

Adult manifestations of childhood sexual abuse

There is a general assumption in the therapeutic community that childhood sexual abuse, in addition to its initial effects upon the child, has the potential to impair later adult functioning. This suggestion is derived from repeated clinical observations of psychological and emotional difficulties evident in patients who have a history of early sexual abuse.

Evidence-based studies have established the link between childhood sexual abuse and later psychological disorders,¹ such as depression, self-destructive behavior, negative self-concept,¹ anxiety,² and isolation.³ In addition, women who have been sexually abused may have difficulty relating to others, including friends, partners, parents, and their own

children because of their inability to trust.⁴ Victims of such early abuse are also more likely to be raped as young adults.⁵ Substance abuse¹ and increased sexual activity⁶ in later years have also been shown as associated with childhood sexual abuse. One study found that sexual penetration and use of force during the abusive acts were associated with adult sexual dysfunctions, specifically with dyspareunia, hypoactive sexual desire, and orgasmic disorder.⁷ There is ongoing speculation whether vaginismus can also be one of the effects.

The following patient case supports the proposition that a child may perceive trauma where none is intended and develop a symptom profile similar to that of an abuse survivor without the history of actual childhood sexual abuse.

Case Report

HISTORY

L. is a young Caucasian woman in her late twenties. She presented with symptoms of depression and several ongoing stressors. Her psychosocial history revealed an alcoholic father and stepfathers, and the ongoing emotional caretaking of her mother and 4 younger siblings. She admitted to a period of alcohol abuse and increased sexual activity as a teenager, and was also a victim of two sexual assaults during those years. Both instances

involved alcohol use and went unreported. At the time, L. did not understand that she had been assaulted and assumed guilt for "losing control."

After college, L. was employed in a camp for difficult youths. One of the adolescent males expressed interest in her, which she rebuffed but did not report to her superiors. However, angered by the rejection, he reported L. for sexual misconduct. An investigation ensued and found her innocent but left her emotionally and financially drained. She moved back home and entered a graduate program at a nearby university.

L. eventually admitted that she was concerned about her sexual health. She and her fiancé of 2 years had not had intercourse,

although they shared the same bed and engaged in kissing and sexual touching above the waist. She admitted she was uninterested in sex and uncomfortable with her own body. A review of her history included the accusation of sexual misconduct, two sexual assaults, increased sexual activity that did not include physical pleasure, a period of increased alcohol use, and risk-taking behaviors. Family messages about female development and/or sexuality were either nonexistent or negative. L. did not appear to have a history of depression; however, she showed a need to overachieve and present herself as strong and composed. She also described denying strong emotional reaction to traumas such as being sexually assaulted or a friend's suicide. Being "strong" is consistent with the role of a parentified child.

As clinicians, we must realize that our clinical interventions may be perceived as invasive and frightening if we do not take the time to communicate with our patients and build a safe and trusting relationship.

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Case Report

L. had no recollection of any early childhood sexual abuse, including incest, but she did recall having bladder problems at the latency age (6 to 7 years old). She recalled the shame of not being able to hold her urine and wetting her pants at school, which had been diagnosed as immature urethra. She had memories of standing naked during the physical exam, wondering why her mother and sister could remain clothed. She remembered the terror and pain of being held down on an examination table by nurses while a doctor catheterized her. L. has no memory of anyone explaining to her what was happening or why. She then had surgery and needed to wear a diaper while healing—another humiliation.

As L. was describing these events in detail, it became apparent that her narrative included the elements of an assault. Her experience of a common medical procedure was one of fear and pain, which left her feeling out of control and humiliated. Both use of force and perceived penetration were present in this situation, as well as the patient's perception of secrecy. Since this occurrence, L. has felt dissociated from her body and has described herself as "asexual." Perhaps it was this dissociation that left her naïve to potential danger.

DISCUSSION

Traditional therapy, paired with EMDR (eye movement desensitization and reprocessing) is currently assisting L. in understanding and restructuring her cognitive associations. She has been able to begin the slow process of allowing herself to experience her sexuality. Unfortunately, her fiancé has seriously damaged her trust by participating in hurtful gossip about her. L. has chosen to remain with him but can no longer trust him, thus ending

further therapy regarding her sexuality issues. Intellectually, L. knows that she is not responsible for being raped, being accused of sexual misconduct, or being betrayed, but emotionally she is trapped in the fear that those are her personal truths.

Clinical implications

Occasionally, a client will not disclose past abuse during the initial assessment as a result of shame, embarrassment, fear, or inappropriate guilt. When the therapeutic process becomes "stuck," the symptom profile can act as a map to assist the clinician in discovering undisclosed abuse. The safety of the therapeutic relationship will allow the client to reveal long-held secrets.

There is no direct evidence that relates the medical procedures and surgery to L.'s later problems. It can be argued that her memory of those procedures has been colored by later events. However, the possibility that these events could be linked must not be ignored. We must realize that our clinical interventions may be perceived as invasive and frightening if we do not take time to communicate with our patients and build a trusting relationship.

References

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