

CHILD SEXUAL ABUSE IN HONG KONG

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SUMMARY

Child sexual abuse in Hong Kong is a relatively neglected topic. Present article attempts to address 3 related issues – the definition, reporting and recognition. Some of the hotly debated issues are reviewed. Recommendations are suggested to deal with the raised questions.

INTRODUCTION

The apparent rarity of child sexual abuse in local territory is in marked contrast with those reported in the west. In the United Kingdom and United States, the annual incidence have been reported as 0.3 (Mrazek et al, 1983) to 0.7 (NCCAN, 1981) per 1,000 children. The prevalence rate is 12% – 62% for females and 8% – 31% for males (Baker & Duncan, 1985; Peters et al, 1986). These figures are mainly restricted to white Caucasian population. Across ethnic groups, the rate has been reported to be higher among Hispanics (Kercher & McShane, 1984), same among Afro-Americans (Wyatt & Peters, 1986) and lower among Asians and Jews (Russell, 1986).

Little can be said about the prevalence of child sexual abuse among Chinese. Most publications were limited to case studies (Kok, 1984; Li, 1987; Ho & Kwok, 1991; Lau, 1992). Some were retrospective recall in an adult population suffering from mental disturbances (Kok, 1984; Li, 1987). An earlier study by Law (1979) described 183 victims of children molesters over 10-years' period. However, the focus of the article was on the description of offenders. A search of local communities dealing with child abuse revealed only 134 sexual abuse cases in 4-years' time (Ho & Lieh-Mak, 1992). The small number of cases in a 1.26 million population under 15 (Census and Statistic Dept., 1990) is far lower than the western counterparts. However, the rarity of reported cases does not necessarily mean absence of the problem. Experience in the United Kingdom and the United States in the past 15 years have well demonstrated that true prevalence is a function of public awareness and professional attention to the problem (Kercher & McShane, 1984; Finkelhor & Baron, 1986). This article attempts to explore the issue from 3 perspectives: cultural variation of the criteria of child sexual abuse, professional reporting and recognition.

DEFINITION OF CHILD SEXUAL ABUSE

Before tackling the issue of prevalence rate, the problem of what constitute a case have to be addressed. Another thorny issue will be the cultural variation in the definition of child sexual abuse.

Early studies did not specify or only give a global description of what constitute a sexual abuse. One of the frequently quoted definition is given by Schechter and Roberge (1976) and it referred to "... the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, are unable to give informed consent to, and that violate the social taboos of family roles." It leaves too many loopholes for subjective judgement. Recent work tends to operationalize the definition which consists of at least 2 components (Mrazek, 1980). Firstly, what behaviours constitute sexual abuse and, secondly the developmental level of the victim. Wyatt (1985) has demonstrated that by varying the four areas of definition, namely upper age limit for sexual abuse; criteria to define a given sexual experience as abusive; inclusion or exclusion of peer experience; use of different criteria for incidents occurring during adolescence, a 14% difference in prevalence rate was found.

Garbarino (1980) suggested the intention of the perpetrator should be considered in the definition. It would help in discriminating between acts performed for the sexual gratification of the perpetrator or for conveying feelings of affection. While it has a clear relevance in terms of management, in practice, it may be very difficult to judge. The perpetrator may not be willing or able to tell his or her intention. It could be a mixture of both. Neither do we have empirical data to support our inference from behaviour to intention. At times, the judgement could be merely speculation.

The ambiguity in definition partly reflects the difficulties in conceptualizing what is abusive and considered as undesirable. Controversies existed in including non-contact sexual experiences (encounters with exhibitionists, solicitation to engage in sexual activity) as genuine abuse cases. While it is considered a criminal act in legal perspective, recent research suggests that they are not as likely to cause long-term effects compared with fondling or intercourse (Peter et al, 1986). Similarly it is hard to equate incest with peer sexual exploration under the same rubric of sexual abuse. To guard against this heterogeneity, researchers have proposed notions of unwanted (Russell, 1983), coercive (Wyatt, 1985) experiences and imposed age difference between perpetrator and victim (Finkelhor, 1979) in the definition. In similar vein, at what age do we acknowledge the ability of an adolescent to give consent to sexual activity? This is an area in which law, custom and social mores are in transition. No universal rule could be applied.

However, it is counter-productive to adopt an extreme cultural relativism stance in which all judgement of treatment on children are suspended in the name of cultural rights (Korbin, 1991). The nature of child development and the requirement of adult society do essentially impose a core idea of child rearing practices. What is left behind is a grey zone of cultural differences. It has been said that child rearing in Chinese is characterized by over-permissiveness in early childhood (Ho, 1981). Taking this perspective, one may not regard a grandmother sleeping with her young favorite grandson in the same bed as abuse though it may constitute an allegation in another cultural setting. Similar misinterpretation of culturally-specific genital greetings as sexual abuse have been documented (Money et al, 1991). However, the variation of this grey zone, from the author's viewpoint, will not be too great. Furthermore, many sexual abuse behaviour, like the use of young children for sexual gratification by adults, are in fact a far departure from one's cultural continuum of acceptable behaviour.

In short, there exists a core group of behaviours that could be labelled as sexual abuse universally. The cross-cultural variability in child rearing practice and beliefs would probably not the major reason to account for a difference in prevalence. The prevailing attitude towards sex and the degree of social disintegration could have significant explanatory power. While a proper epidemiological study of child sexual abuse in Chinese communities is sorely needed, it would better be served to visualize the "sexual experience" in 2 levels, culturally regarded abusive or acceptable experiences. The empirical data could substantiate what childhood "sexual" experiences are commonly accepted, practised and are not condemnable.

REPORTING

Despite there are guidelines for social workers to handle suspected child sexual abuse cases, unreporting is common. In other child care professionals where no instruction is available, a greater variability in reporting is expected.

The phenomenon is not singular in Hong Kong but in fact wide-spread. Pollak (1989) estimated an average of 36% of child sexual abuse cases were unreported despite mandatory reporting is enforced. Attias's (1985) survey revealed more than half of the psychiatrists chose not to report and similar range was found in physicians (Ladson et al, 1987). Zellman (1990), using a case vignette design, identified 2 factors related to reporting, that was the perceived seriousness and predicted efficacy and benefit of reporting. Besides these two factors, age, gender, experience and the nature of professional training of the worker have been linked up with the failure to report (Pollak & Levy, 1989; Attias & Goodwin, 1985).

The high-frequency of unreporting, common emotional recoil in workers handling cases of child sexual abuse, sex-biased minimization, various self-protective manoeuvres and excuses of not reporting lead one to believe countertransference is a relevant issue in the process of reporting. Pollak (1989) suggested the countertransference could be hidden in many forms, a fear of retaliation from disturbed offender, guilty feelings in violating confidentiality and disruption of family, sympathy evoked because of possible victimization, a collusion that family has caring attitude and will change, anger with intrusion on the professionals' autonomy and indictment of competence.

While it may be impossible and infeasible to insist on a policy of mandatory reporting especially in view of the lack of proven efficacy in treatment and possible harms on assessment and court proceedings, subjective individual judgement is neither desirable. Unreporting and denial of existence could easily give the child victims a sense of untrustworthiness, betrayal, helplessness and possibly repeated abusive experience. Standardization of reporting procedures among child care workers are urgently required. Acute awareness of the countertransference is a necessary combat against mere self-protection. The establishment of community child abuse team(s) for consultation will be helpful in this aspect.

RECOGNITION

Experience have told us a differential diagnosis in mind is a prerequisite to make the diagnosis. Child care professionals must have a high awareness of the possibility of child sexual abuse before he or she could recognize the phenomenon. There are reservations to ask each client about child sexual abuse experience. It may not be desirable to start a therapeutic relationship on a negative note. Besides, the answer to such a screening question may not be reliable (Hauggaard & Reppucci, 1988). An advisable strategy is to pursue the question in a selected group of clients.

Finkelhor & Baron (1986) have summarized a list of high risk factors from retrospective survey. Among them, female, preadolescence, step-father families, parental marital conflict, absence of maternal figure either in form of empoly-

ment outside home or disability, poor relationship with parents were regarded as strong associations. Interestingly, most of these risk factors could be identified in a retrospective survey of child sexual abuse in Hong Kong (Ho & Lieh-Mak, 1992). Among the 24 intra-familial cases studied, 4 mothers had chronic physical illness and other 4 had mental problems required regular psychiatric help. Remarkably, in the same group, 3 fathers were noted to be excessive gambling, alcoholic and mentally retarded. The whole picture fits well with the second and third preconditions of sexual abuse (i.e. the offender must overcome internal inhibition and external obstacles against abusing) proposed by Finkelhor (1984). The relative inconspicuous contribution of step-father in the Hong Kong series could be explained by a relatively low percentage of reconstitute families on the sample. The reverse trend was evident in Wyatt's study (1985) that high proportion of broken family in Afro-Americans had a predominance of step-father and male cousins as perpetrators. Overall, Judging from the available data, these risk factors could serve as a reliable guide in Hong Kong.

Wide range of behavioural disturbances have been described in sex abused victims. Sgroi (1982) listed as many as 20 including overly-complaint behaviour to interpersonal aggression. Similar list was compiled as a guide to identification in Hong Kong (Reconvened working group on Child Abuse, 1992). Most of these symptoms do not have discriminant ability. Neither the diagnosis could solely rely on a cluster of emotional and behavioural disturbances.

Confirmation from the victim is often a powerful pointer towards diagnosis. The problem lies in the possibility of false allegation, frequent retraction of previous statements, absence of language to name sexual parts or experiences and high suggestibility of children. Thoennes (1990) in a survey of legal and mental health professionals found false allegation constituted less than 2% of the cases and mostly found in those with custody or visitation disputes. Recent clinical experiences in the West believed the percentage could be higher than expected. Haugaard (1988) summarized various indicators of the true or false accusation and could serve as a useful guide. It is not helpful to treat any retraction as absolute confirmation or refutation but an additional piece of information in the overall assessment. Discussions with the child, away from adults, with the acknowledgement of their anxieties and difficulties may give clues as to the motivation behind the retraction. Frequent interviewing and suggestive questioning will often inhibit or distort a child's description. Many workers would advocate videotaping of a single interview rather than repeated bombardments by different disciplines and cross-questioning in the court.

Anatomically correct dolls has been widely used to facilitate the child to identify body parts and provide a mechan-

ism to act out scenes which they do not comprehend or have no expressive language (Kendall-Tackett, 1992). Guidelines of the procedure were detailed elsewhere (Boat & Everson, 1986; Jones, 1992). Early studies demonstrated that sexually abused children had aggressive, avoidance, sexually explicit and acting out behaviours with the doll (Jampole & Weber, 1987; White et al, 1986). However, a recent study by Cohn (1991) reported negative findings. The use of anatomically correct doll has been questioned because of their potential sexual suggestibility (Yates, 1988) and has been banned from court proceeding in some states of America. But empirical data does not support such worries (Sivan et al, 1988; Britton & O'Keefe, 1991). The considerable argument is unlikely to end at present stage. Perhaps, it is worthwhile to point out the use of anatomical correct doll is only part of the assessment schedule and their interpretation merits a cautious approach.

Medical examination forms an integral part of the assessment of sexually abused victims. Following the Cleveland controversy, (in short, a British Paediatrician regarded reflex anal dilatation as a hallmark for sex abuse) quite a number or reports have been published on this aspect (Butler-Sloss, 1988, Royal College of Physicians Working Party, 1991; Muram, 1989a, b). However, their role could be very limited. Many cases of alleged victims are expected and found to be normal physically (Claytor et al, 1989). The exact percentage of positive physical finding would depend on the chronicity, type and temporality of abuse incidents with reporting (Krugman, 1989). Perhaps with the exception of acquired gonorrhoea, syphilis and forensic evidence of sperm, there are no pathognomonic signs for sex abuse. Many of the quoted findings like hymenal dilatation greater than 4mm, procto-episiotomy and reflex anal dilatation have been found to have low predictive validity, also evident in normal children or associated with other physical condition (Paradise, 1989). In short, making a diagnosis based solely on a physical sign is rarely justified and particularly dangerous because of the potential devastating social consequences.

Another point worth mentioning is the need to assess siblings or close associates of the victim. Schmitt (1970) estimated 20% of sibs could be the second victim and reports of child abused in ritualistic setting often came into headlines recently. Confirmation by genital abnormalities have also been reported in this group of clients (Muram et al, 1991).

A brief review of these assessment procedures inevitably draw us into a multi-disciplinary approach. There is no infallible guide. A comprehensive assessment of sexual abuse would necessarily require a coherent picture drawn from the statement by the child, their behavioural profiles, medical evidence and relevant family and social background (Robinson, 1991).

DISCUSSION

Though there is no empirical epidemiological data, the author believes child sexual abuse is commoner than we used to think of. Some voluntary agencies have initiated public education programmes. However, a coordinated effort from the child care professionals are lacking. An acute awareness of the possibility and the ability to recognize child sexual abuse is the necessary first step. The risk associated with subsequent assessment and management have to be minimized. Standardization of reporting procedures are urgently required. In view of the potential devastating consequences, a management team with experienced staff is highly desirable. The present situation of appointing staff at a first contact/referral basis in which membership of the team change from case to case could not meet the highly-demanding job. At the very least, it prevents an accumulation of experience. The need of such team would apply to psychiatrists, paediatricians, social workers, police as well as legal professionals.

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