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Victimization of Female Children

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Oh, children, children, how fraught with peril are your years!
Dostoevsky

In many regions of the world, it is dangerous to be a girl. Before birth, girls may succumb to sex-selective abortion. During infancy, they are vulnerable to female infanticide or selective neglect of female infants. Girlhood brings the risk of sexual abuse, child marriage, child prostitution and pornography, and female genital mutilation (“female circumcision”). During adolescence and adulthood, they are vulnerable to dating violence, rape, forced prostitution, dowry murders, and partner abuse (World Health Organization, 1997).

Dating violence, child prostitution, and female “circumcision” are described in other chapters in this volume. In this chapter, I describe the two types of victimization of female children: sexual abuse and female infanticide. Sexual abuse of girls is described as it occurs in the United States, and is compared to physical abuse and neglect. Although physical abuse and neglect are more common types of child maltreatment, in this country they affect boys and girls in approximately equal numbers. Such is not the case in other parts of the world, where girls are more likely to be abused and neglected--sometimes fatally so. Fatal abuse and neglect are described in the final half of this chapter.

Sexual Abuse of Girls in the United States

The Third National Incidence Study of Child Abuse and Neglect (NIS-3) revealed that in America, girls’ risk of abuse was 33% higher than that of boys. The difference was due to girls’ increased risk of sexual abuse. Girls experienced sexual abuse at more than three times the rate that boys did (Sedlak & Broadhurst, 1996).

With girls being at higher risk, we might ask how often does sexual abuse occur? Incidence of sexual abuse varies depending on definition of abuse and the population that is surveyed. In samples drawn from people seeking clinical mental health services, percentages are generally higher than when drawing from the community at large. Current estimates across studies of contact abuse are that at least 20% of women (1 in 5), and 5-10% of men (1 in 10) have been sexually abused as children (Finkelhor, 1994; Gorey & Leslie, 1997). The peak age of vulnerability to sexual abuse is between 7 to 13 years of age (Finkelhor, 1994), but children older and much younger have been abused.

Why does this sex difference exist? Two possible explanations have been offered, but neither completely explains the sex differences. One explanation is male dominance of women. In this framework, men are described as the abusers of women and girls, especially within the family. Research has in fact demonstrated that perpetrators of sexual abuse are overwhelmingly male (Finkelhor, 1994), and the majority of victims are female. But this does not explain all sexual abuse. There are male victims and female perpetrators too, and male dominance of women does not explain these, indicating that this theory is not a complete explanation of why sexual abuse occurs (Sedlak & Broadhurst).

Access is another possible explanation for the sex difference in sexual abuse rates. Girls are most likely to be abused by family members, especially step-fathers, while boys are more likely to be abused outside the family (Finkelhor, 1994; Kendall-Tackett & Simon, 1992). Girls may be more vulnerable to sexual abuse because the people most likely to abuse them are right in their homes. Analyzing data across several studies, Finkelhor (1994) found that for girls, 33-50% of perpetrators are family members, while for boys only 10 to 20% are. But girls abused outside the home and boys abused by family members do not fit within this framework. For example, in one clinical study, 10% of girls were abused by “friends of the family,” and 33% of boys were also abused within the home (Kendall-Tackett & Simon, 1992). When looking at the entire data set from this study (males and females together), approximately 10% of abusers were brothers and another 10% were uncles. Grandfathers were the abusers approximately 3% of the time, and strangers were approximately 1% (Kendall-Tackett & Simon, 1987). There were no significant sex differences.

The Effects of Sexual Abuse

The effects of sexual abuse are probably its most highly studied aspect—and its most political. Some claim sexual abuse is *always* harmful. Yet there are many children who show no symptoms at all (Kendall-Tackett, Williams & Finkelhor, 1993). Others maintain that some children actually *benefit* from these sexual experiences, and that research is biased towards negative effects (Sandfort, 1984). The research reveals, however, the complexity of responses to sexual abuse. Some victims will show very few, if any, effects. Others will have mild symptoms. Still others will be severely affected. Briere and Runtz (1987) estimate that 20% of adult survivors of sexual abuse (or 5% of the total population) will experience major long-term effects and show significant symptoms. Studies of the effects of sexual abuse are divided into short-term (the effects on children) and long-term (the effects on adults).

Short-term Effects

Children experience a wide range of difficulties after they have been sexually abused. Some of the most common symptoms are nightmares, depression, withdrawn behavior, aggression, and regressive behavior. Some children are very symptomatic, while others show very few symptoms. Sometimes symptoms appear as “delayed responses.” For others, symptoms may get better over time.

Symptoms of post-traumatic stress disorder (PTSD) are common but not specific to sexual abuse (meaning that children who have experienced other traumatic events may also show symptoms of PTSD). PTSD, as the name implies, is a constellation of behaviors and reactions that occur in the wake of traumatic events. They were first categorized among combat veterans, but more recently, this diagnosis has been used to describe the aftermath of other traumatic experiences including child sexual abuse. These reactions may be manifested as hypervigilance, sleep disturbances, startle responses, intrusive thoughts or flashbacks.

Perhaps the symptom that is most characteristic of children who have been sexually abused is sexualized behavior. Even this symptom does not occur in all sexually abused children, so its absence does not mean that sexual abuse has not occurred (Kendall-Tackett, et al. 1993). Sexualized behavior is also one of the more disturbing symptoms, especially when noted in children who are six years old or younger. It includes public masturbation, sexual play with dolls, and asking other children and adults to participate in sexual activity. As children mature, these activities may be identified as promiscuity, or there may be involvement in prostitution or pornography.

The symptoms that children manifest also vary by age of the child. For example, preschool-age children are more likely to experience anxiety or sexual acting out, whereas adolescents are more likely to manifest substance abuse or illegal behaviors. Table 1 gives an overview of symptoms that are most likely to occur within a given age group. Symptoms may also change over time. For example, a preschooler who is sexually acting out may become a teen who is highly promiscuous.

[Insert Table 1 about here]

Long-term Effects

While not everyone who experiences sexual abuse shows symptoms, the effects of childhood abuse can also continue well into adulthood. These are known as long-term effects. Sometimes children show very functional coping behaviors in childhood (such as seeking the assistance of a supportive adult), and do not become symptomatic as adults. Other times, their coping abilities are less positive but still serve an important function during childhood. Symptoms adult survivors manifest are often “logical extensions” of dysfunctional coping mechanisms developed during childhood (Briere & Elliot, 1994). While these dysfunctional behaviors may have helped the child cope with ongoing abuse, they often have a negative impact on adult functions. Long-term effects can be divided into seven categories (Briere & Elliot, 1994; Kendall-Tackett & Marshall, 1998). These are described below.

Post-traumatic Stress Disorder (PTSD)

PTSD is also a commonly occurring symptom among adult survivors of sexual abuse. According to Briere and Elliot (1994), 80% of abuse survivors have symptoms of PTSD, even if they don't meet the full diagnostic criteria. Again, these reactions may be

manifested as hypervigilance, sleep disturbances, startle responses, intrusive thoughts or flashbacks.

Cognitive Distortions

Sexual abuse survivors may develop a mental framework (or “internal working model”) where they perceive the world as a dangerous place. Further, they may feel helpless and unable to defend themselves. These cognitive distortions make them more vulnerable to both re-victimization and depression because they perceive themselves to be powerless in their lives.

Emotional Distress

Emotional distress is perhaps the most common symptom that occurs among adult survivors. It includes depression, anxiety, and anger. Adult survivors of childhood sexual abuse have a four-time higher lifetime risk of depression than do their non-abused counterparts (Briere & Elliot, 1994). They may also experience anxiety ranging from mild to severe, and may also be angry, or experience rage, on a regular basis.

Impaired Sense of Self

Survivors may have difficulty separating their emotional states from the reactions of others. In other words, their moods may often depend on the moods of others. For example, their partners are depressed or angry, so they are too without necessarily considering whether they really feel the same way. They may also have difficulties in self-protection, increasing their risk of re-victimization.

Avoidance

Avoidance includes some of the more serious sequelae of past abuse. Survivors may experience dissociation, which includes alterations in body perception (including feelings of separation from their bodies), emotional numbing, amnesia for painful memories, and multiple personality disorder. Other types of avoidant behavior are substance abuse, suicidal ideation and attempts, and “tension-reducing activities” including indiscriminate sexual behavior, bingeing and purging and self-mutilation.

Interpersonal Difficulties

Adult survivors may have problems with interpersonal relationships. They may adopt an “avoidant” style, characterized by low interdependency, self-disclosure and warmth. Or they may adopt an “intrusive” style, characterized by extremely high needs for closeness, excessive self-disclosure and a demanding and controlling style (Becker-Lausen & Mallon-Kraft, 1997). Both styles result in loneliness.

Physical Health Problems

Women who report a history of abuse may have a variety of health problems. Some of the symptoms that have been noted in adult survivors of childhood abuse include chronic pelvic pain, frequent feelings of fatigue, severe PMS, irritable bowel syndrome, frequent headaches, trouble sleeping, and frequent vaginal infections. Adult survivors also had overall lower satisfaction with their physical health than their non-abused counterparts (Moeller, Bachman, & Moeller, 1993; Walling, Reiter, O'Hara, Milburn, Lilly, & Vincent, 1994).

Differences in Response to Sexual Abuse

As described earlier, children and adults vary widely in their reactions to sexual abuse. Some of the variation can be explained in terms of the child's overall coping abilities or the support available to the child at the time of disclosure (assuming that the abuse actually was disclosed). But characteristics of the abuse itself can also exert an influence. Some people are more seriously affected by abuse because their experiences were more severe. Characteristics that make an experience more or less serious include the identity of the perpetrator; the severity of the sexual acts; duration and frequency of the abuse; and whether force was used. Some ethnic group differences in response to child sexual abuse have also recently been observed.

Studying the characteristics of abuse demonstrates the complexity of their effects. For almost any statement made, exceptions occur. To further complicate matters, many of these factors are related to each other. For example, a perpetrator who is a family member will have more access to a child and for a longer time. So identity of the perpetrator is often related to duration of the abuse. Severity of the sexual acts is often related to duration of the abuse as well, with more severe acts occurring over time. However, many one-time assaults are rapes. In other words, instead of abuse that becomes gradually more severe over time, the first contact includes penetration. Factors affecting overall severity of the abuse experience are described below.

In general, abuse will be more harmful if the abuser is someone the child knows and trusts, and the abuse violates that trust (Finkelhor, 1987). This is reflected in the difference in the percentage of abuse by parent-figures in clinical vs. non-clinical samples. (Presumably, more harmful abuse occurred among people who are seeking treatment.) Abuse by parent-figures ranges from 16% in non-clinical samples to as high as 62% in clinical samples (Berliner & Elliot, 1996; Kendall-Tackett & Simon, 1987). However, abuse by family members is not necessarily always more harmful. The child's emotional attachment to the perpetrator and sense of betrayal can be more important predictors of harm than is strict familial relationship (Finkelhor, 1987).

Another important component related to symptoms is severity of the sexual acts. "Severity" tends to be defined by whether the abuse experiences included penetration (oral, vaginal or anal). The percentage of subjects reporting penetration also varies by sample. In non-clinical samples, the range is 4% to 25% (Conte & Berliner, 1988;

Russell, 1984), while clinical samples range from 43% to 48% (Kendall-Tackett & Simon, 1987; Pierce & Pierce, 1985).

Abuse that occurs often and lasts for years will typically be more harmful than abuse that happens only sporadically and over less time. The exception is the one-time violent assault (Kendall-Tackett et al., 1993). Not surprisingly, use of force has been shown to increase the severity of reaction to sexual abuse (Elwell & Ephross, 1987). Force may be more likely in stranger and/or one-time assaults, but this is not always true (Kendall-Tackett et al., 1993). While all sexual abuse is, by definition, non-consensual, sometimes the abuser will use trickery or mental coercion, rather than force, to gain compliance. In other situations, the abuser will hit, assault, or physically restrain his victim. Victims who experience this type of abuse are more likely to have symptoms.

There are also some ethnic group differences in both characteristics of abuse and in reactions to it. Asian children tend to be older at the onset of victimization than their non-Asian counterparts, while African-American children tend to be younger at onset of victimization than either their Asian or Caucasian counterparts (Berliner & Elliot, 1996). African-American victims have approximately the same rates of victimization as Caucasian children, but are more likely to experience penetration as part of their victimization experience (Wyatt, 1985). Moreover, Wyatt (1985) found a difference between the age of onset for blacks and whites, but the age for both ethnic groups was prepubescent. Abuse of white girls was likely to start between 6 and 8 years of age, while abuse of black girls was likely to start between 9 and 12 years of age.

The overall rates of sexual abuse are lowest for Asian women, but high for Hispanic women, when reported retrospectively (Russell, 1984). Mennen (1995) found no overall effect of ethnicity on the severity of symptoms manifested by Latina, African-American, or white girls. Mennen did find that ethnicity and type of abuse together severity of influence symptoms. Latina girls who experienced penetration during their abuse had more anxiety and depression than did African-American or white girls. The author feels that some of these findings could be due to the emphasis in Latin communities on purity and virginity. When virginity is lost, the trauma of sexual abuse is compounded because the Latina girls feel that they are no longer suitable marriage partners.

Comparisons with Other Types of Child Maltreatment

In this section, I have focused on child sexual abuse because girls are much more likely than boys to experience this type of maltreatment. However, it is important to realize that although there are no sex differences in other types of maltreatment, many girls are physically abused or neglected (Sedlak & Broadhurst, 1996). For example, in the Third National Incidence Study of Child Abuse and Neglect cited earlier, the rate of maltreatment per 1000 children of sexual abuse is 4.9 for females (1.6 for males). Yet for physical abuse the rate is 5.6 per 1000 and 5.8 for males. For neglect, the rate is 12.9 per 1000 and 13.3 for males. As you can see, when compared to sexual abuse, girls are much more likely to be physically abused or neglected. Girls and boys have approximately the same rates of fatal injuries (.01/1000 and .04/1000 for females and males respectively), and girls are more likely to have had moderate injuries as a result of their abuse than are

boys (13.3/1000 and 11.3/1000), but this is not a significant difference. Although there is not a sex difference in these other types of child maltreatment, they do effect large numbers of girls and should also be of concern.

Conclusions

The experience of sexual abuse differs and reactions to it vary from person to person. The experiences of some survivors are relatively mild, while others experience severe abuse. Even when the experience is severe, however, there is hope for healing. In one study, survivors reported that good came from the tragedy of their abuse (McMillen, Zuravin, & Rideout, 1995). They described how their abusive pasts made them more sensitive to the needs of others. Many felt compelled to help others who had suffered similar experiences.

In describing the impact of past sexual abuse, we must also be mindful of the other types of child maltreatment that girls are likely to experience. In our country, boys and girls experience physical abuse and neglect in approximately equal numbers. But this is not true in other countries. In the next section, I describe two cultures where life-and-death decisions are made on the basis of a baby's sex.

Female Infanticide in India and China

Killing baby girls, or allowing them to starve to death, is something most of us cannot imagine. But it occurs even today. As shocking and disturbing as this behavior is, however, we must look at it within its cultural context. According to Scheper-Hughes (1987), neglect or killing of children may reflect a "survival strategy" that the family adopts. Parents might decide to invest more heavily in their "best bets" and neglect the rest. In some cultures, the best bets are often male (Scheper-Hughes, 1987). Families in these cultures may decide to kill their female children either outright, or passively, through abandonment or starvation to increase the likelihood that their families might survive (Miller, 1987).

Most of us have no trouble labeling infanticide as "wrong." A trickier issue is sex-selective abortion. Sex-selective abortion poses a genuine conundrum for those who support reproductive choice. On one hand, proponents of choice do not want to see a discussion of abortion in a chapter on victimization. On the other hand, many people who support reproductive choice are uncomfortable when it is applied selectively to females. Even the World Health Organization lists sex-selective abortion as one type of violence against women (1997). I have witnessed some spirited, and at times heated, discussions of this issue among my colleagues at the University of New Hampshire. I have included sex-selective abortion in this chapter, but acknowledge that not everyone agrees that it belongs here.

Below I describe two cultures where both sex-selective abortion and female infanticide have been documented: China and India. While infanticide occurs for different reasons, the cultures have similarities. In both cultures, the survival of the group is

weighed more heavily than the survival of any individual. Both cultures also count on their sons to care for their aged. Daughters marry out and are no longer members of their families of origin. For this reason, daughters are considered more a liability than a blessing.

Many times, infanticide and sex-selection in abortion are secretive, and even illegal, actions. Official reports may dramatically underestimate their incidence. On the other hand, many of the statistics and case reports provided by advocacy or relief organizations focus on more extreme cases. The true number is probably somewhere in between. To get an overall view of the problem, however, one statistic is helpful: the ratio of male to female births. In industrialized nations, the ratio is approximately 106 males to 100 females (U.S. Department of State, 1997). As we discuss India and China, I will provide numbers that you can compare to this ratio. This provides at least an estimate of the number of female infants and children who are not surviving, although we must be careful not to assume that all are victims of infanticide.

Birth Planning in China

In 1979, China implemented a highly intrusive policy to limit the number of births per family. Government workers monitor families for birth control use and tell couples when they are authorized to conceive. Couples are pressured to terminate “unauthorized” pregnancies, and this has occurred even in the eighth or ninth month of pregnancy (U.S. Department of State, 1997). The policy was implemented because of the enormous size of the Chinese population. The government predicted that it would be unable to meet its needs (Potter, 1987). The policy is more likely to be enforced in cities than out in the countryside, where families may be allowed to have more than one child because they need extra help on the farm (Potter, 1987).

The government’s policy, however, runs counter to the family traditions of the Chinese people. In Chinese society, sons are the means of continuity, prosperity, and the only valid source of care and support. The happiness of the aging relatives is thought to be secure when there are many sons who can help, thus the village expression: “the more sons, the more happiness.” If a couple has only one child, and she is a girl, there will be no one to care for the parents as they age. It is a cause of great shame when aging parents must rely on the government for sustenance, and the amount provided by the government guarantees that the parents will end their days in poverty (Potter, 1987).

As you can see, there is cultural incentive to have more than one child. To counter this, the government provides steep penalties to families who have “unauthorized pregnancies.” These include psychological coercion, loss of employment, heavy fines (up to twice annual earnings) and confiscation of property. The Government does not authorize the use of force to compel persons to submit to abortion or sterilization, but officials acknowledge that this does occur (U.S. Department of State, 1997).

Interestingly, the new Maternal and Child Health Care Law forbids the use of ultrasound to detect the sex of a fetus. Moreover, regulations forbid sex-selective

abortions, even promising punishment of medical practitioners who violate this provision. However, population statistics at least suggest that these practices continue nonetheless. The Chinese press has reported that the national ratio of male to female births is 114 to 100. One October 1994 survey of births in rural areas put the ratio as high as 117 male births to 100 female. However, these official statistics may actually underestimate the problem in that they may exclude many female births, especially the second or third in a family. Such births are unreported so that the parents can keep trying to conceive a boy (U.S. Department of State, 1997).

In some press accounts, the ratio is even higher. *The London Telegraph* reports that the sex ratio of China's population is 131:100 in favor of males. In Zhejiang province there were 860,000 unmarried males aged 22 and above, but only 360,000 unmarried females of the same age group. Among 20- to 25-year olds, the sex ratio was 167:100 in a rural county in Henan province. In a population of 25 million babies born in China each year, there were 750,000 more males than females (Hutchings, 1997).

Since China is a closed society, it is difficult to obtain accurate statistics. India, on the other hand, is more open and may provide a more candid view of female infanticide.

Female Infanticide in India

The root of female infanticide is different in India than it is in China. In both cultures, there is a preference for male children. However, unlike China, there is no government organization limiting the number of children a family can have. In India the constraint is mostly economic—daughters will require a sizable financial dowry in order to marry. Because daughters leave their families of origin, they are often regarded as temporary members of their families and a drain on its wealth. There is an expression in India that “bringing up a daughter is like watering a neighbor’s plant” (Anderson & Moore, 1993).

The dowry, theoretically illegal under the Dowry Prohibition Act of 1961, is a significant and pervasive theme. Although a law passed in September 1994 prohibits the use of amniocentesis and sonogram tests for sex determination, they are widely used for this purpose and many female fetuses are terminated (U.S. Department of State, 1998). Advertisements in India for ultrasound clinics urge couples to spend “500 rupees today to save 50,000 rupees tomorrow” (World Vision, 1994, p.4). *Washington Post* reporters Anderson and Moore (1993) report that at one clinic in Bombay, of 8,000 abortions performed after amniocentesis, 7,999 were of female fetuses. This estimate was supported by a study of clinic records in a large city hospital in India. Seven hundred individuals sought prenatal sex determination. Of those, 250 were male. All of these pregnancies were brought to term. In contrast, of the 450 determined to be female, 430 were terminated (Ramanamma & Bambawale, 1980).

In rural areas, women do not have access to ultrasound or amniocentesis in order to make a prenatal determination of sex. When girls are born, they are still in

danger either through direct infanticide or through sex-selective neglect. There were tribes and castes that had actually killed all their girls (Janssen-Jurreit, 1992). The Bedees (a branch of the Sikhs) were known as *koree mar*, or “daughter butchers.” Today, in India the ratio of women to men continues to decline from 972 females to 1000 males in 1901 to 935 in 1981 (Venkatramani, 1992).

The English-language newspaper *The Hindu* reports that on an average 105 female infants were killed every month in Dharmapuri district throughout 1997. This was in spite of efforts to protect female children (The Hindu, 1998). In another region, the Kallars (landless laborers in Tamil Nadu), view female infanticide as the only way out of the dowry problem. One mother interviewed in *India Today* said:

I killed my child to save it from the lifelong ignominy of being the daughter of a poor family that cannot afford to pay a decent dowry. But all the same, it was extremely difficult to steel myself for the act. A mother who has borne a child cannot bear to see it suffer even for a little while, let alone bring herself to kill it. But I had to do it, because my husband and I concluded that it was better to let our child suffer an hour or two and die than suffer throughout life (Venkatramani, 1992, p. 127).

Officials estimate that approximately 6,000 female babies have been poisoned in Kallar villages in the past decade. The Usilampatti government hospital records nearly 600 female births among the Kallar every year. Five hundred and seventy are taken immediately from the hospital. Approximately 450 (or 80%) are estimated to become victims of infanticide (Venkatramani, 1992). The Kallar also believe that if you kill your girl, your next baby will be a son.

While some have assumed that poverty was the main motivation for female infanticide (de Lamo, 1997; The Hindu, 1998), the reasons appear to be more complex. If social class were the sole determinant of infanticide risk, then we would expect to see lower rates of female infanticide in the upper classes. However, in the Punjab, India’s richest state, Cowan and Dhanoa (1983) found even higher rates of female mortality. For example, females constituted 85% of deaths among infants ages 7 to 36 months. Further, Miller (1981;1987) has argued that infanticide is *more* likely in the upper rather than lower castes. When the British Colonial government outlawed female infanticide in 1870, they stated that the two chief causes were “pride and purse.” “Purse” referred to the dowry. “Pride” referred to pride of the upper castes and tribes that would rather murder female infants than give them to a rival group even in marriage (Miller, 1987). This may at least partially explain why infanticide also occurs in middle-class and wealthy families.

Birth order appears to be a significant risk factor for girls, with second, third or fourth (or later) born girls at highest risk. First-born daughters are often allowed to live because they will help with the household chores (deLamo, 1997). Perhaps this reflects a general negative attitude toward girls that goes beyond the need to provide a dowry.

Sex-selective neglect may also contribute to female mortality. Girls are breastfed less frequently and for a shorter duration. To us, this may seem to be no big deal, but in

the developing world, this puts them at significant risk. Further, when girls get sick, the family is much less likely to seek medical assistance. One public health physician described this case:

In one village, I went into the house to examine a young girl and I found that she had an advanced case of tuberculosis. I asked the mother why she hadn't done something sooner about the girl's condition because now, at this stage, the treatment would be very expensive. The mother replied, "then let her die. I have another daughter." At the time, the two daughters sat nearby listening, one with tears streaming down her face (Miller, 1987, p. 95).

In one study of infants, toddlers and preschoolers, 71% of females were malnourished compared to 28% of males. Boys are taken to the hospital twice as often (Venkatramani, 1992). Moreover, only 24% of girls in India are literate, compared to 47% of boys, and 84% of boys go to school, compared to 54% of girls. Further, girls comprise 85% of the child labor force. The work is often dangerous, putting them at further risk (Miller, 1987; World Vision, 1994).

Recent efforts to save baby girls in Tamil Nadu have not been particularly successful. Family honor is a barrier to these intervention efforts. Families don't want to allow a girl to live if she will go through life as an outcast, with no caste, identity, or family background. Also, families are concerned that the girl may one day return to dishonor the family or seek vengeance (de Lamo, 1997). For interventions to be successful, they must support parents and address their concerns about the future.

Conclusions

In this chapter, I have presented some grim examples of the victimization of female children. Many of these practices are so pervasive and embedded in the culture that it is hard to believe that they will ever change. As bad as things are, however, there is reason to hope. First, as world attention is drawn to the plight of girls, we can hope that the light of public scrutiny will bring changes to pass. Second, the victims themselves are beginning to act. In our own country, we have witnessed a dramatic increase in awareness of sexual abuse over the past 20 years because survivors of sexual abuse are speaking out. But there is still much to do. Girls are still being sexually abused and our society still doesn't seem to be able to protect them. We also need to increase awareness of the other types of child maltreatment that affect both boys and girls, and develop effective strategies to detect and prevent it.

We have also become much more aware of the neglect and abuse of girls in other countries. People wishing to change these practices, however, need to approach the cultures that permit them with sensitivity and knowledge about why they occur. Otherwise, their efforts will backfire. A similar caution is urged by the Director-General of the World Health Organization's Global Commission on Women's Health, in a speech made April 12, 1994 (WHO, 1996, pp. 2-3). In this speech, he was addressing the issue of female circumcision, but his remarks are relevant to infanticide as well.

We must always work from the assumption that human behaviors and cultural values, however senseless or destructive they may look to us from our particular personal and cultural standpoints, have meaning and fulfil a function for those who practice them. People will change their behavior only when they themselves perceive the new practices proposed as meaningful and functional as the old ones. Therefore, what we must aim for is to convince people, including women, that they can give up a specific practice *without* giving up meaningful aspects of their own cultures.

Table 1

Effects of sexual abuse on children: Most commonly occurring reactions

Age	Most Common Symptom
Preschoolers	Anxiety Nightmares Inappropriate sexual behavior
School-age	Fear Mental illness Aggression Nightmares School problems Hyperactivity Regressive behavior
Adolescents	Depression Withdrawn, suicidal, or self-injurious behavior Physical complaints Illegal acts Running away Substance abuse

Source: Kendall-Tackett, Williams and Finkelhor (1993) ©American Psychological Association. Used with permission.

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