International Medical Journal Vol. 17, No. 2, pp. 107 - 112, June 2010

Childhood Sexual Abuse and Its Impact on Woman's Health

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ABSTRACT

Objective: **This study focused on the impact of childhood sexual abuse (CSA) on woman's health.**

Materials and methods: **Data were extracted from the literature for last seven years using MEDLINE database service. The articles, reviews, clinical and community based investigations and studies pertinent to the theme of this article were considered for this review. CSA included non-consensual touching of private parts, forced sex, and sexual perversion.**

Results: **The perpetrators were either familiar or stranger to the victim. About 25% of them were members of victim's family -father or stepfather, thereby indicating disintegration of relationship bonds in the fabric of the family and community. CSA was associated with parental conflict, disrupted home, or poverty and was significantly correlated with sexually transmitted infections and severe perimenstrual symptoms in their adulthood. Women with CSA underwent more subsequent sexual assaults, physical affronts, or incidences of self-inflicted harm. Psychological risk profiles of sexually abused girls were associated with feelings of hopelessness, suicidal ideation, dating violence, heavy smoking, or drug use before sex. Victims' coping with CSA was dynamic and occurred through processes of psychological escape, cognitive appraisal and positive reframing strategies in the due course of time.**

Conclusion: **CSA being a serious social health problem needs to be addressed, perhaps targeting offenders, with an initiative to promote healthy relationship patterns.**

KEY WORDS

depression, sexual assault, rape, PTSD, STI

INTRODUCTION

Sexual violence is defined as non-consensual sex ranging from use of threats and intimidation to unwanted touching and forced sex (Brown *et al*, 2006). However, childhood sexual abuse (CSA) is often defined according to the penal code and measured by questions defining specific sexual activities, the relationship between the older person and the child, and youth's own perception of the incident (Helweg-Larsen and Boving-Larsen, 2006). Teenagers constitute the largest age group in the world as a link in the lifecycle between childhood and adulthood. In fact, gender based violence exists in all societies and individual woman experiences it in every social and economic set-up (Fitaw *et al*, 2005). WHO-study has confirmed that physical and sexual violence against women is widespread, largely among industrial settings (Garcia-Moreno *et al*, 2006). The sexual abuse at any stage of woman's life adversely affects her biological, social, economic and cultural milieu and is detrimental to positive outcome in life. How does childhood sexual abuse affect woman's health and quality of life? This review specifically focuses on the impact of childhood sexual abuse on woman's health and quality of life living in the society. This is very important for understanding the intricate complexity of this matter before venturing for its remedial measures.

MATERIAL AND METHOD

With a view to find out and understand this aspect of a woman in the society, data were extracted from the literature through MEDLINE data based service for years 2002-08. The search outcome was first scrutinised to build up the

Received on September 25, 2009 and accepted on November 30, 2009
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outlay of the article. The surveys, reviews, community based studies and clinical investigations were included in this article. As a multidisciplinary approach, this article follows tradition review pattern. The data pertinent to the theme of the subject matter were selected and assorted accordingly following the outlay of the presentation

DISCLOSURE OF ABUSE

Sexual violence is a well-recognised global problem. However, the pattern of disclosure varies following the situation and socio-emotional settings of the individual. In Hong Kong, children who experienced multiple incidents of abuse, likely by a family member, took a longer time to disclose because more often abusers had control and power over the abused (Ma *et al*, 2004).

Children's disclosure rates in Israel were greater in sexual than physical abuse cases. Victims were less likely to disclose abuse when a parent was the suspected perpetrator. However, the rate of disclosure increased, as children grew older. When the perpetrator was not a family member, some children delayed disclosure for 1 week to 2 years, some of them first disclosed to their parents and some children did not disclose spontaneously but did so only after they were prompted. The children also reported that they were afraid or ashamed of their parent's responses, and their parents indeed tended to blame the children or act angrily. The disclosure process also varied depending on children's ages, severity and frequency of abuse, parents' expected reactions, suspects' identities, and strategies they had used to foster secrecy (Hershkowitz *et al*, 2005, 2007). Peers were girl's most common choice for disclosing abuse. Sexually abused young adolescents needed distinct, developmentally appropriate screening in school and health care settings (Edinburgh *et al*, 2006).

Children often felt difficulty to find enough privacy for sharing their experience of sexual abuse. They were sensitive to other's reactions. The disclosure of sexual abuse was a dialogical process that became less difficult if children perceived that there was an opportunity to talk and purpose for speaking and that a connection had been established to what they were talking about (Jensen *et al*, 2005). African-Americans, Native American and Hispanic teens were slightly more likely to report abuse than the white or Asian American youth (Saewyc *et al*, 2003). Older women in Australia were much more likely than younger women to say that they were unwilling partners on the first occasion (Dunne *et al*, 2003).

Dynamics of disclosure led through three phases: 1) Self, where children came to understand victimization internally; 2) Confident Selection-Reaction, where they selected the time, place, and person to tell and then whether that person's reaction was supportive or hostile; and 3) Consequences-good or bad, that continued to inform their on-going strategies of telling. Action and reaction of adults were significant to inform about the girls' decisions (Staller and Nelson-Gardell, 2005).

Thus, factors associated with the disclosure of sexual abuse were enumerated as child's age, gender, type of abuse experienced -intra or extrafamilial, perceived responsibility for the abuse, and fear of negative consequences of disclosure. Therefore, developmental, cognitive, and socio-emotional factors need to be considered when evaluating children for sexual abuse (Goodman-Brown *et al*, 2003).

INCIDENCE AND DIAGNOSIS OF ABUSE

Sexual abuse among schoolgirls was higher in Hungary (75%; n = 209) and Ethiopia (68.7%; n = 323) as compared to other counties. A majority of Hungarian schoolgirls aged below 18 were victims of sexual abuse. The perpetrators were either familiar (66%) or stranger (34%) to the victims. Nearly 25% of perpetrators were members of victim's family- father or stepfather. Abuse occurred in multiple occasions and was highest in summer (59%). Vaginal penetration was found in 80% and sexual pervasion in 20% of cases. Physical injury was found in 66% of cases and presence of sperm was confirmed in vulvovaginal smears in 38% of cases (Csorba *et al*, 2005, 2006; Worku *et al*, 2006). Incidence of sexual abuse among schoolgirls was 13.4% in Istanbul as compared to 21% in Kenya and 50% in Sweden (Alikasifoglu *et al*, 2006; Lundqvist *et al*, 2004; Erulkar, 2004).

Diagnosis of childhood sexual abuse requires skill and experience because of the nature of injuries. For instance, 50% of confirmed cases of CSA had normal or non-specific findings. In Hong Kong,, overall assessment showed that 46% of children had no evidence of abuse, 20% had possible abuse, 13% probable abuse, and 21% had definite abuse (Cheung *et al*, 2004).

Most frequent signs in confirmed anal abuse were anal scars often extended to peripheral region, tags, reflex anal dilatation and venous congestion, separately or associated with other signs and no abnormal anal findings in few cases. These findings do not per se provide the proof of abuse but support the child's statement (Bruni, 2003).

Hymenal injuries of pre-pubertal and adolescent sexual assault victims healed at various rates and except for deeper laceration, left no evidence of previous trauma. Abrasions and mild submucosal haemorrhages disappeared within 3-4 days, whereas marked haemorrhages persisted for 11-15 days. Only petechiae blood blisters proved to be a marker for determining the appropriate age of an injury. Petechiae resolved within 48 hours in pre-pubertal girls and 72 hours in adolescents. Most of pre-pubertal girls had smooth and continuous appearing hymenal rim, whereas a majority of adolescents' hymen had normal 'scalloped' appearance and most had no disruption of continuity on healing in these sexually abused victims (McCann *et al*, 2007). Thus, hymenal injuries often prove of no avail as medical evidence for sexual abuse.

Penetration defined as a severe sexual abuse in USA was associated with higher percentage of abnormal findings in girls. The history from the child was the single most important diagnostic feature to conclude that a child had been sexually abused. Only 4% of all children referred for medical evaluation of sexual abuse had abnormal findings on examination at the time of evaluation. Even with a history of severe abuse such as vaginal or anal penetration, the rate of abnormal medical findings was only 5.5% likely rendering this medical finding insufficient for presenting as evidence (Heger *et al*, 2002).

FACTORS ASSOCIATED WITH ABUSE

In Massachusetts, the recurrence of sexual victimization was associated with the immigrant status of the victim. However, this was inconsistent across age of victims and

social or ethnic groups. The immigrant status conferred risk on black adolescent girls and sexually active Hispanic girls aged 15 or less with no effect of their acculturation (Decker *et al*, 2007).

Traditional notions of masculinity and normalization of inter personal violence, poverty and projecting sex as commodity, influence at high risk social norms, weak adult and community protective shield, low self esteem and self efficacy, and inter personal affective anger were associated with the sexual violence in South Africa (Petersen *et al*, 2005). The family structure was significantly related to the rape in Cape Town. Girls who lived with a single parent and those who put up with one biological parent or one stepparent were more likely to have been victims of sexual abuse than those living with both biological parents. The socio-economic status, alcohol use, antisocial behaviour, suicidal dialogue and attempt were also significantly predictor of the victimization of sexual abuse (King *et al*, 2004).

The sexual abuse was found to have association with forced sexual intercourse, alcohol, cocaine or marijuana use, rising level of emotional distress and genital touching within romantic relationship among adolescent schoolgirls at Los Angeles (Raghavan *et al*, 2004). In Kenya, women who had ever been married and those who did not live with a parent or spouse had a higher risk of sexual coercion that was often associated with having multiple sexual partners (Erulkar, 2004). Sexual abuse was also associated with sociality, both directly and indirectly through hopelessness and depressive symptoms, more strongly among Australian schoolgirls (Bergen *et al*, 2003). Thus, no remarkable variation was observed among factors associated with the sexual abuse in different countries. The socio-cultural intervention conducive to enrichment of healthy relationship patterns at community level may prevent CSA and reduce the sequelae associated with this problem.

IMPACT ON REPRODUCTIVE HEALTH

The study in Atlanta revealed that the history of both adolescent physical and sexual abuse was significantly associated with perimenstrual symptoms (PMS). Women physically or sexually abused at adolescent were found to have significantly more severe PMS patterns with more dysphoria than women without abuse (Koci and Strickland, 2007).

Abuse at or before 10 years of age was linked to more lifetime and recent partners in USA. The history of abuse was associated with higher rates of STD test. The odds of having STI were 2.5 times greater if abuse occurred at the age of 10 or younger age (Ohene *et al*, 2005).

The overall prevalence of STI was 26% among raped or sexually abused girls aged ≤ 16 years in Luton, UK. Prevalence of STI was 24% in those who were not sexually active before this index assault and 39% in those who gave the history of previous consensual sexual activity. Chlamydial infection was more common among the girls who disclosed previous consensual sexual activity than those who did not disclose previous sexual activity. The overall prevalence of vaginal candidiasis was 17% and bacterial vaginosis 13%. More than one-third of the study population gave a history of previous sexual, physical or other assault (Kawsar *et al*, 2004).

IMPACT ON MENTAL HEALTH

Those who experienced childhood sexual or physical abuse had a greater risk of poor physical and mental health. The effects of childhood abuse thus appeared to last lifetime (Draper *et al*, 2008). The psychological risk profile of sexually abused high school girls in USA was found to have association with sadness or feelings of despair, suicidal ideation, fighting, physical and dating violence, smoking, multiple sexual partners, alcohol or drug use before sex and unprotected sexual intercourse. The psychological and behavioural correlates of those sexually abused victims suggested those young women were already in wrong footing and needed attention (Howard and Wang, 2005).

PSYCHOLOGICAL DISORDERS

The CSA, physical neglect and emotional abuse were significant predictor of a dissociative disorder in the adulthood as it was trauma-related. About 18% of women in Turkey had lifetime diagnosis of dissociative disorder. Respondents reporting dissociative disorder had borderline personality disorder, somatization disorder, and major depression, post-traumatic stress disorder (PTSD) and the history of suicidal attempt more frequently as compared to respondents without dissociative disorder (Sar, Akz and DoAyan, 2007).

Severe depressive symptoms were significantly more common among Hungarian women who were abused sexually or physically in the past or abused by partner or important person during their lifetime (Csoboth *et al*, 2005). A majority of Swedish women (75%) reported that current psychological problems in the adulthood related to abuse in the childhood (Nilsson *et al*, 2005).

In Australia, the relationship between sexual abuse and suicidal ideation was found to have mediated fully by depression, hopelessness and family dysfunction among girls. Those who currently reported high distress about sexual abuse had three-fold increased risk of suicidal thought and plan as compared to non-abused counterparts (Martin *et al*, 2004).

In New Zealand, hallucinations but not delusions, thought disorders or negative symptoms were found significantly more common in women (65%) with a history of CSA (Read *et al*, 2003). In addition to CSA or physical abuse, family conflict was also found to be a risk factor for the development of psychological distress and depression in adolescence in USA (Meyerson *et al*, 2002).

Persistence of abuse-related shame was most likely to indicate clinically significant levels of intrusive recollections. Persistent shame might explain failure to process the abuse and the maintenance of PTSD symptoms. Hence, shame as a consequence of CSA should be a focus of treatment (Feiring and Taska, 2005).

As to the possible ethnic and cultural difference in psychological symptoms related to CSA, African American girls had significantly higher levels of post-trauma avoidance symptoms than Hispanic girls but not Caucasian girls. No significant difference was found for depressive or intrusive symptoms among ethnic groups (Clear *et al*, 2006).

BEHAVIOURAL SYMPTOMS

Sexual risk behaviour

The sexual at-risk behaviour of sexually abused adolescent girls in Montreal showed that severity of sexual abuse-penetration, multiple perpetrators, physical coercion, and multiple incidents of abuse- was related to a greater number of sexual at-risk behaviours (Cing-Mars *et al*, 2003).

Violence

The CSA was attributive to the carrying of weapons by 25% girls in USA. Thus, exposure to certain forms of early childhood maltreatment might increase the probability of the carrying of weapons by adolescent girls (Leeb *et al*, 2007).

Prevalence of past victimization rates varied from 13% to 43% and dating violence from 25% to 37% depending on the type of violence sustained among adolescent girls in Canada. The extra familial violence experiences were a stronger risk factor for recent dating victimization than intrafamilial experience, especially being sexually harassed by male peers at school (Gagne *et al*, 2005).

Sexually abused girls in Quebec reported significantly more at-risk behaviour than non-abused girls. Adversity was also a consistent predictor of both self-destructive and delinquent behaviours. Violence during abuse, disruptive mother-daughter relationship and depression were also related to self-destructive behaviour, while family economic problem and self-blame for abuse were only correlates of delinquent behaviour (Wright *et al*, 2004).

In USA, CSA also emerged as the strongest predictor of girls' violent and non-violent criminal behaviour. Girls with a history of physical abuse in childhood were most likely to assault their parents. However, marital violence failed to contribute further to delinquency beyond the adverse association with CSA. A unique avenue for delinquency in girls via childhood sexual exploitation was thus observed in the population (Herrera and McCloskey, 2003).

Substance abuse

A community based study in Colorado showed that CSA was more associated with lifetime substance abuse, but childhood physical abuse had a stronger effect than CSA on lifetime substance dependence. However, women were less likely than men to develop substance use disorders (Libby *et al*, 2004). In general, both CSA and substance use disorders were predictive of adult sexual victimisation but no significant interaction was found between these two factors. Overall, substance use disorders were related to rape for all women. However, this relationship was not unique to CSA (Messman-Moore and Long, 2002).

In USA, Girls' CSA was also found to have association with their later substance use. This relationship persisted when age, co-occurring forms of child abuse, childhood depression and aggression, family income, maternal substance use and parenting practice were controlled. Behavioural control mediated the relationship between CSA and later substance use but depressive self-control did not (Bailey and McCloskey, 2005).

Smoking

In Rochester, college women who had experience of CSA were 3.8 times more likely than their non-abused counterparts to be current smokers and were 2.1 times more likely to have initiated smoking before the age of 14 years. This indicates that CSA is a gender-specific stressor that increases girls and women's risk for smoking (De Von Figueroca-Moseley *et al*, 2004).

Young adults having experience of CSA before 16 years of age in Brishane, Australia had significantly higher rate of smoking than those who did not experience CSA. This relationship was independent and appeared to be direct (Al Mamun *et al*, 2007).

Sexually abused survivors in France were current smoker as compared to the non-abused counterpart. The sexually abused individuals consumed more cigarettes per day than non-abused individuals. Respondents abused before 18 years of age tended to have an increased risk for smoking initiation as compared to the non-abused (King *et al*, 2006).

EFFECT ON LATER LIFE

The prior CSA was found to be associated with a range of outcome in the adulthood in Avon, England. These included current membership of a non-traditional family type (single mother or stepfather), poorer psychological well-being, teenaged- pregnancy, parenting behaviour and adjustment problems with the victim's offspring. Impact of CSA on the aspect of parent-child relationship in later life and the offspring's adjustment difficulties was mediated in part by mother's mental health-chiefly anxiety (Roberts *et al*, 2004).

In USA, women with the history of CSA reported more subsequent rapes or sexual assaults, physical affronts, incidences of self-inflicted harm and over 20% increase in subsequent significant lifetime trauma as compared to women without experience of CSA. Sexual revictimization was positively correlated with PTSD, peritraumatic dissociation and sexual preoccupation. Physical revictimization was positively correlated with PTSD, pathological dissociation and sexually permissive attitudes. Self-harm was positively associated with both peritraumatic and pathological dissociation (Noll *et al*, 2003).

The failure to articulate the impact of CSA and to appropriately construct blame resulted in a range of self-destructive behaviours, some of which placed mothers at greater risk of teenage-pregnancy as well as child maltreatment. Repressed feelings associated with the trauma often resurfaced with motherhood as victims reexperienced their innocence and vulnerability as children (Erdmans and Black, 2008).

COPING WITH SEXUAL ABUSE

The coping with CSA was not static; it changed with time. An adaptive outcome might be associated with a particular evolution of strategies in due course of time. Survivors of abuse in UK reported coping predominately by engaging in psychological escape methods initially and then adopting cognitive appraisal and positive reframing strategies in the long-term (Oaksford and Frude, 2003).

In New Hampshire, patterns of both stability and change

as an index of resilient function across multiple domains of 76% of respondent women having record of CSA showed less than a one standard deviation change in scores across 7 years of the early adulthood. Lower resilience was associated with exposure to additional trauma during this period, while positive functioning was related to social role satisfaction and positive sense of community. This suggested that resilience changed over the course of one segment of the lifecycle. The role of retraumatization, social supports and opportunity for making new choices might be important correlates of recovery processes among sexual abuse survivors in due course of time (Banyard and Williams, 2007).

HEALTH CARE COSTS

Significantly higher annual health care utilization and costs were found for women with a history of childhood sexual and /or physical abuse compared to women without comparable abuse histories. Women with both abuse types had higher annual mental health, emergency department, hospital outpatient, pharmacy, primary care and speciality care utilization. Annual health care costs were 16% higher for women with sexual abuse only, 22% higher for women with physical abuse only, and 36% higher for women with both hypes of abuse. Thus, childhood abuses are associated with long-term enhanced health care use and costs (Bonomi *et al*, 2008).

CRIME AND CONVICTION

The majority of CSA in Hungary took place within the family and were disclosed after multiple episodes. Vaginal penetration was the type of abuse in 75%, and sexual perversion in 25% among CSA cases. Six victims were physically injured and presence of sperm could be confirmed on vulvovaginal smears in 2 cases. Nine cases were reported to the police and as a result of legal proceedings; five perpetrators were sentenced (Csorba *et al*, 2006). Thus, perpetrators of sexual abuse are hardly convicted by the court probably due to lack of evidence or initiation of the proceedings.

Factors that predicted severity of sentence in USA were seriousness of sex crime, prior conviction for a sex crime, and young age of the victim. This community, with the high confession and conviction rate, imposed sentences that were consistent with crimes, with more severe sentences for more serious crimes (Faller *et al*, 2006).

PREVENTIVE MEASURES

Strategy to targeting potential victims appears to be flowed because of unabated prevalence of abuse over the history of prevention programmes and pervasiveness of the threat of CSA. It is also difficult to prepare children for diversity of approaches by potential offenders. Therefore, potential offenders may be targeted for preventive measures since a large portion of abuse appeared to be related to sociable relational patterns gone awry. A school based programme needs to be initiated to promote healthy relationship patterns (Bolen, 2003).

CONCLUSION

CSA or physical abuse being involved with psychosocial elements of both victims and perpetrators is hard to wipe out from the society. However, the evolving of a social mechanism needs to manoeuvre transformation of individual's natural instinct to appropriate healthy social relationship patterns through change in the individual's perception and social conception pattern. This may in due course abate this social bane.

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