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ROLE OF CLINICAL PSYCHOLOGIST IN IMPROVING MENTAL HEALTH OF CHILD-VICTIMS OF SEXUAL HARASSMENT

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Abstract

Mental health of a person is very important as equivalent to physical health. For mental health to be good, emotional wellbeing during childhood is very important to develop strong resilience to cope with every situation and grow into well-developed healthy adults. Mental health troubles can arise due to any traumatic event (in the present paper, author focused on child sexual abuse-CSA) in any stage of child development. Many national and international surveys on CSA and their findings state that India has the highest number of CSA cases in the world; over 7,200 children, including infants, are raped every year. In fact, every second child is being exposed to various form of sexual harassment and every fifth child faces critical forms of it which can have a wide range of negative effects on physical, psychological, behavioral, and interpersonal well-being of the victim for a long time. Hence, the role of clinical psychologist is very crucial and extensive to overcome with this issue; starting from application of Psychological First Aid to many therapies and the most effective is Trauma-Focused CBT (TF-CBT). It is designed to minimize negative responses (psychological, behavioural and emotional) following CSA, it also focuses on parents to overcome successfully with their own distress and develop skills that support their children in adjustment.

Key words: Mental Health, Child Sexual Abuse-CSA, TF-CBT

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Introduction

Mental health of a person is more important than his physical health and a key factor which influences an individual's almost all aspect of his life. Owing to many stressful conditions, increasing mental pressure is a vital cause of the mental health problems. With good mental health, one can do various jobs like taking responsibilities of family and oneself, understand and solve the problems, plan for future and adjust with others in all situations by becoming mentally healthy. For mental health to be good, the emotional wellbeing during childhood is very important in fact equivalent to physical health. Children can develop resilience to cope with any situation they face with positive mental health and grow into well-rounded, healthy adults (Mental Health Foundation- MHF, undt).

Most children grow up mentally healthy, but surveys suggest that more children and young people have problems with their mental health today than 30 years ago (MHF, undt). That's probably because of changes in the way we live now and how that affects the experience of growing up. Mental health problems, which can arise due to any traumatic event in any stage of child development, affect about 1 in 10 children and their future life too (MHF, undt). They include depression, anxiety, conduct disorder and many others, and are often a direct response to what is happening in their lives (MHF, undt).

Our experiences in childhood play a big part in shaping our mental health throughout our lives. Sexual abuse in childhood can leave scars that can last for a long time and have a large impact on mental health (Here to help, undt); in fact it is a crime. Children living with a mental illness, learning disability or physical disability are more than twice as likely to report childhood sexual abuse as their peers. Childhood sexual abuse (CSA) can have a wide range of effects in adulthood. Some adult survivors experience few mental health problems (Here to help, undt), while others experience many long-term mental health problems in their life.

The prevalence of CSA is not easy to verify because mostly it is not reported; experts agree that the actual no. of incidence is much more than what is reported to authorities (The National Center for Victims of Crime, undt), many cases are never filed. Some people feel embarrassed or very scared about reporting abuse especially in case of minor. They may feel guilty or ashamed; some blame themselves (Here to help, undt). CSA also is not equivalently defined, so statistics can differ (The National Center for Victims of Crime, undt). The WHO

in 2002 estimated that 73 million boys and 150 million girls in the world under the age of 18 years had faced different forms of sexual assault (WHO, updated 2014). The Center's for Disease Control and the US Department of Justice conducted a study and reported occurrence of being forced to have physical relation at some point in their lives as 11% and 4% of the high-school girls and boys, respectively (Wihbey, 2011). A meta-analysis conducted in the year 2009 analyzed 65 studies in 22 countries and estimated an “overall international figure.” The main findings of the study were (Wihbey, 2011):

- An estimated 7.9% of males and 19.7% of females universally faced sexual abuse before the age of 18 years**.**
- The highest prevalence rate of CSA was seen in Africa (34.4%) (Behere, & Mulmule, 2013)
- Europe, America, and Asia had prevalence rate of 9.2%, 10.1%, and 23.9%, respectively.
- With regards to females, seven countries reported prevalence rates as being more than one fifth i.e., 37.8% in Australia, 32.2% in Costa Rica, 31% in Tanzania, 30.7% in Israel, 28.1% in Sweden, 25.3% in the US, and 24.2% in Switzerland·
- The lowest rate observed for males may be imprecise to some extent because of under reporting.

This horrible condition is not limited to foreign countries only; in fact situation is the worst in India. India is the home having highest number of CSA cases. In 2007, Ministry of Women and Child Development conducted a study in 13 states of India and reported that about 21% of the participants were exposed to severe forms of sexual violence. There were 57.3% were boys and 42.7% were girls, about 40% were between the ages of 5–12 years among the participants who reported being abused. About 50% participants were exposed to different forms of sexual abuse. A study by the National Centre for Biotechnology Information under the US government on Childhood sexual exploitation in India states that: A total of 33,098 cases of CSA were reported in the nation during the year 2011 when compared to 26,694 reported in 2010 which increased by 24%. A total of 7,112 cases of child rape were reported during 2011 as equated to 5,484 in 2010 depicting a growth by 29.7% (Behere, Sathyanarayana & Mulmule, 2013).

India has the highest number of CSA cases in the world. Every year 6,00,000 to 7,00,000 children are sexually abused, for every 155th minute a child less than 16 years is raped, for every 13th hour child under 10, and one in every 10 children sexually abused at any point of time (Childline Organization, 2007). Studies propose that over 7,200 children, including infants are raped every year and it is believed that several cases go unreported (Human Rights Watch, 2013). An analysis done by *Livemint* (2018) of the unit level data of the National Family Health Survey (NFHS) conducted in 2015-16 showed that 99.1% of sexual violence cases are not reported. The government estimates that 40% of Indian children are vulnerable to threats like being drug abused, homeless, trafficking, forced labor, forced prostitution and crime. In India, every second child is being exposed to any form of sexual assault and every fifth child suffers critical forms of it (Behere & Mulmule, 2013).

According to National Crime Records Bureau (NCRB) 2015 data (Save the Children, 2016), 8,800 child rape cases registered using the Protection of Children against Sexual Offences Act (POCSO act, 2012). Data also revealed that 94.8% of rape cases committed by someone children knew, not strangers. The biggest abusers were neighbors (35.8%- 3,149 cases) and the next is children's own direct family members (10% of cases): grandfathers, brothers, fathers and relatives.14, 913 cases registered for CSA in the year 2015 in comparison to 8,904 in the year 2014, under the POSCO Act. In crimes against minors, sexual offences and kidnapping account for 81%. According to Indo Asian News Service, New Delhi and article published in e-paper '*Hindustan Times*' (May 16, 2017), in a survey conducted by humanitarian aid organization, World Vision India, 45,844 children in 12- 18 age group participated in, across 26 states in the country, revealed that one in every two children is a victim of CSA. Survey also reported that one in every five does not feel secure due to the fear of being sexually harassed.

According to latest NCRB report (2016), total crime against children from 2014 to 2015 and from 2015 to 2016 has increased to 5.3% and 13.6 % respectively out of which major crime were kidnapping, abduction (54,723) and crime under POSCO act (36,022). Maximum no. of cases under POSCO act which includes CSA was reported in Uttar Pradesh, Maharashtra and Madhya Pradesh (15.3%, 13.3% and 13.1% respectively). If we talk about metropolitan cities, situation is terrible in Delhi and National Capital Region. Cases of CSA have increased by almost 1,784% only in Delhi; this means that four minor children everyday have been

reported to be sexually assaulted or harassed. In 2016, 1620 cases of CSA were reported in the city. Around 85 per cent of cases of sexual abuse take place inside homes or slums or at places known to the victims. In 38.89% of the cases, the accused are relatives and mostly friends of the victims. Data indicates that on average, 61% of sexual cases were reported only by economically underprivileged groups (Article published in *the pioneer, 6 April 2018*).

Data from various sources reveal rapid growth in this atrocious crime which is not limited to rape only, now has converted to brutal gang-rape followed by cruel murder; and those are survivor, not easy to be adjusting in normal daily lives. A sexually abused child-victim can typically suffers from negligence feeling, low self-esteem, loneliness and an unusual or distorted view of sex. The child may become isolate and suspicious to adults, and can have suicidal tendencies or can be suffered from Post-Traumatic Stress Disorder. PTSD is the most frequent disorder diagnosed in sexually assaulted children (Weinstein, Staffelbach & Biaggio 2000). Trauma is a deep shocking, painful and stressful situation, having wide range of negative impacts on physical, psychological, behavioral, and interpersonal well-being of the survivor for a long time (Singh, Parsekar & Nair (2014), as shown in the table below:

Table 1 showing negative impacts of CSA

Physical	**Psychological**	**Behavioural**	**Interpersonal**
Genital Injury	Post-traumatic stress disorder (PTSD)	Lower academic performance and absenteeism	Insecure relation
Bleeding or Vaginal Infection	Anxiety and Panic disorder		Lack of social competence
	Attempt to suicide	Violation of laws and social conduct	
Early Pregnancy	Depression		Lack of trust
	Guilt and anger		
Urinary tract infection	Low self-esteem	Withdrawn behavior or Violent Behaviour	Communication problem
	Hopelessness		
STD disease including HIV	Loneliness		
	Body image concern and eating disorder	Sexualized behavior	
Gastrointestinal Problem	Affects cognitive and emotional development	Possibility to grow-up as perpetrators	
Menstrual Irregularities			

Alarmingly, the situation is dreadfully worst. However, 70% of children and young people who experience mental health problems have not had appropriate interventions at a sufficiently early age (MHF, undt). Hence, there is an urgent need for application of

psychological treatment from the very first hour, beginning from **Psychological First Aid (PFA),** of this traumatic event for handling the problems affecting mental health of children. Early intervention is important for sexually abused children because the distress level immediately after the incidence is strongly associated with future pathologies and PTSD (Girelli et al., 1986). Cognitive Behavior Therapy (CBT)**,** Mindfulness Integrated Cognitive Behavior Therapy and Eye Movement Desensitization and Reprocessing (EMDR) are some of the techniques used by psychologists for improving mental health of children suffering from sexual harassment.

CBT focuses on altering thought patterns and cognitions to decrease harmful emotions, develop skills to cope with anxiety and negative thoughts, enhance effective social skills, and build up ways to manage depress, anger and future trauma symptoms (National Center for Post Traumatic Stress Disorder-NCPTSD, undt). **EMDR** is an Information Processing Therapy that includes elements of CBT, psychodynamic, interpersonal, experiential and body-centred therapies to treat PTSD. During EMDR, the client focuses on past or present traumatic experiences while simultaneously concentrates on a stimulus such as auditory tones, tactile stimulation, or visual cues (Shapiro, 2002). This leads to divided attention, shifting the processing of the traumatic memories and decreasing anxiety when thinking about the traumatic experience. It has been suggested that PTSD is due to an inability to effectively process the trauma and EMDR may be useful in this reprocessing (Foa et al, 1989).

Group therapy can also be very successful to help survivors, focus on the present and share experiences with others in a healthy and empathetic environment. According to British Crime Survey (2002), over half of the women who faced sexual assault within previous five years never told anyone about their trauma. This silence can be very harmful; in fact can develop PTSD, as the degree of support received can control symptom severity (Dunmore at al., 1999). **Psychodynamic therapy** focuses on the emotional conflicts caused by trauma, especially as they relate to early life experiences. This helps in developing self-esteem, effective ways of thinking and coping, and may be used to treat PTSD (NCPTSD, undt).

Previous psychological therapies and treatments are frequently re-evaluated, as a result new one are developed. For example, to reduce stress and recovery immediately after traumatic incidence, trauma debriefing is generally used. It has been found that debriefing did not help in preventing PTSD and may even enhance the threat of PTSD symptoms, indicating that

treatments should be constantly evaluated and modified (Cuijpers et al., 2005). Certainly, the most effective treatment with strong evidence- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT**) had its origins in pioneer work for the treatment of CSA. This has now been expanded to treat other forms of childhood trauma, maltreatment and painful loss (Cohen et al., 2006; Deblinger & Heflin, 1996). It is an approach to help children, adolescents, and their caregivers overcome trauma-related difficulties. It is planned to reduce negative emotional and behavioral issues following CSA, domestic violence, traumatic loss, and other traumatic events for ages 3 to 18 and parents or caregivers who did not participate in the abuse (Child Bureau-CB, 2012).

Based on theories of learning and cognitive, treatment in TF-CBT focuses on distorted beliefs and attributions related to abuse and provide a encouraging environment in which children are supported to reveal their painful experience. Apart from helping victim, it also guides parents or caregivers to manage successfully with their own emotional pain and enhance skills that help their children (CB, 2012). Undoubtedly, parents are the first helping hand in child's recovery process; therefore this therapy focuses on individual sessions for children and parents with equal amounts of time for both. The parent module addresses on parenting, stress and behavior management and communication skills. As a result, parents are better able to deal with their own emotional distress related with the child's trauma, while also supporting their children more successfully (CB, 2012).

TF-CBT integrates different established treatment approaches and combines elements drawn from (CB, 2012):

• **Cognitive therapy**, which aims to change behavior by addressing a person's thoughts or perceptions, particularly whose thinking patterns create distorted or unhelpful views.

• **Behavioral therapy**, which focuses on modifying habitual responses (e.g., anxiety, anger, fear) to familiar situations or stimuli.

• **Family therapy**, which evaluates patterns of interactions among family members to recognize and alleviate problems.

Protocol Components: Components of the TF-CBT protocol can be summarized by the word 'PRACTICE' (CB, 2012):

- P - Psychoeducation and parenting skills—Discussion and education about child abuse in general and the typical emotional and behavioral reactions to sexual abuse; training for parents in child behavior management strategies and effective communication
- R - Relaxation techniques—Teaching relaxation methods, such as focused breathing, progressive muscle relaxation, and visual imagery
- A - Affective expression and regulation—Helping the child and parent manage their emotional reactions to reminders of the abuse, improve their ability to identify and express emotions, and participate in self-soothing activities
- C - Cognitive coping and processing—Helping the child and parent understand the connection between thoughts, feelings, and behaviors; exploring and correcting of inaccurate attributions related to everyday events
- T - Trauma narrative and processing—Gradual exposure exercises, including verbal, written, or symbolic recounting of abusive events, and processing of inaccurate and/or unhelpful thoughts about the abuse
- I - In vivo exposure—Gradual exposure to trauma reminders in the child's environment (for example, basement, darkness, school), so the child learns to control his or her own emotional reactions
- C - Conjoint parent/child sessions—Family work to enhance communication and create opportunities for therapeutic discussion regarding the abuse and for the child to share his/her trauma narrative
- E - Enhancing personal safety and future growth—Education and training on personal safety skills, interpersonal relationships, and healthy sexuality and encouragement in the use of new skills in managing future stressors and trauma reminders

Many empirical investigations have been conducted evaluating the impact of TF-CBT and they found that it is very useful in reducing symptoms of PTSD as well as symptoms of depression and behavioral difficulties in children who have experienced sexual abuse and other traumas. It is helpful not only for children; in fact research also demonstrates a positive treatment response for parents (Cohen et al., 2000; Deblinger et al., 1996). They often report reductions in depression, emotional distress associated with the child's trauma and an enhanced ability to support their children (Deblinger et al., 2001; Cohen et al., 2004).

Conclusion: In the end, it can be said that situation is very horrifying and the incidence of CSA is increasing day by day, therefore it is the need of the time to think about prevention too, especially for school victims. As it appears that mostly children either do not discuss or delay discussing, prevention efforts must focus on public education of all- girls, boys, teenagers, adults, parents, caretakers to be alert for any possibility of ongoing victimization. For children and early adolescents under investigation, who are ready and able to talk, there is an effective treatment approach and proved successful therapy is TF-CBT. It is helpful for child-victim and their family who have experienced trauma related to sexual harassment, domestic violence or any other, as it addresses both.

Despite its' success rate, many psychologists are unfamiliar of its benefits; and children and parents are deprived of such treatment who are in need. Further, it is also a possibility that there may not be enough trained TF-CBT therapists in many communities of the world. Professionals can be motivated to get required training and compete the increasing demand to implement the TF-CBT model. Along with increased awareness and adequate trained therapist, positive results can be achieved in helping children to release their trauma and cope-up emotional and behavioral issues following sexual harassment and other childhood traumas (CB, 2012).

Hence, to recover the mental health of the sexually abused children, the role of clinical psychologist is not limited to providing therapies only, the services includes counseling of the victim as well as family members. They can assess various dimensions of personality and other psychology variable and provide appropriate guidance accordingly for future.

Note: Information about training for agency providers in TF-CBT is available at the National Child Traumatic Stress Network website (http://www.nctsn.org), and a web-based training program that offers continuing education credits is at the Medical University of South Carolina website (musc.edu/tfcbt).

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