdisciplinary Approach

Edited by Ersi Kalfoğlu and Sotirios Kalfoglou

Published in London, United Kingdom



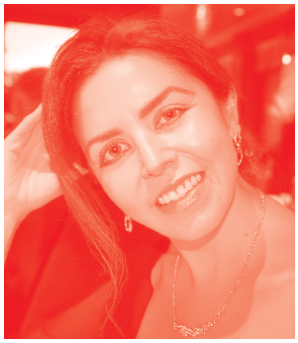




IntechOpen





Supporting open minds since 2005

Sexual Abuse - An Interdisciplinary Approach
http://dx.doi.org/10.5772/intechopen.90974
Edited by Ersi Kalfoğlu and Sotirios Kalfoglou

Contributors
Sara Spowart, Shewli Shabnam, Tara Shuman, David A. McLeod, Zackery D.O. Dunnells, Burcu Ozturk, Dudana Ahmed, Susan Garcia, Dheeshana Jayasundara, Prita Das Gupta, Sarah Thao, Heather Bacon, Susan Richardson, Charol Shakeshaft, Mitchell Parry, Syeda Saima, Eve Chong, Naijia Lindh, Hans Saint-Eloi Cadely, Tiffani Kisler, Nyuiemedi Agordzo Edoh-Torgah, Marien Matafwali, Ersi Kalfoglou, Sotirios Kalfoglou, Taner Güven

First published in London, United Kingdom, 2022 by IntechOpen
IntechOpen is the global imprint of INTECHOPEN LIMITED, registered in England and Wales, registration number: 11086078, 5 Princes Gate Court, London, SW7 2QJ, United Kingdom
Printed in Croatia

British Library Cataloguing-in-Publication Data
A catalogue record for this book is available from the British Library

Additional hard and PDF copies can be obtained from orders@intechopen.com

Sexual Abuse - An Interdisciplinary Approach
Edited by Ersi Kalfoğlu and Sotirios Kalfoglou
p. cm.
Print ISBN 978-1-83969-397-7
Online ISBN 978-1-83969-398-4
eBook (PDF) ISBN 978-1-83969-399-1

Meet the editors

Prof. Ersi Abacı Kalfoğlu obtained a Ph.D. in Forensic Sciences, following a graduate degree in Medical Biochemistry. She taught at the Institute of Legal Medicine and Forensic Sciences, Istanbul University, as a full-time professor for 20 years. Currently, she is the head of the Forensic Medicine Department, Medical Faculty, İstanbul Yeni Yüzyıl University. She also directs the Institute of Health Sciences at the same university. Sexual assault is her specialty and she has authored numerous journal articles on the subject.

Sotirios Kalfoglou studied Political Sciences and International Relations at the University of Marmara, Istanbul, Turkey. Following his undergraduate studies, he obtained his graduate degree from the Terrorism, Security and Policing Program, Criminology Department, University of Leicester, England. Currently, he is lecturing Criminology at Istanbul Yeni Yüzyıl University where he is the general coordinator of the Forensic Sciences Laboratory of the Medical Faculty.

Contents

Preface

Sexual crime is a global public health problem that affects the lives of numerous individuals. A multidisciplinary effort involving many professionals is required to prevent these types of crimes. The establishments involved in sexual assault case identification and victim rehabilitation include the legal system, medical institutions, and law enforcement. In addition to the lawyers, prosecutors, and judges of the legal system, medical experts are often involved as well. It is essential for all parties to be well informed and cooperate in order to deal with cases of sexual assault.

Correct and effective coordination of the various parties is integral to dealing with cases of sexual assault. Any case of this type should involve both identification of the perpetrator and rehabilitation of the victim. Specifically, shame and embarrassment, self-blame, and fear of exposure are among the problems that survivors encounter. Thus, victim rehabilitation should involve supportive care in a healing environment. Various medical specialties that should be involved even in a single case are forensic pathology, gynecology, pediatrics, forensic psychiatry, clinical psychiatry, physiology, dentistry, forensic toxicology, and forensic genetics. The coordination of all these is a seriously difficult task and the victims frequently complain about being re-victimized following the disclosure of an assault. Although most countries around the world have made serious efforts to prevent sexual crime, it is difficult to find a model where the goal has been reached. Therefore, researching and publishing on the subject is challenging.

In general terms, the main target is to achieve an effective prevention program to find a definite solution to the social problem. However, this is extremely difficult due to numerous factors, one of which is the fact that diverse cultures require different strategies to cope with sexual violence. Therefore, a single model will not be suitable for all cases, and societies need to develop their own strategies according to their own needs.

The standardized, objective, timely, and compassionate management of sexual assault in the interdisciplinary approach employed in this book will provide data helpful for civil or governmental authorities to organize prevention strategies.

This book is a compilation of chapters on the multidimensional and highly complicated problem of sexual crime to help facilitate a solution. It brings together the work of distinguished scholars from diverse academic disciplines. It is organized into two sections: “The Behavioral Aspects of Sexual Crimes” and “Responding to Sexual Abuse/Assault”.

In the first section, there are chapters on female offenders in child sexual abuse, school employees as perpetrators, marital rape in different categories of cultures, and women’s empowerment in the context of sexual violence in India. The section also addresses cyber-digital relationship abuse as a new form of dating violence.

In the second section, chapters address child abuse in various countries, intervention strategies for promoting recovery (e.g., one-stop sexual assault center model), and abuse in humanitarian disasters.

I would like to thank all the contributors for their remarkable efforts in providing their valuable knowledge and data.

I would also like to thank Sotirios Kalfoglou for his constant support and invaluable suggestions on the overall organization of the book.

Ersi Kalfoğlu
Faculty of Medicine,
Department of Forensic Medicine,
Istanbul Yeni Yüzyıl University,
Istanbul, Turkey

Sotirios Kalfoglou
Istanbul Yeni Yüzyıl University,
Istanbul, Turkey

Section 1

The Behavioral Aspects of Sexual Crimes

Chapter 1

Female Offenders in Child Sexual Abuse

David A. McLeod, Zackery D.O. Dunnells and Burcu Ozturk

Abstract

In the United States criminal justice system, female sexual offenders are among the most unrepresented groups of individuals, and they have evaded detection and/or prosecution for many reasons. This chapter explores the characteristics and patterns of female sexual offenders based on the collection of available literature. We will discuss how personal trauma histories, mental health, substance abuse, and motivations of female sexual offenders differ from their male counterparts. Additionally, we cover how social perception presents female sexual offenders in a light that adversely impacts their interactions with the social systems and explore empirically validated myths, risks, and interventions for this population.

Keywords: Female Sexual Offenders, Criminal Justice, Adverse Childhood Experience, Mental Health, Substance Abuse

1. Introduction

Female sexual offenders [FSO] are among the most radically unrepresented sexual offenders in the criminal justice system. Some studies suggest that anywhere from 15 to 20% of sexual offenses are committed by females [1, 2]. Among the studies of female sexual offenders, one accepted explanation was that female sexual offenders might have more significant personal abuse histories than their male counterparts [3]. The CDC's Adverse Childhood Experiences (ACEs) study revealed that nearly 25% of females and 16% of males who reported being abused as a child advised that at least one of their sexual offenders was female [4]. FSOs tend to offend across genders and with a wide range of ages [5]. Also, female sexual offenders tend to have young victims, compared to male offenders, which causes a very particular set of problems for these victims, including neurological, behavioral, and other significant outcomes [5, 6]. The impact of female-specific sexual offending is a phenomenon related to, but different from, that generated by male child sexual offenders—the purpose of this chapter to explore to understand female sexual offenders' characteristics in the literature.

2. Origins of research in the area

Perhaps the first formal and scientific mention of female sexual deviancy was in *Psychopatia Sexualis* by Richard von Krafft-Ebing in 1886. Standing as a reference in

law and psychiatry by classifying case studies regarding sexually related psychopathology, this work popularized terms such as sadism and masochism. It introduced satyriasis, which is the idea that females sought sexual contact with males of all ages, including children [7]. This case-based work started the conversation about female child sexual offending. When focused on the topic of pedophilia, von Krafft-Ebing only mentioned one case involving a female who sent her children away out of fear she would molest them [7].

It is important to note that this discussion began in the Victorian Era, which was known for socially imposed perspectives on gender and sexuality. As the research progressed, some suggested that female perversions were related to mental disease or defect. Women could be "sexual criminals" who could sexually abuse and exploit children [8, 9]. Due to the emerging popularity and support of psychoanalytic approaches, it was not until the introduction of Freud's work that understanding the patterns and motivations of female sexual offending began to change [10].

3. Prominent theoretical influence

The most prominent theoretical influences in female sex offender research are *Behaviorist* and *Psychodynamic*, and both are prominent throughout modern literature. Together, these theoretical perspectives prove helpful when investigating this phenomenon.

The Freudian concept of the Oedipal complex might have served as a source of confusion and a reason for the lack of investigation in female sexual offending cases for many years [10]. With that said, psychodynamics' positive contribution is much more evident in the more recent literature. The application of psychodynamic theory in exploring female sexual offenders focuses on the offender herself and the personal deficits that may drive the sexual offending behavior [11]. This approach emphasizes how the subconscious mind stimulates behavior and how deficits are a product of a failure to resolve earlier life problems [11].

Exploring female sexual offending behaviors through the behaviorist lens that tends to describe a person's behavior as a byproduct of life events or antecedents focuses on the behavior itself rather than the deficits of the individual [11]. In opposition to the conventional psychodynamic view, some suggest a separation of behavior and the mind [12]. Put simply, behaviorist approaches focus on how an individual has been conditioned to behave in a particular manner due to trauma and other life events. As opposed to an internalized developmental deficit, the individual's behavior can be conceptualized as a byproduct of their conditioning [11].

4. Who are female sexual offenders?

Most modern research on female sexual offenders is related to the description of who they are and how they compare to their male perpetrator counterparts. In addition to the offense characteristics they display, this description also sheds light on the differences in their motivations, personal trauma histories, mental health, and substance use. Empirical classification and typology have emerged in the literature to separate the female offender from the established norms of the male offender. Discussions of each of these classifications are included in this chapter, with a summary of the literature exploring the impact of perpetrator gender.

4.1 The impact of perpetrator gender

Utilizing 2010 data from the National Child Abuse Neglect Data System (NCANDS), McLeod conducted secondary data analysis to investigate the impact of perpetrator gender [13]. Of the 66,765 substantiated child sexual abuse cases, 13,492, or 20.9%, had females as the primary perpetrator. In 19.9% of the confirmed cases, male perpetrators offended male victims, compared to 80.5% of the cases where male perpetrators offended female victims. In 31.8% of the substantiated cases, female perpetrators offended male victims, compared to 68.2% of the cases where female perpetrators offended against female victims. The victims of female and male perpetrators ranged in age from newborn to 18 years of age, while the female offenders were found to have a greater prevalence of victims ranging from 5 to 9 years of age. Overall, these perpetrators of child sexual abuse were four and a half times more likely to be female if the perpetrator was the child's biological parent and three times more likely to be female if the child was adopted. If the child was experiencing drug-related problems, had a disability, or had prior reports of being sexually abused, the perpetrator was also more likely to be female. If the perpetrator was a stepparent of the abused child, or if the child victim had a cognitive disability or behavioral problems, then the perpetrator was more likely to be male. With male and female perpetrators ranging in age from 18 to 70 years of age, female perpetrators tended to offend between 27 and 39 years of age, and male perpetrators tended to offend between 20 and 42 years of age [13].

Referring to the same NCANDS data set, another secondary analysis was conducted to analyze gender differences and the ways child protective and criminal justice systems responded to male and female perpetrators of child sexual abuse [14]. Compared to the male perpetrators, the female perpetrators were more likely to be involved in the child welfare system at the time of the abuse, to be receiving higher levels of mental health, substance abuse, family-centered, and economic services, and to be referred to the police following a substantiated report of child abuse. However, female perpetrators ultimately represented only 1% of the sex offenders incarcerated for their sexually abusive crimes because, after this initial referral, they were subject to farther-reaching diversion practices [14].

4.2 Personal history

A significant risk marker for the likelihood of abuse against others in adulthood is a personal history of sexual abuse [10]. When focusing on reducing the cyclical nature of this phenomenon, this is important to keep in mind. Furthermore, numerous studies have shown that female sexual offenders demonstrate a significantly higher likelihood of their victimization in childhood [15–25]. Additionally, female sexual offenders are also more likely to have experienced parental or sibling physical and emotional abuse and, compared to nonsexual offending incarcerated females, are more likely to have below a twelfth-grade education [18]. Furthermore, female sex offenders are more likely to be involved in ongoing physical victimization (i.e., domestic abuse, intimate partner sexual assault), bringing up the dual nature of this phenomenon; female sexual offenders are often both victims and victimizers [19, 23].

Female and male sex offenders are similar in that they share a typical history of sexual victimization. Still, the female sex offender is more likely to have been abused at an earlier age, been molested by multiple individuals over an extended period, been molested by both female and male sexual offenders, been sexually aroused during one of their victimizations [16]. Also, they have had the onset of their sexual offending behavior begin within five years of their first sexual

victimization [16]. Compared to a group of nonsexual offending females, sexual offending females more frequently report instances of childhood sexual abuse in their history and for a longer duration, which replicates earlier similar findings [16, 17, 20].

4.3 Mental health and substance abuse

One can imagine that the prevalence of histories of personal abuse and trauma among female sex offenders is likely to have had a significant emotional impact on them during development as children or young adults. One study reported over 70% of female sexual offenders in their sample met full diagnostic criteria for posttraumatic stress disorder [26]. Another finding over one-third of their sample had a history of inpatient psychiatric hospitalization, most of which were non-paraphilic [26, 27]. More broadly, research from numerous unique disciplines (i.e., social work, criminal justice, psychiatry, and psychology) have shown that female sex offenders more often experience issues related to mental health, developmental disability, and substance use [2, 15, 19–22, 25, 28–33].

The search for answers related to what kinds of mental health issues female sexual offenders may specifically face is a relatively new pursuit; however, a handful of studies have helped lead the way for future research. In one study, solo-offending female sexual offenders, those who commit offenses on children without the participation, influence, or coercion of another offender, were more likely to have diagnosable mental health and substance abuse disorders, and those who co-offended were more likely to have personality disorders [31]. Interestingly, no statistical difference was found between female sexual offender cohorts (solo-offender or co-offender) when diagnoses were split into substance abuse disorders and psychotic disorders [28]. Other studies have shown some diagnoses associated with female sexual offenders may include developmental disability, drug and alcohol abuse, anxiety, and depression [2, 18, 19, 28, 29, 34]. Specifically, another author found that up to 22% of their female sexual offender sample to have some sort of developmental disability, and at the time in 1995 would have met the DSM diagnostic criteria for at least mild mental retardation [2]. Referring to diagnoses, Borderline Personality Disorder appears to be one most mentioned in the female sex offender literature. Among a sample of female sexual offenders, Borderline Personality Disorder is significantly associated with personal victimization histories [15].

Focusing on correlations like the one between Borderline Personality Disorder and child abuse, neuroscience has begun to elucidate the connection between traumatic events and the links and attachments individuals make later in their life. A few studies have detailed the impact of these types of events on neurodevelopment, and the debilitating effects childhood trauma can have on developing appropriate behaviors and connections. These studies suggest childhood trauma can cause a significant physical impact on the brain, altering the typical development of neuropathways, which can lead to substantial disturbances for individuals [35, 36]. Childhood trauma is almost exclusively how they can or cannot develop healthy and appropriate relationships, personal positive mental health, and appropriate boundaries with others [35, 36].

4.4 Offense patterns

While the literature suggests that female sex offenders are not a homogenous group, looking for similarities in offense patterns could prove helpful when analyzing large amounts of data [22, 37]. Compared to male sexual offenders, multiple

studies suggest that female sex offenders are more likely to use higher levels of coercion, which may indicate a higher level of emotional or intellectual manipulation connected to their approach [22, 24]. However, this does not necessarily mean that these female sexual offenders believe what they are doing is moral or right. According to at least one author, their decision-making process did not appear to be affected by cognitive distortions about the offense, unlike male sexual offenders [37].

Moreover, female sexual offenders who offend by themselves are more likely to have a single victim compared to those who act with another offender who is more likely to have multiple victims, to have both female and male victims, to be related to the victim, and to have a history of nonsexual offenses [38]. With that said, very few female sexual offenders seem to be coerced into their offending behavior or motivated by fear related to a co-offender [39].

One must also have caution when putting too much weight on a single study related to recidivism, which is difficult to measure when relying solely on data reported by the criminal justice system. For example, one author suggested that recidivism related to female sexual offending may be closer to 28% [40]. This is substantially more than the recidivism rate of 17% of female sexual offenders charged with subsequent sexual offenses after the initial primary offense [40].

Highly documented and accepted within the female sex offender literature, research has repeatedly shown that female sex offenders are more likely than male sexual offenders to offend their biological children, close relatives, and children in their care [19, 24, 25, 33, 41]. One apparent absence in the literature relates to what degree access to children may place into the dynamics of female sexual offenders and their victims and whether these differences would still hold true if male sexual offenders were in consistent caregiving roles.

Another highly documented finding in the female sex offender literature is the lack of discrimination when it comes to victim gender, with numerous studies suggesting that female sex offenders are far less discriminant about victim gender compared to male sex offenders who tend to have an exclusive victim gender preference, typically female [27, 41–43]. Referring to these same studies, some suggested their female sexual offender samples may have a slight inclination toward male victims; however, others noted that female sex offenders in their sample were more likely to have male victims [27, 41–43]. Together, these studies still found that most female sexual offenders in their samples had both male and female victims [27, 41–43].

4.5 Empirical classifications and typologies

While the literature suggests the little, we do know about female sexual offenders do not fit into the same typologies as male sexual offenders, many have set out over the past thirty years to categorize female sexual offenders and their behavioral types [44]. Below you will find a detailed list containing some of the most popular typologies across time and some more modern approaches, which is organized by whether the typology is a psychodynamic or behaviorally influenced theoretical position and organized chronologically after that.

4.5.1 Psychodynamic influence

One of the first and most cited typologies of female sexual offenders was created by Matthews, Matthews, and Spitz in 1991 based on clinical interviews and psychometric testing within a female sexual offender treatment program [45]. The categories are as follows:

Typology	Traits
The Teacher/Lover	• Views her victim as a partner • Generally, intends no harm • Substantial personal histories of physical and emotional abuse • Considers their offending to be true romantic love • Pursues adolescent victims with the intent of an egalitarian relationship. • Has a hard time understanding that their acts are criminal
The Predisposed	• Target's victims in their own biological family or other children to whom they have ready access. • Typically isolated from adult contact • Has substantial history of sexual abuse in childhood, particularly by family members and not unusually by multiple offenders, including others inside and outside the family • Highly promiscuous during adolescence • Claims that they do not enjoy sexual contact
The Male Coerced	• Presents as submissive, passive, and powerless in their personal relationships • Tends to endorse traditional, patriarchal, gender role ideations • Views themselves differently when they are alone • Describe the person they fell in love with as a different person than the abuse partner

In 2004, Vandiver and Kercher created a female sex offender typology [43]. Vandiver and Kercher used hierarchical linear modeling and cluster analysis to assess the relationship between offender and victim characteristics heir based on a sample of 471 female sex offenders who had been convicted of a sexual crime in the state of Texas [43]. The categories are as follows:

Typology	Traits
The Heterosexual Nurturer	• Largest group in the sample • Females with an average age of 30 who were most likely to become involved with adolescent males, with an average age of 12 • Tended to seek emotional connection and more egalitarian relationships from their victims
The Noncriminal Homosexual	• Least likely to recidivate • Same sex victims • Average age of offenders was 32, and victims averaged 13 years of age • Described their relationships with victims as mutually satisfying • Least likely of all groups to commit forcible sexual assault
The Female Sexual Predator	• Most likely to recidivate with sexual crimes • Average offender was found to be 29 years of age, and the average victim was 11 • Victim profiles were 60% male and 40% female.
The Young Adult Child Exploiters	• Youngest average age (28) • Fewest average number of arrests • victims averaged seven years of age and were related to the offender approximately half of the time • Included mothers who were molesting their own biological children alone and with co-offenders

Typology	Traits
The Homosexual Criminals	• Preference toward same-sex victims • Highly likely to re-offend • Highest average number of arrests (n10) • Average offender age was 32, and the average victim was 11 • Crimes included high levels of "forcing behavior," including sexual performance and child prostitution, and for at least a portion of these, the offender's motivation appeared to be financial as opposed to sexually related • 73% of their victims were female.
The Aggressive Homosexual Offender	• Older offenders, who have a preference toward victims of the same sex, and an average [adult] victim age of 31 years • Commonly correlated with domestic violence

In 2007, Sandler and Freeman sought to replicate the previously mentioned work with a sample of 390 registered female sexual offenders from New York State [46]. While they found their sample to be demographically similar to the one in Texas, the six distinct typologies they created were substantially different. The categories are as follows:

Typology	Traits
The Criminally-Limited Hebephile	• Women with an average age of 32 who prefer adolescent victims, around 14 years of age • Victims are primarily male (70%). • Low likelihood of rearrest.
The Criminally-Prone Hebephile	• Average offender is 25 and the average victim age is just under 15. • Preference toward male victims 66% of the time • High likelihood for rearrest in not only sexually involved cases but also drug-related and other offenses
The Young Adult Child Molesters	• Average offender age is 28, and the average victim is four years of age. • Typically not previously arrested and selected female victims 52% of the time
The High-Risk Chronic Offenders	• Highest number of arrests and rearrests • Average offender's age was just under 31 years, and the average victim age was 5 • Targeted female victims 56% of the time • Highest representation of non-white offenders of all 6 clusters (38%).
The Older Non-Habitual Offender	• little to no documented criminality outside the registration for their sexual offense • Average offender was 51 years of age, with an average victim age of 12.
The Homosexual Child Molester	• Smallest cluster in this analysis. • Targeted female victims (91%), with an average victim age of 5 years old. • Average offender in this group was 44 years old, and they had a high rate of arrest for drug-related charges.

In 2011, Wijkman, Bijleveld, and Hendricks created a three-tier typology of female sexual offender behavior based solely on the types and frequency of offenses in their Dutch sample [47]. The categories are as follows:

Typology	Traits
The Once-Only Offender	• Only one known offense • No priors or recidivism
The Generalists	• Criminally diverse • Typical history of violent and drug related crimes • Currently charged with sex crime • Likely to *generally* recidivate
The Specialists	• Likely to have committed multiple sexual offenses • Tend to have limited nonsexual criminal behavior

4.5.2 Behavioral influence

In 2005, Ferguson and Meehan used hierarchal linear modeling and cluster analysis to develop female sexual offending behavior typologies based on three distinct patterns related to perpetrator characteristics, victim age, and use of force [48]. These typologies are organized by the size of a group membership. The categories are as follows:

Typology	Traits
Cluster 1	• Average offender age of 26 • More likely to choose victims under the age of 12 • More likely to use verbal coercion rather than physical force • While it happens rarely, this is the group of female offenders most likely to murder their victims
Cluster 2	• Average offender age is 30 • Highest rate of prior criminal convictions • Most likely to use physical force
Cluster 3	• Mixed results with high diversity in use of force patterns • More likely to pursue victims between the ages of 12 and 16

One of the most important findings of this study is that the authors suggest there to be an escalation in the use of force over the timespan, where younger offenders are more likely to use coercion where older offenders may become more physically forceful [48].

In 2010, Gannon, Rose, and Ward utilized Gannon's earlier Descriptive Model of Sexual offending to examine a twenty-two-person sample and come up with three primary pathways to female sexual offending [49, 50]. The categories are as follows:

Typology	Traits
The Explicit Approach	• Largest group (50% of sample) • Offenders who intend to offend and explicitly develop their plan of attack, directing their behaviors accordingly • Goals include sexual gratification, intimacy, revenge or humiliation, and financial motivation

Typology	Traits
The Directly Avoidant	• Women who may not initiate a sexual offense but were directed, coerced, or manipulated into the offense by a male accomplice or co-offender • Offenders present as passive or dependent and reported to have been groomed for the crime • Physically and/or emotionally abused by their co-offender • Present with cognitive distortions related to their co-offenders and victims, as well as their own participation and offending behaviors
The Disorganized Offender	• No intention of offending and engaged in minimal planning for the offense • Offending is related to impulsivity and a severe self-regulatory failure • Spontaneous • Goals more closely related to intimacy

4.5.3 Typology conclusion

While some of these typologies are similar and others approach the subject from a different perspective, together, they help us recognize the diversity present in this phenomenon. Specifically, they provide insight into the mental health, behavioral, and offense characteristics of female sexual offenders. To reiterate a prior point, female sexual offenders are not a homogenous group, and it is vitally important to examine this phenomenon with empirical complexity and precision.

We must also examine how these typologies are constructed. The typologies mentioned in this chapter have been built from incarcerated, registered, or otherwise legally identified offenders while keeping in mind there is reason to believe most sexual offenses go unreported. There may be other typologies that could do a better job of describing populations of female sexual offenders who evade detection from our child protective and legal systems.

4.6 Motivation and belief systems

Many of the previously discussed typologies examine the idea of motivation with female sexual offenders, which is something that is highly influenced by psychodynamic perspectives. A deeper and more vivid understanding of motivation could have significant impacts on the identification of offenders and treatment and intervention development. While female and male child sexual offenders are radically different, some of their specific offending belief patterns may be similar [51]. Building on this finding, when authors examined the gendered similarities and differences in implicit theory development regarding sexual offending, authors found that females shared four of the five earlier identified belief schemas associated with the phenomenon [52]. The female sexual offenders in this study identified the following belief systems: they viewed children as sexual objects; believing that children were capable of enjoying and desiring sex; they shared the dangerous world implicit theory, viewing the world as a threatening place; they believed in the uncontrollability of the world and viewed events as things that happen to people who have no ability to shape their lives; they shared the belief system that the nature of harm as related to sexual offenses was scalable in that some sexual acts are beneficial to children and do not cause harm. As mentioned previously, there was one implicit theory that the female sexual offenders did not share with the male sex offenders, and that was an entitlement, or a belief that some people were superior to others and by virtue possess a right to having their sexual desires met. Together, these findings may have significant utility in understanding the motivations behind female sexual offending [52].

Furthermore, five motivational typologies related to the motivations behind female sexual offense patterns have been developed [10]. The *Forbidden Lover* offender may superficially appear to be connected to the innocence of romantic love. However, these are typically situations where an older female has become romantically involved with a young individual. The core beliefs behind this motivation are the feelings of weariness about the responsibilities in their life. The offender typically commits the offense in the act of sexual boundary crossing, which is usually connected to the traumatic and abusive issues in the offender's childhood. The idea of consent here is difficult to mediate as it is not uncommon for some of the victims to feel complex feelings of mutual benefit, satisfaction, or even power, although these experiences could prove incredibly disruptive to their adult lives.

Continuing with the motivational typologies discussed in the previous paragraph, the authors describe the *Facilitator* as a female who assists a co-offender with the grooming of the victim, the location, and in the facilitation of the offense itself [10]. This may be motivated by fear of psychical or sexual abuse, torture, or abandonment, but this may not be the only motivation. The facilitating offender is often in proximity, if not actively engaging, due to a possible desire or willingness to participate in the offense. This suggests that the deviant sexual fantasy of the male may have become sexually stimulating for females.

Continuing, the *Instigator* is described as a female who wishes to offend against a child, adolescent, or adult and follows through on her desires alone or with the assistance of a co-offender [10]. The motivations of the female sex offender may be driven by a desire for power, revenge, dominance, or control. This offender may typically be more psychopathic by nature, and their motivation may have less to do with eroticism and more to do with sexual violence related to manipulation and exploitation of others.

The *Psychotic Offender's* motivations are based on psychosis and, specifically, are based on a variety of manifestations of hallucinations and delusions [10].

They describe the fifth category as *Munchausen by Proxy* [10]. This motivation could also be perceived as being heavily influenced by mental health conditions. However, in this case, we are talking less about psychosis and more about anxiety, obsession, or paranoia. These cases involve a parent or caretaker motivated by an irrefutable belief system that their child has been offended. Therefore, subjects the child to increasingly invasive physical and psychological examinations to find their beliefs founded, all the while disregarding the findings and advice of the professionals to whom they are entrusting their child's care.

If one may think that research on female sexual offending is scarce, then it might also be safe to say that the specificity of topics such as motivation in these offenses is non-existent. However, what we do have, as seen throughout this chapter thus far, is based primarily on case studies and small qualitative projects. With that said, the need for further research in this area is apparent.

5. Social perception

One reason for the dearth of literature related to female sexual offenders may be associated with the social perception of the invitation of the phenomenon. Many authors suggest, in comparison to the readily documented nature of male sexual offending, female sexual offending has been all but ignored since females are typically viewed as caring nurturers who are incapable of such heinous, offensive, and socially unacceptable acts [45, 53–60]. This social perception could very well explain how nearly 20% of sexual offenders in our population avoid detection and or prosecution.

At least one author argues that our culture may typically allow for a broader range of acceptable behaviors from females [53]. This may be especially true in the case of varying levels of affection, which may have been contributing to a cultural bias rejecting the possibility of female sexual offending [53]. Others have suggested western society views females as passive, harmless and that these views have been strong enough to infiltrate our legal systems, victim-reporting practices, and professional and clinical responses dramatically contributing to the under-reporting and under-identification of female sexual offenders [61]. Additionally, these social beliefs have also permeated child protective and police services where individuals within these systems discount disclosures, allegations, and reports of child sexual abuse that involve female offenders [62]. One study pointed out that being female does significantly reduce the likelihood of incarceration for offenders convicted of sexual offenses, but sex does not appear to have any significant impact on criminal conviction rates [63]. With all of that said, victim disclosures may have just as much to do with female sexual offending as do biases within our legal systems. Many studies have documented this underreporting of cases involving female sexual offenders [24, 53, 64]. When focusing on male victims, part of the problem could be social perception. People tend to believe that sexual abuse involving a male offender and a female victim is worse than that involving a female offender and a male victim [65]. It is likely that these deep-rooted and highly perpetuated societal gender role norms affect the decision-making process of victims as they attempt to make sense of their own experiences. One author hypothesized about why male victims may choose not to disclose their sexual abuse experiences [66]. Some of these possible explanations include:

- Males do not get pregnant, and evidence of sexual abuse has not been present;
- A double standard in belief systems has existed in which fathers have the potential for evil and mothers are 'all good';
- Adult males have been too embarrassed to reveal their sexual activity with and arousal by their mothers;
- Male children have been presumed to be unaffected by sexual abuse, and reports by sons have been ignored;
- Patients and therapists alike have been unaware of the connection between the sexual abuse of males and the later interpersonal relationship problems.

5.1 Myths

Lending from a societal perception that is disconnected from fact and actual incidence prevalence rates, many myths exist regarding female sexual offending. One author pieced together a list of commonly accepted myths that they argue are a source of victim alienation, which can result in limited protection from professionals, the public, or their own support systems [57]. These myths commonly cited in the literature include:

- Females do not sexually abuse;
- Females only abuse if coerced or accompanied by a male;

- If females sexually abuse, it is gentle, loving, or misguided 'motherly love';
- Females only abuse males;
- If you are a female and you were abused by a female, then you will be lesbian; if [you are] male [you will be] gay or misogynist;
- If you were sexually abused as a child, then you will sexually abuse as an adult;
- People who say they were abused by a female are fantasizing or lying. If you are male and you have sexual fantasies, and if the perpetrator was your mother, you have incestuous wishes. If you are female, you are muddled, and it was a man who really abused you;
- Females only abuse adolescents;
- If a thirty-year-old female were to seduce a thirteen-year-old male, it would not be sexual abuse. If a thirty-year-old male were to seduce a thirteen-year-old female, it would undoubtedly be so;
- If a mother has an incestuous relationship with their son in his late teens/the early twenties, it is sex between two consenting adults and not sexual abuse;
- It is worse to be sexually abused by a female than a male.

5.2 Risk

In reference to prevalence and incidence and the subjugation of the victim to psychological harm, the data show evidence for the contrary of these previously mentioned myths. At least one author suggests that sexual abuse by a female perpetrator is just as psychologically harmful as that of a male offender [67]. This brings up the idea of female sexual offender risk assessment and treatment. This is an area in dire need of further research, and the dearth of empirically validated treatment approaches validated targeted instrumentation, which makes the practice of risk assessment and treatment incredibly problematic [68]. Acknowledging the literature that suggests female sexual offenders can be just as sexually aggressive as male sexual offenders, there exists a lack of psychometric measures specifically developed and validated to consider the developmental uniqueness, which has proven to complicate prosecution, civil commitment, and public protection [69, 70].

5.3 Intervention

While myths appear to permeate social perception and calls for more research and nuanced risk assessment reverberate in the literature, one request seems to rise above the rest. Despite the dearth of attention and literature focused on female sexual offenders, there is no interest and need that seems to rise to the surface more than others; the continued and active call for the development of female-specific sex offender treatment programming. We have repeatedly reiterated that female sex offenders are a heterogeneous group with many unique and radically different characteristics when compared to male sexual offenders. We see this clearly through the examination of the typologies discussed in this chapter. Addressing the dual nature of victim and offender that so many of these women

face is a huge need when developing treatment approaches [23]. However, these treatment approaches must also balance and reflect the idea that female sexual offenders are serious offenders of sexual crimes against children and not solely victims of their own childhood circumstances [39]. Some have suggested the adaptation of existing treatment modalities for male sexual offenders to attempt to meet the specific needs of this group [50]. Nonetheless, the need for the development of empirically validated interventions that can embrace the needs of this population. The cyclical nature of the phenomenon and the importance of addressing myths and social perceptions that could hinder their effectiveness should be clear.

6. Conclusion

Female sexual offending is a newer area of interest, and more research is needed. It is vital to decrease violence when we understand the development of criminal behaviors. Understanding issues specific to female offenders and the typologies they display is essential for us to explore the nuances of the female sexual offender population. The focus of this chapter has been to explore phenomenon specific to female sexual offending and the life circumstances of the females who offend. Additionally, discussion of the impact of social perception of the phenomenon, myths, and appropriate risk assessment and intervention are important to explore further in the literature. The information provided in this chapter aims to inform professionals about female sexual offenders' characteristics.

Conflict of interest

The authors declare no conflict of interest.

Author details

David A. McLeod*, Zackery D.O. Dunnells and Burcu Ozturk
University of Oklahoma, Norman, USA

*Address all correspondence to: damcleod@ou.edu

References

[1] American Humane Association. 1987. Available from: http://www.americanhumane.org/protecting-children/research-evaluation/child-abuse-neglect-data/ [Accessed: 2011-1-10]

[2] Faller K, Coulborn K A clinical sample of women who have sexually abused children. Journal of Child Sexual Abuse. 1995;4(3):13-30.

[3] Strickland SM. Female sex offenders. Journal of Interpersonal Violence, 2008; 23(4), 474-489. DOI: 10.1177/0886260507312944

[4] Center for Disease Control. CDC-Ace study-data and statistics-prevalence-adverse childhood experiences. 2013. Available from: http://www.cdc.gov/ace/prevalence.htm.

[5] Freeman NJ, Sandler JC. Female and male sex offenders. Journal of Interpersonal Violence. 2008; 23(10), 1394-1413. DOI: 10.1177/0886260508314304.

[6] Perry BD. Sexual abuse of infants. Trauma, Violence& Abuse. 2000, 1(3), 294-296.

[7] von Krafft-Ebing R. Psychopatia sexualis: A medico--forensic study. New York: G. P. Putnam's Sons; 1886.

[8] Chideckel M. Female sex perversion: The sexually aberrated woman as she is. Eugenics Publishing Company; 1935.

[9] Wulffen E. Woman as sexual criminal. New York: American Ethnological Press; 1934.

[10] Warren J, Hislop J. Patterns of female sexual offending and their investigatory significance. In Hazelwood R, Burgess A, editors. Practical aspects of rape investigation: A multidisciplinary approach. 4th ed. Ann Arbor: CRC Press; 2008. p. 429-444

[11] Payne M. Modern social work theory. 3rd edition. Chicago: Lyceum; 2005.

[12] Sheldon, B. Cognitive-behavioral therapy: Research, practice, and philosophy. London: Routledge; 1995.

[13] McLeod DA. Female offenders in child sexual abuse cases: A national picture. The Journal of Child Sexual Abuse. 2015;24(1):97-114. DOI: 10.1080/10538712.2015.978925

[14] McLeod DA, Craft ML. Female sexual offenders in child sexual abuse cases: National trends associated with CPS system entry, exit, service utilization, & socioeconomics. Journal of Public Child Welfare. 2015;9(4): 399-416. DOI: 10.1080/15548732.2015.1064849

[15] Christopher K, Lutz-Zois C, Reinhardt AR. Female sexual--offenders: Personality pathology as a mediator of the relationship between childhood sexual abuse history and sexual abuse perpetration against others. Child Abuse & Neglect, 2007;31(8):871-883. DOI: 10.1016/j.chiabu.2007.02.006

[16] Hunter JA, Lexier LJ, Goodwin DW, Browne PA, Dennis CJ. Psychosexual, attitudinal, and developmental characteristics of juvenile female sexual perpetrators in a residential treatment setting. Journal of Child and Family Studies. 1993;2(4):317-326. DOI: 10.1007/BF01321228

[17] Kaplan MS, Green A. Incarcerated female sexual offenders: A comparison of sexual histories with eleven female nonsexual offenders. Sexual Abuse: A Journal of Research & Treatment. 1995;7(4):287-300. DOI: 10.1007/BF02256833

[18] Laque JC. Childhood traumas, substance abuse, and sexual

experiences: A comparison study between incarcerated female sex offenders (doctoral dissertation). Houston: University of Houston; 2002.

[19] Lewis CF, Stanley CR. Women accused of sexual offenses. Behavioral Sciences & the Law. 2000;18(1):73-81. DOI: 10.1002/(SICI)1099-0798 (200001/02) 18:1<73::AID-BSL378> 3.0.CO;2-%23

[20] Matthews R, Hunter Jr. JA, Vuz J. Juvenile female sexual offenders: Clinical characteristics and treatment issues. Sexual Abuse: Journal of Research and Treatment. 1997;9(3): 187-199.

[21] McCartan FM, Law H, Murphy M, Bailey S. Child and adolescent females who present with sexually abusive behaviours: A 10-year UK prevalence study. Journal of Sexual Aggression. 2011;17(1): 4-14. DOI: 10.1080/ 13552600. 2010.488302

[22] Roe-Sepowitz D, Krysik J. Examining the sexual offenses of female juveniles: The relevance of childhood maltreatment. The American Journal of Orthopsychiatry. 2008;78(4):405-412. DOI: 10.1037/a0014310

[23] Travin S, Cullen K, Protter B. Female sex offenders: Severe victims and victimizers. Journal of Forensic Sciences. 1990;35(1):140-150.

[24] Tsopelas C, Spyridoula T, Athanasios D. Review on female sexual offenders: Findings about profile and personality. International Journal of Law and Psychiatry. 2011;34(2):122-126. DOI: 10.1016/j.ijlp.2011.02.006

[25] Wijkman M, Bijleveld C, Hendriks J. Women don't do such things! Characteristics of female sex offenders and offender types. Sexual Abuse: A Journal of Research and Treatment. 2010;22(2):135-156. DOI: 10.1177/ 1079063210363826

[26] Green A, Kaplan M. Psychiatric impairment and childhood victimization experiences in female child molesters. Journal of American Academy of Child and Adolescent Psychiatry. 1994;33(7):954-961.

[27] West SG, Friedman SH, Kim KD. Women accused of sex offenses: A gender-based comparison. Behavioral Sciences & the Law. 2011;29(5):728-740. DOI: 10.1002/bsl.1007; 10.1002/bsl.1007

[28] Fazel S, Sjöstedt G, Grann M, Långström N. Sexual offending in women and psychiatric disorder: A national case–control study. Archives of Sexual Behavior. 2010;39(1):161-167. DOI: 10.1007/s10508-008-9375-4

[29] Gao C, Jiao Z, Zeng T, Zhang Z. Risk factors of sexual wrong-doings in young females. Chinese Mental Health Journal. 2002;16(4):259, 263-264.

[30] Miller HA, Turner K, Henderson CE. Psychopathology of sex offenders: A comparison of males and females using latent profile analysis. Criminal Justice & Behavior. 2009;36(8):778-792. DOI: 10.1177/ 0093854809336400

[31] Muskens M, Bogaerts S, van Casteren M, Labrijn S. Adult female sexual offending: A comparison between co-offenders and solo offenders in a Dutch sample. Journal of Sexual Aggression, 2011;17(1):46-60. DOI: 10.1080/ 13552600.2010.544414

[32] Stavros K, Roe-Sepowitz D. Female juvenile sex offenders: Mental health needs and relationship problems. In: Proceedings of The American Society of Criminology Conference, St. Louis; 2008.

[33] O'Connor A. Female sex offenders. The British Journal of Psychiatry: The Journal of Mental Science. 1987;150: 615-620.

[34] Allen C. Women and men who sexually abuse children: A comparative analysis. Orwell: The Safer Society Press; 1991.

[35] Perry, B. D. (2000). Sexual abuse of infants. Trauma, Violence & Abuse. 2000;1(3):294-296.

[36] Cozolino L. The neuroscience of psychotherapy: Healing the social brain. 2nd ed. New York: WW Norton & Company; 2010.

[37] Jennings KT. Female sexual abuse of children: An exploratory study. US: ProQuest Information & Learning. 2000;60(10):3802.

[38] Vandiver DM. Female sex offenders: A comparison of solo offenders and co-offenders. Violence and Victims. 2006;21(3):339-354.

[39] Nathan P, Ward T. Female sex offenders: Clinical and demographic features. Journal of Sexual Aggression, 2002;8(1):5-21. DOI: 10.1080/13552600208413329

[40] Bader SM, Welsh R, Scalora MJ. Recidivism among female child molesters. Violence & Victims. 2010;25(3):349-362. DOI: 10.1891/0886-6708.25.3.349

[41] Fehrenbach PA, Monastersky C. Characteristics of female adolescent sexual offenders. American Journal of Orthopsychiatry, 1988;58(1):148-151.

[42] Grayston AD, De Luca RV. Female perpetrators of child sexual abuse: A review of the clinical and empirical literature. Aggression & Violent Behavior. 1999;4(1):93-106.

[43] Vandiver DM, Kercher G. Offender and victim characteristics of registered female sexual offenders in Texas: A proposed typology of female sexual offenders. Sexual Abuse: A Journal of Research and Treatment. 2004;16(2): 121-137.

[44] Pflugradt DM, Allen BP. An exploratory analysis of executive functioning for female sexual offenders: A comparison of characteristics across offense typologies. Journal of Child Sexual Abuse. 2010;19(4):434-449. DOI: 10.1080/10538712.2010. 495701

[45] Mathews J, Matthews R, Speltz K. Female sexual offenders: A typology. In Patton PQ, editor. Family sexual abuse. New York: Sage; 1991.

[46] Sandler J, Freeman N. Typology of female sex offenders: A test of Vandiver and Kercher. Sexual Abuse: A Journal of Research and Treatment. 2007;19(2):73-89.

[47] Wijkman M, Bijleveld C, Hendriks J. Female sex offenders: Specialists, generalists and once--only offenders. Journal of Sexual Aggression. 2011;17(1):34-45. DOI: 10.1080/13552600.2010.540679

[48] Ferguson CJ, Meehan, DC. An analysis of females convicted of sex crimes in the state of Florida. Journal of Child Sexual Abuse. 2005;14(1):75-89. DOI: 10.1300/J070v1401.05

[49] Gannon T, Rose MR, Ward T. Pathways to female sexual offending: Approach or avoidance? Psychology, Crime & Law. 2010;16(5):359-380. DOI: 10.1080/10683160902754956

[50] Gannon TA, Rose MR. Female child sexual offenders: Towards integrating theory and practice. Aggression & Violent Behavior, 2008;13(6):442-461. DOI: 10.1016/j.avb.2008.07.002

[51] Beech AR, Parrett N, Ward T, Fisher D. Assessing female sexual offenders' motivations and cognitions: An exploratory study. Psychology, Crime & Law. 2009;15(2):201-216. DOI: 10.1080/10683160802190921

[52] Ward T, Keenan T. Child molesters' implicit theories. Journal of Interpersonal Violence. 1999;14:821-838.

[53] Banning A. (1989). Mother-son incest: Confronting a prejudice. Child Abuse & Neglect. 1989;13(4):563-570.

[54] Finkelhor D. Women as perpetrators. In Finkelhor D, editor. Child sexual abuse: New theory and research (pp. 171--185). New York: Free Press; 1984. p. 171-185.

[55] Finkelhor D. Perpetrators. In Finkelhor D, editor. Child sexual abuse: New theory and research. New York: Free Press; 1984. p. 33-52.

[56] Herman J. Father-daughter incest. Cambridge: Harvard University Press; 1981.

[57] Longdon C. A survivor and therapist's viewpoint. In Elliot M, editor. Female sexual abuse of children. New York: Guilford Press; 1993. p. 47-56.

[58] Saradjian J. Women who sexually abuse children: From research to clinical practice. West Sussex: Wiley & Sons; 1996.

[59] Schwartz B, Cellini H. Female sex offenders. In Schwartz B, & Cellini H, editors. The sex offender: Corrections, treatment and legal practice. Kingston: Civic Research Institute; 1995. p. 5.1-5.22.

[60] Turner,B.F., & Turner,C.B. Social cognition and gender stereotypes for women varying in age and race. In B.F.Turner &L.E. Trol (Eds.),Women growing older; 1994 (p.94-139). Thousand Oaks, CA:Sage.

[61] Denov MS. The myth of innocence: Sexual scripts and the recognition of child sexual abuse by female perpetrators. Journal of Sex Research. 2003;40(3):303-314.

[62] Robinson SE. From victim to offender: Female offenders of child sexual abuse. European Journal on Criminal Policy & Research, 1998;6(1):59-73. DOI: 10.1023/A:1008634516803

[63] Sandler J, Freeman NJ. Female sex offenders and the criminal justice system: A comparison of arrests and outcomes. Journal of Sexual Aggression. 2011;17(1):61-76. DOI: 10.1080/ 13552600.2010.537380

[64] Wong TM, Van de Schoot R. The effect of offenders' sex on reporting crimes to the police. Journal of Interpersonal Violence. 2011;27(7):1276-1292. DOI: 10.1177/0886260511425245

[65] Smith HD, Fromuth ME, Morris CC. Effects of gender on perceptions of child sexual abuse. Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders. 1997;6(4):51-63. DOI: 10.1300/J070v06n04_04

[66] Krug RS. Adult male report of childhood sexual abuse by mothers: Case descriptions, motivations and long-term consequences. Child Abuse & Neglect. 1989;13(1):111-119. DOI: 10.1016/0145-2134(89)90034-3

[67] Elliot M. Female sexual abuse of children: The ultimate taboo. Colchester: Longman; 1993.

[68] Vick J, McRoy R, Matthews BM. Young female sex offenders: Assessment and treatment issues. Journal of Child Sexual Abuse. 2002;11(2):1-23.

[69] Slotboom A, Hendriks J, Verbruggen J. Contrasting adolescent female and male sexual aggression: A self-report study on prevalence and predictors of sexual aggression. Journal of Sexual Aggression. 2011;17(1):15-33. DOI: 10.1080/ 13552600.2010.544413

[70] Vess J. Risk assessment with female sex offenders: Can women meet the criteria of community protection laws? Journal of Sexual Aggression. 2011;17(1):77-91. DOI: 10.1080/13552600.2010.528844

Chapter 2

School Employee Sexual Misconduct: Red Flag Grooming Behaviors by Perpetrators

Charol Shakeshaft, Mitchell Parry, Eve Chong, Syeda Saima and Najia Lindh

Abstract

The sexual exploitation of students is a worldwide problem. In the U.S., the problem is three-fold: (1) Ten percent of public school students report being sexually abused by a school employee. (2) There is little in the existing research that identifies and describes the school culture, patterns, and conditions in which educator sexual misconduct occurs. (3) Because no one has systematically documented the school culture and the behaviors and patterns of adults who sexually abuse children in schools, school professionals fail to understand what patterns and behaviors should trigger concern, supervision, investigation, and/or reporting. Stopping sexual misconduct directed toward students means understanding the process that adults use to prepare students to be abused so that they do not tell, do not fight, and acquiesce. This process, called grooming, has the purpose of gaining student trust, as well as the trust of parents and colleagues. This study examines school employee sexual misconduct toward students in school in the United States and is based upon an analysis of 222 cases of school employee sexual misconduct toward a student where a school employee was convicted of student sexual abuse. The findings identify red flag grooming patterns used with students, colleagues, and parents.

Keywords: sexual abuse, students, grooming, sexual misconduct, schools

1. Introduction

The shared knowledge of educators about the etiology of sexual abuse of students by school employees – what to look for, how to respond, and what actions might reduce risk – is simply inadequate to the scope of the harm. A report from the United States Government Accountability Office (GAO), *Child Welfare Federal Agencies Can Better Support State Efforts to Prevent and Respond to Sexual Abuse by School Personnel* [1], noted the lack of research on the patterns of sexual abuse in schools. Additionally, an earlier GAO report, *K-12 Education Selected Cases of Public and Private Schools that Hired or Retained Individuals with Histories of Sexual Misconduct* [2], reached similar conclusions.

The problem is three-fold. (1) Ten percent of public school students report being sexually abused by a school employee [3]. (2) There is little in the existing research that identifies and describes the school culture, patterns, and conditions in which

educator sexual misconduct occurs. (3) Because no one has systematically documented the school culture and the behaviors and patterns of adults who sexually abuse children in schools, school professionals fail to understand what patterns and behaviors should trigger concern, supervision, investigation, and/or reporting.

Stopping sexual misconduct directed toward students means understanding the process that adults use to prepare students to be abused so that they do not tell, do not fight, and acquiesce. This process, called grooming, has the purpose of gaining student trust, as well as the trust of parents and colleagues.

2. Review of the literature

Grooming behaviors and patterns are red flags, signaling that something is not quite right and that attention and monitoring, and supervision are needed. Most employee to student sexual misconduct in educational organizations involves a pattern of "preparing" the student for the misconduct so that the student trusts the employee. Rarely does the misconduct begin with unwanted sexual touching, although that occurs later in the process.

Sexual misconduct in schools and other youth serving organizations nearly always begins with grooming. Kenneth Lanning, retired supervisory Special Agent from the FBI and a seminal researcher of criminal sexual behavior since the 1970's, describes grooming as "specific nonviolent techniques used by some child molesters to gain access to and control of their child victims" [4]. The patterns, now referred to as grooming, were at one time referred to as seduction within the prevention community. That label changed overtime as researchers learned more about how children are persuaded into targets. The change in terminology had more to do with the perception of the words than the actual behaviors. Lanning and others use the words interchangeably to describe "patterned behavior designed to create opportunities for sexual assault, minimize victim resistance or withdrawal, and reduce disclosure or belief." [4].

Jim Tanner and Stephen Brake [5] developed a framework for understanding the grooming process. They make a distinction between grooming the individual and grooming the "environment. Because offenders need to find potential targets, gain their trust, reduce discovery by others, and reduce the target's credibility if discovered, they groom victims to "overcome resistance, maintain access, and minimize disclosure" [5]. Offenders need access to targets, need to be desirable to targets, and need to convince the target that everything that is happening is normal. The goal is compliance from the child, often misinterpreted as consent. Children aren't legally or emotionally able to consent – this is not an equal interaction – therefore compliance is used by the offender as a stand-in for consent, drawing the child into a belief system that the child has control or power when that is not the case.

Offenders must not only gain the trust of the victim, but also that of the community in which he or she works as well as the environment of the child. Typically, the offender grooms the work and community environment first, then grooms potential victims, then the actual victim or victim's family. Prior to physical sexual abuse of the potential target, the offender seeks to be someone admired by colleagues, recognized in the community as a productive and valuable member, and appreciated by parents as someone who is helpful to the success of their children.

Environmental and individual grooming can occur at the same time, but commonly the offender has first established his or herself as a highly regarded education and/or coaching professional. Tanner and Brake [5] have summarized this process, displayed in **Table 1**.

Purpose of victim grooming	Overcome resistance, maintain access, and minimized disclosure
Target of victim grooming	Emotionally vulnerable child
Goals of victim grooming	Access/affiliate Allure/accept Alibi/assure
Actions of victim grooming	Gaining trust, access, relationship
Bond	Form a special bond, keep secrets, special lures
Reliance	Push and pull of victim. Make victim need offender
Attenuate	Reduce resistance through slow progression and explanation of normalcy
Trap	Prevent disclosure through grooming, threats, guilt, and fear
Environmental Grooming	
Purpose of Environmental Grooming	Find victims and reduce the probability of being reported or victim being believed
Target of Environmental Grooming	Parents/family, teachers, social organizations, peers, significant others, etc.
Goals of environmental grooming	Access: provide entrée Allure: create interest Alibi: minimize risk
Actions of environmental grooming	
Position	Social, Personal
Charm	Personality
Power	Political, fiscal, absolute
Celebrity	Fame

Table 1.
Tanner and Blake's summary of child victim grooming.

Grooming is rarely perceived as a violent act. Instead, it consists of actions that bond the target to the offender such as time spent together, secrets, gifts, special attention. The process presents the offender to the child as kind, gentle, understanding, caring, generous, charming, and accessible. A goal of the offender is to be desirable, needed, and wanted by the child. As the child is progressively drawn-in to this "special" bond, the offender assures the child that the relationship is "normal", often by telling the target that he or she is more mature than the other students, or smarter, or extra special. The more an offender can minimize the nature of the offense and shape it into an acceptable relationship -- counselor, teacher who cares, friend, father figure, peer -- the more the student is led to believe that what is happening is acceptable.

Generally, the only time the offender uses threatening methods are when the student tries to stop the predator after the grooming period and well into the physical or emotional sexual misconduct. At this point the offender uses threats, guilt and fear to keep the student involved. Most grooming and sexual misconduct toward students by adults occurs right in the school: in empty classrooms, in hallways, in offices. Sometimes the abuse is played out in front of other students. It is not unusual for a teacher to take a student into a storage room attached to the classroom and have sexual intercourse while the rest of the class does seat work. Recess and lunch are prime offending times.

Preventing sexual misconduct and abuse directed toward students requires adult bystanders and other students to understand the "red flags" of grooming behavior. The purpose of this study was to identify and describe grooming behaviors that school employees use in their quest to cross sexual boundaries with students.

3. Methods

3.1 Description of the study

If we could (or would) do postmortem examinations each time a student is sexually abused by an adult in a school, we might be able to identify the places where policies, training, supervision, and reporting failed to prevent the abuse. These are sensitive issues for school administrators and communities and, most of the time, the stakeholders just want to put the ugly incident behind them, a response which does little to prevent future abuse. However valuable direct inquiry might be, it turns out not to be feasible to get permission to interview students, teachers, administrators, victims, parents of victims, and predators when an employee has sexually abused a student. Very few, if any, organizations allow such scrutiny.

3.2 Methodological framework

This study uses documents from civil litigation where a parent or child has filed a suit against a school district for not preventing the abuse of the child by a school employee and where the school employee predator has been convicted in a criminal trial of sexually abusing a student. These documents provide the range, detail, and putative accuracy of case evidence that is otherwise unavailable to researchers. Specifically, we analyzed expert witness reports that were developed from civil legal documents. The use of civil legal documents introduces a methodological dimension that is not often deployed in education research, and thus provides an additional approach to education research. These documents provide robust documentation for undertaking these multiple case studies which allow for individual incident descriptions as well as a synthesis of variables across cases. Court and legal records are not uncommon sources of data in social science and historical research [6], but rarely used in non-legal education research.

The documents on which the expert reports used for this study came were based on multiple case records used in civil litigation that the senior author read and analyzed to produce an expert witness report. In each case, the expert report included the same topics and format and produced a report between 50 and 100 pages. It is the report that the researchers in this study used to identify red flags of grooming.

3.3 Sample

The sample was drawn from 220 expert reports written by the senior author between 2004 and 2020 as expert reports in civil litigation. Essentially, the reports represent case study descriptions of the patterns and behaviors of grooming and sexual misconduct as well as the extent that school organizations met prevention protocols. The purpose of this study was to identify red flags of grooming across cases, red flags which were described in the report.

There were six parameters for selection of the reports to be included in this study (1) a student has been sexually abused by an employee of the school district;

(2) the employee has admitted the sexual abuse and been found guilty in criminal court; (3) the school is a PK12 school; (4) the report included information on grooming red flags; (5) consent for use of documents has been given by the plaintiff attorneys; and (6) the criminal and civil cases were closed.

Although this sample is not random (a technique not available in these circumstances), it is a purposeful selection that has characteristics of both snowball and judgment sampling. The cases initially reviewed are varied and are from 33 states; represent both state and federal complaints; include elementary and secondary student plaintiffs; represent urban, rural, and suburban school districts; contain both high- and low-income schools; incorporate schools that serve predominantly white, predominantly black or Latina/o, or mixed race student enrollments. The victims in these cases are both males and females and the predators are both males and females. Thus, the sample replicates the socio-demographic properties of school districts and plaintiffs from the country as a whole.

3.4 Data sources

Litigation and trial data are commonly used in other disciplines, but rarely in education research. Never-the-less the public has a "qualified right of access to court proceedings and records, rooted in the common law. The First Amendment also confers on the public a qualified right of access", including in civil trials [7]. Among the data points for analysis that are included in civil case documentation are school district policies, training materials and requirements, hiring policies and practices, personnel files, student files, medical/mental health files, environmental scans of the school buildings, police files from the criminal prosecution, and pictures of classrooms.

Depositions, as sworn testimony, are as close to that person's "truth" as is likely to be available. People being deposed swear an oath to tell the truth and the penalties of perjury apply, just as they would in trial testimony. In the cases analyzed, there are depositions from the victim, family members, the abuser, members of the abuser's family, classmates of the victim, and school personnel – teachers, coaches, custodians, school lunch monitors, teacher aids, building administrators, district administrators, and school board members. This is a broad and inclusive group of people who are "telling the story" in the civil cases/settings/contexts of sexual abuse.

3.5 Coding

We developed a set of codes that were descriptive of red flag behavior by an adult directed toward a child in these cases. Coding was done on documents in which all identifiers were removed. No school district names or names of people involved were available to coders. They were replaced with role identifiers (for instance, "principal", "2nd grade teacher, student target). Codes aligned with Tanner and Blake's grooming categories.

The authors coded the documents in pairs with the senior author serving as a third coder where there were differences in coding decisions.

4. Findings

Red flag grooming strategies to gain trust of targets, colleagues, or parents are described with examples from cases. Pseudonyms are used in all descriptions.

4.1 Who gets groomed?

In K-12 school settings there is a good deal of variation when it comes to the characteristics of students who are targeted for sexual misconduct by predators and in what types of school these violations occur. In other words: students of all genders, races, academic backgrounds, and personalities are groomed and are targets of sexual misconduct in all kinds of schools at all levels. In this study, we are reporting examples of grooming from both independent and public schools in the United States where elementary, middle, and high school females and males have been targeted with sexualized behavior by school employees. The majority of the cases were male employees grooming female students and others in the environment, followed by male employees grooming male students, then female employees grooming male students. We did not have any cases of female employees grooming female students.

Not all school employees who were grooming a student engaged in grooming the environment, but most who crossed sexual boundaries with students also needed parents and their colleagues to trust and like them, and, therefore, worked to gain their trust. Before actual sexual misconduct can occur, boundaries have to be crossed. Boundary violations occur in public, in front of others. Once boundaries are crossed and trust is gained, much of the abuse occurs in private settings such as closed classrooms, cars, or via social media interactions.

4.2 Tanner and Blake grooming categories

We examined the expert witness documents for examples of the grooming patterns described by Tanner and Blake and found examples of all in these cases with bonding, reliance, and attenuation (or normalization) the most prevalent.

4.2.1 Bonding

Bonding boundary crossing is what most bystanders see and it rarely announces as sexual abuse. School employees who targeted students often start out by identifying a special bond, "you aren't like other students", "you are so mature", "I can talk to you" are all phrases that were used to make students feel special. Female students often reported that male employees would talk about their personal emotional and sexual lives with a wife or girlfriend. "He told me he wasn't happy in his marriage and that his wife didn't understand him. He said I was different." Bonding also came through secrets that could not be shared, "no one can know about us" and comparisons "when I was your age, I had the same problems with my mother."

In many cases where boundaries are crossed and grooming occurs, students, parents, and other educators and administrators mistook these actions that crossed professional and appropriate boundaries as "prosocial behavior" (Tanner & Brake, 2013). Typically, prosocial behavior, such as compliments and direct attention in the classroom, are seen as positive educator behaviors when attempting to mentor students or forge beneficial educator-student relationships for the purpose of improving child learning. Thus, school employees often used tutorial help as a way to bond. A not uncommon pattern is for a teacher to talk with the student or the parent and describe the student as bright and capable, but falling behind. The teacher then offers to help the student catch up and advance. Students reported they felt special and liked the extra attention. Parents reported they were grateful for the extra time given to their child.

But the differences between prosocial and bonding grooming behaviors is the focus of this behavior –behaviors directed toward all or most students vs. a specific

student. Teachers who offer to help lots of students, in open settings, are very different from teachers helping a select student in a regularly closed environment.

A similar pattern revolves around food. A targeted student is invited to have lunch with the teacher in the classroom and the teacher brings the food. Other students are not invited or allowed. Intensity and repetition of these behaviors with a single student moves this from pro-social to boundary crossing and grooming. These boundary violations are carefully planned transgressions that scale in boldness relative to how often the predator can get away with the behavior in the presence of bystanders.

Use of personal – not school sanctioned and monitored -- social media is a common vehicle for bonding grooming. Using a private platform is much like being alone with a student behind a closed locked door. There is no way to monitor and the interactions are hidden and private. For example, in one school, observers frequently reported that a teacher, "was communicating with his 6th grade students via Facebook," thus establishing a private, personal, out of school communication pathway to groom students. When grooming through social media, direct or private messages can escalate quickly due to the relative ease of access predators have to students who may view it as normal behavior because that is how they communicate with their peers. Back and forth texts escalate into more intimate and private conversations and often include exchanges of photos of body parts or other sexual displays. It is not uncommon for hundreds of text messages to be exchanged in a school day, with intimate, connecting, and escalating messages.

4.2.2 Reliance

Another way that victims are groomed is to increase their reliance on the school employee. Sometimes that relates to grades, as in trading grades for time, "I didn't have to do my homework. As long as I spent time with him, he would give me a grade." Sometimes it translates into legitimate help when the school employee is tutoring and teaching a student, but withholds that learning if the student does not comply. Sometimes it is providing food or transportation. Gifts and money are also used in the reliance process, offering students things they do not have. Often those things are cell phones and iPads that provide the adult with easy access to the student. Other times students are given trendy clothes and accessories. But in all cases, the adult is using this grooming strategy as a way to tie the student to him or her, to increase the student's reliance on the adult.

4.2.3 Attenuate: Normalize

Predators work to normalize boundary crossing behavior. They are aided in this by schools that (1) do not teach students or other adults about what is acceptable adult to student behavior and that (2) fail to train students and adult bystanders how and when to report.

Boundary violations in the public eye, for example over public forums on social media or in full classrooms, are often defined by their subtlety--the goal of which is to progressively make children feel that these violations are "normal" or par for the course. Child targets often do not know how to code these actions, having not been taught about what is acceptable behavior from a school employee. As a result, they do not report these behaviors to authority figures who could intervene to interrupt the grooming process. For instance, a student bystander noted that a male teacher would rub up against female students: "…he [teacher] made her uncomfortable and … he would rub his penis against her back while touching her shoulder." Students often reported that the teacher "hugged" all the girls or "hung out" with a group

of students all the time. Sometimes the normalcy of boundary crossing blinds bystander employees to the reality of the violation. Violating school employees may give student victim rides to and from school or to other locations and are often seen by both adults and students leaving the school. And yet, this misconduct goes largely unreported even though in most schools it is an explicitly prohibited action. When queried about these actions, both students and adults would report that "I just assumed it was OK. No one said anything about it."

Adult conversations with students – often in the classroom or to groups of students during lunch or other non-class times – include sexual topics, personal disclosure of adult sexual activity and preferences, and questions to students about their sexual lives. These are disguised as "normal" interactions and topics with students, but they are grooming behaviors that seek to normalize sexual talk. These behaviors often go uninterrupted or only lightly reprimanded by other employees who overhear the boundary crossing conversations.

Normalizing also occurs when the adult behaves the same way as the student, acting as a peer. This is often presented as romance, leading other students to believe (either overtly or covertly) that it is OK for adults who work in the school to date a student. Bystander students, as a result, see sexualized behavior between the adult and, in most cases, a high school student, and explain it as 'normal' romantic behavior: "They are dating...They are boyfriend and girlfriend...[the predator] didn't molest [the victim], they were just making out."

For instance, a male teacher who had been grooming a female student reacted when she threw a Jell-O cup he had given her onto the floor. The teacher intruded on another class the student was in and threw what was described as a tantrum, "throwing things around...slamm[ing the door]...and star[ing] at [the student]." The bystander teacher of the current class period should have recognized and reported the obvious red flags indicating teacher-student boundary violations. The behavior of the abuser resembled an angry tantrum reminiscent of teenage lovers having a fall out, rather than a teacher simply being angry at a student misbehaving. Students described these behaviors as typical boyfriend/girlfriend actions, indicating how the adult had normalized these behaviors so that they were not seen as inappropriate, but, rather, indications of normal romance.

Those who groom students look for ways to touch students. In one middle school, two female students were in a classroom with a male teacher-predator talking about "getting away from someone that's trying to hurt you." The teacher grabbed one of the victims by the arm and said he did it "to show...that it's not as easy to get away from someone as you think." After the teacher was arrested, the girls were questioned and related what had happened. They explained that although they thought it was inappropriate behavior, they did not report the teacher, assuming that it was something teachers could do and that they thought they would not be believed.

Hugs are often normalized. For example, a teacher in an elementary school who hugs students in the hallway between classes and "when the kids would come in from recess" broadcasts an image of friendliness when the intent is to normalize inappropriate touching of children. The teachers who do this often portray this behavior as giving students extra support, "letting them know we care", a rationalization that is accepted by students, parents, and colleagues. In middle and high school, hugs are normalized across all students as praise or reward. That practice camouflages hugs for sexual purposes.

Students make sense of these boundary crossings and potentially illegal behavior from their own frame of reference. They do this because the adults in the school have not taught them another lesson, the policies of behavior (if they exist) have not been explained, and the culture of the school encourages everyone to look the

other way, rather than teaching what the appropriate teacher-student boundaries are and what to do if they see them being violated.

4.2.4 Trap

When school employees were suspected of sexual misconduct and questioned by school leadership or law enforcement, many sent messages – usually through texts – to the students they had targeted warning them not to "tell". The messages often reminded the students that "I could go to jail if you tell." "You would be hurting my family if you tell". "You will get in trouble if you tell". Although not common, some student targets reported that abusers threatened their family members – "He said he would kill my mother if I told." "He said he would kill my sister if I told." "I was afraid he would hurt my family." More often, though, the employee abuser played on the student's feelings for the abuser, "He told me he would go to jail. I didn't want him to go to jail. I just wanted it to stop."

4.3 Overall patterns across grooming actions

Some patterns were used across the victim grooming categories of Tanner and Blake.

4.3.1 Isolation

It is said that grooming occurs in public and sexual abuse in isolation. For the most part, that is true. But grooming can also occur in isolation. Bonding, reliance, and attenuation happen in public spaces and isolated environments. Isolation is not only a tactic to keep actions hidden, but also a strategy to remove the target from friends and family, leaving the employer abuser as the only person the student can confide in.

Isolation is a type of red flag that can go unnoticed due to its nature in being seen as "helpful" or "beneficial" to the victim from an outside perspective, or simply going unnoticed. Isolation is a way that gives the abuser access to the victim, without any suspicion or detection from outside environments. This can take many forms such as having individual coaching sessions, private tutoring, or one-on-one help after school in a classroom.

In one school a teacher, Mr. Park, offered to tutor a student, Jane Doe. This gave him access to her without other students and behind closed doors. Mr. Park began pressuring Jane Doe to meet him outside of school. Jane Doe described this pattern: "If I found a way to make it happen, he would find a place." Jane Doe finally agreed, and they decided to meet. Mr. Park picked up Jane Doe at the 99 Cent Store" and they went to his house, where sexual activity occurred. Jane Doe was receiving tutoring from Mr. Park, which eventually allowed him to isolate her in his home away from other outside environments and interference. Isolating a victim can be especially dangerous because it can lead to sexual abuse and misconduct due to the fact that it goes unnoticed by other faculty and administrators.

There are also instances where isolation occurs on school grounds during the school day. When J.L. did not return to the classroom in a timely manner, her teacher went to look for her and found her with the male classroom aid. They were both stepping out of a dark recessed area outside an empty classroom. The male aid told J.L's teacher that J.L. was afraid to go to the restroom alone. The aid would watch J.L. in the classroom, looking for ways to isolate her in the building that could be explained as "helping". J.L.'s teacher noticed that whenever J.L. left the classroom, the aid left soon after with a variety of excuses. The teacher also noticed that

whenever this happened the aid and J.L. returned to the classroom at the same time. And yet, J.L.'s teacher did not report these behaviors.

A similar scenario occurred in an elementary school when a male paraprofessional targeted a first grade boy. He isolated the male student by driving the student around in his car, which the student thought was fun. The time spent on these drives provided an opportunity to form a bond. By offering to help the family with transportation when the male student stayed late for tutoring or activities, the teacher built the trust of the parents which developed into a strong connection to this family. The boy's parents described the teacher as one of the family and reported that they were so happy the teacher was helping their son.

4.3.2 Gifts

Providing resources or gifts are very common grooming tactics used to pressure victims into gratitude for receiving this specific kind of attention from an authority figure. Gift giving is used to gain trust and make the victim feel indebted to the adult predator. Gifts serve both a bonding and a reliance function.

An example of gift giving occurred in a middle school between a teacher and an eighth grade student. Mr. Toledo targeted a female student for sexual activity and began a full on "courtship", buying her gifts and providing her with things she would not otherwise have. One day, for instance, he texted her and told her that he put a "surprise in her locker". When S.G. went to her locker, she found a pink iPad mini. And she was delighted and excited to have it. When she took it home, her mother questioned her about it. Finally, S.G. broke down and told her mother that Mr. Toledo had given it to her. S.G. felt special when she got this gift. And she wanted to keep it. And it made her like Mr. Toledo even more. Mr. Toledo counted on that. He knew that an expensive and lavish gift would escalate his access to S.G. and make it less likely that S.G. would rebuff his next steps. This gift bonded S.G. to him and also increased her reliance on him.

Gift giving to girls as a grooming step is not uncommon. But, depending upon the gift, it may be more likely to raise concerns from parents. Parents aren't aware of food and candy and privilege handouts to their child from an adult employee in the school, but they are likely to notice "things" that get brought home. For instance, teacher Park targeted Marianna and began giving her extra school supplies. When she brought these home, her mother noted them, but assumed they were part of the school package. Even when she realized that they were not given to all children, Marianna's mother treated the supplies as a way the teacher was helping her child succeed in school. However, when Marianne came home with a new purse, given to her by Mr. Park, her mother knew immediately that this was an inappropriate gift. A realization came to too late to stop Mr. Park from sexual activity with her daughter. The extra school supplies given to Marianna allowed Mr. Park to groom Marianna and make her feel special, portraying the grooming as "helping". Typically, parents and administrators would not question who supplied school supplies to a student whose family could not afford them. And yet, they served the same purpose as the gift of the purse: gaining the trust and good feelings of a child while crossing boundaries and manipulating a child's affections.

4.4 Environmental grooming

In many of these cases, parents were groomed to trust the teacher, usually because the teacher was providing their child with academic support. "We were really grateful that [the teacher] was helping our daughter with her math." Often parents commented on how friendly the teacher was. In other cases, the teacher

befriended the parent, usually a single mother, and provided support such as stopping by with dinner and conversation or, in some cases offering to babysit when the parent needed help.

A not atypical pattern was a male school employee targeting a male student who was the child of a female single parent. The teacher would contact the mother, expressing concern about her son's academic work. The teacher usually praised the boy as being bright, but who needed some extra guidance to get on track. The teacher then offered to tutor the child. The teacher would inject himself into the household, offering to bring the boy (and often siblings) home from school, provide little extras to the household – food, movies, toys – and become a confidant to the mother. The mother described the experience as a dream come true. Worried about the effects of raising a male child in a fatherless home, she felt grateful that "the teacher everyone hoped their child would get" was helping her son learn and providing her son with a good role model. The grooming of the mother was an essential part of this pattern.

Colleagues were also actively groomed by abusers. After a teacher had been arrested or convicted, colleagues reported how surprised they were. The following were typical of comments colleagues made. "He was always so helpful, offering to take care of things after school so that I could get home to my kids." "I just couldn't believe it. He was the nicest person. Always there to help and focused on the well-being of students." "He was teacher of the year in our school district."

5. Conclusions

In Fall of 2019, an estimated 56.6 million children in the United States entered classrooms with 3.7 million teachers, 938,000 administrators, and other staff members (NCES.ed.gov; Department for Professional Employees, 2019). The most recent generalizable available data collected at the student level of victimization document that seven percent of students report being the target of physical abuse by a school employee, most often a teacher or coach [3]. When multiple forms of assault are combined – verbal sexual misconduct (sexual stories or talk about a student's or teacher's sex life) and visual sexual misconduct (pornography, masturbating in front of students) – 10% of students report being victims nationally. Thus, 5.66 million students report sexual abuse by employees in schools.

Prevention of school employee sexual misconduct requires that bystanders [school staff, parents, other students] understand the behaviors by abusers that would indicate that a student is being targeted for sexual misconduct. These behaviors are referred to as grooming and are red flags that should signal boundary crossing and possible sexual misconduct by an employee.

Documenting and describing these behaviors is a step toward prevention. The more able bystanders are to recognize boundary crossing and grooming – and report what they see – the safer students are from school employee sexual misconduct and abuse in school.

All of the cases reviewed for this chapter include grooming behaviors by the school employee directed toward the student. Abusers used tactics to bond with the student by forming special relationships, keeping secrets, receiving special gifts, and one-on-one attention. Abusers also worked to keep the student reliant on the abuser for emotional support as well as for academic help and gifts Abusers worked hard to normalize boundary crossing so that these grooming behaviors would go unreported. When they were reported, abusers used traps and threats to prevent disclosure.

Individual targets were not the only ones groomed, however. Parents, siblings, and colleagues were also groomed to like and trust the abuser in an attempt to ensure that the grooming and sexual misconduct directed toward the student would go unreported. While understanding what grooming looks like will not stop all sexual exploitation of students, knowing the warning signs and red flags and reporting them immediately will go a long way in preventing sexual misconduct.

Conflict of interest

The authors declare no conflict of interest.

Author details

Charol Shakeshaft*, Mitchell Parry, Eve Chong, Syeda Saima and Najia Lindh
Virginia Commonwealth University, Richmond, VA, USA

*Address all correspondence to: cshakeshaft@vcu.edu

References

[1] United States Government Accountability Office (GAO) (2014). *Child Welfare Federal Agencies Can Better Support State Efforts to Prevent and Respond to Sexual Abuse by School Personnel*.

[2] United States Government Accountability Office (GAO) (2010). K-12 Education Selected Cases of Public and Private Schools that Hired or Retained Individuals with Histories of Sexual Misconduct.

[3] Shakeshaft, C. *Educator Sexual Misconduct with Students: A Synthesis of Existing Literature on Prevalence*, Planning and Evaluation Service, Office of the Undersecretary, US Department of Education

[4] Lanning, K. (2018). The evolution of grooming: Concept and Term, *Journal of Interpersonal Violence*, Vol 33, p. 6.

[5] Tanner, J. and Brake, S. (2013). Exploring Sex Offender Grooming, http://www.stephenbrakeassociates.com/Exploring%20Sex%20Offender%20Grooming.pdf

[6] Welsh, S., Dawson, M. & Nierobisz, A. (2002). Legal Factors, Extra-Legal Factors, or Changes in the Law? Using Criminal Justice Research to Understand the Resolution of Sexual Harassment Complaints.

[7] Reagan, R. (2010). Sealing court records and proceeding: A pocket guide. *Federal Judicial Center, p. 2.*

Chapter 3

Under the Cover of Silence: The Burden of Marital Rape among Immigrant, Muslim, South Asian Survivors of Domestic Violence

Dheeshana S. Jayasundara, Durdana Ahmed, Prita Das Gupta, Susan Garcia and Sarah Thao

Abstract

This chapter looked at the experiences of marital rape among immigrant South Asian Muslims domestic violence survivors who are living in Texas, USA. Based on qualitative interviews with 20 participants, this chapter discusses the hidden nature of marital sexual abuse. Specific themes include: abuse took place in a larger context of domestic violence; duality in sexual behavior allowed for husband and wife; submission through threat and intimidation; it is not rape but, I feel the same as a rape victim; shame of talking about something so private; and divorce and vulnerability from sexual advances by outside men. Implications to advocates and human service workers, especially those living in Western countries and work with Muslim communities are discussed, as well as how to effectively assist these diverse communities in a culturally sensitive manner, being mindful of their religious background.

Keywords: Marital rape, spousal abuse, domestic violence, south Asian, Muslims

1. Introduction

Marital rape unfortunately exists in every society. In the US, sexual coercion within marriage was banned in all 50 states by 1993 [1]. Still, marital rape charges are hard to prove, and consent to sex within marriage for each sexual encounter is a concept that remains elusive. Consensual sex between partners within the confines of a marriage is the generally accepted norm in non-abusive relationships. However, like in any other country, in abusive relationships sexual coercion continues to occur in the US and remains a difficult topic to battle. One study found that in the US 40–52% of the women in intimate relationships experiencing domestic violence, also experience sexual violence [2]. These cases can be hidden in some minority communities. The US is made up of diverse communities, and cultures. Immigrants to the US not only abide by US laws and cultural norms of the dominant culture, but also bring with them cultural values, beliefs, and practices from their own countries that are different. Many practice biculturalism, navigating two worldviews that, at times, appear to clash with each other [3]. Multiculturalism and diversity enhance the local culture and force everyone to embrace change, and look to within their

customs and identify areas that need to be remedied. Domestic violence, especially marital rape, is a dark side of any culture and is unfortunately prevalent across all societies [3, 4].

Most South Asian immigrants within the US have their own values and customs regarding marriage. Like anywhere else, consent to sex is a generally accepted norm within a marriage, but how that consent is obtained varies in different cultural communities. In South Asia, marital rape is not a crime under the law, except for Nepal and Bhutan [5]. For example, the penal code of Bangladesh reads that, "sexual intercourse by a man with his own wife, the wife not being under 13 years of age, is not rape" [6]. The legal and the cultural implication of that is that by the consent to marriage, sexual consent is granted at the outset, and sexual acts are not negotiated by each encounter. This means that legally by design a husband cannot rape a wife. While these views on sexual consent within a marriage vary by age, class, education, religion, and other intersectional factors, it creates a situation in abusive relationships where sex can be demanded by the spouse at any time, regardless of their partner's wishes. This is further complicated by patriarchal gendered norms about differences in male and female sexuality that exist within many South Asian communities. In South Asian countries, men are generally granted sole entitlement to initiation of sex and to sexual pleasure, being viewed as having biological sexual needs, and there is a common acceptance of males having multiple sexual partners or sexual encounters before and after marriage. On the flipside, women are typically viewed as the pillars of society for socialization. Hence, viewed as chaste beings, access to sex is generally accepted only through marriage. There is an expectation they will remain a virgin until married and will remain faithful to their partner after marriage. Women's sexual pleasure is not a concept that is often accepted, written about, or talked about [7, 8]. This dichotomy between male and female sexuality creates distinctions within women, where "good women", or those who abide by the cultural norms, have access to marriage and social status. "Bad women", those who do not conform, have difficulty finding marriage partners and are branded within their communities. The more you deviate from those norms, the more negatively you are sanctioned. Sex workers, who are not just viewed as deviants but also as a group who takes advantage of the sexual entitlement and the biological needs of men, are granted the lowest social status, relegated to society's margins, and are criminalized [8–10]. From this perspective, for women who abide by social norms, access to sex is seen both as a reward but also as a duty to the partner for the security and social status that marriage brings. This creates a power differential in relationships that complicates giving willing consent [7]. Misinterpretations of religious passages and cultural practices tied to religion further complicate sexual negotiations within South Asia. In the Muslim faith, many verses in the Quran and hadiths from Prophet Muhammad preach peace, love, and equality within marriage. For example, the verse, "They (your wives) are your garment and you are a garment for them" (Quran - 2:187) [11], describes equality of partners in marriage. Additionally, the hadith (hadith - teachings of Prophet Muhammad) that the Prophet said to his companions: "Not one of you should fulfill one's (sexual) need from/fall upon his wife like an animal; but let there first be a messenger between you" And when asked "What is that messenger?", he replied "kisses and sweet words". In effect, the Prophet Muhammad was talking about foreplay. Several other hadiths and verses from the Quran also show that foreplay was recommended before sexual relations. This recognizes the fact that women need some time for arousal for sex to be comfortable and pleasurable. "And one of the signs is that he created for you spouses from among yourselves so that you might take comfort in them and He has placed between you, love and mercy....." (Quran - 30:21) [11].

Yet, many Muslims believe that men can request sex from their wives anytime. In Islam, marriage is a civil contract, under this contract, both men and women are assigned specific duties. The husband is considered to have *Qiwama* (authority) over the wife, he is expected to provide for her within the marriage. The wife is expected to have *ta'a* (duty to obey) the husband. While this concept of *ta'a* is interpreted differently, many imply sexual obedience [11, 12]. Additionally, the verse "Your wives are tilth for you, so go to your tilth when or how you will...." [Quran - 2:223] [11] is cited as the justification for this religious sexual entitlement by the husband. Furthermore, the old cultural practice tied to Islam where men can have multiple wives is still practiced by some South Asian Muslims, though it is rarer among educated Muslims [12]. These concepts complicate sexual negotiations further within marriage for Muslim South Asian women living in the US.

These intersectional factors create a context where marital rape as a concept is nullified. This allows society to believe that consent is given at the time of the marriage and not with each sexual act. These values further complicate marital rape as it creates a situation where husbands can demand sex from their wives anytime, and as dutiful wives, they need to comply every time. No matter how painful it is, the concept of coercion is not accepted as rape, rather as part of wifely duty, and in some situations with the threat of a second, or third wife hanging over her head. While these concepts may create dilemmas for women even in peaceful families, these cultural norms can have especially detrimental ramifications for women undergoing domestic violence. To understand the impact of marital rape, this paper looked at immigrant Muslim South Asian female survivors of domestic violence experiences of marital rape. At the time of the interviews, all women were living in the US.

2. Methods

The study was conducted in the United States of America. This study is part of a larger study conducted in Texas, looking at domestic violence in the Muslim communities. While the overall study conducted qualitative interviews with 48 Muslim survivors of domestic violence coming from various backgrounds, only 20 South Asian women talked about their experiences of sexual abuse within the marriage. All 20 women were foreign-born and came from Pakistan, India, Bangladesh and Sri Lanka. Ages varied from 23 to 58. The interviews took place between 2011 and 2018. All women were fluent in English and the interviews were conducted in English. The education background of the participants varied with 10 participants having a college degree or some college experience, and 10 participants with no higher education. A content analysis approach was utilized to analyze the data. It is important to note that all participants were seeking services for domestic violence. Themes identified were based on the participants' views only. These should not be generalized to all South Asian cultures or those who are considered Muslim.

3. Results

3.1 Abuse took place in a larger context of domestic violence

Sexual abuse did not take place for these women in a vacuum, rather it took place in a larger context of psychological, physical, financial, spiritual, and at times even immigration related domestic violence. As the participants came from a domestic violence shelter, all the women discussed a range of abuse that took place leading them to seek help from an agency. None of the women sought help because

of the sexual violence, rather it was due to other aspects of abuse. Some were there due to emotional abuse, while the majority experienced physical violence. Some stated that they were talking about their experiences related to sexual coercion and marital rape for the very first time. Women in the study appeared to have a perception that being forced to have sex with their husband was not abuse, similar to other types of abuse they had undergone. Rather it was part of marriage. The women were groomed to believe that culturally and religiously, they were expected to comply with their husband's wishes. Sexual abuse within marriage appears to remain relatively covered up, even though every US state since the 1990s has marital rape laws. The following conversation between the researcher and the interviewee elaborates this context very well.

"Interviewer: Who do you confide about feeling forced to have sex?

Interviewee: No one.

Interviewer: You have not spoken to anyone about what you just mentioned?

Interviewee: Well, I have spoken to a counselor and the case manager about the other abuse, how he tried to choke me and kill me, how the police were involved, but not about other stuff I just told you, no.

Interviewer: May I ask your reasons for not telling anyone?

Interviewee: It is private, our culture, everyone is in the same situation, I think. You have to give in at some point. You married him. We are told that all the time growing up."

South Asian culture in general, and Muslim culture in particular, value modesty in women very highly. Sex is not a subject that is talked about and young girls are not given much information about what to expect with regards to marital relations. They are not aware of what acceptable or "normal" behavior is and what is unacceptable or pushing the boundaries into rape. For them, anything their husband does is to be tolerated, even if they do not enjoy it or find it painful. Consent, or lack thereof, certainly never enters the equation. They are not aware they have a right to refuse certain acts if they choose to do so.

3.2 Duality in sexual behavior allowed for husband and wife

Similar to past studies on sexual behavior from South Asia, the women in the current study identified variations in the code of behavior allowed for men and women, and extending to husband and wife. While men were identified with entitlement to demand sex when desired and even allowed access to other women, the women's role in terms of sexuality was identified by duties and an obligation to the husband. Rather the women were considered more the property of the men, with obligations to fulfill. Participants discussed that men did not consider wives as equal in sexual play, and when sexual pleasure was sought after by women, it was discouraged even within the marriage. Men are sexual beings, while women are mere receptacles. They are not viewed as active participants with sexual desires. This is derived more from South Asian culture, rather than Islamic teachings.

3.2.1 Viewed as property, and duty to oblige at any time

As mentioned above, the participants repeatedly used language of 'belonging' to the spouse, and discussed their role in sexual play as duties and obligations. Interestingly, while the women talked with great dissatisfaction, it was also clear through their conversations that they were also accepting of these societally assigned roles and their husband's treatment of them. As one woman said, "This is not something we talk about in my culture, but he treated me like I was his property. It was an exchange somehow; he gave me a house that he earned money to pay

for where I had to cook and be sexually available when he needed. I was denied any pleasure. There was no emotions in his sexual requests. It was nothing romantic. Just satisfy me, this is your duty".

Other women also echoed this sentiment of being treated as property and the obligations to submit. As one said, "it is like I don't have a say, I am like an animal to him. I just have to do what he tells, my duty and obligations, that is it."

3.2.2 Women are not allowed to initiated sex or enjoy

As mentioned above many women alluded to the concept that husbands are the only one who are normed to get sexual pleasure within the marriage and women are expected to only give pleasure to the husband. Some women discussed this concept in detail. As one woman said, "I didn't feel I could say no. at least most times...no, he didn't care how I felt, he didn't think sex needs to be enjoyable for the wife. Just for the man".

One of the women at the shelter came severely injured internally. Her husband had tried to "cleanse" her with a hose pipe. He wanted a wife who was "pure".

In a focus group discussion two participants had this exchange. One woman was explaining that her husband cheated on her, and how she had to still accept it, but as a woman she cannot do the same:

"Female 1: Yeah. And she already say, we say jealous, okay, it's fine, with the man, what did you do, they said okay fine, but woman, it's no.

Female 2: Because he's a man, he can do whatever, his family is like a property for him, it's not like human being, no. It's his property."

Another woman talked about a time when she was called a slut by her own husband for initiating a sexual act. She said, "One time I watched this video involving French kissing, I was naïve and wanted to see what it was like. I asked him (referring to the husband) if we can try. He told me I was acting like a 'slut' and to stop demanding for sexual things. He was basically telling me I wasn't a good woman because I asked for something sexual and made me feel ashamed. Sadly, he is not alone in this, I know all his friends would feel the same way".

A few others elaborated this further, a few women felt that their husband's expectation for them for sex, beyond pleasuring them is to the have children. One woman simply said, "Another said, "He only wants me to make babies". Another elaborated further, "It was just out of the blue, he just hit me. And I wouldn't accept that. And he wanted me to be a stay at home wife, and wanted me to have kids right away, and I had already told him before we got married, I want to go to medical school. Do you think that's something you can handle? He said yes... I told him, I don't want to have kids until like three, four years down the road. Is that something you're okay with? And he said yes... right. Afterward we got married, everything changed... Right away... Within marriage, as soon as we got married... Yeah. He was like, I don't want you to go to medical school. There's no such thing. And he wanted kids right away, so I started hiding my birth control".

Yet another woman said, "I have children, he just wanted me to keep making children, but, with the last child I went and got an illegal abortion in my country".

Yet not all women bought into the belief that sex is for male pleasure. One woman stated, "I enjoy sex... despite what I went though I would like to get married again".

3.2.3 Expected to be obedient and just comply

The women in the study also talked about their upbringing where they were expected to me obedient and submissive to their husbands. These values were

culturally and religiously emphasized in their childhood socialization process. Their upbringing of expectation that a good wife is someone who is obedient, submissive and one who does not complain about private matters of the household all created a context of future acceptance of sexual coercion by their spouse as normal sexual behavior expected of a 'good' wife. One woman explained, "I was told from the beginning be a good girl, men only marry good girls, I was groomed from the beginning to be a wife, a good wife, and good wife is someone who won't fight her husband, the man is the head of the household, you have to comply to his wishes. It is in the Quran too. So, I was trying to be a good wife. I tried. I tried very hard. I did everything I was brought up to believe, but, it wasn't enough for him, and it got worse and worse".

This expectation to be obedient wife was something that was brought up by several other women also, another woman said, "I was brought up to be obedient to my husband". Another talked about the more complicated dilemma it created for her, "I believe because of seeing my parents, and how I was raised everything would be easy. I didn't expect sex to be this difficult, how do you say yes every time when it hurts every time?"

It is important to note that the majority of the women in the study did not question their culture, rather they used culture to explain their experience, and even the few that were upset with their culture or religion still understood their experience within the context of their cultural and religious backgrounds, as one of the women said, "sometimes I am upset how much I went through, it is our culture, it is my religious background, but when I really think about it, I still question myself too... was I a good wife, are there things I could have done?"

3.3 Submission through threat and intimidation

Beyond duty, women in the study talked about how threat and intimidation were used as weapons to get them to submit to sex. While emotional and physical threat is a constant fear they had to live with if they opposed the sexual demands from their husbands, the women in the study also talked about their husband's threat about, or actual relationships with other women.

One woman talked about how an old Islamic tradition accepted in her country which allowed men to marry more than one woman was a threat for her if she did not comply. She said, "He would threaten me all the time that he can have other women, he can have four women. He told me if I don't have sex with him, he will find someone who would and I just can't do anything about it". Another explained the complex play between actual acts of cheating, using that to get the wife to comply but also make her feel like his cheating is because of her inadequacies in the bedroom. She elaborated, "He found another woman, and he didn't care how I felt. He treated me like I had to accept. It is part of culture that men have a right to sleep with whomever they please. He made me feel like I made him go out though, because I wasn't adequate in that area. For him it was like at least it is just sex, not an emotional relationship, so I should be happy. I still had to give in to him if he wanted and if he feels like it he didn't even look at me sometimes. He threatened to go out more if I didn't".

Beyond the threat of emotional and physical abuse and cheating, women also talked about how some used their religion to force compliance. In a focus group discussion two of the participants said:

"Female 1: Show it by their religion. They say in the past – The men use Quran, interpret it wrong.

Female 2: It's different, yeah, what you – they are like it [Crosstalk].

Female 1: Like I told you, whatever you like.

Female 2: Whatever he like it, you have to obey, honestly, I'm talking about this, it's like this, you have to obey. Because in the religion, in the Quran say that, you have to be like this. You have to respect your husband like this, what he like it. But, I don't know if it means what men say it does. But, we have to comply".

Yet another woman talked about how religion and threats to tell family were used against her, she said, "He would say he has the religious right to have sex with me anytime. He would threaten to tell my family if I did not give in. It would be so embarrassing and my family would have said I wasn't being a good wife".

In South Asian cultures, as well as in Islamic religion, the concepts of fate and patience also play a big role in the acceptance of, and submission to, domestic violence and sexual violence. In Islam it is thought that whatever happens to you has already been decided by *Allah* (god). What *Allah* has decreed will happen and since it was decided by *Allah*, you have to accept it and be patient. That is what *Allah* requires you to do, and you will be rewarded with a place in heaven for your patience. As one woman said, "I know this is a test. It is is already decided for me... he is testing me through him, even he says it, but different".

3.4 It is not rape but, I feel the same as a rape victim

Given the cultural and religious understanding that in a marriage women are expected to comply many women did not identify what they went through as rape. Yet, they talked about the same symptoms of rape survivors. As one woman elaborated, "I don't think I consider it being raped. Rape I see as someone forcibly violating you. I know I have a duty as a wife. It is part of marriage. In my case, I don't think I have a right to say no when he demands. But, I hated it. I hated him showing any affection, because I was afraid it would lead to him wanting sex. I was afraid to go on trips with him, inevitably when the night time comes he would want to have sex. Any as the day got closer to night, I would start feeling sick, I would have a headache, I would feel sick to my stomach, I could feel my body tensing up. I hated the thought of having sex with him, as it comes closer and closer to bed time I would feel more and more stressed... yes, he knew it hurt me, he didn't care. Sometimes, I would say I don't want to have sex tonight, but, if I say that his mood would change and he wouldn't talk, or he would remind me all the things he is doing for me".

Another said, "The whole process made me feel dirty, every time we have sex. It made me want to take shower after shower. It just didn't feel right". Yet, another woman explained a more horrific experience in her very short marriage, "He forced on me repeatedly. He was so violent. I would bleed. Even after I got pregnant it didn't matter. I would cry the whole time... my marriage lasted only a few months". Yet, when asked if she would consider what she went through as marital rape, she was not sure, she said, "I am not sure, it was horrible...may be now...".

One final woman, while also not quite acknowledging her experiences of having sex without emotional consent as rape, talked about how the cultural context of marriage does create a situation where wives at least initially are in a context ripe for rape. Yet, she accepted it as the price of marriage. She explained, "Obviously when you are kind of forced to marry at a young age, and these are arranged marriages, you don't know him. All your life you are told keep your legs crossed, don't let boys notice you, don't let anyone look at you, and suddenly you are supposed to be with this stranger, even though he is your husband. Of course it is going to be difficult. How do you let all that upbringing go? You can't relax, and our men, they are not like in the movies, they don't talk love. They just jump to it. How are you supposed to be okay? It is not going to be okay, but, that is price of marriage".

In many South Asian countries, arranged marriages are still the norm. Girls are brought up in strict environments with little to no contact with members of the opposite sex. Co-educational schooling is limited in conservative areas, and girls usually attend girls-only schools and thus have limited exposure and opportunities for meeting or interacting with boys/men. Marriages are arranged for them by their parents, or families, within the social group. Many of these young women meet their husbands-to-be with both families present. There is little interaction and very few chances for getting to know their prospective husbands. Their first real contact with their husbands is after the marriage ceremony has already taken place, and they have been married to a stranger.

Another woman told her story of experiencing increasingly violent sexual abuse. She said the first few months of her marriage seemed okay, but then she began noticing that her husband started forcing her even when she was not feeling well. In fact he seemed to enjoy it more when she said no. One day she accidently discovered that he watched videos of women being raped. That was when she realized he was acting those scenes out and it scared her enough to leave him. However, she did not identify what he played out as rape. Yet, she talked about the shock, the pain and the emotional trauma.

3.5 Shame of talking about something so private

Almost all the women in the study identified that it is shameful to talk about marital sex. They acknowledged that it is the most private intimate thing in a marriage and that they were brought up not to talk about family matters, especially an area that they deem very private as sex. Some in the study acknowledged that this was the first time they were talking about their sexual abuse and that this was an area that they had not even brought up with their therapists. As one woman said, "I just couldn't talk about such intimate issues with her (referring to the therapist), it is so shameful, it is not like physical abuse, or not giving me money, this is so private." Yet, for another it was the fact that she felt she couldn't comply to her husband's wishes, "I didn't tell even my mother, I didn't want to be judged, I just couldn't give every time, how am I supposed to talk about that to anyone, this was my duty as a wife?" For another woman the shame was questioning herself for husband's extra marital affairs, "In my head, I know it is all on him for cheating like that, but he always said it was my fault that he cheated, because I didn't know how to give him... I couldn't satisfy him, I struggled with that, I questioned my worth with that... even now I feel this shame inside-I worry others think the same, and I know inside, but it doesn't help".

The women talked about how this sense of shame stopped them from reaching to anyone about how they felt. The burden of how they felt due to forcing sex upon them, or cheating on them were placed on the woman herself. The above woman continued, "I felt very alone, I didn't know how, how do I tell anyone I hate doing anything with him, and I then I also tell he is cheating? How, everyone will say it was my fault"

3.6 Divorce and vulnerability by sexual advances by outside men

While these experiences within marriage were bad enough, some younger women also identified the sexual dangers of being a divorced woman. They felt that now they don't have the protection of a man, other men will think they are available for their pleasure. One woman felt like she has to weigh her options before considering divorce. A woman living on her own without a husband is

very vulnerable and exposed to a multitude of dangers... Often she does not have the support of her family and there is no one to turn to if she is harassed. As one woman explained, "It is harder because a lot of men hit on me after my divorce. They would act like they are going to help me, but they end up wanting something else. Not a relationship, but... (referring to sex) you know what I mean... because my visa expired (because her husband didn't apply for extension), I am illegal right, so in the end I thought, I am just going to stay in shelters (referring to DV shelters) till the Visa (VAWA petition) came. I am afraid to go out to work. It is almost a year now, I have stayed in 3 different shelters here, here (referring to current agency) more than 6 months. It is okay I don't have money. I don't want to be treated that way. Visa will come soon... yeah you have to consider is going through everything I went through better or am I now going to experience that from all the other men? But, I would say no. He was too extreme". Another explained, "I am talking to guys also... you know what I am saying... they want a good woman, I am not anymore, guys just want sex and not marriage... the good woman... I am praying either get married or get through my son because he is autistic... this guy try to take advantage of me... but I don't let any take advantage... These days they look at women who work with respect and women who don't work they look down... in India also divorce is not okay".

Gender roles are very strictly defined in Muslim culture. The man is the protector, the provider, and spiritual head of the family. The woman is in charge of the household and of raising the children. With the head of the family out of the picture, divorced women feel very vulnerable to any men who might try to take advantage of them. Since they are divorced, they are viewed by men in their communities as "available". They are sexually experienced and not seen as innocent virgins - leaving them even more exposed. Traditionally, in Islamic culture, the father, or the eldest male, is the "*kafeel*" (one who is responsible) of the women in his household. This means he is responsible for them, and has the authority to speak or act on their behalf. They are under his protection. Once a woman gets married, her husband becomes her *kafeel*. After divorce, the woman may choose to go back to her father's, or eldest brother's, protection. If that is not an option, then she is without a male protector and open to being propositioned by men in the community. Many of the women in the study talked about being the only one in America, or if they had male siblings them being in other states. Thus, many were without a male protector. This becomes a deterrent for many women wanting to leave their abusive relationships. As one woman said, "I had think a lot before I left him, I didn't have anyone to protect me here. I am all alone in this country. It is a matter of who will pray on me now, and to be truthful it is not easy, I try to keep away from people from ... (name of the country), because I don't know how they will view me, I am not a good woman in their eyes anymore, and there is shame there, but it also means men see me as, "oh she is not a virgin, she doesn't have anyone to protect, she is available for just sex".

4. Conclusions

Women this study were all survivors of domestic violence, and findings therefore must be understood within the intersectional confines of of culture, religion, domestic violence and its impact on marital rape. This study findings reflected how South Asian girls' upbringing steeped in patriarchal culture, and misinterpretations of religious passages led to a context ripe for sexual abuse within marriages that were already experiencing domestic violence. Yet, this same socialization

prevented them from understanding marital rape as rape. Even when the women opposed what happened to them, or experienced physical and psychological symptoms related to abuse, or even when they understood the context in which they were forced to have sex by their spouses, they were reluctant to name it as rape. Within the intersectional South Asian culture and Islam, the women in the study identified that girls are taught to be submissive, obedient, silent, and patient. They identified this submissiveness as the ideal and perfect wife/daughter-in-law people are looking for. This added with the direct belief that access to women's sex is through marriage and women's role in sex is to cater to the husband's needs. It means that women in the study believed that they must cater to all the demands from their husbands in the bedroom. Hence the women in the study did not complain about sexual violence and tried not go against societal and religious norms. Unfortunately, this meant that even when they understood other aspects of domestic violence and abuse, marital sexual violence was accepted. This also means that sexual abuse will be not be revealed due to the veil of silence over this subject. As participants identified it is extremely shameful to talk about this aspect of their marriage and they are taught to never bring shame on the family or their husband. Many women in the study identified that talking the researcher was the first time they talked about the sexual abuse within marriage. This contexts of uniqueness are important to understand to identify the circumstances in which marital rape happens and understood. The study findings are similar to other past studies on marital rape in South Asia [3, 7, 12–14]. These findings have implications to human rights advocates, human service workers, and legal advocates. You can't find what you don't know, and you can't fight what people understand as acceptable. Hence, the study findings indicate the importance of understanding contexts in which marital sexual abuse takes places, and the importance of targeting the socialization process itself. The study highlights the importance of long-term cultural change related sexuality, promoting resect and equality that is needed to prevent domestic violence and marital rape. On an individual level, the human service sector working with this population needs to understand these contexts to effectively assist. Legal advocates also need to understand the cultural and religious backdrop that promotes a reluctance to provide evidence in court.

Acknowledgements

This publication was partially funded by Grant Number HHS-2013-ACF-ACYF-EV, Department of Health and Human Services, and the University of North Dakota grant. This affiliated agency also received partial funding from the Robert Wood Johnson Foundation. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or other funders.

Conflict of interest

"The authors declare no conflict of interest."

Notes/thanks/other declarations

We thank all current and former survivors of domestic violence for sharing their stories and insights.

DOI: http://dx.doi.org/10.5772/intechopen.97277

Author details

Dheeshana S. Jayasundara[1*], Durdana Ahmed[2], Prita Das Gupta[3], Susan Garcia[4] and Sarah Thao[1]

1 California State University, Fresno, Fresno, California, USA

2 Community Consultant, Morgan Hill, California, USA

3 Initiative for What Works to Advance Women and Girls in the Economy, Delhi, India

4 Fresno City College, Fresno, Fresno, California, USA

*Address all correspondence to: djayasundara@csufresno.edu

References

[1] Ross JM. Making marital rape visible: A history of American legal and social movements criminalizing rape in marriage [dissertation]. Lincoln, University of Nebraska-Lincoln; 2015.

[2] Campbell JC, Soeken KL. Forced sex and intimate partner violence: effects on women's risk and women's health. Violence Against Women, 1999, 5:1017-1035.

[3] Abraham M. Speaking the unspeakable: Marital violence among South Asian immigrants in the United States. Rutgers University Press; 2000.

[4] Heise LL, Moore K, Toubia N. Defining" coercion" and" consent" cross-culturally. SIECUS report. 1996;24(2):12-4.

[5] Saxena C. 'Half the sky is still dark: Marital rape in South Asia – Analysis' Eurasia review [Internet], 2021

[6] The Bangladesh Criminal Law. Penal Code. ACT NO.: XLV OF 1860, section 375: Rape.

[7] Abraham M. Sexual abuse in South Asian immigrant marriages. Violence Against Women. 1999 Jun;5(6):591-618.

[8] Jayasundara, D. Clients' motives and justifications for visiting sex workers in Sri Lanka. Paper presented at the Annual Meeting of the American Society of Criminology, San Francisco (November, 2000).

[9] Miller, J. The commercial sex industry in Sri Lanka: Some preliminary observations (International Centre for Ethnic Studies Lecture Series). Colombo, Sri Lanka: International Centre for Ethnic Studies. 1999.

[10] Shah CD. South Asian women's sexual relationship power: Examining the role of sexism, cultural values conflict, discrimination, and social support. West Lafayette, Indiana: Purdue University; 2016

[11] Qur'an, translated to English.

[12] Khan IS. Consent in Marriage: A Radical Feminist Analysis of Pakistani Law. Wm. & Mary J. Race Gender & Social Justice. 2019; 26:671.

[13] Chatterjee P. Speaking the Unspeakable: Marital Violence among South Asian Immigrants in the United States. American Journal of Sociology. 2002; 108 (3): 713-715.

[14] Cowburn M, Gill AK, Harrison K. Speaking about sexual abuse in British South Asian communities: offenders, victims and the challenges of shame and reintegration. Journal of Sexual Aggression. 2015 Jan 2;21(1):4-15.

Chapter 4

Sexual Violence and Women Empowerment in India: Findings from a Nationally Representative Sample Survey

Shewli Shabnam

Abstract

Promoting gender equality and the empowerment of women and elimination of violence against women was recognised as an important component in the United Nations 2030 Agenda for Sustainable Development. Intimate partner violence is one of the most common forms of gender based violence throughout the world. Empowering women is an effective measure required to tackle the problem of domestic violence. There are various parameters that are used to measure women empowerment like education, work force participation, women's decision making capacity in the family etc. In this paper we have analysed the relationship between women's experience of spousal sexual violence and women empowerment using the ecological model of domestic violence proposed by Heise. We have used the data of the 4th National Family Health Survey (NFHS-4) conducted in India in 2015–2016. Our results show that common empowerment related factors like education was not significantly associated with women's experience of sexual abuse. Moreover, the likelihood of facing sexual abuse by husband was found higher among working women. We observe that relational and contextual factors like husband's assertion of control over wife, cultural norms that condone wife abuse significantly increased women's likelihood of experiencing sexual violence by husband.

Keywords: domestic violence, women empowerment, sexual violence, patriarchy, ecological model of violence

1. Introduction

Violence against women by intimate male partners is a common practice and an accepted reality throughout the world. It is perhaps the most widespread form of gender based violence denying women's basic human rights, dignity, security and self-esteem [1]. Intimate partner violence (IPV), often referred to as domestic violence, encompasses physical and sexual assaults, stalking and psychological abuse by a current or former intimate partner. IPV also includes threats of harm, coercive tactics or arbitrary deprivation of liberty that may occur in public or in private life [2–4]. IPV may occur in the same-sex relationship, can be perpetrated by women, but most frequently, women are abused by their partners [3]. In 2017 around 87,000 women were murdered and 58 per cent of them were killed by intimate partners or

other family members [5]. According to a report of the World Health Organisation [6], globally almost 30 per cent of women experience physical and/or sexual violence by their intimate partner at any time in their life.

The prevalence rate of IPV in India is more or less similar to the global average. According to the Ministry of Home Affairs, Government of India, in 2019, more than 400,000 cases of crime against women were registered under Indian Penal Code and the highest number of cases was recorded under 'cruelty by husband or his relatives' (31 per cent) [7]. The fourth National Family Health Survey (NFHS-4) revealed that in India, among ever-married women aged 15–49, 30 per cent experienced physical violence, 7 per cent experienced sexual violence and 14 per cent experienced emotional violence by the current or the most recent husband. In fact, the women (aged 15–49) who experienced any physical or sexual violence since the age of 15 years reported that 80 percent of physical violence and 86 per cent of sexual violence were perpetrated by their spouse [8]. In the last three decades ample evidences have been collected on the magnitude of intimate partner violence throughout the world [1, 4, 6, 9–23]. In India, apart from the National Family Health Survey, several population-based surveys also provided the information on domestic violence. According to those surveys, the prevalence rate of physical violence in India varies across regions and socio-economic strata and ranged between 9 percent and 99 percent [24–32]. Koenig et al. [24] noted that in Uttar Pradesh, 34 percent of men committed physical violence and 31 per cent of men committed sexual violence against their wives. According to another study, in five districts of Uttar Pradesh, 18 to 45 per cent of men abused their wives physically and 18 to 40 per cent reported that they forced their wives to have sex [25]. Jejeebhoy found that 40 to 46 percent of women were beaten up by their husbands in Uttar Pradesh [26]. The prevalence of physical violence was found around 43 percent in Maharashtra and 42 percent in rural Gujarat [27, 28]. In Goa, 9.43 percent of married women aged 18–50 years reported lifetime physical violence while only 3.66 percent reported lifetime sexual violence [29]. In Tamil Nadu, the proportion of women who ever suffered beating by their husbands ranged from 33 percent to 35 percent [26]. Solomon et al. noted that among low income communities in Chennai, the lifetime prevalence of physical abuse and forced sex in domestic sphere was unusually high being 99 per cent and 75 per cent respectively [30]. A cross-sectional study conducted in slum areas of Kolkata found that around 17 per cent of women experienced spousal physical violence in one year preceding the survey [31]. A recent study at Mumbai slums revealed that among ever-married women aged 18–49 years, 13 per cent experienced physical or sexual abuse by their intimate partners [32].

What is the root causes behind the worldwide violence against women in general and IPV by men in particular? Violence against women or gender based violence is a social mechanism applied to subjugate women [2]. IPV is the manifestation of prevailing patriarchal values in the society [33]. Patriarchy is an ideological construct which considers men as superior to women at all levels be it economic, social, cultural or political [34]. Patriarchal system establishes a series of norms and constraints regarding gender roles for both men and women and socialises men and women to follow them [35]. As a result with a patriarchal mindset, men think that they have right to control women if they fail to execute their duties [28]. Thus, domestic violence arises from patriarchal notions of ownership over women's bodies, sexuality, labour, reproductive rights, mobility and level of autonomy [36]. However, intimate partner violence occurs due to the interplay of several factors at several levels. Heise [37] proposed an ecological model of factors associated with IPV at four levels. The first level represents the biological or personal factors that increase the likelihood of becoming a victim or perpetrator of violence, like age, level of education, a history of witnessing violent behaviour etc. The second level

identifies relationship factors, e.g., marital discord and male control over decision making in the family. The third level encompasses the community level factors such as poverty, socioeconomic status, isolation of women from the natal family etc. The fourth level is associated with the broad societal factors and cultural norms like rigid gender roles or norms granting male control over female behaviour.

To end the violence against women we need to change the patriarchal mindset of people that view unequal power relations as natural. It is not easy. According to Heise et al., the first step for change is empowering women which can be achieved through increased access to education, economic resources, health information and increased participation in decision making by women and girls [3]. Ruth Dixon-Mueller defined women empowerment as "the capacity of individual women or of women as a group to resist the arbitrary imposition of controls on their behaviour or the denial of their rights, to challenge the power of others if it is deemed illegitimate, and to resolve a situation in their favour" [38]. Kabeer viewed empowerment as the processes by which one could gain the ability to make strategic life choices [39]. One essential feature of female empowerment is 'agency', i.e., women themselves must be significant actors in the process of change [40].

From the above discussion it can be said that women empowerment and intimate partner violence are negatively related. In other words, in a society where women empowerment is higher, the prevalence of domestic violence will be lower. In this paper we have analysed this relationship in the context of India where domestic violence is high and connected to the large number of dowry related deaths each year. Although the reported rate of sexual violence by intimate partners in India is much lower than physical violence but the impact of sexual violence, particularly of coercive sexual intercourse on women is immense as it leads to physical injuries, reproductive health problems and long term mental trauma [41]. Physical violence and sexual coercion compromise women's reproductive autonomy which in turn increases women's risk of unwanted pregnancies and sexually transmitted infections including HIV/AIDS [1]. Sexual assault also increases women's risk of gynaecological problems, depression and suicide [42]. It has been observed that compared to women who only reported physical assault, women who faced coercive sexual intercourse have a lower self-esteem, more negative self-image and are more fearful of sexuality [43, 44]. Besides, since the International Conference on Population and Development (IPCD) held in Cairo (1994) [45], demands for the sexual and reproductive rights irrespective of gender have gained momentum [45]. In this context, we are interested to examine the association between women's experience of spousal sexual violence and women empowerment in India using a nationally representative sample survey. In this study we have selected a number of proxy variables commonly used to measure women empowerment and tried to fit them in the ecological framework of Heise [37]. Previous studies from India that have analysed the determinants of domestic violence did not use the ecological model of Heise to explain the factors associated with women's experience of spousal sexual violence.

2. Data and method

For our analysis we have used the data from the Women's file of the fourth National Family Health Survey (NFHS-4), 2015–2016. It is a nationally representative sample survey which collected data from all the 29 states and 7 union territories of India. We have used the information on background characteristics of the respondents, reproduction, marriage, women's work, husband's background, women's empowerment, other health issues and domestic violence for our study. NFHS-4 provides information

of total 699,686 women aged 15–49. However, for domestic violence module 83,397 women were chosen and 79,729 women completed the interview.

Whether a woman has faced spousal sexual violence has been determined by asking them the following questions: Does (did) your current (last) husband ever do any of the following things to you: Physically force you to have sexual intercourse with him even when you did not want to? (i) (ii) Physically force you to perform any other sexual acts you did not want to? (iii) Force you with threats or in any other way to perform sexual acts you did not want to? Women could answer 'yes' or 'no' to each item; If a woman said 'yes' to one or more of these items, she was considered to have experienced spousal sexual violence. In the women's file of NFHS-4, variable D108 provides information on women's experience of sexual violence ever by husband or partner. As only 0.6 per cent never married women experience sexual violence [8] and many of the empowerment related questions were asked only to the ever-married women, we have restricted our analysis to the ever-married women only.

We have used several background variables that help to understand women's empowerment. These are husband's control on selected issues, women's decision making power and level of education, current work status of women and whether women have bank accounts and mobile phones. In the domestic violence module, respondents were asked if they faced six situations in their marital relationship. These are: (i) He (is/was) jealous or angry if you (talk/talked) to other men; (ii) He frequently (accuses/accused) you of being unfaithful; (iii) He (does/did) not permit you to meet your female friends; (iv) He (tries/tried) to limit your contact with your family; (v) He (insists/insisted) on knowing where you (are/were) at all times; (vi) He (does/did) not trust you with any money. The answers are grouped as 'no' and otherwise (yes or do not know). If the answer is 'no' in all six situations, then it is designated as 'no control'. If the answers are 'otherwise' for 1–2 cases, then it is 'less control' and if the answers are 'otherwise' for 3–6 cases, then it is designated as high marital control over women by their husbands. During the NFHS-4 survey, women were asked if they justify wife beating in the 5 given situations: (i) if wife goes out without telling husband; (ii) if wife neglects the children: (iii) if wife argues with husband; (iv) if wife refuses to have sex with husband; and (v) if wife does not cook food properly. If a woman supports wife beating in any of the given situations, then we conclude that wife beating is justified by that woman.

Cross tabulation and Pearson's Chi square test have been used to examine the bivariate relationship between marital sexual violence and background characteristics of women. Multivariate analysis has been applied to find out the net impact of the variables related to women empowerment on sexual abuse experienced by women. All analyses are done using SPSS version 21.0.

3. Findings

3.1 Background characteristics of women included in the analysis

Table 1 shows the distribution of women selected for our analysis by background characteristics. The selection of background characteristics were based on extensive literature review [3, 4, 11, 14, 17, 19, 24–26, 29, 31–33, 43, 46–53]. In our study 6.7 women (4372 of total 66,013 samples) had experienced sexual violence by their current/last husbands. Among the respondents, 17.3 percent were below 25 years of age and 45.1 per cent were in the age group 35–49 years. More than two third women reported to have 2 or more living children. Less than one-fifth women completed secondary education. Majority of the women were Hindu and

Background Characteristics	**% of women**
Women's ever experience of sexual violence by current/last husband	
No	93.3
Yes	6.7
Age of women (Years)	
15–24	17.3
25–34	37.6
35+	45.1
Education attainment of women	
Incomplete secondary or below	82.3
Complete secondary and above	17.7
Number of living children	
None	10.2
1	19.1
2	32.7
3	38.0
Religion	
Hindu	75.8
Muslim	13.9
Others	10.3
Caste	
Scheduled Caste(SC)/Scheduled Tribe (ST)	34.9
Non- SC/ST	65.1
Intergenerational experience of violence by women	
No	77.1
Yes	22.9
Whether afraid of husband	
No	21.8
Yes	78.2
Women's ever experience of physical violence by current/last husband	
No	72.6
Yes	27.6
Husband's marital control on selected issues	
No control	51.7
Less control (1–2 issues)	30.8
High control (3–6 issues)	17.5
Respondent's health care decided by	
Respondent alone	10.9
Jointly by respondent and husband	65.2
Husband alone or others	23.9
Major household purchase is decided by	
Respondent alone	7.4
Jointly by respondent and husband	67.2
Husband alone or others	25.4

Background Characteristics	**% of women**
Visits to wife's family/ relatives decided by	
Respondent alone	7.9
Jointly by respondent and husband	67.7
Husband alone or others	24.4
Use of husband's earning is decided by	
Respondent alone	6.5
Jointly by respondent and husband	66.6
Husband alone or others	26.9
Wife beating issues justified by women	
No	56.9
Yes/ do not know	43.1
Husband drinks alcohol	
No	69.7
Yes	30.3
Occupation of husband	
Not working	4.3
Agriculture	31.5
Manual work	29.5
Other	34.7
Current work status of women	
Not working	75.4
Working	24.6
Women has bank account	
No	45.8
Yes	54.2
Women has mobile phone	
No	49.0
Yes	51.1
Wealth Index	
Poorest	17.4
Poorer	19.7
Middle	20.4
Richer	20.7
Richest	21.8
Regions in India	
North	21.3
Central	23.4
East	17.3
North-East	12.7
West	10.3
South	14.9

The percentages are computed applying sample weight. Source: Computed from Women's file, NFHS-4, India, 2015–2016.

Table 1
Background characteristics of ever-married women and their husbands included in the analysis

belonged to non-Scheduled Caste/Scheduled Tribe category (The Scheduled Castes and Scheduled Tribes are officially designated groups of depressed classes in Indian society). More than one third women witnessed beating of their mother by their father. Twenty two per cent women confessed that they were afraid of their husbands and more than one fourth of the respondents experienced physical violence by their husbands. Around half of the women said that they did not face any marital by their husbands on selected issues but 17.5 percent women reported high control. Almost two third women reported that they used to take the following decisions jointly with their husbands: about their own health care, about major household purchase, about visits to their family/relatives and about the use of husband's earning. 57 per cent of women did not support wife beating. Thirty per cent of women reported that their husbands consumed alcohol. At the time of the interview, three fourth of the women said that they were not working and 4.3 per cent women reported that their husbands were not working. Almost half of the women did not possess any mobile phone and 46 per cent of women did not have bank account. As per wealth quintile, more or less 20 per cent women belonged to each quintile. According to NFHS-4, India has been divided into six regions [8]. The highest number of respondents were from Central India (23.4 per cent) followed by North (21.3 per cent), East (17.3), South (14.9 per cent), North-East (12.7 per cent) and Western India (10.3 per cent).

3.2 Results from bivariate analysis

In this section we have presented the results of bivariate analysis. Also, the variables have been categorised at four levels according to the general ecological model of IPV described by Heise [37]. It is evident from **Table 2** that women's experience of spousal sexual violence did not vary much with age. Those who had three or more children have experienced higher rate of sexual violence. Those who completed secondary education, 3.8 per cent of them experienced sexual abuse by their husbands. On the other hand those who did not complete secondary education, 7.4 percent of them complained about spousal sexual violence. Muslim, non-SC/ST women reported lower rate of sexual violence. The percentage of women who experienced sexual violence was 2.6 times higher among those who witnessed intergenerational violence than who did not. Working women complained about higher sexual abuse by husbands than non-working women. The highest rate of sexual violence was reported by the women whose husbands were not working. The percentage of women experiencing spousal sexual violence was more than three times higher for those who reported consumption of alcohol by their partners. The percentage of women who experienced spousal sexual violence was lower among those who had bank account and mobile phone.

Table 3 presents the bivariate association between women's experience of spousal sexual violence and other covariates indicating relational aspects between husband and wife. The percentage of women who experienced sexual violence was 2.7 times higher among those who were afraid of their husbands. The percentage of women who faced sexual violence was almost 12 times higher among those who ever experienced spousal physical violence compared to the women who did not. Women who reported higher marital control on specific issues, 19 percent of them complained about sexual violence by their husbands whereas those who did not face any control on those issues, only 2.1 per cent of them reported spousal sexual violence. The percentage of women facing sexual abuse was lower for those who said they jointly took decisions with husbands about their own heath care, household purchase, visit to family/relatives and the use of husband's earning.

Background characteristics	**Sample Size (Unweighted)**	**% women experiencing spousal sexual violence ever**	χ^2	**Sig.**
Level 1: Biological or personal factors				
Age of women (Years)				
15–24	10489	6.7	4.31	0.116
25–34	27568	6.8		
35+	27956	6.6		
Education attainment of women				
Incomplete secondary or below	54935	7.4	202.39	0.000
Complete secondary and above	11078	3.8		
Number of living children				
None	6136	6.0	137.69	0.000
1	12610	6.0		
2	22842	5.8		
3	24425	8.1		
Religion				
Hindu	49546	6.9	21.46	0.000
Muslim	8614	5.9		
Others	7853	6.5		
Caste				
SC/ST	23794	8.2	78.77	0.000
Non- SC/ST	39293	6.0		
Intergenerational experience of violence by women				
No	50588	4.9	991.62	0.000
Yes	15425	12.7		
Husband drinks alcohol				
No	45122	4.0	1667.25	0.000
Yes	20891	13.0		
Current work status of women				
Not working	49355	5.9	219.05	0.000
Working	16658	9.3		
Occupation of husband				
Not working	2674	8.1	80.26	0.000
Agriculture	22363	7.6		
Manual work	19399	6.8		
Other	21577	5.7		
Women has bank account				
No	30272	7.6	66.61	0.000
Yes	35741	6.0		

Background characteristics	Sample Size (Unweighted)	% women experiencing spousal sexual violence ever	χ^2	Sig.
Women has mobile phone				
No	32844	7.8	100.00	0.000
Yes	33169	5.7		

The percentages are computed applying sample weight. Source: Computed from Women's file, NFHS-4, India, 2015–2016.

Table 2
Percentage of ever-married women age 15–49 who reported sexual violence (by current or the last husband) by biological or personal background characteristics with Pearson's chi-square results, India, 2015–2016

Background characteristics	Sample Size (Unweighted)	% women experiencing spousal sexual violence ever	χ^2	Sig.
Level 2: Relationship factors				
Whether afraid of husband				
No	14274	2.9	408.08	0.000
Yes	51739	7.8		
Women's ever experience of physical violence by current/last husband				
No	47333	1.7	6700.20	0.000
Yes	18680	20.0		
Husband's marital control on selected issues				
No control	34565	2.1	3821.71	0.000
Less control (1–2 issues)	20077	7.5		
High control (3–6 issues)	11371	19.0		
Respondent's health care decided by				
Respondent alone	6807	10.2	420.38	0.000
Jointly by respondent and husband	41225	4.9		
Husband alone or others	14684	9.0		
Major household purchase is decided by				
Respondent alone	4653	9.5	440.83	0.000
Jointly by respondent and husband	42571	5.0		
Husband alone or others	15492	9.4		
Visits to wife's family/ relatives decided by				
Respondent alone	4931	9.6	526.82	0.000
Jointly by respondent and husband	42924	4.8		
Husband alone or others	14861	9.8		

Background characteristics	Sample Size (Unweighted)	% women experiencing spousal sexual violence ever	χ^2	Sig.
Use of husband's earning is decided by				
Respondent alone	3874	10.0	426.12	0.000
Jointly by respondent and husband	41276	4.9		
Husband alone or others	16267	9.2		

The percentages are computed applying sample weight. Source: Computed from Women's file, NFHS-4, India, 2015–2016.

Table 3
Percentage of ever-married women age 15–49 who reported sexual violence (by current or the last husband) by relationship related background characteristics with Pearson's chi-square results, India, 2015–2016

From **Table 4** it is evident that the women who justified wife beating in certain circumstances experienced higher rate of sexual violence. The prevalence of sexual abuse in marital relationship was found the highest among the poorest group and the lowest among the richest group. The prevalence of sexual violence was the highest in eastern part of India and the lowest in the western part of India.

Background characteristics	Sample Size (Unweighted)	% women experiencing spousal sexual violence ever	χ^2	Sig.
Level 3: Community level factors				
Wife beating issues justified by women				
No	37444	4.6	571.65	0.000
Yes/ do not know	28569	9.6		
Wealth Index				
Poorest	12838	11.0	636.29	0.000
Poorer	13992	7.9		
Middle	13790	6.6		
Richer	13142	5.4		
Richest	12251	3.6		
Level 4: Broad societal factors				
Regions in India				
North	14062	4.2	513.18	0.000
Central	14941	7.7		
East	11614	10.3		
North-East	8766	6.7		
West	6696	3.4		
South	9934	7.0		

The percentages are computed applying sample weight. Source: Computed from Women's file, NFHS-4, India, 2015–2016.

Table 4
Percentage of ever-married women age 15–49 who reported sexual violence (by current or the last husband) by community level and broad societal level background characteristics with Pearson's chi-square results, India, 2015–2016

3.3 Results from multivariate analysis

In the above section we have discussed the bivariate association between women's lifetime experience of spousal violence and background characteristics of women. To understand the net effect of women's empowerment related parameters on women's experience of sexual violence we have applied binary logistic regression. On the basis of Pearson's correlation coefficient value (r), we found that some variables are highly correlated such as age group of women and number of living children ($r > 0.5$). Decision making on women's health, household purchase, visit to women's family and relatives and the use of husband's earning show strong correlation among them ($r > 0.5$). Also women's level of education and wealth quintile, women's possession of mobile phone and wealth quintile, women's possession of mobile phone and bank account show moderate correlation. Keeping these into account, we have not used all the background variables selected earlier for the multivariate analysis. **Table 5** presents the results of binary logistic regression analysis predicting the probability of a woman experiencing spousal sexual violence. Odds ratio greater than one indicates a positive relationship between the independent variables and the probability of experiencing sexual abuse by husband, and odds ratio less than one indicates a negative relationship.

Background characteristics	Odds Ratio (OR)	95% CI	P-value
Level 1: Biological or personal factors			
Age of women (Years)			
15–24 ®			.128
25–34	.973	.877–1.079	.604
35+	.909	.816–1.013	.084
Education attainment of women			
Complete secondary and above®			
Incomplete secondary or below	1.057	.924–1.210	.419
Religion			
Hindu®			.005
Muslim	1.228	1.084–1.391	.001
Others	1.051	.914–1.208	.488
Caste			
Non- SC/ST®			
SC/ST	1.071	.989–1.159	.091
Intergenerational experience of violence by women			
No®			
Yes	1.371	1.271–1.476	<.001
Husband drinks alcohol			
No®			
Yes	1.689	1.564–1.824	<.001
Current work status of women			
Not working®			
Working	1.254	1.157–1.358	<.001

Background characteristics	Odds Ratio (OR)	95% CI	P-value
Occupation of husband			
Not working®			.013
Agriculture	.931	.779–1.112	.430
Manual work	.844	.706–1.010	.065
Other	.982	.818–1.178	.843
Women has bank account			
No®			
Yes	.874	.811–.943	<.001
Level 2: Relationship factors			
Whether afraid of husband			
No®			
Yes	1.339	1.189–1.507	<.001
Women's ever experience of physical violence by current/last husband			
No®			
Yes	6.929	6.326–7.590	<.001
Husband's marital control on selected issues			
No control®			<.001
Less control (1–2 issues)	2.146	1.942–2.371	<.001
High control (3–6 issues)	4.151	3.754–4.590	<.001
Respondent's health care decided by			
Respondent alone®	.663		<.001
Jointly by respondent and husband	.990	.597–.736	<.001
Husband alone or others		.884–1.358	.866
Level 3: Community level factors			
Wife beating issues justified by women			
No®			
Yes/do not know	1.256	1.165–1.355	<.001
Wealth Index			
Poorest®			.191
Poorer	.953	.862–1.054	.348
Middle	1.040	.930–1.162	.492
Richer	.934	.821–1.062	.295
Richest	.887	.755–1.041	.142
Level 4: Broad societal factors			
Regions in India			
North®			<.001

Background characteristics	Odds Ratio (OR)	95% CI	P-value
Central	.962	.852–1.087	.538
East	1.212	1.067–1.376	.003
North-East	1.260	1.076–1.474	.004
West	.805	.674–.960	.016
South	.826	.716–.953	.009

N = 59915 (Among women who experienced spousal sexual violence ever, information on all selected covariates are available for 59915 women). Source: Computed from Women's file, NFHS-4, India, 2015–2016.

Table 5
Logistic regression results showing the likelihood of ever-married women experiencing spousal sexual violence ever by selected variables, India, 2015–2016

From the logistic regression analysis in **Table 5**, it is observed that age of the women, their level of education and wealth quintile are not significantly associated with women's experience of spousal sexual violence. Muslim women show significantly higher probability of experiencing sexual violence by their husbands compared to the Hindu women (OR 1.228, $p < .01$). Interestingly, in the bivariate analysis we found the opposite result. Another study from India also found similar result [33]. As in the multivariate analysis, other factors are controlled; we may find such contradictory results. It indicates that any/some of the background factors have more influence on marital sexual abuse than religion in case of Muslim women. Caste of women does not have significant impact on spousal sexual violence. Currently working women show higher odds of being Sexually abused by husbands but occupation of husband was not significantly associated with sexual abuse of wife. Also women who had bank account, their likelihood of facing sexual abuse was lower compared to their counterparts (OR 0.874, $p < .001$). After covariate adjustment, it was found that the risk of sexual violence was significantly higher for those who reported consumption of alcohol by their husbands (OR 1.689, $p < .001$). Women who witnessed abuse of their mother by their father, who suffered spousal physical violence, who experienced higher spousal control on several issues, who reported that they were afraid of their husbands, who justified wife-beating were more likely to have experienced marital sexual violence. The results are significant at <0.001 percent level of significance. Compared to the women who alone used to take decision about own health care, those who jointly took decision with husbands were significantly less likely to face spousal sexual violence when other factors are controlled. Finally, compared to the women of North India, the women of Eastern and North-Eastern India showed significantly higher probability of facing spousal sexual violence but the women of Western and Southern India had significantly lower probability of experiencing sexual abuse by their husbands.

4. Discussion

The ecological model of Heise provides a comprehensive framework to understand the factors associated with IPV at various levels. In the first level biological and personal factors like women's age, level of education, religion, caste, labour force participation, own bank account, husband's occupation, are included in our analysis along with the women's intergenerational experience of violence and the consumption of alcohol by husband. Several studies from different parts of the world have found strong correlation between the last two factors and domestic violence [8, 14, 17, 49, 51, 53–55]. Young age is regarded as a risk factor of

experiencing IPV [56]. Education enhances women's cognitive ability, self esteem, and participation in decision making; therefore, educated women are less likely to suffer from domestic violence [33, 39, 56]. However, the positive influence of education frequently disappears when factors associated with relationship stressors are controlled [57]. In our study we have found that age and women's education are not significantly related to sexual abuse of wife. Like education, women's participation in work, particularly paid work is also regarded as crucial factor for women empowerment [39]. It is assumed that labour force participation helps women to attend financial independence. Therefore it is expected that working women are less likely to experience domestic violence. Interestingly, our results are just the opposite. Previous studies from India also found similar outcome [33, 58]. This finding does not fit into the general notion that women empowerment through work force participation will reduce IPV. Actually IPV is a way of asserting male authority on women. As working women acquire some sort of independence by joining the labour force, it poses a challenge to their partners. To keep women under their control, violent measures are used by men. Therefore, only enhancing women's opportunity to education and work is not enough for battle against domestic violence. Although owning a bank account is not a good indicator of women empowerment as husband alone can handle the account, nevertheless, after controlling the effects of other factors, it shows negative association with wife's experience of sexual abuse. In fact, owning a bank account enhances women's sense of financial security.

In the second level, the variables expressing the power relation in the family (women's experience of spousal physical violence, husband's marital control on selected issues, decision making power of women regarding own health and whether women are afraid of their husband) are taken into account. Husband's assertion of control over wife is the manifestation of patriarchal mindset. Women empowerment is closely linked with women's autonomy. Women's autonomy is their ability to determine events in their lives [59] and like the control issues, women's decision making power regarding their health, household purchase, visit to family and relatives, use of husband's earning are closely associated with women empowerment. It has already been mentioned that the variables related to women's autonomy are highly correlated. Therefore, we have used one variable in the logistic regression model, i.e., women's decision making power regarding their health. As health has both intrinsic and instrumental values, decision making power regarding own health is the most important factor compared to other issues mentioned above. Physical violence by husband comes under relationship factors because men use it as an instrument of power by which women are dominated and inequality between men and women are maintained [33]. Besides, literature reveals that sexual abuse often accompanied by physical violence [3]. When women report that they are afraid of their husbands, it indicates substantial lower position of women in gender based power relation.

Under community level factors (third level) we have included attitude of women towards wife beating and wealth index. Previous studies from developing countries have also considered that the community wife beating norms are closely associated with IPV [17, 24]. It is an important contextual-level variable affecting spousal violence. In our analysis we have found that 43 per cent of women supported at least one of the wife beating issues. It reflects conservative attitudes of the society towards gender norms that endorses IPV. As a result, women themselves support wife beating for trivial issues like food is not properly cooked. The socioeconomic status of a family influences both personal and relationship factors of domestic violence. Poverty and unemployment fuels marital conflicts which ultimately led to domestic violence. However, we have found that economic status of a family does not have significant impact on women's experience of sexual violence controlling for other factors.

The fourth level represents the broad societal factors. We have put region of India under this level. Previous studies have focussed on the sharp contrast between the North and South India regarding social and cultural norms, level of education and fertility rates [59–61]. In fact, in India women's status and vulnerability varies from region to region [62]. There is a general notion that women enjoy higher autonomy in North-East India. However, one study found that it is true only for selective indicators [63]. Although in general Indian society is patriarchal by nature, prevalence and manifestation of wife abuse varies across regions due to region-specific cultural norms and traditions. Our studies found that women from East and North-East are more vulnerable to sexual violence under marital relationship.

5. Conclusion

In India domestic violence by husband is a common phenomenon. Using the ecological model of Heise we have tried to find out the association between spousal sexual violence and women's empowerment related variables. Education and workforce participation are often used as proxy to women empowerment but we find that controlling for other relational, community level and broad societal determinants of violence, education and work force participation are not found as protective factors against sexual violence by husband in India. Therefore, empowering women through increased access to education and work will not produce desirable outcome in combating domestic violence, unless and until policy measures take into account the broader cultural norm that view unequal power relation as natural and normal. We think this finding has an important policy implication.

India is a diverse country and cultural norms and traditions vary widely from region to region. Most of the researches on domestic violence concentrate on North-South differences, while the highest prevalence of physical violence as well as sexual violence was recorded in East India [8]. We also observed that after covariate adjustment, women of Eastern India was the most vulnerable to experience spousal sexual violence. Therefore, special strategies should be prepared for this region while formulating policies and programmes to end violence against women in India.

Conflict of interest

There is no conflict of interest as there is no co-author.

Author details

Shewli Shabnam
Bidhannagar College, Kolkata, India

*Address all correspondence to: shewlijnu@gmail.com

References

[1] Heise L, Ellsberg M, Gottemoeller M. A global overview of gender-based violence. International Journal of Gynecology and Obstetrics. 2002. 78 Suppl. 1: S5–S14. DOI: 10.1016/S0020-7292(02)00038-3

[2] United Nations General Assembly. Declaration on the Elimination of Violence against Women. 20 Decmber 1993. A/RES/48/104. 1993. Available from: www.refworld.org/docid/3boof25d2c.html [Accessed: 2021.02.15]

[3] Heise L, Ellsberg M, Gottemoeller M. Ending violence against women. Population reports. Series L, No 11, the Population Information Programme, The Johns Hopkins University School of Public Health, Baltimore, Maryland. 1999. Available from: https://www.researchgate.net/publication/287170875_Population_reports_Ending_violence_against_women/citations [Accessed: 2021.02.15]

[4] Niolon P H, Kearns M, Dills J, Rambo K, Irving S, Armstead T, Gilbert L. Preventing intimate partner violence across the lifespan: A technical package of programs, policies, and practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. 2017. Available from: https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf [Accessed: 2021.02.15]

[5] UNODC. Global study on homicide, gender-related killing of women and girls 2019. Vienna. 2019. Available from: https://www.unodc.org/documents/data-and-analysis/gsh/Booklet_5.pdf [Accessed: 2021.02.16]

[6] World Health Organization. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. 2013. Available from: https://apps.who.int/iris/handle/10665/85239 [Accessed 2021.02.16]

[7] Government of India. Crime in India 2019. Statistics Volume I, National Crime Records Bureau, Ministry of Home Affairs, New Delhi. 2020. Available from: https://ncrb.gov.in/sites/default/files/CII%202019%20Volume%201.pdf. [Accessed 2021.02.16]

[8] International Institute for Population Sciences (IIPS) and ICF. National Family Health Survey (NFHS-4), 2015-16: India. Mumbai: IIPS. 2017. Available at: http://rchiips.org/nfhs/NFHS-4Reports/India.pdf [Accessed 2021.02.19]

[9] Abbott J, Johnson R, Koziol-Mclain J, Lowenstein SR. Domestic violence against women - Incidence and prevalence in an emergency department population. Journal of the American Medical Association. 1995. 273 (22): 1763-1767, DOI: 10.1001/jama.273.22.1763

[10] Evins G, Chescheir N. Prevalence of domestic violence among women seeking abortion services. Women's Health Issues. 1996. 6(4): 204-210, DOI: 10.1016/1049-3867(95)00012-7

[11] Fairchild DG, Fairchild MW, Stoner S. Prevalence of adult domestic violence among women seeking routine care in a native American health care facility. American Journal of Public Health, 1998. 88(10): 1515-1517. DOI: 10.1016/1049-3867(95)00012-7

[12] UNICEF. Domestic violence against women and girls", Innocenti Digest. No.6, UNICEF Innocenti Research Centre, Florence, 200o. Available at: https://www.unicef-irc.org/article/519-innocenti-digest-no-6-domestic-violence-against-women-and-girls.html [Accessed 2021.02.16]

[13] Garcia-Moreno C, Watts C, Jansen H, Ellsberg M, Heise L. Responding to violence against women: WHO's multi-country study on women's health and domestic violence. Health and Human Rights. 2003. 6(2): 112-127. Available at: https://www.who.int/reproductivehealth/publications/violence/24159358X/en/[Accessed 2021.02.16]

[14] Kishor S. Johnson K. Profiling domestic violence – A multi-country study, ORC Macro, Calverton, Maryland, USA. 2004. Available at: https://dhsprogram.com/pubs/pdf/od31/od31.pdf [Accessed 2021.02.19]

[15] Gage AJ. Women's experience of intimate partner violence in Haiti. Social Science & Medicine. 2005. 61: 343-364, DOI: 10.1016/j.socscimed.2004.11.078

[16] Morrison A, Ellsberg M, Bott S. Addressing gender-based violence: A critical review of interventions, The World Bank Research Observer Advance Access. 2007. DOI: 10.1093/wbro/lkm003

[17] Hindin MJ, Kishor S, Ansara DL. Intimate partner violence among couples in 10 DHS countries: Predictors and health outcomes. DHS Analytical Studies. No 18. Macro International Inc., Calverton, Maryland, USA. 2008. Available at: https://dhsprogram.com/pubs/pdf/AS18/AS18.pdf [Accessed 2021.02.16]

[18] Moore AM, Frohwirth L, Miller E. Male reproductive control of women who have experience intimate partner violence in the United States. Social Sciences and Medicine, 2010. 70: 1737-1744. DOI: 10.1016/j.socscimed.2010.02.009

[19] Deribe K, Beyene BK, Tolla A, Memiah P, Biadgilign S, Amberbir A. Magnitude and correlates of intimate partner violence against women and its outcome in Southwest Ethiopia. PLoS One. 2012. 7(4):e36189. https://doi.org/10.1371/journal.pone.0036189

[20] Palermo T, Bleck J, Peterman A. Tip of the iceberg: Reporting and gender-based violence in developing countries. American Journal of Epidemiology. 2014. 179(5):602-612. DOI: 10.1093/aje/kwt295

[21] Durevall D, Lindskog A. Intimate partner violence and HIV in ten sub-Saharan African countries: What do the Demographic and Health Surveys tell us? The Lancet Global Health. 2014. 3(1): e34–e43. DOI: 10.1016/S2214-109X(14)70343-2

[22] Kazaura MR, Ezekiel MJ, Chitama D. Magnitude and factors associated with intimate partner violence in mainland Tanzania. BMC Public Health. 2016. 16:494. DOI: 10.1186/s12889-016-3161-3

[23] Elghossain T, Bott S, Akik C, Obermeyer CM. Prevalence of intimate partner violence against women in the Arab world: A systematic review. BMC Innt Health Hum Rights. 2019. 19(1):29. DOI: 10.1186/s12914-019-0215-5

[24] Koenig MA, Stephenson R, Ahmed S, Jejeebhoy J, Campbell J. Individual and contextual determinants of domestic violence in North India. American Journal of Public Health. 2006. 96(1): 132-138. DOI: 10.2105/AJPH.2004.050872

[25] Martin SL, Tsui AO, Maitra K and Marinshaw R. Domestic violence in Northern India. American Journal of Epidemiology. 1999. 150(4): 417-426. https://doi.org/10.1093/oxfordjournals.aje.a010021

[26] Jejeebhoy S J. Associations between wife-beating and fetal and infant death: Impressions from a survey in rural India. Studies in Family Planning. 1998. 29 (3): 300-308. https://doi.org/10.2307/172276

[27] Kapadia-Kundu N, Khale M, Upadhaye S, Chavan D. Whose mistake? Gender roles and physical violence among young married women. Economic and Political Weekly. 2007. 71-78, DOI: 10.2307/40276748

[28] Visaria L. "Violence against Women a Field Study", Economic and Political Weekly. 2000. 200: 1742-1751. Available at: https://www.jstor.org/stable/4409296 [Accessed 2021.02.15]

[29] Chowdhary N, Patel V. The effect of spousal violence on women's health: Findings from the Stree Arogya Shodh in Goa, India. Journal of Postgraduate Medicine. 2008. 54(4): 306-312. DOI: 10.4103/0022-3859.43514

[30] Solomon S, Subbaraman R, Solomon SS, Srikrishnan AK, Johnson SC, Vasudevan CK, Anand S, Ganesh AK and Celentano DD. Domestic violence and forced sex among the urban poor in South India: Implications for HIV preventions. Violence Against Women. 2009. 15(7): 753-773. DOI: 10.1177/1077801209334602

[31] Panday GK, Dutt D, Banerjee B. Partner and relationship factors in domestic violence: Perspectives of women from a slum in Calcutta, India. J Interpers Violence. 2009. 24(7):1175-1191, DOI: 10.1177/0886260508322186

[32] Daruwalla N, Kanougiya S, Gupta A, Gupta A, Gram L, Osrin D. Prevalence of domestic violence against women in informal settlements in Mumbai, India: A cross-sectional survey. BMJ Open. 2020. DOI:10.1136/bmjopen-2020-042444

[33] Menon N, Johnson MP. Patriarchy and paternalism in intimate partner violence: A study of domestic violence in rural India. In: Misra KK, Lowry JH, editors. Recent Studies on Indian Women. 1st ed. New Delhi: Rawat Publications; 2007. p. 171-195.

[34] Rawat PS. Patriarchal beliefs, women's empowerment and general well-being. Vikalpa. 2014. 39(2): 43-55. https://doi.org/10.1177/0256090920140206

[35] Menon N. Gender. In: Bhargava R, Acharya A, editors. Political theory: An introduction. 1st ed. New Delhi: Dorling Kindersley (India) Pvt. Ltd, licensees of Pearson Education in South Asia; 2008. p. 225-233

[36] Subadra. Violence against women: Wife battering in Chennai. Economic and Political Weekly. 1999. 34(16/17): WS28-WS33. Available at: https://www.jstor.org/stable/4407877 [Accessed 2021.02.16]

[37] Heise LL. Violence against women: An integrated, ecological framework. Violence Against Women, 1998. 4(3): 262-290. DOI: 10.1177/1077801298004003002

[38] Dixon-Mueller R. 1998. Female empowerment and demographic processes: Moving beyond Cairo, Policy and research paper number 13, Available at: https://iussp.org/sites/default/files/PRP13.pdf [Accessed 2021.02.16]

[39] Kabeer N. Gender equality and women's empowerment: A critical analysis of the third millennium development goal. Gender and Development. 2005. 13(1): 13-24. https://doi.org/10.1080/13552070512331332273

[40] Malhotra A, Schuler S. Measuring women's empowerment as a variable in international development. 2002. DOI: 10.1037/e597202012-004

[41] Heise LL, Pitanguy J, Germen A. Violence against women: The hidden health burden. World Bank discussion papers, no. WDP 255, Washington, D.C.: World Bank Group. 1994. Available from: https://documents.worldbank.org/en/publication/documents-reports/documentdetail/489381468740165817/

violence-against-women-the-hidden-health-burden [Accessed 2021.02.17]

[42] Campbell JC, Soeken KL. Forced sex and intimate partner violence: Effects on women's risk and women's health. Violence Against Women. 1999. 5(9): 1017-1035. https://doi.org/10.1177/1077801299005009003

[43] Snead AL, Babcock JC. Differential predictors of intimate partner sexual coercion versus physical assault perpetration. J Sex Aggress. 2019. 25(2): 146-160. DOI:10.1080/13552600.2019.1581282

[44] Shields NM, Resick PA, Hanneke CR. 1990. Victims of marital rape. In: Ammerman RT, Hersen M, editors. **Treatment of Family Violence: A Sourcebook**.1st ed. New York: John Wiley & Sons; 1990. p.165-182

[45] Johnson S. The Politics of Population: The International Conference on Population and Development, Cairo 1994. 1st ed.London: Earthscan Publications Limited; 2005.

[46] Abrahams N, Jewkes R, Hoffman M, Laubsher R. Sexual violence against intimate partners in cape town: Prevalence and risk factors reported by men. Bulletin of the World Health Organization. 2004. 82(5):330-337 DOI: 10.1590/S0042-96862004000500006

[47] Augenbraun M. Wilson TE, Allister L. Domestic violence reported by women attending a sexually transmitted disease clinic. Sex Transm Dis. 2001. 28(3): 143-147. DOI: 10.1097/00007435-200103000-00004

[48] Evins G, Evins, Chescheir N. Prevalence of domestic violence among women seeking abortion services. Women's Health Issues. 1996. 6(4): 204-210. DOI: 10.1016/1049-3867(95)00012-7

[49] Gil-Gonza'lez D, Vives-Cases C, Ruiz MT, Carrasco-Portino M, A'lvarez –Dardet C. Childhood experiences of violence in perpetrators as a risk factor of intimate partner violence: a systematic review. Journal of Public Health. 2007. 30(1): 14-22. DOI: 10.1093/pubmed/fdm071.

[50] ICRW. Domestic violence in India: A summary report of three studies, International Centre for Research on Women, Washington DC. 1999. Available at: https://www.icrw.org/wp-content/uploads/2016/10/Domestic-Violence-in-India-1-Summary-Report-of-Three-Studies.pdf [Accessed 2021.02.16]

[51] Jewkes R. "Intimate partner violence: Causes and prevention. The Lancet. 2002. 359:1423-1429. DOI: 10.1016/S0140-6736(02)08357-5

[52] Khan ME, Townsend JW, Sinha R, Lakhanpal S. Sexual Violence within Marriage: A Case Study of Rural Uttar Pradesh, India. International Quarterly of Community Health Education. 2002. 21(2):133-146. https://doi.org/10.2190/N8QE-27HN-N8Y1-3AMB

[53] Martin SL, Moracco KE, Garro J, Tsui AO, Kupper LL, Chase JL, Campbell JC. Domestic violence across generations: Findings from Northern India. International Journal of Epidemiology. 2002. 31: 560-572. DOI: 10.1093/ije/31.3.560.

[54] Maman S, Campbell J, Sweat MD, Gielen AC. The intersections of HIV and violence: directions for future research and interventions. Social Science & Medicine. 2000. 50(4): 459-478. https://doi.org/10.1016/S0277-9536(99)00270-1

[55] Khosla, AH, Dua D, Devi L, Sud SS. Domestic violence in pregnancy in North Indian women. Indian Journal of Medical Science. 2005. 59 (5): 195-199. DOI: 10.4103/0019-5359.16255

[56] Capaldi DM, Knoble NB, Shortt JW, and Kim HK. A systematic review of risk factors for intimate partner violence. Partner Abuse. 2012. 3(2): 231-280. DOI:10.1891/1946-6560.3.2.231

[57] DeMaris A, Benson ML, Fox GL, Hill T, Wyk JV. Distal and proximal factors in domestic violence: A test of an integrated model. Journal of Marriage and Family. 2003. 65(3): 652-667. https://doi.org/10.1111/j.1741-3737.2003.00652.x

[58] Paul S. Women's labour force participation and domestic violence: Evidence from India. Journal of South Asian Development. 2016. 11(2): 224-250. DOI: 10.1177/0973174116649148

[59] Bloom SS, Wypij D, Gupta DM. Dimensions of women's autonomy and influence on maternal health care utilization in a north Indian city. Demography. 2001. 38(1): 67-78. DOI: 10.1353/dem.2001.0001

[60] Jejeebhoy SJ. Convergence and divergence in spouses' perspectives on women's autonomy in rural India. Studies in Family Planning. 33(4): 299-308. DOI: 10.1111/j.1728-4465.2002.00299.x

[61] Greenspan A. Culture influences demographic behaviour: Evidence from India. Asia-Pacific Population & Policy. 1994. 28:1-4. PMID: 12345406. Available from https://europepmc.org/article/med/12345406 [Accessed 2021.02.19]

[62] Dyson T, Moore M. On kinship structure, female autonomy, and demographic behaviour in India. Population and Development Review. 1983. 9(1): 35-60. DOI: 10.2307/1972894 DOI:10.2307/1972894

[63] Das I. Status of women: North Eastern region of India versus India. International Journal of Scientific Research & Growth. 2019. 3(3):1-8. DOI: 10.29322/ijsrp.org/research-paper-1301.php?rp=P13578

Chapter 5

An Integrative Exploration of Sexual, Physical, Psychological, and Cyber-Digital Relationship Abuse in Adolescent and Young Adult Relationships

Hans Saint-Eloi Cadely and Tiffani Kisler

Abstract

Although detrimental for any age group, rates of experiencing sexual assault (SA) are found to be the highest among young adults; with nearly 25% of young adult women indicating to have experienced SA at least once in their romantic relationship. SA is also common among adolescents, as 33% of young women between the ages of 11–17 indicated to have been raped. The effects from SA include depression, trauma, and interpersonal distress, which are similar to the effects of other forms of intimate partner violence (IPV) (i.e., physical and psychological aggression), suggesting a covariation between these various forms of aggression. Additionally, a new form of dating violence has emerged; cyber-digital relationship abuse (CDRA). This behavior is commonly expressed via means of social media (e.g., Facebook, Twitter, & Snapchat) and through digital means (e.g., texting and email) whereby youth and young adults harass, threaten, control, and monitor their partners whereabouts. Recent studies have indicated that CDRA may serve as a precursor to physical violence in dating relationships. The purpose of this chapter is to provide an integrative exploration of sexual, physical, psychological, and CDRA by tracking the progression and concurrence across these various forms of IPV among youth and young adults. Implications for interventions will also be discussed.

Keywords: cyber abuse, intimate partner violence, sexual abuse, sexual assault

1. Introduction

> *"Unhealthy relationships can start early and last a lifetime"*
> *– Centers for Disease Control and Prevention*

In the wake of the #MeToo movement, the call for more awareness of sexual abuse and its effects on victims spread across the world. Survivors of sexual assault who were previously silenced have gathered the courage to come forward to tell their stories. Perpetrators of such unspeakable acts are now being held accountable for their heinous deeds. Victims are now being heard and societies are learning of the role they played in their normalization of such behaviors. Despite these positive movements,

more is still needed to learn about the effects of sexual abuse. The most effective way to prevent a behavior is to understand its nature. Therefore, it must be understood that sexual abuse may not necessarily occur in isolation from other acts of violence.

As described by the Centers for Disease Control and Prevention [1, 2], intimate partner violence (IPV; also referred to as dating abuse, dating aggression, or dating violence in the adolescent development literature) consists of aggressive or abusive behaviors expressed or experienced within romantic relationships. Such behaviors can be expressed/experienced through means of psychological (i.e., verbal or emotional), physical, and/or sexual abuse. The co-occurrence and progression of these various forms of abuse is well-documented in the literature [3–11]. Using a biopsychosocial framework (see **Figure 1**), we argue that sexual abuse must be studied as an integration with other forms of abuse (see **Figure 2**) and potentially as a development from other forms of aggression, particularly psychological aggression (see **Figure 3**). Understanding the integration of these behaviors will be beneficial for researchers, practitioners, and interventionists in the attempts to reach survivors of sexual abuse.

Moreover, to prevent a behavior, it is also best to address it during its origin. The CDC quote noted above implies that without intervention or preventive methods, the effects and continuation of unhealthy behaviors can progress over time. Surprisingly, adolescent romantic relationships were once deemed as shallow and frivolous given the transient nature of these relationships, particularly among early adolescents [12]. However, research within the past two decades argue that the formation of romantic relationships is critical to adolescent development [12, 13]. For instance, dating partners become a critical source for identity development during adolescence [14–16]. Data from the National Longitudinal Study of Adolescent Health (Add Health) indicated that 55% of adolescents reported to have been in a romantic relationship. Also, from this dataset, 69% of males and 76% of females indicated to have been romantically involved within the 18 months prior to data collection [17]. Additionally, romantic experiences during adolescence can influence

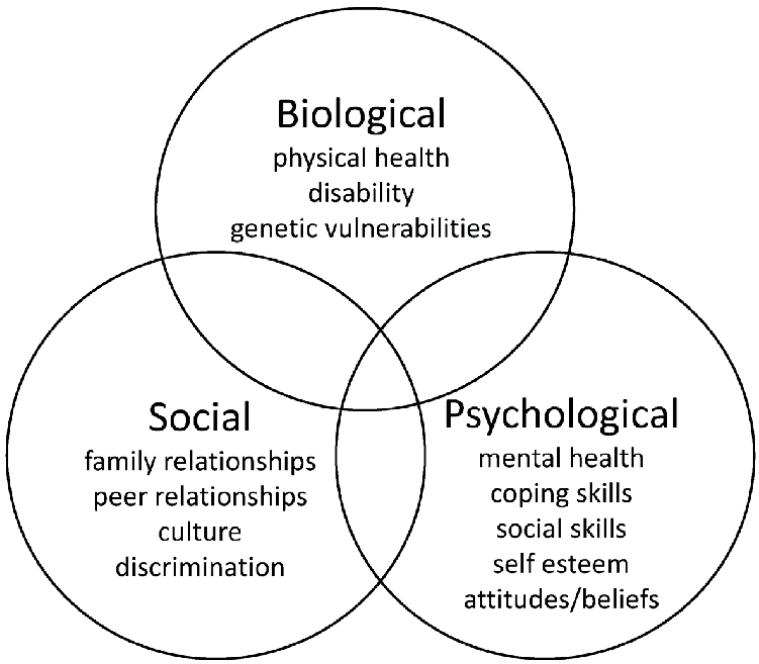


Figure 1.
An integration of abuse via a biopsychosocial framework.

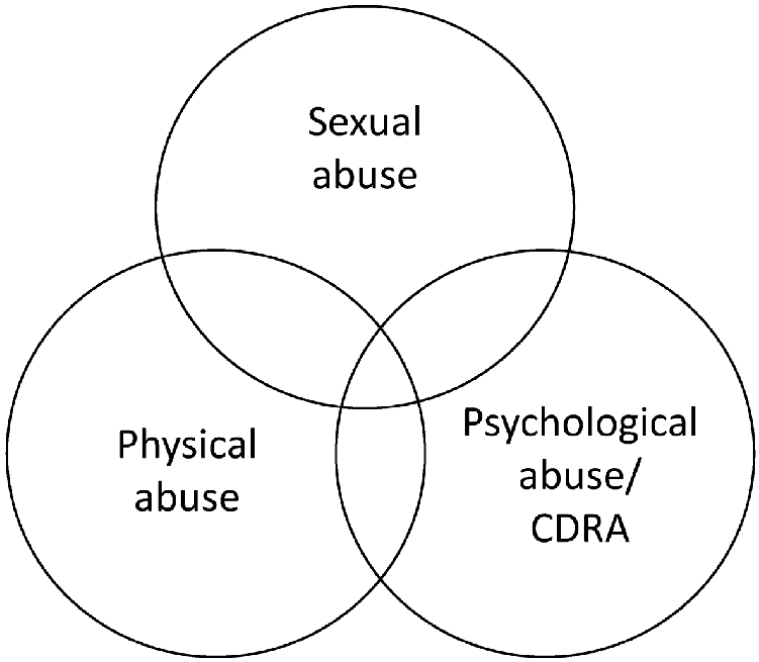


Figure 2.
An integrative illustration of sexual, physical, psychological, and cyber abuse in adolescent and young adult relationships.

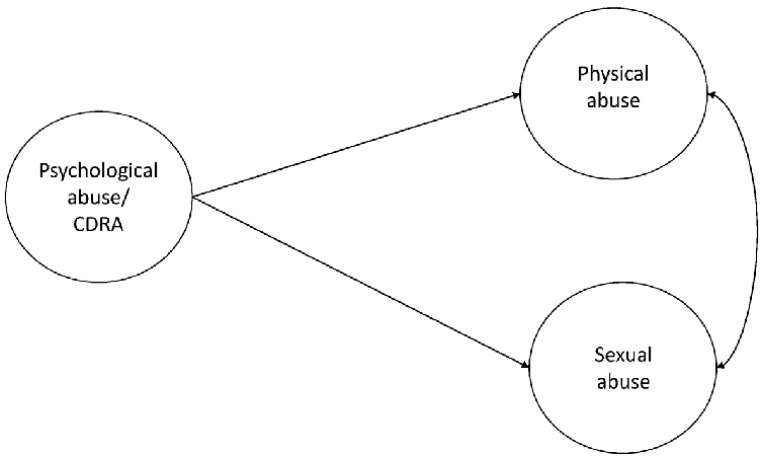


Figure 3.
An illustration of the progression from psychological/cyber abuse to physical and sexual abuse.

well-being and later romantic experiences during young adulthood [18–20]. Such is also the case for adolescents who experience some form of dating violence/IPV in their romantic relationships. The view that the formation of romantic relationships plays an insignificant role on adolescent development can be dismissed for the additional reason that many adolescents who are romantically involved experience abuse in their relationships [2]. Notably, many individuals first experiences of dating violence happen before the age of 18 making youth and young adulthood a critical time for addressing and preventing this public health concern [2, 21–23]. Studies have also shown that the perpetration and victimization of IPV behaviors can extend beyond adolescence up until young adulthood [2, 10, 21, 22, 24–26].

Rates of experiencing some form of IPV in the United States (USA) are approximately 25% for women and 10% for men. Also, approximately 11 million women and five million men experienced some type of IPV before the age of 18 [1]. Furthermore, over three million Canadians aged 15 and older reported to have been victimized by psychological, physical, and/or sexual IPV within the past five years [27]. Rates of experiencing and/or perpetrating specific forms of IPV across various parts of the globe are reported below within their respective sections. Consequences from involvement in an abusive relationship among adolescents and young adults include reports of depression, anxiety, suicide ideation, interpersonal problems, and posttraumatic stress disorder [2, 28–32]. Reports of IPV within these populations have also been associated with unhealthy behaviors ranging from substance use, unhealthy weight control behaviors, sexual risk behaviors, and teenage pregnancy [2, 31, 33–37]. Lastly, victimization from teen dating violence is related to antisocial behaviors (e.g., lying, stealing, bullying, hitting, or engaging in criminal activities) [2, 30, 31, 38, 39].

Additionally, the social and digital age of our current times has given rise to a new form of psychological dating aggression expressed/experienced through means of technology. We term such behaviors as cyber-digital relationship abuse (CDRA). CDRA is also considered to be a new form of psychological dating aggression [40] that may also co-occur and even progress to physical and/or sexual abuse [41].

In the present chapter, we argue that sexual abuse ought not to be examined in isolation as such behaviors may intertwine with psychological and physical abuse. We also argue that both sexual and physical abuse can progress from psychological abuse. Additionally, we focus on the prevalence of these behaviors during the period of adolescence and young adulthood as this is when abusive behaviors within romantic relationships may first originate. We later argue on the implications for researchers, practitioners, interventionists, and high school and college counselors for examining these various forms of abuse from an integrative approach.

2. Sexual abuse

Defining sexual abuse has been challenging among researchers. Particularly because such behaviors can be perpetrated by a stranger, acquaintance, or romantic partner [42–45]. For our purpose, sexual abuse is described as forced sexual activities/sexual contact expressed towards a romantic partner. Additionally, sexual abuse has been defined differently throughout the literature. Some researchers have defined such behaviors based on forced penetrative acts (e.g., "Using force (like hitting, holding down, or using a weapon) to make one's partner have sex"; "unwanted penetration when a victim/survivor is unable to consent or is "unaware", i.e., asleep or under the influence of alcohol") ([42], p. 323; [44], p. 309). Non-physical acts expressed with the intention of forcing one's partner to have sex is also a common form of sexual abuse (e.g., "insisting on sex when one's partner doesn't want to without using physical force"; "the use of non-physical, controlling, degrading, and manipulative tactics to obtain, or attempt to obtain unwanted oral, vaginal, or anal intercourse, including forced penetration and sex with objects") ([42], p. 323; [44]). Sexual abuse has also been defined as non-penetrative sexual acts expressed physically and/or verbally (e.g., kissing or touching one's partner sexually without their approval; "the use of manipulative, psychologically abusive tactics to keep an intimate partner in submissive positions of power; strategies include sexual degradation, non-contact unwanted sexual experiences, and reproductive and sexual control") ([42], p. 323; [46, 47]).

Other forms of sexual abuse include "exposing sexual body parts, being made to look at or participate in sexual photos or movies, harassed in a public place in a way that felt unsafe" ([46], p. 17). In summary, sexual abuse consists of aggressive behaviors expressed either physically and/or psychologically. These behaviors entail more than just rape/forced sexual intercourse and they can be expressed with the intention to control and/or intimidate one's romantic partner. Moreover, the expression of sexual abuse via psychological and physical means further supports the notion of integrating all three types of abuse.

According to findings from the *National Intimate Partner and Sexual Violence Survey* (NISVS), one out of 10 women indicated to have been sexually assaulted by a romantic partner. Findings from their survey also showed that 19 million women were victimized by some form of psychological and/or physical sexual abuse [46]. Similar rates were also shown outside of the USA. For instance, Painter and Farrington [48] indicated that 13% of participants from 10 regions of Great Britain experienced some form of sexual abuse. Also, Fanslow, Robinson, Crengle, and Perese [49] found that 29.1% of Maori women, 14.9% of Pacific women, 3.8% of Asian women, and 16% of European women in Auckland, New Zealand were sexually abused. Among youth and young adults in the USA, rates of having experienced sexual abuse from a romantic partner have ranged from 4–25% [2, 25, 37, 39, 50]. Rates of adolescents perpetrating some type of sexual abuse towards their romantic partner range from 2–21% [39, 47]. Thompson et al. [26] indicated that 8.6% of undergraduate male students consistently perpetrated sexual abuse towards their sexual partners throughout all four academic years. Furthermore, Brownridge [51] indicated that 36.4% of young adult college women in Manitoba (Canadian province) experienced sexual abuse from a dating partner at least once in their lifetime.

Unlike other types of abuse, there is less co-occurrence between perpetration and victimization in reports of sexual abuse among youth and young adults. Primarily because such behaviors are generally perpetrated by men [52]. However, reports of sexual abuse expressed towards men should not be undermined. NISVS findings indicated that approximately nine million men experienced unwanted sexual contact, nonphysical unwanted sexual experiences, were forced to receive oral sex from a male or female, were forced to engage in sexual intercourse with a woman, and/or were forced to penetrate a male or female anally [46]. Furthermore, 12.5% of high school females and 3.8% of high school males were victimized by some form of sexual abuse [2].

Perpetrators of sexual abuse are more likely to report high engagement in alcohol use, high levels of delinquent behaviors, and to report more sexual partners [11]. Victims of sexual abuse are also likely to engage in risky sexual behaviors, experience teenage pregnancy, engage in risky health behaviors to lose weight (excessive use of diet pills, laxative, and excessive vomiting), and experience suicide ideation [37]. Katz et al. [5] indicated that undergraduate female students who experienced both physical and sexual abuse reported less general and sexual satisfaction in their romantic relationship.

3. Physical abuse

Physical abuse consists of aggressive behaviors perpetrated with the intention to harm one's romantic partner. Rates of experiencing physical abuse from a dating partner have ranged between 7–30% among adolescents and young adults in the USA [2, 37, 53]. Concerns relating to physical abuse are not limited to the USA, as according to the Women's National Institute, 66.5% of Mexican adolescents

reported being victims of some type of physical abuse in their relationships. Moreover, it was found that only 10% of these victims were likely to report the abuse [54]. Data collected from Spain by the Government Delegation of Gender Violence [55] revealed that adolescents under the age of 18 who were victims of physical abuse remained in such relationships for an average of 3.5 years; in some cases, relationship lasted up to eight years. Also, recently Exner-Cortens, Baker, and Craig [56] found that 11.8% of Canadian youth (grades 9 & 10) were victimized by physical aggression and that 7.3% of Canadian youth perpetrated acts of physical aggression. These findings suggest that physical abuse is a worldwide health problem among adolescents and young adults.

Rates of physical abuse among adolescents and young adults can also vary based on the severity of the aggression. Specifically, behaviors deemed as minor or moderate (e.g., throwing, grabbing, slapping, and/or twisting a partner's fingers, arm, or hair) are more likely to be experienced/expressed relative to severe forms of aggression (e.g., choking, beating up, burning, and/or using a knife/gun on one's partner) [44, 57]. For instance, among a sample of rural adolescents in North Carolina (13–19 years old), Foshee et al. [57] found that rates of perpetrating minor/moderate forms of physical abuse ranged between 13–21% whereas rates of perpetrating severe forms of physical abuse ranged between 5–9% across five waves of data. Among a community sample of young adults (18–25 years old), Saint-Eloi Cadely et al. [10] found that across eight waves of data, between 21–65% of participants reported to have perpetrated minor forms of physical abuse, whereas between 3–38% of participants indicated to have perpetrated severe forms of physical abuse. Furthermore, among a sample of Latinx adolescents (12–17 years old) whom all experienced physical abuse, Munoz-Rivas, Ronzon-Tirado, Redondo, & Cassinello [58] indicated that between 24–72% of adolescents were victimized by what was defined as mild forms of physical abuse (i.e., being punched or held tightly by a partner, being kicked or bitten, or having been hit or slapped) whereas only 1–2% of adolescents experienced more severe forms of aggression (i.e., being beaten, strangled, or attacked with a knife or weapon).

Importantly, many adolescents and young adults who are victims of physical abuse also report to have perpetrated such behaviors [7, 56, 59, 60]. The co-occurrence between reports of perpetration and victimization may explain the similarity in the reports of these behaviors across sexes. Although often debated, gender symmetry in physical abuse (similar reports across sexes in the perpetration of physical abuse) is largely supported in the literature [52] and is more commonly found among samples of adolescents and young adults [61]. Studies within these populations also found that at times higher rates of perpetrating physical aggression are reported by females relative to males [61–64]. However, adolescent and young adult women are more likely to be injured by physical aggression [61], partially due to adolescent and young adult males being more likely to engage in more severe forms of physical aggression [29, 57, 65, 66].

The effects of physical abuse among adolescents are detrimental. For instance, adolescents who perpetrate physical abuse are more likely to exhibit externalizing and/or internalizing behaviors [31]. Victims of physical abuse are likely to engage in risky sexual behaviors (e.g., lack of condom use and having sex at a young age) [33], drop out of high school [28], and experience mental health disorders such as dissociation, posttraumatic stress, and depression [28, 29]. Even more troubling, many adolescents have trouble leaving a physically abusive relationship. This was found due to the satisfaction and commitment to the relationship, justification for the aggression as joking/playing around, and psychological coercion (e.g., feeling forced to remain in an abusive relationship) [58].

4. Psychological abuse

Psychological abuse (also referred to as psychological aggression or emotional abuse in the literature) is defined as "the use of verbal and non-verbal communication with the intent to harm a partner mentally or emotionally and/or exert control over a partner" [2]. Psychological abuse is by far the most prevalent form of dating violence and is estimated to effect nearly half of all adults [67] and varies across studies from 20% to over 95% among teens [68–70]. Yahner et al. [39], in a large-scale cross-sectional study of 7-12th graders from 3 states in the Northeast, found that nearly one third of their sample reported experiences of psychological abuse. More alarmingly, rates of perpetration of psychological abuse may be more prevalent at younger ages. For example, in a study of middle schoolers (grades 6–8) from four large high risk urban cities, 77% of youth reported perpetrating psychological dating abuse [71].

Psychological abuse is not only a significant health concern for U.S. youth, but is it also a worldwide problem. In an international review of teen dating violence in North America and Europe, Leen et al. [72] found similar rates of adolescent victimization internationally with reports as high as 77% of teens reporting psychological abuse in dating relationships. Additionally, similar to patterns in the USA, psychological abuse was the most prevalent form of dating violence among teens.

Current findings around gender differences in perpetration and victimization of psychological abuse among teens are mixed. In some cases, females are more likely than males to report perpetrating psychological abuse [73, 74]. These findings appear to align with earlier research that suggest that males are more likely to be victims of psychological abuse than females [44]. However, Hébert, Blais, and Lavoie [75], in a representative sample of Canadian youth, found that girls were more likely to report being victims of all forms of abuse with psychological abuse being the most prevalent. Similarly, in a recent national Canadian study, psychological abuse was more prevalent among adolescent females and non-binary youth relative to their male counterparts [56]. On the contrary, in an international review of teen dating violence Leen et al. [72] found rates of psychological abuse to be similar among boys and girls, there were no gender differences. Thus, it appears while the relationship between gender and psychological abuse remains unclear, this form of dating violence is a serious international public health concern.

There are many significant ramifications of psychological abuse in dating relationships. Consequences of psychological abuse include psychological distress, relationship anxiety, relationship deterioration, symptoms of depression and anxiety, substance use, suicidal ideation, and an increased risk of further victimization and perpetration of dating violence [69, 76–80]. Specifically, those who experience psychological abuse are more likely to be victims of physical abuse [81] thus perpetuating a cycle of violence and further supporting the need to integrate these behaviors.

While much attention in the IPV literature focuses on physical abuse, it is psychological abuse that may be more deleterious to mental health [69, 78]. In an 8-week study of teen dating violence among high school students, Jouriles et al. [78] found that not only does psychological abuse occur in higher frequency than other forms of violence, but it is also viewed as more unpleasant and intentionally hurtful than physical abuse. These findings are consistent with the adult literature which indicates that women view their partners' psychological abuse as more negative and associate their distress more so to psychological abuse than physical abuse [82, 83].

4.1 Cyber-digital relationship abuse

Even prior to the COVID-19 pandemic, teens' lives have been dominated by technology use and since the new millennium cell phones and text messaging have been the primary means of communication and social connectedness for teens and emerging adults [84]. In fact, young adults spend more time with technology than any other daily activity [85] and technology use mediates most young adult romantic relationships. This new means of communication has changed the way young adults interact within romantic relationships and has introduced a new form of psychological dating aggression, cyber-digital relationship abuse (CDRA). CDRA (also referred to as cyber dating abuse) [40, 41] or electronic dating violence [86] or technology assisted dating violence and abuse [87] is conceptualized as behaviors where technology serves as a tool to harass, threaten, control, and/or monitor a partner's whereabouts through use of social media (e.g., Facebook and Twitter) and digital means (e.g., texting and e-mail) [88–90].

Prevalence rates of CDRA range across studies from 10–32% for perpetration and up to 51% for victimization [40, 41, 91]. According to the Research Triangle Institute International [92], 31% of 7th graders were victims of some form of CDRA. Smaller rates were found in a cross-sectional study using an ethnic minority sample of 6th graders, where 15% reported to have perpetrated CDRA [93]. It appears that rates of CDRA are even higher among LGB youth and young adults with 38% reporting psychological abuse via CDRA versus 10% of heterosexual youth and young adults [94]. It is important to note that CDRA is more frequent at younger ages [88] thus demonstrating the need for early prevention and intervention efforts.

As CDRA is a relatively new form of dating violence, gender differences are still being revealed. In a large-scale study of youth in the northeast ages 13–18, females reported more CDRA victimization than males [41]. Similarly, in a separate study of 9th graders, females were more likely to report experiences of CDRA [95]. In contrast, Cutbush [96] in a sample of 7th graders found that males were more likely to experience CDRA. This pattern was also found in a separate study by Cutbush [91] in which victimization was more prevalent for boys (42%) than for girls (31%). Ybarra et al. [94] reported equal rates of CDRA victimization by gender. Still other studies found no gender differences to emerge among young adults [88]. Thus, it appears that gender and age may play a unique role in the expression of CDRA and these dynamics need to be further explored. At this time, little is known about the relation between race and CDRA. In one study race was not associated with CDRA among high school students [41] and in another study, Hispanic race/ethnicity was correlated with perpetration of CDRA among middle school students [96]. Like gender, differences in rates of CDRA across race and ethnicity needs further exploration.

Similar to traditional forms of dating violence, CDRA is associated with a number of negative outcomes. For instance, CDRA was associated with depressive symptoms and anxiety among high school students [41, 97, 98]. Additionally, CDRA has been linked with lowered self-esteem and greater emotional distress [99] and is associated with personal and professional harm [94]. In an ethnically diverse sample of youth, CDRA was associated cross-sectionally with mental health and substance use, whereas longitudinal associations between CDRA and substance use were shown [100]. CDRA also increases likelihood of cyberbullying victimization and perpetration [88]. It is important to consider that comparable to patterns identified in traditional forms of IPV, there is a high rate of mutual engagement in CDRA [40, 56]. Essentially, victims and perpetrators are not always distinct from one another. In fact, findings indicated that the victimized often victimize

via CDRA [87]. Therefore, prevention and intervention must be designed around conceptualizing teens as both perpetrators and victims of CDRA simultaneously.

Interestingly, as compared with other forms of abuse, CDRA may be more difficult to escape due to the permanent presence of technology whether it be the various ways to access the victim or the permanent nature of online posts. Moreover, Borrajo et al. [40] found that victims were repeatably victimized with an average of 23 times in last six months. Given the rise of COVID-19, many more relationships are being formed and maintained through technology, making it all the more imperative that youth and young adults are aware of parameters around healthy technology use and how to use technology to build a foundation of healthy relationship dynamics.

5. An integration of abuse via a biopsychosocial framework

Considering the multifaceted nature of dating abuse, a multidimensional framework is critical for assessment, prevention, and intervention. We argue that the biopsychosocial model should be considered for this purpose (see **Figure 1**). Further we argue that a similar framework can be useful to examine the integration of various forms of abuse (see **Figure 2**) and the progression of abuse over time (see **Figure 3**).

The biopsychosocial model is a theoretical and conceptual framework that elegantly bridges the dichotomy between the social sciences and the medical sciences and considers the role of interpersonal, intrapersonal, and psychological dynamics for an individual's health and well-being. George Engel [101, 102], the originator of the biopsychosocial model, proposes that simultaneous attention to biological, psychological, and social aspects are necessary when considering health and pathology processes (see **Figure 1**). The biopsychosocial model operates by way of a family systems perspective to understand the multiple reciprocal factors from various facets of human experience [103]. The biopsychosocial model can be applied to a variety of contexts without attempting to isolate a specific underlying cause of a problem, which is not only unlikely, but it is also highly improbable that a single factor is to blame. Similar to the biopsychosocial model, the integrative illustration of sexual, physical, psychological, and CDRA in adolescent and young adult relationships can work in similar ways. While sexual, physical, psychological, and CDRA can occur in isolation, as you can see indicated in the figure, they can also co-occur (see **Figure 2**) and even progress over time (see **Figure 3**). Assessing for various forms of dating violence can be complex. It is important that our prevention and intervention efforts utilize a multidimensional (biopsychosocial) integrative approach to exploring, treating, and preventing various forms of abuse collectively. Furthermore, considering the many biological (e.g., physical health, disability, and genetic vulnerabilities), psychological (e.g., mental health, coping skills, social skills, self-esteem, and attitudes/beliefs), and social relational factors (e.g., family relationships, peer relationships, culture, and discrimination) that influence or can be influenced by the development and progression of dating abuse further supports the necessity to understand IPV from a biopsychosocial lens.

5.1 Co-occurrence

The argument of examining various forms of IPV from an integrative perspective is supported by the literature indicating concurrent associations between psychological, physical, and sexual IPV. Among a sample of newlywed couples, Hammett et al. [63] found moderate to strong intercorrelations between self-reports

of psychological and physical IPV among husbands and wives. The co-occurrence between psychological and physical IPV is also common among adolescents and young adult couples [7, 59, 66, 99]. Recently, Saint-Eloi Cadely et al. [9] showed concurrent associations between psychological and physical IPV at all five waves of data among a sample of young adults from ages 22–25. Saint-Eloi Cadely et al. [10] also found that young adults who perpetrated both minor and severe forms of psychological abuse over time also reported extensive use of physical IPV over time; these findings coincide with other studies indicating that the frequency and severity of psychological IPV is related to physical IPV [53, 92]. The relationship between psychological and physical abuse is also found based on reports of CDRA. Specifically, Borrajo et al. [40, 88] indicated that self-reports of CDRA victimization and perpetration were related to self-reports of interpersonal forms of psychological and physical IPV. Cohesively, these findings support the notion that physical abuse without psychological abuse is rare (see [104] for a review of the literature) which further supports the need for the integration of both forms of abuse.

White et al. [11] previously called for researchers to investigate the co-emergence between physical and sexual abuse. Additionally, Katz et al. [5] argued that the co-victimization of physical and sexual abuse from a dating partner (i.e., "experiencing both physical violence and unwanted sexual contact from one's dating partner, but not necessarily during the same event", p. 963) ought to be treated distinctly from other forms of abuse standing alone. We argue that psychological abuse ought to be included in this co-emergence of abusive behaviors. Although understudied, the literature hints on a co-occurrence across all three forms of abuse. Within the *National Violence Against Women Survey* (NVAWS) data, Tjaden and Thoennes [105] found that 31% of women who were stalked by their current or former husband or cohabiting partner were also sexually assaulted by that partner. Katz et al. [5] indicated that young college women who were victimized by both physical and sexual IPV were more likely to have experienced psychological abuse from their dating partner. Concurrent associations between sexual abuse and other forms of dating violence among adolescents have also been found. For instance, in a large-scale study of 10 schools in the Northeast of USA (7th–12th graders), victims of CDRA were seven times more likely to have experienced sexual coercion [98]. Additionally, among a sample of adolescents from six high schools in the US Midwest, Saint-Eloi Cadely and Espelage [106] found concurrent associations for the perpetration and victimization of psychological, physical, and sexual abuse at all three waves of data.

Historically, much of the literature has focused on various forms of abuse as if they are truly distinct and occur in isolation from other forms of abuse. However, the research documents that this is not the case and that various forms of abuse often co-occur with other forms of abuse [5, 11, 104]. The co-occurrence literature across these various forms of IPV also hints on a possible progression from psychological to physical and/or sexual IPV.

5.2 Progression

Although the detrimental effects of psychological IPV should not be undermined, such behaviors are often dismissed as normative behaviors among couples (particularly minor forms of psychological IPV) [107]. Thus, it can be found easier for perpetrators to initiate psychological forms of IPV before progressing to other forms of abuse. Previous cross-sectional studies hinted on the possible progression from psychological to physical IPV among adolescents and young adults [3, 4, 59, 66, 99]. Longitudinal studies more strongly support this notion by indicating a relationship between early reports of psychological abuse and

later reports of physical abuse [6–8]. More recently, stronger empirical tests using longitudinal data support the progression from psychological to physical abuse with more confidence. For instance, using cross-lag analysis among a sample of young adults (ages 22–25), Saint-Eloi Cadely et al. [9] compared the associations between early and later reports of psychological and physical IPV in one model across five waves of data. Specifically, the model controlled for the direction of early reports of psychological IPV predicting later reports of physical IPV in addition to early reports of physical IPV predicting later reports of psychological IPV across waves. Results showed that early reports of psychological IPV consistently predicted later reports of physical IPV, whereas the opposite direction either was shown to be non-significant or to work in the opposite direction. Moreover, among a sample of young adult couples (Men, M = 37.56 years old; Women, M = 35.38 years old), it was found that men and women who more frequently perpetrated psychological IPV were more likely to engage in physical IPV one year later [108].

Given the connections between psychological abuse as a segue to later physical abuse among adolescents and young adults, it stands to reason that CDRA may also serve as a pathway to physical forms of abuse should such behaviors be regarded as a new form of psychological abuse. However, this longitudinal pathway along with the longitudinal association from psychological to sexual forms of IPV remains underdeveloped. Similar to physical IPV, sexual IPV is also at times perpetrated with the intention to control one's partner [104]. The use of control in an abusive relationship is a psychologically aggressive act. Abusive partners commonly turn to physical acts of violence as an additional means to control their partner when psychological means are not perceived as enough [82, 109]. Under this notion, it is highly plausible that aggressive partners may turn to sexual abuse for the same purpose. Therefore, it is imperative to further examine the progression from CDRA to physical and sexual aggression and from psychological to sexual abuse. Furthermore, given the evidence supporting the continuation of psychological, physical, and sexual abuse from adolescence to young adulthood [10, 24–26], the progression between these various forms of IPV ought to be examined during this transitional period.

6. Implications and future directions

The foundations for healthy adult romantic relationships begin with a youth's first romantic formation. As we have demonstrated in this chapter, it is clear from the literature that different forms of abuse: sexual, physical, psychological, and CDRA, rarely occur in isolation. Moreover, milder forms of abuse have the potential to develop into more severe forms of abuse over time [66, 99]. Additionally, there is a high likelihood of mutual engagement in the various forms of abuse among teens where there is not always a clear victim and perpetrator but rather both partners have been victimized and perpetrated against [69, 80, 88].

Given the high prevalence of IPV among teens, and the likelihood of mutual engagement, it is all the more imperative that prevention and intervention efforts start early and provide a multidimensional framework inclusive of various forms of dating violence and geared towards both perpetration and victimization in the same curriculum. As we design our prevention and intervention efforts, attitudes towards violence may be an important factor to consider as a potential pathway for prevention and intervention as they have been shown to predict involvement in both victimization and perpetration of dating violence [80, 110]. Moreover, understanding the developmental pathways and integrative nature of dating abuse is crucial as

we work towards preparing and supporting a foundation for healthy adult relationships. Practitioners, interventionists, high school and college counselors, and support staff should provide education around healthy relationship skill building including the development of conflict management/resolution skills, communication training, emotion regulation and de-escalation strategies, and healthy technology use. Assessment of violence should utilize a multidimensional biopsychosocial approach that includes checkups over time to look out for the progression of violence. While a teen may be experiencing only one form of violence at a cross section in time it would be beneficial to be aware of the potential co-occurrence and/or progression of violence over time. Future research must examine the co-occurrence and progression of sexual, psychological, physical, and CDRA longitudinally to better understand the causal nature and interplay among the various forms of aggression in efforts to refine and improve prevention and intervention efforts.

Targeting prevention and intervention efforts towards youth is imperative as IPV is most prevalent among youth and declines with age [111]. As youth and young adults begin to form their patterns of interaction that will then influence their later adult romantic relationships, the development of healthy relationship skills that can potentially prevent experiences of sexual, physical, and psychological abuse, and CDRA in adolescent and young adult romantic relationships is critical.

Author details

Hans Saint-Eloi Cadely* and Tiffani Kisler
University of Rhode Island, USA

*Address all correspondence to: hsainteloicadel@uri.edu

References

[1] Centers for Disease Control and Prevention. (2020). *Preventing intimate partner violence*. Retrieved from https://www.cdc.gov/violenceprevention/pdf/ipv/IPV-factsheet_2020_508.pdf

[2] Centers for Disease Control and Prevention. (2021). Preventing teen dating violence. Retrieved from https://www.cdc.gov/violenceprevention/pdf/ipv/TDV-factsheet_508.pdf

[3] Bates, E. A., Graham-Kevan, N., & Archer, J. (2014). Testing predictions from the male control theory of men's partner violence. Aggressive Behavior, *40*, 42-55. https://doi.org/10.1002/ab.21499

[4] Fawson, P. R. (2015). Controlling behaviors as a predictor of partner violence among heterosexual female and male adolescents. Partner Abuse, *6*(2), 217-229. https://doi.org/10.1891/1946-6560.6.2.217

[5] Katz, J., Moore, J., & May, P. (2008). Physical and sexual covictimization from dating partners: A distinct type of intimate abuse?. Violence Against Women, *14*(8), 961-980. https://doi.org/10.1177/1077801208320905

[6] Murphy, C. M., & O'Leary, K. D. (1989). Psychological aggression predicts physical aggression in early marriage. Journal of Consulting and Clinical Psychology, *57*(5), 579-582. https://doi.org/10.1037/0022-006X.57.5.579

[7] O'Leary, K. D., & Slep, A. M. (2003). A dyadic longitudinal model of adolescent dating aggression. Journal of Clinical Child and Adolescent Psychology, *32(3)*, 314-327. https://doi.org/10.1207/S15374424JCCP3203_01

[8] O'Leary, K. D., Malone, J., & Tyree, A. (1994). Physical aggression in early marriage: Prerelationship and relationship effects. Journal of Consulting and Clinical Psychology, *62*(3), 594-602. https://doi.org/10.1037/0022-006X.62.3.594

[9] Saint-Eloi Cadely, H., Pitman, J. F., Pettit, G. S., Lansford, J. E., Bates, J. E., Dodge, K. A., & Holtzworth-Munroe, A. (2020a). Temporal associations between psychological and physical intimate partner violence: A cross-lag analysis. Partner Abuse, *11*(1), 22-38. https://doi.org/10.1891/1946-6560.11.1.22

[10] Saint-Eloi Cadely, H., Pittman, J. F., Pettit, G. S., Lansford, J. E., Bates, J. E., Dodge, K. A., & Holtzworth-Munroe, A. (2020b). Classes of intimate partner violence from late adolescence to young adulthood. Journal of Interpersonal Violence, *35*(21-22), 4419-4443. https://doi.org/10.1177/0886260517715601

[11] White, J. W., McMullin, D., Swartout, K., Sechrist, S., & Gollehon, A. (2008). Violence in intimate relationships: A conceptual and empirical examination of sexual and physical aggression. Children and Youth Services Review, *30*(3), 338-351. https://doi.org/10.1016/j.childyouth.2007.10.003

[12] Collins, W. A. (2003). More than myth: The developmental significance of romantic relationships during adolescence. Journal of Research on Adolescence, 13(1), 1-24. https://doi.org/10.1111/1532-7795.1301001

[13] Brown, B. B. (1999). *"You're going out with who?": Peer group influences on adolescent romantic relationships.* In W. Furman, B. B. Brown, & C. Feiring (Eds.), *Cambridge studies in social and emotional development. The development of romantic relationships in adolescence* (p. 291-329). Cambridge University Press. https://doi.org/10.1017/CBO9781316182185.013

[14] Kerpelman, J. L., Pittman, J. F. (2001). The instability of possible selves: Identity process within late adolescents' close peer relationships. Journal of Adolescence*, 24*, 491-512. https://doi.org/10.1006/jado.2001.0385

[15] Kerpelman, J. L., Pittman, J. F., Saint-Eloi Cadely, H., Tuggle, F. J., Harrell-Levy, M. K., & Adler-Bader, F. M. (2012). Identity and intimacy during adolescence: Connections among identity styles, romantic attachment, and identity commitment. Journal of Adolescence *35*(6), 1427-1439. https://doi.org/10.1016/j.adolescence.2012.03.008

[16] Pittman, J. F., Keiley, M. K., Kerpelman, J. L., & Vaughn, B. E. (2011). Attachment, identity, and intimacy: Parallels between Bowlby's and Erikson's paradigms. Journal of Family Theory & Review, *3*(1), 32-46. https://doi.org/10.1111/j.1756-2589.2010.00079.x

[17] Carver, K., Joyner, K., & Udry, R. J. (2003). National estimates of adolescent romantic relationships. In P. Florsheim (Ed.), *Adolescent romantic relations and sexual behavior: Theory, research, and practical implications* (pp. 23-56). Mahwah, N.J: Erlbaum.

[18] Kansky, J., & Allen, J. P. (2018). Long-term risks and possible benefits associated with late adolescent romantic relationship quality. Journal of Youth and Adolescence*, 47*, 1531-1544. https://doi.org/10.1007/s10964-018-0813-x

[19] Manning, W. D., Longmore, M. A., Copp, J., & Giordano, P. C. (2014). The complexities of adolescent dating and sexual relationships: Fluidity, meaning(s), and implications for young adults' well-being. In E. S. Lefkowitz & S. A. Vasilenko (Eds.), *Positive and negative outcomes of sexual behaviors*. New Directions for Child and Adolescent Development*, 144*, 53-69. https://doi.org/10.1002/cad.20060

[20] Meier, A., & Allen, G. (2009). Romantic relationships from adolescence to young adulthood: Evidence from the National Longitudinal Study of Adolescent Health. The Sociological Quaterly*, 50*, 308-335. https://doi.org/10.1111/j.1533-8525.2009.01142.x

[21] Cui, M., Ueno, K., Gordon, M., Fincham, F. (2013). The continuation of intimate partner violence from adolescence to young adulthood. Journal of Marriage and Family*, 75,* 300-313. https://doi.org/10.1111/jomf.12016

[22] Gomez, A. M. (2011). Testing the cycle of violence hypothesis: Child abuse and adolescent dating violence as predictors of intimate partner violence in young adulthood. Youth & Society*, 43*, 171-192. https://doi.org/10.1177/0044118X09358313

[23] Saint-Eloi Cadely, H., Kerpelman, J. L., & Pittman, J. F. (2018a). Connections among identity, attachment, and psychological dating aggression during adolescence. Identity, *18*(1), 44-59. https://doi.org/10.1080/15283488.2017.1410158

[24] Swartout, K. M., Cook, S. L., & White, J. W. (2012). Trajectories of intimate partner violence victimization. Western Journal of Emergency Medicine*, 13*(3), 272-277. https://doi.org/10.5811/westjem.2012.3.11788

[25] Swartout, K. M., Swartout, A. G., & White, J. W. (2011). A person-centered, longitudinal approach to sexual victimization. Psychology of Violence*, 1*(1), 29-40. https://doi.org/10.1037/a0022069

[26] Thompson, M. P., Swartout, K. M., & Koss, M. P. (2012). Trajectories and predictors of sexually aggressive behaviors during emerging adulthood. Psychology of Violence, 1-13. https://doi.org/10.1037/a0030624

[27] Burczycka, M. (2016). Section 1: Trends in self-reported spousal violence in Canada, 2014. Juristat. Retrieved from https://www150.statcan.gc.ca/n1/pub/85-002-x/2016001/article/14303/01-eng.htm

[28] Barnyard, V. L., & Cross, C. (2008). Consequences of teen dating violence: Understanding intervening variables in ecological context. Violence Against Women*, 14*, 998-1013. https://doi.org/10.1177/1077801208322058

[29] Callahan, M. R., Tolman, R. M., & Saunders, D. G. (2003). Adolescent dating violence victimization and psychological well-being. Journal of Adolescent Research*, 18*(6), 664-681. https://doi.org/10.1177/0743558403254784

[30] Champion, J. D., Collins, J. L., Reyes, S., & Rivera R. L. (2009). Attitudes and beliefs concerning sexual relationships among minority adolescent women. Issues in Mental Health Nursing*, 30*, 436-442. https://doi.org/10.1080/01612840902770475

[31] Chase, K. A., Treboux, D., & O'Leary, D. K. (2002). Characteristics of high-risk adolescents' dating violence. Journal of Interpersonal Violence*, 17*(1), 33-49. https://doi.org/10.1177/0886260502017001003

[32] Rich, C. L., Gidycz, C. A., Warkentin, J. B., Loh, C., & Weiland, P. (2005). Child and adolescent abuse and subsequent victimization: A prospective study. Child Abuse & Neglect*, 29*, 1373-1394. https://doi.org/10.1016/j.chiabu.2005.07.003

[33] Alleyne, B., Coleman-Cowger, V. H., Crown, L., Gibbons, M. A., & Vines, L. N. (2011). The effects of dating violence, substance use and risky sexual behavior among a diverse sample of Illinois youth. Journal of Adolescence*, 34*, 11-18. https://doi.org/10.1016/j.adolescence.2010.03.006

[34] Foo, L., & Margolin, G. (1995). A multivariate investigation of dating aggression. Journal of Family Violence*, 10*, 351-377.

[35] Howard, D. E., Wang, M. Q., & Yan, F. (2007). Psychosocial factors associated with reports of physical dating violence among U.S adolescent females. *Adolescence, 42*(166), 311-324.

[36] Schiff, M., & Zeira, A. (2005). Dating violence and sexual risk behaviors in a sample of at-risk Israeli youth. Child Abuse & Neglect*, 29*, 1249-1263. https://doi.org/10.1016/j.chiabu.2005.04.007

[37] Silverman, J. G., Raj, A., Mucci, L. A., & Hathaway, J. E. (2001). Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. Journal of the American Medical Association*, 286(5)*, 572-579. https://doi.org/10.1001/jama.286.5.572

[38] Espelage, D. L., & Holt, M. K. (2007). Dating violence & sexual harassment across the bully- victim continuum among middle and high school students. Journal of Youth Adolescence*, 36*, 799-811: https://doi.org/10.1007/s10964-006-9109-7

[39] Yahner, J., Dank, M., Zweig, J. M., & Lachman, P. (2015). The co-occurrence of physical and cyber dating violence and bullying among teens. Journal of Interpersonal Violence*, 30*(7), 1079-1089. https://doi.org/10.1177/0886260514540324

[40] Borrajo, E., Gámez-Guadix, M., Pereda, N., & Calvete, E. (2015b). The development and validation of the cyber dating abuse questionnaire among young couples. Computers in human behavior, *48*, 358-365. https://doi.org./10.1016/j.chb.2015.01.063

[41] Zweig, J. M., Dank, M., Yahner, J., & Lachman, P. (2013b). The rate of cyber

dating abuse among teens and how it relates to other forms of teen dating violence. Journal of Youth and Adolescence, *42*, 1063-1077. https://doi.org/10.1007/s10964-013-9922-8

[42] Bagwell-Gray, M. E., Messing, J. T., & Baldwin-White, A. (2015). Intimate partner sexual violence: A review of terms, definitions, and prevalence. Trauma, Violence, & Abuse, *16*(3), 316-335. https://doi.org/10.1177/1524838014557290

[43] Koss, M. P., & Gidycz, C. A. (1985). Sexual experiences survey: Reliability and validity. Journal of Consulting and Clinical Psychology, *53*, 422-423. https://doi.org/10.1037/0022-006X.53.3.422

[44] Strauss, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The revised conflict tactics scales (CTS2). Journal of Family Issues, *17*(3), 283-316. https://doi.org/10.1177/019251396017003001

[45] Young, B. J., & Furman, W (2008). Interpersonal factors in the risk for sexual victimization and its recurrence during adolescence. Journal of Youth Adolescence, *37*, 297-309. https://doi.org/10.1007/s10964-007-9240-0

[46] Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M., Merrick, M. T., ... Stevens, M. R. (2011). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[47] Wolfe, D. A., Scott, K., Reitzel-Jaffe, D., Wekerle, C., Grasley, C., & Straatman, A. (2001). Development and validation of the conflict in adolescent dating relationship inventory. Psychological Bulletin, *13*(2), 277-293. https://doi.org/10.1037/t00856-000

[48] Painter, K., & Farrington, D. P. (1998). Marital violence in Great Britain and its relationship to marital and non-marital rape. International Review of Victimology, *5*(3-4), 257-276. https://doi.org/10.1177/026975809800500404

[49] Fanslow, J., Robinson, E., Crengle, S., & Perese, L. (2010). Juxtaposing beliefs and reality: Prevalence rates of intimate partner violence and attitudes to violence and gender roles reported by New Zealand women. Violence Against Women, *16*(7), 812-831. https://doi.org/10.1177/1077801210373710

[50] Barnyard, V. L., Arnold, S., Smith, J. (2000). Childhood sexual abuse and dating experiences of undergraduate women. Child Maltreatment, *5*(1), 39-48. https://doi.org/10.1177/1077559500005001005\

[51] Brownridge, D. A. (2006). Intergenerational transmission and dating violence victimization: Evidence from a sample of female university students in Manitoba. Canadian Journal of Community Mental Health, *25*(1), 75-93. https://doi.org/10.7870/cjcmh-2006-0006

[52] Straus, M. A. (2009). Why the overwhelming evidence on partner physical violence by women has not been perceived and is often denied. Journal of Aggression, Maltreatment & Trauma, *18*(6), 552-571. https://doi.org/10.1080/10926770903103081

[53] Berger, A., Wildsmith, E., Manlove, J., & Steward-Streng, N. (2012). *Child trends research brief*. Washington, DC: Child Trends.

[54] Instituto Nacional de las Mujeres. (2016). *Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares. Gobierno* de la Republica. https://www.inegi.org.mx/progra mas/endireh/2016/default.html?ps=microdatos#Datos_abiertos

[55] Delegación del Gobierno para la violencia de género. (2019). *Estudio*

sobre el tiempo que tardan las mujeres víctimas de violencia de género en verbalizar su situación [The time it takes for women victims of gender violence to verbalize their situation]. Secretaria de Estado de Igualdad. https://violenciagenero.igualdad.gob.es/violenciaEnCifras/estudios/investigaciones/2019/pdfs/Estudio_Tiempo_Denuncia4.pdf

[56] Exner-Cortens, D., Eckenrode, J., & Rothman, E. (2013). Longitudinal associations between teen dating violence victimization and adverse health outcomes. Pediatrics, *131*(1), 71-78. https://doi.org/10.1542/peds.2012-1029

[57] Foshee, V. A., Benefield, T., Suchindran, C., Ennett, S. T., Bauman, K. E., Karriker-Jaffe, K. J., Reyes, H. M., & Mathias, J. (2009). The development of four types of adolescent dating abuse and selected demographic correlates. Journal of Research on Adolescence, *19(3)*, 380-400. https://doi.org/10.1111/j.1532-7795.2009.00593.x

[58] Munoz-Rivas, M., Ronzón-Tirado, R C., Redondo, N., & Cassinello, M. D. Z. (2021). Adolescent victims of physical dating violence: Why do they stay in abusive relationships? Journal of Interpersonal Violence, 1-20. https://doi.org/10.1177/0886260520986277

[59] Cano, A., Avery-Leaf, S., Cascardi, M., & O'Leary, D. (1998). Dating violence in two high school samples: Discriminating variables. The Journal of Primary Prevention, *18*(4), 431-446. https://doi.org/10.1023/A:1022653609263

[60] Williams, T. S., Connolly, J., Pepler, D., Craig, W., & Laporte, L. (2008). Risk models of dating aggression across different adolescent relationships: A developmental psychopathology approach. Journal of Consulting and Clinical Psychology, *76*, 622-632. https://doi.org/10.1037/0022-006X.76.4.622

[61] Archer, J. (2000). Sex differences in aggression between heterosexual partners: A meta-analytic review. Psychological Bulletin, *126*, 651-680. https://doi.org/10.1037/0033-2909.126.5.651

[62] Capaldi, D. M., Shortt, J. W., & Crosby, L. (2003). Physical and psychological aggression in at- risk young couples: Stability and change in young adulthood. Merrill-Palmer Quaterly, *49(1)*, 1-27.

[63] Hammett, J. F., Karney, B. R., & Bradbury, T. N. (2021). When does verbal aggression in relationships covary with physical violence? Psychology of Violence, *11*(1), 50-60. https://doi.org/10.1037/vio0000311

[64] Saint-Eloi Cadely, H., Pittman, J. F., Pettit, G. S., Lansford, J. E., Bates, J. E., Dodge, K. A., & Holtzworth-Munroe, A. (2018b). Predicting patterns of intimate partner violence perpetration from late adolescence to young adulthood. Journal of Interpersonal Violence, 1-26. https://doi.org/10.1177/0886260518795173

[65] Archer, J. (2002). Sex differences in physically aggressive acts between heterosexual partners: A meta-analytic review. Aggression and Violent Behavior, *7*, 313-351. https://doi.org/10.1016/S1359-1789(01)00061-1

[66] Hamby, S. L., & Sugarman, D. B. (1999). Acts of psychological aggression against a partner and their relation to physical assault and gender. Journal of Marriage and the Family, *61*(4), 959-970. https://doi.org/10.2307/354016

[67] Smith, S. G., Chen, J., Basile, K. C., Gilbert, L. K., Merrick, M. T., Patel, N., Walling, M., & Jain, A. (2017). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012

State Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[68] Arriaga, X. B., Foshee, V. A. (2004). Adolescent dating violence: Do adolescents follow in their friends', or their parents' footsteps? Journal of Interpersonal Violence, *19*(2),162-184. https://doi.org/10.1177/0886260503260247

[69] Fernández-Fuertes, A. A., & Fuertes, A. (2010). Physical and psychological aggression in dating relationships of Spanish adolescents: Motives and consequences. Child Abuse & Neglect, *34*(3), 183-191. https://doi.org/10.1016/j.chiabu.2010.01.002

[70] Halpern, C. T., Oslak, S. G., Young, M. L., Martin, S. L., & Kupper, L. L. (2001). Partner violence among adolescents in opposite-sex romantic relationships: findings from the National Longitudinal Study of Adolescent Health. American Journal of Public Health, *91*(10), 1679-1685. https://doi.org/10.2105/ajph.91.10.1679

[71] Niolon, P. H., Vivolo-Kantor, A. M., Latzman, N. E., Valle, L. A., Kuoh, H., Burton, T., Taylor, B. G., & Tharp, A. T. (2015). Prevalence of teen dating violence and co-occuring risk factors among middle school youth in high-risk urban communities. Journal of Adolescent Health, *56*, S5-S13. https://doi.org/10.1016/j.jadohealth.2014.07.019

[72] Leen, E., Sorbring, E., Mawer, M., Holdsworth, E., Helsing, B., & Bowen, E. (2013). Prevalence, dynamic risk factors and the efficacy of primary interventions for adolescent dating violence: An international review. Aggression and Violent Behavior, *18*, 159-174. https://doi.org/10.1016/j.avb.2012.11.015

[73] Hines, D. A. & Saudino, K. J. (2003). Gender differences in psychological, physical, and sexual aggression among college students using the revised conflict tactics scales. Violence and Victims, *18*(2), 197-217. https://doi.org/10.1891/vivi.2003.18.2.197

[74] Jenkins, S. S. & Aubé, J. (2002). Gender differences and gender-related constructs in dating aggression. Personal and Social Psychology Bulletin, *28*(8), 1106-1128. https://doi.org/10.1177/01461672022811009

[75] Hébert, M., Blais, M., Lavoie, F. (2017). Prevalence of teen dating victimization among a representative sample of high school students in Quebec. International Journal of Clinical and Health Psychology, *17*(3), 225-233. https://doi.org/10.1016/j.ijchp.2017.06.001.

[76] Exner-Cortens, D., Baker, E., & Craig, W. (2021). The national prevalence of adolescent dating violence in Canada. Journal of Adolescent Health, 1-8. https://doi.org/10.1016/j.jadohealth.2021.01.032

[77] Foshee, V.A., Reyes, H. L. McN., Gottfredson, N, C., Chang, L.-Y., & Ennett, S. T. (2013). A longitudinal examination of psychological, behavioral, academic, and relationship consequences of dating abuse victimization among a primarily rural sample of adolescents. *Journal of Adolescent Health*, *53*, 723-729. https://doi.org/10.1016/j.jadohealth.2013.06.016

[78] Jouriles, E. N., Garrido, E., Rosenfield, D., & McDonald, R. (2009). Experiences of psychological and physical aggression in adolescent romantic relationships: Links to psychological distress. Child Abuse & Neglect, *33*, 451-460. https://doi.org/10.1016/j.chiabu.2008.11.005

[79] Roberts, T. A., Klein, J. D., & Fisher, S. (2003). Longitudinal effect of intimate partner abuse on high-risk

behavior among adolescents. Archives of Pediatric and Adolescent Medicine *157*, 875-881. https://doi.org/10.1001/archpedi.157.9.875

[80] Ybarra, M. L., Langhinrichsen-Rohling, J. (2019). Linkages between violence-associated attitudes and psychological, physical, and sexual dating abuse perpetration and victimization among male and female adolescents. Aggressive Behavior, *45*, 622– 634. https://doi.org/10.1002/ab.21856

[81] Stith, S. M., Smith, D. B., Penn, C. E., Ward, D. B., & Tritt, D. (2004). Intimate partner physical abuse perpetration and victimization risk factors: a meta-analytic review. Aggression and Violent Behavior*, 10*(1), 65-98. https://doi.org/10.1016/j.avb.2003.09.001

[82] Follingstad, D. R., Rutledge, L. L., Berg, B. J., Hause, A. S., & Polek, D. S. (1990). The role of emotional abuse in physically abusive relationships. Journal of Family Violence*, 5*(2), 107-120. https://doi.org/10.1007/BF00978514

[83] Vitanza, S., Vogel, L. C. M., & Marshall, L. L. (1995). Distress and symptoms of posttraumatic stress disorder in abused women. Violence and Victims*, 10*(1), 23-34. https://doi.org/10.1891/0886-6708.10.1.23

[84] Lenhart, A., Ling, R., Campbell, S., & Purcell, K. (2010). *Teens and Mobile Phones*: *Text Messaging Explodes as Teens Embrace It as the Centerpiece in Their Communication Strategies with Friends*. Pew Internet & American Life Project.

[85] Coyne, S. M., Padila-Walker, L, M., & Howard, E. (2013). Emerging in a digital world: A decade review of media use, effects, and gratifications in emerging adulthood. *Emerging Adulthood, 1,* 125-137. https://doi.org/10.1177/2167696813479782

[86] Bennet, D. C., Guran, E. L., Ramos, M. C., & Margolin, G. (2011). College students' electronic victimization in friendships and dating relationships: Anticipated distress and associations with risky behaviors. Violence and Victims, 4, 410-429. https://doi.org/10.1891/0886-6708.26.4.410

[87] Stonard, K. E., Bowen, E., Walker, K., Price, S. A. (2017). "They'll Always Find a Way to Get to You": Technology Use in Adolescent Romantic Relationships and Its Role in Dating Violence and Abuse. Journal of Interpersonal Violence*, 32*(14), 2083-2117. https://doi.org/10.1177/0886260515590787

[88] Borrajo, E., Gámez-Guadix, M., & Calvete, E. (2015a). Cyber dating abuse: Prevalence, context, and relationship with offline dating aggression. Psychological reports, 116(2), 565-585. https://doi.org/10.2466/21.16.PR0.116k22w4

[89] Henry, N., & Powell, A. (2018). Technology-Facilitated Sexual Violence: A Literature Review of Empirical Research. Trauma, Violence, & Abuse*, 19*(2):195-208. https://doi.org/10.1177/1524838016650189

[90] Melander, L. A. (2010). College students' perceptions of intimate partner cyber harassment. Cyberpsychology,*13*(3), 263-268. https://doi.org/10.1089/cyber.2009.0221.

[91] Cutbush, S., Williams J, Miller S, Gibbs D, Clinton-Sherrod, M. (2021). Longitudinal Patterns of Electronic Teen Dating Violence Among Middle School Students. Journal of Interpersonal Violence, *36*(5-6), NP2506-NP2526. https://doi.org/10.1177/0886260518758326

[92] Research Triangle Institute International (2012). New study of 1,430 7th-grader students reports teen dating violence behaviors and risk factors occurring among middle school

students. Retrieved from http://www.rwjf.org/vulnerablepopulations/product.jsp?id=74129

[93] Peskin, M. F., Markham, C., Shegog, R., Temple, J. R., Baumler, E. R., Addy, R. C., Hernandez, B., Cuccaro, P., Gabay, E. K., Thiel, M., & Emery, S. T. (2017). Prevalence and correlates of the perpetration of cyber dating abuse among early adolescents. Journal of Youth and Adolescence, *46*, 358-376. https://doi.org/10.1007/s10964-016-0568-1

[94] Ybarra M., Price-Feeney M., Lenhart A., & Zickuhr K. (2017). *Intimate Partner Digital Abuse*. Retrieved from: https://datasociety.net/pubs/oh/Intimate_Partner_Digital_Abuse_2017.pdf.

[95] Cutbush, S., Ashley, O., Kan, M. L., & Hall, D. M. (2010). Electronic aggression among adolescent dating partners: Demographic correlates and associations with academic performance and other types of violence. Denver: American Public Health Association. Retrieved from https://apha.confex.com/apha/138am/webprogram/Paper229575.html.

[96] Cutbush, S. (2012). Electronic aggression among adolescent dating partners: Associations with parent-child communication about social media use and other types of teen dating violence. San Francisco: American Public Health Association. Retrieved from https://apha.confex.com/apha/140am/webprogram/Paper268298.html

[97] Wright, M. F. (2015). Cyber aggression within adolescents' romantic relationships: Linkages to parental and partner attachment. Journal of Youth and Adolescence, *44*, 37-47. http://dx.doi.org/10.1007/s10964-014-0147-2

[98] Zweig, J. M., Dank, M., Lachman, P., & Yahner, J. (2013a). Technology, teen dating violence and abuse, and bullying. Washington, DC: Urban Institute. Retrieved from http://www.urban.org/sites/default/files/publication/23941/412891-Technology-Teen-Dating-Violence-and-Abuse-and-Bullying.PDF

[99] Hancock, K., Keast, H., & Ellis, W. (2017). The impact of cyber dating abuse on self-esteem: The mediating role of emotional distress. Cyberpsychology: Journal of Psychosocial Research on Cyberspace, *11*(2), Article 2. https://doi.org/10.5817/CP2017-2-2

[100] Lu, Y., Van Ouytsel, J. V, Walrave, M., Ponnet, K., & Temple, J. R. (2018). Cross-sectional and temporal associations between cyber dating abuse victimization and mental health and substance use outcomes. Journal of Adolescence, *65*, 1-5. https://doi.org/10.1016/j.adolescence.2018.02.009

[101] Doherty, W. J., & Campbell, T. L. (1988). *Family studies text series, Vol. 10.Families and health*. Sage Publications, Inc.

[102] Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. Science, *196* (4286), 129-136. https://doi.org/10.1126/science.847460

[103] Burman, B. & Margolin, G. (1992). Analysis of the association between marital relationships and health problems: An interactional perspective. Psychological Bulletin, *112*(1), 39-63.

[104] Carney, M. M., & Barner, J. R. (2012). Prevalence of partner abuse: Rates of emotional abuse and control. Partner Abuse, 3 (3), 286-335. https://doi.org/10.1891/1946-6560.3.3.286

[105] Tjaden, P., & Thoennes, N. (1998). *Prevalence, incidence, and consequences of violence against women: Findings from the national violence against women survey*. Washington, DC: US Department of Justice, National Institute of Justice.

[106] Saint-Eloi Cadely, H., & Espelage, D. (2017). *A progression of dating violence among a sample of middle adolescents*. Poster presented at the Society for Research in Child Development, Austin, TX.

[107] Follingstad, D. R., & Rogers, M. J. (2013). Validity concerns in the measurement of women's and men's report of intimate partner violence. Sex Roles, *69*, 149-167. https://doi.org.10.1007/s11199-013-0264-5

[108] Salis, K. L. Salwen, J., & O'Leary, K. D. (2014). The predictive utility of psychological aggression for intimate partner violence. Partner Abuse*, 5*(1), 83-97. https://doi.org/10.1891/1946-6560.5.1.83

[109] Lloyd, S. A., & Emery, B. C. (2000). *The dark side of courtship: Physical and sexual aggression*. Sage Publications, Inc.

[110] Lichter, E. L., & McCloskey, L. A. (2004). The effects of childhood exposure to marital violence on adolescent gender-role beliefs and dating violence. Psychology of Women Quarterly*, 28*, 344-357. https://doi.org/10.1111/j.1471-6402.2004.00151.x

[111] Breiding, M. J., Chen J., & Black, M. C. (2014). Intimate partner violence in the United States — 2010. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Section 2

Responding to Sexual Abuse/Assault

Chapter 6

Sexual Abuse and Mental Health in Humanitarian Disasters

Sara Spowart

Abstract

This chapter provides an overview of the importance of addressing mental health issues due to sexual violence in humanitarian disasters. It provides an overview of the relevance of sexual violence in conflict and its connection to mental health concerns and a heightening of the impacts of the humanitarian disaster. Sexual violence further destroys societies and increases the repercussions of the humanitarian disaster for decades after the conflict has ended. The very high levels of sexual violence that accompany humanitarian disasters are not inevitable. Underlying cultural and societal beliefs that exist before the humanitarian disaster occurs can be aggravated and brought to surface to further exasperate the negative impacts. Large scale public health initiatives that use marketing such as radio, billboards, social media, and television advertisements for example can be helpful and impactful for changing awareness and consciousness of societal norms and assumed inevitabilities that happen in societies. Humanitarian disaster research has revealed that it is common for individuals to view sexual violence as normal and for perpetrators to minimize the effects of it. However, this is a coping strategy that does not take away from the individual, societal and familial mental health effects of sexual violence from humanitarian disasters.

Keywords: sexual violence, humanitarian disasters, mental health, trauma, stigma

1. Introduction

Sexual violence is an issue that has gained increasing attention in recent years. It was only in 2002 that the World Health Organization officially recognized sexual violence as a key issue that needed attention for global health, development and gender equality concerns [1]. Sexual violence leads to significant mental health concerns and issues including difficulty sleeping, depression, anxiety, panic, Post-Traumatic Stress Disorder, and physical issues resulting from societal, cultural, familial repercussions or physical repercussions directly from the sexual abuse itself. It destroys and breaks down families and societies. It undermines poverty reduction and health efforts, and creates whole generations of children born from rape, especially in regions that have experienced war such as the Democratic Republic of Congo (DRC), or Rwanda for example [2].

In fact, the conflict, accompanying levels of rape in the DRC and resulting trauma, mental illness and societal and familial breakdown as a result of mass rapes have increasingly become a point of investigation on the relationship between humanitarian disaster and sexual violence. Investigation into the DRC alone reveals the interconnection and relationship between humanitarian disaster, conflict,

rape and the resulting breakdown and further societal destruction beyond just the humanitarian disaster. In addition to this, investigation into the situation in the DRC is revealing for understanding the underlying issues that exist and contribute to mass rape as well as the resulting mental health and societal detriments. There is a significant dearth of information on this topic and issue in the current literature, and the significance of identifying sexual violence in relation to mental health and humanitarian disasters is revealing for how little understanding exists on how to prevent and treat the issue, as well as its accompanying negative impact on the consequences of a humanitarian disaster [3].

Through investigating case studies of situations such as in Somalia, the Democratic Republic of Congo, Rwanda, Haiti, and even Hurricane Katrina, we can come to see that there is definitely a direct connection between sexual violence and humanitarian disasters and that furthermore, this connection existed before the disaster even occurred due to underlying cultural, societal and familial belief systems. "Rape is normal here" is a phrase one may hear while spending time in many of these regions that have experienced humanitarian disaster. However, many don't even define sexual violence as rape, but rather as nonconsensual sex. It becomes a way of life, a norm, a part of 'the way things are.' In humanitarian disaster areas regions, it becomes normal not only for militant combatants to commit rape but also for civilians. It is typical for fifteen-year-old girls to be gang raped multiple times, over multiple periods of time, to become pregnant and then kicked out of their families forced to raise the baby on their own with no education, money and to live in shelters with other survivors of rape. It is culturally enforced to not to talk about it, report it, or say anything and if you do, for you or your family to be threatened with violence. It is societally normal for the rare few that do try to report to be treated extremely poorly, blamed and mocked for what happened to them and nothing come of it. Sexual violence connected to humanitarian disasters creates situations for rape survivors to be infected with HIV or other STDS, perpetrators to normalize sexual violence, husbands to reject their wives, and fathers and brothers to reject or harm their family members. The normalization of the issue further exasperates the phenomenon and engrains it more deeply into a culture. Normalization does not improve the situation, it makes it worse [4].

When sexual violence occurs at the level it does in humanitarian disaster situations, it changes society in a deeper way than just the conflict or disaster did. It creates intergenerational harm that tears down the fabric of families and creates a new generation of traumatized survivors. Babies born from this trauma may find themselves abandoned, rejected, with a parent that hates them and growing up around other children who are 'rape babies.' It creates a new norm for an already severely damaged society. Despite the efforts of survivors and perpetrators to behave as if it is normal and life can keep going, it deeply damages societies in ways that last decades beyond the actual disaster that occurred. Therefore, prevention and intervention efforts concerning sexual violence are a necessary part of humanitarian disaster relief efforts. Cultural and gender norms and beliefs about sex, need to be addressed before a conflict even occurs. Societies that breed these issues, had these issues before the disaster occurred. The idea that rape is a natural consequence of war or disaster is one such societal belief that significantly contributes to these circumstances and problems [5].

2. The relationship between humanitarian disasters, sexual violence and mental health

The highest rates of sexual violence related to humanitarian disasters occur with conflict, war-zones, post conflict regions and the resulting internally displaced

population groups that are created as a result of this. Female internally displaced populations, both child and adult, show the highest rates of sexual violence, as well as corresponding gender-based violence. This is true worldwide and is not specific only to a certain culture or region. For example, for women that were displaced due to the natural disaster of Hurricane Katrina, there was a 3-fold increase in intimate partner violence, and a 54-fold increase in the prevalence of sexual violence compared to before the disaster. In addition to this, gender-based violence also creates psychiatric issues such as significantly increased depressive symptoms, posttraumatic stress disorder (PTSD) and suicidality. In a study conducted in war-related experience in Bosnia-Herzogovina, the intensity of depression was strongly correlated with the frequency of physical and sexual abuse. It can be life threatening and dangerous to screen for gender-based violence and sexual violence in war-crime areas. Some individuals that agree to participate in screenings or interviews with aid organizations or others are threatened with further sexual violence, physical abuse or death [6, 7].

In Eastern Congo for example, women or children that come forward to share about any sexual violence they have experienced may not only experience shame and rejection by their families and local society and culture but also death threats and further rape and violence as a result of sharing what has happened. The normalization of sexual violence towards children and women in war-zones is not only damaging and extremely harmful for the women that are violated, but to the children born as a result of rape, and to other women in society that learn to become increasingly fearful due to pervasive gender-based violence. The normalization of perpetrating rape also destroys families, hurts society and creates higher levels of poverty and psychological and physical trauma. This psychological trauma leads to a worsening of the conditions from the humanitarian disaster and makes it even harder to recover. The overall resulting psychological trauma from sexual violence in conflict has significant ramifications for overall recovery in the society at large [8].

Due to the importance of this issue, and the fear of reporting sexual violence where it is either not possible or unsafe, a screening tool that assesses for sexual violence using psychological indicators is a useful way to obtain more accurate data on the prevalence of the issue in a society. By screening for strongly associated psychological symptoms such as suicidality, post-traumatic stress disorder, and depression, it is possible to ascertain data that might otherwise be impossible to obtain [9]. A study of Hurricane Katrina with 194 participants out of a possible 32,841 internally displaced female participants in the Louisiana and Mississippi area found that the odds of post-disaster gender-based violence were 2.5 times more likely with identified sleeping problems, 3.8 times more likely with reported appetite dysregulation, 2.3 times more likely with reported lower self-esteem, and 2.7 times more likely with reported suicidal ideation. In addition to this, each reported depressive symptom increased the odds of post-disaster gender-based violence by 1.2 times. Depressive symptoms, including appetite dysregulation, sleep difficulties, self-esteem and suicidal ideation were most significant in determining the rough estimation of the prevalence of post-disaster gender-based violence [9].

The innovative screening approach applied to the mental health outcomes of Hurricane Katrina survivors, looks at the symptoms that we already know from the literature are most strongly associated with sexual violence in disasters, and uses those symptoms to deduce the probability that gender-based violence occurred. It may not be a perfect mechanism by screening for symptoms of sexual violence, but due to cultural barriers and norms, the trauma of conflict and lack of safe reporting in a humanitarian disaster, this may be a more effective approach to deduce the most accurate data [9].

3. Prevention and intervention

There is generally a gap in psychosocial services provided in a humanitarian disaster, as well as a gap in information on these services. Psychosocial interventions attempt to help survivors cope with the psychological effects of a societal breakdown and social world damaged by violence or disaster. It aims to provide a sense of stability to destabilized situations. Stability is a critical component of addressing the needs of survivors or sexual violence in humanitarian situations. The research base for understanding best practices in psychosocial interventions is limited and varied. A study by Mollica and colleagues, on Cambodian refugees on the Thai-Cambodian border found that the creation of opportunities to improve economic productivity improved psychiatric outcomes. In a study of Bosnia-Herzegovinia and Croatia humanitarian conflict and instability, Agger and Mimica found that group meetings and shared activities reduced psychiatric morbidity compared to individual therapeutic interventions. These two situations alone point to the significance of investigating and understanding the individual experience and perceptions in a culture and implementing culturally and environmentally relevant interventions given the provided conditions. This is especially true with such as culturally sensitive issues such as sexual violence. Forcing a certain type of intervention on a population is not only immoral, it also can be at least ineffective, but on the worse end, harmful. Therefore, due diligence to understand the population you are assisting and to try to view interventions from their perspectives is essential [10–12].

Overall, there is very limited information on effective intervention and prevention programs for mental health issues caused by sexual violence in a humanitarian disaster. However, the information we do have is helpful and relevant for informing new and better ways to address the complexity of sexual violence, and its resulting mental health issues in humanitarian disasters. There is some research that implementing psychological first aid and basic interventions after a humanitarian disaster is effective for relief and providing support for mental health concerns resulting from sexual violence. However, there is conflicting information on the provision of best practices. Other more recent research points to more complex interventions that are evidence-based and targeted specifically at treating mental health issues due to sexual violence [13–16].

Other interventions point to the importance of providing cultural, societal, and familial education in mass regarding gender-based norms, sexual violence and the damage it causes. There needs to be education to help reveal that it is not normal and not acceptable to cause sexual violence in any form and that it is not the fault or responsibility of the victim, it is the fault of the perpetrator. More focus needs to be placed on the perpetrator as well as the harmful reactions by friends, family and society to victims of sexual violence. Survivors are traumatized multiple times. First by the violence they experience and then often by the rejection, judgment and harmful reactions from others. Survivors go from a world where they are relatively safe, to one where their safety has been violated on multiple levels by the perpetrators and the reactions and hurt by others. Those that are supposed to most support them, generally cause additional harm and they may find themselves further ostracized by society and family as a result [13–16].

So how do we address the multiple levels of pain and suffering the survivors experience. One option is to implement an education program to combat social norms and stigma. Stigma is a significant part of addressing this issue and is a core part of the psychological damage that is caused at many levels. A "Training the Trainers" program designed to combat social norms and stigma and to openly address the sexual violence that occurs is a potential intervention that could be effective in making a difference in cultural norm change. Included in a "Train the Trainers" program,

there needs to be educational and cultural reform regarding rape, sexual violence, babies born from rape, as well as a promotion in reporting, education of rights regarding sexual coercion, and an increase in opportunities for women to participate in political, economic and social activities, human rights education, and engagement with men and boys on human rights, including gender equality. Additional factors that may play a positive role in changing cultural norms include microfinance initiatives and savings programs for women [1, 8, 13, 14, 16, 17].

Incorporation of significant cultural factors such as religion and churches as supportive tools for education and support may also be relevant, if the church is supportive. Research has shown that in certain cultures, engaging with religion and spirituality can be a supportive factor of coping for sexual violence victims. However, this is also assuming there has been no prior or current sexual abuse experienced through religious or spiritual leaders. It may also be supportive for coping to have a female spiritual or religious led intervention for children, men and women that have been sexual abused by men. This has been demonstrated as an effective intervention in Columbia for example, where there are the most internally displaced people in the world. The use of churches to provide psychosocial support is an example of a culturally relevant program to create reform [18].

Another potential intervention tool is providing screening for mental illness and sexual violence after a humanitarian disaster. However, due to extreme underreporting of sexual violence in societies both during humanitarian disasters and in general, as well as a lack of understanding and a normalization of sexual violence, it is possible that mental health needs assessments that also screen for sexual violence may not be accurate. It may be better to screen for what are known indicators of mental health concerns related to sexual violence. For example, self-isolation, depression, Post-Traumatic Stress Disorder symptoms, dissociation, drug or alcohol use, intrusive thoughts and memories, etc. However, for survivors of violence and humanitarian disasters it can be difficult to differentiate the experience of trauma related to sexual violence, and mental health issues related to the general trauma that have been experienced. Therefore, a more effective approach may be to screen for mental health concerns along with a general humanitarian relief response and provide the option of giving information on the experience of sexual violence if desired. For example, when providing humanitarian relief for hunger and nutritional concerns, to also integrate a very brief screening for mental health and signifiers of mental health issues related to sexual violence, while giving recipients the opportunity to discuss and report sexual violence related mental health symptoms if they feel safe and ready to do so. This allows for an increase in mental health response and initiatives, as well as demonstrates an increased need for mental health services [6].

However, a general mental health screening provided through general humanitarian relief such as nutritional and sanitation interventions, also provides an opportunity for survivors to discuss needs for issues related to sexual violence. Issues related to sexual violence are often difficult to discuss due to cultural-related shame and religious beliefs. For example, some estimates predict that 90% or more of women from the Congo have experienced some kind of sexual violence due to conflict-related sexual violence. However, very few women will report due to cultural beliefs and cultural discrimination. Therefore, other mechanisms of screening may be more effective in terms of providing services and addressing mental health needs. Mental health needs resulting from sexual violence are not only significant in terms of quality of life and recovery. They are also important for the economic, physical and developmental impacts they may have for transitioning a society from emergency to development. They also have a significance for the intergenerational transmission of trauma and the physical results that are due to this which can

include an intergenerational transmission of low cortisol levels and decreased immune system responses [8].

A positive and effective intervention for the initial early stages of mental health intervention may include psychological first aid. This may include listening (not forcing talk), demonstrating compassion, ensuring basic needs, mobilizing support from family members or significant others, and protecting the survivor from further harm. A mental health action plan for complex emergencies may include first a coordination of any and all mental health care activities. Secondly, an early rapid baseline assessment and monitoring of the population's early resiliency and risk factors, the vulnerable group's mental health disorders and the available mental health resources to address them as well as a monitoring system established to review changes in baseline over time. Next and thirdly psychological first aid should be made available for the entire population, identify and triage seriously mentally ill for psychiatric treatment, and work to initiate community-based resiliency and integration of mental health services to help restore to normal everyday life [19].

Fourthly, mental health services in the local community need to be built up by providing training and education with local doctors, healers, hospitals, clinics and international relief workers. There needs to be an integration of resources that already exist in the community into interventions in order to increase and improve mental health work and apply scientifically validated and established interventions. Efforts need to be made to train all first line humanitarian responders in psychological first aid and basic mental health principles and culturally relevant evidence based mental health interventions. In addition to this, the local community should be engaged in the action plan and implementation of these efforts and an informed consent of mental health processes should be honored and acknowledged. There should also be effective, compassionate care for relief workers that helps them with managing their stress and prevents burnout and other mental health related concerns. This should be provided in a safe, non-punitive confidential setting. Lastly, mental health interventions should be addressed for their cost-effectiveness and overall benefit to individuals and the community [19].

The mobilization of primary care doctors and community providers to apply mental health interventions is an effective intervention and approach. This mobilization can occur both locally or through the use of mobile clinics. These primary care doctors can be very effective addressing issues such as depression and in applying basic cognitive behavioral therapy approaches. Depression is one of the most debilitating mental health concerns worldwide, and is often a consequence of a humanitarian disaster situation or can be worsened by a humanitarian disaster. Depression is also a consequence of sexual violence experienced during a humanitarian disaster and also a symptom of PTSD and trauma. Depression is generally treatable, however left alone without support it can easily worsen and even increase the probability of depression symptoms in children or other dependents in a household [1, 19, 20].

The Global Burden of Disease study in 1990 established for the first time the connection between mental illness and its burden on mortality and disability. It found depression to be the fourth greatest disease burden in 1990, and predicted depression to be the second leading disease burden by 2020. However, some estimates predict, especially with the on-going COVID pandemic that the disease burden of depression now comprises the greatest health burden in the world. Therefore, when there are humanitarian disasters, increased conflict and sexual violence and a decrease in stability and breakdown of infrastructure in a society, depression and trauma related symptoms are likely to increase significantly as a result [19].

4. Potentially most significant trigger for sexual violence and resulting mental illness in a humanitarian disaster

There is a dearth of information on effective interventions for mental health consequences of sexual violence in humanitarian disaster situations. It is widely acknowledged that violence against children and women increases during conflict, natural disasters and humanitarian crises. Humanitarian disasters and conflict increase the vulnerability of already more vulnerable groups to sexual violence. The conflict and humanitarian disasters in Afghanistan and Syria for example, have greatly increased the number of female child marriages and the risk of violence and abuse that female children experience. Other regions such as South Sudan and Somalia for example see rises in rape and group rape as a result of conflict, drought, hunger and other humanitarian crises. However, the crises and conflict aren't necessarily the root causes of the sexual violence and coordinating trauma and mental illness. The underlying issues of social and gender norms, the way that love is learned, and the power dynamics within societies and cultures are all triggered and aggravated when there is severe stress on any system [19].

However, addressing underlying root issues of cultural beliefs and power dynamics, and the way that all individuals in a society are respected and given human dignity even before there is conflict or a humanitarian crisis is not only an important part of prevention but also addressing the psychological consequences from sexual violence. Gender equality is one piece of the issue, however depending on how it is measured, perceived and evaluated, it doesn't necessarily mean sexual violence won't be an issue in the event of conflict or humanitarian disasters. This is in part because of the history and cultural beliefs, as well as family and intergenerational patterns that are passed down from generation to generation. Some of the beliefs, like racism, sexism, xenophobia, homophobia, and other types of prejudices, in times of relative stability, abundance and peace may not be as expressed or societally acceptable. However, there is a trend throughout the world that instability, disasters, disease, poverty, hunger, drought, and other crises can bring out toxic beliefs, patterns, hatreds, power and control issues and prejudices that may not otherwise be accepted and brought to the surface. For example, in Germany the poverty and depression that many Germans experienced in the 1930's led to the reemergence and scapegoating of prejudice and old hatreds of certain groups such as people of Jewish descent. In the United States, we have recently seen how COVID-19 has triggered underlying societal issues of racism that were largely suppressed in cultural consciousness before COVID-19 [21].

Another way of framing this is that when beliefs are tested, their authenticity might not be as deep as expected when not under stress or duress. Meaning, on the surface in a society, it may not be socially acceptable to participate in perpetrating sexual violence, however, if given the opportunity and certain conditions, an individual would not stop themselves and would even perpetrate it multiple times because the conditions allow and promote these underlying belief justifications and motivations. Therefore, this points to a very significant differentiation between 1) the surface beliefs individuals hold when there is less stress in a society due to outside conditions functioning at a higher level (ie. when there is no humanitarian disaster) and the societal tolerance for something like perpetrating sexual violence is lower versus 2) higher stress on a societal system due to a humanitarian disaster and higher tolerance culturally for perpetrating something like sexual violence. This points to the reality, that it given the right conditions, someone would perpetrate sexual violence because the barriers and consequences are low. Their ethical locus of control is external, not internal. The unconscious beliefs that perpetuate sexual

violence can be passed on through cultures and societies, so that an individual is not even conscious of them until they are tested by challenging or changing circumstances. Situations of conflict and humanitarian crisis definitely test underlying cultural constructs and can reveal the ugliness of opportunity that may not otherwise be revealed. Conflict and humanitarian crises demonstrate and test whether an individual will participate in sexual violence when circumstances change and which populations are made even more vulnerable than before [21].

5. Country contexts

When implementing interventions, it is relevant and important to investigate the unique manifestation of sexual violence in various country contexts that have experienced humanitarian disasters. In many cultures with sexual violence and humanitarian disasters, it is not only the perpetration of sexual violence that creates mental illness. It is also largely the response from society and family to the survivors. In some societies, there is victim-blaming, shaming the survivor, forcing them to marry their perpetrator. In some cultures, there are even honor killings where family members kill the survivor of violence for the honor of the family. In Syria for example, many refugees have gone to Jordan. The young female refugees are at high risk of perpetration of false marriage by men from other countries that are hoping for sex with a young virgin female. Syrian teenage girls at the refugee camps in Jordan, are often sold by their families for one-hour marriages, or maybe a marriage that lasts several days. The purpose of this marriage is the buying and selling of sex. Due to the impoverished conditions the families live in, they often consent under duress, essentially prostituting their female children for money. In many other countries such as Somalia and the Democratic Republic of Congo, even if a survivor goes to the police, they may be treated with prejudice and told they are at fault by the police themselves, or even if they have a rape kit done, the rape kit may never be processed for evidence. Throughout the world, the treatment of sexual assault survivors generally creates greater harm for the survivor, if they are a child or an adult and there is little focus on accountability and intervention for the perpetrator [22].

6. Proposed framework for investigation

There has typically been a belief or understanding that addressing mental health issues related to sexual violence in conflict and humanitarian disaster areas is somewhat linear. That it begins with 1) prevention before the event or heightened circumstances occur, then 2) addressing the situation when the events occurs, and then 3) addressing the aftermath of the effects of the event. Another way of understanding and viewing this is to see it cyclically. Meaning an intergenerational pattern that occurs through the conscious and unconscious belief patterns that exist within societies, families, cultures, religions and even between couples and within ourselves [19]. A diagram created by the author is provided below to better demonstrate the cyclical nature of the underlying harmful belief patterns that emerge in reaction to a humanitarian disaster (**Figure 1**).

Therefore, addressing conscious and unconscious societal norms that relate to sexual violence and investigating how those norms manifest themselves is critical for addressing the issues. In addition to this, to best address this cycle of violence and prevent it from flaring up as severely as it potentially could, there need to be long-term grassroots funding and interventions. A typical humanitarian funding intervention may be twelve months is length. It is not typically long-term and is

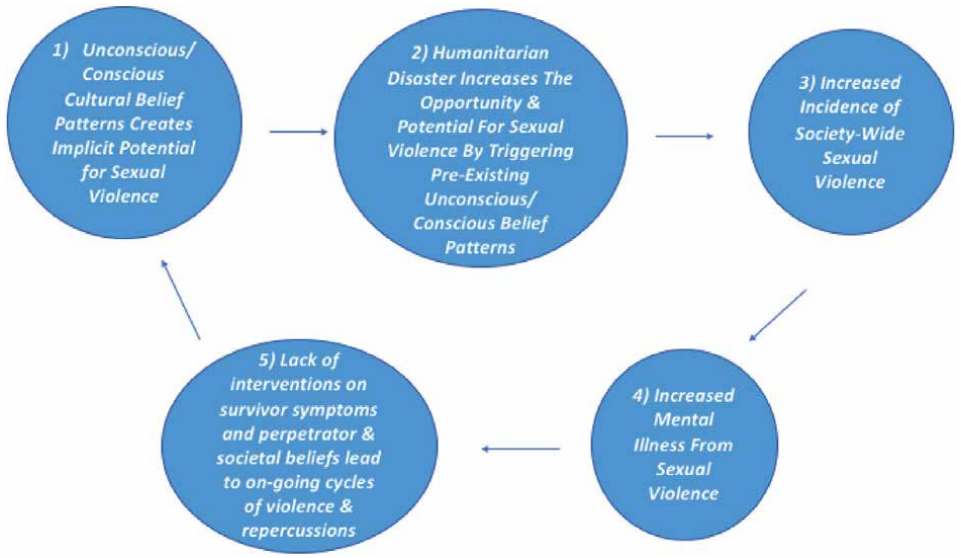


Figure 1.
Framework for understanding societal belief systems that perpetrate sexual violence.

built on addressing emergencies, symptoms and aftermath from conflict and crisis. However, to shift negative cultural beliefs and norms requires longer term interventions that may even be intergenerational. Short-term interventions that address the symptoms of the trauma the survivors experience and the consequences of the perpetrator's actions are incredible, but they are not enough to sufficiently impact the layers and depths of what triggers these issues during conflict and humanitarian disasters [23].

7. Conclusion

An innovative, effective approach to addressing mental health issues due to sexual violence in humanitarian disasters is possible. Through the evidence base that currently exists in the literature, there are certain interventions that may prove more effective than others. A significant component for addressing the problem of mental illness due to sexual violence in humanitarian disasters is for the society and culture to recognize the issue. A normalization of sexual violence does not reduce the mental health impacts that occur such as depression, post-traumatic stress disorder, difficulty sleeping, loss of appetite and other trauma symptoms that generally co-occur. In fact, a normalization of the issue can create social stigma for those that speak out and try to seek help for the problem or stop the problem from occurring. Stigma alone increases mental illness and social damage. The process of de-normalizing sexual violence in humanitarian disaster situations, particularly in conflict regions, is powerful, innovative and will likely result in significant positive change.

Author details

Sara Spowart
University of South Florida, Tampa, United States

*Address all correspondence to: sspowart@mail.usf.edu

References

[1] Schopper, D. (2014). Responding to the needs of survivors of sexual violence: Do we know what works?. *Int'l Rev. Red Cross*, *96*, 585.

[2] Murray, S. M., Robinette, K. L., Bolton, P., Cetinoglu, T., Murray, L. K., Annan, J., & Bass, J.K. (2018). Stigma among survivors of sexual violence in Congo: scale development and psychometrics. *Journal of interpersonal violence*, *33*(3), 491-514.

[3] Johnson, K., Scott, J., Rughita, B., Kisielewski, M., Asher, J., Ong, R., & Lawry, L. (2010). Association of sexual violence and human rights violations with physical and mental health in territories of the Eastern Democratic Republic of the Congo. *Jama*, *304*(5), 553 562.

[4] Mueller, J. C. (2019). Political, Economic, and Ideological Warfare in Somalia. *Peace Review*, *31*(3), 372-380.

[5] Verelst, A., Bal, S., De Schryver, M., Kana, N. S., Broekaert, E., & Derluyn, I. (2020). The impact of avoidant/disengagement coping and social support on the mental health of adolescent victims of sexual violence in eastern Congo. *Frontiers in psychiatry*, *11*.

[6] Morina, N., & Nickerson, A. (Eds.). (2018). *Mental health of refugee and conflict-affected populations: theory, research and clinical practice*. Springer.

[7] Vu, A., Adam, A., Wirtz, A., Pham, K., Rubenstein, L., Glass, N., ... & Singh, S. (2014). The prevalence of sexual violence among female refugees in complex humanitarian emergencies: a systematic review and meta-analysis. *PLoS currents*, *6*.

[8] Wachter, K., Murray, S. M., Hall, B. J., Annan, J., Bolton, P., & Bass, J. (2018). Stigma modifies the association between social support and mental health among sexual violence survivors in the Democratic Republic of Congo: implications for practice. *Anxiety, Stress, & Coping*, *31*(4), 459-474.

[9] Anastario, M. P., Larrance, R., & Lawry, L. (2008). Using mental health indicators to identify postdisaster gender-based violence among women displaced by Hurricane Katrina. *Journal of Women's Health*, *17*(9), 1437-1444.

[10] Kaz de Jong, Jeroen W. Knipscheer, Nathan Ford and Rolf J. Kleber, "The Efficacy of Psychosocial Interventions for Adults in Contexts of Ongoing Man-Made Violence: A Systematic Review", Health, Vol. 6, No. 6, 2014, pp. 504-516.

[11] Mollica, R. F. (2018). The New H5 Model. *Humanitarianism and mass migration: Confronting the world crisis*, 123.

[12] Thoradeniya, K. (2017). War-affected children and psycho-social rehabilitation. *Sri Lanka Journal of Social Sciences*, *40*(1).

[13] Jo Spangaro, Anthony Zwi, Chinelo Adogu, Geetha Ranmuthugala, Gawaine Powell Davies and Léa Steinacker, "What Is the Evidence of the Impact of Initiatives to Reduce Risk and Incidence of Sexual Violence in Conflict and Post Conflict Zones and Other Humanitarian Crises in Lower- and Middle- Income Countries? A Systematic Review", EPPI-Centre, Social Science Research Unit, Institute of Education, University of London, 2013a.

[14] Spangaro, J., Adogu, C., Ranmuthugala, G., Davies, G. P., Steinacker, L., & Zwi, A. (2013b). What evidence exists for initiatives to reduce risk and incidence of sexual violence in armed conflict and other humanitarian crises? A systematic review. *PloS one*, *8*(5), e62600.

[15] Spangaro, J., Adogu, C., Zwi, A. B., Ranmuthugala, G., & Davies, G. P. (2015). Mechanisms underpinning interventions to reduce sexual violence in armed conflict: A realist informed systematic review. *Conflict and health*, *9*(1), 1-14.

[16] Spangaro, J., Zwi, A. B., Adogu, C., Ranmuthugala, G., Davies, G. P., & Steinacker, L. (2013c). *What is the Evidence of the Impact of Initiatives to Reduce Risk and Incidence of Sexual Violence in Conflict and Post-conflict Zones and Other Humanitarian Crises in Lower-and Middle-income Countries?: A Systematic Review*. EPPI-Centre.

[17] Ommeren, M. V., Hanna, F., Weissbecker, I., & Ventevogel, P. (2015). Mental health and psychosocial support in humanitarian emergencies. *EMHJ-Eastern Mediterranean Health Journal*, *21*(7), 498 502.

[18] Le Roux, E., & Valencia, L. C. (2019). 'There's no-one you can trust to talk to here': Churches and internally displaced survivors of sexual violence in Medellín, Colombia. HTS Theological Studies, 75(4), 1-10.

[19] World Health Organization. (2020). Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings.

[20] McGowan, C. R., Baxter, L., Deola, C., Gayford, M., Marston, C., Cummings, R., & Checchi, F. (2020). Mobile clinics in humanitarian emergencies: a systematic r eview. *Conflict and health*, *14*(1), 4.

[21] Ahmad, A. (2018). Conceptualizing disasters from a gender perspective. In *Disasters: Coreconcepts and ethical theories*(pp. 105-117). Springer, Cham.

[22] Hilhorst, D., Porter, H., & Gordon, R. (2018). Gender, sexuality, and violence in humanitarian crises. *Disasters*, *42*, S3-S16.

[23] Ventevogel, P. (2018). Interventions for mental health and psychosocial support in complex humanitarian emergencies: moving towards consensus in policy and action?. *Mental health of refugee and conflict-affected populations*, 155-180.

Chapter 7

Sexual Assault Crisis Center: The First Interdisciplinary Effort in Turkey

Taner Güven, Sotirios Kalfoglou and Ersi Kalfoğlu

Abstract

Sexual violence and assault has a wide range of negative consequences that affect the victims for the rest of their lives. Proper medical as well as psychological care is essential for the survivors who have experienced a traumatic process. One-step institutions that deal with all related issues following the victimization are established in various countries. We took the responsibility to organize such a center for the first time in our country. The designed "Sexual Assault Crisis Center" is active in legal history taking, medical-forensic examination, professional evidence collection by trained personnel, and detailed evidence analysis (DNA, drugs of abuse, trace evidence, etc.). Thus, the victims do not have to go to various institutions one after the other to prove the case. Care providers, law officers, and the legal system are satisfied with the outcomes. An organized collaboration of different organizations is archived to the benefit of the sufferer. Furthermore, a training program for four different related parties, such as medical doctors, nurses, psychologists, and healthcare managers, has been developed in order to train other personnel for the sustainability of the project. The basic aim is to develop this first model as a prototype and contribute to its spreading throughout the country.

Keywords: sexual violence, evidence collection, forensic examination, multidisciplinary forensic practice, rape victim, Turkey

1. Introduction

Sexual assault can be characterized as gender inequality, power imbalance, and hatred that generally results in violence against women. This fact does not exclude children, male, and LGBTI+ victims. Based on surveys on violence against woman performed in the USA, approximately 8 million of women and 3 million of men have experienced rape once or more in their lifetime [1, 2]. In most of the cases, the perpetrators are known to the victims, and false notations like "rape happens to young- and good-looking women" or that "it is committed by mentally problematic people" are incorrect. Likewise, rape does not frequently occur in places that are not properly illuminated or uninhabited remote areas as it is generally acknowledged, but mostly happen in very familiar setting like the home of the victim or the offender. Attractive sexy clothing is never considered a reason for rape [3].

There is a series of well-reported problems that survivors of sexual assaults suffer, in the short and long run following the rape. Medical impacts on genital organs because of physical traumas, pregnancy and unsafe abortion, and sexually

transmitted diseases are complications seen in the short run, whereas anxiety, depression, post-traumatic stress disorder (PTSD), substance abuse, suicidal behavior, eating disorders, and even dental health problems affect the victims in the long run [4–7]. PTSD influences the sexual life of the sufferers in a long run too. Considering rape in war, genocide, prisons, and police stations, the magnitude of the problem increases tremendously [8]. Nevertheless, it is well reported that millions of women are affected all over the world regardless of their age, socioeconomic position, and economic or educational status [2, 9, 10].

In a detailed study that was undertaken in Turkey, while women constitute 35–40% of victims of sexual assault, the proportion of children is 50%, and the average age of these children is 11.5 years. The youngest child was a girl of less than one year of age and a 1.5-year-old boy. We see that 5% adult males, 5% mentally handicapped individuals, 1–3% elderly people, and 90-year-old senior ladies are also victims of this crime. Boys and girls exposed to sexual abuse are equal in number. The reasoning for the attempts was reported as the victim was responsible for the attack, the aggressor was sexually aroused, and that this act was the result of sexual provocation. The way that a 1-year-old child provokes the aggressor has no valid explanation [11].

The study in mention revealed that the rate of realization of sexual attack in desolate and dark places is around 10% only. The riskiest environment seems to be the home of the attacker or the victim, with a rate of 60%. The rate of attack in a different house is around 20%. Another misconception is the belief that the victim of sexual assault must have suffered extensive physical injury. In practice, physical damage can be detected only in one-fourth of the cases. The reason for this is that physical violence is used in only half of the cases, and detectable damage occurs in half of them. Again, while the aggressor is mostly thought to be a stranger, victim screening studies show that 75% of the perpetrators against women and 90% against children are familiar people [11].

Resolving the case, identifying the perpetrator and desiring his/her punishment is an expected reaction of the victims, families, and the societies. Yet, conviction rates for sexually committed crimes are considerably low. There are various reasons that prevent victims to disclose rape cases, the main of them being the possibility of the shift of the blame toward themselves and the disbelief by the legal system. Sufferers think that both police and their families will disregard their claims and disbelieve them.

The negative attitude of the society, the fear that the claim will not be taken seriously, the thought that the aggressor will not be punished, care for the perpetrator himself (in case of close relatives or friends), and the perpetrator's possibility of retaliation can be counted as the reasons for such a low rate of reporting the event. However, the "fear of not being able to prove the incident" forms a serious obstacle for the victim to apply to the court.

It is necessary to discuss the reasons for refusal to notify in Turkey because the society approach is interesting. For many years, the concept of honor was related to sexuality for women and not for men. The veil of honor was present in legislation until 2005. Forced sexual intercourse was not considered a crime, and the abortion with the promise of marriage was legal. All these show that the laws perceived this crime as an act of sexuality only. In this case, the woman's dress and behavior have always been questioned, and the investigation of the victim's responsibility in the attack has been discussed on both social and legal grounds. The criminal law has been changed in 2005, and it has been stated that sexual assault is a crime motivated by domination and control, and it is not a sexually motivated action. However, the negative societal conception is still there. As a result, victims in Turkey are truly rejected from their families and

their communities following a rape victimization, the sexual aggression remains undisclosed, and the rapist is rarely convicted [11, 12].

The "one-stop center" model for supporting survivors of sexual violence has gained attention in recent years. There are several centers functioning in this aspect primarily in the USA. We established the first full-scale sexual assault center, in which we provide confidential support to survivors with specially trained staff over a wide range of services. Apart from performing forensic medical examination, evidence collection, reporting to the police, providing medical care, making a police statement, and giving psychological support are within the scope of the establishment. Although it is not very easy to establish and operate, not surprisingly, there are many positive benefits for survivors. We hope that this will be a model for the Turkish legal system and that this effort will form the basis for a national understanding.

2. Related legislation in Turkey

One of the main actions to be taken in sexual assault cases is the effort to prove the event. This means to determine the signs of physical and emotional damage caused by sexual assault, to determine the existence, degree, and results of sexual intercourse, and to ensure that the attacker is identified.

A new legislation that has been actively used by 2005 has detailed articles related to sexual assault cases and the above-mentioned statements. There is an article that regulates all the activities related to obtaining evidence linked to a crime and legalizes the procedures and principles regarding the various ways of collecting biological evidence, blood, hair, buccal swabs, nails, and similar samples for genetic analysis in order identify the suspect and the accused. According to this regulation, in order to obtain evidence related to a crime, request by the public prosecutor, the judge, or the victim is essential. The decision of the public prosecutor is submitted to the judge or court for approval within 24 hours. The judge or court is obliged to decide within 24 hours.

The internal body examination of the suspect or the accused can be carried out only by the doctor. The external body sample collection can be performed by medical staff (nurses, midwifes, etc.) under the control of a medical doctor.

For the medical examination to be carried out, there should be no foreseeable risk of harm to the person's health. An examination of the genitals or anus area is also considered an internal body examination.

In cases where mentally retarded people or children are involved, the legal representatives have the right to decide. If the child or the mentally ill person is in a position to comprehend the consequences of the testimony, her/his opinion is also taken. The issue becomes more complicated in incest cases where the legal representatives can be the perpetrators themselves.

The results of the examination made on the samples taken in accordance with the provisions of this regulation are considered personal data and cannot be used for any other purpose. The contents of the case file cannot be given to anyone other than those who have the authority to be involved. The analysis results are sent to the relevant authority by a written and signed expert witness report.

In the presence of the victim's consent, the prosecutor's intervention is not required to carry out the analysis. In this case, medical examinations can be performed and samples can be taken to be analyzed. The prosecution and the legal system, in general, are informed following the examination. There are various official institutions that are considered expert witness centers by the law. The Ministry of Justice has its own institution called "The Council of Legal Medicine" and deals

with various issues of forensic sciences. It is centered in Istanbul with branches all over the country. Additionally, the departments related to Legal Medicine and Forensic Sciences are expert witnessing institutions by law. Furthermore, the hospitals have the right of collecting evidence and reporting to the court in all related cases [13].

3. The process of medical examination

Following the victimization, the victims need medical, forensic, and psychological support. The suffering person when she/he decides to ask for help has eventually to go to a hospital for treatment and evidence collection. Following these two steps, additional medical and psychological care should be given to the person. However, this very important step is most of the time avoided by the victims and constitutes one of the main reasons for denying reporting the event. There is a perception that the victims will be poorly treated in hospitals at the early stages of the rape examination and treatment [14, 15]. The possibility that the reported sexual assault may not even prosecuted is also a fact. Owing to the possibility of disbelief, the police may not proceed in informing the prosecution or, sometimes, the prosecution does not trust the confession. On the other hand, the event is not considered a very serious crime and it is underestimated, which certainly is not the case. There is a complex medicolegal attitude that should be undertaken starting from the police to the prosecution, to the nurse, and to the doctors. Once the involved group is so big, coordination is essential for the benefit of medical, legal, and psychological well-being of the suffering person.

Systematically stating, apart from the low reporting rate, hospitals generally do not employ forensic pathologists and nurses, they do not have a proper forensic examination setting, the medical personnel is poorly trained in evidence collection, and they almost never are organized for a legal, psychological, and medical support following the examination. There are no proper settings for medicolegal examinations, and the equipment is far from standardized. The sexual rape examination is a delicate issue, and the traumatized victim is deeply concerned. Sometimes, they refuse to be examined by male doctors and that is frequent for our country. Female gynecologists are not always ready in hospitals to perform this kind of examination. A proper solution for this problem lies in the interdisciplinary collaboration of the various parameters that are involved in the assault and violence cases. Turkey has no effective collaborative networks between the stakeholders. The police, the criminal justice system, and the medical care have little coordination [16, 17]. As a result, a suffering victim has to visit all the involved authorities to be able to complete the application for the court and for the forensic examination with evidence collection. The victim has to go to the police to talk about the event; most probably, she/he will be sent to the appropriate department for application; then, the police direct her/him to the hospital; the medical examination may or may not be performed immediately, a waiting period will follow; sometimes, the hospital visit will have to be repeated because of poor evidence collection, and following all these, the suffering person will have to encounter the burden of talking to prosecutor(s).

To overcome these problems, we established a facility in the form of single-step application (the characteristics of which are given below). The purpose of establishing a one-stop Sexual Assault Crisis Center is to guarantee a system where full and real cooperation between different stakeholders (healthcare professionals, lawyers, police forces, etc.) will result to a broad and inclusive rehabilitation with proper care. The main idea of the establishment is developing and improving accessibility to supporting services for victims. Additionally, it is aimed to get a detailed anamnesis

and correct physical and biological evidence to help the legal system to tackle the crime and punish the perpetrator. We based the establishment on the already present legislation in our country and to best practice examples globally [17–20].

4. Procedures for reporting a sexual assault case in Turkey

The person that has been sexually abused and wants to disclose it, she/he has to go either to the police or to a hospital for seeking help. In case the victim reports to the police, the police, following the history taking, have to decide to which hospital they have to be directed for evidence collection. In the meantime, the police inform the prosecutor for the event. The evidence is reexamined by the doctor in the hospital, and a second history taking forces the victim to talk about the traumatic event. The evidence collected is transferred to the "Council of Forensic Medicine" for examination and report writing. The victim on the other side is in front of the prosecutor for the last history taking being revictimized once more. Then, all the parties wait for the evidence examination report, which is generally delayed. Things get worse especially when there is a need for laboratory examinations such as DNA and illegal drugs for cases under influence. The overall process is distressing and upsetting. The reality is that this is not specific to our country because there are numerous scientific articles complaining about retraumatization and long-lasting periods for the case to be closed.

The second probable way that a victim can choose is to go directly to a hospital for medical examination and sample collection. This is actually not changing the psychological burden for the victim because the hospital has to inform the police, and all the above-mentioned steps are repeated. The victim may not be able to be examined timely, and this is also a problem for the evidence itself that it may be diminished and for the psychology of the applicant. Care seems to be lower for sexual assault victims compared to regular patients in the medical centers. Moreover, although there is a regulation on force as we mentioned above, there are no specific policies and standardized procedures for collecting sexual-assault-related samples as evidentiary material. Therefore, the hospitals are able to collect partly the evidence or sometimes lose them completely by long-lasting procedures or it is possible to contaminate or even degrade the very valuable tool that can be used for justice. However, it is obvious that the biological evidence that is collected from the victim's body serves as a tool to aid the police investigation in a sexual assault case. This kind of evidence can identify the perpetrator(s), give an idea of the time of the assault, point to the presence of violence if any, and can state whether the assault was drug facilitated [21, 22].

Both law enforcement officers and healthcare professionals complain about the inadequate services in rape cases. Commonly, the care that is provided to rape victims is lower than other patients. Additionally, there is no attention paid to the psychological trauma of an assaulted person in the emergency departments. On the other hand, the doctors and the rest of the healthcare professionals are not adequately trained to tackle these sorts of cases. They are not familiar with the ways of forensic examination, history taking, and evidence collection. Proper documentation is another serious issue, and if it is improper, even the collected evidence loses value. Moreover, often the doctors themselves beware to undertake rape cases, and they transfer the victims to other doctors or sometimes even to different hospitals.

5. The establishment of the "One-Step Sexual Assault Crisis Center"

The research team of the university set up a "One-Step Sexual Assault Crisis Center" in order to improve care for victims for the first time in Turkey. This

specialist facility is organized in an interdisciplinary approach, where the victims get legal, medical, and psychological care without any additional burden to what they have experienced. The center accepts all the victims who experienced physical and sexual violence. Diagnosis-treatment stages and the medicolegal issues are carried out in a detailed and sensitive manner, within a one-stop facility and 24/7 principle. We have developed an innovative, sustainable, and expandable cooperation model with advanced technology in forensic laboratory infrastructure, based on the cooperation with different organizations that will contribute to the process with a multidisciplinary approach. We intend to develop methods and measures that can be taken to prevent violence by compiling the services to be provided by this center. Similar models have been established in the USA (Sexual Assault Response Team SART) and the UK (Sexual Assault Referral Centre SARC) and in many other countries to establish cooperation between different services for a less traumatic victim care. The main objective of these centers, as well as for our initiative, is to achieve one single application center and save victims from several visits to police, hospitals, and prosecution, the value of which is mentioned in numerous articles [18, 19, 23]. Vulnerable groups, such as children and mentally disabled people, together with all sexually assaulted or victimized citizens can apply for care. The establishment in mention is the first one in Turkey, and we hope that it can form a model for further initiatives. The main idea is to diminish the psychological revictimization of the assaulted by providing proper medical examination and evidence collection together with psychosocial care and follow-up as in several similar facilities globally [24]. This can be achieved by the coordination of professionals from different areas of expertise.

The center that has been established in Istanbul, the most overpopulated megalopolis of the country, is organized in Yeni Yüzyıl University in two interrelated sections: the main center and the hospital. They are both constructed based on one and single functioning protocol. The workload is primarily in the main center, whereas only cases that need serious medical intervention are headed to the hospital.

The first person that the victim encounters in the center and in the hospital is a specially trained forensic nurse who opens the case and organizes the rest of the visit. The steps that are followed in parallel and/or in tandem are shown as follows:

Actions that are taken regarding the victim:

A. Assigning the case manager

B. Medical/medicolegal history taking

C. Medical/forensic examination and evidence collection

D. Psychological support and follow-up

Actions that are taken regarding the legal system

A. Informing the prosecution

B. Recording the history taking

C. Writing the relevant report for the court

Actions that are taken by the laboratory

A. Receiving the collected evidence from the case manager

B. Analyzing the evidence in the relevant laboratory department

C. Writing and delivering the relevant reports

6. The first step for a successful approach: medical history taking (anamnesis)

Upon her/his arrival, a case manager is assigned by the medical coordinator to the applicant. The second step is history taking. The medical/medicolegal history is a very important step that is essential for the investigation, and it is taken once and recorded for further use if the victim consents. It is crucial to take this history in the proper way, to make it less traumatic to the victim and organize it so that the victim will not be obliged to repeat it in other institutions (several times to police prosecution, etc.). For that reason, we have organized the availability for law enforcement officers or the prosecution to attend the history taking without being physically in the meeting room. The technical equipment is designed such that the related parties can attend the session by an audiovisual system, either within the center or online. The victim talks to a professional psychologist followed by a forensic doctor and talks once. Thus, the deeply traumatized victim is not obliged to repeat the story to the police, prosecutor, and doctor again and again. In the meantime, following the application of the victim, if the police or the prosecution is not informed, they are being notified by our legal team, and they are invited to attend the history taking if they would like to.

After taking her/his consent, the victim is asked to give the details of the event, date, location, and any information related to the perpetrator. This information forms a guide for the activities that will be organized to finalize the report of the case. There is a form with a series of structured questions related to the activities that the victim has been engaged in. The history is taken primarily by the forensic psychologist followed by the forensic pathologist or gynecologist. The medical information may or may not be given to the law enforcement or the prosecution, depending on the requirements of the case and the informed consent of the victim. The involvement of the psychologist is essential once the history taking is done to a deeply traumatized person (to a great extent), and it has to be professional in a way that the victim will be least affected. On the other hand, it has to be as detailed as possible because it is the only tool to be used for the investigation.

7. Medical examination and evidence collection

The characteristics of sexual assaults as well as the victims' psychological capability are dissimilar and variable. Therefore, special care has to be given to each case individually. The physical examination is performed by a forensic pathologist and/or a gynecologist assisted by a forensic nurse having a master degree in Forensic Sciences. The injuries as well as the points of possible evidence traces are documented by external and internal examination. The victim is informed about her/his right to stop the examination at any point. We have already developed a standard sexual assault kit that is used by our doctors in evidence collection. The kit contains all the required material for a correct collection of evidence. Nevertheless, it is very well known that every rape case may have its own characteristics, and further material may be required [25]. We are in a position to provide any additional equipment to document and collect evidence, both in the laboratory and in the hospital, the function of which will be explained later.

The generally accepted evidence collection period for evidence in sexual assault cases is within 72 hours [21, 22, 26]. However, the evidence identification and individualization techniques that are available today are highly developed, and DNA technology can reveal excellent results for trace amounts of material like a bite mark or even fingerprint [27–31]. Hence, careful pre-examination is essential for satisfactory collection. Apart from the physical and biological evidentiary material that is collected, samples of blood and urine are taken for further examination of pregnancy and sexually transmitted disease. In case that the blood and urine examination show positive results as for pregnancy, hepatitis, HIV, or any other sexually transmitted disease, the proper treatment is suggested and one-to-one counseling is offered. A regular psychological or medical treatment is given for all the cases for which the diagnosis is positive.

Although the evidence collected is analyzed in the various laboratories within the center, a secure chain of custody is followed [32]. The collected biological specimens are air-dried and placed in containers that are numbered according to the given case number. Cross contamination is maximally avoided [33]. In some cases, the victim is not ready to pursue; in these cases, the sexual assault kit that includes the collected biological material is kept according to the preservation protocol of the related laboratory.

The victim has no obligation to handle the collected evidence and transfer it anywhere. The center undertakes the responsibility to send the collected evidence to the appropriate laboratory for analysis. The laboratories that are functioning in the center are: DNA and biological evidence, toxicology, trace evidence, forensic anthropology, and andrology. The evidence-related report that comes out from the laboratories is sent to court-related services or to law enforcement, depending on the specificity of the case.

There is a well-reported relationship between rape, alcohol, and substance use in recent studies. The sexual assault may be drug facilitated in some cases [34–36]. The victim in such cases is unable to consent because of drug effects. The alcohol and/or drug use in these cases may be voluntary or involuntary. In both ways, this effect increases the severity of the crime, and its existence has to be indicated by analysis. That is why, a complete toxicology laboratory is established in the center.

In case the victim needs further medical care because of physical injuries, the center collaborates with the university hospital, which is a full-scale multitreatment hospital. All the diagnosis and treatment stages of a person who has been subjected to physical and/or sexual violence are being taken care in this facility. We have established a Forensic Science Department in the hospital supplemented with specially appointed and trained personnel for necessary evidence collection, forensic interview, etc. Anyone who has been raped can access the Forensic Science Department to be directed to emergency services and enter the one-step procedure. The main center and the hospital give a 24-hour telephone information and support. As a result, emergency response, examination, collection of evidence, assault report, giving testimony (history), psychological support, and notification to the forensic units, taking a shower, or providing clothing when necessary are realized both in the main center and the Hospital's Forensic Science Department. Such an interdisciplinary effort enables the detection of suspects or criminals in physical and sexual violence crimes and supports the victims by providing accommodation after violence, economic support, job opportunities, and legal aid, etc., by a cooperation that has been developed with the municipalities of Istanbul. The municipalities are centers where violated victims apply easily if they do not want to be involved in applying to law enforcement units, and they are the institutions that have the availability to support and protect the victims. Therefore, a close collaboration with them appeared to be vital for helping the victim.

8. The issue of forensic nursing in Turkey

The medical examination and evidence collection is generally assisted by specially trained nurses in the USA, Canada, and some of the European countries [37–39]. We do not have specially trained sexual assault examiner nurses (forensic nurses) in Turkey. The concept of forensic nursing is present only at an academic level, and the practicing nurses are not aware of how they can collect physical and biological evidence [40, 41]. However, even doctors are not well trained on the issue, and they do not know how to collect, preserve, and transfer the evidence. They certainly lack the information and practice of being sensitive and sympathetic once they are dealing with traumatized patients not only physically but also psychologically [42]. Another obstacle in the proper and effective collection is the absence of standardized sexual assault evidence collection kits and the lack of a consensus between laboratories on DNA identification procedures [43, 44].

9. Education and training in evidence collection

The basis for this kind of collaboration is a common language that should be developed to share common goals and responsibility for the benefit of the community in general. This needs a specially tailored education and training system in the country because of the lack of standardized educational packages.

The center is accredited by INTERPOL on 4.11.2019 for training in forensic sciences to the police officers in Turkey and globally, and it is also carrying out awareness activities for the prevention of physical and sexual violence.

To train the qualified personnel needed to establish the center, various training programs have been developed and specially tailored for the various parties involved in the victims' care. The training programs are for the nurses, the doctors, and especially emergency and gynecology experts, the police, the lawyers, the prosecutors, and the judges. Providing necessary training to forensic and law enforcement officials, doctors who will perform as first responders, and other stakeholder representatives are essential. The training programs that have been developed are also targeted to all local governments; that cooperation has been established.

10. Future projections

Following the establishment of the center, we started another project that aims to establish a collaboration platform with stakeholders via a mobile-compatible integrated web-based domain where members can provide anonymous data entry and information flow related to their field. Within the scope of smart, safe, and healthy urbanization practices, collecting data on physical and sexual violence cases in the designated regions, processing them with geographic information system (GIS), data analytics, and statistical methods, and innovative prevention mechanisms in the regions are the characteristics that we are concentrating on.

We aim to contribute to the increase of the awareness and accessibility of citizens and related parties, especially nongovernmental organizations, to the services provided. We will also establish a pool of volunteer experts to meet the legal and psychological counseling needs of victims of violence, compliance, relevance, location, etc., in the near future. We are expecting that this awareness-raising activity and communication system will develop and spread to all districts, especially within Istanbul.

11. Conclusion

Sexual assault and violence have destructive consequences for the victims starting from physical injuries to anxiety, depression, drug use, tendency for self-harm, suicide attempts, and very many other that have been very well reported [45–47]. It is reported that at least 20–35% of females are victims [17, 48]. Nevertheless, those that suffer avoid formal help and do not report the criminal activity. The reasons for that are known and may vary in severity in different cultures. The assaulted feel that they have no good communication with the law enforcement units and the health providers and that they will encounter negative attitudes [49]. We believe that interdisciplinary collaboration between different parties that are involved in crime combat is essential. That is the reason why we established a unit under the name of "Sexual Assault Crisis Center" as a one-stop center to prevent victims from the traumatic effects of visiting hospitals, police, and prosecutors for medical examination, evidence collection, and pursuing. The center aims to coordinate policies by the participation of all the actors in combating sexual crime and violence [23, 49]. We already collaborate with police, prosecution, and judges, and we work together as a team with lawyers, psychologists, doctors, nurses, and all the health management responsible. This prototype will also serve as a discouraging effort for the perpetrator, once it will be focused on disclosing the various rape cases by the use of correct evidence collection and evidence analysis. We have also aimed to raise awareness among policy makers and the society in general by collecting, analyzing, and publishing data generated from the activities of the center in the long run. Evidence-based crime combat and prevention is the key element for public safety. Therefore, proper evidence collection with minimum harm to the victim is essential [50, 51].

Acknowledgements

This project has been supported by İstanbul Yeni Yüzyıl University financially and by providing the appropriate resources.

Author details

Taner Güven[1], Sotirios Kalfoglou[2] and Ersi Kalfoğlu[2*]

1 Demiroğlu Bilim University Forensic Medicine Department, Istanbul, Turkey

2 Istanbul Yeni Yüzyil University Forensic Medicine Department, Istanbul, Turkey

*Address all correspondence to: ersi.kalfoglu@yeniyuzyil.edu.tr

References

[1] Basile KC, Smith SG. Sexual violence victimization of women: Prevalence, characteristics, and the role of public health and prevention. American Journal of Lifestyle Medicine. 2011;**5**(5):407-417. DOI: 10.1177/1559827611409512

[2] Tjaden P, Thoennes N. Extent, Nature, and Consequences of Rape Victimization: Findings from the National Violence Against Women Survey. Washington, DC: National Institute of Justice, Office of Justice Programs, United States Department of Justice; 2006. (NCJ 210346)

[3] Burt MR. Cultural myths and supports for rape. Journal of Personality and Social Psychology. 1980;**38**:217-230

[4] Briere J, Jordan CE. Violence against women: Outcome complexity and implications for assessment and treatment. Journal of Interpersonal Violence. 2004;**19**:1252-1276

[5] Backhaus I, Lipson SK, Fisher LB, Kawachi I, Pedrelli P. Sexual assault, sense of belonging, depression and suicidality among LGBQ and heterosexual college students. Journal of American College Health. 2021;**69**(4):404-412. DOI: 10.1080/07448481.2019.1679155

[6] Swanson C, Szymanski D. Anti-sexual assault activism and positive psychological functioning among survivors. Sex Roles. 2021;**85**:25-38. DOI: 10.1007/s11199-020-01202-5

[7] Morris JM, Quevillon RP. Social reactions to sexual assault disclosure: The role of posttraumatic cognitions. Journal of Interpersonal Violence. 2021;**36**(9-10):NP5466-NP5475. DOI: 10.1177/0886260518801940

[8] Ward J, Marsh M. Sexual Violence against Women and Girls in War and Its Aftermath: Realities, Responses, and Required Resources. New York, NY: United Nations Population Fund; 2006 (Briefing paper prepared for Symposium on Sexual Violence in Conflict and Beyond, Brussels, Belgium, 21-23 June 2006)

[9] Ward J. If Not Now, When? Addressing Gender-Based Violence in Refugee, Internally Displaced and Post-Conflict Settings. A Global Overview. New York, NY: The Reproductive Health for Refugees Consortium; 2002

[10] Eisenberg M, Lust K, Mathiason M, Porta C. Sexual assault, sexual orientation, and reporting among college students. Journal of Interpersonal Violence. 2021;**36**(1-2):62-82. DOI: 10.1177/0886260517726414

[11] Yavuz M. In: Özkal ŞŞ, Köprülü AŞ, editors. Cinsel Saldırı Olgularına Adli Tıp Açısından Yaklaşım. Cinsel Suç Kavramı ve Delillendirme. Yeni Yüzyıl Üniversitesi Yayınları; 2015. pp. 67-71. ISBN: 978-605-85154-2-0

[12] Çakmut Ö. The Notion "Violence" Against Women/Sexual Violence And A General Assessment of The Crime Of Sexual Violence Within The Context Of The Turkish Criminal Law Marmara Üniversitesi Kadın ve Toplumsal Cinsiyet Araştırmaları Dergisi, 2-1: 49-54. DOI: 10.26695/mukatcad.2018.16

[13] Physical Examination in Criminal Procedure, Genetic Studies and Regulation on Determination of Physical Identity Ceza Muhakemesinde Beden Muayenesi, Genetik İncelemeler ve Fizik Kimliğin Tespiti Hakkında Yönetmelik. 2004. Available from: https://www.resmigazete.gov.tr/eskiler/2005/06/20050601-13.htm [Accessed: 2021-06-10]

[14] Koçtürk N, Bilginer Ç. Negative reactions to the sexually abused victims, withdrawing the complaint and

outcomes of the litigation: The first data from Turkey. The Journal of Forensıc Psychıatry & Psychology. 2018;**30**(1):152-166. DOI: 10.1080/14789949.2018.1523947

[15] Aydın D. Being a woman in the Turkish criminal justice system. Women & Criminal Justice. 2021;**31**(3):197-209. DOI: 10.1080/08974454.2019.1646191

[16] Brown AW. Obstacles to Women Accessing Forensic Medical Exams in Cases of Sexual Violence (Final Version). Geneva: Prepared for the World Health Organization; 2001 (Background paper to the Consultation of the Health Sector Response to Sexual Violence)

[17] Du Mont J, White D. The uses and impacts of medico-legal evidence in sexual assault cases: A global review. In: World Health Organization. II.Sexual Violence Research Initiative. III.Title. 2007. ISBN 978 92 4 159604 6

[18] Tiena L, Wub Y, Linc T, Wangd S. Different perceptions of interprofessional collaboration and factors influencing the one-stop service for sexual assault victims in Taiwan. Journal Of Interprofessional Care. 2017;**31**(1):98-104. DOI: 10.1080/13561820.2016.1248816

[19] Lovett J, Regan L, Kelly L. Sexual Assault Referral Centres: Developing Good Practice and Maximising Potentials. London: Research, Development and Statistics Directorate, Home Office; 2004

[20] Kelly L. Promising practices addressing sexual violence. Prepared for the Division for the Advancement of Women, United Nations, New York, NY, 2005. (Expert Group Meeting, Violence Against Women: Good Practices in Combating and Eliminating Violence Against Women, Vienna, Austria, 17-20 May 2005)

[21] Kelly L, Regan L. Good Practice in Medical Responses to Recently Reported Rape, Especially Forensic Examinations: A Briefing Paper for the Daphne Strengthening Linkages Project. London: Rape Crisis Network Europe; 2003

[22] Wiese M, Armitage C, Delaforce J. Welch emergency care for complainants of sexual assault. Journal of the Royal Society of Medicine. 2005;**98**:49-53

[23] Moylan A, Lindhorst T, Tajima A. Contested discourses in multidisciplinary sexual assault response teams (SARTs). Journal of Interpersonal Violence. 2017;**32**(1):3-22 DOI: 10.1177/0886260515585530

[24] Classen C, Palesh O, Aggarwal R. Sexual revictimization: A review of the empirical literature trauma. Violence, & Abuse. 2005;**6**(2):103-129. DOI: 10.1177/1524838005275087

[25] Parnis D, Dclassenu MJ. Examining the standardized application of rape kits: An exploratory study of post-sexual assault professional practices. Health Care for Women International. 2002;**23**:846-853

[26] Gaensslen RE, Lee HC. Sexual Assault Evidence: National Assessment and Guidebook [Revised]. Unpublished Document; 2002. Available from: http://www.ncjrs.org/pdffiles1/nij/grants/191837.pdf

[27] Dierig L, Schmidt M, Wiegand P. Looking for the pinpoint: Optimizing identification, recovery and DNA extraction of micro traces in forensic casework. Forensic Science International: Genetics. 2020;**44**:102191. DOI: 10.1016/j.fsigen.2019.102191

[28] Hofreiter M, Sneberger J, Pospisek M, Vanek D. Progress in forensic bone DNA analysis: Lessons learned from ancient DNA. Forensic Science International: Genetics. 2021;**54**:102538. DOI: 10.1016/j.fsigen.2021.102538

[29] Haddrill PR. Developments in forensic DNA analysis. Emerging Topics in Life Sciences. 2021;**5**(3):381-393. DOI: 10.1042/ETLS20200304

[30] Pope S, Puch-Solis R. Interpretation of DNA data within the context of UK forensic science—Investigation. Emerging Topics in Life Sciences. 2021;**5**(3):395-404. DOI: 10.1042/ETLS20210165

[31] Ge J, Budowle B. Forensic investigation approaches of searching relatives in DNA databases. Journal of Forensic Sciences. 2021;**66**(2):430-443. DOI: 10.1111/1556-4029.14615

[32] Acosta ML. Collecting evidence for domestic and sexual assault: Highlighting violence against women in health care system interventions. BJOG: An International Journal of Obstetrics and Gynaecology. 2002;**78**(Suppl. 1): S99-S104

[33] Little K. A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents. Washington, DC: Office on Violence Against Women, United States Department of Justice; 2004 (NCJ 206554)

[34] Busardò FP, Varì MR, di Trana A, Malaca S, Carlier J, di Luca NM. Drug-facilitated sexual assaults (DFSA): A serious underestimated issue. European Review for Medical and Pharmacological Sciences. 2019;**23**(24): 10577-10587. DOI: 10.26355/eurrev_201912_19753

[35] Cárceles P, Osuna E. Legaz I Drug-facilitated sexual assault and other crimes: A systematic review by countries. Journal of Forensic and Legal Medicine. 2021;**79**:102151. DOI: 10.1016/j.jflm.2021.102151

[36] Basile KC, Smith SG, Liu Y, Lowe A, Gilmore AK, Khatiwada S, et al. Victim and perpetrator characteristics in alcohol/drug-involved sexual violence victimization in the US. Drug and Alcohol Dependence;**226**:108839. DOI: 10.1016/j.drugalcdep.2021.108839

[37] Berishaj K, Boyland CM, Reinink K, Lynch V. Forensic nurse hospitalist: The comprehensive role of the forensic nurse in a hospital setting. Journal of Emergency Nursing. 2020;**46**(3):286-293. DOI: 10.1016/j.jen.2020.03.002

[38] Valentine JL, Sekula LK, Lynch VJ. Evolution of forensic nursing theory—Introduction of the constructed theory of forensic nursing care: A middle-range theory. Forensic Nursing. 2020;**16**(4): 188-198. DOI: 10.1097/JFN.0000000000000287

[39] Lynch V. Forensic nursing science and the global agenda. Journal of Forensic Nursing. 2007;**3**(3-4):101-111. DOI: 10.1111/j.1939-3938.2007.tb00094.x

[40] Özkal Ş, Köprülü Ş, Sezgin D, Saygın I, Özdemir İ, Kaya T, et al. Forensic Nursing Education in Turkey. In: 10th Annual Meeting of Balkan Academy of Forensic Sciences, 18-21 June 2014, Alexandroupolis, Greece

[41] Regan L, Lovett J, Kelly L. Forensic Nursing: An Option for Improving Responses to Reported Rape and Sexual Assault. London, UK: Great Britain Home Office Research Development and Statistics Directorate; 2004. (Development and Practice Reports)

[42] Taylor WK. Collecting evidence for sexual assault: The role of the sexual assault nurse examiner (SANE). International Journal of Gynecology & Obstetrics. 2002;**78**(Suppl. 1):S91-S94

[43] Petridis G, Şş Ö, Büyük U, Kalfoglou S. Babalık testinde rapor serüveni: Bir olgu sunumu. Journal of Medical Sciences. 2021;**2**(1):57-61

[44] Kalfoglou S, Kalfoğlu EA. Misinterpretation of DNA Results May

Become a True Disaster for the Families of the Victims: A Case Report Balkan Academy of Forensic Sciences BAFS 12th Annual Scientific Meeting. 2021. ISBN: 978-605-74387-2-0

[45] Newins AR, Glenn JJ, Wilson LC, Wilson SM, Kimbrel NA, Beckham JC, et al. Psychological outcomes following sexual assault: Differences by sexual assault setting. Psychological Services. 2021;**18**(4):504-511. DOI: 10.1037/ser0000426

[46] Sachs CJ, Ladd M, Chapman J. Sexual assault history and physical. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021

[47] Kline NK, Berke DS, Rhodes CA, Steenkamp MM, Litz BT. Self-blame and PTSD following sexual assault: A longitudinal analysis. Journal of Interpersonal Violence. 2021 Mar;**36**(5-6):NP3153-NP3168. DOI: 10.1177/0886260518770652

[48] Campbell R. The psychological impact of rape victims. American Psychologist. 2008;**63**(8):702

[49] McMahon S, Schwartz R. A review of rape in the social work literature: A call to action. Affilia;**26**(3):250-263. DOI: 10.1177/ 0886109911417683

[50] Clonan-Roy K, Goncy EA, Naser SC, Fuller KA, DeBoard A, Williams A, et al. Preserving abstinence and preventing rape: How sex education textbooks contribute to rape culture. Archives of Sexual Behavior. 2021;**50**(1):231-245. DOI: 10.1007/s10508-020-01816-6

[51] Wise PH, Shiel A, Southard N, Bendavid E, Welsh J, Stedman S, et al. BRANCH consortium The political and security dimensions of the humanitarian health response to violent conflict. Lancet. 2021;**397**(10273):511-521. DOI: 10.1016/S0140-6736(21)00130-6

Chapter 8

Intervention Strategies for Promoting Recovery and Healing from Child Sexual Abuse

Tara Shuman

Abstract

The deleterious effects of child sexual abuse (CSA) on youth's social, emotional, physical, cognitive, neurobiological, sexual and developmental functioning are pervasive. Early targeted interventions for both the child who experienced CSA and their nonoffending caregivers are essential for healing and recovery. Effective interventions which are tailored to the youth's developmental level can help mitigate or even prevent some of the serious and enduring negative effects of CSA, including symptoms of posttraumatic stress disorder (PTSD). This chapter is not comprehensive, but examines evidence based interventions for children and adolescents who have been sexually abused including Trauma-Focused Cognitive Behavioral Therapy. Additionally, this chapter will address systemic factors in CSA, recommending coordinated and trauma informed efforts utilizing an interdisciplinary approach, which may include a forensic medical team, investigators, prosecutors and other disciplines. This professional collaboration can prevent retraumatization of the child as the child and family navigate the sequela of CSA.

Keywords: survivor therapy, healing from trauma, CSA intervention, CSA impact, nonoffending caregiver support

1. Introduction

The sexual abuse of children continues to be an extensive international problem with serious long term consequences. There are varying definitions of CSA, with the World Health Organization defining CSA as the involvement of a child under the age of 18 in sexual activity that they do not fully comprehend, do not give consent to, or for which the youth is not developmentally prepared and that violates the social taboos or laws of society [1]. CSA may include penetrative and nonpenetrative acts. Prevalence rates for CSA vary greatly, based on differing definitions of CSA, underreporting of CSA, and differences in child welfare record keeping by country. Prevalence rates for CSA according to a 2009 meta-analysis from 65 studies in 22 countries determined that an estimated 20% of girls and 8% of boys were victims of CSA prior to age 18 [2]. The high prevalence rates and the serious long term emotional, physical, relational and sexual consequences of CSA implore the need for efficacious, trauma informed interventions for the child and family. The vast majority of CSA is perpetrated by an offender the child knows and trusts, mandating that the interventions address the family and not just the victim [3].

Additionally, multidisciplinary coordination of law enforcement, forensic interviewing, child welfare services and therapists is essential to minimize retraumatization of the child and to best promote healing and recovery.

2. Impact of child sexual abuse

There are emotional, behavioral, developmental, relational, physical and sexual sequela of CSA, especially if the child did not receive timely and efficacious interventions and/or the child was not believed nor supported when they disclosed the CSA. The effects of CSA are often dependent on severity and frequency of the CSA as well as the developmental level of the child. Additionally, many CSA survivors have been victims of ongoing and complex trauma and the effects are cumulative and likely to overwhelm the child's coping resources. Emotional impacts can include depression, anxiety, posttraumatic stress symptoms, and angry outbursts, among others [4]. Externalizing behavioral symptoms can include regressions in toileting, temper tantrums, sleep difficulties and nightmares, provocative sexual behaviors, substance abuse, defiance and noncompliance [5]. CSA increases an individual's risk for both minor and major health problems including cancer and diabetes [6]. Relational consequences can include indiscriminant attachments which put victims at further risk, and also withdrawal and mistrust. Mistrust is empirically common if the child experienced betrayal trauma where the perpetrator was a known and trusted individual [7]. Sexual sequela can include sexual acting out behaviors, hypersexuality, poor body boundaries as well as an aversion and fear of affection and sexual behaviors.

The child's relationship with the perpetrator or offender of the sexual abuse impacts symptom presentation and also disclosure. The majority of sexual abuse victims know their perpetrator [3, 7], often making it difficult for the child to disclose due to feelings of loyalty to the family or the perpetrator. The lack of disclosure often results in the sexual abuse continuing over an extended period of time and the youth not receiving needed interventions, which may exacerbate their symptoms and the negative effects of CSA [8].

3. CSA interventions for youth

There is a need for empirically supported, targeted, and child directed interventions for victims of CSA [9]. These interventions should be trauma informed, provided within the context of a strong and supportive therapeutic relationship and include psychoeducation about CSA, coping skills, exposure through a trauma narrative and safety planning. Several of the most widely utilized interventions for CSA victims and their nonoffending caregivers are presented in this chapter.

3.1 TF-CBT

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an empirically supported treatment model for CSA developed to address PTSD symptoms and trauma in children and adolescents [4, 8, 10, 11]. Studies conducted in the last 25 years have provided consistent support for TF-CBT as the superior therapy for sexually abused children and other traumatized children when compared to non-directive or child-centered supportive therapy, as it provides essential support structures for both caregivers and children [11]. TF-CBT treats children and adolescents, ages 3 to 17, by addressing the negative effects of trauma including processing of traumatic

memories, addressing and overcoming problematic thoughts, and building coping and interpersonal skills. This short-term manualized treatment is typically provided in eight to 16 weekly 90-minute sessions, extending to as many as 25 sessions for individuals suffering from complex trauma [4, 8]. The TF-CBT treatment model was developed not only to address PTSD and depression and anxiety symptoms, but also underlying problematic distortions of thought regarding self-blame for trauma, ideas and expectations for safety, and constructs of trust in others and the world [10, 11].

The core components of TF-CBT can be summarized with the PRACTICE acronym, P: psychoeducation and parenting skills, R: relaxation skills or managing physiological reactions to trauma, A: affective modulation skills or managing affective responses to trauma, C: cognitive coping skills that build connections between thoughts, feelings, and behaviors, T: trauma narrative and processing, I: in vivo mastery of trauma reminders, C: conjoint child-caregiver sessions, and E: enhancing safety and future development [4, 8].

A primary curative component of TF-CBT is creation and processing of the trauma narrative (T) [4, 8, 10, 11]. This is the middle third of the duration of therapy, where the therapist and traumatized client focus increasingly on the specific traumas experienced. As the therapist and client progress through the components of the PRACTICE model, the therapist increases gradual exposure and helps the client and caregivers implement the skills learned to prepare them to cope with the inevitable full exposure of trauma reminders that accompany the trauma narrative [4, 8]. The trauma narrative and processing component is essential in the exposure therapy aspect of this treatment model, as it allows the child to extinguish negative emotions and reactions associated with the trauma by wiring new pathways of associations to the traumatic memories and eliciting positive and resilience-focused feelings such as pride and strength [8, 10].

In the trauma narrative and processing component, the youth develop a narrative about their CSA that includes specific traumatic circumstances, cognitions, feelings, behaviors, and other trauma-related experiences. For many of these youth, it is difficult to create a fully integrated trauma narrative, as they may only conjure up fragmented and non-linear pieces of their complex trauma memories [8]. Traditionally, these trauma narratives manifest in the form of written books about the youth and their specific trauma. The youth will complete their trauma narrative, usually ending with a chapter of what they have learned about themselves, relationships with others, worldviews, and expectations of the future, and then have the opportunity to share their narrative with their caregiver [10]. Trauma narratives can both highlight maladaptive core beliefs, and facilitate the integration of thoughts and feelings related to trauma [10]. Trauma narratives have been shown to reduce a child's fear and anxiety related to their abuse and decrease avoidant behaviors related to trauma [4, 8, 10, 11].

3.2 Play therapy

Play is the language of children and play based therapy for CSA is a developmentally attuned and expressive intervention that can facilitate emotional and behavioral regulation and healing from CSA [12]. Children who have been sexually abused frequently have difficulty with verbal recollection and expression of their traumatic experiences both due to the neurobiological impact of trauma on language centers in the brain and the developmental level of the child [13, 14] and play interventions can be familiar and less threatening. Additionally, complex trauma interferes with typical brain development, plus traumatic memories are often stored in the brain's implicit memory, which results in memories of sexual abuse

being stored in areas of the brain and body that are frequently challenging to access through verbal methods [15]. Through play therapy, children use symbolic representation to explore feelings and thoughts. Play therapy can include dolls, puppets, action figures and stuffed animal play for sexual abuse disclosure, which creates distance and an alternative to the children directly discussing their traumatic experiences, as they act it out through play. Play can be incorporated into other treatment modalities, such as play based construction of a trauma narrative in TF-CBT, and is particularly important for younger children who may not have the cognitive and language skills to fully express their feelings through talk therapy [16].

Play therapy for CSA can be directive and focused on the CSA or nondirective and child centered, focused on building rapport and establishing safety in the therapeutic relationship [12]. Play can be used to engage children who have experienced CSA and their caregivers in the therapy process, to teach specific personal safety and coping skills, to create a fun therapeutic environment and to facilitate communication between the child and the therapist [16]. Historically, the efficacy of play therapy for CSA has been difficult to quantify, however, play therapy is beginning to develop an evidence base that is more than anecdotal, and is establishing play therapy as an effective empirically supported intervention for CSA [17, 18].

3.3 Art therapy

Trauma informed art therapy is effective for children who have experienced early relational trauma, such as intrafamilial sexual abuse, which may result in symptoms of PTSD [19]. Art therapy interventions can provide a voice and sense of self-agency to CSA survivors as they creatively and abstractly represent their traumatic experiences and use metaphors and visual symbols to describe their sexual abuse [20]. Through visual arts, youth who have been sexually abused can express overwhelming emotions without requiring words [21].

Healthy emotional expression as well as emotional regulation for children who have experienced CSA can be promoted through art therapy [21]. Children who have been sexually abused may present with dissociative tendencies, limiting their ability to create a verbal trauma narrative and art therapy can provide a medium of construction of the trauma narrative that is not dependent on verbal processing [22]. Art interventions, such as drawing, painting, sculpting, collaging, etc., employed in forming and processing of a trauma narrative can act as a catalyst for children who have experienced CSA to explore thoughts, feelings, trauma memories, and perceptions through visual, tactile, and other sensory means [23]. With child sexual abuse, it is especially important to explore the non-verbal memories that recall fragmented sensory and emotional experiences of the trauma [24]. Art therapy is a visual and sensory modality that assists youth who have been sexually abused with accessing traumatic material stored in implicit memory, which is body-based form of memory that is distinct from explicit, narrative and conscious memory [20]. Art therapy may provide a bridge between implicit and explicit memory that allows children who have experienced CSA to express feelings and memories that are not accessible by verbal means [23].

3.4 Group therapy

To treat CSA, there are numerous efficacious group interventions which aim to decrease symptoms of CSA while also providing future risk reduction skills [25]. Group therapy for CSA is a treatment modality that is frequently used and is often the treatment of choice for CSA. CSA group treatment has growing interest for a variety of reasons, such as an increase in demand for trauma focused mental health

services and a need for a cost-effective approach [26]. Group modalities for CSA include TF-CBT groups, art therapy groups, support groups, psychoeducation groups, and process groups, among others. Children in CSA group therapy benefit from the support and understanding of peers who have had similar experiences. Group therapy provides an important sense of universality for CSA victims which can help combat feeling of isolation, social stigma, shame, guilt, and anger [27]. Universality is a key component of CSA group treatment and can assist with normalization of feelings of powerlessness, betrayal and helplessness, while simultaneously providing skills for resilience [27]. The relational consequences and mistrust that are often a result of CSA can be mitigated in group therapy for CSA as group members begin to connect through the opportunity to interact with supportive therapists and other CSA victims [28].

TF-CBT was initially provided as individual treatment although TF-CBT is frequently provided in a group format and group TF-CBT has also been identified as an efficacious treatment modality for CSA [29]. The group format of TF-CBT promotes cohesion by destigmatizing traumatic experiences. Children learn new skills together and can support one another to implement these skills [29]. When children are attending their group, caregivers are attending collateral group sessions to learn the TF-CBT components [10, 29]. Parenting and coping skills are taught to provide more consistency in the home and psychoeducation regarding trauma is provided [10, 29]. TF-CBT groups for CSA can decrease trauma symptoms such as anxiety, depression, avoidance, hypervigilance, and intrusive thoughts in youth [25]. Group therapy for CSA has shown to be effective for improving overall psychological distress, development of coping skills, and reducing sexual and other behavior problems [25]. Additionally, group TF-CBT has supported youth in developing stronger personal safety skills and decreasing emotional reactions in caregivers [25].

Art therapy groups for CSA are an expressive arts group treatment modality that incorporates creativity and can facilitate processing of traumatic experiences with other youth who have experienced CSA. Various types of abstract and representational art can be created in group and shared with group members in order to increase catharsis and connection/cohesion between group members. For example, group members may draw characters (animals, superheroes, objects) that represent themselves, their perpetrators and protective caregivers and then be asked to tell detailed stories to the group about these characters [20]. In this group art activity, a child may identify as an animal living in their safe place, until a predator presents and harms the animal (i.e., a fox attacking a rabbit, a bee stinging a kitten). Allowing the child to identify with the animal provides distance and separation from the event so as to prevent the children from being retraumatized or overwhelmed by trigger reminders [20]. An eight session art therapy group for latency age girls who had been sexually abused focused on four themes: establishing group cohesion and fostering trust, exploring feelings associated with the abuse, sexual behavior and the prevention of revictimization and termination of the group [30]. Group members utilized painting, drawing, clay sculpting, and dramatic role plays during this art therapy group. Outcome measures from this group art therapy intervention for girls who had been sexually abused evidenced a reduction in symptoms of anxiety and depression [30].

Support groups for CSA provide cohesion, connection with others with a shared experience, and psychoeducation about CSA. CSA support groups may focus on body boundaries, personal safety, CSA education, and coping skills and typically do not have a disclosure or trauma narrative as part of the group curriculum [31]. This may be due to the shorter length of treatment and/or group treatment provided outside of a clinical setting, such as at a school. Due to limited time and the need

for youth to not become emotionally triggered in a school setting, support groups typically do not have group members share details about their victimization.

4. Interventions for NonOffending caregivers

Nonoffending caregivers are primary supports for children who have been victims of CSA and the need for specific and tailored interventions for nonoffending caregivers is increasingly recognized in the literature and caregiver support has been identified as a crucial factors in children's recovery from CSA [32]. Caregiver interventions following sexual abuse of their child aim to reduce caregiver distress, increase adaptive caregiver coping as well as enhance support of the child [33]. Nonoffending caregivers have been referred to as "overlooked victims" in child sexual abuse cases [34]. A recent qualitative study with nonoffending caregivers of children under 13 who had been victims of CSA found that the majority of caregivers reported mental health services were necessary and beneficial for themselves to help them cope with the impact of their child's CSA [33]. Interventions for nonoffending caregivers may include group and/or individual treatment focusing on psychoeducation, information, supports, parenting guidance, and dealing with their own victimization (if relevant). When intrafamilial CSA occurs, the nonoffending caregiver has the essential role of assisting the CSA victims and other children in the family so that safety and security can be restored [35]. Simultaneously, the caregiver is likely experiencing shock, grief, fear and a myriad of other emotions, which are often overwhelming, while they are tasked with shepherding the child who has experienced CSA on their journey of healing and recovery. Nonoffending caregivers often need support, guidance and direction because in addition to the crisis of the CSA, they may be faced with a lack of financial support, legal proceedings, and possible conflict with and separation from extended family whose loyalties may lie with the perpetrator [35]. Caregiver support is an important mediating variable in outcomes for victims of CSA [32].

4.1 Nonoffending caregiver support groups

Support groups for nonoffending caregivers of children who have been sexually abused can provide critical psychoeducation and social support for the caregiver during this vulnerable time of rebuilding and redefining their family [32]. Nonoffending caregiver support groups offer a safe place to begin the difficult recovery process, to normalize feelings and thoughts about their child's CSA and to begin to build a support network with other families [34]. In the group, group therapists teach caregivers the relationship between thoughts, feelings and behaviors and provide guidance on thought restructuring which enables caregivers to deal with their own symptoms as well as modeling appropriate coping skills for their children and coaching their children on these skills. Additionally, caregiver support groups can provide practical information on social services, legal services, housing, school intervention and other needed resources [34].

4.2 Nonoffending caregiver individual therapy

Following disclosure or discovery that their child has been sexually abused, nonoffending caregivers may experience depression, posttraumatic stress and increases in anxiety [36]. Shields and colleagues found that following child sexual abuse disclosure, 24% of caregivers met diagnostic criteria for depression or PTSD or both [36]. Parental distress was associated with decreases in positive

parenting and caregiver involvement with the victim. Individual therapy for the nonoffending caregiver can be beneficial to address mood symptoms, trauma reminders and to increase coping and implementation of parenting skills. This individual treatment can be provided in conjunction with group treatment. If a caregiver has their own history of CSA, they may also benefit from individual therapy to process how their child's victimization is triggering their own CSA experience, especially if the caregiver did not receive interventions for their own CSA victimization [34].

4.3 Caregiver involvement in TF-CBT

TF-CBT incorporates individual and caregiver-focused interventions to inform families of the reactions and effects of trauma in children. Caregivers can be parents, foster parents, relative caregivers or other supportive adults actively involved in the child's life. This caregiver component enhances the positive impact of treatment in terms of decreasing caregiver and child depressive and anxiety symptoms, as factors such as caregivers' emotional distress and caregiver support of the child have been found to be strong and significant mediators to treatment response [10]. Parental and caregiver support is a primary component of the PRACTICE interventions of the TF-CBT model and the caregiver is actively and collaboratively involved in the entire course of treatment with approximately half of the treatment time focused on caregivers [8, 10]. Through both individual caregiver sessions and conjoint sessions with their child, caregivers learn to be present while their child discusses the CSA and how it affected them and caregivers learn skills to be supportive of their child as they work through the recovery process. Through the PRACTICE components, caregivers are taught strategies to express and modulate their affect as well as being taught ways to manage intense emotions in their child [10]. Additionally, caregivers learn parenting and child behavior management skills specific to children who have been victims of CSA. Prior to terminating treatment, skills to safety plan for CSA victims and promote positive future engagement are addressed with caregivers [11].

5. Systemic factors in CSA

Following disclosure or discovery of suspected CSA, a child and family's life may have an influx of professionals involved with the aim of child protection, assessment and promotion of the victim's physical and mental health, prosecution of the perpetrator, and family healing and recovery. Ideally, these efforts are coordinated in order to minimize deleterious impact on the CSA victim and family. In the United States, Child Advocacy Centers (CAC) were developed in response to the desire to limit redundant interviewing of the victim and to coordinate investigative and therapeutic response to CSA [37]. These CACs utilize a multidisciplinary team of medical, mental health, child protective and law enforcement professionals in a "one stop shop" approach to CSA with interagency communication and collaboration. In 2011, The National Children's Alliance in the United States (U.S.), developed Standards to ensure that children across the U.S. receive consistent, evidence based services that help them recover from CSA and other types of child abuse [38]. These Standards are updated every five years, with the most recent Standards from 2017 and to date there are more than 880 CACs in the United States, spanning all 50 states. In 2018, 367,797 children in the U.S. were served by CACs, with an increase in 29% from 2008 to 2018 [38]. However, even with this increase, there are still over ten million children living in the U.S. in areas without a CAC. Additionally,

internationally, many countries lack the funding and infrastructure to implement a coordinated and multidisciplinary response to CSA.

Increased caregiver and child satisfaction were found with these coordination efforts in evaluation and intervention with CSA [37]. CACs can serve as a model for coordinated multidisciplinary services that reduce retraumatization of the CSA victim due to limiting the child having to repeatedly disclose their CSA experiences to police, lawyers, doctors, therapists, investigators and judges [38].

6. Conclusion

This chapter highlighted several empirically supported and highly utilized interventions for CSA. Rather than being a comprehensive review of the literature, this chapter covered best practices for CSA intervention and treatment with attention to both the child and the nonoffending caregiver as it is imperative to simultaneously address the needs of the child and the caregiver to promote healing and recovery from CSA. Multiple modalities for individual, group and collateral caregiver intervention were presented, illuminating their efficacy and implementation for CSA. Selection of a specific treatment modality should be individualized based on cultural and contextual variables for the child and family, the frequency and severity of abuse, the child's and the caregiver's symptomology as well as the treatment setting and the training and experience of the provider. Additionally, the need for coordinated multidisciplinary investigative and therapeutic responses to CSA was highlighted in order to limit the negative systemic impact on the child and family, with CACs presented as a model implemented in the U.S. to address this need.

Author details

Tara Shuman
California School of Professional Psychology at Alliant International University, San Diego, United States of America

*Address all correspondence to: tshuman@alliant.edu

References

[1] World Health Organization. Responding to Children and Adolescents Who Have Been Sexually Abused: WHO Clinical Guidelines. Geneva: World Health Organization; 2017, 86 p.

[2] Pereda, N., Guilera, G., Forns, M., & Gomez-Benito, J. The prevalence of child sexual abuse in community and student samples: A meta-analysis. Clinical Psychology Review 2009; 29(4), 328-338, https://doi.org/10.1016/j.cpr.2009.02.007

[3] Perpetrators of sexual abuse. Child Welfare Information Gateway, [Internet] 2016. Available from Childwelfare.gov: https://www.childwelfare.gov/topics/can/peretratros/perp-sexabuse/ [Accessed 2021-02-01]

[4] Cohen, J., Berliner, L., & Mannarino, A. Trauma focused CBT for children with co-occurring trauma and behavior problems. Child Abuse & Neglect, 2010; 34, 215-224.

[5] National Child Traumatic Stress Network. Sexual Abuse; Effects [Internet] No date. Available from: https://www.nctn.org/what-is-child-trauma/trauma-types/sexual-abuse/effects [Accessed 2021-01-15]

[6] Nelson, S., Baldwin, N., Taylor, J. Mental health problems and medically unexplained physical symptoms in adult survivors of childhood sexual abuse: an integrative literature review Journal of Psychiatric Mental Health Nursing 2012 19 (3), 211-220. DOI: 10.1111/j.1365-2850.2011.01772.x et al 2012

[7] Freyd, J. Betrayal Trauma: The logic of forgetting childhood abuse. Harvard University Press; 1996.

[8] Cohen, J. A., Mannarino, A. P., Kliethermes, M., Murray, L. A. Trauma focused CBT for youth with complex trauma. Child Abuse & Neglect, 2012; 36(6), 528-541. https://doi.org/10.1016/j.chiabu.2012.03.007

[9] Tichelaar, H., Dekovic, M., Endendijk, J. Exploring effectiveness of psychotherapy options for sexually abused children and adolescents: A systemic review of randomized controlled trials, Children and Youth Services Review, 2020, https://doi.org/10.1016/j.childyouth.2020.105519

[10] Cohen, J. A., Mannarino, A. P., & Deblinger, E. Treating trauma and traumatic grief in children and adolescents (2nd ed.). 2017; New York, NY: Guilford Press.

[11] Cohen, J., Deblinger, E., & Mannarino, A. Trauma-focused cognitive behavioral therapy for sexually abused children. Psychiatric Times, 2004; 21(10) https://www.psychiatric times.com/view/trauma-focused-cogntivie-behavioral-therapy-sexually-abused-children [Accessed 2021-01-13]

[12] Gil E. Trauma-focused integrated play therapy (TF-IPT). In: Goodyear-Brown P, editor. Handbook for Child Sexual Abuse: Identification, Assessment, and Treatment. John Wiley & Sons, Inc.; 2012. P. 251-278

[13] Johnson M. The Body in the Mind: The Basis of Meaning, Imagination, and Reason. Chicago: University of Chicago Press; 1987.

[14] Westby C. Child maltreatment: A global issue. Language, Speech and Hearing Services in Schools. 2007; (38), 140-148.

[15] Williams W. Complex trauma: Approaches to theory and treatment. Journal of Loss and Trauma. 2006; 11(4), 321-335. doi:10.1080/15325020600663078

[16] Briggs K, Runyon M, Deblinger E. The use of play in trauma-focused cognitive-behavioral therapy. In: Russ S, Niec L, editors. Play in Clinical Practice; Evidence-Based Approaches, New York: Guilford Press; 2011. p. 168-200

[17] Schoottelkorb A. Doumas D. Garcia R. Treatment for child refugee trauma; A randomized, controlled trial. International Journal of Play Therapy. 2012; 21(2); 257-273; https://doi.org/10.1037/a0027430

[18] Reyes C. Ashbrand J. A longitudinal study assessing trauma symptoms in sexually abused children engaged in play therapy, International Journal of Play Therapy, 2005; 14(2): 25-47. https://doi.org/10.1037/h0088901

[19] Van Lith P. Art therapy in mental health: A systemic review of approaches and practices. The Arts in Psychotherapy, 2016; 47: 9-22. https://dot.org/10.1016/j.aip.2015.09.003

[20] Shuman, T. Johnson, K. Lively Cookson L. Gilbert N. Creative interventions for disclosing trauma narratives in group therapy for child sexual abuse, Journal of Child Sexual Abuse, 2020; DOI: 10.1080/10538712.2020.1801931

[21] McKinnon K. Drawing out trauma: Visual art therapy for child sexual abuse victims. Intuition: The BYU Undergraduate Journal of Psychology, 2019; 14(1): https://scholarsarchive.byu/intuition/vol14/iss1/7

[22] Chong C. Why art psychotherapy? Through the lens of interpersonal neurobiology: The distinctive role of art psychotherapy intervention for clients with early relationship trauma. Journal of Art Therapy, 2015; 20(3): 118-126.

[23] Malchiodi C, editor. Creative Interventions with Traumatized Children. New York: Guilford Publications: New York; 2014.

[24] Talwar S. Accessing traumatic memory through art making: An art therapy trauma protocol (ATTP). The Arts in Psychotherapy, 2007; 34(1), 22-35.

[25] Dorsey S, McLaughlin K, Kerns S, Harrison J, Lambert H, Briggs E, Amaya-Jackson L. Evidence base update for psychosocial treatments for children and adolescents exposed to traumatic events. Journal of Clinical Child and Adolescent Psychology, 2017; 46(3), 303-330. doi:10.1080/15374416.2016.1220309

[26] Liotta L, Springer C, Misurell J, Block-Lerner J, Brandwein, D. Group treatment for child sexual abuse: Treatment referral and therapeutic outcomes. Journal of Child Sexual Abuse, 2015; 24(3), 217-237. https://doi.org/10.1080/10538712.2015.1006747

[27] Yalom I, Leszcz M. The Theory and Practice of Group Psychotherapy, 5th ed. Lebanon: Harchette Book Group; 2005.

[28] Sinanan A. Trauma and the treatment of child sexual abuse. Journal of Trauma and Treamtment, 2015; DOI: 10.4172/2167-1222.S4-024

[29] Deblinger, E., Pollio, E., & Dorsey, S. Applying Trauma-Focused Cognitive Behavioral Therapy in group format. Child. Maltreatment, 2015; 21(1), 59-73. doi: 10.1177/1077559515620668

[30] Pretorius G, Pfeifer N. Group art therapy with sexually abused girls. South African Journal of Psychology, 2010; 40(1), 63-73. https://doi.org.1177/008124631004000107

[31] Deblinger E, Mannarino A, Cohen J, Runyon K, Steer R. Trauma- focused cognitive behavioral therapy for children: impact of the trauma narrative and treatment length. Depression and Anxiety, 2010; 28(1), 67-75. doi: 10.1002/da.20744

[32] van Toledo A, Seymour F. Interventions for caregivers of children who disclose sexual abuse: A review, Clinical Psychology Review, 2013; 33(6), 772-781. https://dx.doi.org/10.1016/j.cpr.2013.05.006

[33] Fong H, Bennett C, Mondestin V, Scribano P, Mollen C, Wood J. The impact of child sexual abuse discovery on caregivers and families: A qualitative study, Journal of Interpersonal Violence, 2017; https://doi.org/10.1177/0886260517714437

[34] Grant, D. Overlooked victims: Working with nonoffending caregiver in child sexual abuse cases, The Alabama Counseling Association Journal, 2006; 32(2). https://files.eric.ed.gov/fulltext/EJ902497.pdf

[35] Group Therapy [Internet]. 2020. Available from: www.gilinstitute.com/service/formats/group.php [Accessed 2021-02-01]

[36] Jobe-Shields L, Swiecicki C, Fritz D, Stinnette J, Hanson, R. Posttraumatic stress and depression in the nonoffending caregivers of sexually abused children: Associations with parenting practices Journal of Child Sexual Abuse. 2016; 25(1) 110-125. DOI: 10.1080/10538712.2015.1078867

[37] Brink F, Thackeray J, Bridge J, Letson M, Scribano P. Child advocacy center multidisciplinary team decision and its association to child protective services outcomes. Child Abuse and Neglect. 2015; https://dx.doi.org/10.1016/j.chiabu.2015.04.011

[38] How the CAC Model Works [Internet]. 2019. Available from: https://www.nationalchidrensalliance.org/cac-model/ [Accessed 2020-12-19]

Chapter 9

Why Cleveland Still Matters: Connections with a New Era

Heather Bacon and Susan Richardson

Abstract

This chapter explores the lasting impact of 1987 Cleveland child abuse crisis in the UK in which 127 children were diagnosed by two paediatricians as having been sexually abused. It highlights how this resulted in tensions, misunderstandings and stresses in the interface between the public and the child protection system, and persistent challenges of creating and sustaining a successful multidisciplinary approach to intervention and protection. It argues that the experience in Cleveland provided unique information about the effects of intervening in child sexual abuse, especially where children are trapped in silence and only come to light by way of a proactive intervention. These children remain difficult to help and the best way of intervening remains contentious. The authors challenge the ethos that leaves sexually abused children vulnerable in the face of investigative and evidential hurdles and suggest ways forward.

Keywords: Child sexual abuse, Cleveland, medical diagnosis, child protection, dilemmas of intervention

1. Introduction

> *'We have learned during the Inquiry that sexual abuse occurs in children of all ages, including the very young, to boys as well as girls, in all classes of society and frequently within the privacy of the family. The sexual abuse can be very serious and on occasions includes vaginal, anal and oral intercourse' ([1], p.243).*

The lasting legacy of the 1987 Cleveland child abuse crisis, in which a medical diagnosis of sexual abuse was made in 127 children, is that Cleveland became a shorthand for difficult issues in child protection, with widely differing meanings, often informed by media rather than professional debate. It was a pivotal point, which has influenced attitudes, policies and politics ever since. The subsequent Butler-Sloss Inquiry [1] left unresolved issues in child protection and had the effect of stifling debate about the dilemmas facing professionals in the field and the communities in which they work. The key issues from Cleveland remain relevant to child protection today. We argue that after Cleveland, what had been a proactive approach to protecting children who were being sexually abused became reactive, focusing only on those children who can disclose abuse, rather than the majority who are trapped in silence, especially the very young whose abuse can only come to light via an adult advocating in their behalf. The critical role of medical diagnosis in advocating for the latter group was effectively ended in the furore which led to the Butler-Sloss Inquiry. The Inquiry failed to grasp the nettle of the problems of protecting these most vulnerable children.

Because the professionals involved in Cleveland were unable to speak publicly, this created an information gap, and powerful myths were generated, influencing both public and professional perceptions; for example that all children seen by the paediatricians were screened for abuse; that a diagnosis of sexual abuse was made on the basis of a single sign (anal dilatation); that the diagnoses were discredited and that children were removed from home for the flimsiest of reasons. Although Butler-Sloss refuted them all, the myths became solidified and entrenched and continue to profoundly affect our society's approach to tackling the reality of child sexual abuse. In 1987, despite the context of increasing awareness and increased willingness to intervene, the management of child sexual abuse was based on a limited understanding of its dynamics and what would happen when attempts were made to bring it to light. There is now a much stronger evidence base, which should inform politicians, professionals and others responsible for making decisions and taking the field forward.

Although the very complex issues involved are now better understood, intervening remains difficult and professionals have inevitably become more anxious and more aware of the risks they take when entering this field. The Butler-Sloss Inquiry addressed but unwittingly increased this struggle. One of the legacies of Cleveland has been professional anxiety, creating a risk-averse climate which has contributed directly to subsequent child abuse tragedies [2]. Professionals, too, are affected by conflict between the need to know and the distress of hearing unspeakable truths.

We argue that the knowledge and understanding gained in Cleveland could have produced positive changes and greater continuity in child protection practice and that this opportunity was lost. The tensions created left an eternal argument about the facts of Cleveland, and continuing failure by the child protection system to tackle the real scale of the problem. The subsequent clampdown on accurate information about the crisis made it difficult for other practitioners to verify the real issues and led many to question whether authoritative interventions based on advocacy for the child are tenable in a social climate which unconsciously supports the denial of the extent of child abuse.

2. Background: the Cleveland crisis and the inquiry process

The Cleveland child abuse crisis had its origins in a seminal paper by Leeds paediatricians Drs Hobbs and Wynne [3], which identified anal abuse as a potentially common childhood syndrome. The medical diagnosis by Drs Higgs and Wyatt of sexual abuse in 127 children in Cleveland placed unprecedented pressure on the resources of police and social services and inter-agency co–operation was stressed to breaking point. A public outcry of disbelief, fuelled by the media and one local MP, led to a major public inquiry [1]. Of the 121 children reviewed by the Inquiry, 27 were under the age of 3 with the youngest under a year old, presenting a uniquely difficult investigative challenge. In the absence at that time of any agreed procedures for intervention into child sexual abuse, procedures designed for other forms of abuse were followed: this involved removing some children from home. This action fuelled the controversy.

The Inquiry's remit did not include establishing whether or not the children had in fact been abused, which was addressed in a parallel process in the High Court. An independent expert panel set up by the Regional Health Authority concluded that in at least 75% the diagnosis of CSA had been correct. The Inquiry had access to the report of this panel but chose not to publish this conclusion. In consequence the public perception, led by a small group of aggrieved parents, a local MP and

consistently biased reporting in the media, was that the diagnoses were incorrect and the cause of the crisis was overzealous intervention by professionals.

At the very point at which professionals were trying to get to grips with dealing with the new phenomenon of children presenting via a medical route, the situation went beyond their control. The local MP made allegations in the House of Commons of 'collusion and conspiracy' (subsequently dismissed by Butler-Sloss) and the Inquiry effectively interrupted all ongoing work. The method of the Inquiry, which, despite its statement to the contrary, was adversarial rather than inquisitorial, was unsuited to the elucidation of a highly complex and sensitive issue such as CSA. This resulted in polarisation and a lack of balance, and encouraged the media to represent the professionals as being wholly wrong and the parents as being entirely innocent, creating a public misconception that has endured ever since.

3. A unique opportunity at the heart of the matter

Professionals in Cleveland were presented with a new opportunity to intervene protectively where children were experiencing the most serious forms of child sexual abuse. Some of the children were able to disclose. For some, disclosure was prompted by the medical examination. Others were identified as having been abused but were unable to say anything about what was happening to them. These children, who were trapped in the silence inherent in the dynamics of the abuse, came to attention through a medical 'window', a diagnosis based on previously unrecognised signs and symptoms. The two paediatricians Drs Higgs and Wyatt have analysed the children's presentation and medical findings and described dilemmas for the doctor [4]. The children who came to attention in this way, via an adult or alerting signs and symptoms rather than purposeful disclosure, then posed an enormous challenge for the professionals as to how to intervene to protect them. We term them 'Group B', in contrast to those who can make a disclosure and assist in an investigation, whom we term Group A.

In the case of children in Group B the identity of the perpetrator is likely to be unknown. Butler-Sloss identified but did not resolve this key dilemma and its relation to the question of removal from home. Removal from home, though fraught and controversial, facilitated disclosure for some children. Paediatricians in Leeds reported a similar pattern, commenting 'We know many children never describe their abuse, others only after months in the safety of a foster home. Children left at home may be threatened and never feel able to disclose, and without some sort of admission from the child professionals are increasingly anxious about taking any action. Yet it may be only by removal of the child from the abuser that the child can develop the confidence to tell' [5].

A theme of the Butler-Sloss Inquiry [1] is that children would normally disclose except for 'rare occasions when an abused child does not choose to tell' (p.207). The tenor of the report equates non-disclosure with no abuse. Rather than recognising how difficult and unlikely any disclosure is, particularly for young children, the report emphasised the risks of trying to assist children by interviewing them in more facilitative ways, such as asking them directly. Expert evidence to the inquiry warned that interviewers can create bias, interviews themselves could be abusive, and that children can lie and fantasise about abuse.

The importance of the medical diagnosis for such children was overridden by the idea that the 'gold standard' for the diagnosis of child sexual abuse was disclosure by the child. This reliance on disclosure as the prime route to diagnosis was accompanied by the discrediting of the medical diagnosis, which was based

on a constellation of signs including reflex anal dilatation (RAD). At this time the evidence base for medical findings in child sexual abuse was small, allowing scope for wide disagreement between professionals, which then deterred paediatricians elsewhere from working with child sexual abuse. More recent research [6] suggests that medical findings can in fact make a very important contribution to the diagnosis of child sexual abuse and that anal dilatation is a highly significant sign. The Inquiry missed this unique opportunity to evaluate this vital issue at the heart of the crisis.

The way the Cleveland crisis was handled had long term negative effects over the succeeding decades, and we believe that knowledge and experience about children in Group B has been lost. Such children have become largely invisible, and even when they do come to light, they remain difficult to help because the best way of intervening remains contentious.

4. The medical diagnosis: was it mistaken?

Since 1987 more research has been carried out into the medical signs that the Cleveland paediatricians described [7]. Despite this, the diagnosis of child sexual abuse has become more complex and uncertain. Very little has been added to the evidence base about anal abuse in children, few cases are documented, and paediatricians are still not all in complete agreement about some of the signs that were detailed by Hobbs and Wynne [3].

Although there is still not a complete consensus on this matter the current evidence- based guidelines for doctors [7] conclude that the so called 'controversial' sign of anal abuse used in Cleveland is one of the most statistically significant findings that can be relied upon in the diagnosis, along with most of the other signs and symptoms that the Cleveland paediatricians found.

After Cleveland the changed perceptions of the medical diagnosis soon became apparent. The Social Services response changed and although there were the same number of child protection case conferences, fewer children were placed on the register, fewer taken into care, and there were fewer criminal convictions. Campbell [2] explores the way in which the expert medical consensus that there was no wholesale error of diagnosis was kept from view, and how it was known that scapegoating the Cleveland paediatricians would undermine the paediatric role elsewhere.

5. The resulting backlash

Since 1987 society has tried to come to terms with the nature and extent of what can now be understood as an 'iceberg' of child sexual abuse. Ongoing secrecy and denial creates a backlash that can be driven by perpetrators, victims, professionals, politicians and the wider society which hampers the best efforts to understand and intervene effectively to help child victims. At the same time, it can be argued that there is far greater acceptance among the wider public of the reality of child sexual abuse, influenced by the courage and integrity of survivors who have come forward to bear witness to their experiences. In our opinion, a Cleveland-type crisis was an inevitable stage of a process whereby professional awareness advanced; but we argue that this took place in a context of impunity for perpetrators and public ignorance of the reality, and the Inquiry was an exercise in containment of the problem. We can now see how the media backlash used the disagreements between professionals to discredit them.

6. The legal system

The adversarial way the legal system dealt with the cases tended to place the families and the authorities in an oppositional rather than a co-operative relationship. This contrasts with countries like France, where the legal system is founded on a more inquisitorial approach. This in turn influenced not only the media and public perceptions, but also the climate for change and the pattern of the services which developed.

The controversy that developed around the medical diagnosis was only one aspect of the difficulties faced in the courts. The investigative process and methods, particularly around efforts to try and facilitate the children to disclose any abuse, was all subject to intense critical attack on the grounds that the process itself was traumatising and damaging to the children. These opinions served to fuel the criticism directed at the interviews in Cleveland, and influenced subsequent recommendations that interviews with children where abuse was suspected should not be in any way directive.

7. Perpetrators: a missing element of the Inquiry

The Inquiry had only a limited remit in respect of addressing the dynamics of child sexual abuse; the nature of abusers and the reasons for sexual abuse of children; the effectiveness and appropriateness of the strategies used once the problem has been identified; and the response of societies and the agencies to those who abuse.

At the time of Cleveland we did not fully appreciate the power of perpetrators, in particular the nature of the threats and other techniques they commonly use to ensure secrecy. For example, an adult survivor, who had been referred to one of the editors via a Child and Adolescent Mental Health Service as a teenager revealed that as a child of 6, she was abused by her father in his car on her way to hospital following a broken arm to make sure that she kept quiet about his ongoing sexual abuse. Children who are dependent on their abusers are often trapped in secrecy, so that abuse by family members and caregivers is unlikely to be revealed spontaneously.

In a climate where very little attention is paid to detecting and intervening effectively with perpetrators, opportunities for protecting children are correspondingly lost. We believe that this was the case in Cleveland. The media storm that gathered and vilified the professionals was exploited by perpetrators and allowed them to hide under the umbrella of being part of 'innocent families.' A specialist colleague working with sex offenders found indications that, post-Cleveland, some perpetrators had changed their behaviour, anal abuse now being seen as reducing the risk of conviction [8].

Unlike the doctors, social workers and psychologist whose actions were scrutinised in detail by the Butler-Sloss Inquiry, the omissions and failure of the police and legal system were subject to less stringent criticism. The successful scapegoating of the health and social services left an unbalanced system where intervention with perpetrators did not go hand in hand with intervention for the child and family.

8. The wrong kind of Inquiry?

We argue that, because the remit of the Cleveland Inquiry was not to focus on what actually happened to the children, the facts were never established and no-one outside the situation could really grasp the reality of the situation. A valuable opportunity to develop new ways of understanding and grasping the problems for

abused children was lost. Indeed, the intervention of the Inquiry had the effect of hindering rather than fostering effective joint working.

The advocates who believed that children had been abused were treated as the bearers of an unwanted message. The impetus was to remove the key figures from post. Those who did remain were largely disempowered. We have given a personal and professional account of this experience [9].

There is still a real climate of fear among professionals. Many paediatricians have left the field or are reluctant to enter it, some having been subject to a series of attacks.

9. Enduring myths

Members of the community produced a leaflet to refute the myths, raise awareness and counteract the media distortion and resultant scapegoating of those who were trying to bring the real problems to light [10]. Commentators have referred to lessons not being learned, but in our view the problem is more that any useful learning is impossible without an informed debate. Whilst this reflects the general difficulties for the public in accepting the reality of child sexual abuse, we think this may also be a reflection of the crucial absence at the centre of the Inquiry report. Without knowing whether or not the children had been abused, most observers have been unable to make their own judgement about whether the child protection professionals intervened appropriately; whether what happened was in itself unnecessarily damaging to the children; and whether they were in need of protection and whether they received it.

10. Ongoing denial and failure to connect

Thanks largely to the courageous efforts of survivors, there is an emerging narrative of widespread abuse in a large range of settings such as children's homes, football clubs and custodial institutions. Over time there has been greater awareness of the real extent of sexual abuse as the numbers of victims in large scale cases have increased. For example, an inquiry in Rotherham U.K. [11] gave a conservative estimate that 1400 young girls had been sexually exploited over a 16 year period from 1997 to 2013.

A major independent inquiry into child sexual abuse in the UK (IICSA) has identified and is addressing broader cultural, structural, financial, professional and political themes, and the importance of social and political narratives in tackling child sexual abuse [12].

From Cleveland to Rotherham the negative treatment of the messengers has continued. IICSA's remit includes an examination of the extent to which the deliberate investment in concealment is a factor in the many emerging cases of past abuse in organisations and institutions. Many of these cases are accompanied by allegations that those with a duty of care were aware of the abuse and either did not act, or covered it up.

11. Social work practice: was the refocusing policy helpful?

The post-Cleveland 1989 Children Act profoundly changed the way that child protection professionals could access abused children hidden within families. Rather than being led by the needs of children, the underpinning of the act was

political, reflecting the view that state intervention in family life was to be avoided wherever possible. Early intervention, effective child protection, and prevention have been casualties of that ideology.

The Children Act 1991 had the over-riding purpose of keeping families together by encouraging local authorities to work with them. During the 1990's it was argued that too many families were drawn into the child protection system. To counter this, the criteria for entry to that system were revised so that the majority of families where children might be at risk would receive supportive family intervention. In effect, this raised the threshold for child protection.

Rather than making child abuse increasingly visible as had been happening in the previous decade, it became laudable to reduce the numbers on the child protection register.

Refocusing the debate in the 1990s placed assessment of risk and inquiry rather than investigation, at the heart of child protection policy in the U.K. [13]. We find it telling that the term 'child protection' has been replaced with 'safeguarding'. We prefer the earlier term, which implies a more pro-active approach and intervention to protect or stop abuse [14].

12. The jigsaw approach

In Cleveland we saw the medical intervention as creating a window of opportunity, through which light could be shone on a problem that might otherwise remain hidden. For Group B children, especially those who were pre-verbal, this was potentially the only way their plight would be recognised. The medical 'window' by which possible abuse is identified by physical examination, has since given way to a 'jigsaw' approach, in which medical evidence is just one of several pieces gathered from several sources [15]. This development has improved our recognition of the factors associated with sexual abuse, for example domestic violence. However, it is bound to be detrimental for children in cases where the medical evidence is the only piece of the jigsaw available. The Royal College of Paediatrics and Child Health (RCPCH) [7] confirmed this approach: 'The child's story of what happened, together with the child's demeanour and emotional response whilst describing what took place, is the single most important factor in coming to a diagnosis'. This leaves many Group B children without a paediatric route, and few will now come to paediatric attention without having first made an alerting comment. The Ministry of Justice guidance for criminal investigations includes a section on the medical examination, making the comment that 'children who do not allege penetration should not receive unnecessary medical examinations' [16]. It assumes that the child will be Group A, that is, will already have disclosed.

Despite the existence of guidelines for doctors, very few children are now referred to the child protection system as a result of a paediatric examination.

13. Why the disclosure process creates difficulties for investigations

We know that disclosure is a process rather than a single event. This is why it does not fit the requirements of evidential interviewing and the court. In response to Cleveland's children we developed the concept of a 'continuum of disclosure' on which children, particularly those in Group B, are highly dependent on external factors, especially the presence of an adult to advocate on their behalf [17].

Although still a contentious issue in the courtroom, since 1987 the problems of such children including delayed disclosure, active withholding, traumatic amnesia

and not being believed have been well documented in research and practice [18]. A review by London et al. [19] of the evidence for the child sexual abuse accommodation syndrome [20], concluded that children who disclose in an informal setting are often able to give an account in a forensic interview, and that children are likely to disclose after an intervention such as a medical examination. This echoes what we saw in Cleveland: some children disclosed abuse only after being taken into care following the medical diagnosis, and, despite increased internal pressures, managed to tell once in a safe place. Out of a sample of 40 children seen by the psychologist because abuse was suspected or confirmed, nine disclosed shortly after the medical examination, whilst still in hospital ([17] Figure 5.2 p. 124).

It is now better understood that the process of disclosure is a dynamic one of the child balancing the need to tell with the need to contain the secrecy. This creates a pressure within the child which any successful intervention must understand and respect, giving some control over when and to whom the child or young person will be able to speak out. For the most part, and particularly in older children, nondisclosure is not a passive non-disclosing experience, but rather an active withholding of information. This has enormous implications for policy, particularly for investigations.

The Children's Commissioner for England has since confirmed this picture and the barriers to disclosure which result in only one in eight sexually abused children being identified by professionals [21]. The report states that the majority of victims go unidentified because the services that protect them, including the police and social services, are geared towards children self-referring or reporting abuse, although they rarely do so. Longfield concluded that the true scale of child sex abuse in England is likely to be significantly greater than official figures suggest.

Some children will remain unable to say what has happened to them, or will even deny proven abuse, especially when they are very young and the abuse is by a parent or other attachment figure on whom the child depends.

The optimal conditions for disclosure can be summarized as: having someone who will listen, believe and respond appropriately and effectively; having knowledge and language about what abuse is; being able to access help; having a sense of control over the process in terms of anonymity (not being identified until they are ready) and confidentiality (the right to control who knows); being asked directly about any experiences of abuse [22].

14. Group B: the silent majority of victims

We subdivide Group B into children who can be helped to disclose their plight, and can then protected; and those who remain trapped in silence with no prospect of protection. The narratives of children and adults in group B are often fragmented and unprocessed and may be dissociated from conscious awareness. They present with a high index of suspicion of abuse but depend on a third party for recognition and protection. The children may be very young and without the ability to communicate other than through their bodies and their behaviour.

In the post-Cleveland climate of reactive rather than proactive intervention, some Group B children were nevertheless recognised when they presented to child mental health services [23]. Work with children and young people who came to attention because of symptoms of trauma such as disturbed, sometimes sexualised behaviour, dissociation and self-harming, confirmed our belief that even these children could be helped, by addressing their internal barriers so that the child's experience could be reached. Despite the inadequacies of the child protection system, children with protective mothers could often be enabled to disclose, even without

a protective intervention, provided they were both supported [24]. However, there were very few successful police investigations. Even when abuse was recognised by other means, some children remained unable to disclose.

Our 20-year review in two linked papers [25, 26] observed that changes in the child protection system had been directed only at children in Group A. In our opinion, the dilemma of children in Group B who cannot climb the continuum of disclosure remains unacknowledged and unaddressed, and the loss of the medical window adds to the number who remain unheard. The significance for policy and practice of the concept of Groups A and B, the continuum of disclosure and the role of the medical diagnosis was highlighted by Itzin [27].

15. The importance of disclosures made in informal settings

A focus of the Cleveland Inquiry was on scrutinising formal, forensic style interviewing. However, it is often those caring for children following abuse who receive the most information from the child.

In Cleveland, the social workers recognised the importance of this, and detailed information was recorded in social work files. Foster carers in particular were asked to keep detailed diaries and encouraged to make notes of what the children said, often at relaxed times of day or situations of intimate care such as bath and bed time. These were often spontaneous, unprompted accounts or direct re-enactments of abusive experiences, the significance of which may not have been appreciated or understood by the carers, who may have been very puzzled by the child's statements and actions.

Children's self-disclosure of sexual abuse is often fragmented, since they only reconstruct their experiences through this process. Everyday activities in foster families can be threatening to a child as they may trigger memories of the abuse. On the other hand, these activities can also create a shared frame of reference that facilitates a child to disclose. Because foster carers naturally react strongly to these experiences, an important task for social workers is to guide foster families through the disclosing process and enable them reflect on what the disclosure evokes.

16. The need to be asked and the need to be safe

Nelson [28] explores the need for potential victims to be asked about any experience of abuse. The Children's Commissioner uses the phrase 'enabled telling' in recommending ways that professionals can approach this ([16], p. 39). The majority of survivors who do not disclose until adulthood say they simply were not asked – or not in a way that they felt safe with.

Nelson [28] points out that, in the context of backlash propaganda, being proactive by asking about a history of abuse takes courage on the part of professionals. This applies particularly to the crucial intervention that children need. Fear of putting words into a child's mouth, ideas into their head, or contaminating any evidence, results in denying the child the one thing they need – to be asked directly. We saw in Cleveland that once children were asked in general terms what had happened to them, often by the examining paediatrician who found signs of abuse, some would then be able to tell what had happened. This moved the investigation on for such children if the perpetrator could then be identified. However, this often depended on an immediate intervention to create external safety for the child, and time to allow that to have an effect on the child's inner world, so that safety became psychologically as well as physically real.

Taking a proactive stance requires assuring the child that they will remain safe, and ensuring that this happens. One major aspect of the tragedy in Cleveland was that the professionals acted in the belief that the court would give this assurance. We then had to face the outcome that many of the children were returned home, in our belief to possible further abuse in some cases. Nelson quotes a child protection worker in a high profile case in Orkney, Scotland who said the most distressing part of the whole affair was 'watching one small girl cross the tarmac to a huge cheering crowd, to her own parents and massed TV cameras... we had failed her, and I will never be able to get that sight out of my mind" ([28] p. 115). In Cleveland, we remain haunted by an 8-year-old child, who whilst on the return journey to her home, asked her social worker what she should do if the abuse started again.

17. The role of protective parents

One of the enduring myths of Cleveland has been that children were removed from, and then returned to 'innocent families'. In fact, many children were quickly returned from interim care situations, subject to conditions imposed by the court, once the perpetrator was known and the child could be protected. If, as was usually the case, the abuse was thought to be occurring within the family, the role of a protective and believing attachment figure was crucial in the process of return. Following the crisis and the lack of an effective child protection system in the 90's, efforts became more directed at empowering protective parents, mainly mothers, to take action [29]. This was important in itself for healing and strengthening the attachment bonds between the mothers and children, which were often damaged by the dynamics of abuse. We came to realise the importance of the child's attachment system in mediating the effects of abuse, particularly if the abuse was by a close family member.

In the absence of parallel legal intervention with the perpetrator, this approach only worked if the mothers were empowered to separate themselves and the child from the perpetrator. The voices of protective mothers were rarely heard [2].

18. Do children lie and fantasise about abuse?

This commonly held assumption has been shown to be erroneous in many studies. A report by the Australian Law Commission states: 'Indeed, research suggests that children may be actually more truthful than adults. Certainly, the research on children's beliefs about court proceedings implies that children may be more cautious about lying in the witness box than adult witnesses' [30].

Although children can make false allegations, it is much more likely that in order to avoid breaking secrecy, punishment, and embarrassment they will deny abuse or retract previous disclosures. This is consistent with our model of the continuum along which children move between disclosure, denial and secrecy, according to the situation.

19. The legal system: has anything improved for child witnesses?

The Achieving Best Evidence (ABE) [16] protocol used in the UK is based on good research about how best to help children tell. It allows for more specialist interviewing with children deemed to be disturbed or otherwise vulnerable.

However because the guidance allows only a reduced number of interviews it is difficult for interviewers to establish rapport with the child and take account of the level of trauma in creating memory problems and confusion. In our view this is unhelpful even for children in Group A who are ready to talk about what has happened, making it far less likely that they will give a full account. To avoid influencing the evidence, interviewers became wary of giving kindly reassurance, or any indication that they believe the child.

The use of carefully structured, supportive interviews can facilitate children who are reluctant to tell and indeed, some children will only tell if they are asked. Nelson ([28], p. 40) comments that the ABE protocol, which requires the child to give a more or less free narrative account, can be seen as a classic example of defensive responses and reactions to the backlash, and does not fit well with children's own feelings, difficulties and reactions.

Although we now know that children can accurately recall and give accounts of abuse, are no more suggestible than adults, and can provide evidence that ought to be acceptable, we also know that they are unlikely to give such information spontaneously. Testifying in court will also be very stressful and likely to create further trauma. Studies have shown [31] that to help them give a fuller account children benefit from support to reduce stress: this will not undermine or reduce the value of the testimony but in fact will enhance the child's ability to recall and give an account of traumatic memories.

20. Support for child witnesses

To provide support to children and non-abusing parents in Cleveland, a specialist therapeutic project was set up and subsequently continued by Barnardo's [32], also piloting pre-trial therapy for children who were to give evidence in court. Not all children who face giving evidence at a criminal trial are given that benefit. In 2017 The Children's Commissioner concluded that 'Overall the lack of consistency or clarity about entitlement and provision of pre-trial therapy appeared to create an additional silencing mechanism, compounding children and young people's sense of feeling repressed from talking about their abuse and delaying their recovery process' ([21] p. 136).

Special measures have been introduced for all children under the age of 16 to have their evidence and cross-examination pre-recorded, although they still face long delays between investigation and trial. Multiple problems still face children and even when cases do reach court, there are long term devastating effects of the whole process. Longfield [21] commented that the vast majority of cases do not progress to this final stage of the justice system.

We conclude that despite the greatly increased knowledge about how to help and support child victims, neither the investigative framework or the courts have become significantly more child-friendly.

21. Developments in understanding trauma and dissociation

Many victims of child sexual abuse become dissociated from the memory of the experience. This is a survival strategy, in which the brain helps the victim bear the ongoing pain and fear via a process of fragmentation which separates mind, body and memory and compartmentalises experiences. This psychological process is the only way that many victims can cope with ongoing abuse, but it means that they

cannot then readily bring the experience back into mind, even in a safe and supportive context. The victim is in effect prevented from accessing protection, and becoming a survivor. We observed the process of dissociation in some of the children in Cleveland but at that time we did not really understand it or know how to help.

While accounts in the clinical literature now shed light on this process in children, [33] the knowledge gained has not been easy for clinicians to apply. The work involved in helping such children is often attacked and misrepresented, especially in court despite a wealth of clinical and research evidence. Dissociation, with its characteristic amnesia, can be a major factor in keeping some children and adults in Group B.

Some perpetrators of organised abuse deliberately induce dissociative states in order to restructure the victim's personality, installing parts who will comply with the perpetrator's commands and remain amnesic for what has occurred [34]. The many mechanisms used by abusers to frighten, compromise and silence their child victims can be almost insurmountable obstacles to disclosing the experiences even in adulthood. Investigations tend to uncover only a part of what has happened. For example, abuse that is part of an organised network might be missed when a single victim comes forward.

In retrospect, some of the children in Cleveland who had gross physical symptoms of sexual abuse but made no complaint may have been dissociated. Many dissociative adults also fall into Group B. This is especially the case for adults suffering on-going abuse. Both adults and children in Group B lack a coherent narrative of what has happened and, if they get as far as an investigation, struggle to assist. There are cases of the victim then being charged with perverting the course of justice. Alternatively, the adult self can be well aware of the abuse but unwilling to report out of fear of the consequences or because of bad experiences of past failed investigations. These factors may be compounded by so-called attachment to the perpetrator, more accurately understood as a trauma bond. The stakes are high for anyone in this position. A debate is needed about how we view capacity in dissociative victims, that is, whether they have lost the conscious ability to take responsibility for behaviour, actions and decisions. This can be difficult to judge where dissociation causes awareness and mental states to fluctuate. We need to debate our role as advocates, and the mismatch between the victim's needs and the requirements of the legal system.

22. Implications of the nature of organised abuse

At the time of Cleveland the organized nature of much child sexual abuse was not fully understood. The networks of perpetrators who deliberately enter professions such as child care, children's homes, teaching, and other youth work, or who groom those in such positions to procure children for them, have operated largely undetected or within a culture of impunity. In Cleveland we had glimpses of networks that could have been pursued, as did practitioners in Leeds [35]; but the investigative focus was mainly on abuse within families. A look back at NSPCC guidance from the 1990's on investigating organised abuse [36] shows how practice has receded, especially as joint investigations are no longer happening.

The difficulties of police officers investigating this dimension of abuse and the suppression of a piece of research by a UK police team are outlined by Mallard [37]. More than any other group, victims of this form of abuse suffer from 'iatrogenic doubting' [38] which reinforces what their abusers have told them, that they will never be believed.

Abusers formally entrusted with the care and protection of children are especially difficult to recognise. There are a number of examples of convictions of professionals who, over a long period, abused children entrusted to their care: care home workers, such as Frank Beck in Leicestershire, who also gave other adults access to abuse the children; and doctors such as the paediatric oncologist Dr. Myles Bradbury, convicted of sexual offences against boys aged 8 to 17 at Cambridge Crown Court in 2014.

23. The Community response

Members of the community in Cleveland have described how adults in the community can have a role in helping children trapped in silence and supporting professionals who advocate on their behalf [10]. We believe their account of a spontaneous grassroots effort to deal with the uncomfortable awakening to the reality of abuse in its midst is the first of its kind. The members of this group were deeply affected by what they learned.

While lip service has been paid to the role of the community, it has been given little systematic attention. This is reiterated by Nelson and Baldwin [39] who draw on a successful project in Scotland to show how to create' active bystanders'. Community responses too have been affected by the backlash with its scapegoating of professionals and promoting of unscientific theories of 'false memory'. Nelson [28] analyses the legacy of the backlash in distorting the discourse, marginalising and obscuring the significance of and obscuring the facts especially in high profile cases.

Children and adolescents more often choose individuals within the community, such as protective parents and friends of their own age, to disclose to than professionals. Collings et al. [40] highlight the role played by both children and significant others in the process of child sexual abuse recognition and reporting. Detection by another was found to be more likely as the trigger for disclosure than purposeful disclosure by the child, which was noted in less than 30% of their sample of young people. Adults who work with children, including many in voluntary organisations, are in a position to ask children directly and to become a valuable part of the child protection system, but require support and understanding of what to expect and how to approach the difficulties. The dilemmas about confidentiality and the slow process of gaining a child's trust are now better understood. This knowledge, together with advice from both adult and child survivors, could be harnessed to build up resources in every community.

24. What happened to Cleveland's children?

The 121 children will now be between 33 and 48 years old. Their records were all destroyed by Social Services after the Inquiry, and it is impossible to know about any who came to the further attention of Social services or other agencies following their return home. We have some information about those children who remained in care and were followed up in the Child and Adolescent Mental Health Service (CAMHS) [41]. One, a group B child age 4 with medical findings of abuse, was protected as her older brothers were able to disclose. Once in care she was able to make a successful new attachment to her adoptive parents. Another girl removed from home at 4 years was successfully adopted, but continued to be troubled. Eventually at age 15, when given the

information about her early childhood along with therapeutic help, she made a good recovery. Another was returned home, but later asked to be taken back into care, and was fostered. Her own little daughter was later referred for help and was placed on the child protection register as the child was still at risk within the family in which her mother had herself been abused as a Cleveland child and returned home.

Over the years we have often been asked whether any of the other children can be traced or are likely to come forward to add their voices to the debate. The fact is that we simply do not know what has happened to them or if any have come forward in other settings. IICSA is hearing evidence from many other adult survivors who have previously been silent, disbelieved, or prevented for many reasons from accessing the justice system. So perhaps it is not surprising that the children who were so effectively silenced in Cleveland in 1987 have never spoken out publicly. If they were successfully protected – and despite the difficulties we have described, some were – they may well be getting on with their lives. If they were returned to their families only to experience further abuse, they are never likely to have trusted further attempts at intervention, and to have become casualties of the long-term effects on their mental and physical health. It is possible that some may even have taken the path of becoming perpetrators themselves. So a more apposite question is, why would they ever come forward? And what would they experience if they did?

25. Asking the right questions: what should we do now?

We believe it is necessary to revisit areas of controversy, especially what the public expect professionals to do in respect of children whose bodies carry the hallmarks of abuse but who cannot disclose.

A renewed public and professional dialogue would need to go back to some fundamental unanswered questions and dilemmas. For Group B children, the need for protection might still be paramount to ensure a safe situation to be able to disclose. It's important to mobilise protective adults within the family and give them support and time to absorb what is happening.

It is clear that children who are trapped in silence need to be given time, listened to and also helped pro-actively. In 2015 the Children's Commissioner described precisely the same issues we were grappling with in Cleveland: 'There is a high level of commitment to tackling this issue among professionals working with children. However, statutory services are largely disclosure-led, with the burden of responsibility placed on the victim' ([21] p. 7). 'Some professionals are hesitant to seek information from a child for fear that such actions will be construed as 'leading the victim'. Victims are likely to exhibit some sign or indicator suggestive of sexual abuse, though in some instances this will not always be obvious or conclusive. Proactive enquiry is therefore necessary to substantiate concerns' (op.cit, Conclusions 4–5 p.9).

26. Re-opening the medical window

In 2018 paediatrician Chris Hobbs commented: 'Despite ongoing disputes and insufficient research, the physical signs of Cleveland stand largely undiminished in the eyes of the U.K. medical community. When present, they continue to provide evidence valued by professional and legal authorities charged with the protection of children' [42].

How would we now act in regard to the child if a medical diagnosis was made? If the medical window could be re-opened how would inter-agency planning aim to manage the disclosure process on behalf of the children?

Attaching greater relative forensic weight to the medical component of the jigsaw would assist Group B children, because 'While behavioural symptoms and disclosure are important in medical treatment and child protective services investigation, positive physical findings are associated with a finding of guilt (in the criminal court)' [43] p. 388.

27. A different approach to investigation

Successful intervention with Group B victims, who include silenced adults as well as children, requires someone who will advocate on their behalf, with the primary goal of providing safety as a route to disclosure. The child protection system should be re-orientated to accept the responsibility for asking children and young people about abuse, and for actively reaching out to help and support those who cannot easily tell. The agencies who are vital at the later stages of a protective intervention, i.e. the legal system and the courts, need to understand and accept this reality.

The present legal system is inherently unsuitable for these often very emotive and difficult cases. Because the courts have relatively little experience of Group B children, they would need to traverse a considerable learning curve. How should the present investigative framework change to accommodate these realities? What kind of legal system could really acknowledge and accommodate these complexities? In the end the court is the ultimate arbiter of child protection, and unless the legal system supports this process of change, and accepts the hard-won knowledge and expertise of professionals, we will still fall at the last hurdle: making a case in court.

28. Conclusion

We are left with more questions than answers and there is a need to progress the debate. Yet the insights from research and from survivors will not be heeded unless society as a whole is willing to believe and empower them. Since the problem is presenting on an ever increasing scale to the point of overload, it must be owned by everyone to avoid yet another cycle of discovery followed by suppression. The core way forward for a problem that is endemic in society can only be a change in social and cultural power structures and attitudes towards women and children, as discussed by Campbell [2].

A key question is how watershed moments in the stages of recognition of child abuse can be held in public and professional awareness long enough for real cultural and organisational change to replace the failures of the past. The emphasis has always been on containment via legal and procedural solutions, and blaming of individuals which is of short term value only and of little help to the survivors. Over time, the detailed history gets lost, sometimes including the documentary evidence. Failures to heed warnings, to learn from past cases and to listen to the victims are repeated. What is needed is a concerted and well-funded effort at public and professional education, training and the development of trauma-aware and trauma-specific services. That all of this is possible is shown by the work undertaken alongside the Royal Commission into Institutional Responses to Child Sexual Abuse in Australia [44]. Who will find the courage and provide the political will that Nelson [28] rightly argues is necessary for this kind of action in the UK?

Acknowledgements

This chapter is an edited summary of the Introduction: 'Why Cleveland still matters; connections with a new era' and the Conclusion: 'Thirty years later: how far have we progressed', originally published in Sue Richardson and Heather Bacon (eds.), Child Sexual Abuse: Whose Problem? Reflections from Cleveland (Revised Edition) 2018; (p. 1-43 & p. 219-236). Re-published with permission of Policy Press (an imprint of Bristol University Press, UK).

Author details

Heather Bacon[1*] and Susan Richardson[2]

1 Consultant Clinical Psychologists NHS (retired), Huddersfield, United Kingdom

2 Independent Practitioner, Attachment-based Therapist, Middlesbrough, United Kingdom

*Address all correspondence to: heatherbacon@icloud.com

References

[1] Butler-Sloss, Rt. Hon. Lord E. Report of the Inquiry into Child Abuse in Cleveland 1987. London: HMSO; 1988.

[2] Campbell, B. '*Secrets and Silence: Child Sex Abuse from Cleveland to Savile and Beyond'.* Bristol: Policy Press; In Press 2022.

[3] Hobbs, C.J. and Wynne, J. 'Buggery in childhood – a common syndrome of child abuse'. *The Lancet.* 1986; October 4: 792-796. DOI: 10.1016/s0140-6736(86)90310-7 PMID: 2429126

[4] Wyatt, G. and Higgs, M. The medical diagnosis of child sexual abuse: the paediatrician's dilemma. In: S. Richardson & H. Bacon, (eds.) *Child Sexual Abuse: Whose Problem? Reflections from Cleveland.* Bristol: Policy Press; 2018 p.83-103.

[5] Wynne, J.M. 'The Cleveland Report. *Child Abuse Review*. 1988; 2, (3):13-15.

[6] Adams, J., Kellogg, N., Farst, K., Harper, N., Palusci, V., Frasier, L., Levitt, C., Shapiro, R., Moles, R., and Starling, S. Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused'. 2016; *Journal of Paediatric and Adolescent Gynecology,* 29 (2): 81-87.https://**doi**.org/**10.1016/j.jpag.2015.01.007**

[7] RCPCH. *The Physical Signs of Child Sexual Abuse: An updated evidence-based review and guidance for best practice*, 2nd edition, London: Royal College of Paediatrics and Child Health; 2015.

[8] R. Wyre, personal communication, quoted in: Frothingham, T. E., Barnett, R. A. M., Hobbs, C. J. and Wynne, J. M. 'Child sexual abuse in Leeds before and after Cleveland'. *Child Abuse Review*. 1993; 2 (1): 23-34. **https://doi.org/10.1002/car.2380020106**

[9] Richardson, S. & Bacon, H. Piecing the fragments together, in S. Richardson and H. Bacon (eds.), *Creative Responses to Child Sexual Abuse: Challenges and Dilemmas*. London: Jessica Kingsley; 2001 p. 29-43.

[10] Cashman, H. and Lamballe Armstrong, A. The Unwanted Message: Child Protection Through Community Awareness. in Richardson, S. & Bacon, H. (eds.) *Child Sexual Abuse: Whose Problem? Reflections from Cleveland.* Bristol: Policy Press; 2018 p.181-199.

[11] Rotherham Council 20113. https://www.rotherham.gov.uk/local-information-statistics/independent-inquiry-child-sexual-exploitation-rotherham-1997- last accessed 19.01.21.

[12] Independent Inquiry into Child Sexual Abuse (IICSA) www.iicsa.org.uk last accessed 19.01.21.

[13] Parton N, Thorpe D, and Wattam C. (1997) *Child Protection, Risk and the Moral Order.* Basingstoke: Macmillan Press; 1997.

[14] Richardson, S. & Bacon, H. (eds.) *Child Sexual Abuse: Whose Problem? Reflections from Cleveland.* Bristol: Policy Press; 2018.

[15] Hobbs, CJ., Hanks, H, and Wynne, J. *Child Abuse and Neglect: A Clinicians Handbook,* London, New York: Churchill Livingstone; 1999.

[16] Ministry of Justice (MoJ) *Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures.* London: Home Office; 2011

[17] Richardson, S. The Continuum of disclosure, in Richardson, S. & Bacon, H. (eds.) *Child Sexual Abuse: Whose Problem? Reflections from Cleveland.* Bristol: Policy Press; 2018. Fig. 5.1 p.123

[18] Allnock, D. & Miller, P. *No-one noticed, no-one heard: A study of disclosures of child abuse*. NSPCC; 2013. https://www.nspcc.org.uk/globalassets/documents/research-reports/no-one-noticed-no-one-heard-report.pdf Last accessed 19.01.21

[19] London, K, Bruck, M, Ceci, S, Shuman, D. 'Disclosure of child sexual abuse, what does the research tell us about the ways that children tell?' *American Psychological Association*. 2005;11(1):194-226. https://doi.apa.org/doiLanding?doi=10.1037%2F1076-8971.11.1.194

[20] Summit, R.C. 'The Child Sexual Abuse Accommodation Syndrome', *Child Abuse and Neglect*. 1983; 7:177-93. doi: 10.1016/0145-2134(**83**)90070-4.

[21] Longfield, A. *Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action.* 2015. https://www.childrenscommissioner.gov.uk/report/protecting-children-from-harm/ last accessed 19.01.21.

[22] Ungar, M., Tutty, L., McConnell, S., Barerm, K. and Fairholm, J. 'What Canadian youth tell us about disclosing abuse',.*Child Abuse and Neglect,* 2009; 33:699-708. doi: 10.1016/**j**. chiabu.2009.05.002. ...

[23] Bacon, H. 'Telling the baby crocodile's story' in S. Richardson and H. Bacon (eds.) *Creative Responses to Child Sexual abuse: Challenges and Dilemmas.* London: Jessica Kingsley; 2001 p. 60-84.

[24] Ambridge, M. 'Monsters and angels: how can child victims achieve resolution', in Richardson, S. & Bacon, H. (eds.) *Creative Responses to Child Sexual abuse: Challenges and Dilemmas.* London: Jessica Kingsley; 2001 p.167-182.

[25] Bacon, H. 'Cleveland 20 years on: What have we learned about intervening in child sexual abuse?' *Child Abuse Review.* 2008; (17):215-229. https://onlinelibrary.wiley.com/doi/pdf/10.1002/car.1034

[26] Richardson, S. 'Cleveland 20 years on: Themes of Disruption and Repair in the Trauma Narratives of Children, Adults and Society'. *Child Abuse Review*. 2008; 17: 230-241. **https://doi.org/10.1002/car.1035**

[27] Itzin, C. (ed.) *Home Truths About Child Sexual Abuse; influencing policy and practice, a reader.* London: Brunner–Routledge; 2000.

[28] Nelson, S. *Tackling Child Sexual Abuse, Radical approaches to Prevention, Protection and Support*. Bristol: Policy Press; 2016.

[29] Forbes, F, Duffy, J, and Mok, J. 'Early intervention for non-abusing parents of victims of child sexual abuse'. *British J. Psychiatry* 2003; 183: 66-72. doi:10.1192/bjp.183.1.66

[30] Goodman, GS and Bottoms, BL. (eds.) *Child Victims, Child Witnesses: Understanding and Improving Testimony.* London: Guilford Press. 1993 p. 14.5-14.24.

[31] Australian Law Reform Commission '*Seen and heard: priority for children in the legal process*' *(ALRC Report 84) Section 14, Children's Evidence: Children as Reliable Witnesses*. 1997. https://www.alrc.gov.au/publications/14-childrens-evidence/children-reliable-witnesses. Last accessed 19. 01.21.

[32] Palmer, T. 'Pre-trial therapy for children who have been sexually abused,' in S. Richardson and H. Bacon (eds.) *Creative Responses to Child Sexual abuse: Challenges and Dilemmas,* London: Jessica Kingsley; 2001 p.152-165.

[33] Waters, F. *Healing the Fractured Child: Diagnosis & Treatment of Youth with Dissociation.* Springer: LLC; 2016.

[34] Miller, A. *Healing the Unimaginable: Treating Ritual Abuse and Mind Control.* London: Karnac; 2012.

[35] Wild, N. J. and Wynne, J.M. 'Child Sex Rings', *British Medical Journal:* 1986; 293: 183-5. doi: 10.1136/bmj.293.6540.183

[36] Gallagher, Bernard *Grappling with smoke: investigating and managing organised child sexual abuse: a good practice guide,* Policy Practice Research Series, London: NSPCC; 1998.

[37] Mallard, C. Ritual abuse – 'A Personal Account and the Unpublished Police Guidelines', in Noblitt, J. R. and Noblitt, P. S. (eds.) *Ritual abuse in the 21st century: Psychological, forensic, social and political considerations,* Brandon OR: Robert D. Reed Publishers; 2008 p. 327-336.

[38] Floris, J. and McPherson, S. 'Fighting the Whole System: Dissociative Identity Disorder, Labelling Theory, and Iatrogenic Doubting', *Journal of Trauma and Dissociation.* 2015; 16, (4): 476-493. DOI: 10.1080/15299732.2014.990075

[39] Nelson and Baldwin 'Community Prevention of C.S.A: A model for practice', In Nelson, S. *Tackling Child Sexual Abuse, Radical approaches to Prevention, Protection and Support.* Bristol: Policy Press; 2016.

[40] Collings, S., Griffiths, S. and Kumalo, M. 'Patterns of disclosure in child sexual abuse'. *South African Journal of Psychology.* 2005; 35(2): 270-285. https://doi.org/10.1177/008124630503500207

[41] Bacon, H. 'A zebra among horses: Sexually abused children in the care system' in S. Richardson and H. Bacon (eds.) *Creative Responses to Child Sexual abuse: Challenges and Dilemmas.* London: Jessica Kingsley; 2001 p.135-136.

[42] Chris Hobbs Pers. comm. 2018.

[43] Palusci VJ, Cox EO, Cyrus TA, Heartwell SW, Vandervort FE, Pott, E.S. 'Medical Assessment and Legal Outcome in Child Sexual Abuse', *Archives Pediatric Adolescent Medicine*. 199ua;153:388-392. https://calio.org/wp-content/uploads/2014/05/Urgent_medical_assessment_after_child_sexual_abuse.pdf

[44] Royal Commission into Institutional Responses to Child Sexual Abuse in Australia 2018. https://www.childabuseroyalcommission.gov.au/final-report last accessed 19.1.21.

Chapter 10

Counseling Sexually Abused Children: Lessons from Ghana and Zambia

Nyuiemedi Agordzo Edoh-Torgah and Marien Matafwala

Abstract

The scourge of child sexual abuse has been on the increase world over, Ghana and Zambia inclusive with millions of children being sexually abused every year at a global prevalence rate of 34.4%. Using the qualitative narrative approach, the interview guide was used to gather data purposively from 112 participants made up of 40 Domestic Violence and Victims Support Unit officers, 32 parents and 40 victims aged 8–17 years who reported their abuse at 15 police stations across Central Region and Lusaka Province of Ghana and Zambia respectively. Data were thematically analyzed. The study found among others that children in both countries received safety nets and pieces of advice on legal and medical procedures. It also found that some victims expressed happiness at their abuses being reported and heard. However, lack of professional counseling training and power imbalances inhibit the police officers' efforts. The study concludes that though officers use some skills and provide a kind of trauma counseling more is needed in the areas of individual and group therapy for comprehensive and effective counseling. Skills such as encouragement, assertiveness, and re-assurance can lead to disclosure, prevent future sexual abuse, reduce anxiety and fear, promote healing and empowerment. When children receive adequate counseling immediately after abuse they do immediate damage repair both of their psychological and social "self". The study recommends training in counseling for the officers in both countries for effective counseling of abused individuals. Additionally, officers should be linked with professional counsellors at universities to refer abuse cases for treatment.

Keywords: child sexual abuse, counseling, qualitative narrative approach, Ghana, Zambia

1. Introduction

The concept of counseling explains how individuals who feel less able to resolve their own problems resort to help in order to solve their challenges [1]. Associated with help seeking is the client's belief that he will receive assistance that will help him understand things that bother him such as complex and confusing emotions experienced during an event (e.g. abuse), receive alternatives, make informed decisions and move on generally in positive meaningful ways. Thus, the chance of successful counseling outcome may be higher, where needed support is provided and children's ability to overcome sexual abuse has been found to be dependent on timely psychological interventions [2].

This study adopts World Health Organisation's (WHO) definition of child sexual abuse as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. The scourge of child sexual abuse (CSA) has been on the increase world over, Ghana and Zambia inclusive, with millions of children being sexually abused every year. In 2004 WHO reported that the global prevalence rate of child sexual abuse [3] was an estimated 150 million girls and 73 million boys under the age of 18 years who were victims of rape or other forms of sexual violence; that between 1 and 21 percent of women were victims of sexual abuse before the age of 15. By 2010, CSA was estimated at 34.4% of global violence cases [2].

Some of the earliest studies on child sexual abuse in Africa [4] reported on cases of child sexual abuse at a Cape Town Hospital with victims ranged from 2 to 12 years with the majority being females. In Malawi, [5] described 20 cases of child sexual abuse, which were presented at the Department of Obstetrics and Gynaecology, University of Malawi, between 1995 and 1997. Half of the victims were less than ten years old [5]. estimated that these cases were merely the tip of the iceberg, and were reported due to the serious injury caused in the rape of very young children. Research on the occurrence of child sexual abuse by [6] reports that one in four girls and one in ten boys is a victim of CSA. In Zimbabwe, CSA studies show that, among unmarried sexually active youths, 52.2% had experienced forced sexual intercourse at least once and 37.4% of the first sexual intercourse was forced on them [7].

Child sexual abuse is recognised as a traumatic experience that can have a number of adverse effects on victims [8] citing [9, 10] and that these children generally reveal significant problems in diverse areas of functioning including but not limited to affect, behaviour, cognition and interpersonal relationships [11, 12].

Research has established a correlation between counseling and other forms of psychosocial support in promoting well-being of people. Although psychosocial supports have been used to investigate individuals' experiences in adverse circumstances, there is a gap in the literature regarding the use of counseling to overcome CSA experiences. While we are inspired by the possibilities offered by the vast literature on CSA, research suggests that psychosocial supports such as counseling services for victims of CSA are unsatisfactory [13, 14] in a number of government institutions globally. A need, therefore, exists for effective treatment through counseling children who have experienced CSA [8]. The purpose of this study, therefore, is to explore how counseling as one if not the most crucial psychosocial support is used to assist victims of CSA in Victims Support Units (VSU) of the police services of Ghana and Zambia.

2. Theory

We connect our study to the works of [15] on the concept of trauma recovery of individuals to provide the theoretical basis for this work [15] developed a three stage model that has been used to treat trauma survivors during rehabilitation process. The model provides a useful set of goals for treatment providers regardless of theoretical orientation. Herman's model gives an in-depth description of the healing process of people who struggle with a number of problems relating to abusive or past traumatic experiences. The three stages of this process are (1) the establishment of safety, (2) remembrance and mourning, and (3) reconnection. This process is not typically linear; there are often advances, regressions, and impasses. It has, however, been suggested that many people do not complete all three stages during their recovery [16].

Establishing safety is the first step in the treatment of trauma because no intervention can succeed without the survivor feeling safe. Safety includes protection from violence and maltreatment by other people, basic needs being met such as medical care, financial security, safe living environments, adequate food and sleep, legal protection, and a supportive social network. Research established that torture and other forms of trauma can cloud an individual's sense of security and safety especially when trauma is experienced in childhood [16, 17]. Re-establishing safety is important in the development of relationships that can be beneficial in the process of recovery for victims of child sexual abuse.

In the remembrance and mourning stage [15] the survivor constructs a narrative of his or her experiences in a therapeutic relationship. This inspires the need for CSA victims to receive counseling on report of abuse. The reconstructive disclosure of traumatic experience has been examined widely in theory and research. Cognitive-behavioural therapy that focuses on exposure to memories and emotions has been found to be a powerful method of treating PTSD with survivors of sexual assault [18].

In the reconnection stage, the focus is on building a future and empowerment. Once the past has been assimilated, the victim can focus on developing a more resilient and complete identity. The trauma victim strives to make a meaningful life through trust and hope that were developed during the first two stages of the recovery. The victim, now a survivor, may have a desire to help others who have been victimised similarly and to prevent future victimisation by raising public awareness through educational, legal, and political activism.

Trauma counseling is thus, geared towards assisting persons recover from overwhelming stress to functioning productively. This is where the traumatic individuals move from the ability to disclose and be believed to be provided help that empowers and strengthens. Drawing from these theories, the following questions guided the study:

1. What is the nature of the counseling services provided to children who report their sexual abuse experiences?

2. What are the challenges associated with counseling services offered to victims?

3. Methods

This research was qualitative in approach. Given the sensitivity of the topic, the denial of perpetrators, silence that mostly surrounds the knowledge of the canker, and the stigma often attached to the victims, qualitative methods were deemed appropriate. This study employed the qualitative Narrative Approach (NA) [19] to understand the nature, benefits and challenges of counseling services provided to victims of Child Sexual Abuse. Critical to the NA is active listening and its ability to externalise the problem beyond the person(s) and the world so as to liberate them from the control of the problem and develop power to address them. Thus, through the narrative discourse, individuals can gain the power to address their own trauma by positioning a 'named problem' (e.g. penetration, fondling). The narrative approach that employs disclosure with strong affinity with attending skills such as listening, questioning and probing, resonates well with Herman's stages of recovery from traumatic experiences.

3.1 Setting

The study was set in the Central Region of Ghana and the Lusaka province of Zambia. Ghana police service in the Central Region has seven divisions,

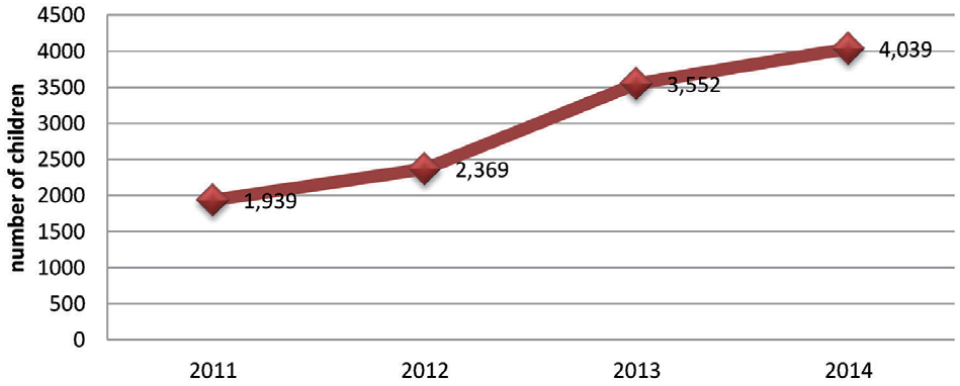


Table 1.
Reported cases of child sexual abuse in Zambia between 2011 and 2014.

thirty-two districts and ninety-nine police stations/posts. The Region also has Police Command and Staff College for Senior Officers at Winneba [20, 21]. The Regional Headquarters has 10 DOVVSU units/desks under its command [22]. Available statistics from DOVVSU suggest a downward trend in cases of child sexual abuse since 2002 (from 820 in 2002 to 670 by the end of 2005) though there is doubt about the reliability of these data [23]. The figures quoted by [23] however, were only on rape. A year earlier, [24, 25] reported that the evidence of sexual exploitation in Ghana is significant and that DOVVSU records indicate that every year quite a number of children and adolescents go through series of sexual abuse. They indicated that reported cases of defilement and rape of children and adolescents were: 1001–2002; 905–2003; 930–2004; 937–2005; 1772–2006. In addition to statistical records of reported cases of child sexual abuse, the Central Region was of interest due to recent public outcry of the rise in teenage pregnancy and social media circulations of sexual abuse against school girls (kitchen stool episode).

In the case of Zambia, according to [24], it is alleged that, majority of children who are sexually abused are females. Between 2011 and 2014, Zambia Police Victim Support Unit annual reports show a steady increase in cases of CSA from 1,939 cases in 2011 to 4,039 cases in 2014 (see **Table 1** above: Zambia Police 2011 to 2014 Annual Reports).

3.2 Data collection procedures

Purposive and criterion-based sampling strategies were employed to contribute to the overall understanding of the topic [26]. In all, 112 participants were recruited from 15 police stations across the Central Region of Ghana and Lusaka Province in Zambia. The criteria for selection were that participants were children, aged between 8 to 18 years, had a history of sexual abuse, reported their abuse to the VSUs of the police and were predominantly English-speaking. In Ghana, the principal researcher and one research assistant collected data while the principal researcher and two assistants gathered data in Zambia. The cases were selected purposively from the police dockets between 2011 and 2016 and victims and their parents located per the address in the dockets. Many victims could not be traced as they have either left their addresses given at the time of the report of abuse or the given addresses could not be traced.

In Ghana, interviews were held with a total of 55 participants made up of 20 girls, 20 officers from seven DOVVSU desks as well as 15 parents. In Zambia, a total number of 57 participants were recruited into the study. This includes 20 VSU officers from 8 provinces, 20 victims and 17 parents of victims.

In both countries, we started with engagement of police officers in charge of abuse cases then hooked in children identified and parents. There were initial challenges of recruitment as some identified parents were not willing to participate nor allowed their children to participate. With a lot of sensitization (one-on-one explanations on the challenges of CSA and the benefits of therapeutic methods) on the need to speak about the issue, some parents got involved and allowed their children to participate. Of the 15 parents from Ghana, 14 were females and only one male while parents from Zambia were all females. In all, parents from both countries comprise 25 mothers, one father, and six caregivers. From both Ghana and Zambia, there were no records of counseling services provided to victims though victims records were available.

The interview activities were conducted mostly under trees or nearby empty classrooms around victims' homes and schools. When a victim was identified, the researcher spent time to explain the rationale, and ethical issues of the study to them. In both countries, participants were informed of the purpose of the research and discussed the meaning of 'sexual abuse' to include fondling, touching, forced sex, defilement and sex without consent. Interview questions covered the: a) nature of the counseling services provided and received, b) operational challenges in receiving and providing counseling services, and c) views on benefits of counseling to victims. In all, each interview with victims and parents lasted approximately 50 minutes while that of VSU officers lasted for about 1 hour.

The data collection process took a total of four and six weeks to complete in Ghana and Zambia respectively. Responses of the interviews were manually recorded by the principal investigators. After data were manually written, they were typed and printed out. Data were then cleaned through proof reading and corrections. Manual coding was done to identify confirming and disconfirming themes within and across narratives. The data were coded with acronyms to promote confidentiality and anonymity. Data were thus coded GPO (Ghana) and ZPO (Zambia) for VSU officers and followed by the assigned number of the participant.

Ethical considerations and trustworthiness of the data and research process were achieved through triangulation of data with all three sets of categories of participants. Participants, especially victims and parents, had the opportunity to corroborate or otherwise the statements provided at the VSU offices. By these, data were cleaned and ready for thematic analysis.

4. Results and discussions

The results of the study were structured into five main sections: background characteristics, nature of counseling, approaches to counseling, challenges, benefits, and the way forward.

4.1 Background analysis of participants and perpetrator characteristics

4.1.1 Profile of reported cases

The summary of sexual abuse cases made in the Ghana and Zambia (selected regions) police dockets and files recorded from 2011 to 2016 were 223 and 345 cases respectively. Of this total number of cases, 105 were initially identified regarding their age at the time of abuse, perpetrator characteristics, and their English-speaking ability. However, only 40 were found and included in this research. Of the 40 cases analysed, 36 (90%) involved victims less than 16 years of age. All victims were females. The mean age of victims was 12.1 years. The youngest victim was 9 year of age and the oldest was 17 years. Seven had experienced sexual abuse more than once and five had

re-experienced sexual abuse after their initial abuse reported to the police. Twenty-two (55%) of the victims were school pupils at the time of the abuse. Of this 22, 18 victims became school drop outs as a result of sexual abuse related issues. Of the school drop outs, twelve sexual abuse incidents resulted in pregnancy in both countries.

4.1.2 Perpetrator characteristics

Most perpetrators were adults. In 36 (90.0%) cases, the perpetrators were less than 30 years of age. Most of the child sexual abuse cases were intra-familial. Of the 40 cases studied, eight victims were raped and or defiled by their fathers, twelve by uncles, six by cousins, four by brothers, four boyfriends, and six by unknown persons. This finding confirms other studies that most rape and defilement incidents are perpetrated by people known to victims and who are usually male family members [2].

4.1.3 Characteristics of reports and reporters

Narratives revealed two types of sexual abuse reports: direct and indirect. Direct reported cases are cases where victims and or their parents lodged complaint following an abuse and this could be following the abuse immediately or later. The indirect reported cases were cases which were not originally reported due to the sexual abuse. Rather, parents/caregivers often accompany victims to lodge complaints of neglect and or denial of pregnancy where interrogations revealed that the girls were impregnated through sexual abuse. About 60% of the cases were indirect reported cases while about 40% account for direct sexual abuse reports. This finding confirms [27] affirmation that, children rarely disclose sexual abuse immediately after the event. Out of the 40 victim participants, 27 (67.5%) pregnancies cases were recorded. Fifteen (37.5%) of the victims had been defiled more than once. Pregnancies were found mostly among 14 year olds and above who were defiled by intra-familial offenders.

4.1.4 Level of training of VSU officers in counseling

The level of education and or professional training of officers is presented in **Table 2** below.

Table 2 above indicates that of the 20 VSU officers from Ghana, 3 hold 2nd degree, 6 had 1st degree, 6 hold diploma and 5 hold certificates. Of these, was also reading law at the time of this study. From Zambia, VSU officer holds 1st degree; five hold diploma and 15 have certificates. Additionally, 20 VSU officers from both countries received certificates from various workshops attended broadly on gender and child abuse issues for capacity building.

	Type of academic qualification				
Country	**2nd Degree**	**1st Degree**	**Diploma**	**Certificates**	**Sub-total**
Zambia	—	1	5	15	20
Ghana	3	6	6	5	20
Total	**3**	**7**	**11**	**20**	**40**

Source: Authors Construct, 2018.

Table 2.
Educational and professional qualification of VSU officers.

Data revealed that in both Ghana and Zambia, VSU officers were not adequately trained in counseling especially in the area of CSA. It must be mentioned, however that, some of the officers who indicated having a certificate did not necessarily undergo formal training in counseling, but were rather referring to certificate of attendance obtained from workshops.

> *For me I think though I don't have any qualification in counseling the capacity workshops we attend from time to time have been helping me. You know, last year I attended a two-week workshop on sexual abuse and reproductive health issues organized by UNICEF at the Kofi Annan Peace Keeping Center. I think this made me better understand sex and its related issues of abuse.* **GPO1**

4.2 Nature of counseling services offered

Under this theme we explored the general approaches, techniques and skills in counseling that VSU officers used in providing support to victims who reported their abuse. VSU officers disclosed that they lacked professional counseling skills. It was found that counseling was rarely offered in some VSU in both countries. VSU officers confirmed that:

> *We rarely provide counseling services to children because of lack of proper counseling facilities and work over load.* **ZPO3**

Similar narratives abound in the data. Narratives above imply that though officers were aware of the essence of counseling they lack the requisite training to practice. They therefore engage victims and their families in what they think best by resorting mostly to advice giving on medical and legal processes leaving out the psychological and emotional assistance that victims need.

4.2.1 Approaches to counseling

Results show that there were various services offered to victims of CSA to help reduce their trauma. These could be classified as: trauma counseling, individual counseling and group counseling.

4.2.1.1 Trauma counseling

VSU officers try their best to handle sexual abuse cases brought before them. Regarding cases reported, VSU officers first and foremost try to secure the victim's safety and then encourage disclosure of abuse. Under this approach, two stages of trauma counseling were identified. These are: establishing safety and security of victims, and encouraging disclosure (remembering and mourning).

4.2.1.1.1 Establishing safety and security

In addressing the issue of the nature of counseling services provided to victims, narratives reveal that officers usually try to provide safety nets as the first step to providing counseling.

> *We normally send them to shelters. Here, luckily for us there are two NGOs who work with us in providing shelter to these girls when they are brought to us.* **GPO17**

> *We make all efforts to get perpetrators arrested and prosecuted* **ZPO11**

> *We made prompt arrest and arraigned the offender before court. One very thing we did was to place the girl with the social welfare to secure her safety.* **GPO9**

Some victims corroborated this:

> *When I reported my problem I was sent to the social welfare home. I spent one week there before my mother came for me. They [VSU Officers] told me that I should stay there so that the man who abused me will not harm me.* **GV6**

This approach by VSU officers in providing safety and security for victims is entrenched in the first stage of trauma counseling [15]. Depending on the perpetrator characteristics, officers provide safety where some children were taken to shelters or social welfare homes for protection and to reduce revictimization. This resonates with [28] that sexually abused children generally need safety upon disclosure.

4.2.1.1.2 Encouraging disclosure

Disclosure of abuse was seen as one fundamental phenomenon in the healing process. When victims report their abuse they are requested to disclose. Data reveal that in most cases, the reports made by non-offending parents are quite incongruent with the disclosure of victims. One officer noted:

> *When the mother came and reported that the daughter was abused through the anus and we asked the girl to tell us, she said the man penetrated through her vagina.* **GPO20**

> *You see, some of the girls do not like to talk to us about their predicament initially. Sometimes we allow them to sit for about two hours or more before they begin to talk. And when they do they take so long to say something meaningful.* **ZPO 18**

> *When I was taken there [VSU office] and I was asked to narrate my problem, I was scared. There were a lot of people around, moving here and there and then some of them were police men coming to the room. So I was not comfortable but I told them later.* **GV15**

To overcome the stress of remembering and mourning, the victim needs to narrate his or her experiences in depth with great detail. The goal is to modify the traumatic memories so they become more meaningful in the person's life and less anxiety provoking. As the narrative develops, the memories become less disjointed, more depersonalised and more coherent. With this emotional reworking and cognitive restructuring, the memories become more manageable and the significance of the trauma changes from a story of victimisation to one of dignity and agency [16]. Once the victim is able to emotionally and cognitively process the traumatic experiences, he or she is then able to mourn the losses experienced during the abuse. Victims face the reality that they may never regain what they have lost. Herman [15] argued that with the new story, the intrusive and hyper-arousal symptoms subside.

Associated with reporting and disclosure is the issue of power imbalance. The police stations do not seem to provide a safe environment that promotes disclosure. Ironically, while the officers were interested in providing safety from perpetrators, their own personalities and immediate environments smack of insecurity and impact on effective disclosure.

4.2.1.1.3 Reconnecting

In most cases, officers attempt to re-unite victims with their families especially with their non-offending parents or caregivers. This is as the result of lack of shelter and other logistics in handling the victims. Officers revealed:

> *We have no place to keep them for long so what we do is to ask the parents to take them back and advised them strongly to take good care of them.* **ZPO5**

> *You see we have the social welfare to take care of these children, but we do so in very severe cases where we suspect revictimization.* **GPO7**

This reconnection is thus exigent on the prevailing circumstances in the VSU offices. One finds it difficult to assess whether reconnection to the families has positive outcome for the victims or not as VSU officers have no means of follow-up on cases. This study thus, revealed that the reconnection stage of Herman's model was woefully completed. Victims were not reconnected in the real sense of recovery geared towards healing and empowerment. At best their reconnections could be described as disposal.

4.2.1.2 Individual counseling

This is normally done with victims in the same office with their parents and other VSU officers. Narratives reveal that for lack of space and other logistics, VSU officers carry out their counseling activities right in the same office with other colleagues. One stated

> *Oh we do the counseling right here [referring to the general office of VSU].* **GPO1**

> *What we call individual counseling is when we sort of interview the victim upon reporting of abuse and take their statements. I think our interviews are like counseling where we listen to them and advise them on what to do.* **ZPO13**

The term individual counseling is used interchangeably with taking victims' statements and asking probing questions for clarification. Through observation and narratives, it was revealed that the individual counseling provided was short of appropriateness. With individual counseling done in the same office with other officers and visitors coming in and out, then the counseling environment is not conducive enough to uphold the principles of confidentiality and to promote disclosure.

4.2.1.3 Group counseling

Data indicate that group counseling referred to in this context is when victims and their non-offending parents or caregivers are provided some advice on seeking medical treatment, legal procedures and general advice on how to prevent being re-victimised.

> *Normally we talk with the victims and their non-offending parents at the same place. We do not put victims together for counseling. You know, we deal with the victims on case-by-case level, individually* **GPO19**.

Group dynamics such as purpose of group formation, theme, and other characteristics were not considered. Group counseling was offered in a form of family therapy usually with non-offending parent or family members.

4.2.1.4 Advice giving

Regarding the approach to counseling, it was found that the counseling that was provided (if at all) that could best be described as group counseling was used in all service (VSU) centers. The counseling provided here is more advice giving especially regarding victims' right to legal assistance, medical treatment, and how victims could ovoid revictimization, and parental protection and provision. Advice on legal procedures and investigations: victims and their parents were also provided needed information on legal opportunities available to them. An officer explained:

> *It is our duty to explain all the procedures and investigation process to the family and what is expected of them especially during the investigations.* **ZPO11**

4.2.2 Counseling skills and strategies

In addition to the approaches used, officers also employed some basic counseling skills such as encouragement, reassurance, and rapport. However, cognitive behavioural counseling techniques skills like assertiveness training, empathising, role-play, art therapy and belief of victims' stories were found missing. These were considered very important in reducing the grief and confusion that children abused normally go through thus, paving way for healing.

4.2.3 Operational challenges in delivering counseling to victims

On barriers associated with counseling service provision, the following subthemes emerged: lack of skilled personnel, lack of logistics, late reporting of cases, family interference, lack of safe and conducive environment coupled with presence of power relations, inadequate time and sessions among others.

4.2.3.1 Lack of training and structure

> *No, we have no guidelines to follow to do counseling. What we do is to take their statements when they come. This is the same way we take all statements at the station. I think we need more to handle these children* **GPO5**

> *We don't have any format for doing counseling. I guess we all rely on what we think is counseling by asking the victims questions and telling them what they should do* **GPO7**

> *We need further training to do counseling* **GPO8**

Data reveal that VSU officers perceived themselves as inadequate in providing counseling services to victims. They, however, bemoan their lack of professional training and capacity. It was noted that in both countries, VSU officers have no psychological tests to administer to victims, they do not have any structured system or documents to use such as intake form upon report of an abuse.

4.2.3.2 Logistics and administrative challenges

Direct observation and in-depth interview report indicated that the VSU officers lacked capacity in terms of resources for their work. Apart from the units in the

regional capitals of the study sites in both countries with one and two computers each in Ghana and Zambia respectively, the VSU desks in the study regions had no computers and therefore no database of cases before them. The police dockets were managed manually by using notebooks and files. Officers did not have filing cabinets. These challenges were acknowledged by the officers at the units. One officer indicated:

> *We do not have the capacity to follow up on cases because of lack of basic resources like computers to keep data on offenders. For instance, for lack of computers there is no database for perpetrators making it difficult to track repeated offenders* **ZPO8**

There were also no vehicles assigned to the VSUs in the study sites in Ghana. However, the Lusaka headquarters unit had one vehicle for investigation of cases. This was however bemoaned as woefully inadequate.

> *You see we are handicapped. When cases are reported, we have no means of taking swift action to cause arrest of perpetrators. We sometimes rely on reporters, other division vehicles or our own vehicles. These cause delay and sometimes give room for perpetrators to abscond. Additionally, this logistic challenge makes it difficult for us to follow-up on victims after their reports to see how they were doing.* **ZPO15**

These reports were corroborated by VSUs from Ghana:

> *We have no means of effecting arrest of perpetrators swiftly. Mostly due to unavailability of vehicle some perpetrators abscond before we got there. It's a big challenge.* **GPO20**

4.2.3.3 Late reporting of cases

Many victims did not report the offence until later when they fell ill or got pregnant and the men refuse responsibility.

> *A pregnant girl was brought here and a complaint was lodged against a man who refused responsibility. They [the girl and the mother] did not report of sexual abuse. It was during interrogation that the girl revealed that she was impregnated by her uncle and when we looked at her age, she was 15 years and we filled a case of defilement.* **GPO18**

Late reporting or indirect reporting of Child Sexual Abuse cases makes it difficult for victims to receive any form of counseling (if any) from VSU officers. This finding resonates with other research that, sexually abused children rarely disclose sexual abuse immediately after the event [27].

4.2.3.4 Family interference

The constant appeals by family members to withdraw the cases from the courts do not only thwart the efforts of the courts to prosecute offenders, it also cuts short whatever counseling interventions that VSU officers could offer the victims since the withdrawals mark the end of victims' visit to the station for further assistance. One officer bemoaned:

> *Hmm, it is difficult to provide the little help we can to these [abused] girls. You see there was this case where the girl came to report her abuse personally just after the incident. Everything was there to see. We made prompt arrest and arraigned the*

> *offender before court. One very thing we did was to place the girl with the social welfare to secure her safety. But do you know the trick the family played to get the case out of court? The family insisted that they want to have and keep the girl with themselves so we allowed them to take her away and to bring her back for hearing. That was all!!! They never showed up. The case was called several times and since the complainant was not present, the case was thrown out of court and the accused released. In this case what else can we do?* **GPO9**

> *Families interfere too much in our efforts to deal with offenders. This also cuts short whatever little assistance we could offer them.* **ZPO11**

These narratives point to the administrative challenges faced by VSU officers. In all, victims were provided first aid counseling. Police dockets revealed that most cases were discontinued. In most cases parents or caregivers request for withdrawal of cases to be settled at home. About 90% of reported cases were not followed up by parents and since the police have no means of following up, the cases die naturally and the courts closed dockets on them. Feedbacks on settlement were not provided by parents. The settlement of defilement cases outside court violates the very spirit and letter of the law on defilement [29] because rape under laws of both countries is a first degree felony [27].

4.2.4 Benefits of counseling victims and the way forward

Regarding benefits of counseling for victims, the following were some of the subthemes: need for professional training; assurance that will lead to disclosure, anxiety and fear reductioning, promoting healing, and empowering victims; non-belief of victim's story and lack of privacy and confidentiality were seen as immediate issues that could be addressed to pave way for effective counseling of victims. The following narratives are revealing:

> *Well, if we are asked to go for further studies, I think I would consider doing counseling because it will help me in my work when I return. That is if I'm posted back to this unit (referring to DOVVSU).* **GPO14**

> *The service needs to support officers to do professional counseling and when they are done, such officers should be posted here to work. And you know, there are some officers who have their 1st degree in counseling. I know some of my colleagues here who did counseling in your university (UEW) but they have not been posted to DOVVSU desks maybe they do not want to work here or the service refuses to post them here. But I think it is more about the bosses up there.* **GPO3**

> *I don't know what to say. You know, my daughter was only talked to by the police woman and after that day nothing happened again. They did not ask us to come again. So that was it. All I observe is that from time to time, she seems lost to herself and sometimes too she wants to be alone.* **GP4**

> *I thank God that I was able to talk to the police about my abuse and they helped me. They talked to me and assured me that the man would be arrested and they arrested him.* **GV10**

> *I wish I was given the chance to talk to the woman alone.* **GV5**

> *I don't think the woman believed me and you see, I could not tell her everything knowing that she didn't believe my story.* **ZV8**

Though some victims feel less threatened by their disclosure to the police the same sense of lack of security prevents detailed disclosure and hinders recovery. This finding corroborates conclusion drawn by [30] that distrust of, and poor experience with, state authorities and public services contributed to individuals abused not seeking help.

4.3 Findings and conclusions

This study attempted to explore the counseling services provided to children who report their sexual abuse to the police in Ghana and Zambia. The study found that, although group counseling was used as treatment for victims of CSA, it did not follow group dynamics and was offered without individual counseling. It also revealed that some clients needed individual treatment before they were ready for group therapy. The study found among others that children in both countries were provided family therapy rather than individual and group counseling that would have been more helpful for disclosure, connecting, and healing. It also found that though some victims expressed happiness that their abuses have been reported and heard, lack of counseling training and power imbalances inhibit officers' efforts.

The study concludes that though police officers use some skills, more is needed to provide comprehensive and effective counseling to CSA victims. When children receive adequate counseling immediately after abuse they do immediate damage repair both of their psychological and social "self".

While this study expands knowledge on CSA and counseling services, it also significantly, seeks to influence policy and suggest ways by which effective interventions mechanisms can support victims of CSA in both countries.

4.4 Recommendations

The study recommends that Police services in both countries should sponsor VSU officers to do professional training in counseling in order to provide effective counseling for abused individuals. Additionally, it is recommended that counseling professionals should help design a framework or protocols to use in providing integrated trauma counseling services for abused children. It further recommends that the service in both countries should team up with universities which offer counseling programs to offer periodic capacity training for their staff. And finally, officers should be linked with professional counsellors at universities to refer abuse cases for treatment.

Acknowledgements

An earlier version of this article was presented at the World Education Research Association Annual Meeting at Cape Town, South Africa in August 2018. We are grateful to the following institutions for allowing us to conduct this research: the DOVVSU Central Region Police Headquarters of the Ghana Police Service, the Zambian Lusaka Police Service, and all our participants.

Author details

Nyuiemedi Agordzo Edoh-Torgah[1*] and Marien Matafwala[2]

1 University of Education, Winneba, Ghana

2 Zambia Centre for Accountancy Studies University, Lusaka, Zambia

*Address all correspondence to: naagordzo@gmail.com

References

[1] Gladding, Counseling: A Comprehensive Profession | Pearson [Internet]. [cited 2021 Feb 18]. Available from: https://www.pearson.com/us/higher-education/product/Gladding-Counseling-A-Comprehensive-Profession-6th-Edition/9780132434560.html

[2] World Health Organization, editor. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013. 55 p.

[3] OHCHR | United Nations Study on Violence against Children [Internet]. [cited 2021 Feb 18]. Available from: https://www.ohchr.org/EN/HRBodies/CRC/Study/Pages/StudyViolenceChildren.aspx

[4] Lalor K. Child sexual abuse in sub-Saharan Africa: A literature review. Child Abuse Negl. 2004 May 1;28:439-460.

[5] Lema VM. Sexual abuse of minors: emerging medical and social problem in Malawi. East Afr Med J. 1997 Nov;74(11):743-746.

[6] Fieldman JP, Crespi TD. Child sexual abuse: Offenders, disclosure and school-based initiatives. Adolescence. 2002;37(145):151-160.

[7] Haworth C, Wright M, Luciano M, Martin N, de Geus E, van Beijsterveldt C, et al. The heritability of general cognitive ability increases linearly from childhood to young adulthood. Mol Psychiatry. 2010 Nov;15(11):1112-1120.

[8] Pretorius G, Pfeifer N. Group art therapy with sexually abused girls. South Afr J Psychol. 2010;40(1):63-73.

[9] Bohn DK. Lifetime physical and sexual abuse, substance abuse, depression, and suicide attempts among Native American women. Issues Ment Health Nurs. 2003 May;24(3):333-352.

[10] Diehl AS, Prout MF. Effects of posttraumatic stress disorder and child sexual abuse on self-efficacy development. Am J Orthopsychiatry. 2002;72(2):262-265.

[11] Kolko DJ, Stauffer J. Child Sexual Abuse. In: Ammerman RT, Hersen M, editors. Case Studies in Family Violence [Internet]. Boston, MA: Springer US; 1991 [cited 2021 Feb 18]. p. 153-70. Available from: https://doi.org/10.1007/978-1-4757-9582-0_10

[12] Najman JM, Dunne MP, Purdie DM, Boyle FM, Coxeter PD. Sexual Abuse in Childhood and Sexual Dysfunction in Adulthood: An Australian Population-Based Study. Arch Sex Behav. 2005 Oct 1;34(5):517-526.

[13] Boateng FD. Victims of sexual assaults: The experiences of Ghanaian women. Int Rev Vict. 2015 Sep 1;21(3):343-360.

[14] Murray LK, Nguyen A, Cohen JA. Child Sexual Abuse. Child Adolesc Psychiatr Clin N Am. 2014 Apr;23(2):321-337.

[15] Herman JL. Trauma and Recovery. New York: Basic Books; 1992. 178 p.

[16] Agordzo N. An exploratory study of coping strategies of adult survivors of child labour in Ghana. [Ghana]: University Of Education, Winneba; 2015.

[17] van der Kolk B. Posttraumatic stress disorder and the nature of trauma. Dialogues Clin Neurosci. 2000 Mar;2(1):7-22.

[18] Foa EB, Rothbaum BO, Riggs DS, Murdock TB. Treatment of posttraumatic

stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counseling. J Consult Clin Psychol. 1991;59(5):715-723.

[19] Freeman J, Epston, Lobovits D. playful approaches to serious problems: narrative therapy with children and their families. Norton Professional Books; 1997.

[20] Ghana police service. Statistics and Information Technology Unit (SITU), CID Headquarters, Accra – Ghana. 2011.

[21] Ghana: UNFPA supports DOVVSU to activate Domestic Violence Hotline [Internet]. UNFPA WCARO. 2020 [cited 2021 Feb 10]. Available from: https://wcaro.unfpa.org/en/news/ghana-unfpa-supports-dovvsu-activate-domestic-violence-hotline

[22] This profile was developed by the Government of Ghana – Department of Children (Ministry of Gender, Children and, Social Protection), supported by UNICEF. CHILD PROTECTION BASELINE RESEARCH: Central Regional Profile. UNICEF; 2015.

[23] Boakye KE. Attitudes toward rape and victims of rape: A test of the feminist theory in Ghana. Journal of Interpersonal Violence. 2009;24: 1633-1493.

[24] The State of the World's Children | UNICEF [Internet]. [cited 2021 Feb 19]. Available from: https://www.unicef.org/reports/state-of-worlds-children

[25] Wardlaw T, You D, Newby H, Anthony D, Chopra M. Child survival: a message of hope but a call for renewed commitment in UNICEF report. Reprod Health. 2013;10(1):64.

[26] Creswell JW. Qualitative inquiry and research design: Choosing among five traditions. Thousand Oaks, CA, US: Sage Publications, Inc; 1998. xv, 403 p. (Qualitative inquiry and research design: Choosing among five traditions).

[27] Morhe RAS, Morhe ESK. The Law on Defilement in Ghana and Challenges in Its Implementation at the Ejisu-Juabeng Domestic Violence and Victims Support Unit of the Ghana Police Service. J Law Policy Glob. 2013;16:23.

[28] Faller KC. Child sexual abuse: Intervention and treatment issues. Diane Publishing Company; 1993.

[29] Adinkrah M. Criminal Prosecution of Suicide Attempt Survivors in Ghana. Int J Offender Ther Comp Criminol. 2013 Dec 1;57(12):1477-1497.

[30] Cohen G, Harvey J. The use of psychological interventions for adult male sex offenders with a learning disability: a systematic review. J Sex Aggress. 2016 May 3;22(2):206-223.

Edited by Ersi Kalfoğlu and Sotirios Kalfoglou

Sexual assaults are special crimes that require an inter-multidisciplinary approach. This book brings together the work of distinguished scientists on sex crimes and their prevention. It is organized into two sections on the behavioral aspects of sexual abuse/assault and the methods of responding to these types of cases. Chapters address such topics as child abuse, dating violence in the online era, marital rape, and much more.

Published in London, UK

IntechOpen

ISBN 978-1-83969-399-1