Introduction

Child sexual abuse is a crime in Australia and New Zealand. All sexual activity between adults and children is part of an unequal power relationship, in which children are exploited and harmed.

The severe trauma of child sexual abuse renders children who have been victims of such abuse vulnerable to psychiatric disturbance and impaired development.

Psychiatrists play an important role in the identification, reporting, assessment and treatment of the effects of child sexual abuse and working with patients affected by child sexual abuse across their lifespan.

As demonstrated by the current Australian Royal Commission into Institutional Responses into Child Sexual Abuse, there is a growing awareness of the profoundly destructive effect of child sexual abuse in the community and a growing number of people who will no longer accept silence and inaction by either individuals or institutions in response to these issues (Middleton et al., 2014).

Evidence

Prevalence of child sexual abuse is difficult to determine accurately. Because of the criminal sanctions against it and the young age and dependent status of the child, there are likely to be a number of unreported incidents (Fleming, 1997). Recent Australian studies that have comprehensively measured the prevalence of child sexual abuse found that that males had prevalence rates of 1.4-8.0% for penetrative abuse and 5.7-16.0% for non-penetrative abuse, while females had prevalence rates of 4.0-12.0% for penetrative abuse and 13.9-36.0% for non-penetrative abuse (AIFS, 2013). In New Zealand, the overall prevalence rates were 23.5% for women from the urban region and 28.2% from the rural region (Fanslow et al., 2007).

The Australian Institute of Health and Welfare compiles data relating to child protection notifications annually. In 2013–14, there were around 40,884 children in substantiated abuse or neglect cases. Sexual abuse made up approximately 14% of these cases. Substantiated sexual abuse was more common amongst girls than boys (AIHW, 2014).

The effects of child sex abuse can be serious, with significant social and economic costs. Child sexual abuse can leave victims vulnerable to both short-term and longer-term harms. Psychiatric effects may include depression, anxiety, post-traumatic stress disorder, eating disorders, suicidal thoughts, and substance abuse (Mullen and Fleming, 1998; Kendler et al., 2000; Arnow, 2004; Widam et al., 2007).

There is also evidence that suggests that sexually abused children suffer from more psychological symptoms than children who have not been abused (Dinwiddie and Health, 2000; Nelson et al., 2002), show more risky sexual behaviours and can be more sexually aggressive themselves (Seto et al., 2010). When a victim of sexual abuse presents for treatment, consideration must be given to their age, current circumstances, safety, family and comorbid conditions. Ensuring their environment is safe from further abuse should be a priority. Treatment often serves a dual purpose; to treat current mental health issues as well as prevention of further sequelae and revictimisation. Although there is some evidence of effective treatment, further work is needed to develop both therapeutic and preventative interventions for...
child sexual abuse, particularly minimising the longer-term implications (Freyd, 2005; Nurcombe et al., 2000).

History of child abuse may be an important element of assessing risk benefit balance when considering antidepressants for treating patients who present with a history of child abuse and may help guide the appropriate level needed for that patient during antidepressant initiation. Research suggests that patients who have a significant history of child abuse have greater levels of suicidality during the initial stage of antidepressant treatment (Singh et al., 2013).

**Children with problematic sexual behaviours**

There is a group of children and young people who, through having themselves experienced sexual or other abuse, witnessed domestic violence, or been inappropriately exposed to sexual material may show problematic sexualised behaviour (Laing et al., 2006). It is important that the behaviour is recognised and addressed, assistance and appropriate intervention from specialist services sought and the child supervised to prevent further harm to themselves or others. Identification and intervention should be done in such a way as to avoid inappropriate labelling or ostracisation of the child. There is very limited research pertaining to young children, however for adolescents, treatment programmes that intervene early and include families have very low recidivism rates (Lambie, 2007).

**Reducing reoffending for adult offenders**

In addition to treatment for victims, treatment programmes have been analysed for child sex offenders. In Australia and New Zealand, there are prison based programmes for sex offenders. In general the evidence of effectiveness of these treatments is equivocal (Hanson et al., 2009). In Australia the programmes predominantly target the known risk factors for sexual reoffending such as empathy deficits, cognitive distortions and general self-regulation (Hoy & Bright 2008).

In New Zealand, the Kia Marama programme connects cognitive and behavioural factors to offending and delivers this in a group format, with the aim of having the offender understand the origins and impacts of their offending. Kia Marama was found to be effective, illustrated through a comparison with a control group of child sex offenders not involved with the programme. Research indicates that the Good Way program from New Zealand also assists the treatment of young people with problematic sexualised behaviour (West, 2007).

**Recommendations**

Child sexual abuse is a crime and psychiatrists have an important role in its identification, reporting, treatment and assessment. Accordingly, the RANZCP makes the following recommendations:

- When child sexual abuse is suspected, the child’s protection is the primary concern and an urgent assessment must be undertaken. Child sexual abuse occurs within a family, social and cultural context, which must be fully assessed with a view to developing an appropriate management plan. The investigation into suspected childhood sexual abuse is the responsibility of child protective services. Psychiatrists, pediatricians and other professionals can have roles supporting the investigative process and supporting young people through this process. Protective issues and child safety must be addressed before effective treatment can commence.

- Intervention by appropriately trained professionals is necessary to minimise the initial effects and long-term consequences of child sexual abuse. Appropriate services should be available for victims, family members and offenders. An effective response requires coordination between protective, legal and therapeutic systems. Failure to establish such coordination may result in further harm to the child.
• Preventive strategies of child sex abuse should address broad cultural practices such as the sexual exploitation of children and adolescents for advertising purposes and the exposure of children to inappropriate sexual material.

• An adequate research base is integral to the processes of assessment, validation, treatment, prevention and community education.

• A high level of community awareness is necessary for the identification and prevention of child sexual abuse.

References


Bakker L et al. (1998) And there was light: evaluating the Kia Marama treatment programme for New Zealand sex offenders against children. Department of Corrections.


West, B (2007) Using the Good Way model to work positively with adults and youth with intellectual difficulties and sexually abusive behaviour *Journal of Sexual Aggression* 13(3): 253-266.


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