

## **SEE NO EVIL, HEAR NO EVIL: THE RISE AND FALL OF CHILD SEXUAL ABUSE IN THE 20th CENTURY**

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### **Abstract.**

*This paper examines the development of a medical perspective on child sexual abuse during the course of the 20th century and argues that such a perspective has not served the best interests of sexually abused children. An alternate social perspective is outlined, which would appear to have the potential to adequately address the needs of sexually abused children in the 21st century. The paper concludes by arguing that, despite its merits, the social perspective is likely to be of little value unless we can learn to more effectively see and hear the voices of child survivors.*

In this paper I will attempt to provide a brief overview of contemporary understandings and practices regarding child sexual abuse (CSA). In providing this overview I will attempt to make four broad, general points: first, despite recent developments, sexually abused children are, in a number of important respects, no better off today than they were at the beginning of the 20th century; second, a lack of fundamental change in the position of sexually abused children can, to a meaningful extent, be attributed to a dominant medical interpretation of the problem which was established and elaborated in the course of the 20th century; third, an alternate, social re-presentation of child sexual abuse is required if we hope to adequately address the needs of sexually abused children in the 21st Century; and forth, despite the merits of a social perspective, such a perspective is likely to be of little value unless we first learn to more effectively see and hear the voices of child survivors.

### **THE 20th CENTURY: THE BEST OF TIMES?**

The view that sexually abused children are fundamentally no better off today than they were 100 years ago contrasts markedly with prevailing views on the topic. After all, studies of the history of childhood tell us that after centuries of children being subjected to the most inhumane and cruel forms of maltreatment, the 20th century represented a time when parents, and society in general, shifted towards a more constructive and helpful mode of relating to children (De Mause, 1980). In addition, studies of the contemporary history of child sexual abuse (Summit, 1988; Olafson, Corwin, & Summit, 1993; Conte, 1994) tell us that after centuries of denial and collective dissociation, child sexual abuse finally emerged as a social problem during the latter decades of the 20th century. In the United States, and in other countries (including South Africa), this new found awareness found expression in saturation media coverage of the topic,

professional and social organisation around the problem, the development and implementation of primary and secondary prevention programmes designed to address both the causes and consequences of abuse, and the promulgation of legislation designed to serve the best interests of sexually abused children.

And yet, as we enter the 21st century, there are a growing number of clinicians and researchers who are beginning to question whether these developments have produced any meaningful change in the lives of CSA survivors. In both the United States and in South Africa: (a) prevalence rates for child sexual abuse continue to escalate at alarming rates (Collings, Wiles, Bugwandeen, & Suliman, 2007); (b) CSA remains a largely unreported phenomenon (Collings, 2006); (c) a significant proportion of sexually abused children continue to experience hostile or nonsupportive reactions to disclosure from family members and from helping professionals (Collings, 2007a); (d) the majority of CSA survivors who report their abuse do not receive social work or counselling services (Collings & Wiles, 2007), and (e) less than 10% of reported cases of CSA result in a conviction and custodial sentence (Collings, 2007b).

Although there are likely to be a number of reasons for this lack of fundamental change, I believe that one of the more important reasons relates to a dominant medical interpretation of child sexual abuse which was established and elaborated in the course of the 20th century.

### **ESTABLISHING A MEDICAL PERSPECTIVE.**

The medical interpretation of child sexual abuse has its origins in 19th century Europe (particularly France), which, Judith Herman (2001) reminds us, was a place and time when the central political conflict revolved around the struggle between the monarchy with its established religion on the one hand, and proponents of secular government on the other. At the time, secular leaders were particularly concerned to establish a secular state in which authority was vested in men of science rather than in religion, and in which “ideological battles were fought for the allegiance of men and the dominion of women” (Herman, 2001:15). In this context, there was a need to challenge the role of the church as the defining authority on issues relating to morality, and to represent moral issues in ways that defined them as the province of science, and which did so in a way that assured the allegiance of men. In other words, what was required was an interpretation of sexual abuse which defined it as the province of the helping professionals, while at the same time providing an understanding of child sexual abuse which served the best interests of men of science, and of men in general.

With respect to child sexual abuse, such a representation of the problem was achieved through subjecting child sexual abuse to a three part transformation, involving three quite distinct interpretative strategies:

- (a) *marginalisation*: which involved shifting child sexual abuse to the margins of everyday society;
- (b) *mitigation*: which involved shifting culpability for sexual abuse from the offender to other involved parties (notably the child and the non-offending maternal caretaker); and

(c) *minimalisation*: which involved the representation of sexual abuse as a non-abusive/benign experience.

### **Marginalisation.**

The first of these interpretative strategies (*marginalisation*) finds its earliest expression in the 19th century work of Krafft-Ebing. In 1880, the German psychiatrist Krafft-Ebing published the first edition of a textbook (*Psychopathia sexualis*) which documented psychopathological manifestations of human sexuality (Krafft-Ebing, 1880/1905). In this text, the very ordinariness, or unextraordinary nature, of child sexual offenders (i.e., offenders as fathers, brothers, respected members of the community), suggested by the work of earlier writers (e.g., Tardieu, 1857), was replaced by an image of the offender as marginal to the moral order. Krafft-Ebing provides us with a perspective on child sexual offending in which moral degeneracy, neuropathology, and / or psychopathology constitute the primary motive for offending, with the dominant image of the offender being the dirty old man, the stranger, or the morally deficient member of the working class. We are, thus, presented with an image of the sexual offender which is: (a) firmly anchored in notions of pathology (making sexual offenders the province of the treating professionals), and (b) objectified in terms of individuals who are located on the periphery of moral and ordered society (effectively challenging the notion of sexual offending as a re-enactment of culturally sanctioned male privilege).

Krafft-Ebing's textbook not only proved to be enormously popular - running to 10 editions, with the 10th edition being translated into English – but also provided a perspective on the sexual offender which was to not only inform the work of clinicians and researchers in the early decades of the 20th century but which also emerged as the dominant social understanding of CSA during the first half of the 20th century (Frisbie, 1965; Frisbie & Dondis, 1965; Freedman, 1987; Gordon, 1988).

### **Mitigation.**

In the first half of the 20th century, the culpability of child sexual offenders was mitigated through a series of interpretations which effectively transferred culpability for the abuse from the offender to the child and / or the non-offending mother. In terms of the child-based aetiologies of the early 20th century, the dominant image of the sexually abused child was that of: the mentally ill child, the child as sexual delinquent, or (more commonly) the child as both mentally ill and delinquent. Consider for example the following citation, taken from the work of Abraham (1907/1949:54): “Children who are disposed to mental illness in later life show an abnormal desire for sexual pleasure which lead them to unconsciously seek out, to overly comply with, or to not adequately resist premature sexual contact.”

What is particularly interesting about this citation is that Abraham manages to combine three quite different interpretive strategies in one sentence. That is, CSA is *marginalised* as being a consequence of psychopathology, culpability is *mitigated* through the use of child blame, and abuse is *minimalised* through the presentation of abuse as a sexual, rather than abusive, activity.

A notion of the child as complicit, or culpable, is also evident in much of the empirical research published during the early years of the 20th century. For example:

"In most cases the child had cooperated or initiated the abuse and therefore the children undoubtedly do not deserve completely the cloak of innocence with which they have been endowed by moralists and social reformers" (Bender & Blau, 1937:514).

"Frequently we considered the possibility that the child might have been the actual seducer rather than the one innocently seduced" (Bender & Blau, 1937:514).

"Childhood sexual abuse constitutes a secondary process, derived from the child's predisposition to psychotic behaviour" (Rascovsky & Rascovsky, 1950:45).

"The majority of victims were seductive and flirtatious, and sexually precocious. Sixty per cent of the victims were participant victims" (Weiss, Rogers, Dutton, & Darwin, 1955:27).

"Victimised children's greater need for affiliation probably reflected a constitutional predisposition which may well have predisposed the child to ... sexual acting out" (Burton, 1968:169).

Furthermore, in terms of the mother-based aetiologies of the mid 20th century, it was generally the mother – nervous, neglectful, hysterical or collusive – who was often found to be ultimately responsible (cf., Caplan & Hall-McCorquodale, 1985; Gomes-Schwartz, Horowitz, & Cardarelli, 1990). For example:

"Typical incest victims are predisposed towards incestuous relationships by a combination of depressive traits and an extremely frustrated relationship with the Mother" (Rascovsky & Rascovsky, 1950:42).

"These girls felt abandoned by their mothers with incest being seen as the child's search for an adequate parent" (Kaufman, Peck, & Tagiuri:270).

"In incestuous families the mother, motivated by a mixture of hostility and unconscious homosexual longings, often facilitated incest between girls and their passive fathers" (Lustig, Dresser, Spellman, & Murray, 1966:37).

Taken together, these child- and mother-based aetiologies not only served to diffuse culpability for the abuse, but also served to *represent* abuse survivors as mad, bad and/or depraved and non-offending mothers as ineffectual, neglectful, or mentally disturbed (and thus the province of helping professionals).

### **Minimalisation.**

A final interpretive strategy involved in the establishment of the Medical interpretation of child sexual abuse was that of "minimalisation". In much of the research and psychoanalytic literature that was published in the early and mid 20th century, child sexual abuse is presented as a somewhat benign experience, with a number of authors even going as far as suggesting that child sexual abuse may have beneficial effects. For example:

"The actual consummation of the incestuous relation ... diminishes the chances of psychosis and allows better adjustment to the external world" (Rascovsky & Rascovsky, 1950:45).

“Only a small proportion of the victimised sample appeared to have been seriously disturbed by the experience” (Kinsey, Pomeroy, Martin, & Gebhard, 1953:121).

“Some of the older females in the sample felt that the experience contributed favourably to their later socio-sexual development” (Kinsey et al., 1953:121).

“Most victims recover rather soon” (Landis, 1956:108).

“Sexual assault of children does not have particularly detrimental effects” (Burton, 1968:169).

“Non-coercive father-daughter incest can in fact produce competent and notably erotic women. Childhood is the best time to learn” (Yates, 1978:48).

Further, in cases where serious psychological problems were observed in the aftermath of abuse, these were frequently attributed to factors other than abuse:

“Constitutional predispositions and not abuse per se, determined the undesirable consequences of abuse” (Rasmussen, 1934:358).

“Less favourable outcomes could be attributed to deficiencies in intellectual competence or a constitutional predisposition to psychotic behaviour” (Bender & Grugett, 1952:829).

“The emotional problems experienced by victims were due to disruptive experiences preceding the abuse rather than the effects of abuse itself” (Weiss et al, 1955:27).

This minimalisation of the effects of child sexual abuse, combined with other interpretative transformations (marginalisation and mitigation), combined to provide an understanding of child sexual abuse which was anchored in notions of individual pathology (thus making child sexual abuse the province of the helping professions), and objectified in terms of individuals (offenders, survivors, and mothers) who were located on the periphery of normal, moral, and ordered society (effectively challenging the notion of child sexual offending as a reflection of culturally sanctioned norms and practices).

### **EXTENDING AND ELABORATING THE MEDICAL INTERPRETATION.**

If the first part of the 20th century can be viewed as a time during which a medical perspective on child sexual abuse was established, the latter decades of the century (post 1970) can be viewed as a time during which this medical perspective was extended and elaborated.

At one level this extension involved a diffusion of medical understandings of child sexual abuse, via the press and other media, in a manner that both informed and shaped popular or common-sense understandings of the problem. Thus, analyses of post-1970 press coverage of child sexual abuse (Goddard, 1996; Corbella & Collings, 2007;) indicate that such coverage was informed by the interpretative strategies of: (a) *marginalisation* (i.e., a focus on bizarre or more extreme cases and on instances where the perpetrator was a stranger), (b) *mitigation* (i.e., the presentation of children as less

than innocent parties to their abuse), and (c) *minimalisation* (i.e., portraying child sexual abuse as a consensual experience). Similarly studies of common-sense understandings of child sexual abuse conducted towards the end of the 20th century identified “distortions” in consensual understandings of the problem which directly reflect the influence of interpretative strategies such as marginalisation, mitigation, and minimalisation (Collings, 1997).

It could thus be argued that, by the end of the 20th century, the medical interpretation of child sexual abuse had moved beyond the “reified universe” of science, to form a basis for both media and consensual (or shared common-sense) understandings of the problem.

The extension of the Medical interpretation in the latter decades of the 20th century is also evidenced in professional attempts to confront child sexual abuse using a disease model. Thus, for example, in the past 30 years:

- Primary prevention has been approached using an *inoculation* model, in terms of which children are exposed to school-based primary prevention programmes in order to make them ‘immune’ from subsequent victimisation. Despite the fact that there is no conclusive evidence that such programmes work (Finkelhor, 2007), they continue to constitute the primary approach to prevention in the United States and in many other countries around the world.
- The notion of a disease model has also been evident in the view of child sexual abuse as an *infectious* experience (i.e., the view that sexually abused children are likely to grow up to abuse other children). Despite the fact that there is no empirical support for such a notion (cf Townsend, & Dawes, 2004), professional and lay opinions regarding child sexual abuse continue to be informed by a “cycle of abuse” understanding of the problem.
- Medico-legal assessment has emerged as the gold standard for diagnosing child sexual abuse, despite the fact that such examinations have been found to produce “no evidence of abuse” in over 90% of confirmed cases of child rape (cf Kreston, 2007).

### **THE SOCIAL INTERPRETATION.**

Although the Medical interpretation of child sexual abuse has been effective at providing an understanding of the problem which serves the best interests of men of science and, indeed, of men in general, it is an understanding which has a number of significant shortcomings: it is an understanding which (a) is not consistent with most empirical findings, (b) does not serve the best interests of innocent parties to sexual abuse (i.e., survivors and non-offending parents), and (c) has not effectively confronted or addressed the problem of child sexual abuse.

Clearly, a new perspective on the problem is required, and I would argue that such a perspective is provided by an alternate interpretation of child sexual abuse which has been clearly articulated at a number of points in the 19th and 20th century but which has, to date, not managed to effectively reverse the epistemic gaze established by the Medical interpretation. I will refer to this interpretation as the Social interpretation.

The Social interpretation of child sexual abuse can be distinguished from what I have been referring to as the Medical interpretation in a number of respects. First, the Social interpretation places child sexual abuse at the centre of everyday life. That is, sexual offenders are defined as un-extraordinary people (fathers, family members, acquaintances), with the family home and other environments which are familiar to the child being viewed as particularly enabling environments for abuse. Second, in terms of notions of causality, the Social interpretation tends to focus not so much on notions of individual pathology, but rather on socially sanctioned practices and beliefs (such as patriarchal authority, rape myth acceptance, and so on) which are seen as providing an enabling context for abuse. And third, the Social interpretation emphasises the ubiquitous nature of child sexual abuse. In other words, the Social interpretation acknowledges that the risk for child sexual abuse does not vary as a function of social address variables such as class and socio-economic status.

Such a social perspective on child sexual abuse has been evident in the work of a number of writers, and I will focus here on some of the more influential contributions.

### **Tardieu (1857).**

One of the earliest expressions of the Social Interpretation of child sexual abuse can be found in the work of the French forensic scientist Ambroise Tardieu. In 1857, Tardieu conducted a study of 632 cases of sexual abuse in females, 85% of whom were under the age of 16 years (cf Labbé, 2005; Roche, Fortin, Labbé, Brown, & Chadwick, 2005). Based on his findings, Tardieu concluded that: (a) child sexual abuse was common in society and needed to be understood as a gendered phenomenon (i.e., perpetrated predominantly by men against girls); (b) patriarchal authority rendered children particularly vulnerable to sexual abuse; (c) offenders were predominantly known persons (fathers, family members, or acquaintances); and (d) child sexual abuse occurred amongst all classes, with the nuclear family providing a particularly enabling environment for CSA.

Of course, in the context of an emerging Medical interpretation of child sexual abuse, Tardieu's work had little impact on the medical community, with his successors in forensic medicine (Alfred Fournier, Auguste Motet, Léon Thoinot, Paul Brouardel) effectively demolishing his work on child sexual abuse. Tardieu's successors were not prepared to consider the clinical signs described by Tardieu as diagnostic of child abuse, preferring rather to dismiss the childrens' allegations of sexual abuse as pure inventiveness (mythomania) (Labbé, 2005).

Despite these unfavourable reactions, Tardieu's analysis does provide us with an understanding of child sexual abuse in terms of which abuse is defined as: (a) central to polite/civilised society; (b) contextualised in terms of gender and class; and (c) a product of patriarchal authority (particularly as manifested in the nuclear family).

### **Sigmund Freud (1896).**

A social interpretation of child sexual abuse was also evident in a series of articles published in 1896 (Freud, 1896/1962a, 1896/1962b, 1896/1962c) in which Sigmund Freud outlined his *neurotica* (general theory of the neuroses). In addition to emphasising the pervasive psychological effects of child sexual abuse Freud also addressed issues relating to sexual power, class, and gender. He maintained that child sexual abuse was:

“... more common than suspected, even in respectable families. He described the power imbalance at the traumagenic core of child sexual abuse, writing that an adult, who had the authority and the right to punish, can satisfy his whims on a helpless child ... [and] explained the frequency of hysteria in women as arising, not from constitutional weaknesses ... but from the fact that girls were more often sexually abused than boys” (Olafson et al, 1993:11).

In letters to Fleiss, but not in his publications, Freud indicated that it was in fact the father who was the perpetrator in every case (Freud, 1897/1962d:259-260).

Although Freud was to go on and renounce his *neurotica* as a general theory of the neuroses (and correctly so, I believe), he continued to acknowledge that child sexual abuse was common, and that such abuse may have lasting consequences (see e.g., Freud, 1917/1963, 1931/1961, 1940/1964). Further, he never renounced the social critique implicit in his analysis; a reality which has been largely ignored in subsequent interpretations of his work (see, particularly, Masson, 1984).

### **Sandor Ferenczi (1932).**

In a paper presented to the International Psychoanalytic Congress in Wiesbaden in September 1932, Ferenczi (1932/1955) argued that child sexual abuse was a lot more common than was generally suspected, and that children of even very respectable families fall victim to rape. Ferenczi also noted that it is the overwhelming power and authority of adults that leads children to surrender automatically and to eventually identify totally with the aggressor, even introjecting the aggressor's guilt (Ferenczi, 1932/1955).

### **Florence Rush (1971).**

On April 17, 1971, Florence Rush presented a paper on child sexual abuse at the New York Radical Feminist Conference. In this paper Rush argued that child sexual abuse needed to be understood as a symptom of institutionalised patriarchy, of female powerlessness, and of mainstream family structures which we are “encouraged to uphold no matter how often we witness the devastatingly harmful effects of this arrangement on women and children” (Satter, 2003:454). For Rush, and for other feminists who were inspired by her address (e.g., Brownmiller, 1975; Armstrong, 1978; Herman, 1981; Russell, 1986), the pervasive silence around the reality of child sexual abuse needed to be understood as a defence of gender and professional privilege and hierarchy (Olafson et al., 1993), with issues of gender and professionalism emerging as central issues in subsequent feminist analyses of the problem.

### **The current status of the social interpretation.**

Despite the obvious value of a Social interpretation of child sexual abuse, none of its proponents have managed to effectively reverse the epistemic gaze established by medicine. Challenges to the Medical interpretation have to the large part been either ignored or discounted, with the feminist critique being subject to a particularly vicious backlash from psychiatry and from other quarters (see e.g., Gardner, 1991). And, as we enter the 21st century the Medical interpretation of child sexual abuse remains the dominant perspective on the problem to the detriment not only of sexually abused children, but of children generally.

## **CONCLUSION.**

In this paper I have attempted to argue that the dominant Medical interpretation of child sexual abuse is not only inconsistent with the bulk of empirical findings relating to the problem, but has also not served the best interest of sexually abused children.

Although the Social interpretation, which I have outlined, holds promise as an alternate perspective, it is far from clear how the dominance of the Medical interpretation can be effectively challenged. And here I need to emphasise that I do not have a “magic bullet” or a clear roadmap regarding the way forward. Clearly what is required is serious and intensive debate on the issue, with my hope being that such debate will lead to the development of plans of action, new policies, and improved procedures designed to finally, and effectively, confront the problem of child sexual abuse.

At the same time there is a need for progressive research designed to challenge the untested assumptions of the Medical interpretation and to provide grounded alternatives which are consistent with the social realities of CSA. An object lesson in how such an approach to research can be implemented is provided by Rebecca Bolen (2003) in her recent critique of the inoculation model of CSA prevention programming. The starting point of Bolen’s critique is her call for a paradigm shift in the way intervention programming is conceptualised, with her subsequent argument having much to commend it, including: a much needed unpacking/explication of some of the core assumptions underlying prevention programming; a carefully considered rationale for a shift away from child-focused intervention strategies; and a much needed extension of the boundaries of the discussion regarding prevention programming to encompass socially mediated beliefs, attitudes, and practices which have relevance to sexual offending.

Of course, while work such as Bolen’s is necessary, it is, in itself, unlikely to be sufficient. In the final analysis, unless we (as academics, service providers, citizens, and/or survivors) can learn to more effectively see and hear the “evil” that is CSA, and are prepared to allow children to play a more active role in defining the terms of the debate regarding their best interests, we run the risk of perpetuating the “confusion of tongues between adults and the child” (Ferenczi, 1984) and thereby of effectively contributing to the ongoing silencing of CSA survivors.

And in this respect, I believe that it matters to point out that the present paper, like many single-authored papers on child abuse, was written by more than one author. Behind the more obvious voice of the adult, is the voice of a child who has learned that, to the extent that phylogeny parallels ontogeny, this paper is: as much about biography as it is about history, as much about testimony as it is about critique, as much about a child’s experiences as it is about the experiences of children in the 20th century; and (at a most fundamental level) as much about a child’s demand to be heard as it is about any critique/advocacy of one or other adult-centred interpretation of children’s experiences.

Of course, such a reading of the text is likely to raise a number of rather obvious objections. First, there are, no doubt, a number of readers who at this point have simply thrown up their hands in despair and shouted “unfair”. After all, “the child’s voice in this paper is simply too silent and too subtle for the author to reasonably have expected it to be heard”. While such an objection might appear to have some merit, it needs to be

emphasised that the voice of the child in this paper is no more silent, and no more subtle, than the voice of the vast majority of sexually abused children; and, as such, a failure to discern the child's voice here is likely to be associated with a failure to discern the voices of most CSA survivors.

A final possible objection to a child-centred reading of this paper is that, as academics, we surely cannot allow the subjectivity of angry, frustrated, and at times petulant children to dominate debate on the matter. And to this, the child might simply reply: "Why not?"

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