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## Childhood Sexual Abuse: Long Versus Short Term Effects

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## Childhood Sexual Abuse: Long Versus Short Term Effects

### Abstract

Research over the past decade indicates that a wide range of psychological and interpersonal problems are more prevalent among those who have been sexually abused than among individuals with no such experiences. This paper summarizes what is currently known about these potential impacts of child sexual abuse. The various problems and symptoms described in the literature on child sexual abuse are reviewed in a series of broad categories including post-traumatic stress, emotional pain, avoidance, an impaired self, and interpersonal difficulties. Research has determined that the extent to which a given individual manifests abuse-related distress is a function of an undetermined number of abuse-specific variables, as well as individual and environmental factors that existed prior to, or occurred subsequent to, the incidents of sexual abuse.

**CHILDHOOD SEXUAL ABUSE: LONG VERSUS SHORT TERM EFFECTS**

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**University of Northern Iowa**

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## Abstract

Research over the past decade indicates that a wide range of psychological and interpersonal problems are more prevalent among those who have been sexually abused than among individuals with no such experiences. This paper summarizes what is currently known about these potential impacts of child sexual abuse. The various problems and symptoms described in the literature on child sexual abuse are reviewed in a series of broad categories including posttraumatic stress, emotional pain, avoidance, an impaired self, and interpersonal difficulties. Research has determined that the extent to which a given individual manifests abuse-related distress is a function of an undetermined number of abuse-specific variables, as well as individual and environmental factors that existed prior to, or occurred subsequent to, the incidents of sexual abuse.

## Childhood Sexual Abuse: Long vs. Short Term Effects

In recent years as public attention to child and adolescent incest or sexual abuse and its consequences have grown, so has knowledge about it. The legal, child welfare, medical, and mental health professions have made significant progress in promoting better understanding and improving responses in regard to the general conceptualization of the long and short term effects of childhood sexual abuse. For example, the term incest covers a large range of variables. Finkelhor (1994), states that most sexual abuse is committed by men (90%) and known to the child (70 to 90%), with family members constituting one-third to one-half of all the perpetrators against girls. Finkelhor (1994), goes on to say that around 20% to 25% of the child sexual abuse cases involve penetration or oral-genital contact, with the peak age of vulnerability between age 7 and 13. In addition, Peters, Wyatt, & Finkelhor (1986), found in their review of 19 surveys, that one in five girls in North America experienced sexual abuse in childhood. Third, the acts of abuse vary in nature, frequency, intensity, and duration. Lastly, childhood incest typically occurs in privacy, masked by secrecy, and most often produces no physical signs, making detection difficult.

Research in the past indicates that a wide range of psychological and interpersonal problems are more prevalent among those who have been sexually abused than among individuals with no such experiences. The aggregate of consistent findings in this literature has lead many to conclude that childhood sexual abuse is a major risk factor for a variety of problems. This paper summarizes what is currently known about these potential impacts of child sexual abuse. The various problems and symptoms described

in the literature on child sexual abuse are reviewed in a series of categories including self development, internal and external outcomes, posttraumatic stress disorder, anxiety, anger, helplessness, depression, psychological profile and an impaired self as immediate effects. Additional effects include dissociation, substance abuse, social and interpersonal difficulties, and revictimization. This list of symptoms is organized by the initial reaction to victimization, the accommodation to ongoing abuse or coping behaviors, to the more long-term consequences reflecting the impact of initial reactions and abuse related accommodations on the individual's ongoing personality formation.

In general, legal and research definitions of child sexual abuse require two elements: (1) sexual activities involving a child and (2) an abusive condition. According to Bagley (1991), the term sexual activity involving a child refers to activities intended for sexual stimulation, excluding touching a child's genitals for caregiving purposes. Bagley (1991), goes on to describe contact sexual abuse as touching the sexual portions of the child's body (genitals or anus) or touching the breasts of pubescent females, or the child's touching the sexual portions of the abuser's body. Contact sexual abuse includes penetration, which includes penile, digital, and object penetration of the vagina, mouth, or anus, and nonpenetration, which includes fondling of sexual portions of the child's body, sexual kissing, or the child's touching sexual parts of the abuser's body. Noncontact sexual abuse usually includes exhibitionism, voyeurism, and involvement of the child in the making of pornography. Verbal sexual propositions or harassment are included as well (Bagley, 1991). Abusive conditions, according to Russell (1984), exist when the



child's abuser is in a position of authority or in a caretaking relationship with the child, or the activities are carried out against the child using force or trickery.

The fact that children are involved infuses heightened emotional urgency. The topic of incest becomes a problem for our society to address because it involves sex with a close family member-who is a child-and America has never been comfortable with dealing in matters that involve such taboo. Recognition that children in general are at risk for sexual abuse, or that a specific child has been abused, is distressing for many adults because of their own histories as victims or victimizers; or because abuse involves emotion-laden issues of relationships, sexuality, and other difficult intra-and personal processes (Conte, 1994). Thus, because incest stirs up strong emotions; denial, minimization, and rationalizations have always played a central role in the societal response to it. Lastly, the victims are children of differing ages and at differing stages of cognitive, physical, and emotional development, making everything about incest more complex as each child will respond differently based on individual unique circumstances.

### Immediate Effects

Age affects the extent to which the child suffers physical consequences, mental health consequences-both long and short term-and makes understanding issues of incest extremely difficult. For example, the development of a sense of self is thought to be one of the earliest developmental tasks of the infant and young child, typically unfolding in the context of early relationships ( Santrock, 1993).

## Self Development

How a child is treated (or maltreated) early in life influences her growing self-awareness. As a result, severe child maltreatment-including early and sustained sexual abuse-may interfere with the child's development of a sense of self. Without such an internal base, individuals may lack the ability to soothe or comfort themselves adequately. This impairment can also cause difficulties in separating the self from others (Walker, 1994). These difficulties may translate into a continuing inability to define one's own boundaries or reasonable rights when faced with the needs or demands of others in the interpersonal environment. Such problems, in turn, are associated with subsequent psychological difficulties, including increased suggestibility or gullibility, inadequate self-protectiveness, and a greater likelihood of being revictimized or exploited by others (Briere, 1992).

The ideology of self-development may be utilized in examining and determining internal and external outcomes of childhood sexual abuse. Research has shown that the impact of sexual abuse can have a profound effect on both behavior and emotional cognition. While some effects of sexual abuse may show continuity throughout childhood, others appear to be age specific.

## Internal and External Outcomes

In studies of preschoolers, a purported effect of sexual abuse is the display of some form of behavior judged to be abnormal. For example, abnormal or "sexualized"

behavior was operationalized to include sexual play with dolls, putting objects into the vagina or anus, masturbation, seductive behavior, requesting sexual stimulation, and age-inappropriate or precocious sexual knowledge (Mian et al., 1986). In addition, the presence of some type of inappropriate sexual behavior has been found with a variety of assessment tools, including parent ratings on the Child Behavior Checklist (CBCL) (Friedrich, 1986), observation of free play with anatomically correct dolls (Everson & Boat, 1988), and ratings of children's human drawings (Cohen & Phelps, 1985).

In a study by Adams-Tucker (1982), reports showed that sexually abused preschool children engaged in less disturbed behavior than older children who were sexually abused. Friedrich (1986) reported that preschool children were more likely to have clinically elevated Internalizing scores than Externalizing scores on the CBCL and sexually abused preschoolers were more passive than non-abused controls during free play, which is suggestive of internalizing symptomology; however, physically abused preschoolers were even more passive and withdrawn. The sexually abused preschoolers and non-abused controls were both less aggressive than were the physically abused preschoolers. Thus, at least within the context of free play with peers, sexually abused children in Friedrich's (1986) sample appeared to show more withdrawn and acting behavior difficulties.

Behavioral and academic problems at school are commonly reported symptoms for sexually abused school-aged children, ranging from 32% to 85% of the sample studied by Adams-Tucker (1981). She reported that over half of the sample was at least one grade behind at school, their teachers rated them as performing significantly less well in their school work, aggressive sexually abused children were more likely to have learning

disabilities or be in special education classes and possess significantly lower IQ ( $M=97.8$ ) compared to controls. Furthermore, all but 28% of the sexually abused children assessed in the Adams-Tucker study received a DSM-III diagnosis, most often adjustment disorder with mixed features.

Sexually abused school-aged children showed more behavioral and emotional problems than their nonclinical controls (Friedrich, 1986). Friedrich (1986) found that sexually abused girls were more likely to show depressive symptoms but less likely to display acting-out symptoms, sexually abused children had more internalizing difficulties, and they were more likely to manifest inappropriate sexual behaviors (e.g., excessive masturbation, sexual preoccupation, and sexual aggression) than did both “normal” and clinical controls. Thus, sexualized behavior appeared to be a type of symptom that was a relatively consistent marker of sexual abuse during the years prior to puberty.

While some effects of sexual abuse may show continuity throughout childhood, others appear to be age specific. Briere and Elliott (1994) note that another common diagnosis of incest is posttraumatic stress disorder (PTSD). Although PTSD was initially associated with adult response to disaster, accidents, and combat experience, more recent research has linked short-term posttraumatic symptoms to childhood sexual abuse.

### Posttraumatic Stress Disorder

A diagnosis of PTSD requires the occurrence of a traumatic event as well as (1) frequent reexperiencing of the event through nightmares or intrusive thoughts; (2) a

humbling of general responsiveness to, or avoidance of, current events, and (3) persistent symptoms of increased arousal, such as jumpiness, sleep disturbance, or poor concentration. Even though most child sexual abuse victims under the age of twelve do not meet the full criteria for PTSD, more than 80% are reported to have some posttraumatic symptoms (McLeer, Deblinger, & Esther, et al., 1992). For example, children who have been abused exhibit more posttraumatic fear, anxiety, and concentration problems than do their nonabused peers (Famularo, Kinscheroff, & Fenton, 1992). Their research focusing on assessing sexually abused children found that these children are more likely to receive the diagnosis of PTSD than their nonabused peers, at rates of up to 48%.

Other PTSD symptoms involve repetitive, intrusive thoughts and/or memories of the sexual victimization-difficulties that many survivors of sexual abuse find both distressing and disruptive. These differ from flashbacks in that they are thoughts and recollections rather than sensory experiences which are more common in adults (Briere & Elliott, 1994). According to these authors, intrusive thoughts center around themes of danger, humiliation, spontaneous sexual contact, guilt, and "badness", whereas intrusive memories involve unexpected recall of specific abusive events, both of which are most prominent in child sexual victims under the age of twelve. Nightmares with violent abuse-related themes are also commonly associated with sexual abuse related PTSD (Briere & Elliott, 1994).

Another short term effect of childhood sexual abuse, closely related to PTSD is anxiety. Child abuse is, by nature, threatening and disruptive, and may interfere with the child's developing sense of security and belief in a safe, just world (Briere, 1992). Thus,

it should not be surprising that victims of such maltreatment are prone to chronic feelings of fearfulness or anxiety. Anxiety can also be a long-term effect of childhood sexual abuse as well. If the child does not receive appropriate treatment early in the stages of recovery, anxiety may also occur in adulthood.

### Anxiety

Elevated anxiety has been well documented in child victims of sexual abuse (Kolko, Moser, & Weldy, 1988). In general populations, survivors are more likely than nonabused individuals to meet the criteria for generalized anxiety disorder, phobias, panic disorder, and/or obsessive compulsive disorder, with sexual abuse survivors having up to five times greater likelihood of being diagnosed with at least one anxiety disorder than their nonabused peers (Stien, Golding, & Siegel, et al., 1988).

Clinical experience suggests that the anxiety frequently has a conditioned component, in that sexual abuse usually takes place in human relationships where closeness and nurturance is expected. However, intrusion, abandonment, devaluation, and/or pain occur, and as a result, a learned association may form between various social or environmental stimuli and danger, such that a variety of otherwise relatively neutral interpersonal events elicit fear (Berliner & Wheeler, 1987). For example, the formerly abused individual may become anxious in the presence of intimate or close relationships, especially fearful of evaluation, or frightened when interacting with authority figures (Berliner & Wheeler, 1987). In Briere's (1984) study, childhood sexual abuse victims

were significantly more likely than nonabused controls to report fear, anxiety attacks, and problems with anger.

Abuse related anxiety can also be expressed physically, resulting from the impacts of sustained fearfulness on bodily function and perception. Physical problems that have been associated with childhood sexual abuse histories include headaches, stomach pain, bladder infections, asthma, and chronic pelvic pain (Cunningham, Pearce, & Pearce, 1988). Such findings suggest that some proportion of medical complaints presented to physicians and other health care practitioners may less reflect inherent bodily dysfunction than somatic equivalents of anxiety that arise from unresolved childhood maltreatment experiences (Briere, 1992).

Another common emotional sequel of child sexual abuse is that of anger. Chronic irritability, unexpected or uncontrollable feelings of anger, and difficulties associated with the expression of anger have been reported by children victims (Friedrich, Beilke, & Urquiza, 1988). Such feelings can become internalized as self-hatred and depression, or externalized and result in the perpetration of abuse against others (Carmen, Rieker, & Mills, 1984).

### Anger

In children, anger is frequently expressed in behavioral problems, with abused children and adolescents displaying significantly more difficulties in this area than what is found typically in the general population (Coleman, 1993). This data suggests that children's aggressiveness toward others-commonly expressed as fighting, bullying, or attacking other children-may be a frequent short-term effect of sexual molestation

(Finkelhor, 1990). Although such behavior may represent an externalization of the children's distress from their own abuse trauma, and, perhaps, a cry for help, the net effect of this angry aggression is often increased social isolation and unpopularity (Finkelhor, 1990).

Carman, Rieker, & Mills (1984), examined the relationship between violence (e.g. any form of physical or sexual abuse, including incest, marital violence, assault, or rape), psychiatric disorder (e.g. alcohol abuse, drug abuse, suicidal, criminality, aggression, depression, psychotic tendencies, and psychosomatic features), and one's ability to cope with anger and aggression in 80 abused and 80 nonabused adolescent psychiatric patients. Four categories of coping behaviors used to measure differing aspects of anger were developed: (1) anger was directed inward in a passive manner, characterized by depression, frightfulness, withdrawal, worthlessness, and hopelessness, but not actively suicidal, (2) anger was directed inward, but in a more overt, active fashion. This coping style was characterized by active suicidal intent and/or savage self-hatred, with loss of control reflected in a variety of self-destructive or self-mutilating behaviors, (3) anger was directed outward in a controlled manner. Anger was expressed appropriately, or displaced and projected elsewhere, and (4) anger was expressed outward with aggressive and sometimes violent behaviors toward others. The results of their study revealed that, compared to their nonabused peers, sexually abused girls scored significantly higher on scales of alcohol abuse, abuse of illicit drugs, suicide attempts, criminal justice involvement, abuse to others, aggression, depression, and all four categories of coping behavior measures. Interestingly, when comparing abused girls only on the coping



behavior scale, over half scored in category one, followed by category 2, then 4, then 3.

According to the authors, these outcomes may be the end result of victims' 1) inability to trust, 2) impaired self-esteem, and 3) difficulty in coping with anger.

Anger among victims of sexual abuse may be understood as attempts to cope with the chronic trauma induced by childhood victimization. The problem behavior may represent a conscious or unconscious choice to be involved in seemingly dysfunctional and/or self-destructive behaviors rather than fully experience the considerable pain of abuse-specific awareness. Unfortunately, although sometimes immediately effective in reducing distress, anger as a method of coping with child abuse experiences may lead ultimately to even higher levels of symptomology, lower self-esteem, and greater feelings of guilt and anger (Carman, Ricker, & Mills, 1987). While there are psychodynamic issues specific to each type of sexual abuse, the psychological and behavioral manifestations of chronic abuse may reflect extraordinary damage to the self, which then could become the object of the victim's hatred and anger or aggression.

Feelings of anger can also affect the victim's sense of helplessness due to the child's ideation of "badness", self-hatred, and her inability to control her environment. Chronic perceptions of helplessness and danger are thought to result from the fact that the child abuse occurred when the victim was physically and psychologically unable to resist or defend against the abuser. This expectation of injury may lead to hyperactivity or "overreaction" to real, potential, or imagined threats.

## Helplessness

The most predictable impact of helplessness is the victim's growing assumption that she is without recourse or options under a widening variety of circumstances (Briere, 1992). Briere (1992) goes on to say that because such experiences are often chronic and ongoing, feelings of hopelessness regarding the future are also likely. Similarly, the child may make assumptions about her inherent badness, based on misinterpretations of maltreatment as, in fact, punishment for unknown transgressions (Briere, 1992). A study of cognition in adjustment of victims of sexual molestation conducted by Faber & Joseph (1985), linked such abuse to subsequent guilt, low self-esteem, self-blame, and other dysfunction or inaccurate attributions as predicted from the above study by Briere (1992). Faber & Johnson (1985) found that child victims of sexual abuse were more likely to attribute the cause of negative events to internal, stable, and global factors, as well as to their character and to their behavior (that is, "this negative event occurred because I am an inherently bad person and will never change").

Helplessness as well as emotional distress is well documented in the research literature regarding incest and its immediate consequences, primarily in terms of increased depression, anxiety, and anger (Browne & Finkelhor, 1986). They note that, "in the clinical literature, depression is the symptom most commonly reported among molested adolescents". A variety of studies have documented greater depressive symptomology among child victims compared to nonvictims (Lipovsky, Sanders, & Murphy, 1989).

## Depression

Lanktree, Briere, & Zaidi (1991) found that child victims in outpatient therapy were four times as likely to have received a diagnosis of major depression than were nonabused patients. In their study, Briere & Zaidi (1991) conducted a detailed review and comparative study of 64 randomly sampled charts for both abused and nonabused child psychiatric outpatients from a major urban university medical center. The variables examined included: gender, age at intake, reference to physical abuse, reference to sexual abuse (both intrafamilial and extrafamilial), age molestation began, duration of molestation, number of perpetrators, whether oral/anal/vaginal penetration occurred, number of suicide attempts, number of family stressors cited, DSM-III-R diagnoses, and total number of psychological symptoms reported. Comparison results revealed that victims were over 4 times more likely to be female (resulting in a 50% abuse incidence rate for girls versus a 11.5% rate for boys), were more likely to have made at least one suicide attempt and to have attempted suicide more frequently, and were more likely to receive a diagnosis of major depression (36.4%) than were nonabused subjects (8.3%). These findings are supported by a wide variety of other studies documenting greater depressive symptomology in adolescents with sexual abuse histories (Elliott & Briere, 1992).

Symptomology among sexually abused adolescents reveal evidence for the presence of depression, low self-esteem, and suicidal ideation or behavior. In a study by Brooks (1985), the author found that one third ( 9 out of 27 ) of the sexually abused subjects in the study had attempted suicide. All presented poor self concept, depressive

symptomology and schizoid/psychotic symptoms (hallucinations), “acting out” behaviors, such as running away, alcohol/drug abuse, and promiscuity.

In a study by Briere (1984), the majority adolescents suffering from depression as a result of sexual abuse became involved in sex rings, compulsive masturbation, prostitution, had significantly higher occurrences of illicit drug use, physical fights with parents and friends, and were involved in delinquent/criminal behavior. Scott and Stone (1986) compared MMPI profiles of sexually abused adolescents and their nonabused peers. The abused subjects scored significantly high on the hypomania scale indicating the presence of excitability, irritability, elevated mood, flight of ideas, brief periods of depression, and purposeless behavior. Interestingly, the group of abused adolescents in this study also scored high on the schizophrenia scale, which measures feelings of alienation and withdrawal from the social environment and interpersonal relationships.

Given all of the above listed symptomology in regard to short term effects of childhood sexual abuse, German, Habenicht, & Fitcher (1990) found that if personality traits are viewed as one profile, a total picture emerges. In their study, the authors compiled data from multiple studies to develop an abused child’s psychological profile.

### Psychological Profile

German (1990) found that the most prominent characteristic of adolescent incest survivors is withdrawal. They tend to be internally restrained, evaluative, avoid arguments, brood, remember unfair treatment, have few friends, and often act individualistically. They are shy, easily intimidated, emotionally cautious, apt to be

embittered and quick to see danger (German et al., 1990). Pairing withdrawal with shyness presents a picture of an adolescent who has made accommodations to the abuse in order to survive.

Low superego strength (e.g. part of one's personality that is the reflection of society's moral standards, and is generally equivalent to what we call conscience) is another prominent characteristic of some incest survivors. Some incest survivors tend to see themselves as self-indulgent, disregard rules, have low regard to moral standards, and tend to be indolent and frivolous, yet in the incestuous environment, the child believes she has the responsibility to keep the family together by submitting to the sexual abuse and keeping it a secret. Under these circumstances, it appears that conventional morality becomes distorted in the child's mind (German, 1990).

According to German et al., (1990), when considering all of these factors, the combination of low self-concept, low energy, withdrawal, shyness, conformity, and guilt, with the occasional unschooled aggressiveness may mix to produce an individual who may be difficult to be with because of her unpredictability. German et al., (1990) states,

Her sullenness, mood swings, lack of energy and drive may make her vulnerable to substance abuse and further sexual or physical abuse. Her choice of friends may be limited to those who are similar to her or will accept her. Her choices, reflecting low self-esteem, limit her healthy growth and mastery of her environment and life. Many times these adolescents remain in adolescence, vulnerable to become battered women. Furthermore, she may rebelliously set her own self-serving criteria for behavior, believing that the world is unjust and cruel. Lastly, her attraction is likely to be towards males who need her (p. 436 ).

It may helpful to understand the adolescent in regard to a psychological profile.

However, the danger in using a psychological profile is that one can ignore the unique characteristics and experiences of each survivor, therefore portraying a very negative

portrayal of the individual which may not be true in the majority of cases. How, then, do the victims see themselves as a result of the abuse and the development of personality or sense of self? One consequence of abuse is that the sense of self may become impaired as a result of an empathetic bond to the abuser.

### Impaired Self

As a component of personality, empathy is often described as the ability to feel what others feel, to experience the emotional states of the other such that one becomes sensitive and responsive to the other's needs (Tavris & Offir, 1993). Furthermore, Jacobs (1993) states that the exchange of feelings and emotions between social actors provides the foundation for the development of an empathic personality, the relational self.

Understanding the female relational self is predicted on the presence of a mutually empathic bond between mother and female child that contribute to the daughter's healthy psychosocial development (Jacobs, 1993). When, however, the female child's empathic development is contextualized by the father's sexual abuse, a rupture in the mother-daughter bond may take place such that the victimized daughter may tend to empathize with and forgive the fathers while turning their rage and anger towards their mothers (Herman, 1981). For example, Herman (1981) states that the multiple boundary violations that inform the child's relationship to the perpetrator create a dynamic of forced intimacy (e.g. sexual violence that represent the most extreme form of social learning, in which the female child comes to experience herself through the eyes of the perpetrator's emotional and physical demands) wherein attachment rather than

separateness defines the daughter's relationship to the father. The forced intimacy characteristic of incest perpetration separates the daughter from the mother, reinforcing the child's feelings of maternal betrayal and abandonment while intensifying her connection to the abusive father (Herman, 1981; Jacobs, 1993; Lustig et al. 1966).

In her study, Jacobs (1993) examined the variables of violence and remorse, the "victimized" perpetrator, and rescuing the perpetrator. For half of the women in her study, violated by the age of eight, the concept of sexual assault was not understood until many years later, after the survivor had language and conceptual framework to recognize and comprehend the unnamed trauma of her early childhood. Generally, after the assault, the perpetrator presents himself as caring for the victim, apologizing, and asking for forgiveness, asking her, the abused child, to understand that he did not mean to hurt her. Empathy is thus engendered under conditions of sexual violence, resulting in the development of an empathic bond in which the feelings of the perpetrator takes precedence. During this act of violation, the child victim not only recognizes the primacy of the aggressor's pain but takes responsibility both for the rape and for the rapist's remorse. While experiencing the perpetrator's violent behavior in connection with his guilt and shame, the child victim comes to identify his shame as her own, a process of internalization that is intensified by the perpetrator, who often blames the child for the shameful acts he has just committed (Jacobs, 1993).

Incest is a prevalent form of family violence in which the ego ( e.g. the conscious part of the personality responsible for decision making and dealing with reality) boundaries of the daughter are invaded by the father. Jacobs (1993) goes on to say:

The father may actually seek maternal nurturing in the abusive relationship with his daughter, but will do so through an identification with the victimized child whom he sees as an extension of himself. In reinforcing this type of father-daughter identification, the abuser further alienates the daughter from her mother as they are forced into competing roles in the incest family. This strengthens the bond between the abuser and the victimized child; the child perceives the abuser as the only family ally, with whom she empathizes and from whom she receives nurturing (p. 137).

One manifestation of the empathic female persona is the desire by the victimized woman to save those men who batter, abuse, and humiliate them. The origins for such self-denial can be found in what Jacobs (1993) calls "emotional exploitation." In their role as sexualized daughters and female nurturers, some abused girls come to value themselves through the protection and caregiving they provide the perpetrator. Frequently, survivors find themselves in abusive relationships that replicate the dynamics of empathic responsiveness that characterized their relationship with their fathers. This form of attachment in adult survivors emerges out of what Jordan (1991) has determined faulty empathy in which a personality construct of an individual's boundaries of self are extremely permeable so that she cannot easily distinguish between her own needs and the needs of others. Jordan (1991) believes that the powerlessness and sexual boundary violations of incest contribute greatly to a diminished sense of self, while the empathic connection further confounds the developing child's sense of separateness as she constructs her identity through her emotional attachment to the abuser. Incest survivors may thus suffer a loss of self that is reexperienced in intimate relationships in adulthood.

Courtois (1988) states that the striving for perfection is frequently found among incest survivors and has often been explained as the creation of an idealized self, which compensates for the negative identity of the real self. The idealized self might also be



understood in relation to the empathy the child feels for the abuser, as she seeks to become the perfect daughter whose “goodness” may alleviate his suffering. According to the author, the role of nurturer defines the child as “the good girl,” an affirmation the child needs to help mitigate the self-condemnation that accompanies sexual abuse.

Jacobs (1993) believes,

In caring for the perpetrator, the child reframes the humiliation, fear, and shame associated with victimization as a loving, caring relationship in which the child is the valued daughter. Nurturing the aggressor thus becomes a strategy for constructing a sense of self-worth under conditions of powerlessness. A consequence for the daughter is a sustained connection to the perpetrator, but one that creates severe disconnection from the child self who has been victimized. Further, and perhaps more significantly, the empathic bond may serve to nurture the daughter as well. In seeking to alleviate the distress of the abusive parent, with whom she identifies, the child may seek to alleviate her own suffering and in doing so to rescue the violated self from the dispare of victimization (p. 141 ).

### Long Term Effects

Age plays an important role in regard to sexual abuse because generally, if a child is experiencing abuse and resulting confusion prior to age 12, she is often left to negotiate the trials of childhood without assistance (Higgs, 1994). Perhaps the most obvious example of conditioned, abuse-related fear among adult survivors is that of sexual dysfunction.

### Sexual Dysfunction

Briere & Elliott (1994) compare sexual dysfunction to a type of cognitive distortion, in that, indiscriminate behavior may be used by some victims as avoidance to interpersonal

relationships. Because childhood sexual molestation is likely to create an association between sexual stimuli and invasion or pain, many adult survivors report fear or anxiety-related difficulties during sexual contact. Meiselman (1978) for example, reported that 87% of her clinical sample of adults molested as children had “serious” sexual problems, as opposed to 20% of those clients without a sexual abuse history. Similarly, Maltz and Holman (1987), found that 60% of the incest survivors that they studied reported pain during intercourse as opposed to 20% of those clients with out a sexual abuse history. 48% were unable to experience orgasms during sex as compared to the non-abused female population in their study.

Another form of avoidance used as a coping mechanism is dissociation. This phenomena is commonly called “spacing out” or amnesia for painful abuse-related memories. Dissociation may be thought of as another level of consciousness, much like a mild trance state, that makes the unbearable bearable by letting the mind go away for awhile.

### Dissociation

Dissociation can be defined as a disruption in the normally occurring linkages between subjective awareness, feelings, thoughts, behavior, and memories, consciously or unconsciously invoked to reduce physical pain (Briere, 1992). Examples of dissociation include: (1) derealization and depersonalization, that is, the experience of self or the environment as suddenly strange or unreal; (2) periods of disengagement during times of stress, for example, via “spacing out” or excessive daydreaming; (3) alterations in bodily perception; (4) emotional numbing; (5) out-of-body experiences; (6) amnesia for painful

abuse related memories; and (7) multiple personality disorder (Steinberg, 1993).

Dissociative symptomology has been linked to sexual trauma in children and adults (Elliott & Briere, 1994). Such symptoms are apt to be prevalent among child and adult survivors because they reduce or circumvent the emotional pain associated with abuse-related experiences or recollections, permitting superficially higher levels of psychological functioning (van der Kolk & Kadish, 1987). Dissociation is thought to underlie many individuals' reports of amnesia for childhood abuse in that such memories are believed to have been defensively excluded from conscious awareness (Lowenstein, 1993). The mind-body split that abuse fosters as a coping strategy is adopted by children and adolescents in order to protect themselves. When dissociation is out of control, the adolescent girl can fragment the various parts of her personality as people do with multiple personality disorders, or, she can become "spacey" and confused, not concentrating for long on anything important (Walker, 1994).

As dissociation relates to long term effects, one study by Herman and Schatzow (1987) suggests that adults in psychotherapy quite commonly report some period in their lives when they had incomplete or absent memories of their childhood abuse. These authors found that 64% of 53 women undergoing therapy for sexual abuse trauma had some period of time prior to treatment when they had incomplete or absent memories of their molestation. Among 450 women in psychotherapy to deal with abuse-related difficulties, Briere & Conte (1994), found in their study that 59% had reported having had some period before the age of 18 when they had no memory of being abused. In both of these studies, self-reported abuse-related amnesia was associated with more severe and extensive abuse that occurred at a relatively earlier age. Lastly, Loftus, Polonsky, &

extensive abuse that occurred at a relatively earlier age. Lastly, Loftus, Polonsky, & Fullilove (1994) found that 19% of more than 50 adult female sexual abuse survivors in treatment for chemical dependency stated that, at some point in their past, they had no sexual abuse memories and that an additional 12% had only partial memories of their childhood sexual victimization. Interestingly, in the later study, the authors interpreted their data as not necessarily supporting the notion of psychogenic amnesia, per se, but rather referred to this process at least in some instances, as “forgetting”.

As a victim attempts to make sense of their maltreatment, coping strategies other than dissociation may occur, having somewhat similar results. Many victims, for example, engage in substance abuse as an attempt to anesthetize psychic pain. Substance abuse can refer to alcohol, illegal drugs, or addictions.

### Substance Abuse

A number of studies have found a relationship between sexual abuse and later substance abuse among adolescent and adult survivors. Briere & Runtz (1993) reported that sexually abused female crisis center clients had ten times the likelihood of a drug addiction history and two times the likelihood of alcoholism relative to a group of nonabused female clients. Thus, some significant portion of those currently addicted to drugs or alcohol may be attempting to self-medicate severe abuse-related depression, anxiety, or posttraumatic stress. It seems likely that sustained drug or alcohol abuse allows the abuse survivor to separate psychologically from the environment, and blur distressing memories.

Certain behaviors reported by adult survivors of child sexual abuse, such as compulsive and indiscriminate sexual activity, bingeing, or chronic overeating, and self-mutilation, can be seen as fulfilling a need to reduce the considerable painful affect that can accompany unresolved sexual abuse trauma. Briere & Elliott (1992) state that often, these activities are seen as “acting out,” “impulsivity,” or, most recently, as arising from “addictions.” For the abuse survivor, however, such behaviors may be best understood as problem-solving behaviors in the face of extreme abuse-related dysphoria. The result of these behaviors are frequently effective in creating a temporary sense of calm and relief, but ultimately these tension-reducing mechanisms in the future is reinforced through a process of avoidance learning. Behavior that reduces pain is likely to be repeated in the presence of future pain (Briere, 1992).

Research and clinical observations have long suggested that child sexual abuse is associated with both initial and long-term alterations in social functioning (Elliott, 1994). Interpersonal difficulties arise from both the immediate cognitive and conditioned responses to victimization that extend into the long-term (for example, distrust of others, anger at and/or fear of those with power, concern about abandonment, perceptions of justice), as well as the accommodation responses to ongoing abuse (for example, avoidance, passivity, addictions, and sexualization) (Briere & Elliott, 1992).

### Social and Interpersonal Difficulties

As an explanation of social and interpersonal difficulties, Finkelhor & Browne (1985) have proposed a model called Traumatic Dynamics Model of Child Sexual Abuse. As they define it, a traumatic dynamic “alters children’s cognitive and emotional orientation

to the world, and creates trauma by distorting children's self-concept, world view, and affective capabilities" (Finkelhor & Browne, 1985, p.531). They believe that the impact of abuse can be accounted for by four dynamics: (a) Stigmatization; (b) Betrayal; (c) Powerlessness; and (d) Traumatic sexualization. Stigmatization "refers to the negative connotations—for example, badness, shame, and guilt that are communicated to the child around the experiences and that then become incorporated into the child's self-image" (p.532). Betrayal "refers to the dynamic by which children discover that someone on whom they were vitally dependent has caused them harm" (p.531). Powerlessness "refers to the process in which the child's will, desires, and sense of efficacy are continually contravened" (p.532). Traumatic sexualization "refers to a process in which the child's sexuality...is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse" (p.531).

Finkelhor and Browne's (1985) model suggests that these dynamics shape the way the adult survivor interacts with the world, possibly accounting for the psychological and interpersonal problems that are characteristic of adult survivors of childhood sexual abuse. Although their model referred to these traumatic dynamics at the time of the abuse during childhood, internalized thoughts and feelings regarding the abuse may still play a role in adjustment long afterwards. For example, sexual abuse usually occurs in the context of close human relationships, with as many as 85% of the cases perpetrated by individuals known to the victim (Finkelhor, 1990). The violation and betrayal of boundaries in the context of developing intimacy can create interpersonal difficulties in many survivors. The intimacy problems appear to center primarily in ambivalence and

fear regarding interpersonal vulnerability (Elliott, 1994). Elliott (1994) goes on to say that although interpersonal difficulties are commonly reported by survivors, they are more prominent when the victimization begins at an especially early age, lasts over an extended period of time, or occurs within the nuclear family.

As adults, survivors report a greater fear of both men and women (Kolko, Moser, & Weldy, 1988). They are more likely to remain single and once married, are more likely to divorce or separate from their spouses than those without sexual abuse histories (Briere & Runtz, 1990). Sexual abuse survivors typically report having fewer friends, less interpersonal trust, less satisfaction in their relationships, major maladaptive interpersonal patterns, and greater discomfort, isolation, and interpersonal sensitivity (Elliott & Briere, 1992).

In addition to experiencing social and interpersonal difficulties, many victims have experienced or fear revictimization. Conte and Schuerman (1987) speculate that adults victimized as children may see themselves as unworthy of relationships with people they consider good or healthy, and that some victims may attempt to gain mastery over the abuse experience by recreating it in the form of involvement in poor or abusive relationships.

### Revictimization

Sexual or physical revictimization (that is, rape or spousal abuse) has been associated with prior child sexual abuse in a number of studies (Conte & Shuerman, 1987). Briere (1984) found that 49% of his sexually abused sample had been victims of battering in an adult relationship, a rate almost three times greater than that of the control group. Of the

sexual abuse victims interviewed by Gorcey et al. (1986), 37% reported that they had been raped as teenagers or adults; 65% had been victims of subsequent rape or attempted rape; and 20% had a history of physical abuse.

Finkelhor (1979) suggests that the association between childhood sexual abuse and revictimization may be due to the factors that force the victimized children out of the family and into high-risk situations for wife abuse or rape. Childhood sexual abuse may also have a corrosive effect on self-esteem, therefore making these women conspicuous targets for sexual exploitative men. In a survey of former and current prostitutes, Silbert & Pines (1981) found that 60% of these women had been sexually abused prior to the age of 16. Women who have been sexually abused as children may idealize men; seeking to recapture the specialness they felt in the relationship they had with their father or abuser. A combination of idealization and oversexualization, together with an impaired ability to correctly identify persons who are trustworthy, are critical factors in explaining revictimization as well as personal variables, such as a sense of worthlessness and self-blame. Together, these variables may co-exist, or follow childhood sexual abuse, leading these women to expose themselves to men who revictimize them, thus confirming their low opinion of themselves (Beitchman et al., 1992).

The suggestion has been made that the ability to derive an explanation of one's victimization is conducive to the psychological adjustment of the person. It has also been suggested that the attribution one makes as to the reason for victimization will influence the person's adaptive response. Blaming of the self, a common phenomenon among victims, has been theorized as contributing to a sense of helplessness. However, internal



attributions of blame have also been found to be adaptive, increasing one's sense of control in preventing any future victimization (Frieze, Greenberg, & Hymer, 1987). These authors go on to say that victims may engage in a process called "rewriting the script" which involves allaying anxiety by telling themselves that the molestation happened because they wanted it to happen. By fantasizing that one is in charge of a stressful event, the associated anxiety is reduced, but, such a coping mechanism is difficult to alter (Morrow, 1991). While such a coping mechanism may increase a sense of control, it does so by distorting reality. According to Morrow (1991), increased self-blame might result from feeling responsible for not being able to stop the abuse from progressing to the point of intercourse which may result in perceptions of the abuse experience as more serious or damaging causing the victim to make more internal attributions.

### Conclusion

Many researchers and clinicians believe that the characteristics of childhood sexual abuse are attributed to the posttraumatic stress disorder conceptualization and is the best predictor of the long-term effects of that abuse. Although various symptoms have been reported to occur in the aftermath of child sexual abuse, ambiguity exists as to which effects may be directly attributed to the abuse and which may be related to other antecedent variables. Since attitudes towards sexuality develop over time and include a multitude of influences, moderating variables which may serve to increase or decrease the long-term impact of sexual abuse on a child's functioning is important. Therefore, sexual abuse is likely to exert its effect in the context of a child's other experiences and a

woman's present perception of her abuse may best predict her adult functioning.

For example, Beitchman, Hood, DaCosta, and Cassavia (1992) believe there may be "sleeper" effects, of which the child and others are unaware, but may emerge with dramatic impact in adulthood. The authors state that sexual dysfunction may not be evident as a short-term consequence of sexual abuse in the prepubertal child, but in adults, however, healthy sexual functioning is considered to be an important component of adjustment. This is not to suggest that short-term effects are more minimal than long-term effects; however a clear understanding of both short-term and long-term effects of child sexual abuse may be helpful in planning treatment. Because an adult is able to assess childhood events from a different psychological perspective than the child, understanding the adult perspective is necessary to unravel the full impact of childhood sexual abuse.

In conclusion, this paper outlines the results of a decade of research on the association between childhood sexual victimization, incestuous experiences and a variety of later psychological symptoms and difficulties. Taken together, the data provide strong support for the negative psychological effects of sexual abuse and perhaps the need for treatment appropriately focused on these negative consequences. Childhood sexual abuse appears both to have sustained impacts on psychological functioning in many survivors and to have the potential for motivating the development of behaviors that, while immediately adaptive, often have long-term self-injurious consequences. At the same time, these data suggest that the extent to which a given individual manifests abuse related symptomology and distress is a function of an undetermined number of abuse-specific variables, as well as individual and environmental factors that exist prior to, or occurred subsequent to, the

incidents of sexual abuse. Lastly, although this paper focuses on the negative consequences of childhood sexual abuse, one must keep in mind that adequate and appropriate therapy has proven through research (too extensive to discuss in this paper) to be most effective in improving resiliency and productivity in victim's lives. Most treatment settings for child sexual abuse survivors offer an array of psychological services intended to help the survivor and her family cope with the immediate impact of discovery of abuse and to prevent the development of short-and long-term psychological sequelae. According to Nelki and Watters (1989), the development of these types of programs is guided by two prevailing assumptions: (1) that abuse almost always result in conditions that can and should be treated, and (2) that the amount and timing of treatment correlates with the likelihood of success. Furthermore, most existing research on these issues consist of descriptive data, pre-and postanalysis, and correlation studies of mixed and nonstandardized treatments which suggest that the rate of spontaneous recovery following disclosure of sexual abuse is high (Beutler, Williams, & Zetzer, 1994).

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