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Intra-familial Child Sexual Abuse in Hong Kong: a Descriptive Study of 23 Cases Referred for Psychological Treatment

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Introduction

The present paper presents a retrospective, descriptive study of 23 clinically established intra-familial child sexual abuse cases referred for psychological treatment to the author in her position as clinical psychologist in the Clinical Psychology Unit of the Social Welfare Department of the Hong Kong SAR Government. The paper aims to identify some common characteristics and patterns in victim, abuser and family associated with these clinically established cases. The second part of the study tries to look at the treatment outcome of these cases and how they may be related to victim and family factors.

All 23 cases in this study were genuine intra-familial child sexual abuse cases established by majority of opinion in multidisciplinary case conferences attended by professionals from the law enforcement, medical, social work and psychology disciplines. The victims were all girls under 18 years of age at the time of disclosure. Detailed information on the victims, abusers and abuse was always included in the minutes of the case conferences which were routinely passed to the author in preparation for follow up psychological service. A retrospective survey of the 23 treatment case files provided the data for the description of these clinical cases.

Victim Characteristics

All victims were girls between the ages of 7 and 17 at the time of the disclosure. All were residing with the abusers who were close family members in the care giving position. After the disclosure, all victims were brought to the attention of the Juvenile Court. Care and Protection Orders under the Protection of Children and Juvenile Ordinance were initiated to put them under statutory protection of a social worker with conditions that the family would be followed up for welfare or treatment services. Their details were entered into the Child Protection Registry for record and case checking. Severity of the sexual abuse in these clinical cases ranged from fondling 26% (6/23), to attempted genital penetration 5% (8/23) and genital penetration 26% (6/23), taking the most serious form of abuse in each case. In one case the abuse involved both vaginal and anal penetration, and in another case the recurrent abuse resulted in a 20-week pregnancy in the child.

From Table 1 it could be seen that most intrafamilial child sexual abuse cases have female victims typically in the pubertal age range and the typical sexual abuse history showed a gradual progression or grooming from exposing the child to pornography or adult sexual activity, to fondling and sexual stimulation of the child's breasts and genitalia, and in some serious cases to genital penetration. As reported by the victims, the progression from the abuser showing initial sexual interest in the child to eventual penetrative sexual abuse ranged from a few months to a year. This gradual progression seemed to have varied depending on whether the child had put up verbal or physical resistance and whether the child was ready to talk about the abuse to other adults. The sexual abuse was predominantly recurrent 92% (21/23) and some might have lasted over three to four years 17% (4/23) before the child finally made a disclosure, or before the abuse was accidentally discovered. Most victims reported other forms of child abuse prior to the sexual abuse or co-existing with the sexual abuse:- physical abuse was reported by 10/23 victims; psychological abuse by 9/23 victims; and gross neglect by 5/23 victims. The pattern seemed to be that the abusers would use some form of violence to threaten the victims and to establish their power prior to the onset of the sexual abuse. However, little physical violence was used during the actual sexual molestation. In fact, some victims were so successfully groomed that they believed that they caused the abusers to attack them. This pattern of victim characteristics is similar to those reported in the research literature (Finkelhor, 1986; MacFarlene, 1986).

From Table 2 it could be seen that child victims did not know what to do after being sexually abused. There was always a delay in disclosing, sometimes up to three to four years before the child was old enough or brave enough to reveal the abuse. The most commonly cited reason for not telling was that nobody would believe what they had been forced to go through. During the delay period most victims went through a mental struggle trying to balance the pros and cons of a possible disclosure. Many of them hoped that the abuser would feel sorry for their acts and would stop by themselves. One victim wrote down the sexual abuse details in a diary together with reasons why she would forgive her father each time. However, after her father attempted several genital penetrations she got so frightened that she finally gave the diary to the teacher. Three other victims, with submissive personality, never intended to disclose the secret but were accidentally discovered by other family members. Most of the disclosures were unplanned precipitated by fear of pregnancy or an outburst of anger at the abuser. A few victims were so ignorant about sexual matters, understandably because of their tender age, that they made a disclosure only after attending sex education groups.

Table 1 Demographic and abuse characteristics of the treated children (n=23)

Gender	
Girls	23
Boys	0
Age	
<8 Years	3
8-10 Years	3
11-13 Years	12
14-16 Years	4
17 Years and over	1
Severity of Abuse	
(only the most severe form checked)	
Fondling	6
Digital penetration	3
Attempted genital penetration	6
Genital penetration	8
Duration of Abuse	
<1 Year	10
1-2 Years	9
3-4 Years	4
Frequency of Abuse	
Single	2
Recurrent	21

Table 2 Disclosure Dynamics

Delayed Disclosure	
No delay	0
<1 Year	7
1-2 Years	10
3-4 Years	6
Disclosure made by child to	
teacher	8
friend	5
parent	1
relative	3
neighbour	1
social worker	2
Main reason for not telling earlier	
No one will believe	10
Fear of family breakdown	4
Fear of revenge	6
Shame	3
Main reason for telling	
Fear of pregnancy	7
After receiving sex education	5
Fear sister will be abused	4
Abuser beat child	4

Abuser Characteristics

Not all abusers denied their abusive acts. Of the 23 cases eight abusers (35%) admitted their abuse, were convicted and had received legal penalty. However, admitting the acts did not mean that they admitted their pathology nor took responsibility for it. None of the abusers in this sample made explicit apology to the victim. Most of them excused themselves by claiming that they had succumbed to their sexual impulses because they had no sexual partner or that they were drunk. Some of them were spouse abusers as well and had successfully coerced the non-offending parent in their blaming of the victims. All abusers were extremely resistant to treatment even during or after their jail sentence. Of the 23 abusers four had met the author for assessment interviews, but then only for one or two sessions. A detailed description of their pathology was therefore out of the scope of the present study.

From Table 3 it could be seen that all abusers were adult males living with the victims during the time and period of the abuse. They were given the authority and the chance to spend time alone with the victim and in some cases they were actually the only adult in the family, playing the role of both the father and the mother. In this clinical sample the biological father formed the largest group of child sexual abusers 52% (12/23), with the second largest group being step fathers or mother's partner 31% (7/23).

Table 3 Demographic of Abusers (n=23)

Gender	
Females	0
Males	23
Age	
21-20 Years	2
31-40 Years	8
41-50 Years	9
51-60 Years	4
Marital Status	
Single	3
Married	11
Cohabiting	2
Divorced	6
Widowed	1
Relationship with Victim	
father	12
stepfather	4
mother’s partner	3
uncle	2
adoptive father	1
grandfather	1
Occupation	
Clerical	3
Manual	14
Unemployed	4
Retired	2
Living with Victim at Time of Abuse	
Yes	23
No	0
Prosecution	
Yes	16
No	7
Court Disposal	
Jail sentence	13
Non-custodial sentence	2

Characteristics of Non-offending Parent

All biological non-offending parents, 22 mothers and 11 fathers apart from one who was deceased before the onset of the abuse, claimed that they knew nothing about the abuse before the disclosure. However, some victims 17% (4/23) insisted that they had told their mothers before they told someone outside the family. One victim reported that the mother forced her to take contraceptive each time after abuse, but later told the police that she had not heard of the abuse. The clinical impression of these non-offending parents, whether they be mothers or fathers, gave a consistent pattern that they were handicapped in their parenting and nurturing role due to a host of similar personal or family problems.

Table 4 gives a general picture of the non-offending parents and describes a number of high risk factors both

Table 4 Demographic and Personal Characteristics of Non-offending Parents (n=33)

Gender	
Males	11
Females	22
Age	
31-40 Years	13
41-50 Years	19
51-60 Years	1
Marital Status	
Single	0
Married	6
Divorced	19
Remarried	8
Reason for Inadequacy as Parent	
Divorced and deserted child	15
Divorced and depressed	13
Unemployed	14
Mentally retarded	5
Blind	1
Mentally ill	4
Working night shift	5
Non-Chinese mothers	4
Drug addicts	3
Abused by spouse	6

in the parents themselves and in the family environment before the onset of the sexual abuse. The victims all came from high risk families-of-origin where there were multiple problems in the biological parents and in the family system. There were a considerable number of families with marital discord, parental separation, family violence, mental or physical disability in parents, unemployment and drug abuse, so much so that the child was made vulnerable and exposed to exploitation either by her own parent or other relatives. The physical or psychological absence of one or two parents had greatly undermined the protection and care the child could normally receive from the family.

Treatment Outcome

All 23 victims and the majority of non-offending parents received follow up psychological treatment from the author over periods ranging from six months to three years. They exhibited varying degrees of severity in the 9 traumatic symptom groups described in the literature (Beverly, 1989):- (1) Traumatic sexualization; (2) Betrayal and Loss; (3) Stigmatization; (4) Powerlessness; (5) Self-blame; (6) Destructive Acting Out; (7) Loss of Body Integrity; (8) Signs of Dissociative Disorder; and (9) Signs of Attachment Disorder. Treatment included behavioral therapies for their anxiety and depression symptoms, resolution of their guilty and shameful feelings towards the abuse and more in depth psychotherapy of their distorted sexuality, low self-esteem and lack of trust in relationship. Parental counseling was also given to non-offending parents to give emotional support to victims.

Treatment outcomes were reported by memo to the referring social workers at the time of case termination and were divided roughly into Good Outcome, Average Outcome and Poor Outcome groups according to clinical assessment of the case on various aspects of personal and social functioning. Of the 23 clinical cases, 11 were assessed to show Good Outcome, seven were Average and five were regarded to have Poor Outcome. In order to explore what factors might have contributed to Outcome a non-standardized checklist on 13 victim and family factors was drawn up to assess these cases. Data in the case files describing the victim and her family at the time of case closure were checked and endorsed against the list of 13 factors. The following Table 5 is the findings so obtained.

The above findings could only be looked at as an exploratory exercise. The choice of the 13 factors represented the author's clinical impression of what might have contributed to better therapeutic outcome. Because of the small and uneven sample size, lack of a consistent measure over treatment outcome, non-standardized measure of the contributing factors and examiner bias, the result could not demonstrate that these 13 factors actually have discriminative or predictive validity of the treatment outcome of child sexual abuse cases. Having said that, the result seemed to lend support to some current research findings which had associated certain individual and family variables to treatment outcome. In this clinical sample there were some factors which were endorsed with a much higher percentage in the Good Outcome group than in the Poor Outcome group: (1) the ability of the victim to attribute responsibility to the abuser and to perceive pathology in the abuser; (2) victim has no depression symptoms; (3) has supportive non-offending parents; and (4) has average or above self-esteem.

The trend in (1) lent some support to the findings by McMillen and Zuravan (1997) that attributions of blame and responsibility for child sexual abuse had some correlation with adult adjustment in victims. They separated attribution of the abuse into self-blame, perpetrator-blame and family-blame and reported some correlation between self-blame and poor psychological adjustment. In the present clinical sample, some victims in the Good Outcome group were able to talk about the abuse in wider perspectives and had been able to ask

Table 5 Victim and Family Factor in the 3 Outcome Groups

	Good n=11	Average n=7	Poor n=5
Has supportive non-offending parents	64	29	0
Has no depression symptoms	64	57	0
Attribute responsibility to abusers	64	72	0
Able to perceive pathology in abuser	82	86	40
Has average or above self-esteem	45	43	0
Motivated for treatment	55	86	20
Has not exhibited sexualized behaviour	64	86	40
Has not suffered prolonged abuse (<6 mths)	45	43	20
Has average or above intelligence	45	43	20
No regret about disclosure	55	72	40
Performing average in school	36	29	20
Has average or above social skills	55	72	40
Has returned home at case closure	55	57	40

(all in percentages)

questions about pathology in the abuser. Victims in the Poor Outcome group remained rather rigid in their attribution style and continued to hold self-blame attributions; for example, that they had actively participated in the sexual activity; had failed to avoid the abuse or failed to seek help. Victims in the Good Outcome group were more able to perceive pathology in the abuser despite other good things that they might do to the victims. Victims in the Poor Outcome group, on the other hand, were highly confused by the abusers' apparent kindness and concern, might feel extremely guilty about causing the abuser to be apprehended and punished.

Another factor which received a higher percentage of endorsement in the Good Outcome group when compared to the Poor Outcome group was related to the attitude of the non-offending parent. Many studies had highlighted the important role played by the non-offending parent in the rehabilitation of child sexual abuse (Faller, 1990; Faller, 1993) and some researchers even believed that it was the single most important therapeutic factor. In the present sample, 7/11 of the victims in the Good Outcome group had emotionally supportive non-offending parents who believed in the child's allegation of sexual abuse; but none 0/5 of the non-offending parents in the Poor Outcome group was believing. Non-believing parents in the Poor Outcome group denied and refused to reconcile with the facts of the sexual abuse; they refused to recognize the damage done to their child; they sent counter-therapeutic messages and sometimes prevented or discouraged the child from treatment. The attitude of the non-offending parent was often cited as a determinant of successful adjustment of the abused victims (Conte & Schuerman, 1989; Gil & Johnson, 1993) and gaining their support was undoubtedly a major challenge to the therapist. Other therapeutic factors might include higher functioning in the victims' personality, emotions or temperament in the pre-abuse stage which might have buffered them from severe psychological damage. In the Good Outcome group a greater number of victims were described to have average or above self-esteem, free from depression and free from acting out sexually on other people. Whether they were motivated for treatment was endorsed positively in both the Good Outcome and Average Outcome groups and might mean that those who were motivated for treatment had a greater chance to benefit from it. Endorsement in the other factors did not give a very clear picture of their significance (whether the victim has suffered prolonged abuse; has average or above intelligence; has no regret about disclosure; has been performing well at school; has average or above social skills and whether victim has returned home at case closure).

In sum the typical victim with improvement seemed to be one with emotionally supportive non-offending parents; with a flexible cognitive style to attribute responsibility of the abuse to the abuser and to consider pathology in the abuser rather then in herself; to have maintained stable emotions and to be able to rehabilitate herself on distorted sexualization. Future trend in comprehensive and effective treatment of child sexual abuse case in the local scene will surely require:- (1) focusing intensively on support and therapy for non-offending parents; (2) highly specialized treatment programs for victims, both individual treatment and group treatment; (3) pre-treatment and post-treatment assessment tools which yield reliable and valid measurements of treatment efficacy to augment clinical judgment. Treatment for the abusers remains a challenge. It is important for local expert to consider a mandatory treatment program or a pre-trial diversion program (Cedar Cottage NSW, 1998) where the abusers could receive specialized treatment for their pathology.

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