Women who sexually abuse children

Doctors need to become sensitised to the possibility

The true extent of sexual abuse of children has been acknowledged only recently. In 1980 Mrazek estimated that between one quarter and one third of all children have had at least one sexual experience with an adult.[1] Much research has confirmed the traditional view that sexual abuse is perpetrated by men on women and girls: typically, over four fifths of sexually abused children are female[2] and over 95% of abusers are male.[3-6] But it seems that the numbers of sexually abused boys and women perpetrators are being seriously underestimated: Krugman found that two fifths of victims seen at the Kempe Centre were boys,[7] and Finkelhor and Russell computed that women may account for up to 13% of the abuse of girls and nearly one quarter of the abuse of boys.[8] Today the medical profession is slowly and reluctantly having to acknowledge that the prevalence of women who sexually abuse children is greater than previously thought. Necessarily the following discussion may shock some readers, but professionals should be aware of the salient facts.

For centuries mothers have been known to soothe boy babies to sleep by stroking and sucking their penises. If such "playful" manipulation of a baby boy's genitals is common today—and anecdotal evidence suggests that this is the case—the practice is likely to be regarded as benign and an expression of a mother's love. On the other hand, a father who owned up to fondling or kissing his baby daughter's genitals would evoke much disquiet and would probably be considered to have committed sexual abuse.

Few studies have been reported on women sex abusers, whether paedophiles in general (women who are sexually aroused by children) or perpetrators of mother-son incest in particular. Most reports take the form of single case histories, usually with a psychoanalytical orientation.[9] In attempts to increase numbers within a sample different categories of women abusers are sometimes grouped together: the independent offender, the coabuser, and the accomplice. In a study of 40 women abusers Faller found that their mean age was 26 and that the mean age of the victims was 6.[10] Seventy per cent of the victims were aged between 4 and 10, 20% were younger than 4, and 10% were older than 10. Four fifths of the perpetrators were mothers to at least one of their victims, and three fifths had abused two or more children. Of 63 victims, 23 were boys.

In her study Faller found that the most common forms of abuse perpetrated by women were fondling of a child's genitals, oral sex, digital masturbation, and actual sexual intercourse, in that order. In nearly half of the cases there were at least two perpetrators and two or more victims, often in polyincestuous family situations, with the abuse usually initiated by men.[10] In a review of 16 cases of mother-son incest Margolin included examples of oral sex (mothers fellating sons and encouraging them to perform cunnilingus) and mutual masturbation. There were eight cases of sexual intercourse: four of the boys were aged around 12, the remainder being in their early and middle teens. One of the 12 year old boys was described as having an erection during intercourse but not experiencing orgasm, while another attained orgasm without ejaculation.[11] In seven of the eight cases of mother-son abuse reviewed by Krug the seduction of prepubescent sons had been continued into early adolescence.[12] My clinical impression is that initial genital fondling by mothers of prepubescent sons may develop over years into full sexual intercourse as the boys grow and mature.

Apologists have sought to show that women who sexually abuse children usually have some psychotic illness. Yet in Faller's study fewer than one in 10 women were psychotic—many fewer than in an earlier study by Mathis, who found that all mothers who abused their sons were suffering from a psychotic illness.[6] In her study of 21 women perpetrators of incest McCarty also found a low incidence of psychosis,[3] while Krug found no evidence of psychosis in his eight cases.[12]

McCarty found that the typical woman perpetrator had been sexually abused herself as a child (usually by a brother), and that although most had married as teenagers, two thirds were now living as single parents.[3] In these and other studies alcohol and drug abuse seem to have been facilitating factors, especially when the woman perpetrated the abuse independently and not as a co-offender or an accomplice.[13] Several of the women abusers known to me started sexually abusing children when they were employed as teenage babysitters. The seriousness of the effects of female abuse on the victims, and whether boy victims suffer more psychosocial sequels than girl victims, are issues that are still debated.[11 12 14] Nasjleti has shown that adult rapists often give a history of having been abused by their mothers in childhood.[15] In his study of sex offenders who had been apprehended or jailed, or both, Groth found that half had been sexually abused when young and a quarter of these had been victimised by women.[16]

Before the public is convinced of the true extent of female sexual abuse doctors first have to suspend their disbelief. A respected child psychiatrist recently dismissed as "an obvious fabrication" and "a physical impossibility" the account of a 7 year old boy who had described to his teacher how his mother had taken him into her bed and placed his "willy" in her "fanny" and used her son as a masturbatory implement. Recently I was asked to assess the likelihood of a successful rehabilitation of a 9 year old boy back to a single, alcoholic mother who, despite overwhelming evidence to the contrary, was vehemently denying that she had encouraged her son to fondle her breasts and genitals while she manipulated his penis with a spoon. If the sexes had been reversed it is difficult to conceive of any social service department contemplating the return of a young girl to the sole care of a drunken, abusing father. Another widely publicised case seemed to apportion equal responsibility to a woman in her 20s and a 12 year old boy who had been having regular sexual intercourse for over a year. The woman was found guilty of sexual abuse but (quite correctly) was not sent to gaol. No condition of treatment was written into her two year probation order. Nevertheless, a man who had seduced a prepubescent girl might have expected to receive at least two years in gaol. The leniency afforded to women by the courts probably explains why only 1% of sex offenders who are sent to prison are women.[17] The judge in the case commented, "Least said soonest mended," thereby choosing to ignore the potential danger this woman may pose to other boys in the future.

Doctors need to become sensitised to the extent of sexual

BMJ: first published as 10.1136/bmj.300.6733.1153 on 5 May 1990. Downloaded from http://www.bmj.com/ on 20 April 2024 by guest. Protected by copyright.

abuse by women, and research must be undertaken to identify similarities and differences between men and women offenders—especially with regard to the motivation to abuse, the selection of victims, the efficacy of treatment, and the propensity to abuse again. Despite the feminist tenet "No penis, no harm," clearly sexual abuse can no longer be considered the exclusive preserve of men.[18]

ROBERT WILKINS
Consultant Child and Adolescent Psychiatrist

Paxton House,
Reading RG3 2BA

1 Mrazek PB. Annotation: sexual abuse of children. *J Child Psychol Psychiatry* 1980;**21**:91-5.
2 American Humane Association. *National study on child neglect and abuse*. Denver: American Humane Association, 1981.
3 McCarty LM. Mother-child incest: characteristics of the offender. *Child Welfare* 1986;**65**:447-59.
4 Kendall-Tackett KA, Simon AF. Perpetrators and their acts: data from 365 adults molested as children. *Child Abuse Negl* 1987;**11**:237-45.
5 Mrazek P, Lynch M, Bentovim A. Recognition of sexual abuse in the United Kingdom. In: Mrazek P, Kempe CH, eds. *Sexually abused children and their families*. Oxford: Pergamon Press, 1987:35-50.
6 Mathis J. *Clear thinking about sexual deviations: a new look at old problems*. Chicago: Nelson-Holt, 1972.
7 Krugman R. Recognition of sexual abuse in children. *Paediatrics in Review* 1986;8:25-39.
8 Finkelhor D, Russell D. Women as perpetrators. In: Finkelhor D, ed. *Child sexual abuse: new theory and research*. New York: Free Press, 1984:171-87.
9 Margolis M. A case of mother-adolescent son incest: a follow-up study. *Psychoanal Q* 1984;**53**:355-85.
10 Faller KC. Women who sexually abuse children. *Violence and Victims* 1987;**2**:263-76.
11 Margolin L. The effects of mother-son incest. *Lifestyles: A Journal of Changing Patterns* 1986;5:104-14.
12 Krug RS. Adult male report of childhood sexual abuse by mothers: case descriptions, motivations and long-term consequences. *Child Abuse Negl* 1989;**13**:111-9.
13 Groth AN. The incest offender. In: Sgroi SM, ed. *Handbook of clinical intervention in sexual abuse*. Lexington: Heath, 1982:215-39.
14 Parsons T. The incest taboo in relation to social structure and the socialization of the child. *Br J Sociol* 1954;5:101-17.
15 Nasjleti M. Suffering in silence: the male incest victim. *Child Welfare* 1980;**59**:269-75.
16 Groth AN. Treatment of the sexual offender in a correctional institution. In: Greer J, Stuart I, eds. *The sexual aggressor: current perspectives on treatment*. New York: Van Nostrand Reinhold, 1983:160-76.
17 Groth AN. *Men who rape*. London: Plenum, 1979.
18 Banning A. Mother-son incest: confronting a prejudice. *Child Abuse Negl* 1989;**13**:563-71.

Unwanted pregnancies

High abortion rates indicate failure of family planning services

The vote last week in the House of Commons reducing the time limit for legal termination of pregnancy from 28 to 24 weeks' gestation (with certain exceptions) has been accepted by all concerned as marking the end of attempts by this parliament to amend the Abortion Act 1967. Public attention should now switch to the inconsistencies and defects in the way the act has been operating and in the provision of family planning services. Whenever parliament has debated the time limit for termination the medical profession has tried to explain that the way to reduce the numbers of late abortions is to make early abortion easier. One of the main reasons for late abortions remains the delay between a woman going to her doctor and the procedure being carried out: a survey by the Royal College of Obstetricians and Gynaecologists found that 45% of women operated on between 13 and 16 weeks' gestation and one fifth of those operated on after 20 weeks had seen their doctors before 13 weeks.[1] Much of this delay is linked with the variation throughout Britain in the way the act is interpreted. Half of the British women who have terminations pay for them—but the proportion varies from 82% in the west midlands to 15% in the Northern region.[2] Far too many women seeking termination still meet covert opposition and obstruction from doctors who dislike the concept of abortion on demand—yet in most of the country that is the way the act is interpreted.

Other countries—France, Italy, and The Netherlands—have recently given women a right to choose an abortion in the early months of pregnancy. Opinion polls in Britain show that around 80% of people think that women should have this right[2]—and if they did we believe that the numbers of late abortions would fall substantially. Meanwhile the Departments of Health have a duty to ensure that all women—wherever they live—have equal access to NHS clinics providing a fast, caring, and efficient service for early terminations.

Late or early, however, the total number of abortions is far too high. In Britain in the 1980s one in every five pregnancies was terminated; and almost all abortions are done essentially because the pregnancy was unwanted (less than 2% are for fetal abnormalities).[3] Since the 1970s four out of every 10 conceptions outside marriage have ended in termination of the pregnancy. These figures horrify the campaigners against the Abortion Act and they should horrify us all. Termination of a pregnancy must always be a miserable event for the woman, her partner, her family, and the doctors and nurses concerned.

The most effective way to reduce the numbers of abortions is not to make them illegal or more difficult but to reduce the numbers of unwanted pregnancies. Research studies have consistently shown that the way to achieve that goal is by making sex education and contraception readily and freely available to the whole population—but especially to the young and single. The rate of abortion per 1000 women aged 15-44 in England and Wales is more than twice that in The Netherlands—clear evidence that our services need improvement.[2]

Yet throughout Britain family planning clinics are being shut and services reduced as health authorities look for ways of making financial savings. Last week the Labour Party's shadow health minister, Harriet Harman, quoted cuts of 20-50% in every NHS region, affecting particularly rural and peripheral clinics and clinics for teenagers. Many general practitioners who offer contraceptive advice do not fit intrauterine devices or caps, nor do general practitioners provide condoms. Alternatives to oral contraceptives are needed, however, at a time when many women have been influenced by reports linking the contraceptive pill with cancer and when the use of barrier contraceptives is being encouraged to reduce the risks of acquiring sexually transmitted diseases.

High priority should, we believe, be given to the maintenance and improvement of family planning services, and that will require specific government action. Most health authorities face such financial problems that they cannot take the long view. We are told that the NHS must become more efficient. Preventing unwanted pregnancy must be one of its most cost effective activities—and one that also helps reduce the total sum of human unhappiness.

TONY SMITH

Deputy editor, *BMJ*

1 Royal College of Obstetricians and Gynaecologists. *Report on fetal viability and clinical practice*. London: Royal College of Obstetricians and Gynaecologists, 1985.
2 Munday D, Francome C, Savage W. Twenty one years of legal abortion. *Br Med J* 1989;**298**:1231-4.
3 Office of Population Censuses and Surveys. *1988 Abortion statistics. England and Wales*. London: HMSO, 1989. (Series AB, No 15.)

BMJ: first published as 10.1136/bmj.300.6733.1153 on 5 May 1990. Downloaded from http://www.bmj.com/ on 20 April 2024 by guest. Protected by copyright.