THE PREVENTION OF CHILD SEXUAL AND PHYSICAL ABUSE

STEVEN KAIRYS*

Child sexual and physical abuse is epidemic in its prevalence in children. Moreover the impact and long term effects are now found to often be lifelong and influencing not only emotional and psychological disturbances but also physical health. Treatment after the fact is difficult, and too often has minimal positive gain. Prevention is key to changing the dynamics and abuse and reducing the toll on the individual child, the family and society. This review details the current evidence base about primary, secondary, and tertiary prevention programs for sexual abuse and then for physical abuse.

Introduction

Child abuse, whether it is sexual abuse or physical abuse, affects a large number of children each year. Moreover, its negative impact may case a shadow over the rest of each child victim’s life. Any country’s official reports of abuse are only the top of the iceberg. In the United States, for example, a country with a very visible and aggressive reporting system, one million children are found to have been abused. However data from many other sources places that number much higher.

In many countries programs have been developed at teaching young children about their bodies and how to protect themselves and also in rates of abuse since the 1990’s. The country also has established hot lines for anyone to call anonymously and reducing affiliations with other deviant behaviors. Moreover, 80% of children who are sexually abused do not inform the authorities and suffer in silence. The abuse will often last for many years only stopping when the child moves out or a new victim is groomed by the offender (4).

There is some suggestion in the literature that the high visibility in the media about sexual abuse labeling of the sexual offender as morally reprehensible and a social deviant, that the increased jail time that the offender must serve has had some impact on preventing some of the potential offenders from starting their abuse patterns. This data is mostly anecdotal and mostly inferred from international data that show a decline in rates of abuse since the 1990’s. The decline is attributed by most researchers to be more closely related to an improved economy, and newer psychopharmacology treatments for some of the mental health disorders existing in the offender population (5). The rates of reports may be an inaccurate barometer because surveys of late adolescent females continue to show a childhood prevalence of sexual abuse of 20%.

There is data that some tertiary prevention programs have been developed that target specific populations. The Centers of Disease Control (CDC) has instituted the Preventing Sexual Abuse in Youth Servicing Organizations as an intervention strategy to reduce the potential for abuse in churches, boy scouts, schools, etc. An example of a strategy for these organizations is to never allow an adult male to be alone for any period of time. Each adult needs to buddy up with a second adult for all activities. Another strategy is to provide the new applicants to look for potential background risks.

Finally a concept of tertiary prevention that targets improving resilience and strengths in the offender population also shows positive results. These community reintegration programs are generally labeled as the Good Life concept. The foundational belief of the process is that rather than focus on the deviant behavior there is a focus on improving the overall capacity for the individual offender to succeed in life. This incorporates improving social skills and helping the offender lead a more successful life. Perhaps the best prototype of

*Jersey Shore University Medical Center

Address: Steven Kairys, M.D., Chairman of Pediatrics Jersey Shore University Medical Center Mirandla Pediatric Associates 1945 Route 35 K. Hovnanian Children’s Hospital Neptune, NJ 07753, USA

E-mail: skairys@meridianhealth.com

The numbers themselves are staggering. Even more alarming is the long term damage wrought by that abuse. Felitti describes in his Adverse Childhood Experiences (ACE) studies the lifelong, hormonally significant impact of adverse experiences such as abuse. His study supports the epidemiological studies of abuse already highlighted. His cohort of adults describes the least of two or four major adverse childhood experiences occurring to at least 20% of his sample. An ACE can be major trauma such as abuse, neglect, sexual abuse, parental violence, parental substance use, a traumatic divorce to the parents. And for every adult so exposed to these traumas, there is an algorithmic relationship between risk of the consequence and the number of experienced ACE’s. The risk of adult depression, drug use, heart disease, liver disease, impaired work performance, promiscuity, and early death increases exponentially as the number of experienced ACE’s (3).

The reasons for these alarming effects are multiple, but a few major determinants are clear. First many children so exposed develop coping strategies that are harmful to themselves. They cope with the damage with risky behaviors such as smoking and drinking and poor eating. They have poor self esteem and difficulty with social skills and performance. The trauma also impacts the developing brain causing an increase in the synapses that favor impulsivity and emotional liability. This appears caused by the increase in stress hormones and neurotransmitters that increase during period of acute and chronic distress. Thus a vicious cycle of poor coping aggravated by the brain’s trauma driven responses is set into action and the result is an escalation of the trauma’s effects.

Treating these issues after they are evident is difficult and rarely effective, the damage is too great and the treatment options too few. Primary prevention is key to reducing the number of children who become victims of abuse. Secondary prevention, the early detection of already occurring abuse, is crucial for reducing the impact that abuse will have for the child/Tertiary prevention, reducing impact for the large number of children already reported for abuse is also of value. This review will highlight the evidence for primary, secondary and tertiary prevention interventions.

Primary Prevention of Sexual Abuse

Prevention of sexual abuse has been elusive in part because the etiology and risk factors for the abusing adult are still poorly understood. Offenders come from all ages and backgrounds, and one third of offenders are adolescents. Offenders are loosely stratified as being fixated or being repressed. Even here the typology is poorly established. At one extreme is the fixated offender, almost always a male, who only chooses child targets and has no remorse for his actions; a sociopathic deviant. At the other extreme is the repressed offender, often married, who suffers from poor social skills and poor self image and then feels remorse and regret about the abuse occurs. The offenders have to exhibit emotional congruence for the abuse, an abnormal sexual arousal towards children, blockage and thinking errors that allow them to groom the child for abuse, and then disinhibition of the internal barriers that would deter the abuse from occurring. Many of the abusers here themselves sexually abused themselves when younger.

Moreover, 80% of children who are sexually abused do not inform the authorities and suffer in silence. The abuse will often last for many years only stopping when the child moves out or a new victim is groomed by the offender (4).

There is some suggestion in the literature that the high visibility in the media about sexual abuse labeling of the sexual offender as morally reprehensible and a social deviant, that the increased jail time that the offender must serve has had some impact on preventing some of the potential offenders from starting their abuse patterns. This data is mostly anecdotal and mostly inferred from international data that show a decline in rates of abuse since the 1990’s. The decline is attributed by most researchers to be more closely related to an improved economy, and newer psychopharmacology treatments for some of the mental health disorders existing in the offender population (5). The rates of reports may be an inaccurate barometer because surveys of late adolescent females continue to show a childhood prevalence of sexual abuse of 20%. This review will highlight the evidence for primary, secondary and tertiary prevention interventions.

Secondary Prevention of Sexual Abuse

In many countries programs have been developed at teaching young children about their bodies and how to protect themselves. Such school based programs as Talking about touching and the Child Assault Prevention Program are aimed at giving children and their parent’s information and skills to reduce the impact of sexual abuse. There is little data to suggest that these very popular programs prevent the abuse from actually occurring. The dynamics of the abuse/ victim relationship are complicated and long term and not so easily dislodged by a school program. However, do seem to be an effective secondary prevention strategy. They do help with the earlier disclosure of ongoing abuse and they do help reduce some of the self blame and psychological distortions that lead too much of the damage from the abuse. Programs that also involve the parents and other adults in the trainings to improve bystander protection for the children; more knowledgeable adults are more likely to be concerned about potential abusive interactions (6).

The United Kingdom has a country wide effort at early detection. The country has a very visible national campaign, the Stop It media campaign that regularly details the factors leading to the abuse and the large impacts it has for the victim. The country also has established hot lines for anyone to call anonymously and receive advice or recommendations. These programs are popular elsewhere also although there is as yet little data to support their effectiveness or efficacy.

In the United States secondary prevention programs have been developed that target specific populations. The Centers of Disease Control (CDC) has instituted the Preventing Sexual Abuse in Youth Servicing Organizations as an intervention strategy to reduce the potential for abuse in churches, boy scouts, schools, etc. An example of a strategy for these organizations is to never allow an adult male to be alone for any period of time. Each adult needs to buddy up with a second adult for all activities. Another strategy is to provide the new applicants to look for potential background risks.

There is data that some tertiary prevention programs have been developed that target specific populations. The Centers of Disease Control (CDC) has instituted the Preventing Sexual Abuse in Youth Servicing Organizations as an intervention strategy to reduce the potential for abuse in churches, boy scouts, schools, etc. An example of a strategy for these organizations is to never allow an adult male to be alone for any period of time. Each adult needs to buddy up with a second adult for all activities. Another strategy is to provide the new applicants to look for potential background risks.

Finally a concept of tertiary prevention that targets improving resilience and strengths in the offender population also shows positive results. These community reintegration programs are generally labeled as the Good Life concept. The foundational belief of the process is that rather than focus on the deviant behavior there is a focus on improving the overall capacity for the individual offender to succeed in life. This incorporates improving social skills and helping the offender lead a more successful life. Perhaps the best prototype of

S. Kairys. The prevention of child sexual and physical abuse. Paediatr Croat. 2015; 59 (Supl 1): 208-211
Prevention of Physical Abuse

As referenced in the introduction physical abuse is a common form of trauma to children. There are two peaks for physical abuse, the first in the 0 to 3 year old population and the second in the teen age years. Physical abuse, like sexual abuse, is more often chronic than acute and often unremitting. There are numerous risk factors for the occurrence of child abuse. Parental characteristics include premature birth, difficult temperament, disabilities, and chronic illness. Parental risk factors include a parent with depression or low self esteem, poor impulse control often related to substance abuse, parents maltreated when they were children, parents with unrealistic expectations or beliefs about the child, parental stress, domestic violence, and parental history of child abuse. There are still many questions about the specific thinking errors associated with trauma. Reactive Attachment Disorder Therapy is a intensive treatment approach that occurs in so many children damaged by abuse. There are still many questions about the specific thinking errors associated with trauma. Reactive Attachment Disorder Therapy is a intensive treatment approach that occurs in so many children damaged by abuse.

Secondary Prevention

Most early identification programs target families with potential risk factors and uniformly screen these parents for risk. The program is called Post Partum Depression Scale screens for maternal depression. There are screening tools for infant temperament, child behavior, domestic violence, parental substance use, and for parental stress and distress. Most pediatricians have integrated these components into their practices.

Conclusion

This paper attempts to provide an overview of some of the evidence based approaches to the primary, secondary and tertiary prevention of sexual abuse and physical abuse. There are still many gaps in our core knowledge of etiology and sequelae. There is no question as to the enormity of the impact both in terms of the number of children affected and the extent and the length of the damage. More work needs to be done about primary prevention because even with improved secondary prevention many children will have had months of mal-treatment prior to being identified. And for sexual abuse most children will take a very long time to disclose the abuse. The review offers hope and shows a number of effective approaches. None of these approaches are easy to produce and many need community commitment. The potential benefits far outweigh the barriers.

LITERATURE