Child Sexual Abuse Across Cultures: What We Know So Far

By Victoria Fahlberg and Sara Kershnar

Reproduced with permission of UNICEF

New York, NY

BRYCS is a project of the United States Conference of Catholic Bishops/Migration and Refugee Services (USCCB/MRS)
1-888-572-6500/ info@brycs.org/ www.brycs.org

Child Sexual Abuse Across Cultures: What We Know So Far

Victoria Fahlberg, PhD, MPH
Sara Kershnar, MPH

Commissioned by UNICEF
February 10, 2003

PURPOSE

As the world community focuses on the risks and hazards particular to children, few are as insidious and common as sexual abuse. The sexual abuse of children cuts across cultures, across socio-economic groups, across race, and across religions. No child, in any part of the world, is safe from being sexually abused by adults. The purpose of this paper is fourfold:

1) to establish child sexual abuse as a world-wide phenomena through a review of existing prevalence studies and report data from around the world,
2) to look at the many contextual variables that contribute to our understanding of child sexual abuse in various cultures, and
3) to understand the links between child sexual abuse and other dangers that children face as we move into this next century,
4) to identify intervention and prevention strategies and recommend next steps.

Most of the studies reviewed for this paper come from English language literature, and the review of the studies is not meant to be exhaustive. This paper is a first step towards promoting an integrated and inclusive discussion of the best means to pursue the issue of child sexual abuse in an effort to confront a legacy whose harm can last a lifetime.

WHO definition of child sexual abuse
World Health Organization, 2001

Child sexual abuse (CSA) is the involvement of a child in a sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent; or that violates the laws or social taboos of society. CSA is evidenced by a activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person [adult or person in a position of power over the child].

INTRODUCTION

Historians and anthropologists have written extensively on the universality of a taboo against incest, yet it appears that incest and other forms of child sexual abuse have occurred regularly throughout history and across cultures.[1] In past civilizations, sexual relations between children and adults were often overt and not always defined as a problem.[2] In many societies, the sexual use of a child by an adult is unacceptable. None-the-less, recent evidence indicates that it continues to permeate cultures around the world, although for the most part it remains an insidious, hidden social ill.

The earliest studies on prevalence of child sexual abuse (CSA) come from the United States. In 1948[3] and 1953[4] Alfred Kinsey and his associates reported on the sexual behavior of Americans. While the focus was not in finding estimates of child sexual abuse, they did report that 25% of the females in their study disclosed unwanted prepubescent sexual experiences with an adult male. Later studies from the United States have shown prevalence rates based on community samples that have varied from 6 to 62% for females and 3 to 16% for males.[5] These studies show wide discrepancies in prevalence rates, especially among females. These variations appear to be the result of definitional differences, sample size and type of sample, and data collection methods. Studies with smaller percentages have focused on restricted age differences between victim and perpetrator, while studies with larger percentages used less restrictive age differences and included both physical contact and non-contact sexual abuse. These same methodological differences, and others, allow only global comparisons of prevalence rates on CSA within a given culture, and become even more profound when rates are compared across cultures.

Many places have not yet produced research on prevalence rates, which use large, community samples and can be complex and costly to undertake. However, some countries have produced statistical data on cases of CSA that were reported to social service providers and legal authorities. The information about CSA found in reported data is often quite different from that found in studies using community samples. Report data is filtered first by a select group of victims who were either willing to disclose, were "discovered" by a third party - who then reported the abuse, or were forced to disclose due to physical consequences of the abuse, such as pregnancy, sexually transmitted diseases, or physical trauma. Secondly, report data is disclosed abuse that reaches authorities through an adult who has chosen to report the disclosed abuse. Most child sexual abuse is never reported, making report data highly selective. Information gleaned from reported data can be useful, as it provides a starting point for validating the existence of child sexual abuse. It can also be used to promote the development of appropriate interventions, as long as it is kept in mind that report data does not provide an accurate picture of victim or offender profiles.

PREVALENCE

Summary of International Prevalence Rates

In 1994, Finkelhor[6] reviewed 21 epidemiological surveys that were conducted on large non-clinical populations. The studies come from predominantly English-speaking and Northern European countries,[7] but also included three Spanish speaking countries (Spain, Costa Rica, and the Dominican Republic), as well as Greece. These studies varied in their operational definitions of child sexual abuse, methodology, type of sampling, sampling area, and sample size, as well as in other ways. Despite these differences, some patterns emerged. First, all countries demonstrated that a large percentage of their populations had experienced sexual abuse as children, with prevalence rates running from 7% to 36% for women and 3% to 29% for men. Most studies found females to be abused at 1.5 to 3 times the rate for males. In all countries, the offenders were overwhelmingly male when the victim was female (above 90%), while studies varied on the sex of the offender when the victim was male. Intrafamilial abuse was more common for girls than boys, constituting about one third to one half of their sexual abuse experiences.

In this summary, Finkelhor also observed that others have reported on the existence of extensive CSA in various parts of the world. These countries/regions include: Japan, Western and Southern Africa, and China. In addition, Finkelhor acknowledged the closely related problem of child sexual exploitation that has been well documented in the Philippines, Thailand, and Sri Lanka.

Since 1994, new prevalence studies using community samples have been done in North America, focusing on non-European sub-cultures, Western Europe, Central America, the Middle East, Africa, Asia, and the Pacific. These studies found prevalence rates for men and women that fall into the same ranges found in the Finkelhor 1994 summary, with three exceptions: a study by LaRocque (1994),[8] cited an 80% prevalence rate of child sexual abuse for Native Canadian females, a study by Madu and Petlzer (2001)[9] found a prevalence rate of 60% for male students living in the Northern Province of South Africa and Singh and others (1996)[10] found a 2.1% prevalence for male paramedical students in Malaysia. Several of these studies also reported ratios of male to female victims somewhat outside the range found in the studies summarized by Finkelhor. A 1996 study in Geneva, Switzerland[11] found a slightly higher rate of 3.2 females abused for every one male. Madu and Petlzer (2001)[12] reported more boys than girls being abused at a rate of .89 girls for every one boy. Olsson and others (2000)[13] reported a ratio of 1.3 girls to every boy in León, Nicaragua, and Haj-Yahia and Tamish (2001)[14] reported that boys and girls in their survey from the Palestinian Authority were abused at similar rates. Finally, Singh and others[15] in Malaysia found that 13 females were abused for every one male.

New studies of report data have also appeared recently in international publications. The studies of report data appear to include more cases of incest than is generally reported in prevalence studies using community samples. They also appear to be almost entirely comprised of cases of female victims and male perpetrators. While most prevalence studies indicate that more female children are sexually victimized than male, report data skews the ratio even more towards female victims. This data also indicates that all perpetrators are male, as compared to prevalence data where studies show some female offenders.

What follows is a brief review of recent prevalence studies on child sexual abuse, as well as studies of report data, published predominantly in English language journals. Since the majority of past studies have focused on white, middle-class females from Europe and North America, this review will attempt to broaden the picture of CSA as it occurs in other cultures, sub-cultures within larger populations, and places around the world. While the breadth and rigor of most of these studies are not sufficient to generalize to a national population, they provide valuable insight into the prevalence of CSA among a diversity of people groups.

Americas and the Caribbean

> It is estimated that over 300,000 children are sexually abused each year in the USA.
> *McMahon and Puett, 2000*

While the majority of North Americans can trace their roots back to Western Europe, there is tremendous diversity in this part of the world. As the following studies show, CSA cuts across race and ethnicity. For example, a study by Romero and others (1999),[16] found that 33% of 300 Latina women living in the United States and aged 18 - 59 reported at least one incidence of CSA, regardless of acculturation, country where they were raised, or citizenship status. More than 80% of initial incidents occurred after the age of six, with 46% occurring between the ages of 12 - 17. While 48% of the women experienced intrafamilial abuse, only one perpetrator was a father and one a stepfather. However, 96% of all

perpetrators were male and about half were under the age of 21 when the abuse was initiated. A total of 73% of the abuse was perpetrated by someone known to the women.

In 1998 Wyatt and others[17] used a random sample of 338 women from Los Angeles County, California, to compare African American women with European American women (i.e. women who traced their roots to Europe). Using a definition that included only sexual body contact, they found an overall prevalence rate of 34% for child sexual abuse: 29% for African American women and 39% for European American women. The difference in the prevalence rate for the two groups was statistically significant. The mean age for occurrence of CSA was 11 years for African Americans and 12 years for European Americans, a difference that did not reach statistical significance. Most women from both groups reported their most severe incident after age 11. Perpetrators were overwhelmingly male, 94% for African American women and 100% for European American women. Most were non-family members (60% of African American and 70% for European American), and most were under the age of 25 (66% of African American and 70% of European American).

Barker-Collo, (1999)[18] cited a study by LaRocque (1994),[19] which used clinical and anecdotal evidence, including the Ontario Native Women's Association research project (1989), to determine that the incidence of sexual abuse among Canada's native peoples is as high as 80% (The Nechi Institute, 1988). Although this study focused on Northwestern Ontario, it has been considered representative of other Native Canadian communities across the country.

Barthauer and Leventual (1999)[20] studied prevalence rates of CSA among poor, rural women in El Salvador. They interviewed 83 women in their village homes. Privacy was difficult to find and in two cases, husbands refused to leave during interviews. Fourteen (17%) women reported a total of 21 experiences of CSA. The median age of occurrence of CSA was 14 years. No women reported intrafamilial abuse. Over 90% reported that the perpetrators were strangers, friends, or neighbors. Given the importance of pre-marital virginity in this culture, some women may have been afraid of afraid of being overheard by others during their interview. This could have resulted in not reporting all past abuse for fear that the information would reach their current partner, or even the perpetrator(s).

Olsson and others (2000)[21] studied prevalence rates of child sexual abuse in León, Nicaragua, the second largest city in the country. They found that 20% of the men and 26% of the women had experienced sexual abuse before the age of 19. The median age at first abuse, 10 years, was the same for both men and women. Women reported that 94% of the perpetrators were male. In this study, most men reported that the perpetrators were male. However, a very large minority of 48% reported that the perpetrator was female. Women reported that 66% of the perpetrators were male family members, with 6% being a father and 17% a brother. For men, 18% reported abuse by male family members who were not father nor brother, 15% by a female family member, 30% by a known male, and 33% by a known female. The ratio of male to female victims, 1:1.3, is somewhat under the ratio range reported by Finkelhor (1994) of 1.5 – 3 females for every male. The authors report that when looking at severe abuse only, the ratio was 2, which falls within the 1.5 - 3 range. The authors suggested that the high rate of moderate abuse among males could "possibly reflect the many men who perceived the sexual initiation, which is commonly arranged by a relative, as a disagreeable experience."[22] The authors did not comment on the high percentage of females who sexually abused the males surveyed in this study.

Barsted (1998),[23] researched reported data in Brazil and found various agencies collecting information on child sexual abuse. In São Paulo, using documents from 1981, 168 cases of child sexual abuse were identified.[24] Among these cases, 70% of the offenders were fathers and 93% of the victims were girls. Another study cited from São Paulo[25] reported that from February of 1988 through March of 1990, 203 cases of child sexual abuse were reported to the Service for Child Advocacy. Barsted also cited a study by UNICEF (1996)[26] that reports on data from the SOS Child (hotline) in São Paulo collected between 1988 and 1993, where the perpetrator was found to be a relative in 75% of the 1000 allegations of CSA, 50% of these being the father. Finally, between 1992 and 1996 in the metropolitan region of Goiânia, in the state of Goiás, 676 cases of child sexual abuse were reported to the specialized police department for women. In 27.6% of the cases, the offender was a relative, nearly half being the father.[27] Bastos, Morris, and Fernandes, (1989)[28] found that in Brazil, among girls who had intercourse before age 15, 55% of their partners were six or more years older. The corresponding percentage for boys was 21%.

Pregnancy can be a consequence of the sexual abuse of adolescent females, which often results in their situations being brought to the attention of authorities. Heise, Moore, and Toubia (1995)[29] cited Rosas (1992),[30] who reported that 90% of new mothers at a maternity hospital in Lima, Peru, aged 12 - 17, were victims of rape - most by their father, step-father, or other male relative. Gershenson and others (1989),[31] in a similar study in the US, found that among 445 girls who became pregnant as teenagers, 33% reported experiencing coerced/unwanted sexual intercourse and 23% became pregnant by the perpetrator. Heise, Pitanguy, and Germain (1994),[32] using Justice System statistics and data gathered from rape crisis centers in Chile, Peru, Mexico, Panama, and the US, found that between one and two thirds of the sexual assault victims were under 16 years of age.

Europe

A 1996 study in Geneva, Switzerland by Halpérin and others[33] used a probability sample of 1116 adolescents, aged 14 to 16 years, and found a prevalence rate for sexual abuse of 10.9% for boys and 33.8% for girls, using a broad definition, which is a ratio of 1:3.2. Girls reported sexual abuse with contact at six times the rate for boys. Most of the children had been sexually abused before the age of 12 years and one third of all abuse was perpetrated by peers. Intrafamilial abuse occurred in 20.5% of girls and 6.3% of boys. A follow-up study in 1999 by Bouvier and others,[34] using this same sample, found that repeated intrafamilial abuse occurred among 10% of the boys and 16% of the girls. A total of 239 out of 252 offenders (95%) were male. Seven of the 13 female offenders abused peer-age boys in situations where no sexual contact occurred and had the lowest rates of coercion. No female offenders committed intrafamilial, repeated abuse.

Reported offenses in Germany have decreased from 1955 to 1995: from 31.9 to 19.6 per 100,000 inhabitants, which Schneider attributes to the low rate of prosecution, that has a negative affect on willingness to report.[35] Of 18,044 children who were victims of sexual abuse in 1995, 91.2% were between 6 and 14 years old, 75.8% were female, and 24.2% male.[36]

In 2001, Carlstedt, Forsman, and Soderstrom,[37] looked at structured data from court dossiers, over a five year period, of all sexual crimes against children less than 15 years of age (legally considered "minors") from the Vastra Gotaland region of Sweden. They found a total of 496 sexual crimes had been committed against minors, and of these, 203 (40.8%) were crimes of child sexual abuse. The number of victims totaled 283, with 85% of the victims being girls, 12% boys and 3% both. All of the 196 perpetrators were men. Most of the perpetrators (72%) were well-known to the child and most of the severe offenses were intrafamilial.

East Asia and Pacific

Collier and others (1999)[38] cite two studies reporting prevalence of child sexual abuse. The first (Marcus, 1991)[39] is based on a 1986 study of child abuse in Micronesia (n = 1027 cases), where 11% of the sample reported child sexual abuse. The second (PCAA, 1991)[40] was a nation-wide survey of the islands of Palau where the sample included 15% of the population. In this study, 24.5% of the respondents claimed to know a person who sexually abused a young child and 14% of the sample actually admitted to having sexually abused their own children.

In Hong Kong, the number of cases of child sexual abuse reported to the Social Welfare Department has increased steadily from 77 in 1994 to 242 in 1997. *Rhind, Leung and Choi, 1999*

Singh and others (1996)[41] used an anonymous self-administered questionnaire with 616 student nurses and medical trainees, where 76.5% of the sample was female and 22.9% was male. Their median age ranged from 20 to 24 years. Most of the students were Malay (84.1%), 9.1% were Indian, and 5.8% were Chinese. Forty-two (6.8%) reported a history of child sexual abuse, all of whom were female except for three (2.1%). The median age of onset of the abuse for females was 5 to 10 years, while the three male participants reported being abused between 15 and 17 years. Participants reported a total of 71.4% of offenders were known to them, where 14.2% were brothers, 24.5% relatives, and 24.5% a family friend. No one reported abuse by natural parents or sisters. The three males reported being abused by people outside the family but known to them.

Justice System statistics and data gathered from rape crisis centers in Malaysia and Papua New Guinea found that between one and two thirds of the sexual assault victims were under 16 years of age.[42] Gibbons (1996), reviewing prevalence rates in Australia, reported that 6 to 62% of women and 3 to 16% of men had experienced child sexual abuse.[43]

In Japan, a national study using a random sample was administered by the National Center for Child Health and Development to 7,000 citizens throughout the country. The Center found that by age 12, 15.6% of women and 5.7% of men had been sexually abused. Nine percent of the women reported forced intercourse and 66.7% said that the sexual abuse was the most serious experience of their life.[44]

In Hong Kong, the number of cases of child sexual abuse reported to the Social Welfare Department has increased steadily from 77 in 1994 to 242 in 1997.[45] Rhind, Leung, and Choi (1999), [46] cite Ho and Mak (1992)[47] who reviewed 134 cases of child sexual abuse among Chinese children living in Hong Kong and found that over 95% of the victims were female, with 73.8% between the ages of 11 and 16 years at onset of the abuse. The mean age at onset of abuse for intrafamilial victims was 9.8 yrs, while the mean age for extra familial victims was 12.6 years.

Africa

Madu and Petlzer surveyed 414 ninth and tenth graders from three secondary schools in the Northern Province of South Africa. Their ages ranged from 14 to 30 years, with an average age of 18.5 years. Using an operational definition of CSA that was restricted to contact abuse only, they found an overall prevalence rate of 54.2%, with rates of 53.2% for female students and 60% for male students, which is a ratio of 1: .89. Overall, 86.7% were kissed sexually, 60.9% were touched sexually, and 28.9% were victims of oral/anal/vaginal penetration. Most of the respondents (61.3%) indicated that the offender was a "friend," in all patterns of sexual abuse. Interestingly, most victims (86.7%) did NOT perceive themselves as victims of CSA and half rated their childhood as happy. This study also broke down prevalence rates according to race and found that 51.2% of "blacks" in the sample were victims, 76.5% of "whites", 90% of "colored", and 36.4% of others. In addition, they found lower prevalence rates for village dwellers (53.1%) than for urban (62.8%). According to the authors, in the Northern Province, many parents work as migrant laborers, usually far from home. After school, many children are often left alone, either at home or with babysitters and grandparents. The authors hypothesized that the absence of an adult male in many families, due to the high incidence of single parenthood and/or to being away working, may contribute to the high prevalence rate found among male students in this study, in that, perhaps the result of adult male absence could increase the possibility that these boys were sexually abused by women. Unfortunately, the sex of the perpetrator was not asked in this survey.

Another study from Africa looked at the frequency of reported cases of CSA in primary schools, where the perpetrator was the teacher. In 2001, Nhundu and Shumba[48] used official recorded cases of CSA that had been reported to school officials in Zimbabwe, over an eight year period. They found a total of 108 students who had reported sexual abuse by their teacher. All of the perpetrators were men, while 98% of the students were girls between the ages of eight and 16, with a model age of 12 years (46% of reported cases). Children between the ages of 11 - 13 years had an incidence rate of 69%. The most common type of abuse was statutory rape (57), followed equally by rape, love affair, and fondling at 17 incidences each, and two incidences of sodomy, which included the only two boy victims. These types of sexual abuse experiences between male teachers and female students, may be related to cultural patterns found in Africa, in which young girls have male sexual partners much older than themselves.

"Situations in which older men are partners of teenage girls have been reported in both urban and rural East African settings, where such men are known as "sugar daddies."[49] A "sugar daddy" is usually an older, relatively wealthy man who entices teenage girls with money and other goods to have a sexual relationship with them. This relationship may be casual, but is often on-going within a limited timeframe. It has been suggested that this type of sexual relationship may be responsible for introducing the AIDS virus to the teenage population.[50]

The 1998 study by Mpangile and others[51] in Tanzania screened 200 teenage girls who were admitted to one of four public hospitals during a 12-month period with abortion complications. Have those screened, 150 admitted that their medical problems were related to poorly done abortions and were subsequently interviewed for the study. The authors were interested in looking at their relationship with the man who had impregnated them. For girls aged 17 and below, they found that 39% reported that their male partners were "mshikaji" (a temporary partner), 39% reported that the man was not well known to them, and 31% were boyfriends. Less than 10% reported that their male partner was a fellow teenager.

Nearly 31% of the girls aged 17 and below attributed their pregnancy to men over 45 years in age. *Mpangile et al, 1998*

Nearly 31% of the girls aged 17 and below attributed their pregnancy to men over 45 years of age. Most of the girls reported that they did not perceive their partner to be a high-income earner. The authors questioned the motive for the relationships, given that it did not appear to be financial.

In a national sample of nearly 10,000 secondary-school girls in Kenya, one-third reported having had sexual intercourse, and approximately 40% of these girls indicated that their first encounter was forced or that they were "cheated into having sex." [52]

Middle East

Haj-Yahia and Tamish (2001)[53] conducted a cross-sectional survey among 652 undergraduate students living in the Palestinian Authority, of whom 81% were Muslim and 19% Christian. No single global prevalence rate for CSA was reported, but the authors stated that this rate "fell within the range of the problem in many other societies" as compared with the 1994 study by Finkelhor. Unlike other countries, which found higher rates of abuse among females, this study found similar rates of abuse among female and male students. Unfortunately, this study failed to inquire as to the sex of the offender.

Schein and others (2000)[54] used a random sample of 1005 adult patients selected from 48 clinics located in cities, development towns and on settlements in Israel. Some non-contact sexual behavior (exhibitionism) was included in the description of CSA, while other non-contact behavior (verbal requests for sex), were not. 92% of the sample was Jewish and 69% were Israeli born. They found that women were abused almost twice as much as men, with 15.7% of the men and 30.7% of the women reporting an experience of child sexual abuse. The most common perpetrators (55%) were adult male strangers. Twenty-six percent of the female victims reported intra-family abuse in comparison to 7% of the male victims. About half of the victims (45%) reported that they had disclosed their experience of being sexually abused during childhood.

Itzhaky and York (2001)[55] studied an urban neighborhood with a population of about 3000, within a prosperous city in Israel. They documented that within this small community, 15 girls came forward with reports of child sexual abuse. Schein and others[56] reported that cases of sexual crimes against children reported to Israel's Police Department have risen from 53 in 1985 to 1531 in 1995. These police files indicate that 16% of the cases were incest, compared to the much lower figure found in these authors' prevalence study cited earlier in this paper.

Shalhoub-Kevorkian (1999)[57] contacted a variety of social service agencies in Ramallah, Nablus, and Hebron of the West Bank, Palestinian Authority. A total of 38 girls were identified who had been sexually abused during the past two years preceding the study. Due to the social sensitivity of sexual abuse in Palestinian society, only eight of the victims were interviewed directly while information regarding the other victims was obtained indirectly through contacts with the social service agencies. The victims, all female, ranged in age from two to 19 years, with most falling between twelve and 18 years. All the offenders were male, with most offenders aged between 20 to 40 years. In 24 cases the offender was a father or brother, while another four were other relatives. One offender was a teacher, one a neighbor, and three were men from the same refugee camp. Five of the offenders were strangers to the victim.

South Asia

A pilot study in Sri Lanka,[58] using a sample of school children aged 13 - 17 from four select schools in "high risk" areas, found that 8% reported doing "sexual things" with other children, 5% with adults, and 6% with adults for money. Results were not broken down by sex of the victim, and no information was asked regarding the adults with whom the children had done sexual things.

National rape statistics from India show that in 1990, 10,068 rapes were reported, of that 2105 were girls between 10 and 16 years and 394 were under age 10. In 1993 Delhi registered 197 rapes of minors, 35 of whom were under age 7. A recent study in Bangalore conducted by a local NGO in collaboration with the National Institute of Mental Health and Neuro Sciences found that 15% of girls surveyed had been sexually abused. The same study found that 14.3% of boys surveyed had been abused by men, 7.3% by women.[59]

Finally, in a short survey administered to UNICEF field officers and other professionals around the world who work in the field of children at risk, all but one reported that they saw CSA as a moderate - to - large problem in the region in which they work.[60]

Defining and Researching Sexual Abuse

While many people would agree that the World Health Organization and survey definitions (see side bars) for child sexual abuse capture the essence of what is understood as child sexual abuse, making these definitions operational requires defining many of the variables included therein. These definitions allow for interpretations across cultures, across time, across sub-populations within larger populations, and even for variations in perceptions across individuals. The first definition focuses on defining types of behaviors that are included in CSA, while the WHO definition specifically calls upon local laws and customs to be utilized in defining CSA, and is conscious of the child's inability to give informed consent to an adult regarding sexual activities. However, the very flexibility that allows these definitions to be used across cultures also creates discrepancies across cultures in prevalence rates on a number of variables, such as defining the age of "child" in the context of sexual behavior, issue of consent, age differentials between child victims and sexual offenders, subjective perceptions, types of abuse, the relationship between the offender and the child, and other issues related to prevalence data.

Definition used on survey
Child sexual abuse (CSA) involves a physical violation of a child's body through any sort of sexual contact or by psychological violation of child's personal space through verbal or visual behavior. Sexual abuse may be overt: kissing, fondling, oral-genital contact, penetration, voyeurism/exhibitionism, sexual jokes – or covert: sexual hugs, invasive hygienic practices, adult pre-occupation with a child's body or body functions. Incest is childhood sexual abuse as defined above, done to a child by an immediate, extended and/or adopted family. When the offender is a family member, a powerful sense of betrayal and abandonment is often added to the trauma of abuse.

Defining "Child"

Although the United Nations Convention on the Rights of the Child (UNCRC), defines "child" as a person age 18 years and younger, the UNCRC also recognizes that childhood is a limited time period in which human capacities and competencies are in a process of development. Article 12 makes specific mention of this process, which affirms that a child may freely express themselves, but their views are given "due weight in accordance with the age and maturity of the child." Article 38 considers the concept of 'child development as a process' in defining age limits for recruiting children into the armed forces. For example, Section 2 of this Article states that State Parties should take "all feasible measures to ensure that persons who have not attained the age of 15 years do not take a direct part in hostilities," thereby implying that there are developmental differences between a 14 year old and 15 year old child. Section 3 further states that "In recruiting among those persons who have attained the age of 15 years but who have not attained the age of 18 years, States Parties shall endeavor to give priority to those who are oldest," which implies a developmental difference between the 15 year old and the 18 year old child, yet still acknowledging that persons under the age of 18 are developmentally different from adults.

Where the question of sexuality is concerned, this issue of development demands attention, and perhaps similar clarification. In many cultures a "child" (especially a female child) is often viewed as an adult once they reach puberty, independent of their age or psycho-social maturity. Although puberty herald's the arrival of the body's ability to reproduce, the psycho-social maturity necessary to engage in sexual relations as an equal partner, and the ability to comprehend and cope with possible consequences of sexual activity, such as pregnancy, may not accompany the physical development of the young person. Cultures vary on their expectations of children's abilities and roles throughout their developmental years, especially in regard to their ability to function sexually as adults. This has enormous implications for children's future development and ability to choose their course in life, as well as implications in defining "age of consent" regarding sexual matters and minimal age for marriage.

In early literature on CSA in the United States, very young children were often blamed for sexual activities with adults, because they had actively or passively allowed the abuse to occur.[61],[62],[63] Bender and Blau (1937) concluded that the children in their study had either initiated the sexual relationship with adults or acted in a seductive manner to entice them.[64] Although these authors defined their study participants as "children," they clearly did not account for their age related developmental differences with the adult sexual partners, nor considered any differences in power and authority between the children and adults. Beyond being considered equal partners, these children were perceived as being so sexually astute that they were attributed with the ability to seduce the unwilling adult into engaging with them in prohibited sexual behavior. These attitudes by adult professionals required answers to questions such as: how much awareness of sexual activity is

necessary before a child can fully comprehend their involvement in sexual activities, how does a child become aware, and at what age are children fully aware?

Mensch, Bruce, and Greene believe that some culturally sanctioned norms permit the sexual violence of children, because the understanding of "child" is too narrow. In their work, *The Uncharted Passage: Girls' Adolescence in the Developing World,* they argue that "a girl remains a girl until she reaches age 20, no matter what occurs in her life prior to that time."[65] For example, they report that many female children experience violence in marriage. They cite Jejeebhoy's (1996) description of the marriage night of young women in India, where the "first sexual experience with their husbands was typically described…as traumatic, distasteful and painful and the use of force was frequently mentioned."[66] Ben Baraka, in *Sexual Coercion and Reproductive Health*, describes how families of young girls in Algeria fear the loss of virginity so much that girls are typically married early and without their consent. On the wedding night, "defloration must be as quick and as bloody as possible with immediate evidence of defloration: a sheet or her dress is shown like a flag to those in the [wedding] party."[67] As a physician, she describes a scenario related to the trauma of sexual initiation:

> *In another version of the story, a young woman is rushed to the emergency room on her wedding night, hemorrhaging profusely. An ob/gyn exam reveals scratches and cuts on her labia minora, a deep cut of 2-3 centimeters in her vagina. Her defloration was so abrupt that she will suffer in each subsequent sexual act. These are results of the official celebrations of a young woman's defloration in Algeria.*[68]

The age limit to childhood is not only important in determining who is a "child victim," but also in determining who can be an offender. Studies from the United States and elsewhere show that a significant portion of child sexual offenders is under the age of 18.[69] In the United States, clinical samples of child victims show rates of sex offenses by juveniles totaling between 42% - 56% of all reported sex offenses[70],[71],[72] and arrest statistics between 17.6% and 49.6% of all those arrested for sex offenses.[73] In Finkelhor's (1979) sample of college students, he found that 34% of women and 39% of men revealed having sexual activity with a partner at least five years older than themselves, yet were still aged between 10 and 19 years. In a study of Latina women in the United States, victims reported that 51% of the offenders were under the age of 20.[74]

How old must an "aggressor" be in order to be accountable for his/her sexual behavior towards others? At what age do children become aware that sexual coercion, either verbal or physical, is wrong? For example, is it CSA when a 12 year old child asks an eight year old child to touch his/her genitals, and the younger child complies?

Halperin and others (1996) study of Geneva adolescents revealed that 35% of abusers were under 18 years of age, the same rate suggested in Great Britain.[75] In New Zealand, police data from the past 9 years revealed a total annual rate of about 11% for juvenile sex offenders,[76] and a recent study in Nicaragua showed that half of the offenders reported were aged 9 - 17 years inclusive when the first abusive incident occurred.[77] Currently a draft bill in Jamaica is adding an amendment that would abolish the common-law presumption that a 14-year old boy is incapable of rape.[78] How old must an "aggressor" be in order to be accountable for his/her sexual behavior towards others? At what age do children become aware that sexual coercion, either verbal or physical, is wrong? For example, is it CSA when a 12-year-old child asks an eight-year-old child to touch his/her genitals, and the younger child complies?

In the field of child sexual abuse, it is often difficult to define concepts such as "child" in isolation of other important elements that must be operationalized in defining sexual abuse. These issues include "consent" as well as the age differential between the child victim and the offender.

The Issue of Consent

It is assumed that adults have sufficient information about sexual activities, including possible consequences and the possibility of community censure, to be able to make informed decisions regarding their actions. It is further assumed that adults are able to cope with the consequences of sexual activity to which they have given their consent. Children are often less aware of the meaning and consequences of sexual behavior, although, their awareness of sexuality, especially as related to gender roles, is constantly growing.[79] They "may mimic behavior with sexual overtones and may engage in sexual exploratory behavior aimed towards attracting attention and favor, but it is unlikely that the child conceptualizes their connotations."[80] If children have witnessed or been involved directly in sexual activities with an adult, it does not mean that they now have the information and experience necessary to understand the possible consequences and community censure and are therefore able to give informed consent. Children gradually acquire the cognitive capacity necessary for

abstract thinking which allows them to recognize the assortment of possible future consequences to their behavior.

If children or adolescents agree to a sexual relationship with an adult in exchange for material goods, does this indicate that they have given their consent? This became a question for social workers and other professionals in the United States around the mid 1970's, as cases of child sexual abuse began coming regularly to the attention of authorities. Professionals who worked directly with child victims began describing how children could be enticed into engaging in sexual activities with adults when they were bribed with candy, toys, money, or other material goods.[81],[82] They found that children, including older children, could feel flattered by the unusual attention - it may have been the first time in their life that an adult had noticed them. They also found that once a child became involved in a sexual relationship with an adult, their own guilt feelings might have prevented them from leaving the situation. Guilt feelings come as the result of feeling responsible for entering into the relationship, for enjoying the attention and material rewards, and even for enjoying the physical pleasure that the sexual activities may bring. "In seeking love and acceptance and with the need for human contact, a child, especially a young adolescent, may invite sexual exploitation."[83] A child may seek out a relationship of affection and attention from an adult, which could be interpreted by the adult as a sexual overture and therefore result in a sexual encounter.[84]

Finally, children around the world are socialized to obey those older than themselves - their survival often depends upon it. Children are taught to trust adults. Their youth and subordinate status puts them into a relationship of dependency with adults and older adolescents, who are invested with authority and power by virtue of age and autonomy.[85] This creates a power dynamic that prevents children from being free to withhold consent from those older than themselves. Even among adolescents, age differentials are thought to correspond to power differentials in sexual relationships.[86] When the perpetrator is an immediate family member, especially a parent, the power over the child is even greater than when the perpetrator is not a family member, since the level of dependency is greatest in this relationship. Herman believes that any sexual relationship between the two:

> *must necessarily take on some of the coercive characteristics of a rape, even if, as is usually the case, the adult uses positive enticement rather than force the relationship. Parents use authority, not force. Consent is irrelevant. Without the power to withhold consent, there is no power to grant it.*[87]

What does this mean in a cross-cultural context? In a previously cited study examining cases of child sexual abuse that had been reported in primary schools in Zimbabwe,[88] the authors found that most frequently, the abusive relationship occurred between female students, of whom 69% were aged between 11 - 13 years, and their male teachers. Among female students, the most common type of abuse was statutory rape, which included 53% of all abuse, and was particularly high among students aged 11 - 13 years (68%). Statutory rape, unlike non-statutory rape, is usually defined as vaginal-penile penetration between an adult male and a female under the legal age of consent as defined by the state. Neither force nor coercion needs to be proven for this sexual activity to be labeled as "abusive" and to be considered a crime. Interestingly, another 16% of abuse reports were cases of teachers falling in love with their students, labeled "love affairs."

The authors of the study do not define what specific behaviors are described by "love affair." "Love affair" would seem to indicate an inappropriate relationship between the young female student and the adult male teacher that did not result in sexual intercourse nor fondling. "Love affair" generally connotes a consensual romantic relationship pursued freely by two individuals. This leads the reader to wonder if the student reported coercion or force in the love affair, especially since half of all abuse cases were reported by the student victims. Abuse in this retrospective study was defined by statutory requirements and Ministry of Education stipulations governing the professional conduct of teachers regarding inappropriate relationships between teachers and students. Although the question of consent was not directly defined, two value judgments are implied regarding consent. First, that children under the statutory age limit (in this case, under the age of 16) do not have the developmental capacity to consent to sexual relations with adults and second, that children are not able to consent to sexual relations when the relationship has an unequal distribution of power and authority.

While the purpose of the 1998 study in Tanzania[89] was not to gather information on sexually abusive experiences of children, the study none-the-less provides insight into young girls' sexual relationships in this culture. In this study, 150 teenage girls who had been admitted to public hospitals with abortion

complications were interviewed. Nearly 62% of the girls aged 17 and below attributed their pregnancy to men over 24 years in age, with more than 30% of the men over the age of 45. Similar to the Zimbabwe study, it demonstrates that young girls may have male sexual partners much older than themselves, reinforcing the idea of "sugar daddies." The authors questioned the motive for the relationships, given that only a small proportion of the girls perceived their partners to be high-income earners. Perhaps, as described in some of the early American literature on child sexual abuse, the motivation is linked to a need for adult attention and affection. This study does not look at the possibility that some of the young girls could have been victims of child sexual abuse. The possibility that statutory rape occurred is never discussed, nor is the possibility that the pregnancies were the result of coerced sexual relations or non-consensual sex due to a relationship in which the age differential produced a relationship of unequal power and authority.

Countries vary on the age limits used to define "age of consent." For example, Colombia's new Penal Code eliminated the offense known as statutory rape, which was defined as "deceit to obtain sexual relations with a minor between the ages of 14 and 18."[90] "The decision to eliminate this offense was based on socio-cultural norms, which recognizes minors between the ages of 14 and 18 as mature persons."[91] Colombia no longer recognizes that adolescent girls are in a developmental process in regards to their sexuality; they are viewed as having the capacity to sexually function as adults. Another example, from Albania, demonstrates again that psycho-social maturity is not considered in defining a girl's ability to sexually function as an adult. Albanian statutory rape laws only apply to girls under the age of 13 or until they reach sexual maturity.[92] These laws, then, enforce the notion that physical maturity is the only developmental necessity in determining one's ability to negotiate sexual relationships.

Finally, the issue of consent as related to child sexual abuse should be examined within the context of marriage in which the bride is a child. Does a girl's childhood end with marriage, regardless of her age?[93] In this case, a girl is usually required to sexually service a man not of her choosing for the rest of her life. Is this child sexual abuse, at least during the time period in which the wife is still a child? Annie George, a researcher from the Tata Institute of Social Science in India, questions whether the notion of consent by virtue of marriage has any validity since the centrality of marriage to the culture is so dominant that marriage is not an option.[94] According to George, in India, girls are married off at an early age, have no say in whom they will marry and are given virtually no information about sex prior to their wedding night.[95] Some argue that the marriage contract grants men unrestricted sexual rights to their wives and therefore the concept of "marital rape" cannot exist in their cultural context.[96] Herman writes that women become objects of exchange as a result of male supremacy: "only male supremacy determines that men have the right to give women for marriage or concubinage, while women have no comparable rights either in men or in themselves."[97]

The issue of consent, which should be considered in creating statutory rape laws, recognizes that young girls below a certain age do not have the capacity to adequately negotiate a sexual relationship with an adult. This has enormous importance in protecting young girls from sexual coercion that their immaturity prevents them comprehending, or from being blamed when they are sexually victimized. Statutory rape laws generally only consider heterosexual relationships in which young girls are victimized, but adolescent boys confront similar sexual pressures from adults, and should not be forgotten in the creation of laws and statutes aimed at protecting youth from older sexual predators.

The issue of consent also has important implications in considering the creation of operational definitions of child sexual abuse used to measure prevalence. For example, the study from Nicaragua assumed that sex between children age 12 and below with anyone else who was older, was abusive. The issue of consent not only needs to consider that children are capable of being enticed into sexual activities with older persons rather than being forced or pressured. It also must consider the possibility of exploratory sexual behavior between children, who are same-aged or who have minimal differences in age. By asking, as these authors do, "When you were 12 years old or younger, did someone older than you ever do something sexual to you,"[98] they open the possibility that childhood exploratory behavior is included as abuse. "Older" is not defined, allowing for small age differentials to exist between the two parties.

Another example of definitional issues related to consent comes from the study among secondary students in South Africa.[99] These authors appear to have assumed that sexual activities between adolescents up to age 16 and persons aged 18 years and older are always abusive. For this study, the abuse had to have occurred before the student reached 17 years of age and the perpetrator had to be an adult OR a person at least 5 years

older than the child - or a person in a position of power. It is not clear which criteria is applied (adult or 5 year age differential) in what situation. However, if an adult is defined as a person age 18 and older, this definition implies that all sexual relationships between 14, 15, or 16 year olds and 18 year olds are abusive, even when neither force nor coercion are used.

Age differential between victim and perpetrator

Because of these difficulties that arise regarding the issue of consent, some researchers began to define consent by using age limitations between the child and perpetrator which take into consideration the questions related to the psycho-social and physical level of maturity of both the child and the aggressor. For example, Romero and others, basing their criteria on an earlier study by Wyatt (1985) clearly took the issue of consensual sex into account by defining it through age limitations:

> *To separate women's childhood sexual victimization from exploratory sexual experimentation before age 12 or consensual sexual activity with peers, two additional exclusion criteria were used. If the perpetrator was more than 5 years older than the respondent, the incident was considered sexual abuse. If the difference was less than 5 years, only contact that was not desired or involved coercion was included…*[100]

Finkelhor (1979) also used age limits to differentiate consensual sex from abuse, which he called the "community standard about what is an exploitative sexual relationship."[101] Finkelhor reported that other "communities" may have different standards about what constitutes an exploitative relationship between adults and children. For his community, he used three criteria for determining abuse: 1) children age 12 or under with an adult age 18 or over, 2) children age 12 and under with another person who is under age 18 but at least five or more years older than the child, and 3) adolescents ages 13 to 16 and legally defined adults at least ten or more years older than the adolescent.

Both Finkelhor's and Wyatt's operationally defined age limits were determined from community standards in the United States, where adolescents are infrequently married before the age of 18 and whose sexual partners are more likely to be close in age. In other countries, very different patterns of sexual behavior of adolescents can be seen. The Demographic Health Survey (DHS) statistics, as reported by Mensch, Bruce, and Greene,[102] indicate that in three select countries a high percentage of adolescent girls married men significantly older than themselves. Among girls in Columbia, Egypt, and Turkey, who married before age 20, 43.1%, 64.7%, and 44.8% respectively, married men at least six years older than themselves. Of these, 17.6%, 24.4%, and 7.1%, married men at least ten years older than themselves. As noted previously, Bastos, Morris, and Fernandes (1989) found that in Brazil, among girls who had intercourse before age 15, 55% of their partners were six or more years older and the corresponding percentage for boys was 21%.[103]

Community standards in some countries appear to encourage sexual relationships between young girls and much older men. These social norms "condone or even force young people into unhealthy sexual behavior by encouraging early childbearing and by failing to sanction older men who have sexual intercourse with young girls."[104] Community standards are often reflected in a community's legislation, which can be a two-edged sword. On the one hand, legislated community norms regarding appropriate adult/child sexual relations can be used to enforce protective measures for children and prevent child sexual abuse. On the other hand, it may serve to legitimize community standards that limit a child's development and future, in which the best interest of the child was not considered. For example, the Council of Guardians in Iran recently rejected proposed legislation to change the legal age of marriage for a girl from age 9 to 15, which is the legal age of marriage for boys.[105] In some places, laws governing the legal age for marriage are determined by social norms that create formidable obstacles for female children who have been raped, thus promoting early marriage for her protection:

> *As Ben Baraka explains, an Algerian girl's entire education is geared toward respecting male authority and safeguarding their virginity until marriage. Loss of virginity brings permanent dishonor to herself and her family. The only way to cleanse the family honor, once tarnished, is to kill the woman, a task normally undertaken by her own father, brother or uncles. A girl's family lives in daily fear that she will lose her virginity before marriage; that is why she's married early, and often without her consent…. With the resurgence of Muslim fundamentalism, however, virginity has again risen in importance and families are now requiring a "virginity" certificate before marriage.*[106]

In those regions of the world that place less emphasis on virginity as a prerequisite to marriage, the minimal age for marriage will likely prove to be higher.

Sexual behavior in all cultures is socially monitored, but the norms which guide sexual behavior, as well as the laws used to enforce these norms, vary vastly across cultures. Most communities have laws that govern the limits of sexual behavior between unmarried persons, including laws for adolescents, but when communities fail to censure sexual relationships between unmarried persons, these laws are often unenforced, no longer being considered relevant to the current social situation. Some communities may promote beliefs that are based on myths that view the male sexual urge as overpowering and in need of satisfaction, and which allows men to rationalize escapades of anti-social behavior, even behavior such as child sexual abuse.[107] Other communities promote beliefs based on myths that view females as a source of evil, anarchy (fitna), and trickery and deception (kaid), a belief that therefore holds them responsible for their sexual victimization at any age and indiscriminate of the age of the offender or the relationship of the offender to the child.[108]

According to Shalhoub-Kevorkian, the phenomena of honor and shame is a central characteristic in "Arab societies", and is generally linked with the sexual conduct of women.[109] This cultural characteristic exists throughout "Arab society", but its strength can differ from one community to another.[110] "For example, Al-Khayyat (1990) has shown that in Iraqi society death will immediately befall a girl from a rural, lower class being suspected of dishonorable sexual behavior. A middle class urban girl suspected of the same offense would probably result in keeping her secluded indoors until her relatives investigate the case."[111]

Therefore, while community standards certainly need to be considered in defining inappropriate sexual activities between adults and children, it must also be recognized that some community standards were formed on norms that did not take into account developmental issues regarding childhood, consent, nor what is in the best interest of the child. In order for any community to begin work in the area of child sexual abuse, guidelines regarding age differentials between victim and perpetrator need to be considered. But to do this, communities need to recognize their own norms and laws, and decide how these norms and laws work in the best interest of children.

Subjective Perceptions

The Barthauer and Leventhal study with women in El Salvador used questions from the 1985 LA Times Survey in defining child sexual abuse. Accordingly, they define a child as a person age 18 or under. However, they ignore the issue of consent and define child sexual abuse through the respondents' subjective judgment regarding the sexual experience by asking, "…can you remember any experience you would now consider child sexual abuse...."[112] While this provides a victim's voice in defining their own experience, this too can create methodological difficulties. As previously mentioned, Madu and Petlzer found that 86.7% of the victims in their study in the Northern Province of South Africa did NOT perceive themselves as child victims of sexual abuse, even though the prevalence rate for child sexual abuse was 54.2%.

Heise and others argue that any definition should include the volition, perception, and feelings of the victim, rather than defining the "moral acceptability" of an act by the act itself or its impact on the victim, because community standards often do not include the victim's voice. *Heise et al, 1995*

Heise and others argue that any definition should include the volition, perception, and feelings of the victim, rather than defining the "moral acceptability" of an act by the act itself or its impact on the victim, because community standards often do not include the victim's voice.[113] When victims are female, social standards are frequently based on "whether a woman is sexually chaste, who she "belongs to" (is she married, still living at home, independent,), who is the perpetrator (does he have sanctioned sexual access to the woman) and the nature of the sexual act (penetrative versus non-penetrative)." [114] However, this group also acknowledged that victims can internalize their culture's mythology about CSA and may not feel that their experience, while painful, qualifies as abuse. Nahid Toubia observed that victims may not have the language to identify abusive behaviors as abuse, but they still feel violated.[115] If a child does not perceive sexual activities with an older person as abusive, should these activities be defined as child sexual abuse? If an adult retrospectively reflects upon her/his personal childhood experience of incest and concludes that they were not abused, were they?

Type of Abuse

One of the difficulties in establishing standardized operational definitions of CSA is determining what types of behaviors to include and which to exclude. Some cross cultural studies only ask about behaviors that include physical contact, such as fondling and penetration[116],[117],[118] while others include non-contact behaviors such as voyeurism and exhibitionism.[119],[120],[121] Studies that include both contact and non-contact sexual abuse generally find higher prevalence rates than those that exclude non-contact abuse. For example, Collings study in South Africa found that 29% of men sampled reported a history of sexual abuse, even though only one third of them had actually experienced contact sexual abuse.[122] In some contexts, only contact abuse may be reported due to the harsh reprisals that can accompany disclosure. For example, among the 38 reported cases among Palestinian girls, all disclosures resulted from consequences that affected them physically: 11 victims desired to terminate a pregnancy, 12 victims were feared the loss of virginity resulting from a perforated hymen, and 15 victims feared their loss of virginity, but in fact, their hymen had not been perforated.

However, even where studies agree on whether to include (or not) both contact and non-contact forms of abuse, the descriptions of types of abuse may be dissimilar. Non-contact sexual abuse, for example, may include verbal behavior, such as giving sexual threats or invitations,[123] or may only include non-verbal sexual behaviors such as exhibitionism and voyeurism. Contact abuse may be very explicit, using many specific questions regarding where the victim was touched, or may ask fewer questions that are less explicit.

In addition, some countries may need new descriptors to more fully encompass their cultural context. For example, one previously mentioned study included "love affair" as a type of abuse occurring between young students and their teachers in Africa.[124] While "love affair" needs behavioral descriptors for research purposes, it is possible that this type of unacceptable sexual behavior is culture-relevant. The authors who studied sexual abuse among Palestinian university students recognized that by solely using Finkelhor's (1979) scale of sexual abuse, they may have failed to capture other sexual acts deemed unacceptable in the "Arab context".[125] They felt that, "the conceptual and methodological aspects were not developed sufficiently to determine which aspects of sexual abuse are unique to "Arab societies" in general and Palestinian society in particular."[126] In a study by Collier and others (1999), 141 elementary school teachers in the Republic of Palau, located in the Northern Pacific Ocean, were asked to rate 25 vignettes on their level of severity of all types of abuse. Three of the five items that could be associated with sexual abuse were ranked 2 through 4, as most severe. The item "sleeping with lonely dad" was ranked 4th and considered more abusive than other items such as: letting a child observe domestic violence (ranked 5th), keeping a handicapped child in a cage (ranked 7th), and beating a child for not doing their homework (ranked 19th). In contrast, the item "sleeping in parent's bed" was ranked 23rd. In Palau, the teachers agreed that "sleeping with lonely dad" was extremely abusive, and may need to be considered as a form of abuse.

Finally, cultures change and with these changes often come the redefining of behaviors that are (or are not) acceptable. For example, in the US, the line between acceptable and non-acceptable levels of coercion among dating partners is clearly changing.

> *Acts that would have been citied as the girl's fault or ascribed to "bad manners" on the part of the boy 20 years ago are increasingly being labeled "date rape." The social definition of acceptable behavior is culturally defined and therefore subject to change. The dominant definition that holds sway at any one time, however, has nothing to do with whether coercion actually occurred. This is a subjective reality that can only be determined by the woman.*[127]

Relationship and Victim Age

The information on perpetrator/victim relationship and average age of the victim at onset of abuse across cultures is not well established. In the United States, it appears that a child's vulnerability to sexual abuse increases around age six, and rises sharply after the age of 10.[128]

Finkelhor (1979) found that 28% of the women and 23% of the men in his study reported incestuous sex, most of which occurred between children of the same generation, although not necessarily the same age.[129] In Geneva, Halperin and others found that 43.7% of the students who reported abuse were 12 years or older when the abuse first occurred, and 5.6% of boys and 25.5% of girls who had been abused reported contact abuse with a family member.[130] A survey of court convictions in cases of child sexual abuse in Sweden found

that 72% of the perpetrators were well known to the child and that the most severe offenses took place within the family, with the most common form of abuse being penetration of a female child by her biological father or a family friend.[131] A study of sexual violence in Bogotá[132] indicated that girls between the ages of 12 and 17 are the population most vulnerable to sexual abuse. The offender is usually known to the victim (80%) and is often a family member (48%). While it appears that sexual abuse of children occurs across cultures, it is currently unclear how it may differ from one region to another.

Available information that is based on cases reported to community agencies from non-western countries appears to have an over representation of father/daughter incest. For example, in the qualitative study that looked at six cases of CSA among Chinese children in Hong Kong, it was found that all six cases were father/daughter incest.[133] These were all of the cases of child sexual abuse that had been closed at the Hong Kong Family Welfare Society during a defined 16-month period. The initial abuse started when four of the girls were age 12, one was 16, and one was age 9 or 10. Shalhoub-Kevorkian, whose sample consisted of 38 Palestinian girls who had been brought to the attention of social service agencies, found that 63% were age 12 and above, where 24 cases were father or brother incest, 4 more were blood relatives, and five cases were strangers.[134] In Israel, 15 cases of CSA of young girls were reported to health agents in a small community. Of these, some were cases of incest.[135] Some regions of the world restrict children, particularly female children, more closely to the home, which may reduce access of non-related sexual predators to children in these societies, while increasing access to relatives and family friends.

However, in a large random sample survey done in Israel, 26% of females and 7% of male victims experienced intrafamilial sexual abuse. Overall, 45% of the perpetrators were previously known to the victims and the mean age of victims at onset of the abuse varied between 10 and 14 years.[136] Using a probability sample, Haj-Yahia and Tamish (2001) found that of their sample of 652 Palestinian undergraduate students, 18.6% had been abused by a family member, 36.2% by a relative, and 45.6% by a stranger.[137]

Other studies also indicate that most sexual perpetrators were known by the children, but vary on the age of onset of the sexual abuse. In the study with El Salvadoran women, the mean age at the time of abuse was 13.6 years. All perpetrators were male, none was a parent, and only two were relatives. A total of 66% of the perpetrators were known to the victims.[138] Romero and others, who studied Latina women living in the United States, found that the mean age of the victim at the time of the abuse was 11 years, although 46% reported being age 12 or older when the abuse occurred.[139] A total of 96% of the perpetrators were male, with 48% being victimized by someone in their family and about 9% by strangers. Of the four reported female offenders, 3 were cousins. A study from rural Australia reports on the CSA of 21 young males, aged between 8 and 11 years, by a single male perpetrator who had worked as a primary level teacher of the victims. Ho and Mak (1992),[140] who reviewed 134 cases of CSA in Hong Kong, found that over 95% of the victims were female and the mean age of victims at onset of abuse was 12.2 years, although mean age of the victims in the case of intrafamilial abuse was only 9.8 years, compared to 12.6 years for extrafamilial abuse.

As mentioned, in Africa young girls may enter into sexual relationships with older men. In some studies, these relationships are defined as abusive, while in others they are not. In Zimbabwe, community standards will not sanction these relationships when the male partner is a teacher. In the study by Nhundu and Shumba that focused on sexual relationships between teachers and students in Zimbabwe, they found that in 69% of all cases, the victim was aged between 11 and 13 years.[141] In the study by Mpangile and others in Tanzania, of 150 girls aged 17 and below, they found that 39% reported that their male partners were "mshikaji" (a temporary partner), 39% reported that the man was not well known to them, and 31% were boyfriends.[142] In South Africa, 61.5% of victims were abused by friends as compared to 10.2% by relatives when the abuse included oral, anal, or vaginal penetration.[143]

What relationships in which age groups are inappropriate in a given culture? Is it possible to define a universal standard that determines what relationships are inherently abusive? How important are community standards in making these decisions, and how does one determine what is in the best interest of the child?

In some places in the developing South, where many young girls work as house maids, concern exists that they may be at risk of sexual abuse by employers and other family members. "A study in Peru of 100 families that employed domestics found that 60% of the adolescent males in these households had their first sexual experience with a "house girl."[144] In Sri Lanka, 100,000 child domestics are at high risk of physical/sexual abuse from their employers, though further research is needed to confirm this.[145] In addition, these house

maids could also be possible perpetrators of child sexual abuse to younger children in the household.[146] Ramsey-Klawsnik (1990), in a study of lone female perpetrators in the United States, found that 25% were babysitters, teachers, or day-care providers[147] and Rudin and others (1995) found that 16.1% of the lone female offenders in their sample of 88 lone female perpetrators were non-familial caretakers.

Finally, the question must be asked, "Can adult husbands perpetrate child sexual abuse against their child wife?" Paragraph six of the Declaration on the Elimination of Violence against Women, recognizes that:

> *"violence against women is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women, and that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men, ….Concerned that some groups of women such as….female children,…are especially vulnerable to violence."*[148]

What relationships in which age groups are inappropriate in a given culture? Is it possible to define a universal standard that determines what relationships are inherently abusive? How important are community standards in making these decisions, and how does one determine what is in the best interest of the child?

Child Sexual Abuse as a Sensitive Subject

Child sexual abuse has been met with different reactions in the west throughout the last century. When Freud first published "The Etiology of Hysteria" in 1896, he reported that women's hysterical reactions were due to incest experiences in childhood. He was greeted with outrage by his Viennese colleagues, who denounced him and his theory.[149] Freud later revised his Seduction Theory so that true childhood sexual experiences reported by his women clients became the fantasized longings of women who had never resolved their sexual fantasies for their father.[150] For another half century the reports of women's sexual abuse experiences were silenced by a culture that could not accept their validity. Even when Kinsey discovered in 1953 that 25% of his female study sample had been molested as children, he "wondered why any child should be so distraught at having its genitals fondled by a stranger."[151] Finally, in the 1960's and 70's, the women's liberation movement and the sexual revolution in the west created a social environment that was willing and able to approach the issue of child sexual abuse.[152]

> "Hysteria was so common among women that if his patients' stories [of sexual abuse and incest] were correct, he would be forced to conclude that what he called "perverted acts against children" were endemic, not only among the proletariat of Paris, where he had first studied hysteria, but also among the respectable bourgeois families of Vienna, where he had establish his practice. This idea was simply unacceptable. It was beyond credibility."
> *~Judith Herman, 1992, p. 257*

While reporting systems, interviewing techniques, and treatment and prevention programs have been developed to help victims of child sexual abuse, even today in the United States, most survivors of child sexual abuse, regardless of ethnicity, do not disclose their abuse to anyone.[153],[154],[155] Cultural and social values that disempower children create an environment hostile to disclosure. Negative consequences following disclosure may also create barriers that prevent children from revealing sexual abuse. Gender and sexual norms, practices and power dynamics that allow CSA to occur privilege those who have a vested interest in silencing experiences of CSA. Patriarchy, a socially constructed ideology which is characterized by a hierarchical social structure that subordinates women and children, appears to be a key source in preventing disclosure of child sexual abuse by the child victim. Patriarchy can play itself out in all institutions (political, social, community, religious, and familial), and affects victims through its myriad of socially constructed norms which rest upon it. Taboos around discussing sex and strict restrictions on expressing one's sexuality are barriers to disclosure as well. Finally, the defining of public versus private space and collective versus individual rights may play a role in determining the willingness of a community to intervene in a sexually abuse situation.

What follows are some examples of both cultural values and negative consequences that impede disclosure. These examples are not meant to encompass all the cultural values that are relevant nor all the negative consequences related to preventing disclosure. In addition, it will be noted that these cultural values are not completely distinct from one another, and are often interdependent.

Family Honor/Shame

The family is the central organizing institution of most societies and therefore is the most powerful factor in determining a victim's ability to disclose their victimization. In the patriarchal system, power within families is distributed based on gender and age: men have more power than women and parents have more power than children. Families are the primary source of support for individuals in both the north and south, and therefore the family system will fight to maintain its integrity when internal or external pressures attempt to change its homeostatic functioning. In some societies, the survival of the community is often perceived as part of this homeostatic system, so that pressures that affect family functioning will affect the community at large as well. Family members are prevented from changing the family system through cultural norms that stress family duty, family honor, and rigid parental obedience.

Disclosure of child sexual abuse is often perceived as a danger to the survival of the family, particularly when the offender is the most powerful member. The disclosure of child sexual abuse forces the family into protective mode, in an attempt to preserve the system. Denial or minimization is often the most effective way to maintain the family intact when assaulted. When these methods are ineffective, more drastic measures may be required. Children, especially female children, are the least valuable members of the family in a patriarchal system, and are therefore the most easily sacrificed for the greater good of the family and community. For example, in Hong Kong, a child's low position in the family hierarchy and fear of disgracing the family leaves them vulnerable to rejection, especially when the offender is the father.[156] They are taught unquestioning obedience and respect towards their parents, which puts great pressure on child victims of incest to submit to abuse.[157]

In some societies, patriarchy has created a cultural value that links family honor to a woman's sexual conduct. This appears to be particularly strong in the "Arab context".[158] Girls and women may only engage in sexual activities within the confines of marriage – unmarried women must remain sexually untouched. Virginity, defined as having an unperforated hymen, is held in such esteem that in some places, a certificate of virginity is required for marriage.[159] Surgical hymen restoration is a common practice in the "Arab world" when it is needed to safeguard the family honor.[160] According to Shalhoub-Kevorkian, in "Arab society", women who do not respect sexual codes of conduct, bring shame upon their families by violating the "family honor." "Such violations sanction or force male members to kill the woman in order to restore 'honor' to the family. As a consequence, society begins to perceive women not as human beings, but as sexual objects and potential victims of abuse."[161] In Shalhoub-Kevorkian's study of 38 sexually victimized Palestinian girls, 3 were murdered by their brothers, one died of an unsanitary abortion, five were imprisoned at home to avoid psychological and social derision, and seven others were married, banished to another country, or institutionalized in orphanages or centers.[162] Upon hearing of the sexual abuse of a little girl, one Palestinian teacher responded:

> *I got so scared…a feeling of total paralysis overcame me…I knew that this is an unsolvable issue culturally…I know that such things happen, but we never knew how to deal with them. Our society covers up such matters. Many girls died as a result of such abuse, but their families claimed they committed suicide, or they became ill and died...Do you know how many girls fell suddenly into water wells and died? We all knew that they were raped, and no one knew how to handle the problem, so they killed them.*[163]

Although the murder of child victims of sexual abuse are not sanctioned by law, Article 340 of the Jordanian Penal Code excuses a male family member who kills or injures a female member of his family and/or her partner if he catches them committing adultery.[164]

"Arab societies" are not alone in defending a code of honor against sexual misconduct. In Brazil, the offense of adultery is in the process of being eliminated, although has been used to sustain "the legitimate defense of one's honor" used in Brazilian courts for decades to defend husbands who murdered their wives accused of adultery.[165]

While the repercussions of disclosure of child sexual abuse for girls are more severe than for boys under a system of patriarchy, boy victims too suffer when their victimization is exposed. Boys are expected to be aggressive, strong, and masculine. Their masculinity is equated with virility and the sexual dominance of females, and is often juxtaposed with femininity. Masculinity requires men to divest themselves of all things feminine. Therefore, sexually abused boys bring shame upon their families because they have failed to defend

themselves against the sexual aggressor and engaged in sexual activities with another male, damaging their manhood and masculinity. [166],[167] Denial of abuse is a means of protecting their masculinity.[168]

"Protection" of Children as a means to Protect Parents and Perpetrators

It is desirable for parents to exercise their rights over their children in order to protect them and to provide them with optimum opportunity for reaching their full human potential. However, some cultural values regarding "protection" may hinder a child's opportunity for social, educational, and mental growth. In patriarchal societies that place great emphasis on protecting female virginity, parents often bond their daughters to male partners at an early age for their protection, through socially constructed strategies as early marriage, polygamy, and marriage between close relatives; other "protective" measures include barring women from economic power and control.[169] Marriage of a sexually abused girl to her offender appears to be a strategy for nullifying the social consequences to the family of the abuse. The child often has no choice but to acquiesce to parental decisions, because their subordinate status in the patriarchal system denies them the right to make decisions for themselves, even in decisions, such as choosing a marriage partner, that will significantly impact the rest of their life.

These cultural "protections" often function to protect the offender even more than the child victim. In Brazil, when the victim of a sexual crime marries her perpetrator, he is granted annulment of the sentence for the sexual offenses.[170] In Zimbabwe, male teachers who sexually abuse their female students can arrange "marriages of convenience" with parents of victims in an attempt to evade prosecution by the courts or summary dismissal by employers.[171] In Argentina, rapists can avoid criminal liability by negotiating with the victim.[172] Jordanian law (Article 292, Jordanian Penal Code) allows rape charges to be dropped against a rapist who subsequently weds his victim.[173] Romero and others reported that forced marriages do not require reporting of statutory rape, and that in their sample of 100 Latina women living in the United States who reported CSA, four had been forced or pressured by their family to marry the perpetrator.[174]

Collective over the Individual

Some societies value the harmony and equilibrium of the group over that of the individual. Savishinsky (1991), wrote that the value of interdependence among Native Canadians could prevent disclosure of sexual abuse in order to avoid bringing disharmony to the group.[175] According to Shalhoub-Kevorkian, in the "Arab world" "when an act of sexual abuse against a female member of society becomes public knowledge, society perceives the crime as being directed against the collective."[176] The shame and dishonor belong to the extended as well as immediate family, and sometimes to the greater community.

Child sexual abuse can be perpetuated through religious systems as well as social systems when a higher value is placed on group harmony and protection of the offender than on the sexual safety of an individual child. Currently, in a highly publicized account by the United States media, hundreds of cases of child sexual abuse by Roman Catholic priests are coming to light. These cases have occurred over the last three decades, but only now has American society created a social environment conducive to supporting the claims of survivors and accepting the validity of their disclosures. In the archdiocese of Boston alone, an estimated 450 alleged victims of CSA at the hands of Roman Catholic priests are seeking redress for past abuse.[177] In many ways, the Roman Catholic Church, and other hierarchical religious institutions as well, function similar to families in their need to maintain homeostatic functioning throughout the system. When pressures are exerted on the system, the initial response is denial and minimization. The male clergy, as the most valued members of the system, will be protected while the vulnerable members of the system will be sacrificed. In the United States, a clash of cultural values is occurring around the issue of child sexual abuse within the Roman Catholic Church: patriarchy is being challenged by its most vulnerable members who are breaking the silence.

When the collective is valued over the individual, it is the powerful who is usually protected by the group rather than the weak. "All that the perpetrator asks is that the bystander do nothing. He appeals to the universal desire to see, hear, and speak no evil. The victim, on the contrary, asks the bystander to share the burden of pain. The victim demands action, engagement, and remembering."[178] By protecting the aggressor, no change is required.

Value of Non-Intervention

Diverse cultures appear to value family privacy and self-reliance which promotes non-intervention by others.

In India, it is culturally unacceptable to make family secrets public.[179] Both men and women are extremely reluctant to challenge an alleged perpetrator of child sexual abuse and therefore, the victim is usually doubted. Native Canadians place high value on non-intervention, and therefore make a concerted effort to avoid enlisting others in helping them cope with sexual abuse. Reciprocally, others in their community refrain from helping even when they become aware of the situation.[180] Intervention from professionals outside a community is often viewed as an intrusion.[181] In a case study in rural Australia, it was reported that values of self-reliance, conservatism, and negative attitudes toward welfare programs may have contributed to a lack of disclosure of sexual abuse by multiple victims of a single perpetrator over a period of seven years.[182] In Israel, when cases of sexual abuse became known in an ethnically diverse community, reactions ranged from apathy and stigmatization of the victims, but no one considered notifying police or social workers.[183]

Resistance by Authorities

Resistance on the part of authorities who work with victims of child sexual abuse occurs regularly, thereby decreasing the chances that children will disclose. For example, the recent creation of the Palestinian Authority in 1993 has not provided sufficient time for criminal justice authorities to properly respond to the problem of child sexual abuse. Police are inexperienced, lack procedures, are unclear regarding legal jurisdiction and legislation - and minimize the gravity of sexual abuse, "We are going through a process of nation building…We are busy dealing with very serious matters; I am not willing to spend my energy on the problems of little girls."[184] In Brazil, Dimenstein reported that "of the more than 2000 crimes of violence against women, including rape, registered through police departments in Rio de Janeiro in 1990, not one of them resulted in the punishment of the accused."[185]

For example, the recent creation of the Palestinian Authority in 1993 has not provided sufficient time for criminal justice authorities to properly respond to the problem of child sexual abuse. Police are inexperienced, lack procedures, are unclear regarding legal jurisdiction and legislation - and minimize the gravity of sexual abuse, "We are going through a process of nation building….We are busy dealing with very serious matters; I am not willing to spend my energy on the problems of little girls." *Shalhoub-Kevorkian,1999*

About 90% of 109 judges from five cities in India said they would not opt for legal redress if they were confronted with the problem of domestic violence, including sexual abuse, involving their daughters or female relatives.[186] In India, in the case of minor girls who were either raped or sexually abused, the system makes it mandatory for the victim to face the judge and the lawyers all alone. No support-person, with whom the child is familiar, is allowed at these hearings.[187]

From Africa too come reports of non-compliance by authorities. In Zimbabwe, reports of child sexual abuse to authorities are met with denial and minimization of the significance of the abuses by the police and some head teachers, and some child protection agencies have recently reported that police may be protecting influential perpetrators who are well known in the community.[188] In Tanzania, parents, religious and key community leaders, and policy makers are "coping" with the problem of teenage sexuality by denying its existence or blaming the victim.[189] Adolescents in Senegal and South Africa are often scolded, refused information, or turned away when they approach clinics for help,[190] while others fear that clinic personnel will report their sexual abuse.[191]

Child sexual abuse continues to be a sensitive subject, where the child victim is often sacrificed to protect the honor of the group and the character of the aggressor. Patriarchy subordinates the needs of children to the desires of adults, with all of its cultural norms, systems, and practices predetermined to embrace the aggressor and exclude the child. To side with the aggressor requires nothing more than silence: from the child victim, the family, the community, and the authorities. To side with the child requires the necessary commitment to break down barriers as old as time. Children who break the silence risk being stigmatized, as do those who stand along side them.

FINDING THE LINKS

Over the past decade, growing documentation of the linkages between child sexual abuse (CSA) and multiple poor health, social, human rights and economic outcomes has emerged largely from industrialized countries. These linkages overlap and often set one another in motion, starting or combining with other histories of violence, oppression and abuse resulting in poor life trajectories for those with histories of sexual abuse compared to their socioeconomic counterparts across country and culture. This section explores the

connection between CSA and multiple poor outcomes, and builds upon the previous discussion of social, economic, cultural and political factors, norms, values and practices that allow child sexual abuse to occur.

Across literature from industrialized countries, the connection between sexual abuse and the following impacts is well documented: eating disorders, sleep disorders, chronic illness and physical pain, HIV and other sexually transmitted infections (STIs), abusive adult sexual and intimate relationships, revictimization for sexual and physical violence, incarceration as an adolescent and an adult, public welfare dependency, poor mental health outcomes, substance misuse, prostitution, reduced learning capacity, barriers to consistent economic earning potential and/or career success, and perpetration of sexual abuse and other forms of violence and abuse.[192,193,194,195,196,197,198,199,200,201,202,203]

The international data that is available indicates that some of these links may be unique to industrialized countries, others unique to developing countries, and many shared by both. The World Health Organization's Report on Violence identifies that across international data, adult survivors of non-contact sexual abuse are four times more likely to suffer Posttraumatic Stress Disorder then non-abused adults, and survivors of contact CSA are twice as likely to suffer depression, panic disorder and drug abuse than non-abused adults.[204] While sexual abuse has been strongly linked to substance abuse and prostitution Western countries, little documentation exists on these relationships in developing countries. In contrast, there is only anecdotal evidence of a link between sexual abuse and the transmission of HIV to infants, children and adolescents in Western, industrialized countries, while documentation of these links is growing in non-Western and/or developing countries.

Despite the lack of formal data from developing, Southern and industrialized, Eastern countries on the linkages between sexual abuse and poor outcomes, at least 50% of the 28 UNICEF field officers and other professionals from partner organizations surveyed for this report identified a connection between child sexual abuse and all of the following poor health and social outcomes:

- ⇨ Child and adolescent physical and mental health, psycho-social development, sexual health, prostitution, and low educational attainment;
- ⇨ Parent-to-Child transmission of HIV
- ⇨ Adult vulnerability to HIV and prostitution
- ⇨ Adult mental and sexual health
- ⇨ Sexual trafficking of children and adolescents
- ⇨ Perpetration of sexual abuse and other forms of violence
- ⇨ Intergenerational cycles of sexual violence

THE SOCIAL IMPACT

Cycle of Violence

Sexual abuse is a form of violence that perpetuates individual, intergenerational and community vulnerability to violating and being violated. For survivors of sexual abuse, these cycles can take the form of either repeated sexual violation throughout their lifetime or becoming perpetrators of violence. For other survivors, participation in a cycle of violence can take the form of a non-protective parent.

Russell's 1986 survey of 930 residents of San Francisco, California revealed that 65% of women with histories of intrafamilial sexual abuse and 61% of women with histories of extrafamilial sexual abuse were raped as adults compared to 35% of women without such histories.[205] Studies from the USA reviewed by Browne and others (1999), found that women reporting a history of sexual abuse are twice as likely to experience sexual assault during adulthood as women without such histories.[206] Cohen and other's multi-site study of 1,645 US women vulnerable for or infected with HIV revealed that childhood sexual abuse was associated with a two-fold increase in lifetime risk for domestic violence.[207]

Sexual abuse is a form of violence that perpetuates individual, intergenerational and community vulnerability to violating and being violated. For survivors of sexual abuse, these cycles can take the form of either repeated sexual violation throughout their lifetime or becoming perpetrators of violence. For other survivors, participation in a cycle of violence can take the form of a non-protective parent.

Paolucci and other's (2001) meta-analysis on the impacts of sexual abuse across studies from the USA and Canada identified an 8% increase in the victim-offender cycle among those who had a history of CSA.[208] Of a sample of men incarcerated across the UK for sexual abuse, two-thirds (68%) reported histories of sexual abuse.[209] And in a meta-analysis of studies of children under the age of 12 with sexual behavioral problems, including perpetration of other children, Burton and others (2000) found 65 to 100% reported histories of sexual abuse.[210] Despite the strong

evidence of histories of sexual abuse among those who perpetrate abuse later in life, the majority of survivors of sexual abuse do not go on to abuse others.[211]

The question remains as to why some survivors of sexual abuse go on to perpetrate abuse when others do not. Skuse and others studied 25 boys in the UK between the ages 11 and 15 with histories of CSA. Eleven boys had gone on to sexually abuse other children while 14 had not. They found no differences between the abusive and non abusive boys in personal and familial characteristics, nor in the type of sexual abuse the boys had experienced.[212] However, they did find that boys who went on to abuse others had histories of physical abuse, neglect, and witnessing intrafamilial violence, with witnessing of family violence having the strongest relationship to future perpetration of CSA.[213]

Neugebauer's study (2000) of the intergenerational transmission of violence is unique in its investigation of the correlation between various histories of abuse and neglect and the subsequent perpetration of diverse forms of violence. Of injection drug users seeking medical attention, those with a history of sexual abuse were four times more likely to assault a family member or sexual partner than those without such a history. The study suggests the importance of continued investigation of the relationship between sexual abuse, other forms of abuse, and the subsequent perpetration of sexual and other forms of violence.[214]

War

Little data exists documenting the relationship between a history of sexual abuse and the subsequent vulnerability to being revictimized or perpetrating violence in developing, Southern countries. The anecdotal evidence suggests that it is likely that links do occur but questions remain as to the extent and the possible cultural specificity of such cycles. Better documented are the cycles of violence from war and poverty which create vulnerability to sexual abuse and exploitation. Human Rights Watch describes the sexual exploitation of children in refugee camps who are forced to sell their bodies for food and supplies and the rape and sexual servitude of children at the hands of soldiers in areas of conflict.[215] Approximately 1 in 8 households surveyed in Sierra Leone by Physicians for Human Rights (2002) reported an experience of sexual violence over the course of its civil war, with many of the victims being young girls.[216]

In early 2002, aid workers from 40 agencies of largely local but also international peacekeepers designated to provide aid to refugee camps in Guinea, Liberia and Sierra Leone, forced girls to provide sexual services in exchange for relief supplies.[217] Girls fleeing sexual violence and civil war in Sierra Leone then find themselves vulnerable to revictimization for sexual abuse at the hands of aid workers.

Commercial Sexual Exploitation, Trafficking and Prostitution

The recently emerging, widespread attention to the scale of commercial sexual exploitation of children and youth across the globe has exposed the interconnections of global inequality and poverty, the global lack of protection for the rights of children, and the organized global and local sex trafficking industries. A majority of this attention has been on developing countries and has focused on sex tourism at the exclusion of child prostitution catering to local customers and the non-commercial sexual exploitation of children and youth.[218,219] Noticeably missing in the majority of the documentation is a discussion of the possible relationship between intrafamilial and community-based sexual abuse and commercial sexual exploitation.

Willis and Levy's global report (2002) on child prostitution distinguishes it from child sexual abuse per its commercial dimension.[220] Such distinctions are important to the extent to which they reveal differing points of entry for prevention and intervention programs and policies. The authors state that the causes of child prostitution differ between countries and communities. The report looked at regions of Nigeria where, similar to the USA, children flee home as a result of abuse and then become involved in prostitution in order to survive. This was compared to Nepal, where child prostitution appears to be more specifically linked to poverty.[221] Farley and Kelly's study (2000) on global prostitution emphasizes the cycles of prostitution, subsequent violence, risk of HIV and other diseases, poor mental and physical health outcomes, homelessness and poverty that are set into motion when CSA is perpetrated.[222] Lack of access to services and support prevent escape from such cycles.[223] Farley and others, in their study of prostitution across five countries (South Africa, Turkey, Thailand, United States, Zambia), note similar cycles.[224] Adedoyin and Adegoke (1995) documented a history of CSA among 50% of the 150 Nigerian teenage prostitutes interviewed. Similarly, the Women's

Adedoyin and Adegoke (1995) documented a history of child sexual abuse among 50% of the 150 Nigerian teenage prostitutes interviewed.

Empowerment and Human Resources Development Centre of India identified poverty, broken families and sexually abusive relatives, co-workers and employers as driving the 825 child prostitutes they interviewed across three cities in Indian into the sex trade.[225]

In contrast to the documentation of poverty and global economics driving child prostitution in the developing South, the literature speaking to child prostitution in the industrialized North indicates that economics was not the single largest driving factor of child prostitution. Equally identified were histories of emotional deprivation, migration, alienation from parents and a lack of supervision of children as contributing factors.[226] In one large study (N=10,828) of all adolescents in public and private schools in Norway, Pedersen and Hegna (2003) found no association between child and adolescent prostitution and socioeconomic demographics including class and legal status (immigrant vs. citizen).[227] The authors assumed a link between childhood sexual abuse and later survival sex and prostitution but did not collect data on histories of CSA among the children and youth they surveyed.[228] However, Farley and Kelly's extensive literature review of prostitution in the USA (2000) offers compelling evidence of consistent and strong associations between prostitution, poverty and childhood sexual abuse. [229,230]

The linkage between child sexual abuse, child homelessness and subsequent prostitution and sexual exploitation of children and adolescents in the United States is well documented.[231,232,233,234] The data indicates that between 52 and 55% of male and female homeless and runaway youth report histories of sexual abuse.[235,236] Booth, Zhang and Kwiatkowski document the connections between sexual abuse, homelessness, and then subsequent prostitution among youth.[237] The rate of homeless youth reporting involvement in sex for money ranges from 22% to 30%, with a higher rate reporting sex in exchange for food, shelter or other material goods.[238,239] In a US study of 118 girls who left home before age 16, 52% had a history of incest.[240] Some data from India suggests a similar path from sexual abuse in the home, to running to the streets, to involvement in child prostitution and sexual exploitation.[241]

Research on adult prostitutes supports the connection between CSA and commercial sexual exploitation. In the US, the estimated prevalence of childhood sexual abuse among adult prostitutes ranges from 55 to 90%, and the average age of involvement in prostitution is 13 to 14 years of age.[242,243] Farley and Kelly note that women of color are over represented in prostitution compared to their representation in the US population as whole.[244] The authors identify several additional barriers to escaping prostitution that are faced by women of color. These include the intersection of poverty and racism in the United States resulting in a lack of access to alternative employment, safe housing, and services that treat posttraumatic stress disorder and chronic mental distress associated with the histories of childhood violence so prevalent among women involved in prostitution.[245] While acknowledging the underreported prevalence and experiences of boys and men involved in prostitution, including their histories of sexual abuse, Farley and Kelly's extensive literature review of global prostitution (2000) emphasized that females are overwhelmingly represented in the sexual exploitation of children and survival prostitution.[246]

Farley and Kelly frame intrafamilial child sexual abuse, rape, and prostitution as part of a broader spectrum of sexual exploitation and abuse. At one end is the selling of children, predominantly girls, into prostitution, brothels and sexual servitude both in their countries of origin and abroad. In some of these cases, children are kidnapped. In others, families unknowingly release their children into the commercial sexual exploitation industry through a local or foreign entrepreneur. Sometimes parents sell their children to a pimps, brothel owners, or to private individuals who use them as sexual servants. Sometimes parents act as pimps, prostituting their child for on-going income.[247,248] Others involved in sexual exploitation include officials whose official role is to protect children within and across their national borders. Thai police and border patrol officials and Indian and Nepali police and officers have been named in the trafficking of girls across borders and the returning of girls to pimps and brothel owners who attempt escape.[249] The involvement of family, police, border officers, and other adults in the community in the sexual exploitation of children and adolescents blurs the distinction between commercial exploitation and CSA that occurs in the family and community.

Further down the spectrum is the use of material bribes to silence a child being abused by a family member, teacher, guardian, or other adult in the community. Meursing and other's research (1995) on sexual abuse in Zimbabwe found that 24% of the offenders (n=54) identified in the study offered rewards for silence, mostly in form of money.[250] In a report completed for the International HIV/AIDS Alliance, Greig reported a case

study offered by the participant in an HIV and gender workshop being conducted in Zambia. The case involved an 11-year-old girl being offered fried dough balls by her uncle in exchange for her silence around his sexual abuse of her.[251] Though not commercial, material goods are being used to support the sexual abuse of children.

Ennew and other's literature review (1996) on Children and Prostitution, prepared collaboratively by UNICEF, the Centre for Family Research, and Childwatch International, notes that the omission of involvement and complicity of local adults in child prostitution allows the blame to be placed exclusively on the foreign enemy, the tourist.[252] While a significant source for child prostitution and a critical focus for international programs, policies, and mechanisms of accountability, the authors warn that its narrow focus prevents an exploration of the national structures, socioeconomics and politics that allow it to occur. Furthermore, it avoids questions about the role of underlying values and norms about sex, gender, childhood, and the sanctity of the family in their ownership of their children in allowing child and adolescent prostitution to occur at the hands of either foreign tourists or local consumers.[253] In these questions may be information on the linkages common and unique to the commercial sexual exploitation and intrafamilial/community-based sexual abuse of children that allow both to continue.

Gender

While gender appears to influence whether or not one is more vulnerable to sexual abuse, with the sexual abuse and exploitation of girls reported in much higher numbers across the globe than boys, it is unclear how it mediates its impact. In Olsson and other's Nicaraguan study, men reported significantly lower impacts from their experiences of childhood sexual abuse than women.[254] Similarly, the previously mentioned Banglore study noted that while girls with histories of sexual abuse tended to blame themselves, boys did not generally perceive it as traumatic, and many even reported their experience with women pleasurable.[255] However, these two studies are the exception. Most data indicates the vast majority of both male and female survivors report experiencing traumatic impacts as a result of their abuse. Reported experience may also differ from actual experience based on gender roles that may prevent men from reporting a sexual experience with a women as traumatic. In the case of the report from Banglore, it may be that within that context it is more acceptable for boys and men to report homosexual CSA as abusive than abuse by a women.

Haj-Yahia and Tamish found similar rates of psychological symptoms among Palestinian male and female students interviewed.[256] Similarly, Booth, Zhang and Kwiatkowski found sexual abuse in the histories of both boys and girls who end up homeless as well as those who prostitute once on the street.[257] Questions remain as to the degree to which gender mediates either the actual or the reported impact of sexual abuse over the life span. The work of Olsson and others suggests that the severity of abuse may reduce any protection that gender offers. Though Nicaraguan men reported less overall impact, those who had experienced penetration during their abuse reported symptoms as severe as their female counterparts.[258]

Although Haj-Yahia and Tamish found similar levels of psychological impact among males and females in Palestine, the abuse of these participants had not been publicly disclosed. Shalhoub-Kevorkian's examination of the impact of disclosure on the lives of 38 sexually abused, Palestinian girls suggests that the consequences for discovery of sexual abuse are significantly more severe for females than males. The author attributes this to Arab tribal notions of children as parental (collective) property, males as holding supremacy over females, the value of family honor and welfare over the individual, the restriction on female sexuality, and the valuing of virginity and female purity. Shalhoub-Kevorkian reports that the consequences may include lack of eligibility for marriage, further violence, disowning by her family and homicide.[259] While dishonor and stigma may follow a sexually abused Palestinian boy, the consequences are neither as severe nor as damaging to his life prospects.[260,261] Similarly, in Swaziland, public knowledge of a girl being raped similarly lowers her value as a prospective bride, damaging her life prospects in a culture with little opportunity for an unmarried woman.[262]

It is unclear whether the differences in impact by gender are the result of the impact on males being reported less, the consequences for discovery of sexual abuse of males being less severe, or the impacts of CSA on males being less than for females.

HIV and other Sexually Transmitted Infections

Many of the linkages mentioned above contribute to the identified linkages between sexual abuse and vulnerability to HIV infection. The specific links between HIV and CSA appear to be different in between industrialized and developing countries. In industrialized countries the connections appear to be largely progressive, starting with CSA victimization, which increases vulnerability to substance use, prostitution, and sexual revictimization, which in turn increases vulnerability to HIV.[263,264,265,266] In developing countries there is growing evidence of HIV transmission as a direct result of the intrafamilial, community and commercial sexual abuse and exploitation of children.[267,268,269,270] There is also the previously mentioned connection between CSA and child, adolescent and adult sexual exploitation and prostitution which increases vulnerability to CSA. These links, however, are not exclusive to either region. Whether the differences in reported linkages reflect a genuine contrast in the connection between HIV and CSA, or instead reflect a difference in documentation is an area for further exploration.

Data available from industrialized countries suggests that CSA may create several vulnerabilities to HIV. Cohen and others multi-site study of 1,645 US women vulnerable for or infected with HIV reflect on the cycles of violence and vulnerability to a range of poor mental and physical health, economic, social and behavioral outcomes set into motion by CSA.[271] Fifty-six percent of women who reported being forced to have sex with someone who was HIV positive reported a history of CSA. The authors concluded that early abuse leads to later abuse and violence which increases vulnerability to HIV through risk behaviors. CSA was strongly associated with having more than 10 male sexual partners, male partners at risk for HIV, and exchanging sex for drugs, money or shelter. [272]

Similarly, the work of Wyatt and others (2002), documents that the combined impact of sexual abuse and the poor socioeconomic status in the lives of women living in the US significantly increases the risk of HIV over the risk for those with a history of just one or the other.[273] The authors found that women with histories of CSA have a seven-fold increase in HIV-related risk behaviors compared to women without such histories. The connection between CSA and HIV appears to remain true for men as well. In a 1991 US study, men who reported child sexual abuse had a twofold increase in HIV infection over those who did not report CSA.[274]

In addition to increased risk for sexually transmitted HIV, not only are adults with a history of CSA more likely to use substances, they are more likely to contract HIV as a result of their drug use. Paone and others demonstrate that those with a history of sexual abuse were found to be 10 to 15 times more likely to share syringes than drug users without such history, putting survivors at much higher risk for HIV and other infectious diseases from syringe sharing.[275]

With South African President Mbeki's announcement of child rape as a national emergency, more attention has been focused in South Africa on the transmission of HIV to children who are being sexually abused.[276] Several authors noted a myth that having sex with an infant will rid a man of HIV and other STI's, identified as beginning in Central Africa and moving south along with the HIV pandemic.[277,278] Pitcher and Bowley identified a 1% HIV seroconversion among 200 child rape victims at Red Cross Children's Hospital in Cape Town.[279] Jewkes and others felt that the naming of this myth was a significant motivating factor behind child rape. Therefore, they named the history of political and interpersonal violence and gender inequality resulting in violence against women and children as the root of the rape of infants, children and adolescent girls in South Africa.[280]

Whether HIV-related myths contribute to the sexual abuse of children or not, sexual abuse appears to contribute to the transmission of HIV. Meursing and other's study (1995) of sexually abused girls in Zimbabwe revealed that of the 12 CSA cases where an HIV test was administered, four girls tested positive (34%), two of whom were under the age of 12.[281] In addition to transmission during abuse, girls with a history of CSA were more likely to have STI's. The work of both Pitcher and Bowley and Jewkes and others linked the contraction of STI's other than HIV to the sexual abuse and rape of girls, which resulted in a two to five-fold increase in the risk for HIV.

While little data exists outside of North America and South Africa on the connection between HIV and CSA, the documentation of vulnerability to teenage pregnancy, early onset intercourse and an increase in sexual partners as a result of child sexual abuse suggests an increased risk of HIV or other STI's. In Nicaragua, those who experienced severe abuse had more sexual partners during both the last year and last five years.[282]

Multiple links between HIV and CSA are described across the literature. These include the role of myths about HIV in a reported increase in incidences of child rape and sexual abuse, the transmission of HIV to children to adolescents who are sexually abused, and the contraction of HIV as a result of subsequent behaviors and/or vulnerability that may result from the initial abuse.

THE PERSONAL IMPACT

A traumatic experience violates the integrity of one's psychological and physical person, and involves the threat of or actual death, physical injury, or other physical violation. Feelings of intense fear, helplessness, and horror accompany the trauma. The traumatic experience may result in the fragmentation of the normally integrated functions of cognition, memory, emotion, identity, sensory perception, and physiological arousal. Traumatic symptoms have a tendency to become disconnected from their source and to take on a life of their own.[283]

Children who have been sexually abused, especially when the perpetrator is a member of the child's family and/or has on-going access to the child, live in an unpredictable world. They understand that they are vulnerable for re-abuse, and so remain in a constant state of vigilance, often referred to as "hyperarousal"[284],[285] in which their body is primed to react in a fight or flight response. However, these children are trapped and can neither flee (where would they go?), nor fight back against the much more powerful older person. Their physiological responses, which would normally allow them to respond appropriately to danger, are constantly primed yet never employed. Therefore, these responses begin to break down, creating some of the many symptoms seen in sexually abused children.[286] Sometimes, these thwarted physiological responses create alterations in those parts of the body that are utilized in fight/flight reactions, and continue to produce symptoms in adults many years after the danger has passed.[287]

No one symptom appears to characterize children who have been sexually abused, nor has any specific syndrome nor single traumatizing process been found in children who have been sexually abused.[288] In a review of 45 quantitative studies from English-speaking countries, on the impact of sexual abuse on children, Kendall-Tackett and others[289] found that symptoms varied by age group, that depression was the only symptom found across all age groups, and the only two symptoms consistently found more often among sexually abused children than non-abused children from clinical samples were post traumatic stress syndrome (PTSD) and sexualized behavior. Only PTSD was exhibited by a majority of sexually abused children, and even then, when severely abused children were excluded, PTSD symptoms only showed up in 32% of the victims, similar to other frequently occurring symptoms such as: poor self-esteem (35%), promiscuity (37%) and general behavior problems (37%).

The process of child development is the process of mastery over one's self and one's environment. Child sexual abuse disrupts this process, pushing children beyond their ability to adapt and assimilate.[290] According to Herman:

> *Repeated trauma in childhood forms and deforms the personality. The child trapped in an abusive environment is faced with the formidable task of adaptation. She must find a way to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable, power in a situation of helplessness. Unable to care for or protect herself, she must compensate for the failures of adult care and protection with the only means at her disposal, an immature system of psychological defenses*[291].

Trauma produces negative impacts upon the traumatized - no matter their cultural heritage. However, those impacts differ across individuals, through a diversity of symptoms that persist for differing lengths of time. In looking at trauma cross-culturally, it is possible that certain symptoms will be more pronounced in some cultures than in others. For example, victims of CSA living in places with easy access to substances may exhibit more substance abuse than victims living in areas where access is limited. Another possibility may be that in some cultures, where "mental illness" is not recognized, symptoms become somatisized. That is, psychic pain is transferred to different parts of the body, when no organic injury or disease is present. These victims will have mysterious pains in their arms, legs, tongue, and head, gastrointestinal problems, and other physical complaints. Sexualized behaviors in very young children may be found to be more common across cultures, since they have spent less time being acculturated. In addition, young children haven't developed the same level of emotional and behavioral control as older children, adolescents, or adults. It is unclear what

may be learned regarding the way in which trauma manifests itself in CSA victims around the world. What is clear is that most victims will exhibit symptoms as a result of the abuse, and these symptoms, without intervention, may persist throughout a life time.

The Kendall-Tackett and others (1993) review showed that sexually abused children actually exhibited fewer overall symptoms than non-abused children in clinical samples used as controls in most of the studies.[292] Environmental conditions that may leave children more vulnerable to being sexually abused, such as family problems, poverty, or war, are often the same conditions that predispose young people to developing psychological symptoms and interpersonal problems. It is therefore difficult to isolate the effects of childhood sexual abuse on development.[293],[294] When Barthauer and Leventhal (1999)[295] looked at the effects of CSA among El Salvadoran women who had experienced 12 years of civil war, they found no differences in measures of psychological functioning between those with and those without histories of sexual abuse. They concluded that the long-term effects of sexual abuse may have been blunted by the cumulative effects of past experiences resulting from the impact of war and poverty.

The Kendall-Tackett and others (1993) review also found that, on average, one third of victims had no reported or observed symptoms.[296] While it is thought that asymptomatic children will eventually develop symptoms, it is possible that these children were truly less affected.[297] Empirical studies show considerable variability in the magnitude of the negative consequences experienced by abuse victims.[298] Cultural and situational conditions under which the abuse occurs as well as personality characteristics of victims are thought to account for the variability of reactions on the part of victims. While many studies have been produced that focus on the relationship between abuse conditions and outcomes, the results are mixed. Therefore, knowledge regarding mediating variables remains limited. Beyond this, very little research has been done cross-culturally on the effects of CSA on victims, thereby limiting the understanding of these effects on children growing up in cultural contexts outside of the industrialized North, the primary geographic area of research. What follows is meant to describe what is known, with the understanding that much more research is yet needed.

Posttraumatic Stress Disorder

> *In this climate of profoundly disrupted relationships, the child faces a formidable developmental task. She must find a way to form primary attachments to caretakers who are either dangerous or, from her perspective, negligent. She must find a way to develop a sense of basic trust and safety with caretakers who are untrustworthy and unsafe. She must develop a sense of self in relation to others who are helpless, uncaring, or cruel. She must develop a capacity for bodily self-regulation in an environment in which her body is at the disposal of others' needs, as well as a capacity for self-soothing in an environment without solace...*[299]

The essential feature of Posttraumatic Stress Disorder is the development of characteristic symptoms following the exposure, directly or indirectly, to a traumatic event, that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and where the person's response involved intense fear, helplessness, or horror.[300] The traumatic event is persistently reexperienced through cognitions, emotions, and/or behaviors, with the persistent avoidance of stimuli associated with the trauma and persistent symptoms of increased arousal.[301]

In the Kendall-Tackett and others[302] review of 45 studies on the effects of CSA, they found that PTSD was the only symptom that was manifested by a majority (53%) of child victims. In Paolucci and other's[303] meta-analysis, a minimum of 20% increase in PTSD outcome over the baseline was found for persons having experienced CSA, and a 143% increase in risk of developing PTSD symptoms following CSA among the general population.

Children reexperience their trauma through intrusive thoughts, images, and perceptions, through uncontrollable emotions, and behavioral re-enactments as in sexualized play or promiscuous behaviors. Their arousal system, activated during the initial traumatic event, works overtime in an attempt at protection from further abuse. Simultaneously, the child withdraws emotionally, cognitively, and socially in an effort to avoid anything that may recall the abuse. Herman's seminal work on trauma, *Trauma and Recovery,*[304] describes the psychological process a child must undertake in order to survive an environment of prolonged fear and horror. While a variety of defense mechanisms, as described by Herman, allow the child to survive childhood, they can become pathological and harmful when the danger subsides.

Recent research suggests that an extreme one-time event or a chronic stressor may alter the regulation of a normal stress response - those with PTSD have abnormally low levels of cortisol and abnormally high levels of norepinephrine.[305],[306] Chronic hyperarousal may also alter certain brain structures, such as the hippocampus, with exposure to abnormal levels of stress hormones.[307],[308],[309] Sexually abused girls have been found to develop major neuroendocrine disturbances in the areas of immune, corticosteroid, thyroid, and sex hormone functions, and have shown that early trauma can reset the hypothalamic-pituitary-adrenal axis by blunting its response to future stress.[310],[311],[312] Teicher found a 38% increased rate of limbic system abnormalities following physical abuse, 49% after sexual abuse and 113% increase following combined abuse.[313] The myriad of physiological responses to severe stress may or may not be permanent, but set the stage for extreme difficulties and multiple among those who have suffered abuse.

Psycho-Social Behaviors

Sexual Behavior

Sexualized behavior is the most commonly studied symptom of sexually abused children and is often considered the most characteristic symptom of CSA.[314] It is common for children to use play as a means of coping with problems, trying out different life roles, and mastering their environment. However, sexually abused children's play can be rigid and repetitive when they use their play to re-enact their abuse. Young children, victims of CSA, may engage in excessive and/or public masturbation, seductive behavior, or impulsively touch the genitals of other children or adults. They may engage in sex play with other children that can be distinguished from sex play resulting from normal curiosity by its intensity, compulsive nature, and demonstration of sexual knowledge beyond what is age appropriate.

As children grow older, their sexualized behaviors may take the form of initiating sexual relationships at an early age and engaging in sex with more partners than non-abused peers.[315],[316],[317] their sexual precocity may include seductive behavior, provocative dress, and sexual promiscuity.[318] In the United States, adolescents with a history of sexual abuse were more likely than their non-abused counterparts to be having sexual intercourse on a regular basis before 15 years of age.[319] Olsson and others[320] found that in Nicaragua, women who experienced sexual abuse involving attempted or completed intercourse, initiated their sexual life at 15.8 years, two years earlier than those who experienced no or non-penetrative abuse.[321] They also found that the median age of sexual onset was 13.6 years among men who reported moderate to severe sexual abuse compared to 15 years for non-abused boys. In a survey of 2059 eighth and tenth grade students in Brazil, it was found that the onset of sexual intercourse before age 15 was significantly related to CSA in both boys and girls. Paolucci and others, in their meta-analysis of 37 studies, found a 14% increase in sexual promiscuity among victims of CSA and 100% increase in risk for becoming sexually promiscuous.[322]

Most girls who have been sexually abused have an early awareness of their sexuality and often confuse sexual behavior with affection.[323] Their sexual behavior may put them in dangerous situations and thereby increase their risk of injury and disease. A 2000 study from a major hospital in the United States shows that adolescents with a history of sexual abuse are significantly more likely than their peers to engage in sexual behavior that puts them at risk for HIV and other STIs.[324] Studies also show that victims of childhood sexual abuse are more vulnerable to becoming pregnant as adolescents than non-abused peers.[325],[326],[327] According to a 1995 study in the US, by the National Child Abuse Network, 62% of adolescent pregnancies are among girls who were sexually abused.[328] Children born to mothers below age 18 are 1.5 times more likely to die before age 5 than those born to mothers age 20-34.[329] Furthermore, Stevens-Simon and others[330] found that studies indicate that previously abused females give birth to a disproportionately large number of low-birth weight infants.

Harmful Substance Use

In the United States and Europe, 24% to 90% of women have a history of both sexual abuse and substance abuse.[331],[332],[333],[334],[335] For men, the range is 23% to 42%.[336],[337] A 1998 study by Feletti and Anda found that adults with a history of CSA are two to four times more likely to smoke, develop alcoholism and/or problems with other substances than their counterparts without such histories.[338] Kendall-Tackett and others found that sexually abused adolescents from industrialized countries are three times as likely as their non-abused peers to engage in drug abuse.[339] Anteghini and others,[340] using a sample of 2059 adolescent Brazilian boys and girls, found that smoking was significantly associated with a history of CSA in both boys and girls. Among boys only, drug use was also significantly associated with a history of CSA.

Substance abuse among victims of CSA often begins in adolescence. At this developmental stage, young people have greater access to tobacco, alcohol, and drugs, while simultaneously recognizing their inability to regulate their emotions. This difficulty in emotion regulation can come from the physiological alterations imprinted upon the body due to the trauma of sexual abuse. The inability to regulate themselves can lead them to self-medicate.[341] Victims may find that substances can numb the emotional pain and anguish resulting from CSA.[342]

Aggressive Behaviors

Sometimes victims of CSA find that their brain has become threat-sensitized.[343] Feelings that were a part of the original trauma, such as fear, rage, helplessness, or sadness, can return to the victim without any warning at all when stimulated through the external environment or internally, through random thought associations or dreams. Outside observers are usually unaware of the reminders found in the external environment that can trigger a victim's memory of their abuse. Victims themselves are unaware of many environmental triggers that stimulate their memories. When memories of the abuse are evoked, children can behave as though they were traumatized all over again. Children, adolescents, or even adults[344] may have difficulty controlling their reactions when uncontrollable feelings are stimulated.[345] This can result in aggressive, socially undesirable behavior.

> *Unaware of the traumatic antecedents of these feelings, they are prone to experience both their own affect storms, as well as the emotional reactions from others, as re-traumatizing. Thus the feelings that belong to the trauma are continually re-experienced on an interpersonal level: traumatized children tend to lead traumatizing and traumatized lives.*[346]

Sometimes victims engage in re-enactments of their abuse that are more controlled, but no less a reaction to their inability to control their inner world. Unless the nature of such re-enactments are understood, children may be labeled as "oppositional," "rebellious," unmotivated," and antisocial."[347] Kendall-Tackett and others found that sexually abused adolescents were three times as likely as their non-abused peers to engage in self-mutilation and violent/aggressive behavior against others.[348] Conflict between sexually abused adolescents and authority figures, such as parents, teachers, and law enforcement officers is common.[349] In one study in the United States, more than 75% of all girls identified as a juvenile delinquent by the courts had been sexually abused.[350]

Sometimes, these behaviors lead to criminal activity. Kang and others[351] found that women who had been sexually abused in childhood were more likely to have had extensive criminal involvement (more incarcerations and arrests), than non-abused women. Another study found that of 150 female inmates interviewed in a USA prison, 59% reported sexual abuse in childhood.[352]

Learning

Just as intrusive thoughts and overwhelming feelings can result in behavioral difficulties, so too can these thoughts and feelings decrease a victim's ability to concentrate. Some sexually traumatized children are found to have difficulty distinguishing between relevant and irrelevant information,[353] and problems with processing novel information and forming mental images of the past, present, and future.[354] All of this interferes with learning. Sometimes sexually abused children will restrict their environment in order to avoid the possibility of encountering reminders of the abuse experience. Sometimes they isolate themselves from others, fearing they may be recognized as victims,[355] or out of shame and guilt. This avoidant behavior diminishes their chances to learn about the world, which in turn diminishes their social contacts and they "miss out on the normal transmission of social skills (language, social graces and cultural education)."[356] Learning from one's environment requires a trust that the environment is a safe place in which to learn.

Paolucci and others performed a meta-analysis on the effects of child sexual abuse across 37 studies, most from the United States.[357] They found that a history of child sexual abuse increased academic performance difficulties by 10%, and increased the risk of reducing one's academic performance by 71%. Kendall-Tackett and others found that across nine studies, 18% of the children with histories of sexual abuse also had school/learning problems.[358] Hyman noted that, holding socioeconomic status constant, the literature reveals that children with histories of sexual abuse tested less well and were more likely to be held back a grade than children without such histories.[359,360] According to Streeck-Fischer, many traumatized children have limited capacity to comprehend complex visual-spatial patterns, which leads to problems with reading

and writing.[361]

Physical Health

Injury

Physical symptoms of child sexual abuse may include: vaginal discharge; anal abnormalities accompanied by pain and/or itching/bleeding; genital pain and/or bleeding/itching/ abnormalities; a history of rash/sore; menstrual problems; abdominal pains; headaches; or history of sexually transmitted infections.[362] The physical findings of child sexual abuse are often ambiguous,[363],[364] and the immediate physical problems associated with child sexual abuse are usually minor and transient.[365] Conte (1991) reported that in the United States, bodily injuries are diagnosed with only 7% of child victims.[366] However, as reported earlier, when a culture places high value on virginity, as defined by a non-perforated hymen, the physical injury resulting from intercourse can create a new set of problems, including the need to undergo surgery for hymen restoration.[367] Abortion may be one recourse to adolescent victims who become pregnant as a result of abuse, which puts the adolescent at risk of damage from the abortion, particularly where abortion is not legal and/or accessible.[368]

Finally, as Shaloub-Kevrokian's study on sexually abused girls in Palestine reports, in some cultures, female victims of child sexual abuse can be killed for losing their virginity, even if they were raped or coerced into having sexual intercourse.[369]

Vulnerability to Pain and Illness

Research in the United States and the United Kingdom also reveals the long-term consequences of sexual abuse on physiology and physical health in the form of chronic illness and chronic pain. This may include chronic pelvic pain, gastrointestinal symptoms, musculoskeletal complaints, obesity and other eating disorders, insomnia, asthma and other respiratory ailments, substance use, chronic headaches and back pain.[370] Women who have been abused are significantly more likely to have chronic headaches, chest pains and nightmares, and more likely to experience chronic pelvic pain than women without such histories.[371,372,373] In addition, 40% of female chronic pain patients, [374] and a women with histories of sexual abuse are overly represented in those diagnosed with fibromyalgia.[375]

Streeck-Fischer reported that adult survivors of CSA have between 10 and 15% increased chance of suffering from cancer, heart disease, and diabetes.[376] In 1996, Leserman found that women with a history of CSA were found to have more pain, more bed disability days, surgeries, psychological distress and functional disabilities compared with those who were not sexually abused.[377] Kendall-Tackett (2000)[378] reviewed the literature on child sexual abuse and Irritable Bowel Syndrome (IBS), whose symptoms include: abdominal pain or cramping; diarrhea or constipation; and bloating or abdominal distention. She found that those who had a history of CSA were twice as likely to have IBS as those without such histories, and those who reported abuse in both child and adulthood were three times as likely to have IBS.[379],[380]

Mental Health

General

The Kendall-Tackett review of studies[381] on child sexual abuse reports that 28% of the abused children in the studies had symptoms of anxiety, 33% had symptoms of fear, and 35% were found to have low self-esteem. Other symptoms included: nightmares, PTSD, withdrawn behavior, neurotic mental illness, and regressive behavior (including uncontrolled urinating and defecating, tantrums, and whining). Heim and others[382] found that women with histories of sexual abuse demonstrated increased rates of mood and anxiety disorders, as well as intensified physiological responses to stress. Without intervention, these children are at a 2.6 to 3.3 increased risk for developing psychiatric disorders as adults,[383] and are five times more likely to be diagnosed with an anxiety disorder.[384] If sexually abused children continue to be abused throughout their adolescence and into adulthood, their risk for a psychiatric disorder is 12 times that of non-abused women.[385] Women who have been sexually abused in childhood were also found to be more likely than non-abused women to have poorer psychological functioning (more parental stress, more distress, more hopelessness, lower self-esteem).[386]

In their study of Palestinian undergraduate students, Haj-Yahia and Tamish found that sexually abused participants expressed significantly higher levels of psychoticism, hostility, anxiety, somatization, phobic anxiety, paranoid ideation, depression, obsessive compulsiveness, and psychological distress compared with

their nonabused counterparts.[387] Olsson and others[388] found that participants in their Nicaraguan study reported high levels of emotional impact as a result of their histories of abuse, although male survivors reported substantively less emotional impact than female survivors. Finally, approximately half of adults seeking services for psychological problems from a large community clinic in Hong Kong, reported a history of childhood sexual abuse.[389]

Isolating Behaviors and Depression

While some children respond to their overwhelming emotions by acting-out, others attempt to stabilize their emotional lives by emotional constriction.[390] Shutting-down may include: emotional numbing, dissociation, disengagement, and emotional and/or physical detachment, which may extend to both trauma-related, and everyday experience.[391],[392] They may display marked avoidant/dissociative behavior including superficial compliance, which helps them avoid a total breakdown of relationships.[393],[394],[395] Their emotional lives become as frozen and constricted as their behavior.[396] The review by Kendall-Tackett and others[397] found that depression was the single symptom that cut across all age groups of sexually abused children, with 30% of the 295 children studied exhibiting internalizing behaviors, including: depression, fearfulness, inhibition, and over control.

Weiss and others[398] reviewed 21 studies from Great Britain, New Zealand, the United States, and Canada, that looked at the effect of child sexual abuse on adult depression. Samples were derived from community populations, college students, and clinical samples. Every study except for one, which used a broad definition of CSA, found a significant relationship between past sexual abuse and depression. The meta-analysis performed by Paolucci and others found that victims of CSA had a 21% increase in depression, and a 150% increase in risk of becoming depressed or suicidal.[399]

Loss of Empathy

When victims of sexual abuse constrict their emotional life as a way to control their emotions, decrease emotional pain, and "forget" the images of the abuse experience, they may inadvertently cut themselves off from knowing their own feelings. If a child (or adult) cannot know their own feelings, their ability to feel for others becomes impaired. If they cannot feel empathy for others, they may, under stress, pass the dehumanization that they themselves have experienced on to others.[400] This lack of empathy enables the victim to re-enact their abuse through acts of violence on others, perpetuating the cycle of violence.

Suicide

Depression is generally accompanied by feelings of hopelessness and powerless and the belief that life is meaningless and will never become better. Depression can often be so debilitating that the depressed person does not have the energy to kill her/himself. However, when energy begins to return yet hopelessness remains, some victims of CSA may commit suicide. The meta-analysis of 37 studies by Paolucci and others found that victims of CSA had a 21% increase in suicide outcome, and a 150% increase in risk of becoming depressed or suicidal.

Anteghini and others,[401] in their sample of 2059 adolescent Brazilian boys and girls, found that the strongest risk factor for suicide attempts among boys was having been sexually abused. It was also found that suicidal ideation and attempts were significantly associated with a history of CSA in both boys and girls. A leading psychiatric journal (2000) reported that US women who report histories of CSA are at a five times greater suicide risk than women without such histories; if abuse continues into adulthood, the risk increases to 12 times that of non-abused women.[402]

Discussion of Linkages

The linkages described above indicate persevering and severe consequences of sexual abuse for individuals and populations. More research is needed to understand the universal impact of CSA within the context of history, culture, and society, as well as those factors that may prevent, diminish, or intensify the impact of child sexual abuse. In addition to individual level impacts, there is a need for more research on the impact of CSA on families, communities, and societies. For many survivors of sexual abuse the struggle to survive often moves beyond the initial abuse, and may continue throughout a lifetime. Sexual abuse is an act that violates the rights of the child at the time of abuse, but whose lasting impact may prevent the fulfillment of the physical, mental, social and economic health of its victims. Children's rights are human rights. Child sexual abuse is universal and has been with us for generations and millennium. But we live at a time of

possibility, when children's rights can be recognized and protected. The first task is to bring into light that which allows CSA to continue, in every place where children still experience its violence. From there, we begin the challenge of helping people everywhere to protect children from sexual violence, even when the abuse is at the hands of family, friends or community.

INTERVENTION AND PREVENTION:

Why prevent and intervene in CSA?

In 1992, the Global Burden of Disease Study[403] was initiated by the World Bank in collaboration with WHO. One purpose of the study was to quantify the burden of disease with a measure that could also be used for cost-effectiveness analysis. The measure chosen was "disability adjusted life years (DALY's)," calculated as the sum of years of life lost and years of life lived with disability. Neither CSA, nor any form of child abuse or neglect was included in the list of causes assessed for their burden of disease and assigned DALY's.[404] However, a number of the documented consequences and links to CSA appear in the top ten causes of disability for both men and women, in both established market economies and in the developing world.

In developing regions, five out of the ten leading causes for disability adjusted life years (DALY's) among women aged 15 - 44 are related to reproductive ill-health, including the consequences of unsafe abortion and chlamydia.[405] In both developing and developed regions, depression is women's leading cause of disease burden. In developing regions, suicide is the fourth. In 1990, an estimated 2.7 million women aged 15 - 44 died, 15.8% from maternal disorders (the leading cause of death), 7.0% from suicide, and 3.4% from HIV.[406] In China, suicide is estimated to be the cause of almost one in four deaths for women between the ages of 15 -44. Suicide rates for women in other parts of Asia and the islands, and South India are also high.[407] For men, aged 15 - 44, depression, alcohol use, violence, and suicide are all in the top ten leading causes of disease burden.[408] Currently, depression is the leading cause of disability in the world, measured in years lived with a disability, and alcohol use finds itself in fourth place.[409] Drug use was found to impact nearly six million people world-wide, or .4% of the total burden of disease, followed by posttraumatic stress disorder, impacting 3,230,000 people, or .2% of the total health burden.[410]

According to Murray and Lopez, the burden of disease, as measured in DALY's, will change radically over the next two decades. In particular, unipolar major depression is predicted to be the second greatest cause of burden of disease by the year 2020. Violence will make itself felt as it moves from 19th place to 12th place in 2020, and self-inflicted injuries will move from33rd place to 14th. [411]

Due to the magnitude of the burden that depression, reproductive ill-health, suicide, HIV, alcohol, drug use, PTSD, and violence are claiming in the form of premature death and poor quality of life, it appears imperative that international and national resources be utilized in coping with these problems. Sexual abuse in childhood is linked to these debilitating conditions, and many begin to manifest themselves in childhood and adolescence. Mental and behavioral disorders are common during childhood and adolescence, although inadequate attention is paid to this area of mental health.[412] In a recent report, the US Surgeon General of the US (DHHS 2001) said that the US is facing a crisis in mental health of infants, children and adolescents.[413] "According to this report, one in ten young people suffers from mental illness severe enough to cause some level of impairment yet fewer than one in five receives the needed treatment. The situation in large parts of the developing world is likely to be even more unsatisfactory."[414] The financial and human toll that these disorders of childhood and adolescence take are very costly to society, because they often lead to more disabling disorders later in life.[415] The aggregate disease burden of these disorders has not been estimated due to the complexity of making such calculations. However, it is likely that these estimates would be staggering.

Behavioral and mental disorders shift the focus of preventative health care from organic disease to "disease" that is rooted, at its core, in dysfunctional interpersonal relationships that are influenced by cultural values which affect impact. According to WHO, "mental disorders are firmly rooted in the social environment of the individual."[416] This may be said of behavioral disorders as well. As the burden of disease world-wide transitions from communicable disease to social disease, world health experts must begin to reframe etiology to include a psychological and sociological perspective. CSA, and indeed, all forms of child abuse and neglect must inform this new perspective.

How might this new perspective look? Fahlberg (199?),[417] in her work on child abuse in Brazil, built on the

ecological models of Bronfenbrenner (1977),[418] Belsky (1980),[419] Cichetti and Rizley (1981),[420] Star (1982),[421] and Kaufman and Zigler (1989)[422] who looked at the etiology of maltreatment as the actions and interactions of protective and harmful factors, within the many layers of the human ecosystem. Building on these models, she proposed that child abuse could be seen as an interaction of these and other factors:[423]

INDIVIDUAL FACTORS

CHILD VARIABLES
temperament
activity level
prematurity
physical or intellectual abnormalities

PARENT VARIABLES
history of abuse
personality characteristics
mental and physical health
level of education
ability to be empathic
alcoholism or drug abuse
single parents

FAMILY FACTORS
communication patterns
power structure
rules
problem solving skills
type of child discipline
family size
support systems
stress: financial, marital, job related, in-laws, health, etc.

COMMUNITY FACTORS
values and attitudes regarding:
- child's rights vs. parental rights
- child discipline
- family planning
- religious beliefs
- violence
- child safety

sense of shared responsibility
level of violence within the community
informal support among residents
governmental and non-governmental support services

SOCIETAL FACTORS

POLITICAL VARIABLES
use of force to solve social problems
policies regarding family health and welfare services
acceptance of exploitation of the weak
commitment to human rights

ECONOMIC VARIABLES
level of poverty
minimum wage
rate of infant mortality
urbanization
distribution of income

SOCIAL VARIABLES
literacy rate
acceptance of child labor
advancement of women's rights
acceptance of child prostitution
acceptance of pornography
acceptance of violence in the media, entertainment, violent crime rate

The various factors proposed in this model are not exhaustive. They should be understood as a starting point for prevention and intervention. While the sheer number of factors influencing the occurrence of CSA could be daunting, they also suggest that many types of interventions can be utilized to effect change through the multiple entry points. This model proposes a type of systems approach, where pressure on one part of the system pressures other parts. This model therefore offers hope, that change at any entry point has the possibility of affecting the entire system. However, given the intergenerational nature of sexual abuse and its role in cycles of violence, prevention and intervention of CSA will be most effective if it occurs at multiple points in the cycle simultaneously. Child victims need early identification and intervention to prevent future vulnerability towards further violence or to becoming perpetrators themselves of sexual abuse. Sexual

offenders need intervention to prevent more children from being victimized, and adult survivors need intervention to help them recover from the harm they suffered during childhood.

Prevention

When the damage resulting from CSA is deep and intervention is delayed, the task of healing becomes more difficult. Some child victims and adult survivors may experience significant healing, but others find that the most intervention can do is keep them safe from future harm to themselves or others. Even in cases where the impact appears to be less severe, the struggle for safe and satisfying lives and relationships can continue throughout life.

> *As survivors attempt to negotiate adult relationships, the psychological defenses formed in childhood become increasingly maladaptive. They prevent the development of mutual, intimate relationships or an integrated identity. As the survivor struggles with the tasks of adult life, the legacy of her childhood becomes increasingly burdensome.*[424]

Thus, the ultimate goal is the prevention of all sexual abuse against children.

A majority of the efforts to prevent the sexual abuse of children over the last decade have focused on developing the capacity of children to "say no" and/or disclose touch that feels "bad". [425,426,427] These efforts reflect an important commitment to naming child sexual abuse as a possibility in the life of any child and can create permission for children who have experienced CSA "to tell."[428] Sex education programs for children and adolescents can promote awareness of CSA and teach children their right to body integrity. Children also need to be able to identify those adults and resources that can help them. However, this approach places the responsibility for prevention on children to refuse an adult who is a) more powerful and manipulative, b) may be in a position of authority, c) may be the child's source of survival, love, and protection, and d) may be loved and protected by the child.

Instead, Tutty's review of CSA prevention efforts suggests that broader programming to support the assertiveness and sense of personal rights of children and youth is more effective in preventing abuse and empowering children.[429] However, usefulness of assertiveness training and promoting ideas of personal rights differs greatly across culture and society by norms and values around collective and parental ownership of children, deference and family honor, and tensions between individual, parental, and collective rights.[430,431,432] In addition, in order for children to assert their rights, systems must be in place that can respond appropriately.

While teaching children their rights may support an increased sense of self-determination and assertiveness, it does not change the physical, emotional and social power that adults hold over children. Prevention requires that adults take responsibility for intervening in child sexual abuse and protecting the rights of the child.

Role of the Media

Initial adult-focused prevention efforts should strive to raise awareness in the general public regarding the prevalence and horror of CSA while linking it to cultural norms and values that sustain it. In the United States, some of the most powerful effects on public awareness of CSA and other forms of family violence came through films made in Hollywood for both the big screen and television. Films like *Nuts*, with Barbara Streisand, *A Thousand Acres*, with Jessica Lange, *The Color Purple,* with Whoppi Goldberg, and *A Deadly Silence,* with Charles Haid awakened the general public to the horror of CSA. Many countries, such as Brazil and India, have indigenous film industries that expose harmful cultural realities. In the past, children's activists were dependent upon the good will of filmmakers to make films promoting their cause. However, with the proliferation of cable TV, greater access is now available to independent filmmakers. While awareness alone will not prevent CSA, it desensitizes the public which allows for discussion on the subject. Teaching videos that are culturally competent have also been found useful in prevention work on CSA.

Television programming and radio talk shows can also provide access to a broad general public. For example, the Al Quds Educational Television in Ramallah provides a variety of programming and has dealt with the subject of sexual abuse of children and the problems of early marriage among young Palestinian women, despite the cultural sensitivity in Palestinian society around CSA.[433] Public service announcements or campaigns through these media will promote CSA awareness. Radio can be particularly powerful for those without access to television. Print media, too, including mass media newspapers and magazines can be

effective.

Intervention

Intervention works best when systems and community mechanisms for child protection and welfare are in place, including a) laws that protect children; b) enforcement of those laws; c) reporting and response systems; d) temporary or permanent placement for children which provide safety from further abuse or retribution resulting from disclosure; e) a responsive, competent and sensitive police and/or community accountability force committed to protecting child victims; and f) trained medical professionals, mental health providers, social workers, teachers, traditional healers, and others who can identify signs of abuse, provide sensitive and appropriate intervention, collect information and/or evidence of the abuse, and provide care for those who suffer with the on-going consequences of CSA.

Systems

According to UNICEF personnel and other professionals who were surveyed for this project, all but three of those in Southern, developing countries reported that the United Nations Convention on the Rights of the Child was being implemented and enforced. Through the implementation of the UNCRC, adequate laws have been or can be created to address the issues of CSA. However, once laws exist to protect children, they need to be enforced to have any effect. In the UNICEF survey, all but three respondents reported a lack of law enforcement which contributed to the risk of CSA in the places where they worked.

In Delhi, a group of teachers, doctors, activists and writers formed the Peoples' Forum Against Child Sexual Abuse. The group organized a campaign and demonstration against the insensitive handling of sexually abused children by the police and judicial process. Their demands included creating laws that would make CSA a separate category of rape, sensitivity training for police who respond to cases of CSA, a reduction in judicial delays, and policies to reduce the trauma of the judicial process for children.[434]

Over the past decade, support for and implementation of response units have begun to emerge. Supported by President Mbeki's declaration of the rape of children as a national emergency, the South African Law Commission issued a report urging the state to provide resources for the treatment of victims of rape, including children.[435] In reports from South Africa, references are made to hospital units designated to collect data and provide medical treatment for injury due to CSA.[436,437] However, these appear to be geographically limited and focus on providing immediate medical services.

Report and response systems are an important step in CSA intervention. Bringing child sexual abuse to light requires wrestling with the denial, silence, and collusion that accompanies the sexual abuse of a child. Research in the US shows that most children never tell anyone about their abuse.[438],[439],[440] According to the US National Center on Child Abuse and Neglect, most of the reports of child abuse (56%) to child protective services were made by professionals who are mandated by law to report.[441] Most of these reporters are teachers, law enforcement and justice personnel, and social workers and mental health professionals. To a lesser extent, medical professionals and child care providers also report abuse. The other half of reports of child abuse come from parents, relatives, friends, neighbors, and others. Reports by alleged victims only occurred in .9% of cases, while 9.2% of all reports were anonymous. [442]

Hotlines for reporting child abuse currently exist in many countries. In the UNICEF survey, all but four respondents reported systems for reporting and responding to allegations of CSA. In some places these systems are governmental while in other locations these hotlines are run by non-governmental organizations For example, in India, a hotline was established by a Bangalore group of therapists, psychiatrists and pediatricians to counsel victims of child abuse and their parents.[443] The high response to the hotline demonstrates the desire to reveal abuse and get support. In Brazil, these hotlines were initially created and run by NGO's. However, Brazil's Statute for Children and Adolescents of 1990 provided governmental support for local report and response systems in the form of special children's counsels. In countries where the cost of disclosure is high—in extreme circumstances death, at best a dishonor to the victim and her family.[444] - report and response systems will have likely have little meaning The cost of disclosure must be reduced before hotlines and other report and response systems will be viable.

In places where the cost of disclosure is high, culturally sensitive data collection may provide the opportunity for safe disclosure for child victims and adult survivors, as well as raise public awareness of the issue. Tang's study in Hong Kong and Barthauer and Leventhal's study in El Salvador, for example, revealed that many of

those surveyed had never disclosed their experiences of sexual abuse until the study.[445, 446] Therefore, it may be useful to think of data collection on prevalence and impact of CSA as the beginning of an intervention requiring cultural sensitivity, safety, and support services to those who are ready to address any consequences of their history. Tang attributes the success of their study to its cultural sensitivity method of data collection, which used an anonymous, self-administered questionnaire rather than a public survey or face-to-face interview.[447]

The World Health Organization supports the importance of anonymity. In their gathering of statistics on sexual abuse, they found that disclosure doubled when an anonymous method was used compared to direct questioning.[448] Report and response systems allow for professionals and others to report CSA rather than directly confront a sexually abusive situation. In Stop it Now's anonymous telephone survey, 75% of participants reported that they would confront someone who had been drinking and was about to drive, but only 9% reported that they would directly confront someone who was sexually abusing a child. However, 65% indicated that they would contact the police or child protection services.[449]

Criminal justice systems are often felt to have a negative impact on child victims. This is certainly true when law enforcement officers, court workers, and judges have no training around CSA, nor sympathy for the plight of a child victim. These positions are often dominated by men, who may find themselves sympathizing with the offender. However, when judges, police, and court workers are sensitive and informed, testifying in court, when done in a child-sensitive manner, does not appear to negatively impact a child.[450],[451],[452] In Israel, the court process for cases of CSA is designed to minimize further victimization of the abused child with criminal proceedings. The Israeli model for questioning any child victim of violence involves a pre-trial proceeding conducted by a specially trained juvenile investigator, rather than a police officer, who can give evidence in court in place of the child. The court also identifies the need for short- (a 6 month minimum) or long-term therapy for the child and emotional support for the guardians.[453]

Support Services

Victims and survivors of CSA, including those who go on to offend, need immediate and long-term support to reduce the consequences of abuse and the possible progression of harmful behaviors. Intervention for child victims is particularly important, to prevent the effects of CSA from becoming woven into the child's developing self. Most industrialized countries offer a variety of specialized support services, including crisis centers, specialized legal, medical, psychiatric and psychotherapeutic services, educational resources, team management, and on-going case management. According to the UNICEF survey, many countries in Asia, the Americas and Caribbean, and the Pacific do not have support services for child victims of CSA. Other countries from the developing South report that support services exist, but are inadequate to meet the needs. In addition, these services may be concentrated in large urban centers, leaving the rural areas without access to the few services that exist.

Support services for victims, survivors, and perpetrators are dependent upon having trained professionals and/or community leaders who are knowledgeable and capable of working with these individuals, and upon the allocation of resources to provide these services. For example, in 1995, 400 state government child care workers in Rio de Janeiro, Brazil, from kitchen cooks to unit directors, participated in a 40 hour training on child abuse and neglect.[454] This training taught state workers how to identify and care for abused and neglected children in their care. In 1996, 30 medical and mental health professionals at the Federal University Pediatric Hospital in Rio de Janeiro, Brazil, spent 40 hours being trained in how to interview and examine children who may have been abused or neglected, and how to coordinate their efforts as an interdisciplinary treatment team on these cases.[455] As a result of the training, hospital staff initiated a specialized service for children suspected of abuse and/or neglect, which cost the hospital nothing more than the training.

The Philippines offers an example of a comprehensive response as part of Manila's Child Protection Unit offering direct medical care, rapid diagnosis and evaluation, and continuing case coordination. The team includes a center director, two social workers, one nurse, one psychologist and two pediatricians. The response involves a child-sensitive examination and an immediate team assessment of safety needs. Care plans are developed, the child and family/guardians are interviewed within 72 hours of the incident, and follow-up through home visits. The procedures were designed specifically to respect the dignity of children and the family.[456]

Because teachers, social workers, medical personnel, mental health providers, and others have regular contact

with children, it is important that these professional people understand how to identify signs of sexual abuse and respond appropriately. In Brazil, Pontifícia Universidade Católica, in Rio, developed a specialized multi-disciplinary graduate program focusing on developing skills for work with abused and neglected children. At the Universidade de São Paulo, the Laboratório da Criança, known as LACRI, developed a specialized graduate program of distance learning on child abuse and neglect. Students around the country gather in small groups to watch the teaching videos to learn about CSA and other forms of child abuse.

Since all professionals who work with children need at least minimal training in recognizing signs of abuse and appropriate responses, it is suggested that CSA and other forms of maltreatment of children be included in the curriculum for these professionals as they are preparing for their profession. Neugebauer's[457] exploration of intergenerational cycles of violence indicates that intervention across all types of child maltreatment is critical in interrupting cycles of CSA. The study found that among children who had been sexually abused, those children who had also been neglected were more likely to become perpetrators of abuse later on than those who had not been neglected. In fact, child neglect was an even more potent risk factor than a history of sexual abuse for future perpetration. This also supports the World Health Organization recommendation to integrate child sexual abuse intervention efforts into a broader agenda of child maltreatment.[458]

Professional workers are not the only adults who might benefit from special training. In the United States, Generation Five offers a model of community leadership development that pro-actively seeks to develop the capacity of community networks surrounding situations of abuse to respond to and prevent child sexual abuse. A year of leadership training is provided to those within any given geographic community in a position to make a difference around CSA. The model provides the framework, information, skills development, and activist network, so that leaders can identify viable actions specific to the needs of the communities in which they live and work.[459] Zimbabwe's FOCUS program, [460] providing support to 6500 children across 2,000 households, works to increase the openness of community members around conversations about sex, sexuality and CSA, and lobbies traditional leaders to protect children from CSA and reduce stigma and silence.

The work of Collier et al[461] in Palau used their study to identify definitions and descriptions that captured the experience of sexual abuse in their community. This then opened a public discussion about CSA. Given the secrecy and silence surrounding CSA, discussion is itself an important step towards raising awareness and identifying: survivors in need of support, perpetrators who may be actively abusing, and cultural norms and practices that allow CSA to continue. Through open discussion, effective strategies can be explored for moving community and state systems towards greater willingness to intervene and prevent CSA.

Although most Palauan teachers in the study recommended intervention for abused children, only a minority supported intervention from outside of the community.[462] Instead, those interviewed suggested the use of traditional, established mechanisms with in the community to address child abuse, identifying the maternal uncle as someone with authority to intervene when a serious problem in the nuclear family occurs. This assumes that the uncle is not the abuser and willing to challenge offender, often other males, in the community around abusive behavior. However, the Palauan expression, "it takes a village to raise a child" is a deep commitment that offers a foundation for the establishment of community mechanisms for intervening in CSA.[463]

Recovery resources for intervention with children who display signs of sexually abusive behavior, a majority of whom have histories of abuse,[464,465] is largely limited to Northern, industrialized countries and is under resourced even in the places that it exists. However, across the literature on offender treatment, the earlier the intervention, the more successful is the prevention of future perpetration.[466] Again, community and traditional healers may also provide avenues and methods for interrupting physiological, mental, spiritual and behavioral consequences of trauma that may lead to perpetration.

Recovery resources are also needed for adult survivors and sexual perpetrators. Industrialized countries provide professional services for adult survivors, which can include: individual, group, or family psychotherapy. In the US, the approach to working with sexual offenders combines legal accountability for their crimes against children with therapeutic and educational support services specialized for sex offenders. This requires criminal justice officers to work collaboratively with mental health professionals.

Some communities may have limited access to these types of support services. In fact, in extremely poor areas families are often missing the basics they need to survive, so that focusing on family violence can be secondary to focusing on survival. Families in these situations will only be able to respond to the violence when these immediate needs are also attended to. Furthermore, these professional services are not culturally appropriate or relevant to everyone, as they were constructed for well-educated, middle-class families. Any services provided to help victims, survivors, family members, or perpetrators of CSA need to be culturally acceptable. Finally, in many places of the world "proof" is required before sex offenders can be prosecuted. Since physical evidence is infrequent in cases of CSA, strategies need to be developed to help victims who may be forced to continue living with an offending parent.

Some Case Studies

Brazil

In 1993 the Family Development Project was initiated in a large, impoverished favela in Rio de Janiero to work with victims of abuse and neglect and their families. The project is housed in the Resident's Association, the hub of community life. This favela, the City of God, has about 120,000 inhabitants, some without access to water or sanitation and whose electrical power is clandestinely siphoned off power lines. It is run by drug traffickers and highly violent.

The project provides psycho-educational services to child victims, parents, and perpetrators of spouse and child abuse, as well as social services including weekly home visits. Professional services include assessment of the abusive situation, development of action plans, and individual psycho-education for parents and children. Because these families often lack basic resources, social workers help those in need obtain food staples, housing, employment, legal documents, slots in public school, medical and psychiatric services, child care, services for alcoholism and drug abuse, etc. Personal contact is made by project staff with as many of the provider agencies as possible through mutual collaboration.

Many projects, both governmental and NGO's, often suffer from lack of funding and therefore shut down. Project staff work hard to maintain an up-to-date list on existing services and client requirements, to better connect families with appropriate services. Intervention continues until the abusive situation is resolved. Project staff also work with the *Juizado do Menor* (Minor's Court) when children are at risk in their homes and need to be removed to a safer place. Staff also find safe places for children to live when they leave the home. The philosophy of care includes an emphasis on helping the nuclear family as well as the extended family, neighbors, and all those involved in the family social network to join together in an effort t stop existing child abuse and prevent future abuse or wife battering.[467]

Canada

In Canada's Ontario province, the Mennonite community has developed a model of community accountability and support for offenders of sexual abuse based on twenty-five years of experience and unprecedented success in the reduction of re-offense.[468] Based on religious notions of restoration and justice, their work seeks to ensure community safety and the protection of children through mechanisms that hold the offender accountable to the community. They define justice as,

> *…essentially restorative in nature and not punitive as is commonly held in [Canadian] society. When a crime is committed, the community is damaged by it. Restorative justice seeks to restore the fabric of the life of the community by addressing the needs of the victim, the fears of the community and the issues in the life of the offender. Based on this premise the work of dealing with the sex offenders…becomes a process of restoration of community, re-creating community in a way which holds both the offender and the community accountable and makes all of our communities a safer place.*[469]

Notions of justice differ by culture and country, but the model offers possibilities for engaging community values that support community accountability for the safety of its children as well as the protection and rehabilitation of its offenders. Simultaneously, it requires the challenging of either or both community complicity in abuse and/or community desire for retribution or violence against the offender.[470] However, the challenge lies with depending upon community leaders to promote change when they may be the ones who have vested interests in protecting the power dynamics that allow CSA to continue. This may be particularly true where traditional community structures are founded on male dominance and sexual privilege.

Thus, such accountability is not possible in a context where the well-being of children, or more specifically

girls, is not prioritized and sexual abuse is not recognized as a crime and/or human rights violation, and where systems for reporting and prosecution and/or enforcement of community mechanisms for offender accountability do not exist. The model offered includes imposed conditions and supervision combined with intensive support for the survivor, offender and family. [471]

Israel

Israel offers an example of a community model to respond to and ultimately prevent further occurrences of CSA. Upon the disclosure of several incidences of the sexual abuse of girls in a small, community a voluntary, representative neighborhood committee was engaged by community worker. For the first two months the committee was involved in daily activities to achieve the following goals:[472]

1. To raise awareness of the existence and extent of the problem of CSA in the community and dispel myths that were leading to the stigmatization of the girls who had been abused,
2. To secure individual and group treatment for the girls,
3. To facilitate education and discussion groups for non-victimized children and youth towards reducing stigma and opening the space for future disclosure of abuse,
4. To establish similar parents' groups in day care settings and schools to address concerns of parents and develop parental capacity to respond appropriately.

While the committee maintained communication with the police, they were only involved in specific offenses with the investigations and criminal proceedings. All service providers in the community were involved, and workshops were convened to increase capacity of service providers and parents, and to reduce parental concerns. Media coverage was avoided in order to protect the privacy of the victims and reduce scandal that could damage hard won efforts to bring new families and businesses into the community. After the initial phase of intensive intervention, the activities of the committee and service providers were integrated into pre-existing community meetings. As the capacity of various community leaders was developed to support CSA intervention and prevention efforts, the leadership was able to become more diffused throughout community life. Over the last year, 10 years after the initiation of activities, no new cases of CSA were reported. The authors attribute the success of the intervention to a combined process of both personal and societal transformation.[473]

Cuba

The integration of the status of women and children into the Cuban revolution has effectively wedded the project of the self-determination of Cuban people to the well-being of their children.[474] The same mechanisms that support the ideals of the revolution are used to protect children from and intervene in abuse. The Committees for the Defense of the Revolution become community accountability mechanisms where community doctors, psychologists, school workers, community and family members can confront offenders with the support and reinforcement of the broader community. Employers may also be enlisted to apply pressure for offender accountability. Incarceration and other forms of state intervention are only used as a last resort. Community doctors, psychologists, public health officials and teachers similarly report very low incidences of all forms of child abuse, particularly sexual abuse.[475]

Society

> *Although tremendous resources have been enlisted to respond to the incidence and impact of both child sexual abuse and adult sexual assaults, intervention strategies have failed to prevent the occurrence, and prevention strategies have usually been aimed at potential victims. Certainly self-protection and defense, reporting, prosecution, and treatment programs are called for in response to this problem, but the ultimate solution is to prevent the development of new offenders so that future generations are no longer at risk. The only proactive approach to sexual abuse prevention is perpetration prevention rather than the descriptive and reactive intervention responses that have been most common.*[476]

Across cultures and countries this involves a shift in gender inequality and male sexual privilege. In his international study of sexual abuse, Finkelhor names male sexual socialization as a common thread.[477] As Meursing and others note of men in Zimbabwe, "like elsewhere in the world, most CSA in Zimbabwe is committed by men who are not drastically different from other men," a majority of whom do not consider sex with a physically developing girl a crime.[478] While a majority of women in the study named the act a

crime, they too had been socialized to regard male sexual privilege as the norm. Shaloub-Kevorkian describes this in an example she gives of a mother's response to discovering her daughter is pregnant by her brother, after he raped her. The mother dismissed the damage to the daughter, stating that if the rape and pregnancy leave her without future prospects of marriage, then she's "not the first woman to go unmarried," and minimizes the actions of her son, stating she "needs to find him a bride," as it "seems to be what he needs."[479]

Across the responses documented in this report, the pairing of personal and societal transformation and community and systemic accountability provide multiple and mutually reinforcing points for intervention and prevention. The specific cultural, social, political and economic context may make an emphasis on one initially more feasible than another. Ultimately the prevention of and intervention in CSA requires a comprehensive effort to address multiple levels of vulnerability. Like so many of the severe barriers to the full securing of the rights and well-being of children across the world, this is a formidable task that will require challenging multiple vested interests. One that requires that we take a stand in what the prevalence, sensitivity and linkages remind us—of the tolerance for the perpetration of abuse against women and children.

> *They remind us that creating a protected space where survivors can speak their truth is an act of liberation. They remind us that bearing witness, even within the confines of that sanctuary, is an act of solidarity. They remind us also that moral neutrality in the conflict between victim and perpetrator is not an option. Those who stand with the victim will inevitably have to face the perpetrator's unmasked fury. For many of us, there can be no greater honor.*[480]

For those of us committed to the realization of the full human rights of children, there is also no option.

When child sexual abuse is understood less as the behavior of deviant offenders and instead as an extreme extension of the dynamics of gender and sexuality, child-adult relationships, family systems, and community tolerance for violence, then prevention may be possible.

Mobilizing Response: Frameworks and Key Partnerships

The linkage between sexual abuse and multiple deeply rooted social and political issues such as war, displacement and poverty, suggest that integrating child sexual abuse into intervention and prevention efforts across issues of child maltreatment, child prostitution and commercial exploitation, HIV prevention, and gender, sexuality, and reproductive health may prove more effective than separating out the issue. Each offers different entry points and opportunities to collaborate on developing joint agendas. However, it's important that a specific commitment be made to its inclusion, or for reasons of discomfort and difficulty it may easily get folded into a broader agenda (i.e. child maltreatment) without any recognition of prevention and intervention approaches that are specific to the dynamics and impacts of CSA.

Child Abuse Prevention

Both the World Health Organization and the United State's Center for Disease Control has recently recognized child sexual abuse as a public health issue needing attention.[481,482] Institutions of public health offer their framework of prevention, tools of data collection and surveillance and their public health prevention and intervention strategies and methodology to preventing the occurrence of CSA.

> *The public health approach to violence focuses mainly on primary prevention rather than on treatment. Though there is recognition that intervention must be provided for those persons who are already perpetrating sexual violence, public health practitioners and researchers are searching for ways to prevent such violence from occurring in the first place. There is a need to look harder for ways to end the violence, to move beyond locking up perpetrators of violence and patching up their victims. This will require a radical shift in the way society thinks about prevention of violence.*[483]

Included in their recommendations is the integration of child sexual abuse into international efforts to address child maltreatment and family and sexual violence. The World Health Organization's (WHO) report on violence suggests bringing sexual abuse more explicitly into the agenda of the Integrated Multisectoral Approach to Child Abuse Prevention.[484]

HIV Prevention

In addition to the activities specific to violence prevention, the link between CSA and HIV provides multiple opportunities for integrating CSA prevention and intervention work into international HIV work. Each of the

links identified between HIV and CSA raises different questions of prevention and intervention. If there are myths connected to HIV that play any role in the rape and sexual abuse of children, what is effective in countering such myths? What role might a collaboration between international children's and HIV programs play in advocating for governmental and religious leadership to educate the public about HIV transmission and dispelling myths and/or customs of sexual cleansing that may support child rape and CSA?

What might the role of prophylactic anti-retroviral therapy play in reducing incidences of HIV transmission as a result of such abuse? Currently, the 15 state hospitals in South Africa are not funded to provide HIV antiretroviral prophylaxis in cases of child rape. Partnering with the efforts like those supported by the Gates Foundation may facilitate the inclusion of prophylaxis treatment for victims of rape and sexual abuse.

How can discussions of the role gender inequality plays in the transmission of HIV include conversations about child sexual abuse? The International HIV/AIDS Alliance (the Alliance) has supported the Zambia Integrated Health Program (ZIHP) in developing a set of gender and sexuality 'tools' for use in HIV/AIDS work in Zambia.[485] The intention of the tools is to better equip the staff of local nongovernmental organizations (NGOs) and community-based organizations (CBOs) to raise issues of gender and sexuality in their HIV/AIDS work with the communities that they serve. The use of the tools has, among other effects, highlighted sexual abuse as an issue at the intersection of gender, sexuality and HIV/AIDS. The urgency of HIV may offer an opportunity for an exploration of gender, sexuality and child sexual abuse that may otherwise be inconceivable. Organizations like the Alliance may therefore prove invaluable partners in raising issues and identifying concrete strategies for addressing CSA.

Commercial Exploitation of Children

As previously mentioned, the same human rights declarations, guidelines and resolutions used to challenge the commercial sexual exploitation of children can be utilized or modified to challenge intrafamilial and community-based CSA. Current anti-exploitation efforts have been raising important questions about the rights of children and the responsibility for their protection like those included in the collaborative report on child prostitution produced by UNICEF, Childwatch International and the Centre for Family Research.[486]

> *Who is responsible for the welfare of children: parents, the community or the state? What mechanisms exist/are used by children to claim their rights? What state welfare mechanisms exist? How effective and accessible are they? What community (traditional) mechanisms exist and how accessible are they?*

The discussion of these questions in relationship to commercial sexual exploitation needs to be asked for intrafamilial and community-based CSA as well but have not yet been integrated as part of a continuum of the sexual abuse of children from trafficking and commercial exploitation to intrafamilial and community-based abuse. Both share linkages to the personal and social impacts discussed in this report and require community mechanisms and state systems for prevention.

The need to address offenders towards the goal of preventing the intrafamilial and community-based sexual abuse of children, was echoed in the speech given by Helene Sackstein, coordinator of the Focal Point on Sexual Exploitation of Children, at the Second World Congress against the Commercial Sexual Exploitation of Children. She noted that, "At the international level, we are still addressing, to use the economic terms, the "supply side" children—but little is done to deal with the "consumers" of sex with children, particularly local ones."[487] Her comment not only supports the need to integrate offenders and "consumers" into prevention efforts but also the interconnection between global and local sexual abuse.

Gender, Sexuality, and Reproductive Health

Reproductive rights work recognizes the link between violence against women and children as a barrier to equality between men and women and a detriment to the development goals of a people, community and or country. The 1994 International Conference on Population and Development (ICPD) held in Cairo developed a Programme of Action that commits itself to combat all violence against women and girls, including sexual violence and to enforce laws on minimum age of consent and marriage. Follow-up action in 2000 to the United Nations 4th World Conference on Women in Beijing held in 1995 committed itself, in Resolution 1216, to:

> *(7.iv) ensure that women who have been subjected to violence are given assistance and increased protection by providing social and psychological and, where appropriate, financial assistance;*

Partnering with international NGO's and governmental bodies whose goals promote gender equality through the elimination of violence against women would strengthen both objectives.

The task of the prevention and intervention of child sexual abuse is a significant one. The magnitude of both the prevalence and its linkage to severe consequences on physical, psychological, behavior, social, and economic health are overwhelming. But, these linkages provide the possibility of bridging international efforts that support the rights and well-being of children and adults. Thus, in those places where there appears to be the greatest despair, there may be the hope of new collaborations that can simultaneously address multiple barriers to safe and satisfying lives for children and secure their lives for the future.

NEXT STEPS:

1. Convene local and regional working sessions to discuss issues brought up in this paper, as well as other issues deemed significant and relevant to setting policy on CSA in that particular region. These issues may include: defining "child" specifically around the issue of CSA; the issue of consent, including consent as it relates to marriages between children and adults; the limits of age differences between aggressor and victim; the role of subjective perceptions in determining CSA; the types of sexual acts that could be considered abusive in a specific community; and overcoming cultural barriers that prevent disclosure to CSA.

2. Assess where and what systems exist that can respond to cases of CSA, as well as the quality of those responses. Focus on strengthening weaknesses in the system, building upwards from the creation/implementation of adequate laws, creation/ implementation of responsive criminal justice systems, awareness raising and training for UNICEF workers, NGO activists, medical professionals, teachers, social workers, mental health workers, and community leaders.

3. Develop strategies for increasing public awareness of CSA that link it with harmful cultural norms and values.

4. Works towards integrating professional, government, and community services where they exist and create new services where they are lacking. Work towards amplifying existing services through training staff on CSA. For example, NGO's that provide services for Domestic Violence may be able to include work with the sexual violence of children, becoming services for "Family Violence." This also begins to integrate the movement of human rights for women with a movement of rights for children, strengthening both movements simultaneously.

5. Integrate community service providers, criminal justice systems, and others with the academic community. As evident in the literature on CSA, academicians in many regions of the world are beginning to research and study CSA. Early integration of NGO's with academic institutions will strengthen the ability of academicians to study CSA as it is being worked with directly in the community, while strengthening the ability of activists to have well documented evidence to promote CSA policy.

6. Integrating CSA into international efforts to intervene in and prevent commercial sexual abuse, exploitation and trafficking, on child maltreatment, and on family and community violence.

7. Identify and engage key partnerships across human and children's rights, international public health, child maltreatment and HIV efforts, commercial sexual exploitation of children, and gender, sexuality, and reproductive health networks.

[1] DeMausse, L. (1974). **The History of Childhood**. New York: Psychohistory Press.
[2] DeMausse, L. (1991). The universality of incest. **The Journal of Psychohistory,** 19, pp.123-164.
[3] Kinsey, A.C., Pomeroy, W.B., & Martin, C.E. (1948). **Sexual Behavior in the Human Male**. Philadelphia: W.B. Saunders Company.
[4] Kinsey, A.C., Pomeroy, W.B., & Martin, C.E., & Gebhard, P.H. (1953). **Sexual Behavior in the Human Female**. Philadelphia: W.B. Saunders Company.
[5] Finkelhor, D. (1993). Epidemiological factors in the clinical identification of child sexual abuse. **Child Abuse & Neglect**, 17, pp. 67-70.
[6] Finkelhor, D. (1994). The international epidemiology of child sexual abuse. **Child Abuse & Neglect,** 18, pp. 409-417.
[7] Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Great Britain, Ireland, Netherlands, New Zealand, Norway, South Africa, Sweden, Switzerland, and the United States.
[8] LaRocque, E.D. (1994). **Violence in Aboriginal Communities**. Ottawa, Ontario, Canada: Royal Commission on Aboriginal Peoples. Cited in Barker-Collo, S.L. (1999). Reported symptomatology of native Canadian and Caucasian females sexually abused in childhood: A comparison. **Journal of Interpersonal Violence,** 14, pp. 747 - 760.
[9] Madu, S.N., & Petlzer, K. (2001). Prevalence and patterns of child sexual abuse and victim-perpetrator relationship among secondary school students in the Northern Province (South Africa). **Archives of Sexual Behavior**, 30, pp. 311-321.
[10] Singh, H.A., Ying, W.W., & Nurani, H.N.K. (1996). Prevalence of childhood sexual abuse among Malaysian paramedical students. **Child Abuse & Neglect**, 20, pp. 487-492.
[11] Halperin, D.S., Bouvier, P., Jaffe, P.D., Mounoud, R.L., Pawlak, C.H., Laederach, J., Rey Wicky, H., & Astie, F. (1996). Prevalence of child sexual abuse among adolescents in Geneva, Switzerland. **British Medical Journal,** 312, pp. 1326 - 1329.
[12] Madu, S.N., & Petlzer, K. (2001).
[13] Olsson, A., Ellsberg, M., Berglund, S., Herrara, A., Zelaya, E., Peña, R., Zelaya, F., & Persson, L. (2000). Sexual abuse during childhood and adolescence among Nicaraguan men and women: A population-based anonymous survey. **Child Abuse & Neglect,** 24, pp. 1579 - 1589.
[14] Haj-Yahia, M.M. & Tamish, S. (2001). The rates of child sexual abuse and its psychological consequences as revealed by a study among Palestinian university students. **Child Abuse & Neglect**, 25, pp. 1303 - 1327.
[15] Singh, H.A., Ying, W.W., & Nurani, H.N.K. (1996).
[16] Romero, G.J., Wyatt, G. E., Loeb, T.B., Carmona, J.V., & Solis, B.M. (1999). The prevalence and circumstances of child sexual abuse among Latina women. **Hispanic Journal of Behavioral Sciences**, 21, pp. 351-365.
[17] Wyatt, G., Loeb, T. B., Solis, B. & Carmons, J.V. (1998). The prevalence and circumstances of child sexual abuse: Changes across a decade. **Child Abuse & Neglect**, 23, pp. 45 -60.
[18] Barker-Collo, S.L. (1999). Reported symptomatology of native Canadian and Caucasian females sexually abused in childhood: A comparison. **Journal of Interpersonal Violence,** 14, pp. 747 - 760.
[19] LaRocque, E.D. (1994).
[20] Barthauer, L.M. & Leventual, J.M. (1999).
[21] Olsson, A. & others. (2000).
[22] Ibid, p. 1587.
[23] Barsted, L. (1998). **Uma Vida Sem Violência é um Direito Nosso**. (A Life Without Violence is Our Right). Sponsored by the Interagency Committees of Gender and Communication of the United Nations and the Brazilian National Department of Human Rights of the Ministry of Justice, Brasília, Brazil.
[24] PNUD/IPEA (1996). **Relatório sobre o Desenvolvimento Human no Brasil** (Report on Human Development in Brazil). Brasilia. Cited in: Ibid, p. 18.
[25] Ministry of Health - **Violência Contra a Criança e o Adolescente: Proposta Preliminar de Prevenção e Assistência à Violência Doméstica,** (Violence Against Children and Adolescents: Preliminary Proposal for Prevention and Assistance for Domestic Violence), Brasilia, 2ª. Edição, 1997. Cited in: L. Barsted (1998), p. 18.
[26] UNICEF. (1996). **A Situação do Abuso Sexual e da Prostituição Infanto-Juvenil no Brasil**, (The Situation of Sexual Abuse and Juvenile-Chld Prostitution in Brazil). Brasilia. Cited in: L. Barsted (1998), p. 19 - 20.
[27] Goiânian Forum to End Exploitation, Violence and Sex Tourism. (1997). **Abuso e Exploração Sexual de Crianças e Adolescents** (Abuse and Sexual Exploitation of Children and Adolescents), Goiânia, Goiás. Cited in: L. Barsted (1998), p. 20.
[28] Bastos, A.V., Morris, L., & Fernandes, S. R. (1989). **Saúde e Educação Sexual do Jovem: Um Estudo em Salvador, Brasil**. Salvador, Brazil: Universidade Federal de Bahia. Cited in: Mensch, B., Bruce, J., & Greene, M. (1998), pp. 49-50.

[29] Heise, L., Moore, K., & Toubia, N. (1995). **Sexual Coercion and Reproductive Health: A Focus on Research**. New York: The Population Council.

[30] Rosas, M.I. (1992). Violencia sexual y politica criminal. **CLADEM Informativo** No. 6. Lima, Peru: CLADEM. Cited in: Heise, L., Moore, K., & Toubia, N. (1995). p. 9.

[31] Gershenson, H., Musick, J., Ruch-Ross, H., Magee, V., Rubino, K., & Rosenberg, D. (1989). The prevalence of coercive sexual experience among teenage mothers. **Journal of Interpersonal Violence**, 4, p. 204-219.

[32] Heise, L., Pitanguy, J., & Germaine, A. (1994). **Violence Against Women: The Hidden Health Burden**. Washington, D.C.: The World Bank.

[33] Halperin, D. & others. (1996).

[34] Bouvier, P., Halperin, D., Rey, H., Faffe, P.D., Laederach, J., Mounoud, R., Pawlak, C. (1999). Typology and correlates of sexual abuse in children and youth: Multivariate analyses in a prevalence study in Geneva. **Child Abuse & Neglect**, 23, pp. 779-790.

[35] Schneider, H.J. (1997). Sexual abuse of children: Strengths and weaknesses of current criminology. **International Journal of Offender Therapy and Comparative Criminology.** 41, pp. 310-324.

[36] Statistisches Bundesamt (1996). Cited in: Ibid.

[37] Carlstedt, A., Forsman, A., & Soderstrom, H. (2001). Sexual child abuse in a defined Swedish area 1993-97: A population based survey. **Archives of Sexual Behavior**, 30, pp. 483 - 493.

[38] Collier, A.F., McClure, F.H., Collier, J., Otto, C., & Polloi, A. (1999), Culture-specific views of child maltreatment and parenting styles in a pacific-island community. **Child Abuse & Neglect**, 23, pp. 229 - 244.

[39] Marcus, M.N. (1991). Child abuse and neglect in Micronesia. **The Micronesian Seminar**, 2, pp. 1 - 7. Cited in: Ibid, p. 231.

[40] PCAA (1991). **Palau child abuse survey for Palau Community Action Agency (Report**). Koror, Republic of Palau: Ministry of Health. Cited in: A. F. Collier, & others. (1999), p. 231.

[41] Singh and others (1996).

[42] Heise, L., Pitanguy, J., & Germaine, A. (1994).

[43] Gibbons, J. (1996). Service for adults who have experiencedchild sexual assault: Improving agency response. **Social Science and Medicine**, 43, pp. 1755-1763.

[44] Okuyama M., Kitayama, A., Uchiyama A., Takase K. & others (2000). **The Incidence of Sexual Abuse among Young Children in Japan**. National Center for Child Health and Development: Japan.

[45] Rhind, N., Leung, T., & Choi, F. (1999). Child sexual abuse in Hong Kong: Double victimization? **Child Abuse & Neglect**, 23, pp. 511-517.

[46] Ibid.

[47] Ho, T. P., & Mak, F.L. (1992). Sexual abuse in Chinese children in Hong Kong: A review of 134 cases. **Australian and New Zealand Journal of Psychiatry**, 26, 639 - 643. Cited in: N. Rhind, T. Leung, & F. Choi (1999), p. 511.

[48] Nhundu, T. J., & Shumba, A. (2001) The nature and frequency of reported cases of teacher perpetrated child sexual abuse in rural primary schools in Zimbabwe. **Child Abuse & Neglect,** 25, pp. 1517-1534.

[49] Mpangile, G.S., Leshabari, M.T., Kaaya, S., Kihwele, D. (1998). Abortion and unmet need for contraception in Tanzania - the role of male partners in teenage induced abortion in Dar Es Salaam. **African Journal of Reproductive Health** 2, p. 109.

[50] Ibid.

[51] Ibid, pp. 108 - 121.

[52] Cited in Mensch, B., Bruce, J., & Greene, M. (1998). **The Unchartered Passage: Girl's Adolescence in the Developing World.** New York: The Population Council, p. 51.

[53] Haj-Yahia, M.M. & Tamish, S. (2001). The rates of child sexual abuse and its psychological consequences as revealed by a study among Palestinian university students. **Child Abuse & Neglect**, 25, pp. 1303 - 1327.

[54] Schein, M., Biderman, A., Baras, M., Bennett, L., Bisharat, B., Borkan, J, Fogelman, Y., Gordon, L., Steinmetz, D., & Kitai, E. The prevalence of a history of child sexual abuse among adults visiting family practitioners in Israel. **Child Abuse & Neglect,** 24, pp. 667-675.

[55] Itzhaky, H. & York, A.S. (2001) Child sexual abuse an incest: community-based intervention. **Child Abuse & Neglect,** 25, pp. 959-972.

[56] Schein, M. & others (2000).

[57] Shalhoub-Kevorkian, N. The politics of disclosing female sexual abuse: A case study of Palestinian society. **Child Abuse & Neglect,** 23, pp. 1275-1293.

[58] Miles, G.M. (2000). "Children don't do sex with adults for pleasure": Sri Lankan children's views on sex and sexual exploitation. **Child Abuse & Neglect**, 24, pp. 995-1003.

[59] Prakash, A. (1995). Lost Innocence: The demand for stricter laws intensifies, as it becomes clear that the sexual abuse of children is a widespread malaise. **www.outlookindia.com**.

[60] This study was commissioned by UNICEF as part of this project. See Appendix for a summary of the results.

[61] Sloane, P., & Karpinsky, E. (1942). Effects of incest on the participants. **American Journal of Orthopsychiatry,** 12, pp. 666-673.
[62] Weiss, J., Rogers, E., Darwin, M., & Dutton, C. (1955). A study of girl sex victims. **Psychiatry Quarterly**, 29, pp. 1 - 27.
[63] Kinsey, A.C. & others. (1953).
[64] Bender, L. & Blau, A. (1937). The reaction of children to sexual relations with adults. **American Journal of Orthopsychiatry,** 7, pp. 500-518.
[65] Mensch, B., Bruce, J., & Greene, M. (1998).
[66] Jejeebhoy, S.J. (1995). **Women's Education, Autonomy, and Reproductive Behaviour: Experience from Developing Countries.** Oxford: Clarendon Press, p. 11. Cited in: Mensch, B. Bruce, J. & Greene, M. (1998). p. 46.
[67] Cited in Heise, L., Moore, K., & Toubia, N. (1995), p. 17.
[68] Ibid.
[69] Fahlberg, V. (1988). **The juvenile sexual offender: Perceptions of self-image and family functioning**. Unpublished doctoral dissertation. Union Institute, Cincinnati, Ohio.
[70] Deisher, R.W., Wenet, G.A., Paperny, D.M., Clark, T.F., & Fehrenback, P.A. (1982). Adolescent sexual offense behavior: The role of the physician. **Journal of Adolescent Health Care**, 2, pp. 279-286.
[71] Groth, A.N. & Loredo, C.M. (1981). Juvenile sex offenders: Guidelines for assessment. **International Journal of Offender Therapy and Comparative Criminology,** 25, pp. 31-39.
[72] Thomas, J. (1981). Child sexual abuse victim assistance project, **Research Foundation of Children's Hospital**, Washington, D.C. Cited in: A.N. Groth & C.M. Loredo (1981).
[73] O'Brien (1985). Adolescent sexual offenders: A community faces reality. **East Community Family Center,** Maplewood, MN, pp. 1-3.
[74] Romero, G.J., & others. (1999).
[75] Glasgow, D., Horne, L., Calam, R., & Cox, A. (1994). Evidence, incidence, gender and age in sexual abuse of children perpetrated by children; Toward a developmental analysis of child sexual abuse. **Child Abuse Review,** 3, 196-210, Cited in: S. Lightfoot & I. M. Evans (2000). Risk factors for a New Zealand sample of sexually abusive children and adolescents. **Child Abuse & Neglect,** 24, pp. 1185 -1198.
[76] Graveson, W. (1997). **Police information on offender apprehensions and clearances. National statistics**. Wellington, NZ: New Zealand Police Internal Departmental Bulletin. Cited in: S. Lightfoot & I. M. Evans (2000).
[77] Olsson & others (2000).
[78] **Women of the World: Laws and Policies affecting their Reproductive Lives, Latin America and the Caribbean.** (1997). New York: The Center for Reproductive Law and Policy, p 139.
[79] Finkelhor, D. (1979).
[80]Sgroi, S.M., Blick, L.C., & Porter, F.S. (1982). A conceptual framework for child sexual abuse. In: S.M. Sgroi (ed). **Handbook of Clinical Intervention in Child Sexual Abuse**. Lexington, MA: Lexington Books, p. 30.
[81] Blumberg, M. L. (1978). Child sexual abuse: Ultimate in maltreatment syndrome. **New York State Journal of Medicine**, March, pp. 612 - 616.
[82] Sgroi, S.M., Blick, L.C., & Porter, F.S. (1982).
[83] Blumberg, M. L. (1978). p. 614.
[84] Herman, J. L. (1981). **Father-Daughter Incest**. Cambridge, Massachusetts: Harvard University Press, p. 42.
[85] Sgroi, S.M., Blick, L.C., & Porter, F.S. (1982).
[86]Mensch, B., Bruce, J, & Greene, M. (1998), p. 49
[87] Herman, J.L (1981), p. 27.
[88] Nhundu, T. J. & Shumba, A. (2001).
[89] Ibid.
[90] **Women of the World: Laws and Policies affecting their Reproductive Lives, Latin America and the Caribbean, Progress Report 2000**. (2001), New York: The Center for Reproductive Law and Policy, p. 35.
[91] Ibid.
[92] **Women of the World: Laws and Policies affecting their Reproductive Lives, East Central Europe,** (2002), New York: The Center for Reproductive Law and Policy, p. 26.
[93]Mensch, B., Bruce, J, & Greene, M. (1998).
[94] Quote by Annie George cited in L. Heise, K. Moore & N. Toubia, (1995), p. 15.
[95] Ibid.
[96] Heise, L., Moore, K., & Toubia, N. (1995), p. 19.
[97] Herman, J.L. (1981), p. 62.
[98] Olsson, A. & others (2000), p. 1582.
[99] Madu, S.N., & Petlzer, K. (2001).
[100] Romero, G. J. & others. (1999), p. 225.

[101] Finkelhor, D. (1979), p. 52.
[102] Mensch, B., Bruce, J, & Greene, M. (1998).
[103] Ibid.
[104] Hughes, J., & McCauley, A. (1998). Adolescents' needs and future programs for sexual and reproductive health in developing countries. **Studies in Family Planning**, 29, pp. 233-244. p. 234.
[105] National Public Radio, Dec. 7, 2002.
[106] Heise, L., Moore, K., & Toubia, N. (1995), p.17.
[107] Finkelhor, D. (1979), p. 29.
[108] Haj-Yahia, S. & Tamish, S. (2001), p. 1304.
[109] Ibid, p. 1305.
[110] Shalhoub-Kevorkian, N. (1999), p. 1278.
[111] Al-Khayyat, S. (1990). **Honour & Shame: Women in Modern Iraq**. London: Saqi books. Cited in: Ibid.
[112] Barthauer, L.M., & Levanthal, J.M. (1999), p. 1119.
[113] Heise, L., Moore, K., & Toubia, N. (1995), p. 20.
[114] Ibid.
[115] Heise, L., Moore, K., & Toubia, N. (1995), p. 21.
[116] Wyatt, G. E., (1985), using a sample of European American and African American women in California, United States.
[117] Romero, G.J. & others. (1999), using a sample of Latinas in California, United States.
[118] Madu, S.N., & Petlzer, K. (2001), using a sample of secondary students in the Northern Province of South Africa.
[119] Finkelhor, D. (1979), using a sample of college students in New Hampshire, United States.
[120] Barthauer, L.M., & Leventhal, J.M. (1999), using a sample of El Salvadoran women.
[121] Halpérin & others. (1996), using a sample of ninth graders in Geneva, Switzerland.
[122] Collings, S. J. (1991). Childhood sexual abuse in a sample of South African University males: Prevalence and risk factors. **South African Journal of Psychology**, 21, p. 153 - 158. Cited in: D.Finkelhor, (1994), p. 411.
[123] Levett, A. (1989). A study of childhood sexual abuse among South African University women students. **South African Journal of Psychology**, 19, pp. 122-129. Cited in: S.N. Madu & K. Petlzer (2001), p. 312.
[124] Nhundu, T. J. & Shumba, A. (2001).
[125] Haj-Yahia, M.M., & Tamish, S. (2001).
[126] Ibid., p. 1321.
[127] Heise, L., Moore, K., & Toubia, N. (1995), p. 20.
[128] Finkelhor, D. (1993).
[129] Finkelhor, D. (1979).
[130] Halpérin & others. (1996).
[131] Carlstedt, A., Forsman, A. & Soderstrom, H. (2001).
[132] Centro de Investigaciones Sociojurídicas de la Faculdad de Derecho de la Universidad de los Andes, Investigación sobre violencia sexual en Bogotá (2000). (unpublished study). Cited in: **Women of the World: Laws and Policies affecting their Reproductive Lives, Latin America and the Caribbean, Progress Report 2000**. (2001), p. 36.
[133] Rhind, N., Leung, T., & Choi, F. (1999).
[134] Shalhoub-Kevorkian, N. (1999).
[135] Itzhaky, H. & York, A. S. (2001).
[136] Schein, M. & others. (2000).
[137] Haj-Yahia, M.H. & Tamish, S. (2001).
[138] Barthauer, L.M. & Leventhal, J.M. (1999).
[139] Romero, G. J. & others. (1999).
[140] Ho, T. P., & Mak, F.L. (1992). Cited in: N. Rhind, T. Leung, & F. Choi (1999), p. 511.
[141] Nhundu, T.J. & Shumba, A. (2001).
[142] Ibid.
[143] Madu, S.N. & Petlzer, K. (2001).
[144] Barker, G. & Knaul, F. (1992**). Three times exploited, three times empowered: The urban adolescent woman in difficult circumstances.** Final draft of a report to the Urban Section of the United Nations Children's Fund (UNICEF), 28 October. Cited in: Mensch, B.S., Bruce, J., & Greene, M. (1998), p. 38.
[145] Miles, G. M. (2000).
[146] This author verified an occurrence of this type in 1993, in Rio de Janeiro, Brazil. The victim's mother was a professional social worker taking a class in the identification of child sexual abuse by this author.
[147] Ramsey-Klawsnik, H. (1990, April). **Sexual abuse by female perpetrators: Impact on children**. Paper presented at the National Symposium on Child Victimization, Keepers of the Children. Cited in: Rudin, M.M., Zalewski, C., & Bodmer-Turner, J. (1995). Characteristics of child sexual abuse victims according to perpetrator gender. **Child Abuse & Neglect**, 19, pp. 963 - 973.

[148] **Declaration on the Elimination of Violence against Women**, 85th Plenary Meeting of the General Assembly of the United Nations, December 20, 1993.
[149] Summit, R.C. (1981). Beyond belief: the reluctant discovery of incest. In M. Kirkpatrick (Ed.), **Women in Context**. New York: Plenum Press.
[150] Rush, F. (1977). The Freudian cover-up, **Chrysalis**, 1, pp. 31 - 45.
[151] Kinsey, A.C. & others. (1953), p. 121.
[152] Finkelhor, D. (1984). **Child Sexual Abuse: New Theory and Research**. New York: Free Press.
[153] Finkelhor, D. (1994). Current information on the scope and nature of child sexual abuse. **The Future of Children**, 4, pp. 31 - 53.
[154] Green, A. H. (1996). Overview of child sexual abuse. Cited in S.J. Kaplan (Ed.), **Family Violence: A clinical and legal guide.** Washington, D.C.: American Psychiatric Press.
[155] Kessler & Hayden, (1991). **Clinical symposia: Physical, sexual, and emotional abuse of children**. Summit, NJ: Institute of Justice.
[156] Rhind, N., Leung, T., & Choi, F. (1999).
[157] Ibid.
[158] Shalhoub-Kevorkian, N. (1999).
[159] Ben-Baraka cited in L. Heise, K. Moore & N. Toubia (1995), p. 17.
[160] Goodwin, J. (1994). **Price of honour: Muslim women life the veil of silence on the Islamic world.** London: Warner Books. Cited in N. Shalhoub-Kevorkian, (1999), p. 1278.
[161] Al-Saadawi, N. (1992) **Al-wajh al-ari lil mara'a al-Arabia** (The naked face of the Arab woman.). Cairo: Dar Al Nashr Al-Arabi (Arabic). Cited in: N. Shalhoub-Kevorkian, (1999), p. 1279.
[162] Shalhoub-Kevorkian, N. (1999).
[163] Ibid, p. 1286.
[164] Moghaizel, L. (1986). The Arab and Mediterranean world: Legislation towards crimes of honor. In M. Schuler (Ed.), **Empowerment and the law: Strategies of Third World women**. Washington, DC: OEF International, pp. 174-180. Cited in: N. Shalhoub-Kevorkian, (1999), p. 1288.
[165] **Women of the World: Laws and Policies affecting their Reproductive Lives, Latin America and the Caribbean, Progress Report 2000** (2001). p. 26.
[166]Haj-Yahia, M.M. & Tamish, S. (2001).
[167] Shalhoub-Kevorkian, N. (1999).
[168] Nhundu, T.J. & Shumba, A. (2001).
[169] Shalhoub-Kevorkian, N. (1999), p. 1276.
[170] **Women of the World: Laws and Policies affecting their Reproductive Lives, Latin America and the Caribbean, Progress Report 2000**. (2001), p. 27.
[171] Nhundu, T.J. & Shumba, A. (2001).
[172] **Women of the World: Laws and Policies affecting their Reproductive Lives, Latin America and the Caribbean, Progress Report 2000.** (2001), p. 14.
[173] Khadar, A. (1998). **Al-qanoun wa mustaqbal al-mará al-filistinyyeh** (Law and the future of the Palestinian woman). Jerusalem: Women's Center for Legal Aid and Counseling. Cited in: N. Shalhoub-Kevorkian, (1999), p. 1288.
[174] Romero, G.J. & others, (1999).
[175] Savishinsky, J.S. (1991). The ambiguities of alcohol: Deviance, drinking, and meaning in a Canadian native community. **Anthropologica**, 33, pp. 81 -98. Cited in: S. L. Barker-Collo (1999), pp. 748 - 749.
[176] Shalhoub-Kevorkian, N. (1999), p. 1280.
[177] Robinson, W.V. & Kurkjian, S. (Dec. 1, 2002). Archdiocese weighs bankruptcy filing. **Boston Sunday Globe**, Section A, p. 1.
[178] Herman, J.L. (1992), p. 7-8.
[179] **Business Line**, (2001). India: Rampant but under wraps. January 26, Islamabad.
[180] Savishinsky, J.S. (1991), Cited in: S. L. Barker-Collo (1999), pp. 748-749.
[181] Ibid.
[182] Clapton, S. Lonne, R., Theunissen, C. (1999) Multi-victim sexual assault: A case study in rural Australia. **Child Abuse & Neglect,** 23, pp. 395-404.
[183] Itzhaky, H. & York, A.S. (2001), pp. 959-972.
[184] Shalhoub-Kevorkian, N. (1999), p. 1284.
[185] Dimenstein, G. (1996). **Democracia em pedaços: Direitos humanos no brasil.** São Paulo: Editora Schwarcz, p. 20.
[186]**Business Line**, (2001). January 26. From a survey conducted in 1996 by the NGO Sakshi.
[187] **Business Line**, (2001). January 26.

[188] Chinowaita, M. (2000). Stop child sex abuse scandal. **The Standard**. January 26, p. 1. Cited in: T.J. Nhundu and A. Shumba, (2001), p. 1528.

[189] Mpangile, G.S., & others, (1998), p. 120.

[190] Abdool-Karim, Q., Abdool-Karim, S.S., & Preston-Whyte, E. (1992). Teenagers seeking condoms at family planning services: A provider's perspective. **South African Medical Journal**, 82, pp. 360-362. Cited in: J. Hughes & A.P. McCauley (1998). p. 235.

[191] Senderowitz, J. (1997). **Health facility programs on reproductive health for young adults**. Washington, DC: FOCUS on Young Adults. Cited in: J. Hughes & A.P. McCauley (1998). p. 235.

[192] Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, E.F., Spitz A.M., Edward V., Koss M.P., Marks J.S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults**. American Journal of Prevention Medicine,** 14, pp. 245-258.s

[193] Tabachnick, M., & Henry, M. (1997 Aug. 29). Perceptions of Child Sexual Abuse as A Public Health Problem. **Morbidity Mortality Weekly Report,** 46, pp. 801-803.

[194] Friedman, M.A., Wifley, D.E., Welch, R.R., & Kunce, J.T. (1997). Self-directed Hostility and Family Functioning in Normal-weight Bulimics and Overweight Binge Eaters. **Addictive Behaviors**, 22, pp. 367-375.

[195] Ganje-Fling M. (1996). Impact of childhood sexual abuse on a client spiritual development: Counseling implications. **Journal of Counseling and Development**. Pages 253-266.

[196] Skuse, D., Bentovin, A., Hodges, J., & Stevenson, J. (1998). Risk factors for development of sexually abusive behavior in sexually victimized adolescent boys: Cross sectional study. **British Journal of Medicine,** 317, pp. 175-179.

[197] Hillis, S., Anda, R., Felitti, V., & Marchbanks, P. (2001). Adverse childhood experiences and sexual risk behaviors in women: A retrospective cohort study. **Family Planning Perspective**, 33, pp. 206-211.

[198] Paolucci, E., Genuis, M., & Violato, C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. **The Journal of Psychology**, 135, pp. 17-36.

[199] Cohen, M., Deamant ,C., Barkan, S., & Richardson, J. (2000). Domestic violence and childhood sexual abuse in HIV-infected women and women at risk for HIV. **American Journal of Public Health,**. 90, pp. 560-565.

[200] Neugebauer, R. (2000). Research on intergenerational transmission of violence. The next generation. **The Lancet,** 355, pp. 1116-1117.

[201] Hyman, B. (2000). The economic consequences of child sexual abuse for adult lesbian women. **Journal of Marriage and the Family,** 62, pp. 199-211.

[202] Booth, R., Zhang, Y., & Kwiatkowski, C. (1999). The challenge of changing drug and sex risk behaviors of runaway and homeless adolescents. **Child Abuse & Neglect.** Vol. 23, No. 12, pages 1295-1306

[203] Wyatt, G., Myers, H., Williams, J., Ramirez-Kitchen, C., Loeb T., Carmona J.V., Wyatt, L., Chin, D., Presley, N. (2002). Does a History of Trauma Contribute to HIV Risk for Women of Color? Implications for Prevention and Policy. **American Journal of Public Health,** 92, pp. 660-665.

[204] World Health Organization. **Report on Violence.** www5.who.int/violence_injury_prevention.

[205] Russell, D.E.H. (1986) **The Secret Trauma: Incest in the lives of girls and women**. New York: Basic Books.

[206] Browne A, Miller BA and Maguin E (1999). Prevalance and Severity of Lifetime Physical and Sexual Victimization Among Incarcerated Women. **International Journal of Law and Psychiatry** 22(3-4), 301-322.

[207] Cohen, M., Deamant ,C., Barkan, S., & Richardson, J. (2000).

[208] Paolucci, E., Genuis, M., & Violato, C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. **The Journal of Psychology,** 135, pp. 17-36.

[209] Elliott M., Browne K., Kilcoyne J. (1995). Child Sexual Abuse Prevention: What Offenders Tell Us. *Child Abuse and Neglect*, 19 (5), 579-594.

[210] Burton, D.L. (2000). Were adolescent sexual offenders children with sexual behaviors problems? **Journal of Sexual Abuse,** 12 (1): 31-48.

[211] Giaretto Institute (1995). Report. Giaretto Institute: San Jose.

[212] Skuse, D., Bentovin, A., Hodges, J., & Stevenson, J. (1998). Risk factors for development of sexually abusive behavior in sexually victimized adolescent boys: Cross sectional study. **British Journal of Medicine,** 317, pp. 175-179.

[213] Ibid.

[214] Neugebauer, R. (2000).

[215] Human Rights Watch (1999). Promises Broken: An Assessment of Children's Rights on the 10th Anniversary on the Convention on the Rights of the Child. www.hrw.org

[216] Reis, C., Amowitz, L., Hare-Lyons, K., Iacopino, V. (2002). **War Related Sexual Violence in Sierra Leone.** Physicians for Human Rights: Boston.

[217] Moszynski, P. (2002). UNICEF sets up programme to prevent sex abuse by aid workers. **British Journal of Medicine,** 325, pp. 732.

[218] Willis, B., & Levy, C. (2002). Child Prostitution: global health burden, research needs, and interventions. **The Lancet,** 359, pp. 1417-1422.

[219] Ennew, J., Gopal, K., Heeran, J., & Montgomery, H. (1996). **Children and Prostitution: How Can We Measure and Monitor the Commercial Sexual Exploitation of Children?** Report for UNICEF, Centre for Family Research and Childwatch International.
[220] Willis, B., & Levy, C. (2002).
[221] Ibid.
[222] Farley, M., & Kelly, V. (2000). Prostitution: a critical review of the medical and social sciences literature. **Women and Criminal Justice**, 11, pp. 29-64
[223] Ibid.
[224] Farley, M., Baral, I., Kiremire, M., & Sezgin, U. (1998). Prostitution in Five Countries: Violence and Post-Traumatic Stress Disorder. **Feminism and Psychology,** 8, pp. 405-426.
[225] Menon, V. (2000). Innocence Betrayed: A study reveals child prostitution to be flourishing in three cities. **Outlook India.com.**
[226] ECPAT International. (2002). Facts and Figures on Child Sexual Exploitation and Prostitution in the United States. **www.ecpat.net**.
[227] Pedersen, W., & Hegna, K. (2003). Children and adolescents who sell sex: a community study. **Social Science and Medicine,** 56, pp. 135-147.
[228] Ibid.
[229] Farley, M., & others. (1998).
[230] Farley, M., & Barkan, H. (1998). Prostitution, Violence and Posttraumatic Stress Disorder. **Women and Health,** 27, pp. 37-49.
[231] Booth, R., Zhang, Y., & Kwiatkowsk,i C. (1999).
[232] Farley, M., & others. (1998).
[233] Wurtele,S.K. & Miller-Perrin,C.L. (1992). **Preventing child sexual abuse**. Lincoln, NE: University of Nebraska Press.
[234] Farley, M., & Kelly, V. (2000).
[235] Wurtele,S.K. & Miller-Perrin,C.L.(1992).
[236] Booth, R., Zhang, Y., & Kwiatkowski, C. (1999).
[237] Ibid.
[238] Ibid.
[239] Farley, M., & Kelly, V. (2000).
[240] Densen-Gerber, Bernard (1976).
[241] Wadhwa, S. (1998). For Sale: Childhood. **Outlook India.com**
[242] Wurtele,S.K. & Miller-Perrin,C.L.(1992).
[243] Farley, M., & others. (1998).
[244] Farley, M., & Kelly, V. (2000).
[245] Ibid.
[246] Ibid.
[247] Wadhwa, S. (1998).
[248] Human Rights Watch (1999.
[249] Ibid.
[250] Meursing, K., Vos, T., Coutinho, O., Moyo, M., Mpofu, S., Oneko O., Mundy V., Dube S., Mahlangu T., Sinbindi F. (1995). Child Sexual Abuse in Matabeleland, Zimbabwe. **Social Science and Medicine,** 41, pp. 1693-1704.
[251] Greig, A. (2002). **Report on HIV and gender workshop in Zambia.** International HIV/AIDS Alliance: London.
[252] Ibid.
[253] Ibid.
[254] Olsson, A., & others (2000).
[255] Prakash. A. (1995).
[256] Haj-Yahia, M., & Tamish, S. (2000).
[257] Booth, R., Zhang, Y., & Kwiatkowski, C. (1999).
[258] Olsson A., & others. (2000).
[259] Shalhoub-Kevorkian N. (1999).
[260] Ibid.
[261] Haj-Yahia, M., & Tamish, S. (2000).
[262] Meursing, K., & others (1995).
[263] Zierler S., Feingold L., Laufer D., Velentgas P., Kantrowitz-Gordon I., Mayer K. (1991). Adult survivors of childhood sexual abuse and subsequent risk of HIV infection. **Am J Public Health**;81(5):572-5.
[264] Wyatt G., & others. (2002).
[265] Paone, D., Chavkin, W., Willets, Il, Friedman, P., Deschenes, E., & Jarlis, D. (1992). The impact of sexual abuse: Implications for drug treatment. **Journal of Women's Health**, 1, pp. 149-153.

[266] Cohen, M., & others. (2000).
[267] Jewkes R., & Abrahams, N. (2002). The Epidemiology of rape and sexual coercion in South Africa: an overview. **Social Science and Medicine,** 55, pp. 1231-1244.
[268] Meursing, K., Vos & others. (1995).
[269] Menon, V. (2000).
[270] Farley, M., & Kelly, V. (2000).
[271] Cohen, M., & others. (2000).
[272] Ibid.
[273] Wyatt G., & others. (2002).
[274] Zierler S., Feingold L., Laufer D., Velentgas P., Kantrowitz-Gordon I., Mayer K. (1991). Adult survivors of childhood sexual abuse and subsequent risk of HIV infection. **Am J Public Health**;81(5):572-5.
[275] Paone, D., Chavkin, W., Willets, Il, Friedman, P., Deschenes, E., & Jarlis, D. (1992). The impact of sexual abuse: Implications for drug treatment. **Journal of Women's Health**, 1, pp. 149-153.
[276] South African Press Association (2001). Johannesburg, South Africa.
[277] Jewkes R., & Abrahams, N. (2002). The Epidemiology of rape and sexual coercion in South Africa: an overview. **Social Science and Medicine,** 55, pp. 1231-1244.
[278] Pitcher, G., & Bowley, D. (2002). Infant rape in South Africa. **The Lancet.** Vol. 359, Issue 9303, pages 274-275.
[279] Ibid.
[280] Jewkes, R., Martin, L., Penn-Kekana, L. (2001). Commentary in response to G. Pitcher and D. Bowley's "Infant rape in South Africa" in The Lancet. **MRC News Release:** www.scienceinafrica.co.
[281] Meursing, K., & others. (1995).
[282] Olsson, A., & others. (2000).
[283] Herman, J.L. (1992). **Trauma and Recovery**. New York: Basic Books.
[284] Ibid.
[285] Herman, J.L. (1992).
[286] Ibid.
[287] Ibid.
[288] Kendall-Tackett, K., Williams, L.M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. **Psychological Bulletin**, 113, pp. 164-180.
[289] Ibid.
[290] Sgroi, S.M., Blick, L.C., & Porter, F.S. (1982).
[291] Herman, J.L. (1992), p. 96.
[292] Kendall-Tackett, K., Williams, L.M., & Finkelhor, D. (1993).
[293] Hibbard, R.A. & Orr, D.P. (1985). Incest and sexual abuse. **Seminar on Adolescent Medicine**, 1, 153-164.
[294] Rosenberg, D.A., & Krugman, R.D. (1991). Epidemiology and outcome of chid abuse. **Annual Review Med**, 42, pp. 217-224.
[295] Barthauer, L.M. & Leventhal, J.M. (1999).
[296] Kendall-Tackett, K., Williams, L.M., & Finkelhor, D. (1993).
[297] Ibid.
[298] Haugaard, J.J., & Reppucci, N.D. (1988). **The Sexual Abuse of Children**. San Francisco, CA: Jossey-Bass.
[299] Herman, J.L. (1992), p. 101.
[300] **Diagnostic and Statistical Manual of Mental Disorders**, 4th Ed. (1994). Washington, D.C.: American Psychiatric Association.
[301] Ibid.
[302] Kendall-Tackett, K., Williams, L.M., & Finkelhor, D. (1993).
[303] Paolucci, E., Genuis, M., & Violato, C. (2001).
[304] Herman, J.L. (1992), pp. 96-114.
[305] Yehuda, R. (1999). Biological factors asociated with susceptibility to post-traumatic stress disorder. **Canadian Journal of Psychiatry,** 44, pp. 34-39.
[306] Yehuda, R. Levengood, R.A., Schmeidler, J., Wilson, S., Guo, L.S., & Gerber, D. (1996). Increased pituitary activation following metyrapone administration in post-traumatic stress disorder. **Psychoneuroendocrinology**, 21, pp. 1-16.
[307] Bremner, J.D. (1999). Does stress damage the brain? **Biological Psychiatry**, 45, pp. 797-805. Cited in: K. Kendall-Tackett (2000).
[308] Lovallo, W.R. (1997). **Stress and Health: Biological and Psychological Interactions**. Newbury Park, CA: Sage. Cited in: K. Kendall-Tackett (2000).
[309] Southwick, S.M., Bremner, D., Krystal, J.H. & Charney, D.S. (1994). Psychobiologic research n post-traumatic stress disorder. **Psychiatric Clinics of North America**, 17, pp. 251-264. Cited in: K. Kendall-Tackett (2000).

[310]Putnam, F.W. (1997). **Dissociation in Children and Adolescents**. New York: Guilford. Cited in: A. Streeck-Fischer & B.A. van der Kolk (2000). Down will come baby, cradle andall: diagnostic and therapeutic implications of chronic trauma on child development. **Australian and New Zealand Journal of Psychiatry**, 34, pp. 903-918.

[311] DeBellis, M.D., & Putnam, F.W. (1994). The psychobiology of childhood altreatment. **Child and Adolescent Psychiatric Clinics of North America**, 3, pp. 663-678.

[312] DeBellis, M.D., Deshavan, M.S., Clark, D.B., Caey, B., & Putnam, F.W. (1999). Developmental traumatology part II. Brain development. **Biological Psychiatry**, 45, 1271-1284. Cited in: A. Streeck-Fischer & B.A. van der Kolk (2000).

[313] Teicher, M.H., Glod, C.A., Surrey, J., & Swett, C. (1993). Early childhood abuse and limbic system ratings n adult psychiatric outpatients. **Journal of Neuropsychiatry and Clinical Neurosciences**, 5, 301-306. Cited in: A. Streeck-Fischer & B.A. van der Kolk (2000).

[314] Kendall-Tackett, K., Williams, L.M., & Finkelhor, D. (1993).

[315] Hibbard, R.A. & Orr, D.P. (1985). Incest and sexual abuse. **Seminar on Adolescent Medicine**, 1, pp. 153-164.

[316] Rosenberg, D.A. & Krugman, R.D. (1991). Epidemiology and outcome of child abuse. **Annual Review Med**, 42, p. 217-224. Cited in: Stevens-Simon, C. & Reichert, S. (1994).

[317] Browne, A. & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. **Psychological Bulletin**, 99, pp. 66-77.

[318] Runtz, M., & Briere, J. (1986). Adolescent "acting out" and childhood history of sexual abuse. **Journal of Interpersonal Violence**, 1, pp. 326-334.

[319] Hillis, S., Anda, R., Felitti, V., & Marchbanks P. (2001). Adverse childhood experiences and sexual risk behaviors in women: A retrospective cohort study. **Family Planning Perspective**. 33, pp. 206-211.

[320] Olsson, A. & others (2000).

[321] Olsson, A. & others (2000).

[322] Paolucci, E.O., Genuis, M.L., & Violato, C. (2001).

[323] Sims, P.L., Stamper, A.M., Jones, J.E., Defrain, J., & others (2000). Talking abous sexual abuse: Teacher as catalyst. **Journal of Family and Consumer Sciences**, 92, pp. 46-52.

[324] Brown, L.K., Lourie, K.J., Zlotnick, C., & Cohn, J. (2000). Impact of sexual abuse on the HIV-risk-related behavior of adolescents in intensive psychiatric treatment. **American Journal of Psychiatry,** 157, pp. 1413-1415.

[325] Gershenson, H.P., & others. (1989).

[326] Butler, J.R., & Burton, L.M. (1990). Rethinking teenage childbearing: is sexual abuse a missing link? **Family Relations**, 39, pp. 73-80.

[327] Boyer, D. & Fine, D. (1992). Sexual abuse as a factor in adolescent pregnancy and chid maltreatment. **Family Planning Perspectives**, 24, pp. 4-11.

[328] Boyer, D. (1995). **Adolescent Pregnancy: The role of sexual abuse**. National Resource Center on Child Sexual Abuse of the National Center on Child Abuse and Neglect, 4,1-3.

[329] **Equality,Equity, and the Empowerment of Women**. (1999). http://www.cedpa.org/cairo/media/empowerment.htm

[330] Stevens-Simon, C., & Reichert, S. (1994). Sexual abuse, adolescent pregnancy, and child abuse. **Archives of Pediatric Adolescent Medicine**, 148, pp. 23 - 27.

[331] Browne, A., & Finkelhor, D. (1986). Impact of sexual abuse: A review of the research. **Psychological Bulletin,** 99, pp. 66 - 77.

[332] Ladwig, G.B., & Andersen, M.D. (1989). Substance abuse in women: Relationship between chemical dependency of women and past reports of physical and/or sexual abuse. **International Journal of the Addicitons,** 24, pp. 739-754.

[333] Miller, B.A., Downs, W.R., & Testa, M. (1993). Interrelationship between victimzation experiences and women's alcohol use. **Journal of Studies of Alcohol**, II (Suppl.), pp. 109-117.

[334] Paone, D., & others. (1992).

[335] Resnick, H.S., Kilpatrick, D.G., Dansky, B.S., Sanders, B.E., & Best, C.L. (1993). Prevalence of civilian trauma and post-traumatic stress disorder in a representative ntional sampleof women. **Journal of Consulting and Clinical Psychology**, 61, 984-991.

[336] Paone D., & others (1992).

[337] Kang, S.Y., Magura, S. Laudet, A., & Whitney, S. (1999). Adverse effect of child abuse victimization among substance-using wmen in treatement. **Journal of Interpersonal Violence**, 14, pp. 657 - 670.

[338] Felitti V.J., & others. (1998).

[339] Kendall-Tackett, K., Williams, L.M., & Finkelhor, D. (1993).

[340] Anteghini M., Fonseca H., Ireland M., Blum R. (2001). Health risk behaviors and associated risk and protective factors among Brazilian Adolescents in Santos, Brazil. **Journal of Adolescent Health,** 28, pp. 295-302.

[341] Streeck-Fischer, A., & van der Kolk, B.A. (2000). Down will come baby, cradle andall: diagnostic and therapeutic implications of chronic trauma on child development. **Australian and New Zealand Journal of Psychiatry**, 34, pp. 903-918.
[342] Herman, J. L. (1992).
[343] Kendall-Tackett, K., (2000).
[344] Daley, M., & Argeriou, M. (1997). Characteristics and treatment needs of sexually abused pregnant women in drug rehabilitation. **Journal of Substance Abuse Treatment**, 14, pp. 191-196.
[345] Ibid.
[346] Streeck-Fischer, A., & van der Kolk, B.A. (2000), p.910.
[347] Streeck-Fischer, A., & van der Kolk, B.A. (2000).
[348] Kendall-Tackett, K., Williams, L.M., & Finkelhor, D. (1993).
[349] Sims, P.L., & others (2000).
[350] Calhun, Jurgens, and Chen (1993). Cited in A. Kendall-Tackett,.
[351] Kang, S.Y., & others. (1999).
[352] Browne et al. (1999)
[353] Streeck-Fischer, A., & van der Kolk, B.A. (2000).
[354] Ibid.
[355] Sturkie, K. (1983). Structured group treatment for sexually abused children. **Health and Social Work**, 4, pp. 299-309.
[356] Streeck-Fischer, A., van der Kolk, B.A. (2000), p. 912.
[357] Paolucci, E., Genuis M., Violato C. (2001).
[358] Kendall-Tackett, K, Williams, L.M., & Finkelhor, D. (1993)... (1993).
[359] Paolucci, E., Genuis, M., & Violato, C. (2001).
[360] Hyman, B. (2000).
[361] Streeck-Fischer, A. & van der Kolk, B.A. (2000), p. 912.
[362] Rosenberg, D.A. & Gary, N. (1988). Sexual abuse of children. In: D.C.Bross, R.D. Krugman, M.R. Lenherr, D.A. Rosenberg, & B.D. Schmitt, (Eds.). **The New Child Protection Team Handbook**, New York: Garland Pub.Co., pp. 66-81.
[363] Emans, S.J., Woods, E.R., Flagg, N.T., & Freeman, A. (1987). Genital findings in sexually abused, symptomatic and asymptomatic girls. **Pediatrics**, 79, pp. 778-785.
[364] Muram, D. (1989). Child sexual abuse: relationship between sexual acts and genital findings. **Child Abuse & Neglect**, 13, pp. 211-216.
[365] Dubowitz, H., Black, M., Harrington, D., & Verschoore, A. (1993). A follow-up study of behavior problems associated with child sexual abuse. **Child Abuse & Neglect**, 17, pp. 743-754.
[366] Conte, J.R. (1991). The nature of sexual offenses against children. In C.R. Hollin & K. Howells (eds.), **Clinical approaches to sex ofenders and their victims.** Chichester, NY: John Wiley, pp. 11-34.
[367] Shalhoub-Kevorkian, N. (1999).
[368] Shalhoub-Kevorkian, N. (1999).
[369] Ibid.
[370] American College of Obstetricians and Gynecologists (2000). Adult Manifestations of Childhood Sexual Abuse. **American College of Obstetricians and Gynecologists Educational Bulletin.** No. 259.
[371] Collett BJ, Cordle CJ, Stewart CR, Jagger C. (1998). A comparative study of women with chronic pelvic pain, chronic nonpelvic pain and those with no history of pain attending general practitioners. **Brittish Journal of Obstetrics & Gynaecology**, 105, pp.87-92.
[372] Goldberg RT, Goldstein R. (2000). A comparison of chronic pain patients and controls on traumatic events in childhood. **Disability & Rehabilitation**, 22, pp. 756-63.
[373] Toomey TC, Seville JL, Mann JD, Abashian SW, Grant JR (1995). Relationship of sexual and physical abuse to pain description, coping, psychological distress, and health-care utilization in a chronic pain sample. **Clinical Journal of Pain**, 11, pp. 307-315.
[374] Goldberg RT, Goldstein R. (2000).
[375] Finestone HM, Stenn P, Davies F, Stalker C, Fry R, Koumanis J. (2000). Chronic pain and health care utilization in women with a history of childhood sexual abuse. **Child Abuse and Neglect**, 25, pp. 1133-6.
[376] Streeck-Fischer, A. & van der Kolk, B.A. (2000).
[377] Leserman, J., Drossman, D.A., Li, Z., Toomey, T.C, Nachman, G., & Glogau, L. (1996) Sexual and physical abuse history in gastroenterology practice: How types of abuse impact health status. **Psychosomatic Medicine**, 58, pp. 4-15.
[378] Kendall-Tackett, K. (2000). Physiological Correlates of childhood abuse: Chronic hyperarousal in PTSD, depression, and Irritable Bowel Syndrome. **Child Abuse and Neglect**, 24, pp. 799-810.

[379] Talley, N.J., Fett, S.L., & Zinsmeister, A.R.. (1995). Self-reported abuse and gastrointestinal disease in outpatients: Association with iritable bowel-type symptoms. **American Journal of Gastroenterology**, 90, pp. 366-371. Cited in Ibid.

[380] Talley, N.J., Fett, S.L., Zinsmeister, A.R., & Melton, L.J. (1994). Gastrointestinal tract symptoms and self-reported abuse: A population-based study. **Gastroenterology**, 107, pp. 1040-1049. Cited in K. Kendall-Tackett, (2000).

[381] Kendall-Tackett, K. (1993).

[382] Heim, C., Newport, J., Heit S., Graham, Y.P., Wilcox, M., Bonsall, R., Miller, A.H., & Nemeroff, C.B. (2000). Pituitary-Adrenal and Autonmic Responses to Stress in Women After Sexual And Physical Abuse in Childhood. **Journal of the American Medical Association,** 284, p 592-597.

[383] Kendler, K.S., Bulik, C.M., Silberg, J., Hettema, J.M., Myers, J., & Prescott, C.A. (2000). Childhood sexual abuse and adult psychiatric and substance use disorders in women: an epidemiological and cotwin control analysis**. Archives of General Psychiatry,** 57, pp. 953-959.

[384] Stein, J.A., Golding, J.M., & Siegel, J.M. (1998). Long-term psychological sequelae of child sexual abuse: The Los Angeles epidemiological catchment area study. In G.E. Wyatt & G.J. Powell, (Eds.). **The Lasting Effects of Child Sexual Abuse.** Newbury Park: Sage.

[385] Kendler, K.S. & others (2000).

[386] Kang, S.Y., & others (1999).

[387] Haj-Yahia, M.M. & Tamish, S. (2000).

[388] Olsson A. & others, (2000).

[389] Tang C.S. (2002). Childhood experience of sexual abuse among Hong Kong Chinese college students. **Child Abuse and Neglect,** 26, pp. 23-37.

[390] Herman, J.L. (1992).

[391] Putnam, F.W. (1993). Dissociative disorders in chidren: behavioral profiles and problems. **Child Abuse & Neglect,** 16, pp.39-45.

[392] Deblinger, E, McLeer, S.V., Atkin, M.S., Ralphe, D., & Foa, E. (1989). Posttraumatic stress in sexually abused and non-abused children. **Child Abuse & Neglect**, 13, pp.403-408.

[393] Putnam, F.W. (1997). **Dissociation in child and adolescents**. New York: Guilford. Cited in: A. Streeck-Fischer & B.A. van der Kolk, (2000).

[394] Deblinger, E, & others. (1989).

[395] Bower, G.H. & Sivers, H. (1998). The cognitive impact of traumatic events. **Developmental Pschopathology**, 10, pp. 625-653.

[396] Streeck-Fischer, A. & van der Kolk, B.A. (2000).

[397] Kendall-Tackett, K., Williams, L.M., & Finkelhor, D. (1993).

[398] Weiss, E.L. (1999). Childhood sexual abuse as a risk factor for depression in women: Psychosocial and neurobiological correlates. **The American Journal of Psychiatry**, 156, pp. 816-828.

[399] Paolucci, E., Genuis M., Violato C. (2001).

[400] Streek-Fischer, A. & van der Kolk, B.A. (2000).

[401] Anteghini, M., & others. (2001).

[402] McCauley, J., Kern D.E., Kolodner K, Dill, L., Schroder A.F., DeChant H.K., Ryden J., Derogatis L.R., & Bass E.B. (1997). Clinical characteristics of women with a history of childhood sexual abuse. **Journal of the American Medical Association,** May 7.

[403] Murray, C.J.L.., & Lopez, A.D. (Eds.) (1996). A Summary of **The Global Burden of Disease**. Summarized by Phillida Browne, Harvard School of Public Health on behalf of the WHO and the World Bank: Boston, MA.

[404] World Health Organization. (2001). **The World Health Report 2001**. http://www.who.int./whr2001/2001/main/en/annex/annex3.htm

[405] Murray, C.J.L.., & Lopez, A.D. (Eds.) (1996).

[406] Murray, C.J.L.., & Lopez, A.D (1997). Mortality by cause for eight regions of the world: Global Burden of Disease Study. **Lancet,** 349, pp. 1269 - 1276.

[407] Ibid.

[408] Murray, C.J.L.., & Lopez, A.D. (Eds.) (1996).

[409] Murray, C.J.L.., & Lopez, A.D (1997).

[410] World Health Organization. (2001).

[411] Murray, C.J.L.., & Lopez, A.D. (Eds.) (1996).

[412] World Health Organization. (2001). http://www.who.int./whr2001/2001/main/en/chapter2/002e7.htm

[413] Ibid.

[414] Ibid.

[415] Ibid.

[416] World Health Organization. (2001). http://www.who.int./whr2001/2001/main/en/chapter2/002h6.htm

[417] Fahlberg, V. (1996). **Fatores que influenciam o risco de violência doméstica**. (Factors which influence the risk of domestic violence). Internal Publication, Pontifícia Universidade Católica, Dept. de Serviço Social, Rio de Janeiro, Brazil.
[418] Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. **American Psychologist**, 32, 513-531.
[419] Belsky, J. (1980). Child maltreatment: An ecological integration. **American Psychologist**, 35, 320-335.
[420] Cicchetti, D. & Rizley, R. (1981). Developmental perspectives on the etiology, intergenerational transmission and sequelae of child maltreatment. **New Directions for Child Development,** 11, 31-56.
[421] Star, R.H. (1982), **Child Abuse Prediction: Policy Implications.** Ballinger Publishing Company. Cited in: D.C. Bross, R.D. Krugman, M.R. Lenherr, D.A. Rosenberg, & B.D. Schmitt. (Eds.). (1988). The New Child Protection Team Handbook. New York: Garland.
[422] Kaufman and Zigler (1989).
[423] Fahlberg, V. (1996).
[424] Herman, J.L. (1992). p.114.
[425] McMahon P.M. (2000). The Public Health Approach to the Prevention of Sexual Violence. **Sexual Abuse: A Journal of Research and Treatment,** 12, pp. 27-36.
[426] Schneider H.J. (1997).
[427] Plummer C. (1997). The History of Child Sexual Abuse Prevention: A Practitioner's Perspective. **Journal of Child Sexual Abuse,** 7, pp.77-95.
[428] Tutty L. (2000). What children learn from sexual abuse prevention programs: Difficult concepts and developmental issues. **Research on Social Work Practice,** 10, pp. 275-300.
[429] Ibid.
[430] Tang C.S. (2002).
[431] Shalhoub-Kevorkian N. (1999).
[432] Rhind H., Leung T., Choi F. (1999).
[433] Kuttab, D. (2002) Forced off the air in Ramallah. **New York Times**, April 6, Sec. A, p. 15.
[434] Prakash A. (1996).
[435] Pitcher G., Bowley D. (2002).
[436] Ibid.
[437] Meursing K., & others, (1995).
[438] Russell, D.E.H. (1983). The incidence and prevalence of intrafamilial and exrafamilial sexual abuse of female children. **Child Abuse & Neglect**, 7, pp. 133-146.
[439] Mendel, M. (1995). **The Male Survivor: Impact of Sexual Abuse.** Thousand Oaks, CA: Sage.
[440] DeVoe, E.R., & Faller, K.C. (199). The characteristics of disclosure among children who may have been sexually abused. **Child Maltreatment**, 4, pp. 217-227.
[441] **Child Maltreatment 2000**. National Center for Child Abuse and Neglect. http://www.acf.hhs.gov/programs/cb/publications/cm00/cm2000.pdf
[442] Ibid.
[443] Prakash A. (1996). Lost Innocence. **Outlook India.** www.outlookindia.com.
[444] Shalhoub-Kevorkian N. (1999).
[445] Tang C.S. (2002).
[446] Barthauer L., Leventhal J. (1999).
[447] Tang, C.S. (2002).
[448] World Health Organization (2001).
[449] Ibid. Tabachnick M., Henry M. (1997 Aug. 29). Perceptions of Child Sexual Abuse as A Public Health Problem. **Morbidity Mortality Weekly Report,** 46, pp. 801-3.
[450] Tedesco, J.F., & Schnell, S.V. (1987). Children's reactions to sex abuse investigation and litigation. **Child Abuse & Neglect,** 11, pp. 267-272.
49 Goodman, G.S., Taub, E.P., Jones, D.P.H., England, P., Port, L.K., Rudy, L., & Prado, L. (1992). Emotional effects of criminal court testimony on child sexual assault victims. **Monographs of the Society for Research on Child Development.** Chicago, IL: University of Chicago Press.
[452] Berliner, L., & Conte, J.R. (1995). The effects of disclosure and intervention on sexually abused children. **Child Abuse & Neglect,** 19, pp. 371-384.
[453] Schneider H.J. (1997).
[454] Training by V.Fahlberg & team, at the Universidade Estadual de Rio de Janeiro, sponsored by Fundação de Infância e Adolescência, July 1 - 31, 1995.
[455] Training by V.Fahlberg & team at the Universidade Federal de Rio de Janeiro, June, 1996.
[456] **Businessworld.** (1997) UP unit to provide health services for abused children.

[457] Neugebauer R. (2000). Research on intergenerational transmission of violence. The next generation. **The Lancet.** 355, pp. 1116-1117.
[458] World Health Organization (2001).
[459] Generation Five (2002). **Social Action Plan.** www.generationfive.org.
[460] Lee T., Foster G., Makufa C., Hinton S. (2002). Families, orphans and children under stress in Zimbabwe. **Evaluation and Program Planning.** 25, pp. 459-470.
[461] Collier A., & others. (1999).
[462] Acebes-Escobal B.C., Nerida M.C., Chez R.A. (2002). Abuse of women and children in a Philippine community. **International Journal of Gynecology and Obstetrics,** 76, pp. 213-217.
[463] Ibid, p. 239.
[464] Skuse D., Bentovin A., Hodges J., Stevenson J. (1998). Risk factors for development of sexually abusive behavior in sexually victimized adolescent boys: Cross sectional study. **British Journal of Medicine,** 317, pp 175-179.
[465] Ryan G. (1997). Perpetration Prevention: Primary and Secondary. In **Juvenile Sexual Offending: Causes Consequences, and Correction**. San Francisco: Jossey-Bass Inc., p. 433-454.
[466] Ibid.
[467] This project was initiated in 1993 by Dra. Victoria Fahlberg, Rio de Janeiro, Brazil.
[468] Heise E., Horne L., Kirkegaard H. et al. (2000). **Community Reintegration Project: Circles of Support and Accountability.** Mennonite Central Committee, Ontario.
[469] Ibid, p. 9
[470] Ibid.
[471] Schneider H.J. (1997).
[472] Itzhaky H., York A. (2001).
[473] Ibid.
[474] Personal interviews with Matilde Caridad and Olga Pedreira at Policlinico Plaza de la Revelucion, community doctors and public health officials in Havana, Cuba, 2000.
[475] Ibid.
[476] Ryan G. (1997). p. 434.
[477] Finkelhor D. (1982). Sexual Abuse: A sociological perspective. **Child Abuse & Neglect,** 6, pp. 95-102.
[478] Meursing K., & others. (1995).
[479] Shalhoub-Kevorkian N. (1999).
[480] Herman, J.L. (1992). p.247.
[481] McMahon P.M., Puett R.C. (1999). Child Sexual Abuse as a Public Health Issue: Recommendations of an Expert Panel. **Sexual Abuse: A Journal of Research and Treatment***,* 11, pp. 257-266.
[482] World Health Organization (2001).
[483] McMahon P.M. (2000). The Public Health Approach to the Prevention of Sexual Violence. **Sexual Abuse: A Journal of Research and Treatment,** 12, p.28/29.
[484] World Health Organization (2001).
[485] Greig, A. (2002).
[486] Ennew, J., Gopal, K., Heeran J., and Montgomery H. (1996): **Children and Prostitution: How can we measure and monitor the commercial sexual exploitation of children?** UNICEF, Centre for Family Research and Childwatch International.
[487] Sackstein, H. (2001). **Bridging the Gap Between Reality on the Ground and International Action.** Speech given at the Second World Congress against the Commercial Exploitation of Children, Uruguay.