REVIEW OF ARTICLE

CHILDHOOD AND ADOLESCENT SEXUAL ABUSE: Incidence, Complications and Management

*IF Abdul, FWACS.
Department of Obstetrics and Gynaecology, Maternity Hospital, P.M.B. 1339, Ilorin, Nigeria.

SUMMARY

Sexual abuse in children and adolescents is a silent epidemic because despite the fact that close to 20% of children and adolescents (1 out 5) are affected, less than 10% of the cases get reported to law enforcement agents or medical practitioners.

Sexual abuse is associated with physical injuries such as bruises and lacerations to the neck, back, buttocks, extremities, vulva and the vagina. Other complications relate to sexually transmitted diseases, unwanted pregnancy and psychological pathologies such as intense anxiety, anger, depression, mood swings, nightmares, phobias and somatisation. This review discusses the apparent low incidence and of sexual abuse in children and adolescents, complications as well as management. The aim is to increase the level of awareness of sexual abuse among medical practitioners and improve the care of victims.

(Key word: Sexual abuse; Childhood and Adolescence; Incidence; Complications; Management).

INTRODUCTION

Childhood and Adolescent sexual abuse is a complex clinical problem considering the associated complications in the children requiring multiple specialists' care apart from the psychosocial effects on their parents. Sexual abuse is also a form of violence against children and preventing it is a public health priority according to the World Health Organization (W.H.O) and the Centre for Disease Control (C.D.C)[1]. The issue of sexual abuse was part of violence against women discussed extensively at the fourth world conference on women held in Beijing in 1995[2].

Children and Adolescents are a group whose medical care requires adaptations aimed at understanding their vulnerability in terms of their developing physical structures and immature mental functions. These adaptations by the paediatrician or the gynaecologist as in cases of rape are necessary for a successful therapy[2].

In discussing this topic, a deliberate attempt was made to lump children and adolescents together. Adolescents are a transitional group, with characteristics of children in many respect and adults in a few aspects. Sexual abuse is also important because of its legal[3] and medical aspects, though it is rarely discussed in medical circles despite the possibility of 1 out of every 5 children being sexually assaulted[4,5,6]. An attempt will be made in this article to define sexual abuse, and what constitutes adolescents and children's, apart from looking at the reasons for the apparent low incidence. The specific health complications *vis-a-vis* general physical injuries, gynaecological injuries, infections and psychological problems will be discussed. The management of the complications will follow, and finally preventive measures will be suggested.

WHAT IS A SEXUAL ABUSE?

Sexual abuse has been broadly classified into rape and sexual assault. Rape is an unlawful carnal knowledge of a woman or girl, without her consent, or with her consent, if the consent is obtained by force or means of threats or intimidations of any kind, or fear of harm, or by means of false and fraudulent representation as to the nature of the act or, in the case of a married woman, by impersonating her husband[3]. Sexual assault on the other hand is defined as "any sexual act" performed by one person on another without the person's consent[3]. Sexual assault includes genital, anal or oral penetration by a part of the accuser's body or by an object[3].Although most

*Correspondence: IF Abdul, FWACS.
Department of Obstetrics and Gynaecology, Maternity Hospital, P.M.B. 1339, Ilorin, Nigeria.
E-mail: abdul@aesl.net

definitions centre on forced sex of a woman by a man, newer definitions are often gender neutral [4].

WHO IS A CHILD AND WHO IS AN ADOLESCENT?

The word adolescent stands for boyish, girlish growing, teenage, young, youthful youngster or teenager [5]. The W.H.O defined it as those between 1 and 19 years of age [6]. Adolescence is not like puberty, a scientific term that refers to the period during which secondary sexual characteristics begin to appear to their maturation. Therefore anybody below the age of 1 year is regarded as a child. Although international law recognizes childhood as a separate status, it does not attach distinct status to adolescence [7]. However like childhood, adolescence is socially constructed and the definition arbitrary and artificial. The arbitrariness is seen in attempt at subdividing adolescence into early, middle and late adolescence[8]. For these reasons childhood and adolescence will be used interchangeably for the purpose of this article.

INCIDENCE OF SEXUAL ABUSE IN CHILDREN AND ADOLESCENTS

Half a million children are believed to be sexually abused each year in the United State[9]. In 1994, the U.S department of justice indicated that the annual incidence of sexual assault was 200 per 100,000 people[10]. Recently an American Medical Association report on sexual assault suggested that one in five women are sexually assaulted by the time she is 21 years of age[5]. Less than 10% of cases of Sexual assault are ever reported to law enforcement agents or hospitals for treatment in Australia, and the United State of America[11,12,13]. Therefore, much less percentage will get reported in Nigeria, a much more conservative country with higher tendency for stigmatization. In an on going 10 year survey, a total of 88 cases of sexual assault/rape were seen at the maternity wing of the University of Ilorin Teaching Hospital, Ilorin, Nigeria. This represented 0.46% of all gynaecological consultations. Children accounted for 0.9% while adolescents accounted for 71.8% and adults, only 27.3%. Assuming the 88 cases represented about 10% of sexual assault in the community, and then the actual number of cases would have been 880 or 4.6% of gynaecological consultations.

PHYSICAL AND GYNAECOLOGICAL INJURIES FROM SEXUAL ABUSE IN CHILDREN

Up to 40% of victims who are sexually assaulted sustain injuries[14]. The extent of the injuries depends upon the violence of the attack and whether the victim attempted to protect herself or not. Most injuries are minor. About 1% of the injuries require hospitalization and major operative repair, and only 0.1% is fatal[6,14].

Criminal sexual assault often involves the use of weapons. Lives are endangered, bodily harm or physical violence is inflicted. The bodily harm includes bruises, or lacerations about the neck, back, buttocks and extremities. Injuries may be present around the vulva and rectum because of manipulation of these areas with the hand, penis or weapons such as candlesticks. Such lesions may be superficial or extensive. Lacerations of the hymen and vagina, injury to the urethra, and occasionally rupture of the vaginal vault into the abdominal cavity may be noted. Bite marks are common and should be looked for in all regions of the body, particularly around or at the genitalia and breasts. Occasionally foreign objects may be found in the vagina, urethra or rectum. Children and adolescents presenting with any of these injuries should be suspected to be sexually assaulted, unless the cause is known to be otherwise[2,4,11,14].

SEXUALLLY TRANSMITTED DISEASES (STD) IN SEXUALLY ABUSED CHILDREN

In children, the isolation of a sexually transmitted organism may be the first indication that abuse has occurred. *Chlamydia trachomatis* and *Neisseria gonorrhoea* infections could be contracted through sexual assault in children. Lesions may be present that suggest *Human Papilloma Virus* (HPV) infection and *Trichomoniasis*, and *candidal* infections. The risk of contracting *Human Immunodeficiency Virus* (HIV) is low during a single act of heterosexual

intercourse usually less than 1 percent but the risk depends on the population involved and the sexual act performed. *Bacterial Vaginosis* (BV) has also been identified among sexually abused children. *Hepatitis B virus* is 20 times more infections than HIV during sexual intercourse. *Syphilis* can be contracted theroretically, but is rare in sexually abused children[4,5].

PSYCHOLOGICAL AND SOCIAL IMPLICATIONS

A sexually abused child or adolescent looses control over her life during the period of the assault. Her integrity and sometimes her life are threatened if found to be mentally matured at the time. She may experience intense anxiety, anger or fear. After the assault, a "rape-trauma" syndrome often occurs. The immediate response (acute phase) may last for hours or days and is characterized by a distortion or paralysis of the individual's coping mechanisms. There could be emotional signs of depression, anxiety and mood swings. The next phase-the delayed (or organizational) phase, is characterized by flashbacks, nightmares, and phobias[4,16]. The repressed or dissociated traumatic memories of sexual abuse carry the potential for producing future psychopathology through displacement in the form of conversion symptoms or somatisation. These often lead to alcohol or drug abuse as the child grow up. This set of children for the same reasons may have greater sexual vulnerability during adolescence or adulthood[16-18]. The degree of these complications depends on the extent and the frequency of such sexual victimization[19].

MANAGEMENT OF THE COMPLICATIONS

Informed consent, from the guardian or parent must be obtained before the examination of a sexually abused child or adolescent is begun and specimens collected[4]. In addition to fulfilling legal requirements, this informed consent also help the parents participate in regaining control of their emotions. As regards babies and infants, and incestuous assaults on children, the proper diagnosis that such an assault has taken place may require the physician's awareness and suspicion of the possibility that an assault has occurred[15]. The physician should work with the appropriate authority to place the assaulted child in a protective environment away from potential assaulters[2,4,11,14].

Physicians should treat the injuries of a sexually abused child or adolescent and perform appropriate tests to detect, prevent and treat infections and to detect and, if desired, prevent pregnancy. They are also to arrange for specific care in case of children as well as counseling for the victims and those intimately involved with them[2,4,11,14].

After acute injuries have been determined and the patient stabilized, a careful history and physical examination should be performed[4,20]. A chaperon or victim advocate should be present during the history taking and physical examination to reassure the victim and provide support. Multiple obstacles can hinder the medical evaluation of suspected sexually abused child. The need for diagnostic accuracy is high. Knowledge of sexual abuse risk factors, an understanding of the victimization process, and awareness of the varied clinical presentations of sexual abuse can be of assistance. Open-ended questioning of the suspected victim or parent or guardian is the most critical component. Skillful medical interviewing requires time, patience, and practice[4,11].

Colposcopy has assisted greatly in reaching consensus regarding diagnostic accuracy. Cases of acute sexual assault require familiarity with the forensic rape examination, STD screening and prophylaxis and pregnancy prevention. The primary concern should be for the child's physical and emotional well being[16,20].

Some peculiar problems in Nigeria in the management of the sexually abused child are the absence of an enabling environment and poor standardization or format. An enabling environment that will allow for a team (Consisting of Paediatricians, Gynaecologists, Social workers, Psychologists and Psychiatrists) approach[4,9,11] to management must be put in place. This may be difficult in developing countries where members of this team are not likely to be present in one institution. This is apart from the fact that many sexually transmitted infections like HPV,

chlamydia, Herpes simplex and *Hepatitis B virus* cannot be detected in many centres in Nigeria, ditto for their treatment. For forensic purposes it may be difficult to detect the presence of spermatozoa when rape present late in this environment because of lack of simple wood light which makes dry semen fluoresce not to talk of fluorescence in situ hybridization.

When the need to prevent pregnancies in adolescent victims of rape arise, knowledge of emergency contraception is important. Some of these methods are high doses of combined oral contraceptives (Yuzpe Regime), postinor (a high dose progestogen), Intra uterine contraceptive devices (IUCD) and mifepristone RU486[4].

As regards the rape-trauma syndrome, it is similar to a grief reaction. It can be resolved when the victim has emotionally worked through the trauma and loss of the event and replaced it with other life experiences[17]. There may be need for anxioylytics and antidepressants in the acute phase of the syndrome[4,16,20,21].

Follow up reevaluation of the medical and psychological status of the patient is necessary. Further counseling could be offered during this period aside from collection of serum for reevaluation if the initial exposure did not produce enough concentration to result in positive test. Pregnancy test may also be repeated during such visits.

Prevention of sexual abuse in children and adolescent essentially revolve around close monitoring to prevent situations that promote interactions of potential victims and assaulters in privacy or in lonely places. It is known that close to 90% of sexual assaults on children and adolescents are carried out by people familiar to the victims[1,2,4,12]. This is unlike in adults where strangers such as armed robbers have been implicated. Insane people or people of unsound mind should be closely monitored to reduce the chance of sexual assault on children, as this is one sure cause of childhood sexual abuse[9,11,18].

In conclusion, childhood and adolescent sexual abuse has profound health implications, which may not be fully appreciated because of under reporting and low level of awareness. The problem is further compounded by the possible absence of the multitude of specialists needed for effective management, as well as inadequate materials and manpower for diagnosis and treatment of the complications. An understanding of these Health implications (immediate and long term) and the associated management inadequacies as discussed will hopefully lead to the much desired improvement in the management of the sexually abused child and adolescent by the Health Team.

REFERENCES

1. Perceptions of child sexual abuse as a public health problem, **Vermont**, September 1995. **MMWR** 1997; 46**(34)**: 801 - 803.
2. Fourth world conference on women Beijing 1995. **Plat form Action Beijing**, paragraph 113.
3. **Hymel KP, Jenny C**: Child sexual abuse. ***Del Med J*** 1997; 69 **(8)**: 415 - 429.
4. **Criminal Code Act, CAP 77**, Laws of the Federation of Nigeria; 1990. Sections 216 - 222 as well as sections 357 and 358.
5. **Fleming JM**: Prevalence of childhood sexual abuse in a community sample of Australian women. ***Med J Aust*** 1997; **166** (2): 65 - 68.
6. ***American Medical Association:*** Strategies for treatment and prevention of sexual assault. **Chicago:** AMA. 1995.
7. ***ACOG: Educational bulletin*** - sexual assault, ***Int J Gynae and Obs*** 1998; **60:** 297 - 304.
8. ***Collins Concise Dictionary and Thesaurus,*** New Edition, Harper Collins publisher, 1995.
9. ***World Health Organization (WHO):*** Pregnancy and abortion in Adolescents, **Technical Report series**, No. 583.

10. ***Van Bueren G:*** International rights of the child. (Martinus Nijhoff publishers: Dordecht/Roston/London) 1995.

11. ***Population Reports:*** Meeting the needs of young adults. Published by centre for communication programms, The Johns Hopkins School of Public Health. Series J, Number 41, October 1995.

12. ***Chasan Taber-L, Tabachnik J:*** Evaluation of a child sexual abuse prevention programme. **Sex Abuse** 1999; **11** (4): 279 - 92.

13. ***U.S. Department of Justice.*** Criminal Victimization 1994. Bureau of Justice statistics bulletin. National crime. Victimization survey. Washington, DC: U.S. Government printing office, 1996.

14. ***Beebe DK, Gulledge KM, Lee CM, Peplogle W:*** Prevalence of sexual assault among women patients seen in family practice clinics. ***Fam Pract Tes J*** 1994; **14:** 23 - 28.

15. ***Marchbanks PA, Lui KJ, Mercy JA:*** Risk of injury from resisting rape. ***Am J Epidemiol*** 1990; **12:** 257 - 277.

16. ***Hammerschlag MR:*** Sexually transmitted diseases in sexually abused children: medical and legal implications. ***Sex Transm Infect*** 1998; **74**(3): 167-174.

17. ***Burgess AW, Holmstrom LL:*** Rape trauma syndrome. In. Burgess AW II eds. Rape: victims of crisis. Bowie, Maryland: ***Robert J Brady Co,*** 1974: 37 - 50.

18. ***Vander Kolk BA:*** The body keeps the score: memory and the evolving psychobiology of posttraumatic stress. ***Harvard Rev Psychiatry*** 1994; **10:** 253 - 265.

19. ***Green AH:*** Comparing child victims and adult survivors: clues to the pathogenesis of child sexual abuse. ***J Am Acad Psychoanal*** 1995; **23** (4): 655 - 690.

20. ***Follete VM, Polvsny MA, Bechtle AE and Naugle AE:*** Cummulative trauma: the impact of child sexual abuse, adult sexual assault and spouse. ***J Trauma - Stress*** 1996; **9:** 25 - 35.

21. ***Resnhaw DC:*** Treatment of sexual exploitation. Rape and incest. ***Psychiatric Clin North AM*** 1989; **13:** 257 - 277.

"Sahelian Words"

"There is no strong performance without a little fanaticism