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Child sexual abuse: intervention strategy from the prevention models

Review Article

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SUMMARY

Child Sexual abuse is a global problem, experienced in all societies; it is difficult to document since it usually occurs in a private environment. Many children in Colombia are affected by this serious problem, either within their family nucleus or outside it. According to scientific evidence, women have between 1.5 and 4 times more risk of child sexual abuse than men, and it has been identified that the age of onset of abuse is mostly between 8 and 12 years, with a second peak between 6 and 7 years. The prevention of child sexual abuse is complex, challenging and very necessary, since sexual abuse of children and young

people represents a widespread problem throughout the world. Efforts to prevent child sexual abuse can be directed to different target groups, such as possible offenders, children, caregivers or the community. In this article we review the existing models and preventive interventions in order to offer a vision about the current and future possibilities in this matter.
Keywords: child sexual abuse, prevention, pedophilia.

EPIDEMIOLOGY

Child Sexual Abuse (ASI) is a widespread global problem. The main epidemiological prevalence studies conducted in many countries since the 1990s reveal that ASI rates have not decreased [1]. Specifically, the ASI universal prevalence estimates vary between 8 and 31% for girls and between 3 and 17% for boys. Individuals who suffer abuse as children often become vulnerable to other forms of trauma, including physical, emotional and mental health disorders. ASI survivors suffer long-term difficulties with interpersonal relationships, including higher divorce rates, and are at greater risk of limited educational attainment, unemployment and lower earning potential in adulthood. They are also more likely to report poorer physical health and more frequently use health services associated with high-risk behaviors such as tobacco use and alcohol abuse.

This suggests the comorbidity of child abuse and domestic violence with mental disorders. In a study conducted in 2003 aimed at the Caribbean population (Halcón et al., 2003), 34.1% of Caribbean children reported having been sexually active before age 16; of these children, 47.9% of women and 31.9% of men identified a family member or someone known as their sexual partner [2]. It is widely recognized that in 75 to 95% of cases the child and the offender live together, are related or at least know each other [1].

In Colombia it is estimated that only 50% of children reveal the existence of ASI; only 15% are reported to the authorities; and only 5% derive in legal proceedings [3]. According to the National Institute of Legal Medicine, the ASI in Colombia is a growing problem since the sexological examination rate for alleged sexual offense has gone from 31.9 per 100,000 inhabitants in the year 2000 to 49.08 per 100,000 in 2011 [3]. During the 2009-2014 sexennium, the National Institute of Forensic Medicine and Forensic Sciences (INMLCF) conducted 127,703 medical examinations for alleged sexual offenses; of these, 84.3% (107,698 cases) correspond to valuations in women and 15.7% (20,005 cases) in men. Sexual abuse in children and adolescents is a scourge that is increasingly expressed in our society; according to the Colombian Family Welfare Institute (ICBF), during 2011 to September 2013, 2,135 cases of commercial sexual exploitation were registered in boys and adolescents, 84.26% in females and 15.7 in male sex [4].

According to the 2015 Forensis, 22,155 legal medical examinations were carried out in the INMLCF for alleged sexual offenses, with a rate of 46 cases per hundred thousand inhabitants and an increase of 1,040 cases with respect to

2014, with women being the most affected, in 85.2%. According to the age distribution, the average age of the victims was 12.45 years (standard deviation, 8.42) and the modal age of 13 years. According to the distribution by sex, the average age of men evaluated was 9.73 years (standard deviation, 6.95) and in women 12.93 years (standard deviation, 8.56). The five-year group most affected is 10 to 14 years old. The alleged aggressor in 88% of the cases (16,813) corresponds to a close person such as a family member, partner or ex-partner, friend, or caregiver of the victim. Housing [4]. The main scenario for the occurrence of this type of violence was housing.

The risk factors for ASI are limited mainly in a context of child abuse and domestic violence, where social isolation of children, poor attachment to parents, alcoholism and consumption of psychoactive substances of parents are important risk factors. The psychological impact of sexual abuse on children depends on the coping strategies of the victim and the degree of blame that the parents and the community have on him or her. At least 80% of the victims suffer negative psychological consequences. Very young children may not understand their severity in the first stages, a situation that is related to the continuing expressions of affection towards the abuser. In the children of school age, feelings of guilt and shame are frequent.

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In general, there are events of school failure and unspecific difficulties of socialization. In girls most commonly anxious-depressive reactions and in children aggressive sexual behaviors arise [3].

DEFINITIONS

Child Sexual Abuse (ASI)

According to the World Health Organization and the International Society for the Prevention of Child Abuse and Neglect (2006) the ASI is defined as "the participation of a child in a sexual activity that he or she does not fully understand, of which he is unable to give informed consent, or for which the child is not prepared according to its development, or that violates the laws or taboos of society".

Children can be sexually abused by adults or other children who, by virtue of their age or stage of development, are in a position of responsibility, trust or power over the victim [1]. The ASI is evidenced by this 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 is designed to meet the needs of the other person [6]. This may include but is not limited to:

- The inducement or coercion of a child to participate in any illegal sexual activity.
- The exploitative use of the child in prostitution or other illegal sexual practices.
- The exploitative use of children in pornographic shows and materials.

Pedophilia

It is considered a psychiatric disease that belongs to the group of paraphilias, among which are exhibitionism, fetishism, froteurism, pedophilia and voyeurism. The International Classification of Diseases (ICD) defines pedophilia as "a sexual preference for children, or for boys and

girls, usually pre-pubescent or in the first stage of puberty" [10].

ASI PREVENTION

World Health Organization (WHO) adopted the public health approach to address the prevention of violence. This approach involves four interrelated steps: (1) identification of the nature and extent of the problem; (2) identification of underlying causes and risk factors; (3) design and test interventions that address the underlying causes and risk factors; and (4) expansion and monitoring of effective interventions through their integration into policies and programs [6]. With regard to step 3 in the ASI, through a systematic analysis of the literature, three categories [1] can be designated, aimed at differentiating the prevention intervention:

a) ASI prevention interventions;
b) Meta-analysis of ASI prevention interventions;
c) Theoretical models on prevention and the child.

The first category consists of specific interventions of primary prevention, or facilitated efforts before any type of ASI has occurred. The second category consists of the different meta-analyzes that review the effects of ASI prevention interventions and the third category includes models and theories on prevention in general and on the child before and after the abuse [1].

It is important to bear in mind that when developing a prevention program, several quality criteria must be considered. Nation et al (2003) listed nine basic principles of effective prevention programs, ranging from comprehensiveness to outcome assessment [5]. See table 1

Table 1. Basic principles for carrying out prevention programs
Integral (multiple interventions and multiple configurations are important to ensure a long-term impact).
Made by well-trained staff.
Various teaching methods.
Sufficient dose (appropriate session lengths, number of sessions, total program duration).
Theory driven (based on theory and past experience).
Positive relationships (providing opportunities to develop strong and positive relationships).
Appropriate time (timed in a child's life to have maximum impact).
Socioculturally relevant.
Evaluation of results.
Acceptance of the participants.
Source: *Müller A, Roder M and Fingerle M. Child sexual abuse prevention goes online: Introducing "Cool and Safe" and its effects.*

PREVENTION INTERVENTIONS OF THE ASI

A variety of studies have documented a range of factors associated with an increased risk of ASI. These include gender (girls), age (between 7 and 12 years), a series of family characteristics (for example, substance abuse, violence) and disability. In spite of this, most of the prevention is organized as primary prevention and, therefore, as an intervention directed at entire populations; an example of this is the One in Five Campaign, launched in 2010 by the Council of Europe to end sexual violence against children. The campaign is aimed at European children, their families and societies in general who wish to equip them with the necessary knowledge and tools to prevent and report sexual violence against children. In addition, the objective is to ensure the implementation of the Council of Europe Convention on the protection of children against sexual exploitation and abuse in all European countries. These interventions are usually focused on offenders and are usually organized as media campaigns, anonymous telephone counseling and possible psychological treatment. However, the three most common target groups for intervention in primary prevention of ASI are: Children, parents and professionals [1].

Preventive interventions aimed at children

The majority of preventive interventions in children are oriented to educational programs focused on personal safety. These programs use school curricula to disseminate knowledge about ASI and personal safety skills to potential victims. Studies have shown that parents in countries such as China, the United States and Australia voluntarily support school-based approaches and that their participation is crucial to the success of child-centered programs. Most programs are delivered within a model of behavioral skills training and based on principles of social learning and skill acquisition through instruction, modeling, testing and feedback [1].

There are big differences in which specific teaching method a specific program uses, the duration and what kind of learning material the program uses. The topics and concepts taught in the programs vary, but the main learning objectives will often be one of the following:

• That children acquire knowledge about ASI concepts such as body ownership, information about the tactile continuum (good / confusing / bad) and the difference between appropriate and inappropriate secrets.

• That children acquire self-protection strategies such as running away, trusting their intuition and saying "no" if they experience something that crosses the boundaries.

• That children acquire knowledge about support systems, where to get advice (anonymous) and what to do (persistent disclosure to a trusted adult) if they experience actual or potential abuse.

Examples of programs that contain these elements are the Program of Prevention of Violence, Intimidation and Abuse of the Canadian Red Cross; the globally used Good Touch Bad Touch; and the American program for the prevention of sexual assault (American Child Assault Prevention Pogram), which is also adapted for other countries, such as the Netherlands. The aforementioned Campaign One in Five (Council of Europe, 2012) includes educational material on the Underwear Rule, a simple guide to help parents explain why others should not touch their child, how to react and where to seek help.

Even so, more knowledge is needed on the best way to structure these interventions didactically. What is the ideal age for children to participate in them, if interventions are incorporated into a broader paradigm of healthy relationship, and how to use parental instruction simultaneously? [1].

As a local experience in Medellin, Colombia, a quasi-experimental study was carried out, with the application of the Prudence Test questionnaire of the Non-Governmental Organization (NGO) Save The Children, in a population of children between 5 and 14 years of educational institutions public. As a conclusion of this study, the program "Strategy Development of Self-Protection Behaviors" of the NGO Save The Children is recommended, as an effective program to improve the knowledge of children about ASI prevention, and considers that it can be broadly executed. in public and private educational institutions [3].

Preventive interventions addressed to parents

Home is a fundamental scenario to teach children to take care of themselves, and the participation of parents in the prevention of abuse has so many obvious advantages that it is worrying that this potential has hardly been used. According to the Plummer (2001) review of 87 programs, only about half of the child-centered interventions have some type of parent component; the most used is the material to take home, tracking material associated with a program at school. Other means are simply factual education of parents about the signs of ASI. However, the participation of parents in the educational process may encounter some obstacles. It has been shown that a large part (50%) of parents plan or discuss the least frightening parts of prevention with their children (for example, not walking with strangers, not receiving gifts). However, parents do not talk about the fact that an abuser may be someone the child knows and has an emotional connection with (a teacher, coach, or family member). A study has shown that this problem could be corrected if parents receive the proper guidance and instruction on how to discuss ASI with their children in the right way. In that order of ideas, it is emphasized that parents are in a unique position to involve

their children in dialogues on topics related to sexuality and, therefore, both help to prevent ASI and take quick measures to treat the trauma and minimize the damage [9].

In sub-Saharan Africa, a program aimed at families called Families Are Important! (FMP); is an evidence-based intervention for parents and caregivers of children ages 9 to 12 that promotes positive parenting practices and effective communication between parents and children on issues related to sex and sexual risk reduction; they are based on authentic narratives contributed by young people with an interactive curriculum that is based on contextually relevant and emotionally convincing scenarios and adapted to the needs of adult low literacy students. FMP places prevention and response to ASI within the context of a holistic program of parenting skills. It is conceived as a valuable component of the integral multisectoral response to ASI [9].

Preventive interventions aimed at professionals

These interventions are directed to different professional groups: Teachers, day care providers and health care personnel. The Kenny study (2004) showed that teachers reported a lack of knowledge about the signs and signals of ASI and the reporting procedures. In addition, a research study from Denmark has shown that many teachers consider that they do not have the necessary educational resources to teach about sexuality and how to avoid being forced to have sex. It could be argued that the lack of compulsory education focused on the prevention of ASI is a big problem, since these professionals often have a very close and continuous contact with children and therefore could play a central role in the prevention and detection.

Interventions directed at the aggressor

In particular, this target group, although it could have a greater impact on the decrease in the presentation of cases, is the most difficult group to intervene, since, despite knowledge of the risk factors for ASI, the majority of the potential aggressors are not identified, or are recognized after committing the abusive act. Usually the campaigns directed to the potential aggressors are based on education and intimidation due to the sanctions or legal consequences that imply the abusive acts with minors. However, in a study carried out in Germany during the period 2014-2017, aimed specifically at young people with sexual preference for the preschool and / or early school children, emphasizes the need to focus on young people from 12 to 18 years old as an objective group for preventive measures, in order to prevent the sexual victimization of children. In this study, in the first year a total of 49 young people got in touch with the project; the majority (n = 41) of them did so after a campaign was launched in November

2014 after a press conference. More than half of these young people were diagnosed and 21 young people were included in the project. The vast majority (82.5%) of the young people who had contacted the project had already shown sexually abusive behavior against children. In most cases, contact with the project was initiated by their legal guardians or adults with the right to custody. As the media campaign continued, more young people contacted the project according to their own motivation without being presented by their parents or legal guardians. A central finding of this study was that the group of young people from 12 to 18 years of age with sexual preference for pre-school and pubertal children exists as an objective group for preventive measures. It was also shown that sexual preference can be evaluated during adolescence through the investigation of masturbatory fantasies. However, there are also some limitations for the present study, since most of the diagnostic data was based only on self-reports and the sample size is relatively small, for which important statistical analyzes were not performed, and the findings can not be generalized [7].

Another study also conducted in Germany in 2009, known as the Berlin Prevention Project Dunkelfeld (PPD), aimed to prevent ASI by targeting men who feared sexual abuse of children, and who sought help without being forced to do that; they showed that these men with pedophile sexual preference could be reached through media campaigns, if they are not exposed to the moral evaluation regarding their sexual preference. Once they gain confidence and comply with the treatment, they can learn to permanently exercise self-control over their impulses. Obtaining this capacity would be the most effective means of preventing ASI. This confidence is, of course, reinforced by favorable German legislation on confidentiality, which does not allow therapists to report crimes committed or planned [8].

What motivates sexual abusers?: A study of 63 men who admitted and / or were convicted of sexual contact crimes against children in the United Kingdom and the United States, demonstrated during the semi-structured interviews that the subjects identified as central the formative life experiences for the development of their motivations to sexual abuse. Sexual interest in children, although common, was not the only motivational factor that influenced behavior; other key factors include obtaining personal affirmation and a desire for power and control. There seems to be an association between the type of formative life experience described and the specific motivations of offenders to facilitate sexual abuse [11]. Likewise, it is important to highlight the relationship that exists in the fact that abused children can become abusers, for which it is necessary to implement prevention strategies not only in children at risk, but also to consider the intervention aimed at abusers and / or potential abusers.

META-ANALYSIS OF ASI PREVENTION INTERVENTIONS

The predominant conclusion of these reviews is that most interventions are successful in imparting knowledge about sexual abuse to children, while documentation of the gains from self-protective skills is weaker but still positive. The investigations that have been carried out on school ASI prevention programs have been done with preschool and school children; generally the interventions are based on an educational program where they perform activities such as role plays, films and discussions. According to the Cochrane review, most studies report significant improvements in measures of knowledge and protective behaviors in simulated risk situations. In studies that evaluated behavioral changes, it was found that a higher proportion of children in the intervention groups showed safer behaviors [3]. One of the last meta-analyzes was conducted by Zwi and colleagues (2008) that included 15 randomized clinical trials (RCTs) or quasi-RCTs. These studies were analyzed in four outcomes: protective behaviors, knowledge based on questionnaires, knowledge based on vignettes, and disclosure of abuse. Significant improvements were found in both the measures based on the questionnaire and in the vignettes and protective behaviors in simulated risk situations among children who had received school programs [1].

Could prevention programs cause harm?

Some researchers have raised the question of whether prevention programs could cause harm, either immediately or in the long term when the recipients of the programs are adults. The concern with children is that the introduction of ASI-related topics could make them fear adults. These negative effects are rarely measured in a standardized manner and tend mainly to be based on the observations of the parents or the teacher. Tall and Edelaar demonstrated (1997) that some older children developed feelings of discomfort with nonsexual touch after participating in an intervention. In conclusion, the evidence about possible short-term or long-term damages is mixed, and the effects reported are few, of a slight nature and of short duration. However, ethical considerations regarding the potentially negative effects of prevention programs are important and an appeal could be made for all future evaluation studies to include a systematic examination not only of the positive effects but also of the negative effects of prevention programs; these issues should be disseminated carefully and consistently and respectfully with the development of the child.

COMPLEXITY OF THE PREVENTION OF SEXUAL ABUSE

Smallbone and colleagues (2008) have documented that up to 95% of offenders knew their victim before abuse and 47% were related or lived with the child. As a result, the child has often established emotional and loyal ties with the offender, which in many cases will compromise their ability to identify and exercise self-protection against sexual abuse that they may have learned in an educational program. This relational component makes sexual abuse very complex for any child (or adult); Wurtele (2009) has pointed out that only some of the existing interventions are broad enough to support real preventive actions from the child and directed towards the primary caregiver. Renk and colleagues (2002) also question whether young children are mature enough to understand the concept of ASI and claim that the use of child-centered interventions is placing a burden on children's shoulders, of which they are not responsible. Instead, they propose that efforts should be directed mainly to the really responsible: the adults. By emphasizing the responsibility of adults they are pointing out adults who protect and help children avoid abuse, as well as potential criminals. It is also described in the literature the position that advocates a greater dissemination of interventions to all identified target groups, but these measures are always preceded by the lack of economic resources.

THEORETICAL MODELS AND PREVENTION OF ASI

The models about the child focus mainly on the child after the abuse and on the psychological symptoms. These theoretical models are interesting because they can serve as a theoretical basis for the development of specific interventions. To create a coherent understanding of how the ASI prevention area could be structured, an introduction to these models is necessary.

General models of prevention

Several theoretical and conceptual frameworks structure preventive health services in general. Among them, the public health model and the ecological system model of Bronfenbrenner (1977) seem to provide the basis, often in combination, for several ASI prevention efforts. The public health model is a broad concept, applied by Rosenberg and Fenley (1991), to the prevention of ASI. This model distinguishes three types of interventions. Primary interventions are offered to all and include support and education before abuses occur. Secondary interventions are targeted at families in need and consist of additional support to alleviate identified problems and prevent escalation. Tertiary interventions include legal care and protection services and are implemented to help keep children safe and reduce the after-effects of symptoms

when abuse has occurred. The public health model is the template used to structure preventive efforts in many countries of the world. In the ecological system model of Bronfenbrenner (1977), risk factors and interventions can be conceptualized as part of the microsystem (for example, towards the child, the parents), the mesosystem (for example, towards parents, teachers) and the exosystem and / or macrosystem (for example, towards criminals). A common feature of these two models is that they share the understanding that ASI will be eradicated only if faced at multiple levels.

Models about the child and sexual abuse

Research on children and sexual abuse focuses mainly on the symptoms that the child develops as a response after abuse and which protective factors can prevent or explain the variability within these symptoms. Finkelhor (1988) has contributed with a framework called the Traumagenic Dynamics Model. It proposes that abuse involves four types of key experiences: traumatic sexualization, impotence, stigmatization and betrayal, which alter the child's cognitive and / or emotional orientation towards the world and distort the child's self-concept and affective capacities. Spaccarelli (1994) describes a transactional model that conceptualizes sexual abuse as a series of stressors (for example, abuse events, events related to abuse and events related to disclosure), each of which increases the risk of maladaptive outcomes. Other current models of the consequences for the sexually abused child are based on the theory of development (Cole & Putnam, 1992), the theory of attachment (Alexander, 1992) and various models of post-traumatic stress disorder (Gospodarevskaya, 2013; Foy, 1993). One of the latest attempts to implement integrative models on the consequences of sexual abuse for children is the diagnosis of a traumatic developmental disorder for interpersonal childhood trauma proposed for the Diagnostic and Statistical Manual of Mental Disorders, 5th edition. Models on the traumatized child are used to study the generation and mediation of ASI's long-term impacts and play a role in structuring secondary and tertiary ASI prevention strategies.

FUTURE IN PREVENTION

Most prevention programs, regardless of the target audience, are usually carried out through brochures, education and teaching programs in a face-to-face context. Wurtele (2009) argued that modern means allow new forms of prevention programs and should be used to deliver prevention programs to target groups. A comparable statement was recently presented by Collin V, Daigneault, and H Ebert (2013). The authors suggested using websites or interactive online games for the prevention of sexual abuse [5].

Kenny (2007) was one of the first researchers to develop a web-based training for master's students and students of education that included information on signs and symptoms of sexual abuse, statistics, consequences of abuse, and reporting procedures. An evaluation showed that the program was effective in improving the knowledge users had about the ASI. Since then, several other programs have been developed that teach professionals about ASI (for example, Darkness to Light, 2014, Hoffmann et al., 2013, Paranel, Thomas and Derrick, 2012). These examples show that information about the ASI can be taught successfully through web-based training. Due to the promising results, it is desirable to expand the development of web-based offers to teach knowledge and improve preventive skills. Proposals must be developed, implemented and evaluated for different target groups (for example, children, professionals, possible offenders). The claim that Internet-based offers for children should be created is supported by findings from other areas of prevention, where it has already been proven that Web-based offers can be delivered successfully to children. For example, Rubin-Vaughan, Pepler, Brown and Craig (2011) were able to demonstrate that an online game can raise awareness about bullying and promote knowledge about friendship and fairness. Palmer et al. (2005) reported a significant knowledge gain in fifth grade students after taking part in an online prevention program called Healthy Hearts 4 Kids [5].

"Cool and Safe" Program: This is a web-based prevention program aimed at children of primary school age. The main goal of "Cool and Safe" is to prevent ASI by teaching knowledge about safe behaviors, appropriate and inappropriate touches, as well as good and bad secrets. Since offenders can be strangers and relatives to the child, and can address them in person or through the Internet, the topic is addressed with respect to three different environments of children's everyday life: 1) interactions with strangers; 2) Internet and 3) interactions with acquaintances or relatives. The program is available on the Internet and can be accessed free of charge at www.coolandsafe.eu (the available languages are German and French). "Cool and Safe" is divided into five thematic units that must be completed in a predesigned order. Unit one contains the subjects bad feelings and good feelings, as well as good and bad secrets. In addition, it is explained that every child has the right to decide, who is allowed to touch him o her. In unit two the subject of the strange danger is discussed. Children learn that they must keep distance from cars and that it is their right to refuse to talk to strangers when they are alone. Security strategies are discussed for ambivalent or risk situations. Unit three focuses on topics that are typical for Internet use such as friend requests on social networks, responses to harassment in chat programs and protection of private information. The issue of sexual abuse of acquaintances and family members is addressed in unit 4. Children are taught that no one has the right to injure or touch them in private parts of their body. In unit five, all training contents are repeated and summarized. The completion of the entire program takes approximately two hours. The

program can be paused at any time and can be continued at a later time. With the help of a user and a password, children can access the training at any time. As the training is designed for elementary school children, the training is read out loud by a tutor figure who guides the children through the training. Children participate in the program through various movie clips, stories, tasks and games and can choose between different behavioral alternatives [5].

In the study conducted by Müller A. et al; It was shown that online programs can be effective in teaching children's knowledge and behavioral intentions for preventing ASI without causing negative side effects. The "Cool and Safe" program is available in German and French at www. Coolandsafe.eu. The program is free for users. This approach to the prevention of sexual abuse makes it easier for children, parents and teachers to access information and gain knowledge about this important topic [5].

CONCLUSIONS

It is proposed as a strategy for the effective prevention of ASI, the joint attack of the different fronts of action according to the target populations that may be the object of intervention. It is clear that prevention interventions are required for children, parents, professionals and potential aggressors. It has been evidenced in the literature that versatile educational campaigns and teaching of measures of self-protection to children, education and teaching to parents, advertising campaigns aimed at the treatment of potential aggressors, training of professionals in contact with risk groups, can show positive results in terms of prevention. In that sense, online programs can be a massive and effective alternative that can reach the different target populations in terms of teaching the knowledge related to ASI prevention without causing negative side effects.

In Colombia, the "Self-Protection Behavior Development Strategy" of the NGO Save The Children, already applied and studied, can be an effective program to improve the knowledge of children about ASI prevention, and it is considered that it can have a broad execution in public and private educational institutions.

Likewise, it is necessary to incorporate public health prevention models into the intervention strategies for the comprehensive management of ASI.

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