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Current view of sexual abuse in childhood and adolescence

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Abstract

Objective: To review single aspects, which involve sexual abuse in childhood and adolescence, giving subsidies for accurate diagnosis and management, emphasizing the short and long-term consequences.

Sources of data: National and international literature review of the MEDLINE and LILACS databases, using abuse and sexual violence as keywords (1988 to 2005), in addition to the authors' theoretical and practical experiences.

Summary of the findings: Sexual abuse has a great impact on child and adolescent physical and mental health, affecting development and causing lifelong damage. Its early detection allows for adequate treatment and follow-up, with minimum consequences. Family involvement must be taken into consideration, and any kind of improper relationship should be evaluated and treated, so that it can be discouraged and eliminated; otherwise, intergenerational abuse will result and probably recur. The identification of domestic violence and of physical and psychological warning signs concerning sexual abuse is part of the general evaluation.

Conclusions: Pediatricians should be able to identify the signs and symptoms sexually abused children and adolescents carry with them. They have to listen carefully to the patients, perform the necessary clinical examination and establish the proper treatment. They should also be able to deal with psychological aspects and have enough knowledge about the laws and about legal and social protection measures, which are always very useful in assisting victims of sexual violence.

J Pediatr (Rio J). 2005;81(5 Suppl):S197-S204: Sexual abuse, sexual violence, incest, childhood and adolescence.

Introduction

Among family structures, according to Lévi-Strauss, in *Las estructuras elementales del parentesco,*[1] a basic kinship system includes consanguineal relatives (brothers and sisters), parental relationship (parents and children) and affinal relatives (sons-in-law, daughters-in-law, stepfather and stepmothers).

According to Freud, S. *Totem y Tabú,*[2] for the first two parental relationships, legal care rules date back to remote times, long before laws existed, where two fundamental principles always ruled the relationships between people – prohibition of cannibalism and prohibition of incest.

These principles are conveyed in different ways (e.g.: education, religion, culture), and no human being living in society is unaware of this law, which is passed from one generation to the next. This is the major rule that should also be followed in affinal relationships, in which the behavior of one individual towards another is determined by upbringing.

Sexual practice, which is increasingly widespread, may involve "distorted" behaviors due to the non-stop search for new situations and experiences, no matter if it means failing to show respect for each other.

At all times, the strongest always ruled over the weakest in different social strata, including different forms of power (political, government, social and family). In this relationship of power, of quests for excess, for whatever is different or even abnormal, little importance is given to children and adolescents and to the consequences of their abuse.

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This way, even after the improvement of moral and legal principles in defense of children and adolescents, the cases of sexual abuse did not cease to exist, and neither are they seen by society as a crime that produces (often incurable) sequelae.

Sexual abuse or violence against children and adolescents is defined as a situation in which children or adolescents are used for the sexual pleasure of an adult or older adolescent, (legally responsible for them or who has some family relationship, either current or previous), which ranges from petting, fondling of genitalia, breasts or anus, sexual exploitation, voyeurism, pornography, exhibitionism, to the sexual intercourse itself, with or without penetration. There is a presumption that children younger than 14 years are unable to give informed consent (adapted from ABRAPIA, 1997).[3]

Cases of sexual abuse of children and adolescents are usually unsuspected and difficult to confirm, and are committed by people who are often closely related to the victims and over whom they have some kind of power or dependence.

It is not always characterized by apparent physical violence and may present different forms and levels of severity, which greatly hinders the chances of reporting by the victim and diagnostic confirmation by medical-legal examination.

The psychological effects of sexual abuse may be devastating and its consequences persist into adulthood.[4]

It is a universal phenomenon found in all age groups, social classes, ethnic groups, religions and cultures that may be regarded as any other gender-related act or behavior, which inflicts physical, sexual or psychological harm or suffering on the victim and, in extreme cases, results in death.

Survivors of sexual abuse often repeat the cycle of victimization, sexually abusing their own children (intergenerational abuse).[5]

The possibility of going from passive to active experience and inflicting the aggressive event he/she suffered on the external world allows the child to "take revenge by proxy."

Thus a defense process is established, which tends to be long-lasting: identification with the offender as a psychological manner to overcome the abuse. By equating with his/her offender and becoming a molester, the victim transfers sexual abuse to the next generation.[6]

Otherwise, the victim may establish an abusive relationship with himself/herself, as occurs in cases of revictimization.[7,8]

Violence in numbers

Sexual abuse of children is regarded by the World Health Organization (WHO) as one of the major public health problems. Studies conducted in different countries suggest that 7-36% of girls and 3-29% of boys suffered sexual abuse.[9]

Its actual prevalence rate is unknown, since many children hide the fact that they were abused, and can only talk about the subject in their adult life.[10]

Therefore, statistical data are not absolute. Sexual abuse is a phenomenon that is secretly hidden, "a wall of silence," in which family members, neighbors, and sometimes the health professionals who treat the victims, take part.[11]

Moreover, countries with limited socioeconomic resources may not be able to handle all the reports of suspected sexual abuse or collect data related to it.[12]

European studies show that 6-36% of girls and 1-15% of boys had abusive sexual experiences before the age of 16. Likewise, in U.S. studies, in a sample with 935 individuals, 32.3% of women and 14.2% of men revealed that they had been sexually abused in their childhood and 19.5% of women and 22.2% of men had suffered physical violence.[13]

Data from the Police Department – Secretariat of Justice and Security of the State of Rio Grande do Sul (Brazil) – revealed that 1,400 individuals were abused in 2002, 872 (62%) of whom were sexually abused. In 2003, 1,763 were victims of violence, 1,166 (66.14%) of whom were sexually abused. From January to July 2004, among 525 abused children, 333 (63.43%) were sexually abused.[14]

These extremely alarming figures indicate that sexual abuse is the type of maltreatment that has been more widely reported to and investigated by this secretariat; however, they cannot be regarded as prevalence ratio, considering all types of maltreatment to which children and adolescents may be subjected.

The Network for the Protection of Children and Adolescents at Risk of Abuse, Curitiba (Brazil), registered 1,356 reports of abuse in 2003. Of these, 17.6% corresponded to sexual abuse (75.6% were girls and 24.4% boys) (Table 1).[15]

Table 1 - Number and percentage of registers according to type of violence from the Network for the Protection of Children and Adolescents at Risk of Abuse, Curitiba (Brazil), 2003

Type of violence	n	%
Negligence	537	39.6
Physical	476	35.1
Sexual	238	17.6
Psychological	90	6.6
Abandonment	15	1.1
Total	1,356	100

Source: CE/SMS - Data from the Network for the Protection of Children and Adolescents, Curitiba, Brazil, 2003.
Note: One register (0.1%) did not report any type of violence.

Sexual violence was the most prevalent type of domestic violence, amounting to 75.2% of cases. In 24.8% of reports, abuse occurred outside the victim's

house, but even so, nearly all of these cases were committed by people who had a trustworthy relationship with the victim. This shows the nonconformity of society in this type of violence, when usually, the offender would be a stranger, delinquent or psychopath.

It should be underscored that sexual abuse affects both sexes, but the highest incidence occurs among females, since it is more culturally accepted for the act itself and for reporting. International statistical data indicate that 10% of the victims are boys. The data from the Network for the Protection of Children and Adolescents, Curitiba, show that among 238 reports of sexual violence investigated in 2003, 24.4% concerned boys.[15]

Why children and adolescents keep quiet

In approximately 20% of all cases of child and adolescent abuse there is sexual abuse, always followed by psychological maltreatment, just as all types of violence in this age group.

The most frequent cases of sexual abuse up to adolescence involve incest, i.e., when the offender has some degree of kinship with the victim, causing a much more severe psychological injury than the violence committed by strangers.

It is a type of domestic violence that often occurs repeatedly, insidiously, in a favorable relationship environment without the child initially perceiving the abuse by the offender, who makes the child feel as a teaser and participant, making him/her believe he/she is to blame for the abuse.

The offender uses the trust he/she has established with the child or adolescent and his/her power as legal representative in order to come closer and closer, committing acts that the victim initially sees as a display of affection and interest. This approach is, at first, received with satisfaction by the child, who feels privileged receiving attention from the adult. The offender conveys the idea of protection and that his/her acts would be normal between fathers and daughters, or sons, or for the degree of kinship he/she has with the victim.

The approaches, which become more frequent and more abusive, produce a feeling of insecurity and doubt, which may persist for a long time, depending on the victim's maturity, on his/her system of values and knowledge, in addition to the possibility or not of having a dialog with and support from another adult in the family, usually a facilitator, who is aware or unaware of the abuse.

When the offender realizes that the child is beginning to see his/her acts as abuse or at least as abnormal, he/she tries to swap the roles, placing the blame on the child for having accepted his/her caresses. He/she uses the immaturity and insecurity of his/her victim, casting doubt on the child's importance to the family, lowering the victim's self-esteem even more by showing that any complaint would be useless or seen as a lie. Then the offender demands that the victim keep quiet about what happened using all the types of threats to the victim and to the persons whom the child most loves or depends upon. The abuse is progressive and the more fear, aversion or resistance the victim feels, the more pleasure the offender has, and the more severe the violence.[16]

Feeling unprotected by the other adult, usually the mother, who allowed the abuser to get closer to him/her, insecure for thinking that he/she would never be heard or believed, ashamed of what has happened and of not being able to report on the offender, with low self-esteem and also threatened by the one on whom he/she usually depends physically and emotionally, the child keeps quiet, sometimes for the rest of his/her life.

Homosexual abuse accounts for 10% of the cases of sexual violence, according to the international literature. According to the Network for the Protection of Children and Adolescents at Risk of Abuse, Curitiba, 2002 and 2003,[15] these cases were found in 21% of reports of sexual abuse. This type of violence is more frequent between the male adult and the boy or adolescent, but it does not represent a definitive homosexual behavior by the offender or by the victim. This type of violence often belongs to a general abuse situation, of pedophilic nature, in which girls also suffer the same kind of abuse.

A family pact of silence

As part of a family disease, in order for reporting of the sexual abuse to occur, it is necessary that the domestic balance be broken, in a relationship distortion known as incestuous family. In more common cases inside a patriarchal structure of power inherited from previous generations, the mother becomes the *silent partner* – having a silent participation in a general abuse situation.

Felizardo et al.[17] cite Kaufmann et al., who in 1954 described a common profile of these mothers: almost all of them had a domineering, cold and emotionally detached mother, who rejected her daughters in favor of her sons. Hirch[18] states that due to the consequence of unequal socialization of genders, this mother develops the female inferiority complex. This mother seeks to maintain the "stability and safety" of the family, which represents her safe harbor. In several cases, the mother, either consciously or unconsciously, delegates the heavy role of mother and wife, in every respect, to her adolescent daughter.[17]

In some situations, when incest is discovered, the mother shows jealousy, regarding her daughter as a rival, blaming her for the abuse. To corroborate this practice, the mother finds it difficult to admit incest, as this would acknowledge her failure as a mother and wife, whereas the offender uses all the tricks to keep his acts secret and unrevealed.[18]

Another fact that shows the complex impact of this type of violence on family structure is that incest is more frequently reported in families with a lower socioeconomic background and more easily concealed by upper-class families[19] (adapted from Kaplan et al.).

Therefore, we may conclude that sexual abuse is part of a group of relationship ruptures in a sick family structure, which comes from the life history of every family member, including the offender. This history may determine permissiveness towards the sexual act, through depreciation of childhood and adolescence, and also of the women's role, consisting of a collective "blindness" and "deafness" to the victim's (often silent) requests.

Diagnosis

The diagnosis of sexual abuse and the consequent protection necessary for the child and adolescent also depend on whether the pediatrician regards it as a possibility.[20]

General signs

The major problem faced by pediatricians and by protective agencies is the confirmation of sexual abuse in the absence of physical evidence. As a matter of fact, unlike this form of violence whose diagnosis is based on observed consequences, sexual abuse is often defined by indirect signs of psychological abuse, together with the facts reported by the victim or by a closely-related adult.[21]

In general, there are oral, digital and genital contacts with the external genitalia and anal region. Except in the case of vaginal penetration, injury is limited to the vulvar and anal regions. When the offender rubs his penis against the child's vulva, there may be erythema, edema, injury and chafing to the outer lips. Similar findings can be observed when the offender touches the vulva or vaginal introitus with his fingers without penetrating it.

However, children do not reveal immediately that they were sexually abused, which allows total healing to occur within a few days and, when the child is examined later, the anatomical characteristics of the anogenital region may not show evident injuries.[22]

Some authors tend to consider all anogenital injuries to be caused by sexual abuse. Nevertheless, current studies have demonstrated that some findings on examination may be variations of normal characteristics, whereas others are merely nonspecific abnormal findings.[23,24]

Pediatricians are usually the first health professional that is sought when one or both parents or any other family member are concerned with the possibility of sexual abuse. The review of a child's sexual experiences should be a routine procedure in medical history with an in-depth investigation if the child describes symptoms related to the genitalia or anus or if she or he has an age-inappropriate sexually-oriented behavior.[25]

A thorough physical examination should be performed in every child and adolescent and the inspection of genitals and anus should be a routine practice. Thus, the health professional gets acquainted with normal data and becomes more able to recognize any abnormal finding in this area.[26]

The inability of some pediatricians to distinguish between normal and abnormal characteristics of the genitals, not the least the female genitalia, is a concern.[27,28]

The possibility that a child has of revealing an abuse may lead other children and adolescents from the same family environment to report on an abuse they are suffering or have already suffered. In some cases, the discovery of sexual abuse of a child or adolescent by grandparents, granduncles or grandaunts may "break" the posttraumatic amnesia of an abuse suffered by the victim's own mother or father.

In other situations, the child or adolescent can be induced to accuse a stranger or any other distant person who cannot defend himself from the accusation, thus covering up the actual offender. These are usually inconsistent stories that do not resist a more detailed argument. Only when the victims develop some trust in the health professional will they reveal the abuse, which is often repetitive and long-established, committed by parents, family members or acquaintances.[9]

The interview with the patient should be conducted with caution, according to the reaction and approach of each health professional, refraining the victim from repeating his/her story to different health professionals, since this will make him/her reexperience suffering and even intensify it.

The assessment of the patient history collected in different moments from other people involved (besides the patient himself/herself, his/her parents or surrogates), trying to determine incoherence and contradictions, may lead to definitive diagnosis. The complaint is not always clear and, in more common cases, which are chronic and have no specific physical signs, the participation of specialized professionals, such as psychologists, psychiatrists or psychoanalysts, is of paramount importance.

Strategies such as playing with dolls or puppets or role-playing the parent-child relationship may indicate some signs or symptoms. Also, in drawings, the child describes, sometimes in symbolic detail, all his/her suffering.

The set of relevant data, if possible documented with pictures of the existing physical injuries, must be recorded on the patient's medical chart, respecting the ethical and legal principles of secrecy and confidentiality (Manual of Safety, SBP, 2004).[16]

The possibility of false reporting should also be raised. In this case, the child or adolescent is induced or convinced to accuse one parent, in couple's fights, as a way to keep that parent from having the custody of the son or daughter, or as a form of revenge.

The consequences of sexual abuse of children and adolescents may be characterized by signs and symptoms that originate from psychological injury to which the victims are subjected, such as permanent sadness, prostration, daytime drowsiness, exaggerated fear of adults (usually of those of the same sex as the offender), history of escaping, age-inappropriate sexual behavior, frequent and uncontrolled masturbation, tics or manias, enuresis or encopresis and low self-esteem.

Specific signs

Although they are not always present, the signs and symptoms of physical injury are quite conclusive for the diagnosis of sexual abuse of children and adolescents and should always be investigated.

The diagnosis of sexual abuse should be made whenever either of the signs and symptoms below are found:

- Injuries to the genital region.
- Edema, bruises or tears in or close to the genital region, such as inner thighs, outer lips, vulva, vagina, scrotal or anal region, in girls and boys.
- Anal or urethral dilation, or perforated hymen, indicate sexual abuse, but these signs are not always evident within normality thresholds, often requiring a careful examination by forensic experts.
- Injuries such as ecchymosis, bruises, bites or tears on the breasts, neck, inner or upper thighs, low abdomen and/or perineal region.
- Vaginal or anal bleeding in prepubertal children, accompanied by pain, after ruling out the physical problems that might cause them.
- Sexually transmitted diseases such as gonorrhea, syphilis, HPV, chlamydia, among others.
- Abortion – natural or provoked fetal loss.
- Pregnancy

Manual of Child and Adolescent Safety, DCSCA, SBP 2004.[16]

Treatment

Primary care

The first step towards a good physical and emotional treatment is showing a welcoming attitude towards the child or adolescent and his/her pain. Listening to his/her story without prejudice, interruptions or requests for further unnecessary details, shows respect for those whose body, image and self-esteem were disrespected.

Pediatricians should not forget that they are treating an extremely emotionally broken child, who is confused, feeling humiliated, ashamed, guilty, afraid and helpless. It is necessary to establish a good relationship, always explaining what is going to be done and why, never promising unfeasible things (e.g.: that this type of violence will never happen again or that the child will always be protected).

There should be a distinction between the implementation of primary care for acute rape situations or other form of sexual abuse, which is an emergency and demands immediate action to manage physical and emotional injuries, and chronic and repetitive abuse, although both are extremely detrimental to the child or adolescent.

In acute cases, less than 72 hours after the event, legal actions must be in place in order to accompany the diagnosis and treatment. The basis for legal charges requires that sexual abuse be confirmed and that exams for the identification of the offender be performed, but before that, parents or surrogates must file a charge at the police department, which will request a forensic report from the Medical Legal Service.

If parents or surrogates refuse to file a charge, the hypothesis of perpetration of violence by them, complicity or powerlessness should be raised, and in this case, the Guardianship Council must intervene by requesting the temporary custody of the victim and implementing the necessary protective measures. If the Guardianship Council cannot be reached, the Children and Youth Court should be notified.

Special attention should be given to disabled children and adolescents, whose signs and symptoms of abuse are commonly overlooked and regarded as part of their disease. Physically impaired and sensorially impaired individuals are at great risk for all types of violence, including sexual abuse, due to the heavy dependence on others in their daily life. In case of mentally impaired individuals, abuse by an adult is easier, as the child's or adolescent's mental age does not match the development of his/her body, or of his/her hormone levels, and then they firmly believe in whatever the offender proposes.

Pediatricians should be prepared to perform a thorough physical examination, including gynecological examination, to search for possible physical, genital or extragenital signs of abuse. In the most traumatic cases and in cases of emotional imbalance, the examination must be carried out under sedation and/or anesthesia, after informed consent by parents or legal representatives. When the abuse has been committed by a parent or surrogate, this consent must be obtained from the Guardianship Council.[16]

In chronic cases, which unfortunately are the great majority, the child or adolescent is extremely emotionally broken and may present all the signs of destruction and self-destruction, as a result of the emotional sequelae caused by the abuse. The general signs are less drastic but not less severe. The family situation must be carefully investigated, in an attempt to identify or not the participation of other persons, due to powerlessness, complicity or neglect.

The related risks should be assessed in each case and also the necessity for prophylaxis against hepatitis B, pharmacological protection against nonviral STDs, chemoprophylaxis for HIV infection and, in female victims of reproductive age, emergency contraceptive administration. This stage of care is crucial to protect the victim from damage and complications that may result from the abuse, and should be implemented up to 72 hours after the event.[16]

All the history of sexual abuse and its circumstances, as well as the findings of physical examination, diagnostic tests and therapies used, must be carefully described and recorded on the patient's medical chart. This guarantees the possibly necessary protection in cases of interest to the Justice and provides data for the application of measures, based on the information contained in the chart, of the "Indirect Medical-Legal Examination Sexual Intercourse Report."[16]

It has been estimated that 15% of the victims of sexual abuse acquire some kind of STD and that one in every 1,000 women is infected with HIV.[29]

The most important sexually transmitted diseases are the following: *Neisseria gonorrhoeae*, *Chlamydia trachomatis*, *Trichomonas vaginalis*, *Treponema pallidum*, human papillomavirus (HPV), herpes simplex virus (HSV), human immunodeficiency virus (HIV).

A detailed description of physical examination and signs of sexual abuse can be found in the Manual of Child and Adolescent Safety published by the Brazilian Society of Pediatrics, which also includes the necessary treatments, standardized by the Brazilian Ministry of Health. The description of these items is not within the scope of the present study, so they will not be addressed herein. Anyway, they are well documented in the publication by the Brazilian Society of Pediatrics.[16]

Tools for the legal protection of sexual abuse victims and their weaknesses...

The Brazilian Constitution of 1988, in article 227, establishes that "It is the duty of the family, the society and the State to ensure children and adolescents, with absolute priority, the right to life, health, nourishment, education, leisure, professional training, culture, dignity, respect, freedom and family and community life, as well as to guard them from all forms of negligence, discrimination, exploitation, violence, cruelty and oppression."[30]

On July 13 1990, Law 8069 was decreed and sanctioned in Brazil, with provisions regarding the Child and Adolescent Statute,[31] establishing the rights and duties of children and adolescents and determining the responsibilities of the government, society, and family for the future of new generations, bringing a new vision and posture in relation to childhood and adolescence. Children and adolescents are regarded as subjects of rights, considering the peculiar nature of developing human beings, deserving absolute priority.

The term *Sexual Abuse* is found in Legal Medicine books and in the Child and Adolescent Statute in article 130,[31] but it is not included in the definitions of sexual crimes of the Brazilian Penal Code.[32] In this code, sexual crimes are classified as: rape, lascivious indecent exposure, seduction, sexual possession through fraud, indecent exposure, sexual harassment, corruption of minors, kidnapping through violence or fraud. The article on consensual kidnapping[32] was removed from the Brazilian Penal Code this year.

Rape is defined by the Brazilian Penal Code as vaginal penetration using violence or severe threat. There is a presumption that children younger than 14 years are unable to give informed consent.[32]

Usually, initial sexual abuse as a form of domestic violence occurs insidiously and progressively, and the offender uses different strategies for approaching, intimidating, and even threatening the victim, but these strategies are not always accompanied by physical assault.

Lascivious indecent exposure is characterized by someone's forcible engagement in lascivious acts, without vaginal penetration, using violence or serious threats. There is a presumption that children younger than 14 years are unable to give informed consent.[32]

In all cases of sexual abuse, physicians (especially pediatricians) have to be qualified for the clinical and psychological management of victims, including knowledge about specific laws. This demands sensitivity, availability and experience. Negligence in these aspects can be interpreted by the patient as a new process of "victimization," as well as by the health service.

In sexual abuse of children and adolescents, lewd acts are the most common ones. Initially, by way of seduction and intimidation, followed by threats against the child or some family member, usually against the mother, the offender obliges the child to practice sexual acts that do not include vaginal penetration, not characterizing rape, but exposing him/her to a wide variety of sexual contacts, often including oral sex and anal penetration.

The few cases that are reported to supposedly protective agencies end up as inconclusive forensic examinations or as lewd acts without physical evidence or without confirmation by current criteria of the Brazilian penal code. Basically bodily injuries that result in incapacitation to perform usual activities for over 30 days, in risk of life, limb loss or weakness, loss of sense or function, anticipated childbirth, incapacity for work, incurable disease, permanent deformity, abortion or death[32] are defined as severe by this Code.

The articles of this Code, written in 1940, based on the insufficient knowledge of that time about special characteristics of a developing human being, have been used as models for forensic reports issued by the Medical Legal Service. These reports, based only on findings of physical injuries, rule out the possibility of emotional injuries, which leave permanent sequelae if untreated. However, these reports have been the major legal instrument for the classification of violent acts, although they use the same criteria for adults, children and adolescents, in all lawsuits.

This sequence of incomplete assessment of physical and emotional sequelae caused by sexual abuse of a child or adolescent demonstrates failure in legal instruments, which should prioritize the protection of children and adolescents. It is not possible to assess the physical, psychological and sexual risks and injuries or neglect resulting from abuse by using the same criteria for adults and for children and adolescents.

They are considered yet more severe once they are types of abuse in which the offender is the parent or legal guardian, or is someone who has a family-type relationship with the child.

In several cases, nonexistent or inconclusive forensic reports do not allow apportioning the blame on the offender and protecting the victim, who often shares the same household with the offender, depending on him, and suffering more violence after reporting of the abuse, due to impunity.

Prognosis

One should bear in mind that all types of sexual abuse may lead to developmental imbalance in children and adolescents and that the lack of diagnosis of vaginal penetration (which characterizes rape) should not be

minimized, or given a milder connotation. Sexual abuse with vaginal or anal penetration or that without penetration or by other violent sexual practices are sick and perverse forms of child and adolescent abuse, which cause definitive consequences on their physical and emotional development.

With the progression of incestuous relations and of adolescence, the offender, usually the mother's partner, stepfather, or father, becomes more violent and possessive, fearing that the victim will report on him or that he may lose her/him to others, and then starts to interfere in the relationships with his/her peers and society. The offender prevents or tries to stop the victim from going to school, participating in social gatherings and in leisure activities, and from having any friends or any other form of relationship, keeping the victim under slavish oppression.

This sequence triggers a set of self-defense or self-destruction reactions, depending on the care and protection these victims receive.

The victim's vulnerability to the sequelae of sexual abuse depends on the type of abuse, on its chronicity, on the victim's age and on the relationship with the offender. Its effects may be devastating and permanent;[19] however, no specific psychiatric symptom resulting from sexual abuse has been described.

According to Kaplan et al., in the chapter entitled *Problems Related to Abuse or Neglect,* under-three-year-olds tend not to have a verbal recollection of previous traumas or abuse, but their experiences may be reproduced through games or role-playing.[19]

At preschool age, immature cognitive development, poor perception of the world, combined with speech difficulties, affect the understanding of facts, and consequently, the reporting, follow-up and assessment of abuse cases.

At school age and in adolescence, shame, guilt and feeling of unprotectedness or complicity with other legal guardians, combined with incomplete development of moral values (to a greater or lesser extent, depending on the family environment and on bonds of affection), in addition to the difficulty or impossibility to have a dialog with parents or legal guardians who are not directly involved in the abuse, turn underreporting into a commonplace situation.

Sexual abuse should be considered a predisposing factor for later symptoms such as phobias, anxiety and depression, and dissociative identity disorder, also known as multiple personality disorder, with the possibility of self-destructive and suicidal behaviors.

The best results regarding the follow-up of victims of sexual abuse are obtained when children remain cognitively intact, when the abuse is identified and interrupted at an early stage and when the whole family takes part in the treatment.

Conclusions

Pediatricians, by accomplishing their professional role and duty, are supposed to be able to prevent sexual abuse, diagnose its risks, and raise an early suspicion, and when violence is in the process of being established, to make a timely diagnosis and reporting, so that the physical and emotional integrity of the child or adolescent can be warranted. Thus, by way of routine care, emergency treatment or follow-up, pediatricians can notify all legal and social protective services available, which should at least guarantee the treatment of the child or adolescent, his/her protection, family support and treatment, as well as withdrawal of the offender.

Continued and specialized treatment of physical and emotional health of sexually abused children and adolescents, and of his/her family, by an interdisciplinary team will always be necessary. Recovery of self-esteem and physical and emotional integrity of the victims depends on the quality of care, reestablishing the victim's confidence in other people and in his/her capacity to fight for his/her life with dignity.

Besides the ethical, legal and moral duty, every pediatrician should know the importance of his/her intervention to prevent or stop sexual abuse in childhood and adolescence.

Through this different approach that consists in observing details and listening to unspoken complaints, followed by the implementation of all necessary protective measures, new and good paths may be created for these children and adolescents.

Pediatricians must be aware that when they treat a child or adolescent presenting some of the signs previously mentioned or when they suspect of sexual abuse, even through apparently unfounded complaints made by a suffering child, these victims seek in them the hope to break the pact of silence that involves the incestuous family and the surrounding environment. These victims want to be protected!

Many of these victims, if left to their own devices, will carry along this suffering child in them, as well as their pain and sequelae, for the rest of their lives.

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