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Review

Impact of Child Abuse on Sexuality. How to Prevent Short and Long-Term Consequences

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Abstract

Objective: To highlight predisposing conditions to Child Sexual Abuse (CSA) and to give tools to healthcare providers to deal with this scourge. **Mechanism**: A descriptive literature review. **Findings in Brief**: Nowadays, children and adolescents can be more easily affected by a wide variety of social contingencies that may predispose them to domestic and social violence, such as drug use, early pregnancy, offender behavior, peer violent situations, behavioral disorders, and school dropouts. CSA is not included yet in professional health teams' training nor considered by authorities who are responsible for implementing preventive measures and public policies, even though presenting considerable magnitude in epidemiologic terms. Pediatricians, general physicians, and other specialists who deal with children and adolescents should incorporate a process of detection for signs and early symptoms of sexual abuse and social actors should put in motion preventive measures. **Conclusions**: CSA is a concern that should involve the whole society. Actions to reduce its incidence are required in three different targets: social awareness, comprehensive sexuality education, and acting on the predisposing factors.

Keywords: child abuse; maltreatment; domestic violence; sexual abuse

1. Introduction

At present, children and adolescents, especially in developing countries, are affected by a wide variety of social contingencies, such as drug use, early pregnancy, offender behavior, peer violent situations, behavioral disorders and school dropouts. Modern society presents some social changes that are prone to provoke all these situations. These changes include easy access to addictive substances, the different forms of family disintegration, domestic and social violence, economic crisis, changes in the traditional social values, and the educational deficit. They constitute some of the background elements surrounding and affecting the children's welfare [1].

Sexual abuse (SA) as a manifestation of children and adolescents' maltreatment is not a new phenomenon, but the awareness of this problem has arisen public notoriety and consciousness among professionals, especially in recent times [2]. In developed countries, studies including incidence and predisposing factors have endorsed the development of preventive measures. However, in Argentina, as in other developing countries, the magnitude of this problem remains mostly ignored. Due to the lack of collection of registers and studies, the causal factors are disregarded and prevention is not planned. This reality is evident since the first contact with health centers and social care resources is late in excess in a high number of cases. At the same time, health care providers are not well enough prepared for proper management both at first care and in the future medical and psychological consequences [3].

Child Sexual Abuse (CSA) is not included yet in professional health teams' training nor considered by authorities who are responsible for implementing preventive measures and public policies, especially in developing countries, even though presenting considerable magnitude in epidemiologic terms [2]; therefore, pediatricians, general physicians, and other specialists that treat children and adolescents should incorporate a process of detection for signs and early symptoms of CSA and social actors should put in motion preventive measures [3].

2. Eradicate Myths of Child Sexual Abuse

Myths are those social concepts or beliefs that part of society construct without further questioning making invisible or normalizing social problematic situations. Myths enable the persistence of these problems without showing changes impeding their eradication. There are countless myths about CSA that difficult its emerge as a real social and public health problem facilitating its preservation through time. The most frequent myths related to CSA include:

- "Sexual abuse occurs only if there is rape or genital penetration from the abuser"; however, this situation repre-

sents less than 10% of the cases considered as CSA [3].

- "CSA is not frequent or doesn't exist", due to its conceptualization as a crime and the absence of registered cases. This misconception could be considered true because it is not made public [3].

- "Sexual aggressors are mentally ill"; even though they may present mental health alterations, they are conscious of their acts and even consider them as normal actions exercising power for their self-satisfaction [4].

- "CSAs are easy to detect"; there are plenty of factors that do not allow early discovery of this scourge [4].

- "Children generally lie when they point out they are being victims of some kind of abuse"; the most natural behavior in children is to tell the truth. Fantasies exist within them, only if previous experiences have occurred [3].

- "CSA occurs only in poverty"; it takes place in all social strata and social and economic classes [5].

- "CSA is elicited by the victim"; essentially, this is the wrong interpretation that the aggressor makes of the child's behavior. The aggressor consider the child's attitude as a provocation to justify its action [4].

- "CSA takes place in lonely, dark places"; reality shows that in most cases, people close to the child are involved and it usually happens in familiar or habitual places [4].

- "CSA affects older children or adolescents"; CSA is presented equally between the ages of 2 and 15. The risk of becoming victims of CSA is just as likely at any age [3].

CSA is defined as the imposition to a child or adolescent of sexual activities that they do not fully understand [5–10]. It is achieved through threats, mischiefs, or the use of force from an adult to a child or an older/larger in size adolescent to a child, in his/her position of power over a minor. CSA may be exercised without physical contact in cases such as child pornography or exhibitionism, or with physical contact and this may take place with or without defilement [5–7]. The child is submitted to the will of the abuser who executes a position of authority in different levels of coercion [8].

3. Describing the Unwanted Condition

According to a global estimation by the World Health Organization (WHO) in 2006, up to 65% of CSA cases are domestic, where a parent or another relative behaves as the aggressor. The rest of the cases are extra-familial, where the aggressor is non-familial but is part of the child's or adolescent's inner circle. Only 10% of the CSA are committed by strangers and those cases are sexual assaults [11]. In general, aggressors are middle-aged males and frequently members of the victim's family or part of the child's inner circle [6]. Between 70–90% of the cases, the child knows the aggressor, and in half of the cases, is a family member [7].

The abuses may involve either physical contact with the victim (such as groping, fondling, rubbing, sexual caresses) or no physical contact (such as in the cases of child pornography, witnessing sexual acts, child exhibitionism, etc). The most frequent type of aggression is rubbing, in 90% of the cases. Only 4 to 10% of the CSA among adults and children involve intercourse [12]. For this reason, lesions are hardly ever observed in a forensic examination [9,13–15].

The abuser, due to the family relationship and the exercise of the abusive authority, accomplishes the abuse gradually and progressively, going through different stages (Table 1, Ref. [6,10]).

Several surveys suggest that one-fourth of the adults have suffered from physical maltreatment during their childhood and 1 every 5 women and 1 every 13 men sexual abuse during childhood [4]. Noteworthy, a meta-analysis including sixty-five articles covering 22 countries revealed that 7.9% of men and 19.7% of had suffered some form of sexual abuse prior to the age of eighteen [12], and in Spain, 20% of the population (23% women and 15% men) reported to have suffered from at least one CSA in 1994 [16]. In surveys conducted among secondary or superior education students, 18% of the females report unwilling sexual activity and most of them took place between the ages of 13–16 years old [16]. It is to note that CSA has been associated with suicidal behaviors [7].

Finally, it is crucial to highlight the risk factors. Regarding the victim, the main risk factors are female sex, ages between 8 and 12, restricted functional capacities or families with non-consolidated affective bonds; and concerning the abuser, traumatic or unpleasant experiences during the own childhood or adolescence [17–19]. In other opportunities, trans-generational maltreatment is involved [20]. Finally, environmental or social factors may play a role as well as alcohol consumption (or other substances addiction), helplessness or child neglect [18].

4. Health Care Providers' Involvement in CSA Situations

In cases of CSA, it is important to keep in mind that the absence of stigmata or physical signs does not discard the existence of sexual abuse. Health care providers should not act as policemen or magistrates but they must focus on precisely collecting the data the victim provides and give their medical interpretation.

The physical examination can only be done with the consent of the victim after providing the appropriate information of its usefulness. A whole-body examination with a detailed description of any findings is mandatory including a graphic register through very neatly and thoroughly performed drawings or photographic register if it is necessary because recent lesions may heal or disappear through time. A gynecological examination should be performed in the presence of an adult in whom the child trusts or with the presence of another professional, following the same protocol used in the general physical examination. Some details

Table 1. Stages of domestic child sexual abuse [10].

Stage	
Seduction	The abuser manipulates the dependence and the trust of the victims, inviting them to participate in abusive acts that are presented as a game or as a normal behavior. In this stage, the abuser is cautious choosing the adequate moment and place to initiate the cycle of abuse.
Abusive sexual interaction	The abuser begins with exhibitionism and "voyeurism" acts, followed by touching of genital areas and/or genital penetration.
Secrecy	The abuser imposes a code of silence through threats.
Disclosure	The situations of sexual abuse are discovered through clinical suspicion that confirms pregnancy, or sexual transmitted diseases or, because the child or adolescent leaks out information about it or because there are witnesses of that abuse.
Repression	Families and victims tend to deny what has happened, concealing the problem.

Child maltreatment is a global problem with serious consequences that may last the rest of the victim's life. The World Health Organization (WHO) estimated in 2006 that approximately 150 million girls and 73 million boys had been victims of some kind of sexual abuse before the age of 18 [10]. However, it is not easy to determine the real incidence of a problem that takes place in a private environment when minors may feel impotent to reveal the abuse [6].

Table 2. Summary of negative impacts of CSA on child behaivour.

Emotional problems	Widespread fear—hostility and aggressiveness—guilt and shame—depression—anxiety—low self-esteem and stigmatization feelings—rejection of his/her body—distrust and resentment towards the adults—post traumatic disorder—self-destructive behaviors, suicidal behaviors and ideations.
Relation problems	Isolation and social anxiety—Difficulties in couple relations—Difficulties raising his/her children.
Behavioral problems and social adjustment	Hostility-Changes in his/her eating habits (hyporexia, compulsive eating, anorexia, bulimia). Drug and alcohol use—escapes from home—self-destructive behavior—hyperactive behavior. Poor school performance.
Functional problems	Eating disorders—Body pain—conversion disorders—non-epileptic convulsion crises—dissociative disorders—somatization disorders—gynecologic pain—substance abuse.
Sexual problems	Early or inappropriate sexual knowledge for his/her age—compulsive masturbation—excessive sexual curiosity—exhibitionist behavior—sexual aggression towards other minors—Rejections to caresses, kisses or physical contact—Sexual identity problems—unsatisfactory and dysfunctional sexuality—early maternity—prostitution—re-victimization (exposure to new sexual abuse situations).
Physical problems	Sleeping disorders: nightmares, insomnia, sleepiness. Loss of normal sphincters control (enuresis, encopresis).

to be taken into account are positions of examination: frog gynecological position plus the Caprano's shunting for correct visualization of the female genitals, specifically, of the vaginal introitus; and the knee-chest position for a correct observation of the anal region.

5. Short and Long-Term CSA Consequences and its Prevention

Almost 80% of the victims will suffer from mental health disorders. These conditions will depend on the family's companionship and the individual capacity to face it. The older the victim is, the deeper consciousness of the abuse situation and, therefore, the higher vulnerability exists [9]. The emotional impact of sexual aggression is modulated by four variables: the individual profile of the victim (the psychological stability, age, sex, and family context); the characteristics of the abuse (frequency, severity, violence, threats and chronicity); the existing relationship with the abuser; and last, consequences associated to the discovery of the abuse (family support, family disintegration, police and/or criminal complaint) [17]. In general, the more chronic and intense the situation of CSA, the greater possibility of mental disorders.

The relationship victim-aggressor must also be taken into consideration since intense emotional impacts are associated with cases of former great emotional relationship between the victim and the aggressor. Parental support, the credibility of the victim's testimony, the protection, and the family accompaniment are key elements to assure minimum repercussions in long-term mental health (Table 2).

For the prevention of the CSA, it is mandatory that all institutions where the victim develops individually, should recognize the existence of this scourge and incorporate preventative measures educating the children and assessing them for early communication. Some actions that could be implemented are: getting to them with reliable and easy interpretation of the information in family spheres and at home; while in the educational institutions, providing permanent teacher update training courses about the teaching of the self-care, respect and body privacy to children and

adolescents. Therefore, formative and teacher training programs should be implemented in educational programs of integral sexual education which should include CSA prevention and early detection. For health professionals, the training should include tools to provide orderly, articulate, and perform human assistance avoiding the re-victimization of the child or adolescent. Finally, the government authorities should implement and grant resources for education on CSA prevention.

6. Conclusions

CSA is a concern that should involve the whole society. To confront CSA in social, educational, health and legal fields is not an easy task. It is necessary to address the issue of sexuality, self-care, and the respect of body diversity from childhood to be able to incorporate the tools to prevent CSA in the future years and generations.

The multi-factorial etiology of CSA requires the implementation of actions to reduce its incidence in three fundamental targets. Firstly, social awareness for its prevention and early diagnosis. Secondly, scopes should include comprehensive sexuality education to the society, understood as respect for identities, social identities development, and sexual maturity. In addition, it is essential to provide tools and personal care guidelines to children and adolescents to prevent and detect early situations of personal threat or vulnerability that could end up in CSA [21]. And finally, thirdly, act on the predisposing factors such as the lack of education, poverty, overcrowding, the increment of substances use and education for the no gender-based violence, estimating that, even if there are male and sexual diversity victims, female victims are the majority.

Author Contributions

MFR and CCB designed the research study, performed the research, analyzed data, and wrote the manuscript. DB critically review the manuscript and add valuable data. All authors contributed to editorial changes in the manuscript. All authors read and approved the final manuscript.

Ethics Approval and Consent to Participate

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