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REVIEW ARTICLE

Child Sexual Abuse in India: Current Issues and Research

David K. Carson · Jennifer M. Foster · Nishi Tripathi

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Abstract Child sexual abuse (CSA) is a serious and widespread problem in India as it is in many parts of the world today. The trauma associated with sexual abuse can contribute to arrested development, as well as a host of psychological and emotional disorders, that some children and adolescents may never overcome. When sexual abuse goes unreported and children are not given the protective and therapeutic assistance they need, they are left to suffer in silence. This article discusses the nature and incidence of the sexual abuse of minors in India and presents an overview of research findings to date. Socio-cultural and familial risk factors involved in CSA are discussed. Common symptoms and disorders associated with sexual abuse are outlined. Finally, some implications for counselors working with children in India who have been sexually abused are highlighted.

Keywords Child sexual abuse · India · Research, prevention · Intervention

Child maltreatment in India is a pervasive problem that often results in immediate negative effects on children, followed by the potential for numerous problems throughout the lifespan (Deb 2006, 2009; Deb and Mukherjee 2009; Kacker and Kumar 2008; Priyabadini 2007). Research has documented that child sexual abuse (CSA) may hinder proper growth and development (Cicchetti and Toth 2006; Foster 2011; Goodman et al. 2010) and place children at risk for a host of mental health disorders, including but not limited to: anxiety, depression, anger, cognitive distortions, posttraumatic stress, dissociation, identity disturbance, affect dysregulation, interpersonal problems, substance abuse, self-mutilation, bulimia, unsafe or dysfunctional sexual behavior, somatization, aggression, suicidality, and personality disorders (Briere and Lanktree 2008; Deb and Mukherjee 2009, 2011; Goodyear-Brown 2011). Hence, the experience of CSA can have a profound influence on a child's functioning (Deb and Mukherjee 2009; Goldfinch 2009; Tomlinson 2008; Priyabadini 2007). Common sequelae for adult survivors of CSA include: mental health problems (e.g., depression, anxiety, substance abuse, posttraumatic stress), relational challenges (e.g., sexual health, intimacy, and increased risk for sexual assault and domestic violence), and spiritual concerns (e.g., shattered assumptions about life, people, and self, as well as changing belief systems, following the trauma) (Chawla 2004; Davidson et al. 2009; Deb and Sen 2005). However, some adult survivors of CSA demonstrate resiliency and posttraumatic growth (Wright et al. 2007). Hence, healing and change are possible.

This paper explores the nature and incidence of child sexual abuse in India and summarizes the research findings to date. Factors that put children, youth and families at risk for sexual abuse are discussed. Challenges for adequately addressing CSA in India are presented as are suggestions for counselors and others in positions of helping.

Definition of Key Terms

Child sexual abuse (CSA) is defined as the misuse of power and authority, combined with force or coercion, which leads to the exploitation of children in situations where adults, or children sufficiently older than the victim to have greater

D. K. Carson (✉)
Graduate Program in Counseling Psychology, Palm Beach Atlantic University, 4700 Millenia Blvd., Suite 100, Orlando, FL, USA
e-mail: david_carson@pba.edu

J. M. Foster
Department of Counselor Education and Counseling Psychology, Western Michigan University, Kalamazoo, MI, USA

N. Tripathi
Department of Psychology, Sam Higginbottom Institute of Agriculture, Technology and Sciences, Allahabad, India

strength and power, seek sexual gratification through those who are developmentally immature, and where, as a result, consent from the victim is a non-concept. Such gratification can involve explicit sexual acts, or may involve invasive and inappropriate actions not directly involving contact (Miller et al. 2007).

Child sexual exploitation can involve the following: possession, manufacture and distribution of child pornography; online enticement of children for sexual acts; child prostitution; child sex tourism; and child sexual molestation.

Trauma is defined as "the realization of one's worst fears, the experiences that every human being would never want to have" (Klempner 2000, p. 77).

Grooming is defined as methods used by perpetrators to earn trust and keep children involved in sexual acts. Common strategies for such manipulation include giving the victim gifts or special treatment or privileges, which is often a confusing experience for the child victim (Lanktree and Briere 2008). Abusers gain access to their child victims and attain their trust through the giving of special attention and time. Perpetrators often trick or deceive the child and others in order to ensure that the abuse is kept secret.

Re-victimization is that which places a person who was sexually abused as a minor at greater risk for further abuse in adulthood. Re-victimization may occur in the form of unwanted sexual contact, physical abuse, and psychological maltreatment.

Sexual Assault is a class of sexual conduct prohibited by the law that includes forcible sex offenses such as rape and sodomy of a perpetrator toward or upon a victim. The victim may be a minor or an adult.

Overview of Child Sexual Abuse in India

Estimated Incidence Rates of Child Sexual Abuse

India has a large child population that is vulnerable to all types of abuse, neglect and exploitation (Chawla 2004; Deb 2005, 2009; Priyabadini 2007). According to Deb (2002, 2009), Deb and Mukherjee (2009), and Iravani (2011), child sexual abuse (CSA) in India has been an age-old and deep-rooted social problem, and child trafficking for commercial sexual abuse has become a serious issue for policy makers. Of the total population in modern day India, about 44.4 % are under 18 years of age (children and adolescents), and one in every two children is deprived in terms of not receiving primary education, adequate nutrition and medical care (National Family Health Survey 2005–2006).

Presently there is a dearth of information about the extent of CSA in India with the exception of a few recent studies. However, there appears to be a gross under-reporting of crimes against children in India (as in the United States and other countries), including various types of child sexual abuse. Thus, there is also a general consensus that the problem of child abuse is much more prevalent than what is commonly understood or acknowledged (Chawla 2004; Deb and Mukherjee 2009).

Researchers in India estimate that between 18 % and 50 % of their country's population may have experienced some type of sexual abuse in their life time (Chatterjee et al. 2006; Chawla 2004; Deb 2006, 2009; Deb and Mukherjee 2009; Deb and Walsh 2012). These statistics may not account for the number of children (1 in 5) who are sexually solicited while using the internet, and the high number of victims who never disclose their sexual abuse from in and outside the family. Children who fail to disclose may be between 30 % and 87 % (Deb 2005, 2009; Deb and Mukherjee 2009, 2011).

There is additional empirical evidence which supports the assertion that incidences of CSA in India are high. In a recent study, Deb and Walsh (2012) found, for example, that of 160 boys and 160 girls who were randomly selected from Grades 8 and 9 in school in the state of Tripura an average of 18 % of the children had experienced sexual abuse in the home environment. Girls reported higher incidences of sexual abuse than boys, whereas boys were more likely to have experienced physical and psychological abuse in the home. Overall social adjustment scores for girls were significantly lower than those for boys.

According to Iravani's (2011) examination of studies of CSA in India based on lengthy interviews with adults, approximately 30 % of men and 40 % of women remember having been sexually molested during childhood, with "molestation" defined as actual genital contact and not just exposure. This researcher noted that about half of these incidences were directly incestuous with family members (although with the knowledge or complicity of other caretakers in at least 80 % of the cases) and the other half occurred with perpetrators outside the immediate or extended family. Other studies examined in this article support these high incidences of CSA. Iravani (2011) concluded that:

> These experiences of seduction are not just pieced together from fragmentary memories, but are remembered in detail, are usually for an extended period of time and have been confirmed by follow-up reliability studies in 83 % of the cases, so they are unlikely to have been fantasies. The seductions occurred at much earlier ages than had been previously assumed, with 81 % occurring before puberty and an astonishing 42 % under age 7 (p. 151).

Socio-Cultural and Family Factors Involved in Child Sexual Abuse in India

The most significant challenges to addressing all types of child abuse and neglect (CAN) in India include overpopulation that

involves poor service delivery for children and families, poverty, illiteracy, abandonment of children, underreporting of CAN, and cultural beliefs and practices pertaining to parental rights and styles. These include parents believing that children are their personal property, and that the rights and choices of children solely belong to the parents (Deb 2009; Deb and Mukherjee 2009). Deb (2005) and Deb and Mukherjee (2009) also note that parents and/or close relatives are the most common perpetrators of CAN, which includes child sexual abuse (Virani 2000). Girl children, who occupy a lower status in the family and society, are particularly vulnerable to CAN, including sexually abusive acts (Chawla 2004; Deb and Mukherjee 2009). Further, girls in India, especially in rural areas, are discriminated against in terms of education, nutrition, and medical care, are more likely to experience infanticide, and are often treated as more of a burden to the family (Deb 2006; India Country Report on Violence against Children 2005). In addition, boy children are typically valued and preferred in Indian families, and boy children often reap the better fruits of what parents have to offer. All of these factors put girl children especially at greater risk for child sexual abuse and exploitation.

Another socio-cultural factor in child sexual abuse is family secrecy. In India the business of the family stays in the family, especially with regard to any actions that are considered inappropriate or taboo (Choudhury 2006). This is because in India there are cultural elements of blame and shame (including in family systems), and families will go to great lengths to protect the reputation of the family in the community (Baradha 2006; Choudhury 2006). It is also not unusual for children to be blamed for their own abuse because the rights and statements of adults tend to trump those of children (Baradha 2006; Priyabadini 2007). Moreover, since the child's identity is rooted in the family's identity and standing in the community, anything that would embarrassment the family or tarnish their good name is kept private – in some cases even from other immediate or extended family members (Patnaik 2007; Priyabadini 2007). This practice of secrecy only serves to protect the sexual perpetrator and allows the cycle of abuse to continue (Baradha 2006; Patnaik 2007). In addition, the parents or caregivers refusal to believe the child victim about the sexual abuse or cover it up further exacerbates the child's distress (i.e., *betrayal trauma*) and prevents her or him from getting therapeutic help when needed (Priyabadini 2007).

According to Kacker and Kumar (2008), traditionally the care and protection of children in India has been the responsibility of families and communities. They may be correct in their observation that a strongly knit patriarchal family system has seldom held the belief that children are individuals with their own rights. These authors note that even though the Constitution of India guarantees many fundamental rights to children, these rights are more needs based than rights based, and the government has the challenging task of implementing constitutional and statutory provisions for children. Hence, "..... with an increasing incidence of child abuse, India needs both legislation and large scale interventions to address this problem" (2008, p. 98). Widespread public education about child sexual abuse and exploitation is also sorely needed, especially in Indian schools and families (Deb and Mukherjee 2009; Priyabadini 2007). The protection of children against all forms of child abuse and exploitation needs to be a chief priority at the local, state and national level, and current laws need to be enforced when children and adolescents become victims of a perpetrator's acts, including perpetrators being prosecuted to the full extent of the law.

Key Studies of Child Sexual Abuse in India

Kacker and Kumar (2008).

The purpose of the Kacker and Kumar (2008) "Study on Child Abuse: India 2007" was to develop a dependable and comprehensive understanding of the phenomenon of child abuse in India ".....with a view to facilitate the formulation of appropriate policies and programs meant to effectively curb and control the problem of child abuse" (p. 98). The specific objectives of the study were to: (1) assess the magnitude and forms of child abuse in India among children ages 5 to 18; (2) study the profile of abused children and also the social and economic circumstances leading to their abuse; (3) facilitate analysis of the existing legal framework to deal with the problem of child abuse in the country; and (4) recommend strategies and program interventions for preventing and addressing issues of child abuse. Child abuse was defined as intended, unintended and perceived maltreatment of the child, whether habitual or not. This study focused on four prominent forms of child abuse, including physical abuse, sexual abuse, emotional abuse; and child neglect. The results for sexual abuse are reported here.

Two states were selected from each of six zones: North, South, East, West, Central and Northeast, as well as the city of Mumbai. These states represented the upper and lower literacy quartiles in each zone. Subsequently, data on crimes and offences against children from the NCRB were examined to see the status of these states in terms of crime and offences against children. Respondents included children (5–18 years), young adults (18–24 years), and stakeholders. There were five specific categories of children: (1) children in a family environment, not attending school; (2) children in schools; (3) working children; (4) street children; and (5) children in institutional care. Fifty children were selected from each of the above five evidence groups. An attempt was made to have equal number of boys and girls in each evidence group. Child friendly tools and techniques were used to create an enabling environment for children to respond with ease and share their experiences about different forms of child abuse. The tools and techniques used included focus group discussions (FGDs) and one-to-one interaction with the children and young adults.

There were several important findings across all forms of abuse: (1) younger children (5–12 years of age) reported higher levels of abuse than the other two age groups across type of abuse suffered and across evidence groups, (2) boys and girls were found to be equally at risk of physical abuse, (3) persons in positions of trust and authority were the major abusers, (4) the majority (70 %) of abused child respondents never reported the matter to anyone, (5) approximately half (53.2 %) of the children reported having faced at least one form of sexual abuse, (6) across the country, 20 % of children faced severe forms of sexual abuse, (7) street children, working children, and children in institutional care reported the highest incidences of sexual assault, and (8) Andhra Pradesh, Assam, Bihar and Delhi reported the highest percentages of sexual abuse among both boys and girls.

We believe, with Kacker and Kumar (2008), that this study has helped put ..... the subject of child abuse on the national agenda and will help to strengthen the understanding of all stakeholders including families, communities, civil society organizations and the state. . . . This understanding must be translated into action, not only by the central government, but by state governments, civil society, families and children themselves. A better understanding of the child rights perspective can create an enabling environment wherein a child is protected from abuse and exploitation (2008, p. 100).

Deb and Mukherjee (2011).

The purpose of this study was to examine the psychological, social and emotional adjustment of sexually abused girls aged 13–18 in Kolkata, West Bengal. The investigators also attempted to understand how these sexually abused girls responded to and perceived the individual and group counseling they had received. One-hundred twenty (120) sexually abused girls housed in either government “Observation Homes” or NGO based “Rehabilitation Homes” were compared with 120 Indian schoolgirls of similar cultural and economic background who reported no incidences of sexual abuse. These shelters are for children in distressed conditions, including trafficked and sexually abused children. Both quantitative and qualitative methods were used to collect information regarding participants’ history of CSA, psychological and emotional symptoms, and background information.

The results indicated that 93 % of the sexually abused girls came from families that were rural, poor, low in educational background, and of a nuclear family structure. Almost three-fourths (73.3 %) of the trafficked sexually abused girls were lured with promises of job prospects as well as marriage and a better life. Other key findings of the study are highlighted as follows.

- Strangers were the perpetrators in the case of more than half of the girls, while about one-third of the girls were sexually abused by their relatives.
- More than half of the sexually abused girls also indicated that they were lured with better future prospects and then sold into brothels. In addition, more than half of the sample were abused three times or more and were forced to work as child sex workers/prostitutes or bar girls/dancers.
- More than half of the abused girls did not have any communication with their families.
- The sexually abused girls performed worse than non-abused girls on psychometric measures of depression, self-esteem, anxiety and despair.
- Sexual abuse was found to be significantly associated with domestic violence in the home, solvent/inhalant use, and the employment status of the mother (i.e., mothers unemployed or not working outside the home).
- The majority of the family members, when they came to know the whereabouts and latest status of their children, wanted to take them back; however, the majority of girls did not want to return to their home environment because of earlier unhappy experiences.
- Out of 120 subjects, only two incidents of sexual abuse were reported to the police where the victims received assistance in terms of security and legal pursuance of the case. The investigators indicated that the poor in India as a general rule do not feel comfortable with law enforcement agencies and/or are scared of the police.
- Although most of the sexually abused girls were examined by doctors and received medical treatment, this did not happen immediately after the sexual abuse. The medical care and supervision were rendered only after the trafficked girls were rescued from the red light areas.
- The majority of the girls reported that they benefitted greatly from counseling. However, not all of the counselors were equally competent in dealing with the trauma the girls had experienced, and the homes in Kolkata did not have adequate numbers of trained counselors to deal with the posttraumatic stress of these sexually abused girls.
- The authors recommended that every rehabilitation and observation home recruit more trained counselors and therapists and train them in dealing with sexually abused traumatized children and youth. In addition, the establishment of vocational and social skill training programs would be beneficial in improving the adjustment capacity of the abused girls.
- According to these investigators there is a strong possibility of the suppression of accurate information with respect to the real extent of sexual abuse in India.

Findings from Other Major Studies of Child Sexual Abuse in India

In a Kolkata-based study, Chatterjee, Chakraborty, Srivastava, and Deb (2006) observed that sexually abused trafficked children often encountered mental, physical and social problems, and that

depression, loneliness and loss of interest were characteristic of nearly every child. Social discrimination and rejection by family members were common experiences of the abused children. HIV/AIDS was found in 14.6 % of the sexually abused children. According to Deb and Sen (2005), since there are an inadequate number of professionals to deliver psychosocial and medical services to sexually abused children, the majority of sexually abused children live with the psychological trauma of the abuse for a life time, affecting their interpersonal relationships, personality, and career development.

In a study of sexually abused girls and their family members in Western Madya Pradesh, Sahay (2010) found that, despite the fact that legal action was taken against the perpetrators of sexual abuse whether in or outside the family, the family members of many of the sexually abused girls forced the victims to keep the behavior of the abuser a secret. Parents and other family members asked the girls to forget the events and in many cases even forgive the offenders for the sake of family honor and family solidarity. Often family members went further in compelling their girls to forfeit the need for counseling and any other medical help even when the girls were suffering from significant mental and emotional symptoms of sexual abuse. According to Sahay, the sexually abused girls found it difficult if not impossible to forgive the abuser or forget the trauma of their sexual abuse. In addition, the paradoxical behavior of the girls' family members became a new source of trauma.

Finally, an investigation of male children in an Observation Home in Delhi, Pagare (2003) revealed that 38.1 % had been sexually abused as indicated by self report and assessment based methods. Clinical examination of the sexually abused boys ($n=72$) indicated that physical signs of abuse were observed in 23.8 %, and behavioral and emotional difficulties in 16.3 % of the sample. The most common perpetrators of sexual abuse were strangers. This relatively low number of symptoms observed in or reported by the boys might indicate that boys mask or repress the pain associated with sexual abuse more effectively than girls, and that part of the reason for this might be because sexually abused boys in India face greater social stigma and embarrassment than girls who have been sexually abused.

Summary: The Current State of Knowledge About Child Sexual Abuse in India

Several tentative conclusions can be made about CSA in India – many of which parallel findings from studies in the United States (see Crossen-Tower 2009; Deb and Mukherjee 2009; Finkelhor 2008). First, empirical research is providing evidence that the incidence rates of CSA in India are much higher than have been typically acknowledged in the general society and even by many family members. Although CSA in families may run somewhere between 18 % and 20 % (possibly a conservative estimate), some recent reports of CSA as a whole in India are estimated at 50 % and sometimes higher, with children on the street, at work, and in institutional care reporting the highest incidences of sexual abuse and assault (Chatterjee, et al. 2006; Chawla 2004; Deb 2006, 2009; Deb and Mukherjee 2009). Second, there may be some variations in CSA across states and regions in India. Although this notion is in need of further empirical support, it does raise a question about whether there are higher risk cities and areas of the country for sexual abuse, and if so, what implications this may have for intervention, education and prevention. Third, girl children and adolescents are targeted much more frequently for sexual abuse and exploitation than boys, although boys too remain vulnerable. Fourth, the clinical consequences and developmental delays often associated with sexual abuse pose a serious threat to the individual well-being of children and youth, as well as families and communities throughout India. Fifth, sexual abuse often goes hand in hand with other forms of abuse in the family (physical, emotional, psychological). Sixth, although sexual exploitation of children in India is highly associated with poverty, sexual abuse in families occurs at all socioeconomic levels of society and across all religious traditions. Seventh, prevention of CSA requires needed changes at the family, community, state, and national level. Children's rights must continually be at the forefront of local, state, and national government laws and priorities. Further, there needs to be a national campaign to educate children and youth, as well as parents and other caregivers, about the nature and prevention of sexual abuse and other forms of abuse and neglect. In addition, law enforcement and the court system must work together in enforcing laws that protect children from all forms of abuse and punish perpetrators to the maximum extent of the law. This will send a persistent and powerful message throughout Indian society. Eighth, government organizations and NGO's need to play a larger role in intervention services and the prevention of CSA in India. Ninth, counseling for child victims is extremely important and has been shown to be effective in helping children, youth and their families after sexual abuse has been reported or discovered. Finally, there must be much greater attention regarding the secrecy of CSA in families throughout India, and these family secrets must be made taboo by all sectors of society for the protection and welfare of children and adolescents. It is also important to remember that CSA in the Indian context is likely to be different than in other countries of the world due to a number of factors that include poverty, crowded and unhygienic living conditions in many families, extended family living arrangements, multiple caregiving of children, children living on the street and in some areas the lack of enforcement of child labor laws, a lack of recreational facilities and opportunities for families, and a host of other factors.

Challenges for Counselors in the Treatment Process

There are two major goals in working with child victims of sexual abuse (Anderson and Hiersteiner 2008; Briere and Scott 2006). First is to help the victim express and work through her/his emotions regarding the abuse, including about and toward the perpetrator, in the here and now. This is a long term process for many victims of CSA. The second goal is to help the child or adolescent move from a sense of victim to survivor to victor; i.e., the Resilient Self – characteristics that include: independence, connectedness, creativity, insight, play and humor, morality, self-regulation, initiative, and spirituality.

For victims of CSA, processing and working through their sexual abuse is often an extremely difficult task (Oz 2005). Common challenges that counselors need to prepare for when the counseling process begins are: (a) increased symptomatology for some period of time in treatment, (b) non-linear, slowed or halted progress, and (c) drop out. Counselors are encouraged to confront these challenges through providing adequate levels of challenge and support for the child and the child's family. Moreover, exposure to traumatic memories and content before the child is ready can be damaging to the child's well-being and therapeutic relationship. The concept of the therapeutic window helps avoid both retraumatization and failure to move towards recovery (Briere and Scott 2006). Therefore, when implementing any therapy with sexually abused children, therapists must determine whether the child is ready for trauma treatment or initially needs to be stabilized and made to feel safe following the abuse (and establish a *safe place* they can learn to go to in their thoughts and feelings).

It is important to remember that children often experience some ambivalence between having a desire to protect the secret of CSA as well as unburden their story to a safe and caring person (Crenshaw and Hardy 2007). In order to begin the unburdening process, children must feel secure, supported, and believed about the abuse. Therapy begins with establishing a therapeutic relationship between the child and counselor. Developing a relationship with children who have experienced extreme trauma, including sexual abuse, has been described as "a harrowing feat" (Crenshaw and Hardy 2007) and the counselor's role as one of an "empathetic witness of injustice" (Kaminer 2006, p. 488). Due to the nature of CSA, trust is a central issue. Many abused children tend to respond to others with either blind trust (that does not distinguish between safe and unsafe people) or an inability to trust anyone in any circumstance. Other victims of CSA fear that the counselor will betray their trust and they will be harmed again. An important component to the healing process is for children to learn how to trust others again, a process which begins in the counseling relationship and continues over time (Kaminer 2006). Failure to establish a safe, trusting relationship often leads to the failure of any method or technique employed since the efficacy of counseling is directly related to the therapeutic relationship (Gil 2006).

During the trauma narrative process (the child telling or sharing her/his abuse story), the counselor works closely with the child to help them recall, write about, and process their experience (Foster 2011). Children may initially fear recalling their trauma, believing that the remembering will lead to an unbearable reliving of the events. It is important to help the child distinguish between a memory (past events that are gone and not operating in the present) and the here-and-now and to make sure that the child understands this difference. When fears are expressed, it is helpful for the counselor to explain the rationale of the trauma narrative and what the counselor will do if symptoms arise. It is also important to assure the child that they will work at his/her own pace. At this stage, it is vital for the counselor to be an empathetic, nonjudgmental listener as the child becomes ready to tell his or her story (Kaminer 2006). When children share trauma in the form of the narrative, they are actively involved in the process of moving towards closure.

Closure is defined as the survivor becoming free from habitually thinking about the trauma in such a way that causes distress (Klempner 2000). During this process, children seek to understand their trauma and its impact, which may involve addressing why the trauma happened to them (Tuval-Mashiach, et al. 2004) and understand that in no way is anything their fault. It also involves exploration of the ways in which the experience has changed their view of self, others, and the world. Children (when they are developmentally capable) can explore and discover personal meanings within the traumatic experience. The act of making meaning out of one's trauma (e.g., "that which does not kill me makes me stronger") often helps children attain some level of closure (Briere and Lanktree 2008). Integrating the traumatic experience into one's life is the last portion of trauma recovery. For children, the ability to adapt and move forward often lies in their courage to face their pain and process the emotional impact of the abuse on them, while at the same time learning new ways of coping with life. It is important to remember that children need ample time to successfully complete treatment.

Finally, involvement of supportive parents or caregivers in treatment is recommended for children who have experienced sexual abuse (Lanktree and Briere 2008). This improves treatment outcomes for children (Cohen and Mannarino 2008) and helps promote positive family relationships (McPherson et al. 2012). One of the major goals is to increase parents' and caregivers' ability to talk openly about the trauma with their child (Cohen and Mannarino 2008). Many adults have difficulty talking about sexual abuse, which often leaves children feeling isolated and alone. Adults may also fear that openly talking about the abuse will re-traumatize the child, and therefore they avoid the topic altogether (Ogawa 2004). Children are aware of whether or not the abuse can be talked about

openly with their parents, and they too may avoid the topic out of fear that it will make their parents sad or angry. However, bringing the trauma out in the open and helping the child express her/his thoughts and deep inner feelings helps "de-mystify" the experience of CSA for them and emotionally work through the trauma. Children also need to know what to expect in sessions, what their role is and the role of the counselor. Parents and caregivers should also be informed of the potential increases in symptoms and decline in functioning for some period during treatment with some children and how to respond to their child during these sensitive periods.

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