



University of Cyprus  
Department of Psychology

Technical Report

**Strengthening national policies to stop sexual violence against children:  
A Council of Europe project involving pilot initiatives in Cyprus**

Irene-Anna Diakidoy, Kostas Fanti, Eleni Karayianni,  
Maria-Zoe Hadjicharalambous, & Evita Katsimicha

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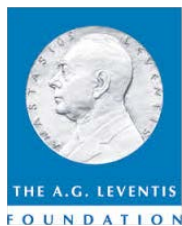
Report of the research co-funded by the A.G. Leventis Foundation and the Parliamentary Assembly of the Council of Europe (PACE), in the framework of the Council of Europe ONE in FIVE Campaign.

Council of Europe campaign  
to stop sexual violence  
against children



ένα  
στα πέντε

Εκστρατεία του Συμβουλίου της  
Ευρώπης για τον τερματισμό της  
σεξουαλικής βίας κατά των παιδιών



## **“1 in 5” Research Project Final Report**

### Summary

#### **“Strengthening national policies to stop sexual violence against children: a Council of Europe project involving pilot initiatives in Cyprus”**

The research project aimed (a) to define the incidence and nature of child sexual abuse in Cyprus, (b) to identify actions already in place and their effectiveness, and (c) to provide recommendations for a revised action plan. The overall motivation for this research was to put Cyprus in a position to ratify and implement the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (“Lanzarote Convention”). This objective was achieved in the Fall of 2014.

The sample included 2000 adolescents and young adults, 15 to 22 years of age (75% female) recruited from high schools, technical schools, universities and colleges around the country, and 169 professionals from education, health and legal sectors. The adolescents completed online a questionnaire that was based on the ICAST (Zolotor, Runyan, Dunne et al, 2009). A different questionnaire was developed for professionals in order to measure their frequency of contact with sexual abuse cases, the types of sexual abuse cases they encounter, the procedures they implement in handling them and their background training in handling sexual abuse cases.

Overall, the results indicated that 19.6 % of adolescents reported having experienced at least one type of sexual abuse with the most frequent types of sexual abuse being speaking in a sexual way directly (16.5%) or through the internet (19%), showing and/or touching body private parts (average 9 %), photo and/or video solicitation (average 8.3 %), and having sexual intercourse (7 %). In the majority of the cases, the perpetrator was a boy or a man that was known to the victim (average 66 %). Finally, only 14 % of those who had experienced some type of sexual sought help from family or professionals. Professionals, on the other hand, reported coming into contact with sexual abuse cases (38 %) but having little knowledge in how to handle cases appropriately and effectively or about the legal framework. Although the majority (90 %) of those who have had contact with sexual abuse cases reported doing something about them, they also cited insufficient evidence, fear/hesitation on their part, and intervention by the victim’s family as the more frequent reasons for doing nothing. Follow-up interviews with representatives of the Social Welfare Services of the Ministry of Labour (SWS), Ministry of Health Mental Health Services (MHS) and the Ministry of Education Educational Psychology Services (EPS) indicated a common understanding of what constitutes child sexual abuse and the prevalence of the phenomenon in Cyprus but also the obstacles in handling the cases effectively.

These findings indicate that child sexual abuse is indeed a phenomenon in Cyprus as in Europe. Although Cypriot society may have some way to go in terms of openly acknowledging, accepting and addressing the occurrence of child sexual abuse in its communities, it is, nevertheless, imperative that immediate action is taken to implement prevention policies and to make the necessary changes to protect children and safeguard families. For this to occur there needs to be a continuous, well-coordinated, and well-planned effort from individuals and organizations involved and invested in child sexual abuse prevention alike.

## **“1 in 5” Research Project Final Report – Brief Version**

### **Project identification and rationale**

#### *Full Project Title*

“Strengthening national policies to stop sexual violence against children: a Council of Europe project involving pilot initiatives in Cyprus”

The research project aimed to achieve the following:

1. Define the incidence and nature of child sexual abuse in Cyprus,
2. Identify actions already in place and their effectiveness,
3. Provide recommendations for a revised action plan, including proposal of revisions to the current legal framework.

The global objective was to put Cyprus in a position to ratify and implement the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (“Lanzarote Convention”) within the next three years, on the basis of data collection and analysis.

#### *Funding*

Funding for the project was provided by the Parliamentary Assembly of the Council of Europe (PACE) and the A.G. Leventis Foundation, in the framework of the Council of Europe ONE in FIVE Campaign.

### **Project personnel and collaborators**

Department of Psychology,  
University of Cyprus  
1 Panepistimiou Ave, 2109 Aglantzia

Principal Investigators (PI):

Irene-Anna Diakidoy, Ph.D., Associate Professor in Educational Psychology

Kostas Fanti, Ph.D., Assistant Professor in Developmental Psychology

Eleni Karayianni, Psy.D., Licensed Clinical Psychologist (Reg. #178),  
Clinical Practicum Coordinator, Ph.D. in Clinical Psychology

Research Collaborators:

Maria-Zoe Hadjicharalambous, M.Sc., Ph.D. Candidate, Clinical Psychology Program

Evita Katsimicha, M. Phil., School Psychology, Ph.D. Candidate, Psychology Program

## Research Protocol and Results

The current project aimed to cover the gap between past research and data collected by various organizations regarding the incidence of sexual violence against children so as to better aid with the implementation of the “Lanzarote Convention” in Cyprus. This was achieved not only via data collection from a community sample, but also via review and assessment of past data and reports produced, actions taken thus far, and the current state of battling CSA in Cyprus on various levels (e.g., schools, associations and agencies, police, legal system).

Therefore, the overall purpose of the study subsumed three interrelated and complementary objectives.

### Objective 1

Our first objective was to examine and report the incidence and the nature of sexual abuse of children by collecting data in sectors and services most likely to come to contact with this particular violation: public and private health services (Ministry of Health, hospitals, clinics, paediatricians and general practitioners), public and private mental health services (Ministry of Health, counselling centres, and practicing psychologists), social services (Ministry of Labour, child and family welfare services, associations targeting awareness of human and child rights and the prevention of their violation), education services (Ministry of Education and Culture, Educational Psychology Services, school psychologists, school principals, school counsellors and teachers), and law and order services (Attorney General Office, judicial court records, and police records). Epidemiological data from an actual student (ages 15-18) and young adult (ages 18-25) samples were also collected.

We expected the awareness, recording, and reporting of child sexual abuse violations to vary across services as well as within services, influenced by the geographic and socioeconomic characteristics of the targeted area and social groups.

Therefore, we conducted a multi-level field research with representative samples from each sector and service providers, as well as self-reports of abuse incidence, in order to capture the expected variability that would allow us to form a more complete and accurate picture of the incidence and nature of child sexual abuse in Cyprus.

### Objective 2

The question that follows from any data with respect to the incidence and the nature of sexual abuse of children concerns the extent to which any action is taken by each of the above sectors and services in response to reported cases and the nature of such action.

Therefore, our second objective was to examine the extent to which any actions are taken in response to child sexual abuse and the nature of these actions which may vary across sectors and services.

Data collected in the context of this second objective was expected to provide information as to how each of the services identified address and respond to the problem of child sexual abuse.

### Objective 3

We assumed that services which are most likely to come to contact with cases of sexual abuse of children are also more qualified to provide insights as to the ways that would be most suitable for addressing the problem.

Our third objective was to collect input from all sectors and services regarding the legal framework, the procedures, and the plan of action that they consider necessary in order to more effectively prevent and intervene in cases of reported sexual abuse. Best practices in dealing with sexual abuse on a national, multi-level stage were also considered in providing the aforementioned recommendations.

### *Methodology*

The project was completed in a period of 18 months in three separate stages:

In Stage 1, a variety of available materials, such as questionnaires and semi-structured interview guidelines, were examined as to their suitability for the purposes of this study. Materials were further developed and enriched in some cases in order to provide more detailed answers to the specific questions the study posed and to align the current study with the overall current research framework on child abuse, maltreatment and aggression. In addition, permissions to conduct the study were obtained from the Cyprus Bioethics Committee, the Pedagogical Institute, individual schools, universities and social partners.

In Stage 2, data were collected from students within their familiar school setting and young adults. Schools were randomly selected in urban and rural areas. Before data collection, informed consent procedures were followed. Data were also collected from health and social service professionals (education, health, mental health, law and order services) working in the public and private sectors. In addition to information regarding the incidence of sexual abuse in Cyprus, professionals were also asked to report their knowledge of the present legislation/laws, as well as their action plan after identifying a case of abuse. Finally, professionals were also asked to provide an open ended statement expressing their opinion on what the appropriate action after identifying an incidence of child abuse should be.

All actions in Stages 1 and 2 aimed to enable the collection of comprehensive and reliable data, both quantitative and qualitative, on the many forms of sexual violence against children and the main patterns of abuse. This was recognized to be of crucial importance for the design of efficient evidence-based national policies, effective implementation of laws and functional co-operation of professionals to stop sexual violence against children as proposed by Article 10 in the “Lanzarote Convention.”

In Stage 3, self-report and interview data were analyzed using multiple analytical strategies and the results disseminated in the form of presentations, news articles, etc.

### *Participants*

The sample was recruited from high schools, universities and general population in Cyprus (Nicosia, Limassol, Paphos, Larnaca, Ammochostos). In Nicosia 14 high schools were approached and 11 agreed to participate, in Limassol 10 high schools were approached and 7 agreed to participate. In Larnaca, from 7 high schools approached, 4 agreed to participate, in Ammochostos 1 out of 2 and in Paphos, 5 out of 6 accepted to participate. Seven technical schools and two private high schools agreed to participate. Young adults recruited from five

universities (public and private) as well as from the general population in the age group of 15-22 also participated. The final sample was composed of 2000 participants (75% female), 62% were between 15-18 years old, 25% were 19-22 years old and 13% were above 22 years old.

Various professionals were invited from public and private sectors (education, health, mental health, social welfare, law and legal). The sample included 169 professionals, 22 teachers, 2 school counselors, 3 physicians/ psychiatrists, 17 nurses, 72 psychologists/ counselors, 7 social workers, 11 police officers, 8 lawyers and 27 from other occupations. Of those classified as Other, many were volunteers in various organizations and committees while a few were either currently unemployed or retired. Most of participants were women (136 females), 33.5 years old as mean, 67 participants were in public sector and 75 in private. Most of them had a post graduate degree (128 participants).

For the semi-structured interviews 5 professionals (100% women) participated from 3 different public services (i.e., Ministry of Labour Social Welfare Services, Ministry of Health Mental Health Services, and Ministry of Education Educational Psychology Services) and 2 different sectors (i.e., regional and national).

### *Measures*

#### *Self-report Questionnaires (adolescents/young adults)*

The questionnaire that was given to students and young adults were administered online and was divided in four parts. First part was about participants' demographics: gender, age, current location, hometown, nationality, and parents' educational level.

The second part of the self-report questionnaire included questions from the ISPCAN Child Abuse Screening Tools (ICAST; Zolotor, Runyan, Dunne, et al, 2009). The ICAST measures various aspects of sexual violence and other types of maltreatment. For the present study, questions measuring 4 different types of maltreatment were administered: violence (7 items), physical abuse (18 items), psychological/ verbal abuse (23 items) and neglect (7 items). Measuring different types of maltreatment is important as sexual violence does not occur in isolation. Participants rated if each type of maltreatment had happened to them, specifying the timing of the occurrence and the perpetrator.

The third part of the self-report questionnaire included ICAST questions measuring sexual violence (6 items). Participants also answered 6 additional questions measuring cyber sexual violence/ solicitation, survival sex (i.e. trafficking to cover basic needs such as clothes or food) and trafficking, which were developed for the purposes of the current study. Participants who responded positively to any type of sexual violence, had to specify their age at the time of the victimization, who was the perpetrator, the relationship with the perpetrator, and the perpetrator's residence at the time of the abuse.

The fourth and last part of the self-report questionnaire measured the way participants handle the abuse, if and how they sought help, and if the help received was effective.

#### *Self-report Questionnaires (professionals)*

The questionnaire that was given to professionals was administered online and was divided in five parts. The first part pertained to participants' demographics: gender, age, work location (Nicosia, Limassol, Paphos, Ammochostos, Larnaca), sector (government, private,

other), occupation, years of work experience, educational level achieved, education sector, contact with cases of violence against minors, and involvement in dealing with child sexual abuse cases.

The second part assessed training issues. For example, participants were asked to report whether they had obtained specialised training in dealing with violence against children in general and/or specialized to sexual abuse during the formalised training, in the form of continued education, or in their own time. Examples of areas assessed include the length of the training, the depth of the training and type (e.g., victim recognition, assessment, therapy, etc), and knowledge around legal framework on child abuse issues, both local, European, and international.

The third part pertained to specific types of sexual violence against children they have encountered, the types of reporters and perpetrators, as well as the relationship of the reporter and perpetrator to the identified victim.

The next part measured issues of case handling procedures in terms of number of cases handled out of the ones reported, the method utilised to handle the case, the effectiveness of the method implemented, and the decision-making process which aided in deciding to handle the case or not.

The last part of the questionnaire was about knowledge of the legal framework, processed and effectiveness in implementation. For example, participants were asked to indicate knowledge of existing procedures in reporting and handling child sexual abuse cases, their knowledge of the Cypriot legislation, and their assessment of the appropriateness and effectiveness of the guidelines and legislation in their implementation.

### *Semi-structured interviews with key stakeholders*

The semi-structured interview was based on the CSA Prevention Focus Group Questions provided by the Washington Coalition of Sexual Assault Programs (WCSAP, 2013). The specific instrument requires that key stakeholders from various organizations are interviewed on areas such as knowledge, available resources and efforts pertaining to CSA. Participants were asked to provide information in nine general areas about sexual abuse (e.g., definition, frequency, risk and maintaining factors, obstacles in reporting or managing the incidents, etc). They were also asked questions specific to their representative sector in handling sexual abuse incidents. Lastly, feedback was requested on the way prevention of CSA could take place in the future.

## *Results*

### *Adolescents and Young Adults' Results*

*Demographics:* The current epidemiological study collected self-report data from a large ( $N=2000$ ; 75% female) and representative sample of participants. The majority of the participants were 16 to 18 year old (62%), with some participants being in the 19-22 (25%) and 22-25 (13%) age range. The sample was diverse in terms of parental educational levels: 13.4% did not complete high school, 42.5% had a high school education, and 44.1% had a university degree, which is representative of the population in Cyprus. The majority of the participants were of Greek-Cypriot nationality (89.6%). The larger minority was of Greek nationality (6%), with some representation of Turkish-Cypriots (0.3%), Maronite (0.8%), Turkish (1.1%), and other

(2.2%) being reported. The majority of the participants reported that they currently live in the city (72.3% in a city and 27.7% in a village).

Initially, the findings will be presented separately for each question related with different types of abuse, covering the prevalence, age at time of occurrence (i.e., Childhood: 0-11 years old; Early adolescence: 12-15 years old; 15 and up), gender differences in prevalence rates, the reported perpetrator of violence, and the relationship with the perpetrator. Findings will also be reported in group form using graphical depictions.

### Sexual abuse:

*Q1: “Made you upset by speaking to you in a sexual way or writing sexual things about you?”*

From the total sample, **16.5%** (1.9% childhood; 5.3% early adolescence; 7.5% 15 and up) reported yes. Significant gender differences were identified, with boys (13.2%) being less likely to report this type of abuse than girls (17.4%). Most often the perpetrators reported were an adult male (40%; 25% family; Non-family member: 38% unknown, 37% known) or a boy (48%; 24% family; Non-family member: 29% unknown, 47% known). The percentage of reported female perpetrators was lower (12%).

*Q2: “Made you watch a sex video or look at sexual pictures in a magazine or on the computer when you did not want to?”*

A much smaller percentage, **3.5%** (0.7% childhood; 1.3% early adolescence; 1.5% 15 and up) reported yes. Significant gender differences were identified suggesting that boys (5.3%) were more likely to report this type of abuse than girls (3%). In more than half the cases, the perpetrator was a known boy (54%), followed by a known adult male (34%), with the smaller percentage being female (12%).

*Q3: “Made you look at their private parts or wanted to look at yours?”*

A **9.1%** (2% childhood; 3.5% early adolescence; 3.6% 15 and up) reported yes. No significant gender differences emerged. Most often the perpetrator reported was a boy (59%; 27% family; Non-family member: 19% unknown, 54% known) or a man (33%; 24% family; Non-family member: 40% unknown, 36% known). The percentage for females was lower (8%) with the majority being non-family members.

*Q4: “Touched your private parts, or made you touch theirs?”*

A **8.8%** (1.8% childhood; 3% early adolescence; 4% 15 and up) reported yes. No significant gender differences were identified. Most often the perpetrator reported was a boy (52%; 28% family; Non-family member: 16% unknown, 48% known) or a man (37%; 35% family; Non-family member: 16% unknown, 48% known). The percentage for females was lower (11%), with the majority being non-family member.

*Q5: “Made a sex video of you alone or with other people doing sexual things”*

The small percentage responding yes to this question, **1.5%** (0.2% childhood; 0.4% early adolescence; 0.9% 15 and up) suggests that this type of sexual abuse is the lowest in prevalence. No significant gender differences emerged. Most often the perpetrators reported were an adult male (48%; Non-family member: 50% unknown, 50% known) or a boy (43%) who was a non-



family member. The percentage for females was 9%, with the majority being non-family members.

*Q6: “Tried to have sex with you when you did not want them to?”*

From the total sample, **7%** (0.8% childhood; 2.7% early adolescence; 3.5% 15 and up) reported yes. No gender differences were identified. Most often the perpetrators reported were an adult male (42%; 17% family; Non-family member: 12% unknown, 71% known) or a boy (45%) who was not a family member but known to the victim. The percentage for females was 13% with the majority being family members.

*Online sexual solicitation:*

*Q7: “Talked to you in a sexual way via internet or mobile phone”*

The high percentage responding yes to this question, **19%** (0.3% childhood; 7.5% early adolescence; 11.2% 15 and up), indicates that this type of solicitation is the highest in prevalence. Significant gender differences were identified where boys (13%) were less likely to report this type of abuse compared to girls (21%). Most often the perpetrators reported were an adult male (43%; Non-family member: 64% unknown, 36% known) or a boy (45%; Non-family: 45% unknown, 55% known). The percentage for females was 12%, with the majority being non-family members (40% unknown, 60% known).

*Q8: “Asked you to meet via internet or mobile phone, and were not the person they had presented to be (older)”*

The smallest percentage regarding types of online sexual solicitation, **3.4%** (1.7% early adolescence, 1.7% 15 and up), was reported for the question suggesting that this type of sexual solicitation is the lowest in prevalence. No significant gender differences were identified. In more than half the cases the perpetrator was a non-family member adult male (60% of cases; 80% unknown, 20% known), followed by a non-family member boy (25%; 60% unknown, 40% known), with the smaller percentage being female (15%; 10% family; Non-family member: 50% unknown, 50% known).

*Q9: “Asked to record you or view you live via internet in order to get sexual arousal or satisfaction”*

A **8.7%** (4% early adolescence; 4.7% 15 and up) reported yes. No significant gender differences emerged. Most often the perpetrator reported was a man (50%; Non-family member: 83% unknown, 17% known) or a boy (35%; Non-family member: 74% unknown, 26% known). The percentage for females was 15% with the majority being non-family members, unknown (75%) to the victim.

*Q10: “Asked you to send them naked photos of you or with sexual content via internet or mobile phone”*

A **7.8%** (3.2% early adolescence; 4.6% 15 and up) reported yes. No significant gender differences were identified. Most often the perpetrator reported was a man (44%; Non-family member: 80% unknown, 20% known) or a boy (44%; Non-family member: 50% unknown, 50% known). The percentage for females was 12% with the majority being non-family members, unknown to the victim.

### Survival sex and trafficking:

*Q11: “Made/Asked you to have sex or engage in other sexually related activities either with them, or with other people in exchange of money or other types of bribe (e.g. food, clothes, etc)”*

From the total sample, **1.7%** (0.5% early adolescence; 1.2% 15 and up) reported yes. No gender differences were identified. Most often the perpetrator reported was an adult male (56%; Non-family member: 71% unknown, 29% known), followed by boys (24%; Non-family member: 50% unknown, 50% known) and females (20%; Non-family member: 50% unknown, 50% known).

*Q12: “Made/Asked you to go to another district or to the occupied area in order to engage in sexually related activities (e.g. sex) for your and/or their financial reward”*

A **0.8%** (0.2% early adolescence; 0.6% 15 and up) of the sample reported yes in response to Q12. No significant gender differences were identified. Importantly, the only type of perpetrator reported for this question was an adult male, known to the victim.

### *Summary of findings*

Figures 1 to 3 present the findings for all twelve questions for comparison purposes. As shown in figure 1, the higher percentages reported were Q1 and Q7 suggesting that these items represent the types of sexual abuse with the highest prevalence. The majority of items ranged from 7% to 9.7%, with Q2 and Q5 having the lowest prevalence for sexual abuse, and Q8 for solicitation. Questions pertaining to survival sex and trafficking had in general low percentages, as expected.

As reported in figures 2 and 3, adult males and boys were equally likely to be reported as the perpetrators for Q1, Q5, Q6, and Q7. Boys were more likely to be reported as the perpetrator for sexual abuse questions 2, 3, and 4, while adult males were more likely to be the perpetrators for sexual solicitation questions 8 and 9 and for questions involving survival sex and sexual trafficking.

After grouping questions together according to overall type of sexual violence against children, the total prevalence for sexual abuse (Q1 – Q6) was 23.7%, for sexual solicitation 23.8% (Q7 – Q10), and for sexual trafficking 1.9% (Q11 and Q12). It noteworthy, however, that 1% of the sample had experienced all three forms of sexual violence, while 10.8% of the sample had experienced any two forms of sexual violence.

Finally, participants were asked whether they asked for help after the incidence of sexual abuse. Among participants who were abused, 86% did not ask for help and only 14% asked for help. Of those who asked for help, 8% reported that they went to a professional (police - 2%, lawyer - 1%, hospital/psychiatric services - 2%, private physician - 1%, psychologist - 1%, social services - 1%), and 6% reported someone they knew, with 4.5% going to family members (immediate or extended) and 1.5% to friends.

## Percentage-types of sexual abuse

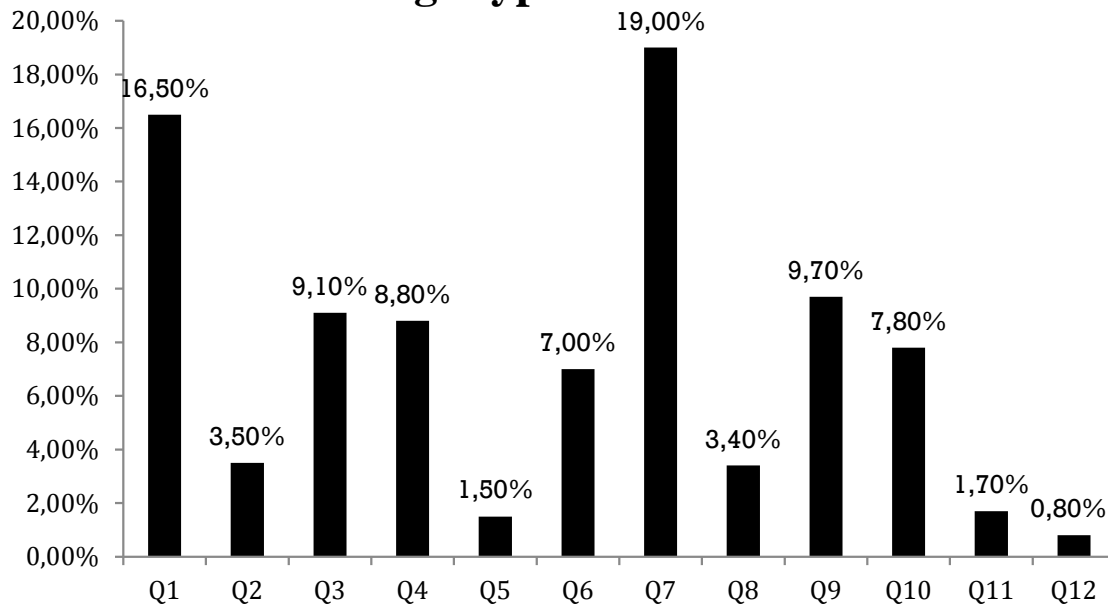


Figure 1: Percentages of different types of sexual abuse.

## Perpetrator-adult male

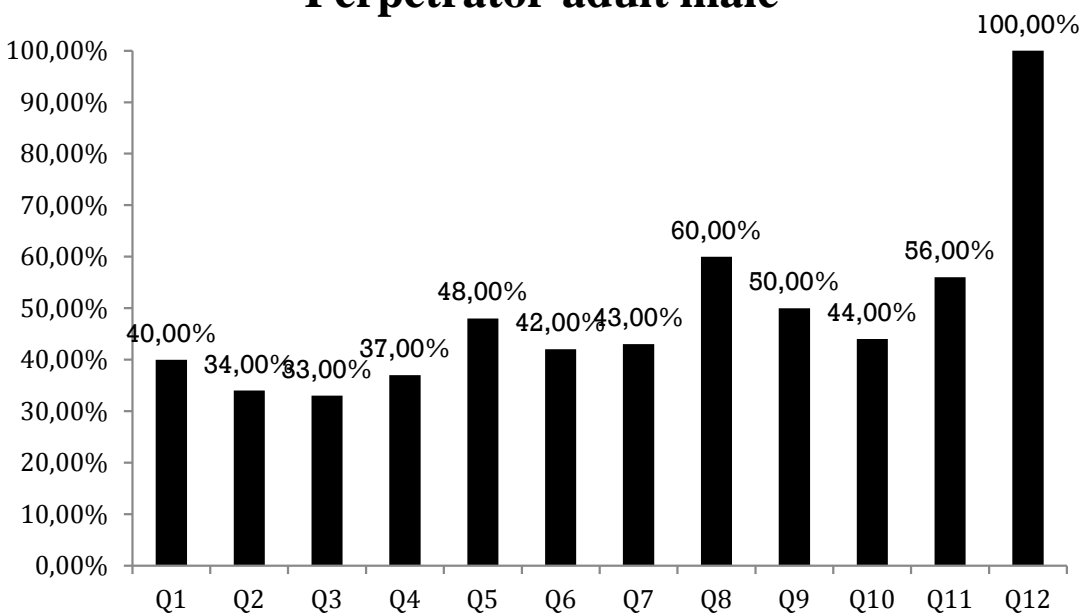


Figure 2: Percentage of adult males as perpetrators.

## Perpetrator-boy

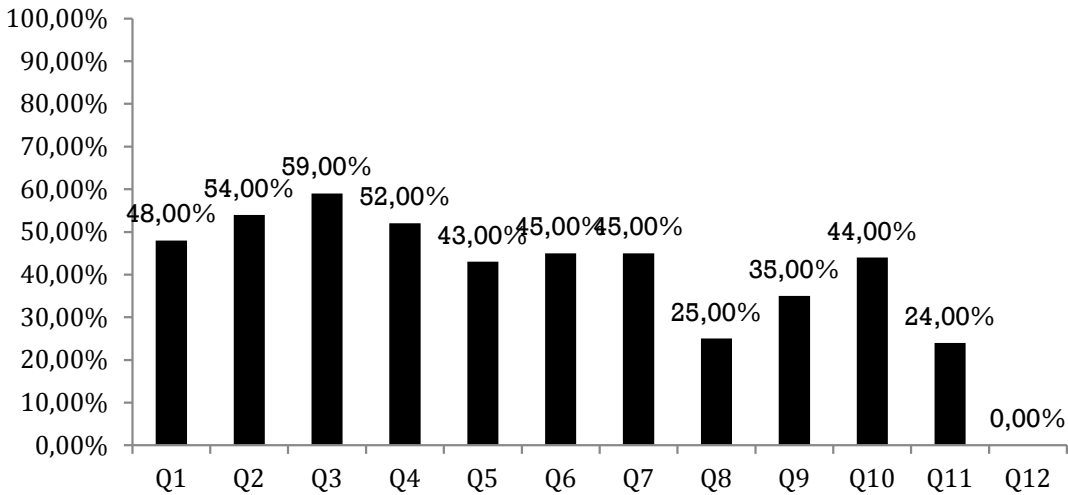


Figure 3: Percentage of boys as perpetrators.

### *Professionals' Results*

#### Results from the questionnaire

Due to the relatively limited number of professionals who completed the online questionnaire and the ensuing limited data, responses obtained from different but related questions in each part of the questionnaire were pooled together in order to provide a more cohesive and comprehensive picture of key aspects regarding the incidence of abuse and sexual abuse according to their reports as well as their knowledge and actions in handling abuse and sexual abuse cases.

Table P1 shows the sample's professional situation and characteristics in each Occupation category. It is notable that the professionals who choose to respond to the questionnaire are relatively young with few years on their job.

*Table P1.* Gender, Mean Age, Work Sector, and Average Years of Professional Experience.

Occupation	Gender (M/F)	Mean Age	Work Sector (Public/Private)	Prof. Experience
Education	3 / 21	31.5	12 / 7	6.9
Health	4 / 16	34.6	15 / 4	10.3
MHSW <sup>a</sup>	16 / 63	34.1	20 / 47	8.3
Law/Legal <sup>b</sup>	5 / 22	33.3	7 / 13	10.7

Other	5 / 22	31.9	7 / 13	7.6
Total <sup>c</sup>	33 / 136	33.4	67 / 75	8.5

<sup>a</sup> Professionals in Mental Health and Social Welfare

<sup>b</sup> Professional in Police Force and Judicial System

<sup>c</sup> Total N less than sample size due to missing values in some questions.

Although the majority have a high education level as indicated by the numbers having obtained at least one postgraduate degree, few report having had any relevant education or training during their studies in handling abuse cases in general and sexual abuse cases in particular (see Table P2). Professionals in the Mental Health, Social Welfare, Law Enforcement and Legal categories report more relevant knowledge. However, the differences between occupation (categories) and work (public/private) sectors are not statistically significant.

*Table P2.* Education Level and Relevant Education for handling Abuse and Sexual Abuse Cases.

Occupation	Education Level (Bachelor/Postgraduate)	Relevant Education (%)
Education	7 / 17	29 %
Health	8 / 10	30 %
MHSW	7 / 72	46 %
Law/Legal	12 / 7	42 %
Other	7 / 20	15 %
Total <sup>a</sup>	41 / 128	36 %

<sup>a</sup> Professionals having only a High School Diploma = 8.

Table P3 shows the percentage of professionals who have had contact with one or more abuse and/or sexual abuse cases. As expected, the correlation between years of professional experience and contact with abuse and sexual abuse cases was positive and significant. Although a higher percentage of education professionals report having contact with abuse cases, caution must be exercised in interpreting this result given the very low number of professionals in this category ( $n = 24$ ) who participated in this study.

*Table P3.* Percentage of Professionals reporting contact with Abuse and Sexual Abuse Cases.

Occupation	Abuse Cases	Sexual Abuse Cases
Education	67 %	29 %
Health	45 %	30 %
MHSW	67 %	51 %
Law/Legal	47 %	42 %
Other	37 %	15 %
Total	57 %	38 %

It must be noted, however, that professionals who report having had contact with abuse and sexual abuse cases also report having more relevant education for handling them than those who report no contact. An examination of the responses to the more detailed questions regarding relevant education indicated that, in addition to formal training and education, a number of professionals who have had contact with abuse and sexual abuse cases obtained relevant education through professional development seminars and workshops or on their own initiative.

However, when asked to indicate in more detail the extent of their knowledge in recognizing, screening, evaluating, interviewing, preventing, intervening, and legal issues, it becomes obvious that the extent of the professionals' relevant knowledge in handling abuse and sexual abuse cases is limited (see Table P4) and the differences between occupation and work sectors are not significant.

*Table P4.* Extent of Relevant Knowledge in handling Abuse (max. possible = 12) and Sexual Abuse (max. possible = 11) cases overall, and of the Legal Aspects (max. possible = 4) in the sample.

Occupation	Abuse Mean (min/max)	Sexual Abuse Mean (min/max)	Legal Aspects Mean (min/max)
Education	1.5 (0/10)	1.2 (0/9)	0.4 (0/2)
Health	1.9 (0/10)	1.5 (0/8)	0.4 (0/3)
MHSW	2.6 (0/12)	2.2 (0/11)	0.5 (0/4)
Law/Legal	2.9 (0/11)	2.4 (0/10)	1.0 (0/4)

Other	1.5 (0/12)	1.3 (0/11)	0/6 (0/4)
Total	2.2 (0/12)	1.8 (0/11)	0.6 (0/4)

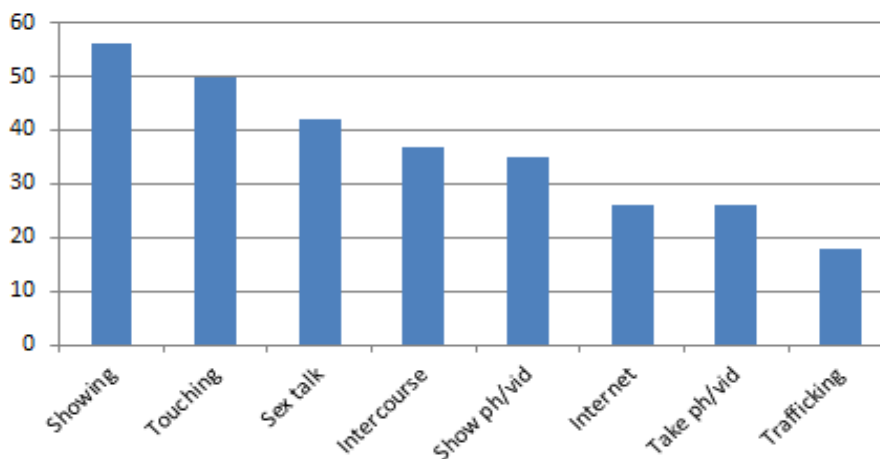
Note. Differences in occupation categories regarding knowledge aspects (e.g., legal vs. psychological interviewing, screening, intervening, etc.) were taken into account.

Therefore, those who report having relevant knowledge (education and training) tend to have knowledge that is limited to one or few aspects of handling the cases such as recognizing characteristics, interviewing, designing prevention programs, etc., only.

With respect to sexual abuse cases in particular, it must be noted that results and therefore, conclusions are limited due to a high number of missing values (no response) to the relevant questions. In fact, only 31 Professionals continued responding to the relevant questions. Nevertheless, professionals reported having encountered an average of 2.9 cases (min/max = 0/80), with those in the public sector reporting more cases on the average ( $M = 3.8$ ) than those in the private sector ( $M = 2.4$ ). The victim (15 %), his/her family (19 %) and/or friends (15 %) are more frequently seeking help than the perpetrator (0 %), his/her family (11 %) and/or friends (7 %). A substantial number of sexual abuse cases professionals encountered were referred to them by educators (15 %), health professionals (7 %), psychologists and social workers (26 %), the police (5 %), or anonymously (2 %). Therefore, it appears that psychologists and social workers followed by educators are the ones who refer more frequently sexual abuse cases to other professionals.

With respect to the kinds of sexual abuse professionals reported having contact with, showing (56 %) and touching private parts (50 %) represent the most frequent kinds of sexual abuse encountered by professionals:

### Types of CSA encountered by Professionals (%)



The majority of professionals (90 %) indicated that they proceeded to handle the case(s) by referring or reporting (83 %) to another professional (supervisor, psychologist, social worker, police) or by evaluating (72 %) or intervening (72 %) in a manner appropriate for the occupation category. Moreover, the professionals considered that their handling was effective in 73 % of the sexual abuse cases in protecting the victim. In some cases, however, professionals reported that they did not or could not handle a sexual abuse case. The reported reasons for doing nothing were the lack of sufficient evidence (32 %), fear/hesitation on their part (19 %), intervention by the victim's family (17 %), lack of effective procedures or services (15 %), lack of services (13 %), or the refusal of the victim (13 %).

### Results from the interviews

Interviews were conducted with representatives of the Social Welfare Services of the Ministry of Labour (SWS), Ministry of Health Mental Health Services (MHS) and the Ministry of Education Educational Psychology Services (EPS). Overall results indicate that, even though the role of the three services differs significantly in the handling of cases, there appears to be a common understanding of what constitutes child sexual abuse, the prevalence of the phenomenon in Cyprus, the obstacles in effectively dealing with the cases, as well the services' potential, needs, and future goals. Common themes/responses given to each question posed are presented below.

#### *General Questions:*

1. *What do you consider child sexual abuse and exploitation?*

The responses here were consistent with the areas covered in the legislation.

2. *What is the frequency of CSA in Cyprus?*

Estimated numbers approximated the 1 in 5 EU statistics. None the less, services reported that there has been a notable increase in reports in the last five years and the statistics might be higher, especially in the age group between 5 to 8 years old.

3. *In what ways is CSA most often discovered?*

School was the most often reported place of reporting. The Police and the Services themselves were the second place of reporting of the cases. It was noted that teenagers tend to report the CSA themselves, as do younger children without realizing they are actually reporting sexual abuse. Quite often, cases are discovered while the children are being referred and evaluated for a different reason.

4. *What do you consider as the reasons for CSA taking place?*

Most often, conditions within the family have been reported as the reasons for CSA taking place within a family. These can include other forms of abuse, CSA, substance abuse, psychopathology, lack of knowledge, intrafamilial and intergenerational abuse, etc.

5. *What preserves the phenomenon within the Cypriot community?*

In addition to family conditions, other factors reported included lack of knowledge in terms of sexual development milestones, the tolerance by the non-offending parent due to their own



history of abuse or lack of symptom recognition, the existence of a common secret within the family and also within the community, where people know, talk about the abuse, but don't intervene as they do not wish to disturb the close relationship that the family of the victim may have with the perpetrator.

6. Which are the possible obstacles in the reporting of cases in Cyprus (e.g., lack of knowledge, religion)?
  - Approaching the child from a young age where a relationship is built with the family also places the victim at a disadvantage where, even when reported, the family does not believe and/or support the child (extensive denial).
  - Families often fear social exclusion, gossip, and the identity of the child/family becoming known.
  - Notable inability of the system to act effectively; i.e., although the reporting process is fast, the case might take up to 3 years to go to court. Usually, perpetrators and families disobey orders, become challenging towards the child, and the child recants. The child is often revictimized.
  - Lack of general, as well as specialized knowledge in identifying cases and effectively responding whether it is by reporting, supporting, or monitoring cases.
  
7. Which are the possible obstacles in dealing with the cases in Cyprus (e.g., lack of knowledge, religion, family)?
  - Ineffective/insufficient protection of the identity of the victim and the family.
  - The lack of effective procedures in handling cases, especially after the reporting stage (as noted above until the case reaches the courtroom).
  - The existing procedures manual is not child focused in terms of handling the case. In addition, while it maps out the procedures, it does not secure the quality of the procedure (e.g., data gathered, communications, continuity of care, etc).
  - The return of the perpetrator to the home, the community (e.g., neighborhood of victim). Usually it is the victim removed from their home leading to further stigmatization of the child.
  - Specialized treatment post-report is limited in terms of available specialized professionals. There is also a notable absence of treatment provisions for the perpetrator. Generally, there is an observed lack of knowledge on the topic even though attempts have been made.
  - The changes in professionals being involved in the case due to service structure and/or lack of follow up/through due to services being understaffed.
  
8. What do you think is creating the community norms of silence around CSA?
  - The belief that a parent will put their child's welfare above all else is not widely held.
  - Factors within the family (as noted above).
  - Within society, people avoid talking about the topic. It is still considered a taboo, so society reacts very conservatively.
  - Lack of knowledge in terms of recognition and dealing with the issue.
  - Social groups tend to exhibit pity towards the victim and the family, the family feels devalued and marginalized, and oftentimes children are labeled as "bad" or "dangerous" because of their sexual knowledge.

- It is commonly observed that when a report is made, children and teens develop fearful response (e.g., that they will be victimized also). Reportedly male teens may approach female victims for sexual favors and they can even bully the victim if she declines.
  - Within the school and also within families, there is great resistance in discussing sex related issues.
9. What is the level of concern regarding CSA and CSA prevention in your community?
- In theory, people agree that something needs to be done. However, practically nothing usually happens. To this contributes a significant difference in perception of what constitutes prevention (e.g., between key players such as schools, parents, church). Furthermore, attempts of communication are usually inhibited by moralization.
  - People do not “speak the same language” in order to communicate effectively and agree on things.
  - There is limited capability to respond preventatively.

*Service-Specific Questions:*

10. Do you consider that you can contribute to the handling of the phenomenon? If yes, how? If not, why?
- All services considered that they can and do contribute to the handling of the cases to the extent that the job can be performed (e.g., limited staff number, limited specialized personnel, workload, effective communication and coordination with other services) and that services are rendered on the basis of legislation (i.e., how the law defines their statutes). They also reported that they could potentially play an even greater role had these limitations not existed.
  - It was noted that while their role is very clear in the handling of CSA cases, the lack of a child focus renders their handling problematic in terms of effectiveness and continuity of care (e.g., time consuming paperwork, time for the case to reach court, family SES and lack of substantial family support).
11. How do you handle reports?
- All services reported having clear in-house procedures about how to handle a case (incoming or in process) once it is reported.
  - Usually an evaluation is conducted and the necessary reports are produced.
  - With the new legislation, a written report is sent immediately to the Police and SWS.
  - It was noted that when “family counselors” were utilized in the past to follow through with the cases, follow up was easier and more efficient (2000-2007).
12. What factors contribute to how you handle reports?
- Previous knowledge and education (e.g., crisis intervention, trauma).
  - The lack of specialized knowledge and skills.
  - The lack of clarification on what constitutes “suspicion” and how it is interpreted for professionals to be able to decide on whether to report or not.
  - Indirect reporting (e.g., if a family member calls a service or the school reporting, but requesting that the person receiving the information make the report in their stead).
  - The lack of inter-disciplinary teams.

- Delays in the legal processing of cases (e.g., court delays).
  - If the report is made during a therapeutic session where the sense of trust has already been established, it is usually easier to report and follow through as the family is already supported psychologically.
13. What is the role of each team within your organization?
- All service professionals were able to vocalize the role of the professionals within their organization in terms of who provides the initial evaluation, who provides the support, etc.
14. What tools do you use to handle the cases?
- Most often used is the clinical interview with the child, the siblings, and the family.
  - When necessary, intelligence testing is performed.
  - In younger ages, projective methods are used (e.g., drawings, play therapy used as assessment).
  - Anatomically correct dolls are seldom used.
  - The existing manual is used as a tool.
  - Video-recording of the interview, as well as other tools within the courtroom (e.g., separation from perpetrator) are used.
  - Efforts are made to connect families to other services.
  - Removal of the child.
  - Evaluation of the family.
15. Which are the tools, which you have not used, but think they may be helpful (e.g., further education, legal counsel, consultation)?
- Decentralization of services (e.g., through an NGO)
  - Improved collaboration between services
  - Specialization of professionals through further education
  - Better organization of departments involved in providing support.
  - Assigning “Family counselors” as noted above
  - Forming interdisciplinary teams in each area/town, which never materialized.
  - Supervision
  - Continued education
16. What areas of staff or organizational capacity are problematic?
- Intra-organization supervision and support
  - Mutual and common policy within organizations and for Cyprus
  - Workload
  - Limited staffing
  - Lack of resources, despite having requested their development repeatedly in the past 8 years.
  - Lack of specialization – everyone does everything
  - Lack of proximity of family with services/support
17. What type of training on CSA do you need?
18. What type of training on CSA prevention do you need?

- Education needs (questions 17 and 18) noted were similar, if not the same in certain areas, for all organizations. Notably, needs covered the following areas:

Basic training:

- Symptom recognition and diagnosis
- Sensitization to the topic in general
- Legislation

Specialized training:

- How to secure follow through, improved collaboration between services
- Interviewing children
- How to talk to a child who has been sexually abused
- How to approach a child that refuses to collaborate
- How to deal with and support children in court
- Implementing CSA evaluation and forensic evaluation, and determining who conducts the various aspects of the evaluation

Suggestions were made on the following:

- Ongoing (systematic) training for continued sensitization and reminder to evaluate/assess cases
- Use of new technologies for training
- Wide provision of materials for professionals
- Training to be provided by one, common provider
- Provide incentives for training

*Future Directions:*

19. What do you envision for the future direction of CSA prevention in Cyprus?

- Creation of a one-stop shop center for evaluation and treatment (e.g., Children's Home in Iceland and other treatment centers in Europe and the USA) where personnel will be experienced and specially trained.
- A team approach to dealing with cases (e.g., multidisciplinary approach) where the team of experts includes psychology, police, welfare, education, and other professionals.
- Improved prevention (e.g., early intervention in people already "in the system" by early recognition of signs/symptoms and handling; parenting skills training for new parents or for young people prior to becoming parents; training for healthier teens on responding to emotional needs, sex education from an early age (Kindergarten), building skills and resilience; school personnel training.
- Increased and/or improved involvement of the services in their respective areas (e.g., EPS to be involved in school/parent/child education) by changing procedures and improving role definitions.
- To try new things by adopting and implementing best practices from abroad
- Creating a child-focused way of handling cases
- Develop a more mature and continued societal mobilization

## Conclusions and Implications

It is evident from the results, both from the adolescents and young adults, and the professionals, that child sexual abuse is indeed a phenomenon in Cyprus similar in incidence as in the rest of Europe. The results clearly indicate that (a) as a society we may have a long way to go in terms of accepting the occurrence of child sexual abuse in our communities and dealing with the matter effectively, and (b) it is imperative that we act as soon as possible in order to protect the children and safeguard families.

Implementing a prevention policy and making the necessary changes to protect children is not an easy task as it calls for a societal paradigm shift. For this to occur there needs to be a continuous, well-coordinated, and well-planned effort from individuals and organizations involved and invested in child sexual abuse prevention alike.

The recommendations outlined below are to provide a general framework for the effort to follow and to be implemented in time in order for the results to be fruitful.

### *Framework for Current Recommendations*

The recommendations were derived from the following areas:

- the results of the present study
- the recommendations made in 2004 following an initial evaluation by the Advisory Committee on the Prevention and Handling of Domestic Violence of the interdisciplinary procedures manual that they produced in 2001, and which had been adopted by services in 2002.
- from best practices noted in the bibliography on CSA, and
- from the literature on evidence-based procedures

It has to be noted that they are also in line with the recommendations made by the United Nations Secretary-General's Study on Violence against Children (A/61/299) released in 2006.

### *The need for a National Plan and a National Task Force*

The National Coalition to Prevent Child Sexual Abuse and Exploitation (2012) proposes a focus on primary prevention and positive youth development. The establishment of a National Plan outlining the goals to be reached can do just that. The National Plan needs to cover areas such as decreasing the risk of future perpetration; increasing the engagement of effective bystander actions; promoting standards that support healthy behaviours and messages, as well as environments and education to support healthy emotional growth; collaboration between media, policymakers, and businesses to develop and implement effective prevention strategies; and promoting steady and secure relationships for children in their environments.

In order for the aforementioned areas to be addressed, the Coalition notes that the National Plan should cover action areas such as instituting ongoing research to evaluate its implementation and effectiveness. In addition, efforts for public awareness need to be continuous and can be enhanced via adopting collaborative practices between organizations, and establishing intra- and inter-organizational practices and guidelines. Such guidelines and practices have been well established in the literature in the recent past as they pertain specifically to CSA and could be easily adapted and adopted to the Cypriot reality. It is imperative that the National Plan take into consideration difficulties in funding efforts and developing an action plan for raising funds for specific projects.

Furthermore, it is strongly evidenced from the results that the National Plan needs to be in line with the new legislation voted in June 2014 and to turn the focus away from services and towards the welfare and wellbeing of the child. Thus, the framework for the Plan ought to be CSA specific, open to ongoing assessment and revision based on developing/changing needs and effectiveness. For this purpose, two conditions need to be upheld: a) supervision of and support for the implementation, and b) creating a record tracking CSA cases.

It is recommended that a National Task Force be created in order to take on the responsibility of proposing such a Plan and overseeing that it is adopted and followed through. The role of the Task Force can include responsibilities such as acting as a policy think-tank where policies are proposed, developed, and modified based on research findings; coordinating and monitoring national programs in collaboration with partner organizations; and, acting as a national advocate for CSA issues to elicit support for programs and projects.

The Cyprus National Plan ought to take into consideration and include the following areas noted below based on the results of the present study:

#### *For the Children and Families*

##### *Child-Focused Education*

Developmentally appropriate prevention programs for children on:

- Personal safety
- Relationships
- Peer abuse and peer support
- Sex education and sex health
- Online safety, cyberbullying, and cyberstalking
- Children's rights
- Self confidence
- Sexual abuse (e.g., legislation, procedures)

While children have been involved at some level in policy-making or advocacy (see Commissioner for Children's Rights Teen Consultants Group, Teen Parliament), there is a notable need for more active involvement of children in children's rights advocacy. Moreover, programs ought to cover all age groups, not just adolescents, in order to be considered preventative and for there to be a measureable effective of prevention in the long run.

##### *Child-Focused Parent Education*

Training programs offered for parents

- Sexual abuse (e.g., general, law, procedures, peer abuse, effective responding, etc)
- Sex education and sex health
- Communication skills
- Parenting skills
- Online safety, cyberbullying, and cyberstalking
- Child safety
- Children's rights

##### *Bridging the gap between families and services*

- Development of multilevel specialized treatment services and easy access to them for traumatized children and their families
  - Including rehabilitation, shelter, foster care, counselling, education, vocational training, and recreation.
- Development of multilevel specialized treatment services for perpetrators (U18 and adult, as for the victims and families).
- Development and dissemination of readily available resources for children and families (e.g., posters, booklets, practical guides of responding to csa)

### *For The Professionals*

#### *Development and Adoption of CSA Guidelines*

- Development and implementation of organization-specific practices, guidelines, and action plan,
- Better definition of role of each organization involved in evaluating and treating cases, and clear guidelines for the connection between organizations,
- Creation of multidisciplinary team(s) within selected key organizations and/or between organizations at a national level in the community to correspond to CSA cases. These teams could include psychologists, counsellors, lawyers, social workers, educators, parents, etc,
- Development and/or adoption of guidelines for handling internal cases, where the CSA occurs within organizations by a staff member (e.g., within schools),
- Adopt and implement standardized interviewing protocols and methods for different age groups so as to secure interviewer neutrality, accuracy and lack of bias of information gathered, and evaluation of interviewing method effectiveness,
- Adopting and implementing innovative techniques for reducing victim stress during court interviews, psychological/forensic and medical examinations. For example, adopting the Children's Home model from Iceland where all professionals are present under one roof to perform one single evaluation of the victim at the time of the report.
- Classification of existing programs to provide a readily available resource guide for children and families in need of services, and to organizations for the development of a networking and referral system.
  - Programs need to undergo continuous evaluation, redesign if needed,
  - Specialized staffing need to be in place (e.g., of hotline, programs providing treatment).

#### *Educational Practices*

- Incorporating training in the training curriculum of psychology, social work, nursing, medical, police, and education students.
  - Promoting the knowledge and adoption of best professional practices in assessing and handling of CSA cases.
- Continued education yearly for professionals involved in the service provision of CSA cases.
  - Education should not only focus on specific aspects of CSA, but also on professionals gaining knowledge regarding healthy developmental milestones (e.g., expected sexual behaviours and knowledge by age) and specialized issues such as CSA in children with developmental needs.

### Multiphasic Education

Training to be provided in two phases of those involved in various aspects of interview, diagnosis, treatment:

- Phase 1: broad training (e.g., recognizing symptoms/diagnosis, multidisciplinary collaboration)
  - Police
  - Psychologists
  - Psychiatrists
  - Social services
  - Judges
  - Schools
  - Doctors/Nurses (frontline staff at hospitals and clinics, paediatricians, pathologists)
- Phase 2: specialized training (e.g., interviewing, evaluation, treatment) to professionals providing specialised services.

### *For the Community*

For this project to be successful in terms of promoting a societal paradigm shift, as well as the National Plan being implemented in its entirety, there needs to be increased involvement of the community. The two guiding principles for the community aspects of the Plan can be:

- By the community and for the community, and
- By adults for children

### Community Programmes

- Increasing Mass Media involvement and gaining exposure for CSA issues year round. This can be achieved via:
  - Social marketing campaigns
  - Establishing guidelines for previewing materials, monitoring of materials presented, reporting and restricting harmful materials.
  - Establishing collaborations with media companies where time is allocated to discuss, debate, and provide visibility to topics surrounding CSA.
- Increasing access to information and resources through technology (especially online). Making these resources readily available in the community (e.g., at schools, after school programmes, youth centres, community mental health centres).
- Working with vulnerable communities to offer services and education opportunities to at risk children, both school and community based.
  - These programmes can include early detection of children-at-risk for violence and provision of preventive services (e.g., community support, psychoeducation).