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Case Series

The mental health and legal perspective of child sexual abuse: a case series

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ABSTRACT

Child sexual abuse (CSA) is not only a health concern, but also remains a socially neglected issue in every country. It has significant psychological and social issues that are often underreported. The immediate psychological effects have a negative impact on the child's mental health and social development, creating long-term physical and mental health consequences. CSA victims are always at risk of anxiety, adjustment issues, dissociation, depression, dysfunctional sexual behaviors, somatization, and suicidality. The long-term mental health morbidities and sociocultural issues are frequently experienced by the adult survivors of CSA.

Keywords: Child sexual abuse, Mental health morbidities, Legal perspective, POCSO act

INTRODUCTION

Child sexual abuse (CSA) is a significant psychological and physical issue that is often underreported. Ultimately, it contributes to the delayed development of emotional well-being and the subsequent mental health morbidity in adulthood. The immediate psychological effects have a substantial detrimental impact on the child's development and should be addressed as soon as possible to prevent long-term physical and mental health impacts.[1] The CSA has devastating consequences, such as the disruption of the child's emotions and behaviors, as well as the substantial interference with psychosocial development and positive mental health.[2] The CSA is not only a health concern, but it remains a socially neglected issue in every country. CSA is defined as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society.[3] CSA may result from physical contact (e.g., vaginal, oral, or anal intercourse, touching, or both), exposure to pornography, adult exhibition, or solicitation for sexual favors. Epidemiological studies estimate that CSA in minors ranges from 5% to 18%, depending on geographical location and culture. Approximately 85% of perpetrators are male and average 30-40 years old.[2,4] The perpetrators of the vast majority of incidents involving females are acquaintances, relatives, or individuals who are known to the child's family, and the child's residence, educational institution, or recreational facilities are frequently the sites of the incident.[5]

Numerous studies show that children aged six to twelve are most at risk of maltreatment. Over three times as many girls are mistreated as males. However, other studies have revealed that boys typically refuse to admit being abused due to masculinity and fear of stigma and labeling.[5] Numerous studies have shown that CSA victims are at risk of anxiety, depression, PTSD, adjustment issues, dissociation, interpersonal problems, dysfunctional sexual behaviors, somatization, aggression, suicidality, and personality disorders.[1,6] Mental health morbidities, linked obstacles (sexual health and

intimacy), and socio-cultural issues (spiritual concerns, uncertain future repercussions, altering belief system regarding opposite sex) are frequently experienced by adult survivors of CSA.[7]

The POCSO Act has been misused in a variety of contexts over the past decade, including personal grudges, personal or monetary gain, and trial failure due to socio-cultural contexts and societal stigma. This has resulted in the evolution of mental health symptoms and a barrier to psychological trauma counseling for child victims of CSA.

This article will analyze and investigate the challenges of CSA in the Indian context. After obtaining consent from the legal guardians (parents), the diagnostic and statistical manual of mental disorders: DSM-58 criteria were administered for the diagnosis. This case series predicts the emergence of mental and behavioral symptoms that vary in clinical manifestation and duration after CSA and the immediate legal consequences after the police case is reported in all cases under the POCSO Act. Given the extraordinary sensitivity of the instances, ICMR child safety and welfare guidelines were followed in each case.

CASE SERIES

Case 1

A 14-year-old female child reported to the hospital with frequent loss of consciousness, hyperventilation, suicidal ideation, chest pain, childish behavior, sudden academic decline, and extreme apprehension of males. Over the past two months, her health had deteriorated. During interrogation, her mother disclosed that the child was alone in the house two months ago when a male stranger in a mask entered the house without her knowledge and he forcibly tied the girl's hands and ankles with the room's clothes and stripped her. However, she was unable to recall the subsequent events that occurred. After returning home, her parents discovered their daughter was missing and subsequently found her at the nearest railway station. However, the minor was unable to provide an account of her journey to the railway station. The symptoms developed immediately after that incidence. Clinical manifestations indicated PTSD9 with Suicidal Ideas and Dissociative (conversion) Disorder9 in the child. Pharmacotherapy and counseling sessions (psychoeducation, ventilation) were advised. During therapy, the child exhibited regressive behaviors, bodily symptoms, psychological stress, and expressed emotions by family members. However, the parents avoided regular counseling sessions out of fear of being scrutinized by the local community, and as a result, the case was dropped out. Despite the parents' objections, the hospital authority informed the police under the POCSO Act.

Case 2

An 18-year-old female college student presented to the OPD with a lack of interest in academics, difficulty in forming friendships, distrust of others, a depressed mood, and an inability to derive enjoyment from any social or academic activities. She preferred to remain at home. She detailed the repeated molestation she endured from her cousin brother for months and years at various periods in time, beginning at the age of 14. Without her parents at home, molestation included forcible genital touching, kissing, embracing, and sexual activities. The perpetrator visited her house regularly as her cousin sibling, and abuse was easy without parents.

Although she struggled with social integration during her development, her academic performance did not suffer significantly. After three years, she disclosed the matter to her mother, but her parents avoided discussing it due to social stigma. She expressed emotional disturbances, four years after entering a professional institution. Physical examinations revealed that she had self-inflicted repeated cut marks on her thighs, forearms, and shoulder, which she admitted to doing whenever she experienced emotional overwhelm and episodes of fury.

On MSE, she maintained a restricted affect and refrained from making eye contact. PTSD components, borderline, and paranoid personality traits, as well as depressive symptoms, were identified during the personality assessment (Million Clinical Multiaxial Inventory-III). Regular follow-ups were recommended in conjunction with pharmacotherapy and trauma-focused therapy (12 sessions). Trauma-informed principles were used in the therapy sessions (e.g., safety planning, caregiver sessions, use of evidence-based protocols like TF-CBT). Thereafter, there were enhancements in both academic and social domains. Despite of her parents' resistance, the hospital authority conveyed this matter to the police as per Institutional guidelines.

Case 3

A 16-year-old female child reported to the hospital with chest pain, headache, hyperventilation, loss of consciousness, and a diminished interest in the study for the last 6 months. The child was repeatedly informed of the inappropriate touching and hugging by a teacher who was over 50 years old after repeated explorations. She experienced repeated episodes of loss of consciousness, diminished interest in academic pursuits, and diminished peer group relationships after six months of this form of molestation. The incident was not disclosed to the child's family members due to the dread and rejection she experienced as a result of her age.

Her family members believed that her symptoms were solely caused by academic stress. She was diagnosed with Dissociative (conversion) Disorder 9 after considering all the symptomatology. The child didn't cooperate for counselling sessions, for which initially benzodiazepines were given. Subsequently, regular counseling sessions were conducted for past trauma after the child disclosed the incident as her primary stressor.

Her academic and social functioning improved after three months. Her father declined to register the case under the POCSO Act, however, the hospital authority informed the police for the same.

Table 1: Summary table of the case series.

S. no.	Age (years)	Abuse type	Perpetrator	Diagnosis	Intervention	Legal action	Follow-up/ outcome
Case 1	14	Sexual abuse	Unknown stranger	PTSD with Suicidality with Conversion Disorder	Psychotherapy	The case was registered despite the objection of the Parents.	Lost to follow up because of being scrutinized.
Case 2	18	Touching the genital, kissing, and sexual abuse	Cousin brother	PTSD Component with Borderline and Paranoid Personality Trait with depressive symptoms	Antidepressants with Mood stabilizer with Psychotherapy sessions	The case was registered despite the objection of the Parents	Follow up continuing with improvement in Academic, social and family functioning.
Case 3	16	Inappropriate touching and hugging by a fifty years old teacher.	Teacher	Conversion Dissociation Disorder	Benzodiazepine with Psychotherapy.	Case was registered under POCSO Act	Follow up continuing with improvements in daily functioning.

DISCUSSION

In the cases mentioned above, any form of CSA, has resulted in both short-term and long-term mental health consequences, resulting in a severe disruption in the psychosocial health of the affected child in the latter part of adolescence or adult life.

In each of these instances, the emotional development of the female child in the later stages of life is disrupted in any form by CSA. The child's normal biopsychosocial health is disrupted by the arrested development of psychosexual health, resulting in the manifestation of a variety of mental health morbidities that differ in duration and symptomatology.[9] Dissociative symptoms, PTSD, somatization, deliberate self-harm behaviors (DSH), suicidal tendencies, maladaptive development of personality traits, and regressive childish behaviors, which were found in the cases after CSA after different period of time with one or more symptoms in all cases.[10-12] Furthermore, there are indications of psychotic behaviors, detachment from the family, and recurrent episodes of unconsciousness, which were found in the above-described cases that lead to poor academic performance and disengagement in social activities.[7,11,12]

Even though our country has made progress in preventing CSA with the POCSO Act, social stigma, family members' attitudes, and the victim's fear of social rejection are the main barriers to parents or relatives registering cases and bringing them to court. Again, children's lack of awareness about sexual activities and sexual assaults/ molestation contributes to underreporting.[13] Since CSA perpetrators are usually family members, all parents should be informed about it through evidence-based educational modules.

The proof of establishment of CSA is neither an easy process, nor the investigations of variable mental health symptomatology ascertained after the clinical presentation in a short period of time.[14] The mental health morbidity was only determined after conducting concurrent required medical assessments and counseling sessions.[14-15] The counselor encountered the following obstacles during the interview persistent symptomatology despite repeated interventions, slow improvement, dropping out of regular counseling sessions, and family members' reluctance to disclose CSA. The victim child's positive well-being is disrupted by the development of a variety of mental health morbidities in all cases.

CONCLUSION

The analyzed cases indicate that CSA has both immediate and persistent mental health consequences, with a range of psychological symptoms appearing at different intervals. This includes early onset psychopathology, as well as arrested psychosocial and psychosexual development, which results in severe disruptions to the victim's positive mental health well-being. The beneficial aspect of POCSO Act should always be communicated to the parents or family members by the different stakeholders associated with assessments, investigations and legal aspects of CSA. A multidisciplinary team of mental health professionals should investigate CSA in the early evaluation of childhood or adolescent-onset mental health morbidities, as both pharmacological and psychotherapeutic interventions improve psychopathology. The research findings indicate that prioritizing the early reporting of sexual abuse cases, implementing sex education during adolescence, conducting community awareness programs, and involving mental health professionals post-reporting are

essential for maximizing the effectiveness of the POCSO Act.

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