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AN INTERPRETIVE PHENOMENOLOGICAL ANALYSIS OF CHILD SEXUAL ABUSE CASE SERIES: IMPLICATIONS FOR PSYCHOLOGICAL INTERVENTIONS

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ABSTRACT Child sexual abuse (CSA) is a physical, sexual, and psychological maltreatment of a child. Child be it male or female is equally prone for abuse, girls being slightly more vulnerable. Most of the time children are abused by their own family members or a close relative who is having an easy access to the child. Abuse by their own parents is not an exception and is prevalent world- wide. In the present study an attempt has been made to study the aftermath of CSA among children using a case study approach. 5 cases (3 females and 2 males) from a tertiary care centre were recruited. All participants were between 9-18 years with a mean age of 15.4 years and the mean age of the onset of sexual assault was 9.8 years. Analysis has uncovered various common and uncommon themes ranging from various physical, psychological, and behavioural issues to the uncommon themes which include difficulty in disclosure by male victims, female perpetuator, hyper-sexualization and porn addiction, homosexual tendencies and gender confusion, dissociation, and psychosis NOS. The study has further tried to correlate the Finkelhore's model with emerging themes and four traumagenic dynamics—traumatic sexualization, betrayal, stigmatization, and powerlessness—which were identified as the core of the psychological injury inflicted by abuse.

KEYWORDS : Child sexual abuse, common and uncommon themes, link of theory with practice, suggested interventions.

INTRODUCTION

Child Sexual abuse (CSA) is a form of abuse in which a child is used for sexual stimulation generally by a trusted adult or an adolescent [1]. Because of associated myths and social stigma and subsequent humiliation faced by victims; the disclosure even sometimes takes years and under-reporting is high when it happens within the core or extended family. Although CSA is still a marginalised and under researched issue in many countries, now-a-days as the incidence rate is increasing and people are becoming more aware about the problem, the victims and their parents are breaking the silence.

Sexual abuse has immediate as well as long-term effects on the child ranging from emotional and behavioural problems to abnormal sexual behaviour and psychiatric disorders. Studies have established a causal relationship between CSA and certain specific areas of adult psychopathology, including suicidal ideation/attempt, antisocial behaviour, post-traumatic stress disorder (PTSD), anxiety and alcoholism [2]. Post CSA, some gradual/sudden physical and behavioural changes in the child, like bed wetting, hysterical reactions temper tantrums depression, anxiety, withdrawn behaviour, poor academic performance, self-harm, masturbation, precocious sexual behaviour, and regression are also often reported. Hence, CSA is a complex experience which can't be explained exactly either through a diagnosis or a disorder. Rather the meaning attached to this adverse experience by children is the key to assess perceptions, emotions, cognition related to the incident and people, thus, crucial for planning of psychological interventions for recovery and resilience building.

Children are frequently the sole "eyewitness" to CSA, and their experiences are important to understand [3]. Most of the studies are limited to adult's recollection of their memories and, thus, little is known from the perspective of the children. Further adults' memories about their past experiences which may be years old, may get influenced by their emotional maturity and sometimes they repress the important details as a part of coping. In that case, interventions for children based on adults' recollections may not be appropriate. Consequently, it is crucial to understand CSA experiences through the eyes of children to enhance prevention and intervention efforts.

Although a large number of quantitative studies reflect the extent of the short-term and long-term impacts of CSA, somewhere the meaning and cognition of a child's experience is lost. Smith et al[4] argue that a suitable approach for investigating how individuals are making sense of their personal and social world is interpretative phenomenological analysis (IPA) [5,6] IPA has been developed as a distinctive approach to conducting qualitative research in psychology offering a theoretical foundation and a detailed procedural guide. [5].

Smith[7] characterised IPA as having three defining features: it is idiographic, inductive and interrogative. The idiographic nature of IPA means that the participant's "lived experience" is coupled with a subjective and reflective process of interpretation, in which the analyst explicitly enters into the research process [8] . Each participant's interview is systematically analysed and a table of themes individually constructed; only when the researcher has achieved closure, the next analysis begins. Cross-referencing for similarities and differences occurs at the end. The inductive nature of IPA means that unlike quantitative research, it makes no attempt to limit itself by establishing hypotheses at the outset. By adopting a loose rationale, unlikely and unpredicted themes can emerge. Finally, the process is interrogative in that themes and patterns that are elicited do not exist in isolation but are linked to theoretical knowledge of mainstream psychology through critical evaluation and discussion.

MATERIALS AND METHODS:

OBJECTIVES: The present study employed IPA for a series of uncommon CSA cases to outline the specific clinical guidelines for faster recovery. The study aims at exploring some common and uncommon themes emerging out of the narratives regarding victims' feelings at the time of abuse and after the abuse in terms of the kind of physical, psychological, and behavioural consequences they are faced. An attempt has also been made to relate the narratives with existent theory and the psychological management.

APPROACH AND DESIGN: IPA was used to undertake this qualitative research to throw insights into how a child/adolescent perceives and makes sense of this significant personal experience. Psychological, interpretive, and idiographic components were analysed.

PARTICIPANTS: 4 cases (2 females and 2 males) from a psychiatry out patient department (OPD) and 1 female from in-patient department (IPD) of a tertiary care teaching hospital were recruited. All participants were between 9-18 years.

METHOD OF DATA COLLECTION: A detailed face to face Interview (un-structured) was conducted for all the five cases after taking consent of the child/adolescent along with consent of the family members/caregiver/legal guardian. Since all cases were referred to the authors for further psychological treatment, willingness of participants and caregivers was voluntary. Majority of the questions asked were open-ended and provided enough scope for ventilation of the emotions. We considered guided discovery to elicit perception, emotion, cognition, and interpretation of the CSA incident for each sample. The reporting was good in case of all the four cases except the

younger child as rapport building took more time than usual. A lot more probing and play method along with drawing helped in the establishment of rapport with him and also provided valuable information about the case. Family members of the children were also interviewed and they provided valuable information regarding the various consequences faced by these children. A written account was kept for all the narratives and the information given.

RESULTS

The findings showed that the youngest of the cases was a 9-year-old child while the eldest was 18 years. The mean age of the children was 15.4 years and the mean age of the onset of sexual assault was 9.8 years. All of them belonged to middle socio-economic status. The number of episodes ranged from single episode to multiple episodes in all the cases. Three cases were of non-penetrative sexual assault and two (one female and a male child) were penetrative sexual abuse. In all the cases the perpetrator was either a close family member or someone known to the child. All the patients were given structured psychotherapy for the treatment of PTSD symptoms. The trauma focused psychotherapy was given and 5 sessions were provided to all patients which lasted for 40-45 mts. Here are five cases with important narratives shared by victims.

In summary, each case was different from the other because in the first case the perpetrator was the mother which is less commonly reported. In the second case the perpetrator was from within the family which is a very common phenomenon. In the third case, the child was abused by a group of older children at school which was also common. The fourth case was unique because it showed about the vulnerable behaviour of a teen and the high risk of getting trapped by perpetrator, followed by incident of multiple abuse. The fifth case was of a young male adolescent from a dysfunctional family and a history of multiple traumatic events in his life including sexual abuse, which later resulted in dissociation and homosexual orientation. A detailed account of the Uncommon and common themes is given below:

UNCOMMON THEMES

INHIBITIONS IN DISCLOSURE FOR MALE VICTIMS

One important and less highlighted theme is that the disclosure rates of sexual abuse by boys and men are lower than those for girls and women while the abuse rate is almost similar or somewhat higher in male children. Boys may be especially inhibited from disclosing sexual abuse for various reasons that are different from girls. They experience powerful barriers in disclosing their experiences to others due to fear of non-acceptance and blaming attitude. It is evident in their verbatims: *"I would always feel so dirty, helpless, scared, and angry. I was angry at her but mostly myself. I felt it was my fault" (Participant-1). -Self blaming* Many in society will have difficulty in fully acknowledging and accepting the reality of the sexual abuse of males during childhood/adolescence. Further the masculine stereotype does not sanction the expression of feelings of dependency, fear, vulnerability, or helplessness" - feelings that are commonly associated with child sexual abuse. Another important factor is that "boys are more likely than girls to be assaulted by either siblings or other older boys" and are then more likely to experience "confusion about whether the experience is an assault or is typical and appropriate for their gender".

"During the abuse I had a feeling that something was wrong, but I was too little to understand" [Participant 2, 3])- confusion.

They also harbour greater fears about being perceived as the instigator of the abuse by family members where the abuser is a sibling. This fear and confusion regarding disclosure is very well reflected in our case studies and bring into attention the selective disclosure.

FEMALE PERPETRATOR

Another uncommon theme is the presence of female perpetrator. Generally, it is believed that sexual assault is done by a male perpetrator only, for females and males, but assault by a female perpetrator is something which has recently got noticed. In the present study, we are also having a case of a mother who sexually abused her own daughter. This phenomenon is still not highly prevalent and sometimes either go unreported or unacceptable due to its rare existence especially here in India. It has also been observed that the effects on victims of female perpetrated abuse are like those of male perpetrated abuse, and include low self-esteem, anger, emotional and behavioural difficulties [9]. However, the myth related to gender-role expectations of females as non-abusive nurturers can lead to confusion and difficulty in perceiving the behaviour as abusive [10].

HOMOSEXUALITY AND GENDER IDENTITY

Another important and uncommon theme in CSA is related to a homosexual orientation. The sexual abuse of children and adolescents by the same sex perpetrator may lead to a negative attitude towards the gender of the perpetrator and create confusion over gender identity. This theme is evident in case 1 and 5 viewed that both developed homosexual orientation towards the same sex person because of the abuse. Case 5 also developed some confusion regarding acceptance for his own gender identity. In his own verbatims: *"I think I am a gay, and my family is having expectations from me because I am the only son. But I am not attracted towards females and this thing really disturbs me."*

"I feel that there is a snake inside me, and I am the queen of that snake kingdom".

HYPER-SEXUALIZATION AND PORN ADDICTION

Sexual abuse in an impressionable age when the psychosexual development is still in formation, may lead to hypersexuality in both men and women, however, the association is stronger in men who have experienced abuse as children and adolescents. Hypersexual individuals experience sexual urges and behaviours that are difficult to control, causing great distress for the victim. In her own words P (case 4) says: *"Now I have started enjoying it. I was liking it and therefore I went with one more guy to have sex with him."*

The sexual thoughts and actions may be so frequent and intense that it may result in high-risk sexual practices and sometimes may lead to addiction towards watching porn material. This theme of hyper sexualization and porn addiction is strongly evident in the case study 4 where the adolescent girl is involved in risky sexual behaviours and starts enjoying it after some time and become restless and aggressive if family members try to stop her for watching porn material. According to P:"*I can't stop it. I have a strong urge to watch porn material and if I don't, I feel restless and aggressive."* This hypersexuality is sometimes called compulsive sexual behaviour or sex addiction, though we did not assess that.

DISSOCIATION

Dissociation is another less commonly reported theme emerging out of the case studies. Sexually abused children, particularly those abused by a family member, may show high levels of dissociation, a process that produces a disturbance in the normally integrative functions of memory and identity. Many abused children can self-hypnotize themselves, space out, and dissociate themselves from abusive experiences [11]. In the present study victims 4, and 5 were experiencing significant dissociative experiences and were trying to detach themselves from the traumatic memories and the thoughts. According to case 5: *"I remain in that state for 3-4 hours, where I completely turn into a female. I keep on lying down on floor. Many times, remain unconscious for hours."*

Further dissociation may be correlated to the intensity of the trauma or length of time a trauma was endured. For example, individuals who repeatedly experienced CSA may be at a higher risk of developing dissociative disorders than individuals who have experienced an isolated incident of abuse. Both the victims in the present study are cases of repeated victimization.

PSYCHOSIS NOS

It has been observed recently that children who are having a history of CSA (Multiple abuse) are coming up with some strange, bizarre symptoms like irrelevant talk, disorganized behaviour, and some incident of auditory or visual hallucination. The symptoms are not fully syndromal and thus fall into the category of psychosis NOS. These symptoms will improve after trauma narration because in most of the cases children will hide their thoughts and feelings from their family members and friends due to fear of stigma, and judgemental attitude towards children. In the present study both case no. 2 and 4 showed some non-specific psychotic symptoms which further improved with medicines and therapy. According to patient P: *"I hear voices. They ask me to hit myself, to jump from the balcony."*

COMMON THEMES

Apart from the uncommon themes, there are various common themes also which got reflected very well during narratives. Some of them are*: Broken Trust/ Betrayal,* aggerated feelings of anger, guilt and sadness. It is not surprising to see numerous descriptions of broken trust.

Children are naturally trusting of adults, and those who are there in their surroundings as an extended family member or a friend or a caretaker. Perpetuator will get benefit of that trusting relationship and will make the child their target. Once trust is established, the perpetrator slowly initiates sexual acts using desensitization and by creating opportunities for abuse. This theme of broken trust is evident in all the five cases whether it is about a young girl's trust for her mother, or a child's trust on her home servant, a boy's trust on his cousin or a girl-friend's trust on a boyfriend In addition to reflecting on broken trust, participants shared their feelings about their perpetrators. Feelings ranged from love to hate, sadness to anger, and desiring reunification to never wanting to see the person again. Here are some of the excerpts:

"I felt so sad when he was touching me" [Participant 3, 5])-Sadness.
"After the abuse I felt mad. I was angry." [Participant 1, and 5])-Anger
"I was experiencing guilt because I felt very responsible for it. It felt as if I let him in. what would my parents think about me if they will come to know about this" [Participant 4])- Guilt.

The consequences of child sexual abuse are varied and long lasting. Many times, they are not present at the time of incident, but they may occur later as a part of PTSD symptoms and will be further worse in the absence of any psychological or social support provided.

DATAANALYSIS: The five interviews were transcribed and analysed using the guidelines provided by Smith [6] from which tables of themes were generated. The thematic content that emerged indicated deeper meaning attached to the incident by the adolescents. The manual transcripts were coded in considerable detail, with the focus shifting back and forth from the key claims of the participant, to the researcher's interpretation of the meaning of those claims. IPA's hermeneutic stance is one of inquiry and meaning-making methods and so, the authors attempted to make sense of the participant's attempts to make sense of their own experiences, thus creating a double hermeneutic [8,12]. We aimed to understand what a given experience was like (phenomenology) and how someone made sense of it (interpretation).

DATA TRANSCRIPTION: After transcribing the data, the researchers worked closely and intensively with the text, annotating it closely ('coding') for insights into the participants' experience and perspective on their world. We identified recurring patterns of meaning (ideas, thoughts, feelings) throughout the text thus 'themes' were identified. Here, our themes were likely to identify both something that *matters* to the participants (i.e., an object of concern, topic of some import) and also to convey something of the *meaning* of that thing, for the participants.

BALANCE OF DESCRIPTION AND INTERPRETATION: We tried to balance phenomenological description with insightful interpretation, and which anchored these interpretations in the participants' accounts so as to maintain an idiographic focus (so that particular variations are not lost), and to keep a close focus on meaning (rather than say, causal relations). A degree of transparency (contextual detail about the sample, a clear account of process, adequate commentary on the data, key points illustrated by verbatim quotes) was also maintained.

CREDIBILITY: We used triangulation method to establish credibility of data. Data was also collected from caregivers, official medical records, social work records apart from the participants.

The summary of all five cases is presented in Table 1for a comparative view and better insight into the cases. The qualitative analysis of themes is presented in Table 2. Another common theme is the presence of various physical, psychological, and behavioural consequences because of sexual assault. (Table-3)

Table-1 Table showing detailed information about the CSA victims

Sl. No.	Case Description	Abuse Description (Onset age, nature, type, duration)	Abuser description (relationship & place of abuse)	Disclosure description	Lived-in-emotional experiences	Impact of abuse-Victim's report	Impact of abuse-parents/caregivers' report	Psychopathology /Psychiatric diagnosis	Information from other sources	Description of rapport building & therapeutic alliance
1	17 years female, class XI, lower-middle socio-economic status	PA-6 years onward & SA-13 onwards; chronic; 4 years	Biological mother; home	Disclosure was first done in front of father and later during therapy session. Patient looked agitated, anxious, aggressive, and depressed during disclosure.	Feelings of betrayal, self-blame, low self-esteem, socially withdrawn, confusion, feeling of being trapped, life being destroyed, hatred and revenge feelings.	Significant Academic failure, personality changes (shy, inhibited), lack of confidence, low mood, anxiety episodes	Aggression, less communicative, always in sad mood, remains anxious	D & GAD On medication	Information was obtained from father and younger sister	Rapport building was done in the very first session only as patient was very much keen to talk to someone and wanted to share her suppressed feelings and traumatic memories with someone.
2	18 years female, completed class XII, upper middle-class SES	SA= 5 Years, once	Servant, Home	Disclosure was made during the therapy sessions for borderline symptoms, patient was reluctant to talk about it	Hesitation in sharing the incident, looked apathetic and less willing to share the details	Patient report of having not much impact on her now as she was very young at that time and does not even knew whatever happened with her at that time. Having an avoidance approach	Mother was unaware about the abuse	D and BPD, on medication	Could not be attained as mother was not aware about the incident	Rapport building was done within 2 sessions. Patient was comfortable in sharing her emotional and personal issues during therapy

3	9 years, male, class 4th, upper middle-class family	SA=8 Years onwards, chronic, I year	Group of older children, school toilet	Disclosure was done at home in front of his Bua when she was psycho-educating him regarding the CSA through showing a video	Feelings of sadness, self-blame, withdrawn, excessive crying, suicidal ideation and irritable	Aggressive behavior, lack of interest in studies and other playful activities, lack of sleep, refusal to go to school and social withdrawal.	Prefers to stay alone, stopped playing outside and withdrawal from other activities like drawing, music etc. Express his wish to die and agitation	Depression and PTSD	Mother and father	Rapport building was done after 3-4 sessions as child was not willing to share much and had withdrawn behavior. Play material like drawing, puzzles were used to minimize hesitation
4	17 years, female, class 12th, middle class family	SA= 15 years onwards, episodic, multiple times	Older male friends, Outside home	Disclosure was first done in front of mother and then later during therapy sessions.	Feelings of betrayal, fear, self- blame, and a feeling of being trapped, hurting her parents' feelings and breaking their trust	Significant Academic failure, anxiety, self-harm tendencies, psychosis NOS, Hyper-sexualization, porn addiction	Aggressive behavior, high on suicidal ideation and multiple attempts also, watch porn material frequently, make random friends on Facebook, physical fights with siblings	Psychosis NOS, Dissociation	Mother and sisters	Rapport was easily established in 2nd session; patient was open about her traumatic experiences and wanted to talk about the trauma as she felt that she has cheated her parents by getting involved in sexual relationships
5	17 years, male, class 12th, lower middle-class family	SA= 8 Years, single episode, Second episode=14 years, single episode,	Cousin brother, At cousin's place	Disclosure was first done after 2 episodes in front of family members and later during therapy	Frustration and aggression towards family members as they asked him to keep shut his mouth, feelings of revenge and helpless	Significant Academic failure, personality changes (Shy, attraction towards males) low mood, dissociative trance episodes	Poor academic performanc e, aggression	GID, Dissociation	Father	Rapport was easily established during initial session. Patient feels comfortable in sharing his emotional and personal issues during therapy

Abbreviations: PA= Physical abuse; SA=Sexual abuse; D= Depression; GAD= Generalized anxiety disorder; DD= Dissociative disorders; PNOS= Psychosis non-specific origin; PD=Personality disorder; SUA= Substance use addiction; BA= Behavioral addiction, SES= Socio-economic status, BPD= Borderline personality disorder, PTSD= Post traumatic stress disorder, GID=gender identity disorder

Table-2 Table showing details about the therapeutic process and the outcomes

Sl. No.	Intervention description	Target symptoms	Techniques used	Unusual approach in clinical management	Status of involvement of family members	Change in the symptomatology/Clinical picture
1.	Trauma focused psychotherapy	Repetitive thoughts regarding sexual assault, aggression, emotional disturbance, depressive symptoms, poor self- esteem, anxiety	Graded exposure, Correcting cognitive errors, enhancing cognitive skills, breathing exercise, thought replacement	Trauma narration and minimization of intensity of the affect through sharing facts regarding the prevalence of CSA in India as well as in other countries, Accepting the trauma as one dark side of one's life and focusing more on the rest of the other positive aspects, Looking within to explore the hidden talent and mobilization of Synergy	Father and younger sister were involved in therapy and provided emotional and psychological support to the patient	Reduction in aggression, and anxiety symptoms, patient developed better coping skills, change in self -esteem from negative to acceptance of the self, improvement in depressive symptoms and patient started contributing in household chores. (As reported by patient and her family members)
2	Cognitive behavior therapy	Aggression, disturbed social, emotional, and interpersonal relationship, self-injurious behavior, substance abuse	Anger management, s	Correcting dysfunctional thoughts regarding same sexual preference	Mothers' involvement in providing	Improved interpersonal

3	Cognitive behavior Intervention	Withdrawn behavior, suicidal ideation, self-blame, poor self esteem	Graded exposure, Correcting cognitive errors, thought replacement, enhancing coping mechanisms, distraction techniques		Both the parents were supportive	Less aggression, patient started playing with parents and with other children also, reduction in temper tantrums, improvement in academic functioning also as he agreed to go to another school (As reported by mother)
			emotional regulation skills, relaxation techniques, relapse prevention for substance abuse, restructuring negative thought	Correcting dysfunctional thoughts regarding same sexual preference	emotional support and care as patient had neglected parenting, engaging her in some constructive and pleasurable activities to cope with craving for substances	relationship, reduction in self harm, reduction in substance abuse (from cannabis to plain cig.), better mood state as reported by patient as well as mother also.
4	Trauma focused psychotherapy	Repetitive thoughts regarding sexual assault, aggression, emotional disturbance, self-harm tendencies, self- blame, dissociative symptoms	Trauma narration, correcting cognitive errors, thought replacement, enhancing coping mechanisms, distraction techniques and limit setting for phone, Harm reduction for self-harm	Trauma narration and minimization of intensity of the affect through sharing facts regarding the prevalence of CSA in India as well as in other countries, Accepting the trauma as one dark side of one's life and focusing more on the rest of the other positive aspects, Understanding and accepting trance state as an extension of one's own self used as an excuse for justifying self-harm tendencies and escaping further guilt	Mother and sisters are supportive and involved in treatment process through monitoring the patient's mobile use, involving in other constructive activities, taking her out for regular morning walk and helping her in her schoolwork assignments	Improvement in mood state and psychotic symptoms, reduction in self-harm behavior, less use of mobile and watching porn also reduced, frequency of dissociative state reduced significantly. (As reported by patient and her mother)
5	Cognitive behavior Intervention	Repetitive thoughts regarding sexual assault and bullying at school by teachers, aggression, emotional disturbance, poor self-image, dissociative symptoms, Confusion regarding sexual preference and gender identity	Anger management, emotional regulation skills, enhancing coping mechanisms, Thoughts restructuring and accepting oneself and his sexual preference, relaxation techniques	Creating acceptance and understanding regarding gender identity confusion as a part of dissociative state as it mostly occurred during dissociative states. Increased acceptance of biological gender and rejecting the other feminine aspects of oneself as they emerged during a trance state.	Less involvement of the family members in the treatment process as well as lack of emotional and psychological support. Possibility of psychological problems in mother also.	Positive self-image, reduction in anger, reduction in dissociative symptoms, less confusion regarding sexual identity. Feelings of revenge improved, and patient started accepting himself as a competent male. (As reported by patient himself)

Abbreviations: TF-CBT=Trauma focused cognitive behavior therapy, CBT=Cognitive behavior therapy, CSA=Child sexual abuse,

Table-3 Thematic content in terms of various consequences

Physical Consequences	Psychological consequences	Behavioural Consequences
• Sleep disturbance • Eating disorder (binge eating/ not eating properly) • Headache • Stomach ache • Bed wetting. • HIV and other sexually transmitted diseases • Genital injury and intense persistent pain. • Chances of getting pregnant	• Emotional disturbance • Fear, Anxiety • Depression • Anger and hostility • Low self esteem • Suicidal behaviour • Substance abuse • Feelings of guilt, shame • Negative self-concept • Interpersonal problems • Crying easily • Fear of being left alone at home • Poor academic performance • Blaming herself	• Unspecified anger outburst, • Hitting others, • Demanding-ness • Irritation • Self-harm behaviour • Laziness • Unwillingness to go out and play with friends. • Withdrawn behaviour.

DISCUSSION

The present study utilized phenomenological narrative analysis to capture the experiences of 5 participants' interpretive accounts of CSA, which were recorded in the form of verbatims. Trauma narratives along with other feelings were explored to better understand children's perceptions with the intent of developing of sound prevention approaches and counselling interventions.

The phenomenological interpretative analysis uncovered various common and uncommon themes, which illustrate children's journeys from the beginning of their sexual abuse through the disclosure and sharing of their thoughts and feelings, emotions, conflicts, apprehension, anger, guilt, and sexual conflicts experienced by them. The physical, psychological, behavioural and emotional consequences are the common repercussions of the child sexual abuse. Among the physical consequences these children reported of having sleep disturbance, eating disorder (binge eating/ not eating properly), headache, stomach ache and bed wetting. As These children are at risk of HIV and other sexually transmitted diseases that have its own ramifications in adulthood, CSA may lead to genital injury and intense persistent pain. Although not seen in these cases but the unwanted pregnancies have also been found in those cases where abuse was continuous and included penetration. The horrific case of alleged rape of 34 minor girls housed at a state-run shelter home in Bihar's Muzaffarpur district is an example of this where 3 minor girls were found to be pregnant.

The wide range of serious long- and short-term psychological consequences include emotional disturbances in the form of fear, anxiety, depression, anger, hostility and low self-esteem. These children also showed hysterical reactions, suicidal behaviour and substance abuse. The feelings of guilt, shame and negative self-concepts, interpersonal problems and self-destructive behaviours were also reported by them. Crying easily, fear of being left alone at home, withdrawn behaviour, poor academic performance and unwillingness to go out and play with friends was reported by all the children as an aftermath of CSA

There have been significant behavioural changes among these children after the incident occurred. Parent's report of unspecified anger outburst, hitting others, demandingness, irritation and self-harm behaviour. An array of sexualized inappropriate behaviour in the form of over-sexualized behaviour, interest and curiosity about sexual matters and attraction towards same sex person has been reported by the victim. Further the behavioural consequences of sexual abuse are affected by the child's age, development, and severity of abuse, threats and chronicity of act. Child's resilience and relationship to the perpetrator will also affect the overall consequences.

Children suffering from long term or continuous abuse are also on the risk of developing confused sexual identity or the homosexual tendencies. In the second case young girl who was sexually abused by a man in childhood became lesbian. The young boy (case 5) also developed romantic feelings towards male teacher in school. Many children react similarly when they get sexually abused by someone in their childhood. This leads to enormous sexual identity confusion as listed in the long-term effects/aftermath of child sexual abuse by Pinki Virani [13]. In her book "Bitter chocolate" she mentioned that as reported by an NGO for Lesbians in Mumbai, many people will ask "if they have turned lesbians because they were sexually abused in their childhood". This is not to say that all men or women who were sexually abused in their childhood become lesbians or homosexuals but the trauma will certainly affect their choice of sexuality to some extent or will make an impact on their feelings towards opposite sex people. The real choice is taken away from the children and the choice of becoming a "gay" comes from within the darkness of confusion, disguise, guilt, shame and pain. Beitchman, et al. [14] reviewed the long-term effects of child sexual abuse. In their observation "Adult women with a history of child sexual abuse show greater evidence of sexual disturbance or dysfunction, homosexual experiences in adolescence or adulthood, depression and are more likely than non-abused women to be re-victimised." They add, "There may be a small but significantly increased rate of homosexual activity among women who have been sexually abused in childhood."

Further the study also establishes a link between theory and practice. In an attempt to develop a systematic understanding of the outcomes of CSA, Finkelhor and Browne proposed a categorization of the effects of child sexual abuse including four trauma genic dynamics – traumatic sexualization, betrayal, stigmatization, and powerlessness [15]. First it is the motivation of the abuser that includes the abuser's sexuality. In the first case study the girl child was abused by her own mother and was also beaten up brutally. It is very difficult to accept it in Indian society that a female can also be a perpetrator because it denies the central significance of "Male Power" in sexual abuse and a motive to get sexual pleasure from abusing their own child. Women in our society are the carer and protector and it is therefore very impossible to digest that some women can be abusers also. But now it is coming into existence that a significant number of minors are abused by women and it challenges the contemporary image of a female.

We do not know about the sizeable number of women who sexually abuse children in Asian culture but the cases which are available are of women who themselves had been abused in their own childhood. In this case mother was not available for the analysis but in other similar cases as pointed out by Seshadri "women themselves had a history of child sexual abuse or they perceived it a settling power issue within themselves". Women perpetrator emotionally neglect their children and tries to create a blanking out space which is symbolically a hidden desire on the part of the mother not to hurt her own children in the way she was hurt by her own elders. In case of those women who did not have any history of child sexual abuse a close inspection shows that they are the one who are under the influence of powerful, dominant, sexually, physically, and emotionally abusive males [13]. So, although it challenges the view of feminism but no child should get suffered because of denial of reality that a female can also be a perpetrator.

Second factor is the absence of internal inhibitions (moral values of the adult). In all the 5 cases the perpetuator was either a closed family member or someone whom the child trusted. The perpetuator had no morality in his mind while breaking the trust of a child or a family by abusing the child for his/her own sexual gratification. Children in a very young age not able to understand that whatever is happening with them is not a part of play but rather it is a kind of abuse and in the absence of knowledge and awareness the children develop a tendency towards re-victimization. This allows the abuse to go undetected over prolonged period.

The third factor is the absence of external inhibitors (supervision of child by others) like protective family, secure attachment to the primary care giver, good monitoring of the child's whereabouts and confiding relationship for the child's increased chances of abuse [16,17]. This lack of supervision and secured attachment was noted in all the five cases where children did not get any prior knowledge about what sexual abuse is and how to behave in that situation in order to save himself/herself. Later when they realize about the abuse, they develop a kind of self-hatred and blaming attitude. In the third case the young child is having a negative sense of self. He will often criticize himself and will say" I deserve whatever happened with me, it's better if I will die." Child feels agitated and visualize that he is hitting his perpetrator. At the same time, he is having this feeling of powerlessness also.

Last it is the lack of child's own resistance towards the adult which also increases the chances of abuse. Children get threatened by the abuser as happened in the majority of the cases due to which the abuse continues. It is the fear and the stigma which prevent them to disclose the matter in front of anybody. Wiehe also highlighted that the victim is often not mature enough to understand that the sexual activity is abusive or the fact that the abuse often occurs in the context of abuse of authority (e.g. While babysitting, teaching etc.) so they are less likely to report [18]. Earlier research study [19] found that 53% of male respondents compared with 37% of female respondents had never, prior to this study, disclosed their abuse to anyone. Similarly, in another study,[20] it is found that 61% of adult women had told someone as a child compared with 31% of men. More recent research also indicates that men are less likely to disclose child sexual abuse during childhood compared with women and to make fewer and more selective disclosures [21,22].

FROM CONCEPTUALIZATION TO PRACTICE

Understanding and treating victims of CSA is a complex process. Children who were sexually abused will feel traumatized during the most critical period of their lives: when they are going through a formative process of developing identity about self, others, and the world; and when coping and relationship skills are first acquired. Considering its critical importance, intervention should focus on the following issues: the intensity and the severity of the abuse, the meaning attributed to the consequences/symptoms by the child, and the varied feelings towards the perpetrator and other significant figures in the family. The intervention with the child should focus on developing coping skills, gradual exposure to traumatic memories and reminders, and education about child sexual abuse, healthy sexuality, and personal body safety skills training. Many empirical studies have evaluated the efficacy of diverse psychological treatments for child

sexual abuse. Some of the qualitative reviews carried out in this context indicate that the behavioural approach, abuse-specific CBT is considered effective for the treatment of anxiety, depression and behavioural problems in children and adolescents. Apart from this, art therapy and individual supportive therapy are the most effective since they encourage the expression of emotional reactions to the experiences of abuse. More recently, TF-CBT is the key evidence-based intervention approach for the CSA victims.

CONCLUSION

This study shows important findings in terms of revealing some untouched and uncommon aspects/ issues relevant in case of CSA. But few things we need to explore more like the disturbing characteristics of the perpetrators, family dynamics and peculiarity in the mothers or the fathers who themselves abuse their own children. There is something in the family which makes these children more vulnerable to CSA and less open and hesitant in sharing their experiences with others. Probably lack of trust, fear, and doubt that the parents will blame them for whatever happened is leading to devastating consequences. Furthermore stigma, shame and guilt lead the family to hide the matter from society and the trauma sometimes continue if not physically then psychologically.

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