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Consequences of Sexual Abuse in Children and Adolescents

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The clinical and age-related features of psychogenic disorders in children and adolescents subjected to extrafamilial sexual abuse were studied. A total of 90 victims aged 5–18 years (29 boys, 61 girls) took part. At different stages of the legal situation, victims developed marked psychogenic states with the following ICD-10 diagnoses: acute stress reaction (ICD-40 F43.0) was present in 84%, PTSD (F42.1) in 14%, brief depressive reaction (F43.20) in 34%, prolonged depressive reaction (F43.21) in 24%, phobic anxiety disorders (F40) in 16% of minors (aged 9–13 years), and mixed disturbance of emotion and conduct (F43.25) in 12% of minors. The age-specific characteristics of mental disorders included a predominance of neurotic disorders and rudimentary psychopathological manifestations. The double (nonspecific and specific) role of sexual abuse in forming psychogenic disorders in children is emphasized.

KEY WORDS: sexual abuse of children, psychogenic reactions, PTSD, acute stress reaction, age-related features.

The question of sexual abuse of children is currently very relevant because of the quite high incidence of offending and the extremely harmful medical and social consequences for health. Many studies have provided evidence showing that sexual offences, which have disorganizing influences on the whole sphere of a child's mental activity, remain in memory for prolonged periods and affect self-image, further development, and the nature of future relationships with others [12].

Sexual abuse relates to the "involvement of dependents who are mentally and physiologically immature children and adolescents, in sexual activities that violate the social taboos of family roles and which they do not fully comprehend and for which they are unable to give informed consent" [14].

The US National Child Abuse Service [16] defines sexually abusive behavior as an act imposed on another person without consent, in an unequal manner, or under duress. In this case, consent requires the following conditions: 1) an understanding of the essence of the proposition made; 2) knowledge of general standards in relation to the proposition; 3) knowledge of the possible consequences and alternatives; 4) the premise that consent or non-consent will be treated with equal respect; 5) unconstrained decision-taking; and 6) mental competence. Equality requires that both participants have the same levels of power in interactions, neither being under the control or duress of the other. Duress is defined as the abuse of authority, use of bribery, threats, force, or intimidation with the aim of obtaining interactions or consent.

Data on the incidence of sexual abuse of children and adolescents in different countries are extremely contradictory. This is primarily because crimes of this nature are secret (families try to hide the facts of sexual abuse), but also because of unclear definitions and the fact that many victims lack adequate emotional resources for this situation [2, 3, 5, 7, 10]. However, data from UNICEF (2000) indicate that every year about a million adolescent girls are subjected to sexual abuse, more than 1.5 million children and adolescents are subjected to violence by the adults responsible for their care, and two million children are subjected to exploitation by prostitution and pornography.

Sexual abuse is an extreme situation leading to particular psychological sequelae, i.e., crisis reactions. These reactions are unpredictable both in time (no preparation can be made for them) and content (with the result that they are perceived as injustices, blows of fate). The nature of crisis

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reactions depends on the adaptive capacity of the person concerned and the type of reaction mounted to life circumstances [1, 3, 11, 16]. They are most severe in rape and are described by investigators as "rape trauma syndrome" [11, 13].

In children, the negative sequelae of sexual abuse can be very variable in terms of both depth and clinical manifestations – ranging from mild, transient psychoemotional changes to post-traumatic stress disorders with autoaggressive tendencies and the formation of pathological personality [7, 8, 10, 11]. Some occur in children immediately after sexual assault, others become apparent as the child develops, and others appear after many years, when the child has grown and begins to recognize the nature of the trauma experienced [12, 14, 15].

The aim of the present work was to identify the clinical and age-related features of psychogenic disorders in children and adolescents subjected to sexual abuse of the extrafamilial type.

MATERIALS AND METHODS

A total of 90 children and adolescents who had been victims of illegal sexual acts (Articles 131–135 of the Criminal Code of the Russian Federation) and were undergoing complex psychological-psychiatric assessment at the V. P. Serbskii State Scientific Center for Social and Forensic Psychiatry were studied.

Subjects included 46 (51.1%) minors aged from five to 14 years (26 girls, 20 boys) and 44 (48.9%) adolescents aged from 14 to 18 years (35 girls, nine boys). Mean age was 13.2 years.

The study used clinical psychopathological, experimental psychological and statistical methods, along with sexological and paraclinical methods. Disorders were characterized on the basis of the clinical diagnostic criteria of the International Classification of Diseases (ICD-10) and guidelines and glossaries of child and adolescent psychiatry [4, 6, 9].

RESULTS AND DISCUSSION

Victims at different stages of the legal process (criminal, post-criminal, investigative) developed characteristic psychogenic states which were classified in accordance with the ICD-10 as follows: acute stress reaction (F43.0), post-traumatic stress disorder (F42.1), brief depressive reaction (F43.20), prolonged depressive reaction (F43.21), mixed disturbance of emotion and conduct (F43.25), and phobic anxiety disorders (F40).

The phenomenon of the conversion of sexual abuse into a specific mental trauma and the structural-dynamic features of the mental disorders developing in adolescents depended on a complex of factors: the characteristics of the sexual assault, the type of criminal situation (non-conflict interaction, conflict-stress interaction), the victim's individual psychological characteristics and age, the presence of a pathological background, psychosocial influences, and additional psychogenic problems. For 10% of the victims, the psychologically traumatizing influences of the legal investigation were decisive and precipitating, having stronger actions than the sexual abuse itself.

Acute stress reactions developed in 84% of the victims of sexual abuse occurring in criminal "conflict-stress" interactions with offenders using aggressive and rough behavior and physical duress. The clinical picture was characterized by different depths and durations of symptomatology. Affective-shock and subshock reactions, with characteristic structural dynamics and phased courses, were seen in 36% of victims. In the first phase, the combined influences of sexual and physical abuse led to increases in affective arousal, anxiety, and fear for life, with perplexity, feelings of hopelessness, and vasoautonomic disorders. The next phase, affective subshock, was characterized by signs of psychogenic narrowing of consciousness, with fixation of attention on the narrow range of psychologically traumatizing events, fear, sometimes developing into horror and despair, along with psychomotor inhibition of different levels of severity, reaching the level of stupor. Subsequent affective amnesia occurred in 8% of victims, as "fragmentary" forgetting of individual moments and details of the events occurring on the background of marked affective tension, general "numbing," and feelings of "stupefaction." In the remaining 48% of victims, affective reactions to criminal sexual abuse were apparent as marked emotional tension, startle, fear for life, feelings of perplexity, resentment, humiliation, and harassment, with feelings of personal helplessness and impotence, emotional lability, but with no signs of psychogenic narrowing of consciousness.

Brief depressive reactions occurred in 34% of victims (predominantly among adolescent girls) in the post-criminal situation, with low mood, sadness, loss of appetite and interests, the desire "to forget what happened," accompanied by feelings of hopelessness, despair, and disillusionment. The dominant depressive component was generally combined with other psychopathological symptomatology: disturbed sleep (anxious, restless, and shallow sleep), somatoautonomic disorders (palpitations, sweatiness, vertigo, dyspeptic disorders), increased anxiety, etc. All victims experienced deterioration of status with exacerbation of depressive symptomatology during investigations (repeated interviews, confrontations, assessments, etc.). In terms of the predominant affective components, depressive reactions could be divided into the following variants: the asthenodepressive, anxious-depressive, and dysphoric variants of depression. The durations of reactions in these cases was no more than one month.

Among adolescent girls, 24% developed *prolonged depressive reactions* with a wave-like course (averaging

3–6 months) with deterioration in status during investigations. The clinical picture was characterized by low mood, sadness, and preoccupation with painful memories, focusing of attention on the events of the negative incident, "depressive ruminations" with feelings of guilt, referential ideas, self-incrimination, and in some cases a complex of exaggerated feelings reflecting the psychologically traumatizing event, the developing situation, her position in it, the feeling of harassment and humiliation, selectivity in behavior, and a grim and pessimistic view of the future, subtle somatoautonomic disorders, and sleep disturbance. Suicidal thoughts appeared from time to time in some victims. The illness had a wave-like course, the constituent depression not being complete deactualized but not always being externally apparent; victims coped with their duties and attended classes, which demanded considerable effort. Memories of the psychologically traumatizing situation in all victims of this group induced deterioration of status with increases in the depth of depressive symptomatology.

Signs of *post-traumatic stress disorders (PTSD)* were seen in 14% of adolescent victims of sexual abuse. The incidence of PTSD in this contingent of victims resulted from the fact that the sexual trauma, which is an extreme form of assault on the person, is a major psychologically traumatizing and extreme event. The details of the sexual abuse when it was sudden, massive (rape or several forms of sexual abuse applied simultaneously), occurring in conditions of a conflict-stress interaction influenced by the aggressive and rough behavior of the offender (or group of offenders) and the use of physical duress, played a role in the development of PTSD among victims. The clinical picture of the disorder was variable in nature: some symptoms were seen in virtually all victims, and these could be regarded as obligate signs of PTSD among victims of sexual abuse; some symptom were encountered in most victims (facultative signs); some were present only in occasional cases. The following symptoms were obligate: depressive affect, repeated unconnected intrusive memories and thoughts about the events (reminiscences), sleep disturbance with repeated nightmares in which the victims reexperienced the events, sharp deterioration in status in situations serving as reminders of any aspect of the traumatizing events, psychosocial disturbances (avoidance of conversations and places linked with the abuse situation, of socialization with peers, refusal to attend classes, etc.), decreases in the range of affective reactions, hypervigilance, phobic disorders, somatoautonomic disorders, and feelings of humiliation and harassment. Facultative signs included the feeling of detachment, emotional detachment, distraction of attention, degraded memory, suicidal thoughts, and the inability to orientate to a long-term life view. Only some victims reported intrusive images, apparent as sudden, bright, "flowing" pictures reflecting the details of the events – flashbacks, intrusive and unpleasant sensations in the anal-genital area, marked psychological distress with movement restlessness, anxiety, and crying when seeing the rapist. The disorder was long-lasting and had a wave-like course.

Victims who were minors (up to 14 years old), the features of the psychological state depended largely on the characteristics of the sexual abuse. In non-conflict interactions and single depraved assaults, especially by known people, no clearly delineated psychological state developed. This can be explained by the absence of a psychologically traumatizing effect of sexual acts due to the child's ignorance of sexual interactions. When the abuser's behavior was non-aggressive, the sexual acts were perceived by the children as games, albeit unpleasant, but not events dangerous to life. With growth and the approach to puberty, knowledge of sexual interactions increased, and the sexual acts acquired the nature of specific sexual trauma. Thus, identifiable psychogenic disorders were apparent by age 11–12 years. Some 16% of young victims (9–13 years old) developed *phobic anxiety disorders*, in which the clinical picture was dominated by anxiety and fear. Fears (phobias) arose on the background of increased anxiety, marked restlessness with internal tension, depressed mood, the feeling of encroaching danger, and fears of repetition of the psychologically traumatizing situation in contexts similar to those in which the previous psychogenic events had taken place. There was a clear link between fear context and the sexual trauma experienced: children feared unfamiliar males and dark and empty places, and refused to go out into the street or to stay at home without their parents. Symptoms intensified in response to minor stimuli, especially during investigations (repeated interviews, confrontations, etc.). This disorder was transient in nature, lasting no more than two weeks.

Psychogenic disorders in children and adolescents were almost always accompanied by behavioral abnormalities. In some cases, these abnormalities were not only the leading factor in the clinical picture of psychogenic disorders, but could be the only feature – a "mask" [4]. Some 12% of victims who were minors (equal numbers of boys and girls) showed symptoms of *mixed disturbance of emotion and conduct*. The clinical picture was characterized by both affective disorders and behavioral reactions: increased irritability, short temper, intolerance of adults' remarks, a tendency to demonstrative and accusatory types of responding, and a lack of "affective resonance" with the alien experience. Victims most frequently demonstrated protest reactions, with disobedience, rudeness, provocative behavior, aggression, and hostility to close persons, and in some case self-aggression (attempts at self-cutting and taking overdoses). The intensity of affective disorders varied from subdepressive to mild depressive states. The affective component was sometimes not externally apparent: victims appeared to be well-disposed and calm, though this "facade" hid marked tension with an inclination to suicidal tendencies which became apparent in response to reminders of the psychologically traumatizing events.

Thus, the age-specific features of mental disorders in child and adolescent victims of sexual abuse consisted of a predominance of the neurotic level of psychological states and a rudimentary degree of psychopathological signs.

The nature of the sexual abuse and the features of the criminal situation were found to play a double role in the formation of psychogenic disorders in children and adolescents – nonspecific and specific. The nonspecific action was independent of the victims' age and resulted from the affective nature of the mental trauma without internal processing of the events which had occurred, with acute stress reactions developing in the criminal situation. The specific action was seen in adolescent victims who were able to understand the specific nature and significance of sexual interactions at the personal-social level, with internal processing of the negative experience (the psychosexual orientation stage) and the development of different depths of depressive reactions and post-traumatic stress disorders.

This study provides evidence that sexual abuse generate the need for the earliest possible psychological correction and psychotherapy with the aim of protecting children and terminating the abusive treatment of them. However, the specific characteristics of the sexual abuse, and the absence or limited amount of life experience of children and adolescents on which all-round assessments of the situation are based, as well as their uncritical belief in the selflessness and goodwill of adults, require clearly developed, appropriate, and maximally effective intervention strategies.

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