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Clinical Practice Guidelines for Child Sexual Abuse

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INTRODUCTION

Child sexual abuse (CSA) is the involvement of children and adolescents in sexual activities (usually for adult sexual stimulation or gratification) that they cannot fully comprehend and to which they cannot consent as a fully equal, self-determining participant, because of their early stage of development [[Box 1](#)].

It is important to understand the nature and type of CSA as the severity of the impact of the abuse depends on not only on the type of abuse but also on the duration of the abuse and very importantly, whether the abuser is a known/trusted person or a stranger [[Table 1](#)].

Thus, CSA is a complex issue, wherein impact and recovery depend on all of the above variables and how they combine to influence the child's experience of abuse. Even where there are two children, who have been impacted by identical forms and processes of abuse (similar variables), they may still be different in terms of their responses. This difference is accounted for personality and temperament of each child, and social context and circumstances of each child, due to which each child perceives and internalizes the abuse differently, thus resulting in different emotional and behavioral states to the abuse, and necessitating different psychosocial and mental health responses.

CSA is not a clinical condition or diagnosis. Clinical practice guidelines for standard child psychiatric conditions can be developed based on existing knowledge and practices. However, to develop clinical practice guidelines for an experience that is both nuanced and complicated by psychological and social processes is a particular challenge. Clinical practice guidelines for CSA, therefore, necessitate mental health professionals to work with many processes and systems to effectively assist the child.

CONTEXT OF CONSULTATION

There are broadly three contexts in which children present for consultation on sexual abuse issues. The first is when CSA is already established by agencies and individuals, and they refer the child to the mental health system. Such referrals may be received from: (i) District Child Protection Units; (ii) Childline and child care agencies/service providers; (ii) Police; and (iii) Courts and judicial personnel. Children are brought by such agencies and bodies either for interventions in the wake of trauma and emotional problems and/or for inquiry and evidence gathering for use in court cases. Thus, in this context, the mental health system is not required to establish whether or not CSA has occurred, as it is already known – usually, children would have reported abuse or in case of children in sex trafficking, they have been rescued through a raid on sex work institutions, and so the abuse has come to light.

The second context is one in which the child has reported to his/her parents but they, in turn, have not reported the abuse to police or legal systems. However, they seek consultation to provide the child with mental health interventions.

The third context is when it is not (yet) known that he/she has been sexually abused; the child comes to the mental health system for some psychological or psychiatric manifestation, but on enquiry and examination, CSA issues emerge in one of the following ways:

- The child discloses or reports abuse
- An adolescent girl is found to be pregnant
- (Frequent) urinary tract infections in the child are reported by the child/caregivers and/or genital injuries in the child are reported/observed
- Emotional and behavioral issues that are associated with anxiety, anger, and depression.

There is what is called an index of suspicion in CSA, i.e., when to suspect CSA and how true one's suspicions likely to be. [Figure 1](#) represents the index of suspicion in CSA. At the peak of the triangle, the index of suspicion is the highest, i.e., there is no doubt when a child reports or discloses that abuse has taken place, especially when a child spontaneously reports without particular inquiry by an adult.

Equally high on the index is pregnancy (in adolescent girls) – a sure sign that sexual abuse has occurred. Genital injuries and frequent urinary tract infections must lead to suspicion that there is digital handling and sexual abuse is very likely to have taken place. Emotional and behavioral changes observed in the child are important indicators of CSA; however, they come lower on the index of suspicion because these psychological changes may occur due to some reasons (unlike pregnancy or genital injuries which do not have a range of reasons for their occurrence!).

Emotional and behavioral issues relating to anxiety and depression may occur due to sexual abuse but may also be due to other difficult and traumatic experiences such as parental marital conflict, bullying, learning difficulties and academic pressures, loss, and grief (death-related) experiences... so, while emotional and behavioral changes may lead to CSA suspicion, further examination and inquiry needs to be made (by a psychosocial or mental health professional) to understand exactly what difficult event(s) or experiences they are attributable to in a given child. During the inquiry, if sexual abuse is ruled out, then the signs and symptoms may be attributable to other difficult experiences. Below are indices of CSA [[Table 2](#)].

PROCEDURE FOR ESTABLISHING AND CONFIRMING CHILD SEXUAL ABUSE

The procedure for establishing and/or confirming CSA has three components, namely, (i) Psychosocial and Mental Health Assessment; (ii) Developmental Assessment; (iii) Abuse Inquiry or Forensic Interviewing for CSA. The third component particularly, is predicated on the first two components, which makes it necessary for the three assessments to be done in the order in which they are listed and described.

Psychosocial and mental health assessment

It is important to obtain a detailed history and assessment of the child, including information on family and school context, developmental level and functionality, emotional and behavioral issues (pre- and post-sexual abuse), circumstances of the alleged abuse, the child's experience and understanding of the abuse and other related problems. Treatment and interventions for abuse must be developed based on the complete assessment of the child's context and issues; this is because every child is unique and has his/her own unique ways, based on age, developmental stage, personality and temperament, family and social circumstances, and the nature of abuse, of processing the abuse experience. Information requires to be obtained through the assessment of the child and family/caregivers.

The immediate aftermath of the abuse, i.e., within the first few days is not the time for asking the child to provide the abuse narrative in great detail as this is likely to distress and traumatize the child further. The objective of the Psychosocial and Mental Health Assessment [[Box 2](#)] is to establish that abuse has occurred and to know the nature of abuse, i.e., contact versus non-contact, penetrative versus nonpenetrative abuse with a view to making decisions regarding medical interventions, as well as posttraumatic stress disorder (PTSD) interventions, as necessary.

It is important to understand any emotional and behavioral issues the child had before the abuse and compare these to those that may have occurred post-abuse. This is because (i) we need to understand exactly which emotional and behavioral problems that are attributable to abuse; (ii) we need to understand how pre-abuse emotional and behavioral issues may have determined the ways in which the child has processed the abuse experience and been impacted by it. In either case, the child would need to receive treatment and assistance for all emotional and behavioral issues, both pre-existing ones as well as those that developed as a result of the abuse.

Developmental assessment

The developmental assessment requires to be completed before any forensic interviewing processes and/or interventions are entered into with children for eliciting abuse narratives.

The purposes of conducting a developmental assessment in the context of CSA are two-fold:

- To make decisions about the feasibility and use of methods to elicit the abusive narrative in accordance with the developmental abilities of the child, for treatment and intervention purposes and/or as part of evidence gathering for court cases/legal processes
- To be able to design and/or deliver age-appropriate interventions; this includes the use of communication and methodologies that are comprehensible to a child in the course of treatment, including to provide personal safety education and awareness (which forms a part of the treatment interventions).

There are five specific domains of development that children require to be assessed in: physical or locomotor, speech and language, cognitive, social and emotional development. If the abilities and skills in these domains are not age-appropriate, then there are implications for forensic interviewing and evidence gathering for court cases and legal processes [Box 3].

Inquiry with the child: Forensic interviewing for child sexual abuse

This includes interviewing the child to obtain information on the sequence of abuse events and how they occurred according to the child, and how the child perceived and understood the abuse. The interview may have to be carried out in well-planned sessions, over a period of time, especially in the case of younger children or children with posttraumatic disorder. Creative play methods, such as stories, art and toys/dolls may have to be used to elicit children's narratives. Such indirect methods are gentle and nonthreatening and also allow younger children with less developed verbal abilities to communicate their experiences of abuse. During these sessions, while eliciting children's abuse narratives, open-ended questions that encourage children to express themselves freely should be used. A detailed verbatim recording of the interview should be done through written documentation as well as video recordings in case of play sessions with young children so that these can also be used for legal proceedings.

Introduction and rapport building

- Greet the child and tell him/her your name and then, ask the child his/her name
- Sit at the same physical level as child (if the child is on the floor, sit on the floor... if the child is sitting on a chair, sit on the chair next to her)
- Use toys and play activities (dolls, puzzles, picture books, and coloring books...) to engage young children and give it to the child as soon as (s)he comes to the court (while waiting for you)
- Enter into play with the child and spend 5–10 min engaging child in play activity... “what are you doing? What is the doll doing? May I see what you are coloring?”
- Engage in neutral conversation with the child for a few minutes (this also helps to assess the child's developmental abilities and skills as well as mental state)--What did you eat

for breakfast today? How did you come here today? Who are these people who have come with you?.... “

- For older children and adolescents, you may say “I really want to know you better. Tell me about the things you like to do”
- Introduce the space and the purpose of the child being there, including your role:
 - “My name is... my job here is to make sure that children are safe and no one hurts them. If we hear that someone is hurting or troubling children, then we do things to stop that from happening”
 - “You may be wondering about this busy place and many rooms...many people come here, just like you to talk about people who have hurt or troubled them...that's why we need a big space like this and many people to help”
 - “Although this place may seem a little scary and confusing, you are safe here...and after we have spent a little time talking, you can go back home with your parents or caregiver.”
- Explain the need for video camera/microphone (in case you are using such equipment) – “As you can see, we have a video-camera and microphones here. They will record our conversation so I can remember everything you tell me. Sometimes, I forget things and the recorder allows me to listen to you without having to write everything down.” (In case you are taking notes, you may provide a similar explanation to the child).

Ensuring accurate reporting

This is to ensure that the child has the competency to differentiate between truth and lies and to ensure that children tell the truth. Establish the need for telling the truth, and child's capacity to differentiate between what's true or not and to say “I don't understand” or to tell examiner when he makes a wrong statement:

- Part of my job is to talk to children (teenagers) about things that have happened to them. I meet with lots of children (teenagers) so that they can tell me the truth about things that have happened to them. Hence, before we begin, I want to make sure that you understand how important it is to tell the truth
- For younger children, explain: (“What is true and what is not true”). “If I say that my shoes are red (or green) is that true or not true?” (Wait for an answer, then say:) “That would not be true, because my shoes are really (black/blue/etc.). And if I say that I am sitting down now, would that be true or not true (right or not right)?” (Wait for an answer.) It would be (true/right) because you can see I am really sitting down.’ “I see that you understand what telling the truth means. It is very important that you only tell me the truth today. You should only tell me about things that really happened to you.” (Pause)
- “If I ask a question that you don't understand, just say, “I don't understand.” Okay?” (Pause) “If I don't understand what you say, I'll ask you to explain. “What would you say if I made a mistake and called you a 2-year-old girl (when interviewing a 5-year-old boy,

etc.)?” (Wait for an answer.) “That's right. Now you know you should tell me if I make a mistake or say something that is not right.

You may record your observations as follows:

- Capacity to differentiated “truth” established Yes No
- Capacity to say “I don’t understand” established Yes No
- Capacity to tell interviewer that she/he “is not right” established Yes No.

Training in episodic memory

Episodic memory represents our memory of experiences and specific events in time in a serial form, from which we can reconstruct the actual events that took place at any given point in our lives. It is the memory of autobiographical events (times, places, associated emotions, and other contextual knowledge) that can be explicitly stated. Individuals tend to see themselves as actors in these events, and the emotional charge and the entire context surrounding an event is usually part of the memory, not just the bare facts of the event itself (http://www.human-memory.net/types_episodic.html). It is essential to encourage children to provide detailed responses early in the interview as this enhances their descriptive responses to open-ended prompts in other parts of the interview, particularly those related to the abuse incident. Hence, at this stage of the interview, training in episodic memory or narrative practice should be done as follows:

- ” It is very important that you tell me everything you remember about things that have happened to you. You can tell me both good things and bad things”
- Identify a recent event the child experienced- the first day of school, birthday party, holiday) and build up on that using qualifiers like tell me, what happened next, “Think hard about (activity or event) and tell me what happened on that day from the time you got up that morning until (some portion of the event mentioned by the child in response to the previous question). “Tell me more about (activity mentioned by the child).” (Wait for an answer.) Use this prompt as often as needed throughout this section]
- “Earlier you mentioned [activity mentioned by the child]. Tell me everything about that.”

Note: Focus on real-life events; avoid focusing on accounts relating to television, videos, and fantasy.

Abuse enquiry

- Now transition to substantive issues to enable the child to provide you with the narrative by using open questions such as:
 - “Now that I know a little about you, I want to talk about why (you are here) today”
 - “I heard you talked to “X” about something that happened – tell me what happened”
 - “I see you have (a bruise, a broken arm, etc.,) – tell me what happened”

- “I heard you saw (the doctor, a policeman, etc.) last week – tell me how come/what you talked about”
 - “Is (your mom, another person) worried about something that happened to you? Tell me what she is worried about”
 - “I understand someone might have troubled you – tell me what happened”
 - “I understand someone may have done something that wasn’t right – tell me what happened”
 - “I understand something may have happened at (location) – tell me what happened”
- Young children, who either do not have the language to name private parts and genitals or are unwilling to name these parts due to fear and embarrassment, use pictures or dolls to assist the child--”I will show you a picture (here is a doll)... can you show me/point to where this person touched or hurt you...”

Probe for disclosure

Use gentle probes, including some close-ended questions to confirm some details. If child has mentioned telling someone about the incident(s), ask details, if not then probe about possible immediate disclosure by saying: “Does anybody else know what happened?” How did they come to know? [\[Box 4\]](#)

Closing the interview

The closure phase helps to provide an end to a conversation that may have been emotionally difficult for the child.

- “You have told me lots of things today, and I want to thank you for helping me.”
- “I want to especially tell you how brave you are for telling me all that happened... things like this happen to many children, but they don’t always want to tell others about it... because they are afraid. You may also have been scared, but you were brave to tell people about it – I am sure your parents are proud of you... I am too”
- “Is there anything else you think I should know?”
- “Is there anything you want to tell me?”
- “Are there any questions you want to ask me?”
- “If you want to talk to me again, you can call me at this phone number and come and see me again.” (Give the child or caregiver your name and phone number).

IMPACT OF CHILD SEXUAL ABUSE AND IMPLICATIONS FOR INTERVENTION

After eliciting the abuse narrative, it is critical to understand the methods and processes used by the perpetrator to sexually abuse the child. CSA is a process that consists of a series of actions

entailing lure, seduction, manipulation and/or coercion and threat. Different methods and processes of abuse have different psychological impacts on children and adolescents. Not all CSA results in trauma; in fact, where CSA methods use lure, seduction, and manipulation to “manufacture” the consent of the child (versus methods of threat, violent coercion, and aggression), there may be the less overt or visible traumatic reaction in the child [Table 3].

Abuse in the context of “manufactured consent”

When abuse has taken place through grooming processes (i.e., lure, inducement, and manipulation) and violence, threat and coercion methods have played little or no role in the abuse process, children/adolescents are less likely to be aware of and acknowledge the abuse [Box 5].

Implications for intervention

- Focus on helping children recognize various types of child (sexual) abuse, including understanding why and how certain actions constitute abuse
- Reassurances to child on safety and protection (from the perpetrator)
- Arrangements with parents/caregiver to ensure the child's safety and protection.

Abuse of young children

In younger children, the methods of abuse entail (i) inducement and lure and/or (ii) coercion and threat. Inducement and lure entail the use of sweets and toys to get children to perform or cooperate in sexual acts for adult stimulation. Perpetrators also use attention and affection in exchange for sexual favors, i.e., provision of attention and affection when the child complies with the adult on sexual acts and withdrawal of attention and affection when the child does not. These methods are followed by the perpetrator creating excitement and secrecy around the sexual act, often presenting it to the child as a “special new game,” a “secret game” that no one else plays and no one else knows about; and young children, who have no understanding of sexuality are vulnerable to such ruses.

Implications for intervention

- Medical assistance in case of violent abuse and physical injury
- Teaching children about safety issues related to strangers as well as known persons
- Enabling children to learn how to protect their bodies, i.e., which body parts should not be touched by anyone except for select family members such as mothers/caregivers during personal hygiene activities
- Helping children discern between “safe” and “unsafe” secrets
- Validation of emotions and provision of reassurance for children who may be traumatized by the CSA.

Abuse of adolescents

In older children and adolescents, the processes of abuse are similar, but the use of lure and inducement are slightly different and these processes are also known as ‘grooming’ [Box 6]. Given that adolescents are at a life stage wherein they are interested in issues of love, attraction and sexuality and are also keen to experiment with these experiences, perpetrators tend to use lure and inducements that are more emotional in nature (rather than the more material ones used with younger children). This means that they smooth talk adolescents about their physical appeal and qualities, making promises of long-term emotional, and romantic relationships with them—and adolescents interpret these actions as being loving and romantic.

Again, given the life stage adolescents are at, often also under peer pressure to experiment with sexuality, offenders have the perfect opportunity to manipulate them into sexual engagement by transmitting all sorts of misconceptions about sexual behaviors and norms. For instance, appealing to adolescents’ need to “fit in” with their peers, perpetrators tell adolescents that it is necessary to gain sexual experience, that it would be “uncool” if they are ignorant about sexual acts. As a result, adolescents, who are still acquiring life skills such as (sexual) decision-making, are negatively influenced, believing in the misconceptions transmitted to them, confused by how they should respond.

Following such manipulation and abuse, adolescents experience feelings of tremendous confusion, especially as they have shared “deep” sexual and romantic relationships with the offender. They find it exceedingly difficult to discern this as an abused process and defend the offender, often refusing to accept that this is abuse.

Implications for intervention

- Medical assistance in case of violent abuse and physical injury
- In case of pregnancy, decisions around medical termination of pregnancy, depending on the medical issues as well as the adolescent's desire to have/keep the child, i.e., from a child rights’ perspective, facilitating discussions with the adolescent to help her make decisions about her pregnancy
- Helping adolescents explore notions of love, romance, and relationships
- Enabling adolescents to understand various forms of coercion, ranging from material lure to persuasion and threat; focussing on an understanding of consent in sexual relationships [Box 7]
- Personal safety awareness and education focussing on equipping adolescents with sexual decision-making skills (a life skills approach)
- Validation of emotions and working with notions of self-identity, including feelings of guilt and shame, in children and adolescents who may be traumatized by the CSA.

INTERVENTIONS

As also shown in [Figure 2](#), CSA interventions can be broadly categorized into three types of responses:

- a. Medical assistance

- b. Psychosocial interventions
 - i. First level responses for children
 - ii. Depth therapeutic interventions for children
 - iii. Interventions for parents and caregivers.
- c. Legal assistance.

Medical assistance

In case a child is referred immediately after abuse, i.e., within a few hours or days), it is necessary to first proceed with a medical evaluation and requisite medical interventions as a priority. Treatment history and response to treatment (in case the child has already undergone or is undergoing treatment) should be recorded. Ideally, it must be ensured that the child is provided with emergency medical services within 24 h of filing the first information report (FIR) in case a police report has been filed or even otherwise.

Physical examination

- Physical examination of the child to be conducted including 2 ID marks
- The child's family or caregiver should be present in the room during the examination
- Permission of the child and consent of the parent to be taken before the examination
- What physical symptoms does the child have at present/(e.g., burning sensation during micturition, White Discharge per Vagina, itching in the perineal area, bleeding, any injury, pain in any area, etc.)

Post-exposure prophylaxis

If a child is within the 36 h window period (especially in case of penetrative abuse):

- Has the child received Postexposure prophylaxis (PEP) (within 36 h) in case of penetrative abuse?
- If not, refer to Paediatric ART Centre for PEP
- Even if the child is not in the window period and the penetrative abuse has occurred within a month, refer to the Paediatric ART Centre so that a decision can be taken regarding initiation of PEP
- Ensure that the child/adolescent has received oral contraceptive pills to prevent pregnancy
- Ensure that the child has been medically evaluated by a Registered Medical Practitioner, namely a paediatrician or gynecologist from a government hospital, for sexually transmitted diseases (STDs), urinary tract infection and/or injuries. The STD investigation must be repeated at the end of 4 weeks, 3 months, and 6 months.

Forensic examination

Check whether an additional specific forensic evaluation has been done (examination requested by police documenting abuse, if swabs have been taken in case of penetrative abuse), and if so, whether the report is available. Obtain the report from the relevant source.

Pregnancy tests

- Ensure that a urine pregnancy test has been done
- In case the results are a false negative, it would be best to obtain an additional gynecological opinion
- In case the child/adolescent is under 20 weeks pregnant, discussions about abortion may need to be done with the child/adolescent and her caregivers. It is also advisable to liaise with an obstetrician at this time.

Psychosocial and mental health interventions for children and families

Following medical assistance, or simultaneously, psychosocial and mental health interventions should be initiated for the child and family, based on the Psychosocial and Mental Health Assessment completed. Developmental assessments and forensic interviewing may follow subsequently, and be embedded in the counseling and therapy processes.

Pharmacotherapy

Pharmacotherapy is not specifically indicated for CSA unless it results in severe anxiety and depressive states. Children who have undergone CSA and present with severe PTSD will require medication in addition to other psychosocial interventions:

- These medications include specific serotonin reuptake inhibitors (SSRIs) and/or benzodiazepines, in dosages recommended as per body weight. SSRIs are also indicated in situations where CSA results in severe depression associated with self-harm behaviors, dissociation, and agitation. States of agitation may call for SOS medication with low dosage benzodiazepines
- There are a group of children with pre-existing vulnerabilities or those in whom the trauma is so destabilizing that it results in mood dysregulation. This group of children may require mood stabilizers.

Older children and adolescents, particularly, must not be coerced to take medication in case they are unwilling i.e. they require to be counselled, including on issues of need and adherence [[Box 8](#)].

First level psychosocial responses for children

Asking questions, and attempting to establish depth interventions when the child is facing a crisis, i.e., in the immediate aftermath of abuse, is not a useful beginning. This is not the time to for detailed enquiry. If there are serious and disruptive manifestations such as self-harm behaviors, incapacitating anxiety, PTSD symptoms with severe panic, appropriate psychiatric

referral at this stage is important (as psychiatric medication may be required for anxiety symptoms to reduce before any counseling work is initiated). However, certain initial responses or what are known as first level responses [Box 9] of a supportive nature require to be provided to the child.

Ensuring child's safety

Depending on where the abuse occurred and who the perpetrator is, it is essential to immediately take measures to protect the child from further abuse. This is especially applicable when the perpetrator is a family member or a person known to the child, and where the abuse has occurred at home or in places the child frequents on a daily or regular basis (such as school/tutorials, etc). Even in instances where the child and/or family are not willing to file an FIR with the police, it is imperative to take actions that keep the child safe, i.e., remove the child from being in contact with the perpetrator. These may necessitate (temporary) measures such as making alternative living arrangements for the child, with relatives/extended family with whom the child feels safe and comfortable.

In case the abuse has occurred at school, the child may be permitted to stay away from school until such time as other processes, legal and psychosocial, are in place; at a later stage, a change in school may also be considered, should the child and family wish not to return to the same school.

Rest and recreation

Children who have been sexually abused first and foremost require time to rest and recover from traumatic experiences. They may, therefore, be encouraged to play, listen to music, do art activities purely for recreational purposes to keep them entertained but at the same time also occupied (so that they are not sitting idle and constantly thinking about the traumatic experience). Parents and caregivers must be encouraged to spend quality time with children, playing with them and reassuring them about their safety, but not trying to extract details of the abuse.

Relaxation exercises

Drawing from cognitive behavior therapy methods, relaxation exercises can be used to help sexually abused children control and manage anxiety or anxiety-provoking thoughts. Essentially, this means getting children to focus on thinking or doing something different, to calm and/or distract the mind at times of high anxiety. Such exercises entail deep breathing and guided imagery (Guided imagery is a method of relaxation which concentrates the mind on positive images in an attempt to reduce pain, stress, etc. The activity gets children to use their imagination to leave their present (difficult situation/thoughts) and think of or “go to” happier places and situations instead), who will need to be taught how and when to use these techniques, i.e., to use them every time they feel the abuse images returning (PTSD) and their anxiety increasing.

Resuming daily routine and developmental activities

As and when children are ready, it is best for them to resume their daily routines so that their developmental needs continue to be met. Abuse-focused healing interventions alone are insufficient and healing and recovery can also take a long time; in the interim, it is therefore

important to recognize the importance of maintaining children's developmental trajectories – which are disrupted by experiences of trauma and abuse. Enabling children gradually to return to daily schedules and activities such as school and play helps to restore:

- Normalcy and balance
- Predictability (something that is lost in the abuse situation due to the lack of predictability of abusers and of abuse events)
- Control, i.e., enables children to feel that they have some control over their time and activities, and decisions on what to do.

All of the above therefore also help reduce anxiety. Helping children to structure and organize their day to accommodate various activities such as daily self-care activities (bathing, eating, etc.), school, play, relaxation and recreation, family/social time also leaves a lot less time for children to be thinking about the abuse events that lead to anxiety.

Depth therapeutic interventions for children

Longer term therapy entails regular sessions between a trained therapist or mental health professional to engage the child in reflection and dialog to process and resolve the abuse experiences. It is only after the first level responses that healing interventions are undertaken. They are longer-term processes, entailing in-depth work with the child. The purpose of therapy with sexually abused children or adolescents is NOT to help them “forget” the experience and “get past it.”

The objectives of depth therapeutic interventions for sexually abused children and adolescents are:

- Inquiry – Helping child to detail/provide a narrative on sexual abuse experience in a gentle, non-threatening manner
- Healing and Recovery – Enabling child to overcome abuse trauma and move from confusion to clarity; empowering child to develop coping & survivor skills
- Personal Safety and Abuse Prevention: Identifying ways to cope/respond in case abuse is imminent or after abuse has occurred (for children); acquire life skills such as decision-making, assertiveness, negotiation (for adolescents).

Therapeutic methods need to be innovative and age-appropriate. Thus, multiple creative methods that allow for children and adolescents to understand and reflect on situations and experiences require to be used (versus mere information and instruction giving). Below is a framework for designing activities and interventions to assist children with the trauma of sexual abuse [Figure 3]. Various types of creative methods, ranging from art and story-telling to theater, and cognitive-behavior therapy methods for containment and emotional regulation may be used.

- i)

Memory work (confusion to clarity):

- Helping the child detail the event: who, when, what

- Helping the child make sense of what happened, including feelings/emotions/behaviors.

• ii)

Skill training (self-estrangement to self-awareness; poor survivor skills to good coping skills, entrapment to empowerment; negative self-image to self-acceptance):

- Assertiveness skill building
- Self-esteem enhancing tasks
- Re-gaining control and mastery
- Affect (emotion) regulation.

• iii)

Vision for the Future (self-estrangement to self-awareness; poor survivor skills to good coping skills, entrapment to empowerment; negative self-image to self-acceptance):

- Who am I/Identity establishment
- What do I want to be

• iv)

Containment and emotional regulation (poor survivor skill to good coping):

- Relaxation techniques
- Guided Imagery/music/deep breathing
- Maintenance of a mood diary
- Normalization – going back to school/play/routine activities.

The NIMHANS CSA and Personal Safety activity books [Box 10], including the adolescent life skills series on gender, sexuality, and relationships may be used for preventive-promotive and curative purposes. These activity books have been developed using what is called a “window approach” [Figure 4], to provide a framework for understanding abuse and sexual decision-making (in the case of adolescents). A window approach entails not speaking directly or only about abuse (prevention), which may be the final objective and therefore, the last discussion in the activity sequence, but “opening each window,” one by one to introduce different but related concepts of personal safety and abuse.

For children, the activity books begin with “Body Games” wherein the activities focus on getting children to be comfortable with and appreciate their bodies because of all the fun and interesting things they can do with their bodies. This is followed by the theme on “Body Parts and Functions” wherein there are a series of activities that give children a language to be able to name body parts, especially private parts (which children often have no names for), and to be comfortable with naming body parts, including private parts. Building on this basic

understanding of the body, the third theme focuses on “Physical Safety” or things we do to keep the body safe and protected. The next theme is “Privacy and Boundaries” wherein activities help children understand concepts of privacy, and which actions we perform in privacy and why; further, the concept of personal boundaries (an issue related to privacy) is also introduced. The fifth theme moves on to people safety. Through story-telling activities, children will be able to obtain an understanding of stranger safety and safety from known people; the latter is particularly important as most CSA occurs within homes and families and/or by known people, thereby creating the need for children to understand and maintain privacy and boundary rules even with people they know. This theme also touches on the issue of disclosure through discussions on secrets, for children are often lured or threatened into secrecy, by abusers. The sixth theme is “What if it still Happens... Knowing what to do” in which there are discussions on what children can do in case of abuse still occur, despite their best efforts to keep safe; it helps children prepare and identify who they would trust and report to in case someone hurts them.

For adolescents, the activity book begins with (acknowledgment of) love/attraction and physical pleasure, it moves on to examining and understanding concepts of privacy, consent, and boundaries; learning about health and safety; and finally to consider relationship contexts (roles and expectations of others, and activities we do with various people by virtue of our relationship with them). Adolescents learn to use each window and concept individually and then collectively to arrive at decisions about sex and sexuality behaviors [Box 11].

The activities use a range of innovative and creative methods that allow for children and adolescents to understand and reflect on situations and experiences (vs. mere information and instruction giving), and derive their conceptual understanding on personal safety from daily life situations. Thus, the activities use methods such as movement games, body mapping, art, board games, adaptation of common children's group games (hopscotch), story-telling and narratives, and film clips to make learning a participatory and entertaining experience for children.

It is recommended that these activity books be used in conjunction with other existing materials on CSA treatment, such as “Activity Book for Treatment Strategies for Abused Children, From Victim to Survivor” by Cheryl L. Karp and Traci L. Butler [Box 10]. The authors offer a brief review of child sexual development and then present a four-stage approach to recovery for children aged from 6 to 12 years. Designed for use in conjunction with traditional therapeutic interventions, the volume guides therapists through establishing a therapeutic rapport to helping children explore the trauma, repair their sense of self and become future-oriented.

Interventions for parents and caregivers

When they learn about their child being sexually abused, parents and caregivers are also likely to be in a state of confusion and distress. From understanding what medical and legal processes to follow and where to report to making decisions about seeking mental health assistance are some of the areas that parents initially require help with. In fact, for many, the issue is whether to seek legal recourse at all, especially where the perpetrator of abuse is a known person and/or someone from within the child's family.

Psychoeducation and support to parents/caregivers on child sexual abuse

- Enable them to accept, or even believe the child's experience of abuse

- Help them understand abuse dynamics, i.e., how and why CSA occurs (and the processes by which it has occurred in their child), including the importance of not blaming the child
- Explain to parents the child's mental state, including symptoms of anxiety/depression/PTSD the child may have, and how they need to provide supportive, reassuring responses to the child. They may also be needed to be educated on ways to manage children and adolescents who are in extreme distress, with self-harm behaviors
- Help parents/caregivers to engage the child in developmentally appropriate activities and get the child back to maintaining a regular home (mealtime, bedtime) and school routines
- In instances of adolescent sexual abuse, facilitate discussions between parents and child on issues relating to pregnancy, particularly to help parents/caregivers understand the child's thoughts and perspectives.

Mandatory reporting guidance

The Prevention of Child Sexual Offences Act 2012 states that "... any person (including the child), who has apprehension that an offense under this Act is likely to be committed or has knowledge that such an offense has been committed, he shall provide such information to (i) the Special Juvenile Unit; or (ii) the local police..."

The purpose of mandatory reporting, under POCSO, is to ensure that sexual offense comes to light and gets punished, to ensure that the child (especially when abuse takes place within the family) is safe and does not continue to suffer abuse, to provide justice to the child concerned and prevent abuse of other children. As justified as it is in its intent, the stipulation of mandatory reporting is ridden with dilemmas and is often difficult to implement. Parents and caregivers are often reluctant to report CSA for reasons ranging from stigma and discrimination associated with sexual abuse to fear of legal procedures and systems.

It is not only the parents/caregivers who need to be engaged in discussions on mandatory reporting; older children and adolescents also need to be part of the decisions on reporting and legal action. Where there is a difference of opinion between parents/caregivers and children on mandatory reporting, i.e., wherein children wish to take legal action and parents do not, child rights principles dictate that mental health professionals follow the decisions of the child, working with the parents to help them support their child on his/her decision to report.

It is recommended, therefore, that mandatory reporting is not a one-off procedure but that it follows a process which entails the following:

- Written documentation of the child's (or family's) report/account of sexual abuse in an official manner, i.e., there should be nothing loose or informal about documentation, which must also be done in a clear and meticulous way
- Explaining to the child and family that there are laws about CSA (POCSO) and that it is recommended that they report the abuse with reasons for how and why it could be advantageous to them, i.e., how it would ensure the safety of the child/other children, get the perpetrator to be punished, etc.

- Reassuring the child and family that there would be no pressure or coercion – that ultimately no report would be made without their consent and that were they to choose, in due course/after due consideration, to report, we will assist them to do so
- Understanding the child and family's hesitancy to report, i.e., to elicit the reasons and fears they have not to want to report, and then to try and address these fears and concerns one-by-one. (should their concerns be addressed, they might be more willing to go ahead with the reporting process)
- Assuring the child and family that confidentiality would be maintained through the processes of reporting, i.e., the press/media/school/general public would not be aware of the identity of the child.
- Explaining all processes involved in reporting, to child and family, i.e., to guide and assist them through the gamut of agencies involved, from the police to child welfare committee and the magistrate; preparing the family and child about the sequence and type of reporting that would be necessary at each stage gives them greater clarity and reassurance and increases the likelihood of their reporting abuse
- To start with healing interventions and tell the child that we can re-visit the reporting issue at a later point when he/she feels ready to do so
- To always support a child's decisions to report to police/legal personnel and work with the parents to get on board with their child's decisions to do so.

Thus, it is recommend that reporting be embedded in the process of psychosocial interventions for the child and family rather than a disconnected, stand-alone process that needs to be done immediately—and which then only serves to exacerbate the confusion and trauma that the child and family is already experiencing soon after the abuse incident/disclosure or discovery.

Legal assistance

There are two legal processes that may call for the involvement of mental health professionals – that of mandatory reporting and that of being an expert witness in a court of law.

Role of mental health professionals in mandatory reporting

A child may be referred to mental health services by police, child welfare committees and/or legal personnel for forensic interviewing and/or treatment of CSA -related problems. In such an instance, reporting processes are taken care of by the referring agencies. However, if the child is brought to mental health services by parents/caregivers and CSA is discovered in the process of mental health assistance, the onus of mandatory reporting is also on the mental health professional/team. It is recommended that in the wake of hesitation on the part of the child and/or family to report CSA to the police/legal authorities, mental health professionals may also follow the mandatory reporting guidelines outlined in the previous sub-section on working with parents and children on this issue.

Mental health professional as an expert witness

According to the POCSO Act 2012, every state is required to set up Special Courts to ensure speedy trial of CSA cases. The Special Court judge may call upon mental health professionals to

assist in the court proceedings to be an expert witness. Thus, if a mental health professional receives the summons from the court, he/she will need to appear in court to provide evidence for the CSA case. In light of this, it is recommended that mental health professionals make the following preparations:

- Ensure detailed documenting of all sessions and interactions with the child from assessment and inquiry to treatment and intervention reports
- Given the medico-legal nature of the case, such documentation should be in accordance with the formal record-keeping systems of the mental health service/institution; this includes the maintenance of documentation in safe custody
- Study the case in minute detail before appearing in court, in preparation for detailed examination by the prosecutor as well as the defense lawyer.

Other components of the mental health professional's role in court may include:

- Providing an opinion on the ability of the child to depose as a witness – this would call for presenting developmental assessments as well as psychosocial and mental health assessments to the court, including recommendations on the child's ability to provide abuse narratives, to enable the judge to make decisions on such matters
- On request of the judge, assisting the court with child-friendly methods of inquiry and communication when they interview a child.

(Note: These last two components are particularly relevant in the context of very young children, under age 5 years and children with disability).

ANNEXE

What mental health professionals need to know about systemic responses

Schools...

Preventive workshops, personal safety workshop, life skills education can help as preventive strategies. However, when an incident takes place, the system should have a clear protocol for a response. This protocol should entail the following:

- Whether the CSA incident occurs within or outside the school premises, by school staff or others, especially if a child reports to anyone in the school, the school's position must be one of acknowledgment and involvement
- Every school must have there should be a pre-set response plan which should include:
 - An identified person (known to the children) who can respond in a sensitive and gentle manner to alleged instances of abuse reported by the child
 - A next-level reporting authority (such as the principal) who will inform the parents

- The school should guide and make available to parents the first level medical and other facilities to seek assistance.
- Unless the school has a trained counselor or CSA expert, it should not attempt to interrogate the child. This needs to be done by trained experts, preferably in child mental health agencies or accredited comprehensive child response units/institutions
- The school needs to take a proactive stance with the concerned parents and other parents. They may also need to be alert to the impact on other children and get appropriate experts to do de-briefing as necessary
- Furthermore, preparation needs to be made to receive the child back to the school in natural and nonstigmatizing ways so that the child re-integrates comfortably.

Police...

Police and legal inquiry should be embedded within the psychosocial assistance processes (the idea is not to obtain legal evidence first and “let counseling carry on” as police personnel has often understood).

Police interviewing must avoid:

- Interviewing children at the police station (or taking the child to the police station at any stage of the inquiry)
- Having the perpetrator and the child come face to face
- Repeated questioning
- Taking the child to the scene of the crime and/or re-enacting event
- Persuading child to provide information through insistence/use of sweets, toys, chocolate
- Touching the child unnecessarily.

RECORDING OF MAGISTRATE’S STATEMENT AND INQUIRY BY JUDICIAL PERSONNEL...

As per Section 164 of POCSO Act 2012, children and adolescents are required to give a statement to the magistrate, regarding the abuse, within 24 h of filing the FIR. Repeated inquiry regarding the abuse may result in further traumatization of the child. However, given that the law mandates the magistrate's statement, it is important that the magistrates and other judicial personnel be trained in sensitive and child-friendly ways to elicit the child's narrative and record the statement.

- Very young children, (ages 0– 3.5 years) will be unable to provide a statement
- At a minimum, a child has to be about 3.5 years of age, to even attempt taking a statement. (Even then, some children will have language delays and be unable to report)
- A systematic developmental assessment of the child needs to be conducted (by a mental health professional) to establish the ability of the child to be able to provide a statement

- Children with intellectual disability will need to be assessed to understand what their abilities and deficits are, and if they can report. Those with moderate-to-severe intellectual disability may find it especially hard to provide a statement
- Children with severe trauma/PTSD and associated dysfunctionality no matter what the age and developmental ability, may be unable to provide the statement, or at least not within the stipulated time or until psychosocial assistance is well underway
- In the above instances, it is recommended that the magistrates make the exception and attempt to obtain the statement by:
 - Allowing child development/mental health professional to assist with statement recording in spaces comfortable to children (i.e., outside the court), using play and other creative methods to elicit narratives (especially from young children with limited verbal abilities and/or children with intellectual disability or trauma)
 - Permitting of use of an audio-visual recording of child's statement, especially when it is recorded by mental health professionals in spaces other than the court (such as in hospital playrooms and therapeutic spaces)
 - Ask for additional/specialized assistance by the way of interpreters, translators, sign language experts, and special educators for children with disability
 - Allowing family and caregivers to accompany the child and remain with the child during the magistrate's statement recording; this especially applies to institutionalized children, who often have no family to accompany them and wherein the child's caregiver and/or therapist/counselor should be allowed to be with the child during the statement recording.

In addition, the magistrate's statement must avoid:

- Hurrying the child to talk
- Persuading the child to provide information through insistence/use of sweets, toys, chocolate
- Asking children to enact what happened
- Probing for details of how the child felt at the time of abuse (unnecessary details that might re-traumatize child)
- Touching the child unnecessarily.

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Figures and Tables

Box 1

CSA is
 An interaction between a child and an adult where the child is used for sexual stimulation
 Exploration of sexuality between a minor, traditionally understood as below 18 years of age, could be exploitative if the age difference between them is >5 years
 Not restricted to rape/penetrative genital contact
 Digital handling of the child's genitalia
 Nongenital forms of sexual touching
 Noncontact forms of abuse for the pleasure of the perpetrator such as exposing the child to pomography or taking nude pictures of the child

CSA – Child sexual abuse

Defining child sexual abuse

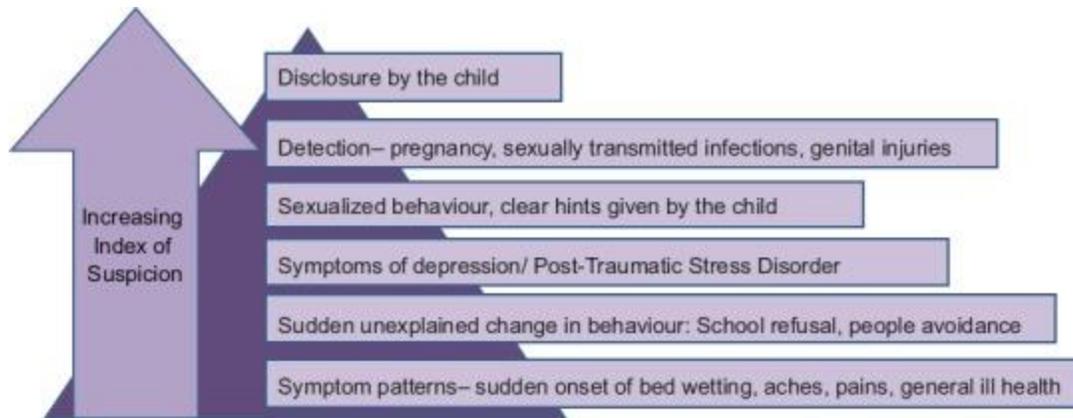
Table 1

Nature or type of child sexual abuse

Type of abuse	Contact versus noncontact	Contact abuse entails touching of the intimate body parts including perpetrator fondling or masturbating the victim, and/or getting the child to fondle and/or masturbate him/her Noncontact abuse entails offensive sexual remarks/exposing child to nudity or perpetrator's private parts or observes the victim in a state of undress or in activities that provide the offender with sexual gratification or exposing child to pomography
Number of episodes	Penetrative versus nonpenetrative	Using the penis or other objects to penetrate any orifice of the child's body (including vaginal, anal or oral penetration) versus other forms of contact abuse that may not be penetrative
	Single versus multiple episodes of abuse	One incident of abuse versus many incidents of abuse (over a period of time ...days/months/years)
Perpetrator(s) of abuse	Known versus unknown perpetrator	Abuse perpetrated by a family member/caregiver or some person known to the child versus a stranger; within known people, if the person is responsible for care and protection of the child (such as institution staff, parent, teacher, school attender...), it qualifies as aggravated abuse, resulting in more severe punishment under POCSO Act 2012, because this person abused the child in a situation or relationship wherein he/she is meant to be caring for and protecting the child
	Single versus multiple perpetrators	Abuse by a single perpetrator versus abuse by more than one or many/different perpetrators

POCSO – Prevention of Child Sexual Offence

Figure 1



Index of suspicion in child sexual

Table 2

Emotional and behavioral indices of child sexual abuse

Emotional and behavioral indices of CSA	
In younger children...	In older children/adolescents...
Sexualized behaviour	Self-harm
Avoidance of specific adults	Depression/isolation
Nightmares/sleep disturbance	Anger
Clingy behaviour/separation anxiety	Fearfulness and anxiety
Fearfulness and anxiety	Sleep disturbance/nightmares/flashbacks
Bedwetting	Avoidance of specific adults
School refusal	School refusal
Decreased scholastic performance	Decreased scholastic performance
Medically unexplained body aches and pains	Medically unexplained body aches and pains/fainting attacks
	High risk behaviours-Sexual behaviour/substance abuse/runaway ^a

^aAdolescents who have been sexually abused may either respond to sexuality and relationship issues with avoidance (i.e., the trauma and negative associations with sexuality cause them to not want to engage in sexual relationships at all) or with high risk behaviours. High risk sexual behaviours such as unsafe sex with multiple partners-these behaviours are either due to sexualization and preoccupations with sex as a result of the abuse or due to feelings of inferiority and low self-esteem, also due to CSA experiences, which cause an adolescents to feel that "I am dirty and damaged anyway... how does it matter what I do now and how many people I sleep with." Substance use is often a result of the anxiety and depression caused by CSA-when children do not know how to manage their traumatic experiences, they are likely to resort to smoking, alcohol consumption and other substances to help them cope with difficult emotions. CSA – Child sexual abuse

Box 2

Demographic details

Name, gender, age, date of birth, gender, place of residence/address, who the informant is and how he/she is related to the child

Referral

Agency referral (CWC/National and State Commissions for Protection of Child Rights, other medical specialists such as GP/paediatrician/ gynaecologist): A letter from referral service/agency should be requested/ filed, including the date and time of referral and the time lag between this and the initial consultation with the mental health/other medical services; the letter from the referral agency should state circumstances of referral, whether a case has been filed, and the current status of the case. If a case has been filed a copy of the FIR, sexual offence report is required for our case file

Self-referral-by child's parents: Whether parent or primary caregiver is present at the time of initial and subsequent consultations should be noted; in case only one parent is available, information about the other parent and his/her absence, possible parental marital conflict/separation/divorce issues, or the fact that the alleged perpetrator of CSA could be one of the parents, need to be documented; relevant identification and contact numbers of persons accompanying the child/adolescent should be noted. (Again, if parents/caregivers have filed an FIR, a copy of this must be placed in the file)

Initial account of abuse incident(s)

Documentation should include information (obtained from persons accompanying the child and/or child if child is willing to provide the information) regarding

Circumstances of the alleged abuse

Who was the alleged perpetrator?

What happened?

Where it happened?

When it started, the number of times abuse occurred?

How disclosure came about and circumstances following disclosure?

Where and with whom is the child living now? Is he/she safe there?

Agencies that the child and family have been in contact with prior to the referral to mental health establishment/pathway to referral to mental health establishment (e.g.: Police, CWC, National/State Commission for Protection of Child Rights, Child Protection Services, Other hospitals, NGO)

Collateral information from other sources (e.g.: Police, CWC)

Medical examination and tests

In case of penetrative and/or abuse that caused physical injuries, check if requisite medical examinations and tests have been conducted and ask for the reports/documentation on these tests

Medical tests and examinations include physical examination for injuries, HIV testing and pregnancy testing (the last depends on the age/sex of the child)

Mandatory reporting query

In case CSA was not the primary context of consultation and that it emerges in the course of the mental health assessment from caregiver/child, i.e., it is not a case referred by any government/welfare/legal authority

Explain to caregivers and older children/adolescents the mandatory reporting clause in POCSO Act 2012

Offer assistance if they wish to report to police/legal authorities

Do not coerce child or caregivers if they do not wish to report at this stage

Ensure that you have documented the discussion on mandatory reporting

Assessing for CSA-associated psychiatric morbidity

Children need to be assessed for common mental health disorders resulting from CSA are PTSD, depression and anxiety. Below are some suggested scales and checklists for use with children

CDRS-R

SCARED

CITES

Ask the parents/caregivers about emotional and behavioral responses and changes in the child following the abuse incidents; older children and adolescents may be interviewed directly to understand emotional and behavioral changes

Academic and school history

This includes the child's educational and school status, the child's academic performance (both current and past) and any learning issues/disabilities the child may have

Family history

This includes basic demographic information on the child's parents/caregivers (in terms of their educational qualification, occupation and income level) as well as the child's living arrangements, parental relationships, child's emotional relationship and attachment to parents, illness and alcoholism in parents, parental marital conflict, single-parenting, any loss experience suffered by child of primary caregiver

Institutional history

This includes information on places the child has lived in other than the family home (if applicable) which institutions child has lived in or is living in currently, for what periods of time, reasons for institutionalization

Mental status examination

On first contact or during the first meeting with the child, he/she should be assessed for

General appearance

Speech, mood, thought, suicidal ideation, perceptual disturbances, orientation

Signs of subjective distress, clinging, crying, reactions to touch

FIR – First information report; CSA – Child sexual abuse; CWC – Child Welfare Committee; PTSD – Posttraumatic stress disorder; CITES – Children's Impact of Traumatic Events Scale; SCARED – Screen for Child Anxiety Related Disorder; CDRS-R – Child Depression Rating Scale-Revised; POCSO – Prevention of Child Sexual Offence

Box 3

Narration (or statement provision) is a function not only of speech and language abilities but also of social, emotional and cognitive skills/abilities of a child. Thus, exceptions to recording statements for legal and mental health processes must be made for

- Very young children (ages 0-3.5 years)
- Children with intellectual disability
- Children with speech and language delays/problems
- Children (of any age) with severe trauma/PTSD and associated dysfunctionality

In such cases, statements from parents and caregivers and/or mental health professionals should be recorded*

At a minimum, a child has to be about 3.5 years of age, to even attempt taking a statement

Children with intellectual disability including speech and language delays will need to be assessed by mental health professionals, to understand what their developmental abilities and deficits are... and whether or not they will be able to provide a narrative

The child's emotional state of readiness needs to be considered before engaging in CSA inquiry processes. If the child is recovering from serious injury or medical issues and/or PTSD, adequate time must be allowed for recovery before broaching inquiry regarding the abuse incidents

Additional/specialized assistance from translators, and sign language professionals should be sought in case the child has speech and language disabilities

Play, art and other creative methods should be used to elicit narratives from young children and/or children with intellectual disability

PTSD – Posttraumatic stress disorder; CSA – Child sexual abuse

Applying child development assessment to CSA inquiry and intervention

Box 4

Other than open and close ended questions, one way to categorize questions is leading versus nonleading questions or techniques of inquiry. Even within this, there is a spectrum

Nonleading techniques of inquiry: Questioning should proceed from general to more detailed. Talk about "Things that happen" in the child's life-things that happen at home, in school, or in another setting. Such neutral approaches serve as excellent openers to discussion. Then work toward a key question such as

Do you know why you're here today? What was explained to you about why you are here today?

Is there something that you want to tell me?

Is there something that you wish to tell me? (Or need to tell me?)

Are there any worries you have about home or school...?

Minimally leading techniques

I understand that you have had some trouble sleeping recently. Could you tell me if anything has happened that would make you to have trouble sleeping?

Has anyone done things to harm you or upset you?

I understand there have been some problems in your family. Can you tell me about them?

Moderately leading techniques: These questions further narrow the range of possible responses a child might make. Example:

Did anything happen to you when you went to visit (person)?

How did you get along with (person) when she went to see him?

What do you and (person) do when you go to visit?

I understand that some things have happened between you and (the abuser). Tell me about those things

Is there anything that has happened to you recently that has made you really upset?

Can you tell me what happened between you and (the abuser)?

I'd like you to tell me about the things you like about (the abuser) and the things you don't like about (the abuser)

I need to know how your pee-pee got hurt. Can you tell me how that happened?

Maximally leading techniques: These include questions which tell the child what the investigator wants to discuss. In maximally leading questioning, the interviewer does not follow the lead of the child's responses, but introduces content to the child, often communicating the interviewer's desired response. Example:

Did he (the abuser) touch your pee-pee with his finger?

Did he (the abuser) take off his clothes when he laid down on top of you?

He (the abuser) put his finger in your pee-pee, didn't he?

Did (the abuser) he touch you under your clothes or over your clothes?

These are close-ended questions, which also assume that abuser has engaged in certain behaviors with the child (thereby leaving out others)

As the interviewing methods proceed from nonleading and minimally leading, toward more directive and leading questions, the risk of contamination of the child's report increases. Children may make reports which are not entirely accurate. It is therefore recommended to begin with open, nonleading questions moving on to minimally leading questions and then using moderately and maximally leading questions to close with confirmatory details

[Open in a separate window](#)

Techniques of Inquiry: Leading questions

Table 3

Understanding trauma dynamics: The impact of child sexual abuse

Effect	Processes: How it occurs	Psychological impact	Behavioral manifestations
Traumatic sexualization The conditions in sexual abuse under which a child's sexuality is shaped in developmentally inappropriate and interpersonally dysfunctional ways	Child rewarded for sexual behavior in inappropriate to developmental level Offender exchanges attention and affection for sex Sexual parts of child fetishized Offender transmits misconceptions about sexual behavior and sexual morality Conditioning of sexual activity with negative emotions and memories	Increased salience of sexual issues Confusion about sexual identity Confusion about sexual norms Confusion of sex with love and care getting/care giving Negative associations with sexual activities Aversion to sexual intimacy (long-term effect)	Sexual preoccupations and compulsive sexual behaviors Precocious sexual activity Aggressive sexual behaviors Promiscuity Prostitution Sexual dysfunctions; flashbacks, difficulty in arousal and orgasm (long-term effect) Avoidance of or phobic reactions to sexual intimacy (long-term effect)
Stigmatization The negative messages about the self that are communicated to the child around the sexual arousal experience	Offender blames, degenerates victim Pressure on child for secrecy from the offender Child infers attitude of shame about activities Child blamed for events Victim is stereotyped as "Damaged goods"	Guilt, shame Lowered self-esteem Sense of differentness from others	Isolation Drug/alcohol abuse Criminal involvement Self-mutilation Suicide
Betrayal The child's immediate or delayed discovery that someone on whom they are virtually dependent has caused them harm	Trust and vulnerability manipulated Violation of expectation that others will provide care and protection Child's well-being is disregarded Lack of support and protection from parents	Grief, depression Extreme dependency Impaired ability to judge trustworthiness of others Mistrust, particularly of men Anger, hostility	Clinging, vulnerable Isolation Aggressive behavior Delinquency Discomfort in intimate relationships Long-term effects: Marital problems; allowing own children to be victimized
Powerlessness The child's will, wishes and sense of efficacy are repeatedly over-ruled and frustrated and the child experiences the threat of injury or annihilation	Body territory, invaded against child's wishes Vulnerability to invasion continues over time Offender uses force or trickery to involve child Child feels unable to protect self and halt abuse Repeated experiences of fear Child is unable to make others believe her experience	Anxiety, fear Lowered sense of efficacy Perception of self as victim Need to control Identification with the aggressor	Nightmares; phobias Somatic complaints; eating and sleeping disorders Depression; disassociation Running away; school problems, truancy delinquency Vulnerability to subsequent victimization Aggressive behavior Becoming an abuser

Box 5

Children and adolescents are less likely to recognize and/or acknowledge abuse when...

The abuse is carried out in a seeming context of consent and mutual pleasure

The abuse is carried out by persons in whom children have tremendous trust so children are in a state of confusion when these persons are suddenly "Vilified"

Emotional and material benefits are gained from the offender

They are blamed for "Giving consent" causing ensuing feelings of shame and guilt

There is a threat from the perpetrator, including when threats take conflicting forms wherein the perpetrator puts the onus of protecting him/her on the child i.e., "I will be destroyed...my life will be ruined..." as a result of which the child feels guilty and responsible for having got the perpetrator "Into trouble"

When and why children do not acknowledge abuse experiences

Box 6

Identifying and targeting the victim (vulnerable parents/child in difficult circumstances)
Gaining trust and access (special attention, sympathy to child, play games/ give gifts to gain child's friendship)
Playing a role in the child's life ("no one understands you like I do and vice-versa")
Isolating the child (from family/others)
Creating secrecy around the relationship (letters/phone calls)
Initiating sexual contact
Controlling the relationship (using age/power/threats/emotional manipulation making child believe it was her fault)

The grooming process

Box 7

It is often assumed that adolescents who get involved in sexual relationships, given their age and life stage, have done so by giving their consent i.e., they consented to the sexual relationship and therefore they are to be blamed. Thus, in addition to the perpetrator, other well-intentioned persons, such as caregivers, welfare, legal and medical system personnel, who are meant to be playing a helping role, also end up vilifying the child instead of supporting him/her. It is therefore critical to make the difference between so-called consent and "Informed consent." Consent on the face of it simply entails saying "Yes" and entering into the sexual relationship. But informed consent assumes that the adolescent has given consent by knowing and understanding the consequences of sexual engagement i.e., with full information on the following

Permission and consent: What coercion means and how to recognize direct and indirect methods of coercion

Relationships: The contexts in which sexual relationships can play out in a happy, healthy and responsible manner, including who the person is, whether the person can be trusted and whether there is an emotional connect with the person

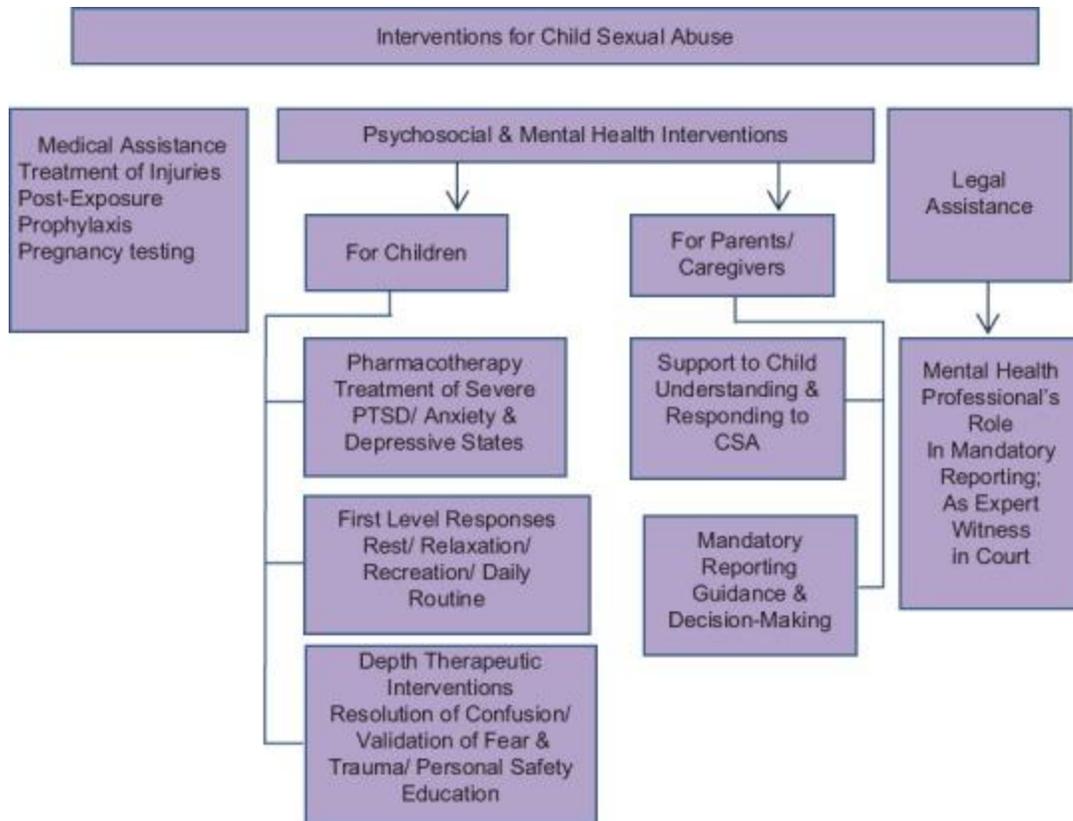
Health and safety: Issues of unprotected sex, pregnancy risks, sexually transmitted diseases

Protection and abuse: What sexual abuse entails and how to recognize it

It is only if an adolescent knows and makes relationship and sexuality-related decisions based on the above framework can it be considered as informed consent-which is usually not the case in child and adolescent sexual abuse

The issue of consent

Figure 2



Child sexual abuse interventions

Box 8

Always prepare children and adolescents for medical evaluations and procedures as these can be frightening and invasive for them; in fact, they can be almost as frightening and feel as invasive as the abuse experience. It is necessary therefore to reassure them on their safety, ensure their comfort during medical evaluations by having known/familiar/trusted people or caregivers with them; and it is important to give children information on the medical tests and procedures in simple, comprehensible ways so that they feel that they have some predictability and control over an otherwise difficult and frightening situation

In contexts of sexual abuse/sex work/high risk sexual activity, tell children

“We want to ensure that your health is alright. When children have been in unsafe circumstances and have been hurt/abused, they may acquire some infections. Testing for this will help us identify if the infection is indeed present and start the appropriate treatment fast.” (In case of Sexually abused children)

“When one take risks, like having (unprotected) sex with unknown or more than one person or use substances (like injecting drugs), there are chances of injury and disease-especially as we do not know what infections those people have. So, we need to do some tests to check for any possible infection so we can treat it.” (In case of adolescents engaging in high risk sexual activities)

“Since you have been hurt and abused by someone in ways that are physical and sexual (or you have been voluntarily engaging in sexual activity), there are chances of your being pregnant. It would be important to do a test and find out if you are pregnant, for a few different reasons

Doing a test early enough may help you terminate the pregnancy in case you do not want to continue with the pregnancy/keep the baby i.e., if we delay finding out, it may be hard to implement the medical processes necessary to terminate the pregnancy

In case you wish to keep the baby, then it will be critical for you to maintain your health and your baby’s health in certain ways - so finding out early will help us guide you on how to do this. So, finding out sooner about whether or not you are pregnant will help you make some decisions comfortably and offer you more options in this regard.” (In case of adolescents at risk of pregnancy)

Note 1: In case of HIV testing, in keeping with the NACO guidelines, pretest counselling needs to be done before the test is actually administered. Note 2: Children with intellectual disabilities are especially vulnerable to abuse/sexual exploitation. Due to their disabilities, it may be difficult to ascertain what their experiences are in this regard. Therefore, medical examination and relevant testing for pregnancy/STDs etc., are especially important for them, and should be conducted as soon as they arrive in any care and protection home (whether it is a transit/temporary shelter or a longer term care facility). STDs – Sexually transmitted diseases; NACO – National AIDS Control Organization

[Open in a separate window](#)

Preparing the children and adolescents for medical tests and treatment

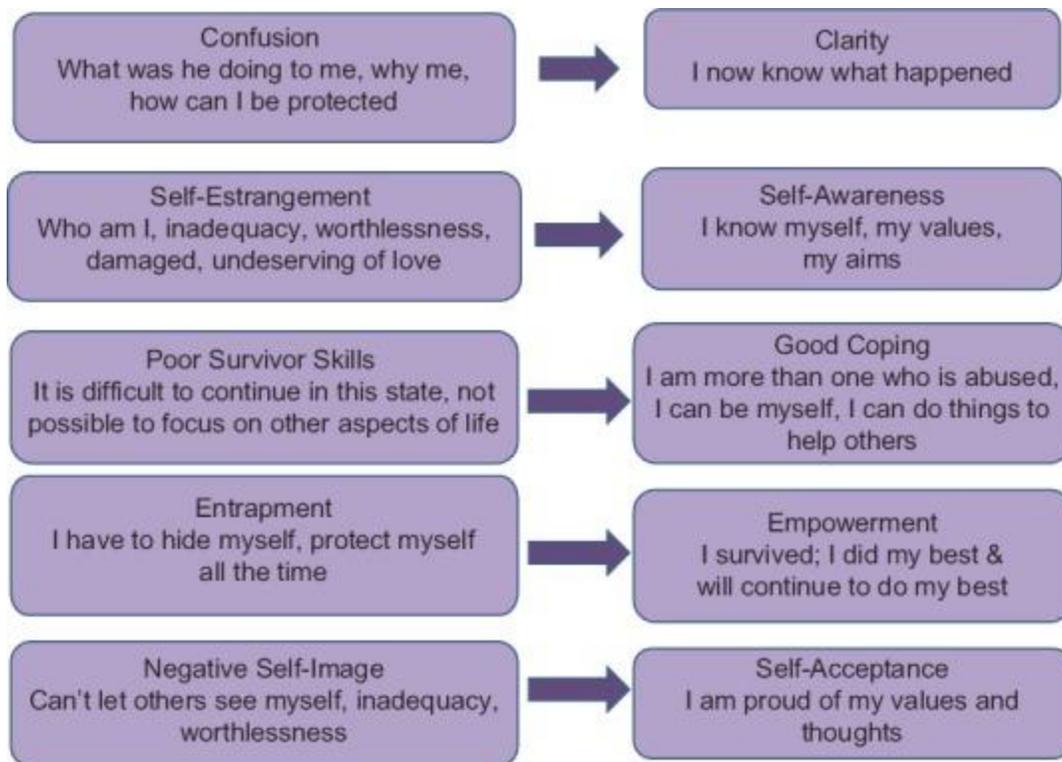
Box 9

First-level response is about alleviating immediate suffering and providing initial relief
 If anxiety is not dealt with, or is very severe, it becomes difficult for the child to carry out daily activities
 Feelings of unpredictability and lack of control can be debilitating for a child
 Anxiety becomes the basis for development of depression (and other psychological problems)
 Severe anxiety manifesting itself in aches/pains/black-outs can be very frightening and worrying for children and caregivers-therefore immediate reassurance on the cause should be provided
 Makes the child increasingly vulnerable to negative coping mechanisms-such as aggressive behaviors, substance abuse etc.

CSA – Child sexual abuse

Objectives of first level responses to child sexual abuse

Figure 3



Areas of focus for healing

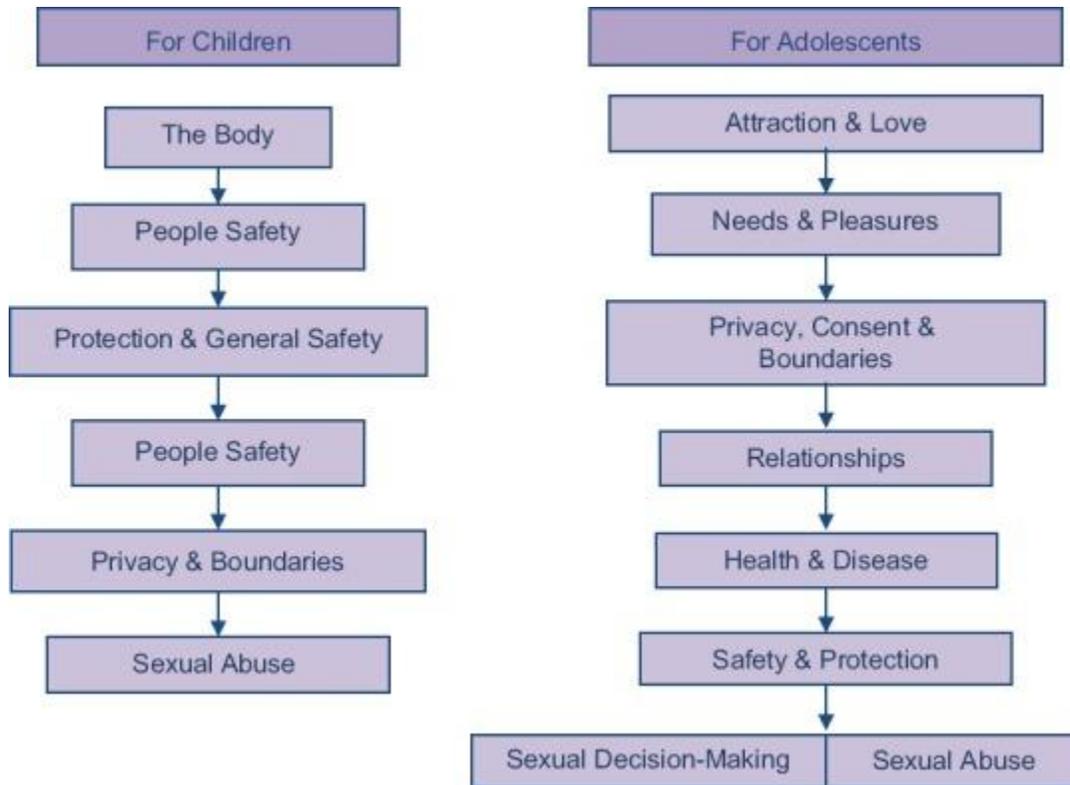
Box 10

Activity Book for Treatment Strategies for Abused Children, From Victim to Survivor by Cheryl L. Karp and Traci L Butler
 Activity Manual for Adolescents by Cheryl L. Karp and Traci L. Butler and Sage C. Bergstrom
 The Courage to Heal Workbook for Women and Men Survivors of CSA by Laura Davis
 3 activity books for use with children/adolescents, developed by Community Child and Adolescent Mental Health Service Project, Department of Child and Adolescent Psychiatry, NIMHANS
 CSA Prevention and Personal Safety (for children aged 4-7 years)
 CSA Prevention and Personal Safety (for children aged 7-12 years)
 Life Skills for Adolescents Series (II): Gender, sexuality and relationships

NIMHANS – National Institute of Mental Health and Neurosciences;
 CSA – Child sexual abuse

Suggested materials for use

Figure 4



The window approach to personal safety and child sexual abuse

Box 11

Sex education (as it is called in schools and institutions that pride themselves on conducting such programs) is very different from life skills education and training on sexuality and relationship issues: the former i.e., sex education merely imparts information about the body and physiological processes of reproduction, usually in a manner that is didactic (teacher to student or parent to child); the latter i.e., sexuality education, may include some discussions of physiology, especially on parts that pertain to health and safety, but the emphasis is on the socio-emotional component of sexuality. This includes an understanding emotions such as attraction and love, of relationship contexts, for instance, based on which recognition of abuse and coercion take place; and the learning of skills such as assertiveness and refusal (saying “No” to sexual overtures if desired), or negotiation (for condom use and safe sex), and problem-solving (coping with peer pressure that compels an adolescent to experiment with sexual acts). Thus, sex education by itself is unlikely to help children and adolescent to keep safe i.e., mere knowledge of physiology and health is not helpful unless children, or more so adolescents, are enabled to explore and take perspectives on sexuality and decision-making issues. Furthermore, “Value education” (or “Moral science”) classes which are imparted in schools and children’s centres are not the panacea to child safety and CSA prevention either; sexual decision-making is not about morality (i.e., not a “Right” or “Wrong” issue) but about life choices - and individuals make such life choices, including on sexuality issues, differently, based on their unique contexts, circumstances and personal beliefs and value systems. Whatever these contexts and beliefs/value systems are, the focus of intervention is on the window approach framework (discussed above), which moves way beyond sex education, to emphasize sexuality education, which in turn entails life skills training in the context of sexual decision-making and safety

CSA – Child sexual abuse

Distinguishing between sex education and sexuality education