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Pregled
Review

THE PREVENTION OF CHILD SEXUAL AND PHYSICAL ABUSE

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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.

Descriptors: CHILD ABUSE, PREVENTION OF ABUSE, EARLY IDENTIFICATION OF ABUSE, COMMUNITY HEALTH

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.

Straus in his anonymous telephone surveys of conflict in the home details over 15% of low income families and 10% of middle income families with significant physical violence in the home (1). Myriad of studies document that as many as 20% of late adolescent females and 10% of males report having been sexually abused as a child (2).

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The numbers themselves are staggering. Even more alarming is the long term damage wrought by that abuse. Felliti describes in his Adverse Childhood Experiences (ACE) studies the enormous impact of adverse experiences such as abuse. His study supports the epidemiological studies of abuse already highlighted. His cohort of adults describes at least three 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 worker 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 regressed. Even here the typology is poorly defined. 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 regressed offender, often married, who suffers from poor social skills and poor self image and then feels remorse and regret after the abuse occurs. The offenders have to exhibit emotional congruence for the abuse, an abnormal sexual arousal toward 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 adolescents were 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 and the 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%.

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. He programs, 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 also 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 Serving Organizations as an intervention that details strategies 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 profile the new applicants to look for potential background risks.

Tertiary Prevention

Tertiary Prevention of Abuse has enormous appeal in countries that utilize the strategies, even though the actual impact appears to be limited. The United States has taken the lead with these approaches such as Offender Registration laws; known in the US as Meghan's law and also Community Notification of offenders moving into a neighborhood. There is a feeling of security that these programs impart to a community that the offenders are now visible and that the community is aware of the individuals.

Studies however should limited or no impact and the potential for negative effects. In many communities there are high rates of non-compliance by the offender and often only sparse oversight provided by law enforcement. These programs reinforce the false belief that most offenders are strangers to the victims and dirty old men in raincoats. Moreover most new offenses come from offenders not previously known to law enforcement. Recidivism of known offenders is only 14% and only 10% of new offenses come from previously known offenders. Stranger abuse is a small minority of the abuses. Over 25% are by family members (7).

There is data that some tertiary prevention is effective. Cognitive Behavioral Therapy is an approach that reduces the thinking errors and poor coping strategies that are high risk factors for most of the regressed offenders and some of the fixated offenders. For adolescent offenders, the Multi-Systemic Therapy process shows a great deal of promise. This process combines intensive family interventions with improving parenting skills, improving school performance and reducing affiliations with other delinquent appears. Studies show as much as a 30% reduction is recidivism (8).

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 generically labeled as the Good Life concept. The foundational belief of the process is that rather than a 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

this approach is the Canadian Circles of Accountability and Support (COSC). This program has spread to a number of other countries. It incorporates the use of volunteers who help develop normative relationships with the offender and improving offender strengths. The process is more successful the deeper the relationship established by the volunteer and the offender. In one study, this program demonstrated a 70 & lower rate of recidivism compared to a control matched population of offenders. These sorts of programs appear especially useful for the regressed offender population and much less so for the fixated sociopathic offender (9).

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 then acute and often unremitting. There are numerous risk factors for abuse. Child 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's behavior or development and parents with a punitive childrearing style. Social risk factors include physical isolation, domestic violence, poverty, being a single parent. And triggering situations can include a crying baby, a child's misbehavior, family conflict, toilet training failure or major life transitions.

For most children the physical injuries are short term and do not leave long term damage. The major exception is abusive head trauma. The developmental, intellectual, behavioral and emotional aftereffects, however, are chronic and often disabling. The earlier the abuse, the more chronic, the more intense, the more emotional distant the parent - all of this increases the damage. For abused infants the impact can include Reactive Attachment Disorder, delayed development, stunted growth. For older children the aftermath includes ADHD type behaviors, anxiety, depression, aggression, PTSD symptoms, school failure, substance use and delinquency. As with sexual abuse the key to ameliorating the impact for the child, the family and the society is prevention.

Primary Prevention

There are a number of programs that have strong evidence base of effect in prevention child abuse. The most highly tested program is the Nurse Family Partnership Program developed and still tested by Dr David Olds in the USA (10). This program is a rigorous program that used nurses working with young single parents. The program begins in mid-pregnancy and extends to the first two years of the childhood. The program is voluntary and includes skill building, parenting support, support with personal growth and problem solving. This program has been active for the past 20 years and the data document a 48% reduction in child abuse.

A less tested program is the Healthy Families program that uses non professional home visitors for women starting after the birth of the infant. There are weekly home visits and is also voluntary. One study showed a preliminary 75% reduction in child abuse measured two years after the intervention.

Another evidence based program is the Triple P (Positive Parenting Program). This program originated in Australia but has been widely tested in the USA. It is a community based program that works at many levels, form general information and media support about positive parenting, to universal education about parenting through lectures, to more intensive home based support for families identified by primary care The program was instituted throughout 18 counties in the State of South Carolina in the 2000's. The data showed a 28% reduction in child abuse and a 44% reduction in out of home placement (11).

More targeted evidence based approaches include the Period of Purple Crying, and the Don't Shake the Baby effort in the newborn period. Both work with hospitals to engage families to understand that crying is natural in early infancy and there are techniques that work.

Several community based programs also desire attention. The Durham (Durham, North Carolina) Family Initiative is a broad community wide that provides a plethora of interlocking and interconnected initiatives. These include universal home visits, cross training of staff, integration of involvement, broad communication with physicians and parents, and area wide data collection. The program has documented a 57% reduction in child abuse. The theory of change holds that child abuse is a breakdown in the child-parent relationship that occurs in the context of risk in which a) the family is dysfunctional b) the community does not provide sufficient supports and c) the broader health and legal systems do not provide adequate support for families (12).

Secondary Prevention (early identification)

Most early identification programs target families with potential risk factors and uniformly screen these parents for those risk factors. The Edinburgh 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 resisted using an organized screening process. The Bright Futures initiative of the American Academy of Pediatrics has packaged many of these components into its tool kit. Project SEEK started by Dubowitz in Baltimore uses screening and then social work support to help pediatricians when confronted with a family in distress. The project reports a reduction in child abuse reporting in the practices engaged in the project (13).

Tertiary Prevention aims to reduce the damage that abuse brings to a child or adolescent. As with sexual abuse there are trauma specific therapies that appear to be effective. Cognitive Behavioral intervention does increase problem solving and orientation. Dialectic Behavioral Therapy is an offshoot that targets the specific thinking errors associated with trauma. Reactive Attachment Disorder Therapy is a very intensive process of working with the young child and the parents to increase trust, attachment, and security and reduce shame and projections. The most damaged of these children are at times referred to as 'onions' in that there appears to be no inner core, no self that can identified and thus the ongoing mistrust, lying, aggression, and self inflicted injuries (14).

Less studied but promising interventions include those directed at the distorted brain architecture and processing now evident of functional MRI in traumatized children. Brain spotting, EMDR appear to hold promise in some way altering the brain interconnections and therefore reducing components of the vicious cycle of perception and reaction that occurs in so many children damaged by abuse.

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 maltreatment 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 showcases 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.

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Saţetak

PREVENCIJA DJEČJEG SEKSUALNOG I FIZIČKOG ZLOSTAVLJANJA

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Dječje seksualno i fizičko zlostavljanje ima epidemijsku prevalenciju u djece. Dodatno, nađeno je da su utjecaj i dugotrajni učinci često doživotni i utječu ne samo na emocionalne i psihološke poremećaje već i na mentalno zdravlje. Terapija nakon događaja je teška, i prečesto ima minimalni pozitivni dobitak. Prevencija je ključna za mijenjanje dinamike i učestalosti zlostavljanja te smanjenja negativnih ishoda koje ima na dijete, obitelj i cijelo društvo. Ovaj pregledni članak iznosi trenutno stanje o primarnim, sekundarnim i tercijarnim preventivnim programima seksualnog zlostavljanja te zatim i fizičkog zlostavljanja.

Deskriptori: ZLOSTAVLJANJE DJETETA, PREVENCIJA ZLOSTAVLJANJA, RANO PREPOZNAVANJE ZLOSTAVLJANJA, JAVNO ZDRAVSTVO

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