Psychiatric Aspects of Sexual Abuse

A. Reese Abright, M.D.

Sexual abuse of children and adolescents has become an increasingly publicized phenomenon. Psychiatrists and other mental health professionals are often called upon to evaluate and treat children and adolescents who may have been sexually abused, to provide counseling or treatment to the families of such children, and to provide reports and testimony for proceedings about such cases in the child protection system, the criminal justice system, and in custody disputes. Clarity regarding the medical, psychiatric, and legal aspects of sexual abuse is essential in carrying out such professional activities and in evaluating and formulating research on sexual abuse. In this paper current knowledge regarding these aspects of sexual abuse is summarized, and the role of psychiatrists in clinical and forensic work involving allegations of sexual abuse is discussed.

Sexual abuse has become one of the most publicized of the calamities that afflict children and adolescents, rivaling and probably surpassing such topics as drug abuse and suicide in this regard. Sensationalized reports of the sexual exploitation of children by adults at home, in day care centers, in schools, and in pornography and prostitution rings appear almost daily in newspapers and on television. Adults of both sexes come forward with dramatic accounts of unwanted sexual experiences during their childhoods and of the long-term effects of such experiences on their emotional development. Accompanying the publicity are sobering statistics indicating substantial rises in the annual reporting of sexual abuse.

Psychiatrists and other medical and mental health professionals are called upon to comment publicly on this phenomenon, often under harried circumstances, and to offer advice and help to concerned children, families, law enforcement officials, judges, and juries. The questions raised are many and perplexing: What are the factors that cause such abuse? What are the short- and long-term effects? What are the most effective means of intervention with children, families, and perpetrators? How reliable are children as witnesses? What in fact is meant by the term "sexual abuse" and what is the relation of this phenomenon to other forms of child abuse?

The purpose of this paper will be to explore the medical and psychiatric aspects of such questions and to delineate these clearly from other equally important aspects of the phenomenon of sexual abuse.

History

The phenomenon of sexual activity between close relatives and between

Address reprint requests to Dr. Abright, Chief of Child and Adolescent Psychiatry, St. Vincent's Hospital and Medical Center of New York, 203 West 12th St., New York, NY 10011.

adults and children has been a continuing source of fascination for poets, artists, theologians, lawyers, biologists, and anthropologists. Medical and legal documentation of sexual assaults on children began at least as early as the nineteenth century. Many of the issues that perplex us now were familar then, including statistics indicating high numbers of sexual assaults on children, with more than 36,000 reports of such assaults in France between the years 1827 and 1870, recognition of the high proportion of cases of incest and especially father-daughter incest in the reports, questions concerning the reliability of children as witnesses, and heavy reliance on the legal system for data.[1]

Freud[2] was apparently the first psychiatrist to suggest that sexual experiences between adults and children might have deleterious long-term psychologic effects on the child and might result in the delayed onset of adult psychiatric illness. Although, as is well known, Freud came to question the reliability of reporting of childhood experiences by his adult patients and to emphasize the importance of fantasy in the genesis of psychic conflict and illness, he did not entirely abandon the belief that actual sexual experience between children and adults can and does sometimes take place and can have harmful consequences.[3]

Nevertheless, Freud's emphasis on the role of fantasy and unconscious distortion in retrospective accounts of childhood experiences by adults, together with official estimates through most of this century placing the incidence of incest at only about one case per million population in Western Europe and the United States,[4] probably did contribute to a lack of extensive psychiatric interest in the occurrence and effects of actual sexual behavior between children and adults. Although there is a consistent flow of scattered reports on the subject in psychiatric literature from the 1930s through the 1970s, the current high level of interest in the public and in the profession has emerged only over the past five to 10 years and has followed the similar increase in interest in child abuse that began in the early 1960s.[5,6]

Definitions

The problems in *definition of sexual abuse* are substantial and have constituted one of the most serious methodologic limitations in studies in this field. On the one hand, there is considerable overlapping and blurring with terms such as "incest," "seduction," "rape," "sexual assult," "sexual contact," "sexual molestation," and "sexual misuse." On the other hand, the spectrum of activities covered by such terms ranges from the vague "excessive stimulation" through a multiplicity of specific behaviors including voyeurism, exhibitionism, touching, fondling, genital manipulation, kissing, oral sex, penetration by foreign objects, vaginal and anal intercourse, pornography, and prostitution.

The difficulties in definition are magnified in the psychiatric literature, where multiple terms are used almost interchangeably and often without specification, and in state criminal laws and child protection statutes, where still other factors such as the age differences between those involved, the intent of the initiator

of the action, and the presence or absence of the overt use of force or violence are often added. Similar problems occur with the *definition of incest* and are compounded by variations in the degree of relatedness between participants, which are used as the criterion. Bienen[7] has provided a useful listing of the incest statutes in the 50 states.

In an attempt to bring some uniformity into the definition of sexual abuse, the National Center on Child Abuse and Neglect has formulated the following "tentative" definition of child sexual abuse: "Contacts or interactions between a child and an adult when the child is being used for the sexual stimulation of that adult or another person. Sexual abuse may also be committed by a person under the age of 18 when that person is either significantly older than the victim or when the abuser is in a position of power or control over another child"[8]. Fraser[9] has suggested as a more succinct definition "the exploitation of a child for the sexual gratification of an adult" (p. 58).

Causes

Discussion of the causes of sexual abuse must be clearly distinguished from discussions of the causes of psychiatric illnesses that may be found in association with sexual abuse. For example, although a psychiatric illness such as pedophilia may be a major component in the cause of some cases of sexual abuse, the factors that cause pedophilia and those that cause sexual abuse are not necessarily the same. Weinberg[4] and Henderson[10] have provided concise reviews of theories regarding the causes of incest whereas Finkelhor[11] has speculated about the factors in individuals and society that may lead to sexual abuse. In sum, the causes of incest and sexual abuse may overlap but are not always identical and most likely stem from a complex interplay of biologic, psychologic, familial, and sociocultural influences, the relative weights of which probably vary greatly from case to case.

Incidence and Demographic Characteristics

The National Center on Child Abuse and Neglect[12] estimates that in the United States there are about 1,000,000 cases, per year of child abuse or neglect, which are divided as follows: 700,000 to 800,000 neglect, 100,000 to 200,000 physical abuse, and about 100,000 sexual abuse.

Russell and Trainor[13] have provided a more detailed look at the child abuse reporting data over the years from 1976 to 1982 and have outlined a number of ways in which the reported cases of sexual abuse differ from those in other categories. In contrast to the distribution in composite reporting of all cases of abuse or neglect, sexual abuse victims are much more likely to be female (80% of cases) whereas the composite figures for all cases of abuse and neglect are evenly divided between males and females; are older and more often adolescent than the composite average age; and have a racial distribution closely matching that of all U.S. children whereas there is a preponderance of black children in the other categories of abuse and neglect. The perpetrator is male in about 80% of reported cases of sexual abuse whereas

males are the perpetrators in only about 40% of the composite cases. The majority (70%) of perpetrators of sexual abuse are parents of the victim but the proportion of parents is much lower than in the other categories, where about 90% of the perpetrators are parents. Also, the proportion of natural parents in sexual abuse is 56%, whereas in other types of maltreatment 85% of perpetrators are natural parents. Families in which sexual abuse occurs have more health problems and fewer economic stresses than the other families, and sexual abuse victims are usually not reported to have suffered other kinds of abuse and neglect. Russell and Trainor conclude that the profile of families of sexual abuse victims is much more like that of the average U.S. family than that of the families in other forms of maltreatment.

Estimates of frequency of sexual abuse in the population are usually reported in terms of *annual incidence*—or numbers of new cases per year—and are based on reports to child protection services and criminal justice systems. Estimates of *prevalence*—total number of cases at a given time or over a specified period of time—are less common and usually stem from surveys of adults who report sexual experiences in childhood and from extrapolations of data on incidence. Studies by Finkelhor,[14] Russell,[15] and Sedney and Brooks,[16] based on questionnaire or interview surveys, have indicated that from 5% to 10% of men and 8% to 30% of women report childhood experiences of sexual activities with adults or older children.

All data on incidence and prevalence of sexual abuse are subject to severe limitations, which include possible under- or overreporting, variations in definitions of activities reported, and difficulties in verification of reports. Statements about *changes* in incidence and prevalence are highly speculative because it is only in the past decade that national data on reports of child abuse have been systematically collected. Nevertheless, the preponderance of evidence does strongly support a conclusion that many adults of both sexes have had childhood experiences that can be classified as sexual abuse and that many children of both sexes are currently likely to be exposed to such experiences.

Legal Aspects

The subjects of sexual abuse offers much opportunity for increased general understanding of the relation between psychiatry and the law. Nevertheless, no aspect of sexual abuse is likely to be more perplexing to the psychiatrist or other mental health professional. Such perplexity can be alleviated by knowledge of the legal systems and procedures that obtain and of the principles governing psychiatric work in such cases.

The two major legal systems in which cases of sexual abuse may appear are the *child protection system* and the *criminal justice system.* Fraser[9] has provided an excellent summary of the differing philosophies and practices of these two systems. The specifics vary from state to state but there are enough similarities to make some general observations. Criminal justice statutes define certain sexual behaviors toward children as *crimes* and provide grounds for apprehension, trial, and punishment of alleged offenders

who are found guilty. *Child protection statutes* are based on the doctrine of *parens patriae* and permit the state to intervene when parents or guardians are suspected of not providing adequate care or protection for their children or of actively abusing them. The identification of cases is supported in all states by laws that require *mandatory reporting* of *suspected cases* by physicians, teachers, and others who have professional involvements with children and families and that render such professionals liable themselves to charges of *criminal misdemeanor* for *failure to report*. Such laws provide immunity to professionals for violating the confidentiality of children, parents, and guardians. The important issue of *informed consent* regarding such laws *before* evaluation of children and families has yet to be explored.

The reporting requirements pertain mainly to cases of intrafamilial abuse or neglect, although cases involving day care workers are also covered in some states. Confusion may occur when a child or adult reports abuse by someone outside the family such as a teacher or a stranger. In such a situation the obligation of the professional is to help the parent or guardian determine how best to protect the child from further abuse and whether to report the matter to the criminal justice authorities. If the parent or guardian appears to be unwilling or unable to take the necessary steps to protect the child, then the professional may be under an obligation to report the parent or caretaker to protective services on grounds of *neglect*.

Whenever possible, a decision to report a case to the protective service system should be discussed fully with the involved family members *before* the report is made, and the mandatory requirement for such reports should be made clear. It may also be helpful to point out that the purpose of the child protection system is to *help* rather than to *punish*, although some forms of abuse may also subject a parent or guardian to criminal charges.

Cases reported through child protection systems are adjudicated in *family courts* or *juvenile courts*, whereas cases reported to the criminal justice system go through *criminal courts*. The requirements for proof of abuse are very different in these two systems. In family courts decisions may be based on a *preponderance of evidence* that the child has been abused, and it is not necessary to prove the identity of the perpetrator, whereas in criminal courts it must be proved *beyond reasonable doubt* that an alleged perpetrator actually committed the crime of abuse against a particular child and did so with *unlawful intent*. The definitions of abuse in the criminal statutes of a state may differ significantly from those in the child protection statutes. The stages of a proceeding in family courts are the *adjudication hearing* and the *dispositional hearing*, whereas the stages in criminal proceedings are the *preliminary hearing*, the *grand jury hearing*, the *trial*, and *sentencing*.

Recommendations stemming from dispositional hearings in family courts in sexual abuse cases are aimed at protection of the involved children and resolution when possible of circumstances thought to be responsible for the abuse. Some recommendations may include re-

moval of a child or parent from the home and psychiatric treatment of one or more family members. Criminal cases result in findings that accused persons are innocent or guilty. If found guilty, such persons may be sentenced to prison or in some cases mandated to participate in psychiatric treatment.

Many sexual abuse cases may be processed through both family and criminal courts, thus subjecting children and families to multiple interviews and proceedings with significantly different purposes and results. In addition, allegations of sexual abuse may also arise during divorce, custody, and visitation proceedings and may then also be routed through the criminal or child protection systems. Defendants in the criminal justice system have the right to confront their accusers, including children, at the preliminary hearing and the trial but not at the grand jury hearing. The short- and long-term effects on children and other family members of participation in such proceedings is an underexplored area in psychiatry and the law but is a subject of much concern, particularly in view of the possibility that in some cases the effects of the legal proceedings on a child may be as deleterious as those of the abuse itself. In response to such concerns, various methods of obtaining children's testimony have been tried, including interviews in judges' chambers, videotaped interviews, and substitution of reports by psychiatrists and other professionals for direct testimony by the child; but the relative value of such methods in protecting children from untoward effects of participation in legal proceedings remains to be determined.

Psychiatric involvement in the legal aspects of sexual abuse can be regarded as consisting of *three distinct activities.* These are *identification* and *reporting* of suspected cases of abuse; use of *basic knowledge* of development, psychopathology, and interviewing skills to aid in determinations of *competence* of children and adults as witnesses and in assessment of *reliability* and *consistency* of a child's account of sexual abuse; and *evaluation of psychiatric status* of children and adults and *recommendations* regarding *disposition* and *treatment.*

It is crucial to determine the legal status *at the outset* in every referral involving sexual abuse. If the case is not known to the child protection system, then the psychiatrist or other professional may have a *reporting obligation* under law and an *ethical obligation* as a professional to take appropriate steps to protect a child who may be at risk for further abuse. If legal action has already begun, then it is essential to determine which legal system is involved and the stage in the system that has been reached. Decisions regarding competence are made *before* adjudication and are totally at the discretion of the judge. Terr[17] and Billick[18] have summarized the factors that enter into determinations of the competence of children.

The reliability and veracity of allegations of sexual abuse are the subject of *fact-finding* efforts before hearing and *legal findings during* hearings and trials. The pendulum with regard to believability of children's accounts of sexual abuse has swung from relative skepticism in the past to recent vigorous assertions by some that "children don't lie"

about such matters. Rosenfeld *et al.*[19] have commented on the "role of fantasy and reality in children's reports of incest" while Goodwin *et al.*,[20] Renshaw,[21] and Benedek and Schetky[22] have discussed false allegations of sexual abuse. The general consensus is that children's reports of abuse should be taken seriously and examined on a case-by-case basis with regard to the child's developmental and cognitive status, the circumstances under which the report was made, and external corroborating evidence.

The separation of the role of psychiatrists and other mental health professionals from that of legal professionals should be emphasized. Thus, although psychiatrists may contribute relevant information and impressions regarding sexual abuse, *legal findings* that such abuse has or has not occurred or that a defendant is or is not guilty of a crime are made by judges and juries and *not by psychiatrists or other mental health professionals.*

Such a recognition helps to put into perspective such common current practices as the use of *anatomically correct dolls* and drawings in evaluations of children who are alleged to have been sexually abused. Interviews with such children must be viewed in the context of general principles of interviewing in child psychiatry. Anatomically correct dolls and human figure drawings may be useful in the same way as are other interview and play techniques. That is, their value is enhanced when they are spontaneously selected by a child as a vehicle of expression from a range of other potentially attractive options (including conversation) rather than when they are urged on the child by an interviewer. The child who comments colorfully on anatomically correct dolls and is thus considered to be "sexually preoccupied" or to have been likely to have been exposed to "excessive sexual stimulation" may be in the same position as the child who plays vigorously with an alligator puppet and then is considered to be "orally aggressive." The important question in each instance is not only what the child said and did with the toy but what the circumstances were in the interview under which these statements and behaviors arose and what the other available options were for play. The answers to such questions should be *clearly documented* in clinical reports and court records. Reactions to anatomically correct dolls, drawings, performance on projective psychologic testing, and direct statements may all be *compatible* with an *impression* that a child has been sexually abused but they *cannot prove* that such abuse has actually taken place or that a given individual is the perpretrator; such proof is not the province of medicine or psychiatry.

It should also be emphasized that *legal findings* that a child is a competent and reliable witness and has actually been sexually abused are *not equivalent* to a conclusion from psychiatric evaluation that the same child also has psychiatric illness and may be in need of treatment. Similarly, a child who is found *not* to be a competent or believable witness and *not* to have been sexually abused may nonetheless be suffering from psychiatric illness and be in need of treatment.

Psychiatrists may also be asked to as-

sess the possibility of future psychic damages in cases of sexual abuse. Terr[23] has discussed the general principles involved in assessment of psychic damages to children but does not specifically address the question of sexual abuse. As we will see in a following section, limitations on data regarding long-term effects of sexual abuse are such that the psychiatrist must make it clear that any estimates he or she may make regarding later psychic damage are at best informed guesses, the accuracy of which may be severely curtailed by the imponderable effects of growth, development, and treatment.

Another fertile area for forensic psychiatric involvement in cases of sexual abuse is thorough evaluation of alleged adult and juvenile offenders.[24–28]

Medical Aspects

The medical aspects include but are not confined to the psychiatric aspects. Although there is consensus in the literature that many children who have been sexually abused may have no physical signs or medical sequelae of such abuse and although statistics from the American Humane Association[13] seem to support such a view in that most cases of sexual abuse are not also reported as cases involving other forms of physical abuse or neglect, there is also a substantial body of evidence summarized by Becker and Skinner[29] that indicates that both extra- and intrafamilial sexual abuse are associated with physical threats and actual violence toward the victim in a substantial proportion of cases. Data also suggest the possibility that children who have *preexisting* physical or emotional illnesses or handicaps may be at higher risk than other children are for sexual abuse just as they are for other forms of physical abuse.[30]

The Council on Scientific Affairs of the American Medical Association[31] has issued guidelines regarding physical signs that may be associated with sexual abuse. These include multiple venereal infections and indications of genital trauma as well as pregnancy. Full medical history, review of systems, and physical examination are indicated in every case, as are pregnancy tests in girls and other appropriate cultures and laboratory tests. Pelvic and rectal examinations should be performed by physicians experienced with such procedures with young children.[32]

Adults who are suspected perpetrators of sexual abuse should also have full medical histories and physical examinations. In view of evidence that sexual offenders have often had multiple sexual contacts[27] and are thus at high risk themselves for sexually transmitted infections, testing for antibodies to the virus (HTLV-III/LAV) that has been associated with acquired immune deficiency syndrome should be considered in both offenders and victims. The possibility that an adult offender with venereal infection might have contracted it from a multiply abused child should also be kept in mind.

Psychiatric work without adequate attention to medical history and physical status of the patient can be as misguided and harmful in cases of sexual abuse as in any other facet of psychiatry.

Clinical Psychiatric Aspects

Evidence suggesting an association between childhood sexual abuse and psychiatric disorder has come from direct studies of children and adolescents,[33-45] from reports indicating a high frequency of childhood sexual abuse in adolescent and adult psychiatric patients,[2,46,47] and from follow-up studies of children who have been sexually abused.[48-51] Disorders reported in association with sexual abuse have included virtually every condition known to psychiatry and have ranged from the acute, such as psychosis, adjustment disorders, and rape trauma syndrome,[52] to the chronic, such as schizophrenia, affective disorders, and conduct disorders. Disorders that may be delayed in onset, such as hysteria, multiple personality disorder, or posttraumatic stress disorder, have also been included. Information about psychiatric conditions in victims that may pre-date the abuse has been sparse. *No* convincing evidence exists that any one condition is invariably linked to sexual abuse or that any particular constellation of character traits in victims or perpetrators is always present.

Although often referred to as a diagnosis in the medical literature, sexual abuse is not listed as such in the official nomenclature of the American Psychiatric Association and in fact is not mentioned at all in DSM-III.[53]

The literature on the short- and long-term *effects* of sexual abuse has been clouded by multiple methodologic flaws,[54-56] of which perhaps the most serious has been the tendency to assume that psychiatric disturbances found in sexually abused individuals are *caused* by the abuse. Overall impressions from the literature are that sexual abuse is a strong marker for possible psychiatric illness, that not all individuals who have been exposed to sexual abuse will have or develop such illness, and that other stressors that are often present in such cases (for example, familial discord or break-up) may be as or more important than the abuse itself in the genesis of associated illnesses. An additional impression is that tactful and developmentally appropriate inquiry about sexual history should be considered even in young patients who are referred for reasons other than sexual abuse because many psychiatric patients of all ages are reported to have experienced such abuse. Concerns that such inquiry may suggest replies from patients are reminiscent of similar concerns that inquiries about suicidal ideation may suggest suicide. In view of the potential increase in clinical understanding that may emerge from such inquiries, these concerns, although possibly realistic in some cases, do not seem to constitute an adequate reason for avoidance of the inquiries, especially if clinical reports clearly indicate whether the patient discussed the subject spontaneously or in response to questions.

Evaluations of individuals and families involved in sexual abuse cases should not be regarded as being intrinsically different from other evaluations in child and adult psychiatry. The standard techniques that serve well in other cases and that may include family inter-

views and discussions with teachers and others who know the child or family, as well as home and school visits when indicated, should be used. Exclusive focus on sexual abuse should be avoided because failure to notice a developmental delay that may be unrelated to abuse or underestimation of a child's grief at separation from a parent, even if the parent is abusive, can be as much of a disservice to patients in these cases as in any others. A thorough and well-conducted evaluation, especially one that extends over several meetings, can be a highly effective form of crisis intervention. Recommended treatments should be specific for disorders that are discovered.

Sexual abuse may also be associated with suffering that does not meet criteria for psychiatric diagnosis. Efforts to alleviate such suffering fall well within the humane tradition of medicine and psychiatry but should be clearly distinguished from treatment of associated *illnesses.* A number of authors[29,56–63] have discussed special considerations in treatment of sexual abuse cases.

Treatment of sexual offenders has been a subject of considerable attention in the literature.[27,64] So-called "diversion programs" in which sexual offenders are allowed to participate in mandatory treatment programs rather than face trial and possible imprisonment have also generated much interest.[60,63]

An important question is the determination as to when and whether an abusing parent may be permitted to be reunited with his or her family. The paramount consideration in such cases is *not* psychiatric but protective. How safe will the child be from further molestation? Psychiatric considerations concern the possible effects on the child and other family members of re-uniting the family versus those of prolonged separation and predictions regarding further molestation. These are both extremely gray areas in which the clinician must rely more on intuition and experience than on established data based on well-controlled studies.

Efforts to prevent sexual abuse through prohibitory legislation and through education of the general public and of professionals can be regarded as a form of *primary prevention* of associated illnesses. Questions regarding primary prevention of such illnesses also arise in situations in which evaluation of an abused child reveals no current signs or symptoms of psychiatric or other illness and clinicians must decide whether to recommend treatment in an effort to prevent possible later occurrence of such illnesses. Unfortunately data on the efficacy of such treatment in accomplishing the preventive goal is lacking. The approach that often seems most sensible in such situations is to recommend periodic follow-up and evaluation with the aim of *secondary prevention* through early detection and treatment of illnesses that may develop. *Tertiary prevention* refers to efforts to limit disabilities imposed by illness.

Research

The problems in research on sexual abuse are challenging but not insurmountable. There is a pressing need for rigorously designed studies with uniform definitions of sexual abuse and diagnos-

tic criteria, careful efforts to assess psychologic and physical status of victims *before* abuse occurred, matched comparison groups, and well-defined follow-up techniques and outcome measures. Among the many issues requiring further exploration through such studies are the relation between sexual abuse and other forms of abuse, risk factors predisposing to abuse and to development of psychiatric illness in association with such abuse, differences in outcome of abuse with and without overt use of force and of abuse of short or long duration, and the relative merits of various therapeutic approaches.

Conclusion

Clarity regarding the medical and psychiatric aspects of the multifaceted phenomenon of sexual abuse is essential in clinical and forensic practice and in research. These aspects include the description, diagnosis, treatment, prevention, and understanding of illnesses that may be associated with sexual abuse as well as use of basic interviewing skills and developmental knowledge to aid in determinations of competence and reliability of children and adults as witnesses.

Moral and legal condemnations of sexual abuse do not relieve the physician or other medical professional from the obligation to make individual assessments in each case regarding the presence or absence of illness and the need, or lack thereof, for treatment. Awareness and acknowledgment of the extent and limitations of current knowledge regarding causes, effects, and treatment provides the soundest basis for enlargement of understanding and for working with children and adults who come for help whether in shame and secrecy or in the bright glare of public disclosure.

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