

Mental Health and Society lecture on Child Sex Abuse Week 19

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'Initially Freud was quite prepared to accept that women's experiences of childhood sexual interferences were real ... Beneath every case of hysteria, he believed, was 'one or more occurrences of premature sexual experience' ... His paper was ignored or ridiculed by other members of the Society. Later after a variety of personal and professional problems, and the threat from colleagues that if he pursued this line of thinking he would be ostracised from psychoanalysis, Freud reneged. His new analysis of his patients' experiences was that they were lying to themselves and to him.' (Herbert, 1989, p156)

What are we talking about?

Krug, (2002: 149) 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work'.

Burstow (1992) p.109: 'This term refers to any sexual activity between an adult and a child, whether the activity involves actual sexual contact or not. Implicit in this term is the contention that sex between an adult and a child is always non-consensual. Even where the child appears to be a willing or even eager participant, sex is non-consensual and therefore abusive because children have neither the knowledge or the power necessary to give true consent.'

Sheldrick (1991, p56) quotes Schechter & Roberge (1976) 'the involvement of dependent, emotionally immature children and adolescents in sexual activities that they do not fully comprehend, are unable to give informed consent to, and that violate the social taboos of family roles'

So the consensus is that abuse occurs regardless of the experience or apparent 'consent' of the child concerned.

The extent:

Difficult to determine because of under reporting. Framing of the situation by professionals. Perhaps used as a metaphor to understand distress originating in childhood. West (1985) surveyed all the women of 20-39 yrs off a GP's list. 42% claimed to have had some kind of sexual contact with adults when they were children. 18% exposure to flashers. 2% full sexual intercourse. 10% genitals fondled. Source of abuse: Strangers, 49%; Family friend, 24%; Uncle, 6%; Stepfather, 5%; Boyfriend, 5%; Authority figure (teacher, GP, Vicar), 4%; Father, 4% Brother/cousin, 3%.

Interviewed a smaller subsample. About 1% penetrated by natural father and 1% by stepfather. 2% attempted intercourse by brother. Self claimed effects: Pity, amusement, 71%; Anger, 69%; Indifference, problem worked through, 58%; Wary of men, 53%; Guilt/disgust, 49%; Regret, 41%; Hatred/resentment toward adult, 36%; Confusion about sexual norms, 32%; Anxiety for other children, 24%; Emotional/sexual dysfunction, 22%.

Other estimates: May-Chahal and Cawson (2005) report a UK study of 2,869 young adults of whom 16% reported maltreatment, and 11% reported sexual abuse involving contact.

Russell (1983) surveyed a random community sample in San Francisco. 38% reported at least one instance of sex abuse before the age of 18, 16% at least one instance of intrafamilial abuse, 4.5% abuse by biological or stepfathers. Baker and Duncan (1985) nationally representative UK survey 10% experienced some form of CSA, 0.25% incestuous abuse. So estimates vary. BBC Childwatch interview survey of 2,041 adults probability sample of areas and quota sample of individuals. Reported in Stevenson (1989) 4% girls and 1% boys 'sexual activities for the abusers gratification: might be intercourse exposure or pornographic' (p25) Of those abused 32% had experienced full or attempted intercourse; 62% sexual kiss or touch; 23% made to do something sexual; 27% other or unstated; of girls 60% reported first incident happened when they were under 10, 40% boys reported first incident occurred when they were under 10.

Finklehor, (1979) estimated 27%, Timnick, (1985) 25%, Kinsey et al (1953) 25%.

A systematic literature search by Gorey and Leslie (1997) identified 16 cross-sectional surveys that had been published in peer-reviewed journal papers (coincidentally these all concerned the North American population). Nearly all of these related to the prevalence of sexual abuse (only one included a separate estimate of physical abuse). The unadjusted prevalence of sexual abuse during childhood for the adult population of females was 22% and was 8.5% for males. However, there is a need to make some corrections to these estimates to take account of no-response rates. An adjusted estimate for females is between 12-17% and for males 5-8%. These estimates are for sexual abuse. This may often co-occur with physical abuse. For example, Horowitz, Putnam, Noll, and Trickett (1997) were able to confirm physical abuse distinct from episodes of sexual abuse in 28% of sexually abused girls aged between 6 and 16 years of age.

Gilbert et al (2009) summarise a variety of studies to suggest that between 4-16% of children are abused and 10% are neglected each year in high income countries. During childhood they estimate that between 5-10% of girls and 5% of boys are exposed to penetrative sexual abuse.

What happens?

Cahill et al (1991a) discuss incest (ps 119 et seq.) How much? Meiselman (1978) 25% of abuse involved one incident, average duration of abuse was 3 years. Russell (1986) 16% of the abuse progressed from nonsexual contact.

When it happens most 'victims' react 'passively', fear, deception, feelings for abuser, threats, fear of others finding out, feeling needy and craving attention, economic dependence on perpetrator. Few 'victims' tell anyone at the time though many eventually try to tell someone. Person usu. refuses to believe or get involved. Where the abuse is severe or involves a family member the disclosure is less likely to be met with a supportive response. E.g. Meiselman (1978) of 20 father daughter incest 'victims' who disclosed to mother only 5 threw father out, where mother wasn't getting on well with father anyway. Russell (1986) abuse tends not to stop unless something is done by the 'victim' (44% of her cases) e.g. avoidance, or action taken by someone else (27%) and a combination of the two (21%). Action taken about the abuse typically at 14 or 15 when e.g. dangers of pregnancy, realisation that they can do something about it emerge.

What's traumatic?

Some authors say that the effects of child sex abuse are to do with culture (Kinsey et al, 1953, p121.) 'it is difficult to understand why a child, except for its cultural

conditioning should be disturbed at having its genitals touched, or disturbed at seeing the genitalia of other persons, or disturbed at even more specific sexual contacts.' But according to e.g. Oremland & Oremland (1977) the disparity in size and social sophistication between children and adults renders such encounters inherently traumatic.

Kids inherently at some disadvantage in British society in the last few hundred years. E.g. ancient Rome men had the right to dispose of their descendants pretty much as they wished. In Britain between 1856 and 1860 '3901 coroners inquests were held into suspicious deaths of infants less than two years of age' (Daly and Wilson, 1988, p67) in London alone. Newspapers described dead babies being found in London Parks as many as five per day. Conditions for women in 19th century London may be partly to blame. In this century (e.g. Baartman, 1990) professionals did not readily acknowledge child abuse until recently. E.g. cases of STD in children explained in terms of indirect contact. Toilets, towels, bedclothes etc. assumed to be the sources of infection. Baartman identifies four reasons why: i) Cognitive incompetence of the child, not to be able to know what had happened to them. ii) Moral unreliability - children don't know it's wrong to present fantasies as reality. iii) Children who claimed abuse were disturbed. iv) Seducing child - the child provoked the abuse. These kinds of reasons tended to make it improbable that people would believe children. Maybe also: i) reluctance to acknowledge that parents could act this way towards their children. ii) Not wanting to disrupt the 'medical confidentiality'. iii) Not wanting to lose control to other agencies.

Why are there bizarre events in children's accounts of abuse?

Children's accounts of abuse often contain events which seem bizarre, improbable and even impossible. E.g. when there are accounts of ritual abuse. It is often the case that professionals and the public are less likely to believe accounts which appear bizarre or contain ritualistic features. As one attorney told a psychologist (cited in Everson, 1997) 'Your report was fine until you mentioned the mask and the candles.'

Dalenberg (1996) conducted a study of fantastic elements in children's stories of abuse, based on 644 videotaped interviews with children where they made disclosures. In the case of half of these children (the 'gold standard') there was good evidence that the abuse had indeed taken place. That is, e.g. the perpetrator had confessed or if there was conclusive medical evidence. The other half contained some more questionable cases where corroborative evidence was lacking.

'Fantastic' elements were defined as highly implausible or impossible events, or events which seemed to be a gross exaggeration of a plausible event. Fantastic elements were found in 12 cases, and 10 of these came from younger (3 to 9 yr. old) children in the 'gold standard' group. The majority of these fantastic elements occurred in cases where the abuse involved penetration, the use of force or threats or repeated abuse.

Everson (1997) proposes that unusual events exist in children's accounts of abuse for the following reasons:

- 1) They may be an accurate description of reality.
- 2) Deception may have been entered into to confuse or discredit the child.
- 3) Drug induced distortions. E.g. Finklehor et al (1988) found that of a sample of 43 cases 30% involved some allegation of children being drugged.
- 4) Threat incorporation. Threats made against the child are incorporated as if they really happened. Or surrounding material is incorporated, e.g. Dalenberg (1994)

describes a case where the parent's reading to the child about war atrocities was incorporated into the story.

5) Traumagenic misperception or memory distortion. In cases where the traumatic events are witnessed it is clear that the children have radically divergent memories when questioned later. Terr (1979; 1983) described the accounts given by children after their school bus had been hijacked by three Caucasian men in their 20s and 30s. Some children reported seeing a 'black man', a 'bald man', 'a lady', a 'fat chubby man' and 'an old man who used his shotgun as a cane to support his missing leg', none of which corresponded to reality as reported by other witnesses.

6) Mastery fantasies. Children may incorporate elements of retaliation or rescue into their accounts of traumatic events.

7) Expression of affect through metaphor and hyperbole - the child may exaggerate the more traumatic aspects of the event, or invent fantasy characters that populate his or her environment.

8) Misreports by the child to deflect blame or deny victimisation - e.g. children may express their abuse via accounts of imaginary friends. Or describe abusers in terms of religious or fantasy imagery, e.g. 'the devil'.

9) Misperception or miscommunication due to developmental limitations. Children may not know the correct terminology for what has happened to them.

10) Distortion due to attempts to assimilate novel events into existing schemata. E.g. children who witness adults having sex may say that they are hurting one another. Or they may add elements which commonly occur together, e.g. may add reports of beating to events involving discipline. 'Poking' with 'sticks'.

In addition the system of reporting and acquiring disclosures may introduce errors

11) Successive misrepresentations. The Chinese whispers effect.

12) Miscommunication due to interviewer error - Whether things mean the same to interviewers and interviewees. E.g. what does 'without clothes on' mean?

13) Impact of leading or suggestive questioning. As well as leading questions there are hypothetical questioning strategies, and offering helpful suggestions that might aid a child's recall.

14) Distortion introduced by interview props. As well as the well known 'anatomically correct dolls', other artefacts can influence stories, for example the colour of the pen.

15) Confabulation - filling in gaps in the memory to complete the story.

16) Interview fatigue. Can result in fabricated stories or may result in defences being broken down so that the more traumatic aspects of abuse come to light.

17) Exaggeration for attention or approval. The interest, sympathy and concern of adults may be a powerful motivator, especially for abused or neglected children.

18) Snowballing of an innocent lie. Children may need to produce more and more elaborate falsehoods to cover existing stories.

19) Deliberate exaggeration - children may accuse adults out of anger at them. Or as teenagers to reduce their own culpability in sex and drug activity.

20) Fantasy lying - children may indulge in storytelling with little or no basis in reality for reasons of their own.

There is also material about children's apparently false reports of abuse in O'Donohue et al (2010).

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More on Child Sex Abuse: Consequences and therapies Week 19

Depression and abuse as a child

Women with a history of CSA (child sex abuse) report more depressive symptoms (Alter-Reid et al, 1986; Beitchman et al, 1992). They are more likely to meet diagnostic criteria for depression (Bifulco et al, 1991). CSA is associated with recurrent or persistent depression in adulthood. (Andrews, 1995). Whiffen and Clarke (1997) surveyed 91 men and 76 women attending clinics in Canada and discovered that women were more depressed and reported more CSA. Indeed, CSA accounted for a significant proportion of the sex difference in depression levels. On the other hand, reports of adult victimisation were not correlated with depression. Fergusson et al (2008) report a survey of 1000 young adults where those subject to child sex abuse had greater likelihood of depression, anxiety, conduct disorder, drug or drink problems and suicidality. Fitzpatrick et al's (2010) study reported higher rates of post-traumatic stress disorder, alcohol and substance abuse, antisocial personality disorder, trauma symptoms and life problems in participants who had been sexually abused.

A closer look at emotions and effects:

This is largely culled from therapeutic practice, but there are some large sample surveys e.g. Fergusson et al (2008).

- i) Depression significantly higher in abused than non abused samples (Bonomi, 2008; Cahill et al 1991a, p121)
- ii) Low self esteem. Survivors/'victims' report sense of self had been permanently changed. 'Predominantly negative self image'. Esp. women refer to themselves as e.g. dirty, bad, shameful, damaged goods, sluts.
- iii) Depression
- iv) Physical symptoms e.g. nausea and joint pain.
- v) 'Distorted beliefs' or at least counterproductive. e.g. 'It is dangerous to get close to someone because they always betray, exploit or hurt you.' 'I am inferior to other people because I did not have normal experiences.' 'No man can be trusted.' 'No man could care for me without a sexual relationship.' 'I must have been responsible for sex when I was young because it went on so long.'
- vi) Sense of being branded or stigmatised. Feelings of isolation.
- vii) Guilt, anger and self blame Guilt because 1) they may not have physically resisted the abuse 2) may be some physical or emotional satisfaction(!) 3) abuse may be durable 'have I allowed it to continue?' Anger may be directed at other family members in incest.
- viii) Relationship problems e.g. inability to trust and love, polarised view of the sexes, finding themselves in other abusive relationships as adults. E.g. Russell (1986) Incest victims were twice as likely to report being assaulted at some time in their lives and 68% more likely to report being raped.
- ix) Marital problems, some reports that incest 'victims' likely to leave home and live with a man almost immediately - almost as if the man is seen to be a protector. Idealised view of marriage. Can lead to problems e.g. Russell (1986) most severely traumatised more likely to have been married or divorced. Those who had undergone 'severe' or 'considerable' trauma more likely to have raised one or more children. Sometimes those with kids report difficulties in coping with children's demands, affection, 'discipline'.

x) Problems with sexuality including 1) feeling revulsion at their own or partners' bodies, difficulty in arousal 2) arousal contingent upon control 3) orgasm detached from pleasure. Lots of the terms and concepts used to describe women's difficulties with sex are themselves rather sexist and tend to assume an implicit model of genital heterosexuality so be careful! Cahill et al (1991a) 'frigidity' 'vaginismus' 'orgasmic dysfunction' Avoidance of sex, compulsion towards sex. Some surveys of prostitutes report high levels of CSA (Champion, 2011). Risk taking in the context of sex (Senn & Carey, 2010).

xi) Alcohol and drugs e.g. Browne and Finklehor (1986) report 17% of 'victims' saying they had symptoms of alcohol abuse and 27% reporting symptoms of drug abuse.

xii) May be some drop in socioeconomic status. E.g. Russell (1986) most severe trauma less likely to do much college, least income. But people who experienced 'some' or 'considerable' trauma do better than those who report 'none'

xiii) Miscellaneous symptoms. Can be self harm, somatic complaints, 'eating disorders', suicidal tendencies, psychotic episodes. may be confusion as to whether they have been abused at all. Another review of the symptoms is contained in Sheldrick (1992).

Liem et al (1992) women who'd been abused showed more 'need for power' than a comparable group of nonabused women.

Identifying the problems in the people who've been through the process of being victimised is inherently controversial.

Some argue against identifying pathologies in the people who've been abused (e.g. Jenny Kitzinger, 1992) and against 'therapy' which is aimed at restoring heterosexual function. 'The ways in which psychology insists on sexual 'restoration' for survivors is only one part of this process of co-option, a process concerned with helping women to accommodate to living under heteropatriarchy and ensuring that male access to women's bodies continues unimpeded. Psychology is consolidating its monopoly of defining both the 'problem' and the 'solution' to sexual violence'. (p234).

Interpreting the symptoms as consequent solely on the abuse is difficult, because other factors may differ between abusive and nonabusive homes. Nash et al (1993) 'Perceived family environment appears to be an important mediating variable in determining general level of adult psychological distress' (p282) There is some debate as to the extent to which family dysfunction can be blamed: 'Families do not commit abuse but many men do' (Hall & Lloyd, 1993, p27)

Family systems type models are controversial

Another factors that some authors mention is the economic climate (Kruttschnitt et al, 1994). For example Gelles (1992) said that 'violence towards children is more likely to occur in households with incomes below the poverty line'. (Gelles, 1992).

Children are more likely to be abused in settings where e.g. their parents take drugs or where there is intimate partner violence or where parents are 'not coping' (Devaney and Spratt, 2009).

Remembering abuse

E.g. Sigmund (1993, p147) some people don't have conscious memories of abuse occurring and then recollect abuse suddenly: 'For these individuals , the experience is likened to awakening into a nightmare that in a perverse way resolves a lifelong sense of ill-defined shame and inadequacy. For example: "Five years ago I was driving down a long hill near my home when all of a sudden I was hit with it! I had

been sexually abused as a child! It was like waking up and finding out you are in the middle of a nightmare only you're not asleep. " Sometimes specific events can act as triggers - Palmer et al (1993) '...in our own practice a patient in her 30s developed a severe clinical eating disorder after gynaecological examination triggered a flood of distressing memories of a prolonged abusive relationship with his uncle which had taken place 20 years before' (p503). It's these kinds of recollections from many years before that are particularly contentious and might lead to accusations of 'false memory syndrome'.

Evidence that abuse can be forgotten. Williams (1994) followed up 129 women who had previously documented histories of sexual abuse. Their participants were women who had been taken to hospital following abuse and subject to examination to collect medico-legal evidence, and treatment. At that time the participants ranged in age from 10 months to 12 years. In 1990 and 1991 these people, now young women, were re-contacted and 129 (84%) completed interviews about their experiences. Of these, 38% could not remember the index abuse. Those who were younger at the time of the abuse and those who were abused by a close family member were more likely to have forgotten.

Are they repressing, forgetting or simply not mentioning it? A study by Femina et al (1990) suggested that people didn't report aspects of the abuse at follow up interviews because they did not want to recall it because it would elicit too many emotions.

Perhaps forgetting the abuse serves an adaptive function for those who were abused (Freyd, 1997) in that it allows social networks and attachment systems to remain intact.

On the other hand, one of the academic supporters of the idea of *false memory syndrome*, Elizabeth Loftus (e.g. 1993) wonders why it should be that memories of abuse are repressed or forgotten:

"It is common to see analogies drawn between Vietnam war veterans and the incest survivors... do they share in common the use of 'massive repression' as a mechanism for coping? If so, how do we explain findings obtained with children who witness parental murder and other atrocities? In one study (Malmquist, 1986) not a single child aged 5 to 10 years who had witnessed the murder of a parent repressed the memory. Rather, they were continually flooded with pangs of emotion about the murder and preoccupation with it." (Loftus, 1993, p 21) So why does child abuse experience get 'repressed'? Could it be, as FMS advocates charge, that memories can be implanted in therapy? Or that therapists might over zealously interpret clients' contemporary interpersonal difficulties in terms of abuse as a child. However, the difference noted by Loftus between witnessing a murder and being abused might be because with a murder 'there will be no school, a lot of police officers and journalists. Nightmares and tantrums will be regarded sympathetically. The murder will be a family and community event and the child will be part of a larger experience' (Scott, 1997, p 34.)

End results - classifications and syndromes

Perhaps the consequences of abuse can be characterised as PTSD (post-traumatic stress disorder). Van Den Bosch et al (2003) identify high levels of post-traumatic stress and dissociative symptoms in child sex abuse survivors. Lev-Wiesel (2008) says the symptom profile is more akin to dissociative disorders than PTSD. Some authors have identified syndromes e.g. Finklehor (1987) writes of his 'traumagenic dynamics model of child sex abuse': 'A traumagenic dynamic is an

experience which alters a child's cognitive or emotional orientation to the world and causes trauma by distorting the child's world view, or affective capacities. For example the dynamic of stigmatisation distorts the children's sense of their ability to control their own life. When a person tries to cope with the world through these distortions, what we see are the psychological and behavioural problems that are characteristic of abused children and adults' (ps 345-355). Another construct by Briere & Runtz (1987) 'symptomatic behaviours that were initially adaptive responses, accurate perceptions, or conditioned reactions to abuses during childhood, but that were elaborated and generalised over time to become contextually inappropriate components of the victim's (sic) adult personality' (p374) e.g. self induced dissociation during sex, powerlessness, and fear or anxiety in relation to sex or men.

Therapies and the therapy process.

E.g. Lev-Wiesel, (2008), Burstow (1992, ps109-147) and Cahill et al (1991b) 'Treatment should be based on the issues raised by the nature of the experience and on the victim's (sic) unique response to them' (Courtois & Watts, 1982, p278) E.g. Cahill et al (1991b)

- i) Therapeutic relationship. E.g. feelings of liking respect etc.
- ii) Relating the experience some consensus that it's good to be able to describe what's happened. Catharsis.
- iii) Enabling a greater attribution of responsibility to the offender.
- iv) Client coming to terms with perceived losses. E.g. innocence 'normal' adolescence, childhood. May be some mourning or grief for lost childhood.
- v) Anger and rage directed at abuser but also at client's mother, perhaps in incest.
- vi) Development of positive self image making clients aware of their beliefs and enabling the development of more self positive beliefs.
- vii) Examination of client's relationship with e.g. family members and others. May be trying to reduce 'victim behaviour'
- viii) Dealing with sex problems, e.g. Masters and Johnson sensate focus, dealing with anger and guilt.
- ix) Dealing with disclosure and confrontation with other family members. May need to cope with denial and rejection.
- x) Education - reading of books about CSA and by CSA 'victims'.
- xi) Keeping a journal and 'unsent letter' writing.
- xii) Creative therapies (Lev-Wiesel, 1999; Robarts, 2006).

Does therapy do any good?

Some authors (e.g. Miltenberg and Singer, 1997) complain that there has been a lack of systematic research into the effects of therapy for abuse sufferers. Even more recently Lev-Wiesel (2008: 671) makes the same complaint, pointing to 'a startling paucity of outcome studies'. However, Jehu (1988) shows how cognitive restructuring has sometimes helped people. Yet others have highlighted the trauma that therapy often involves for the client and the therapist. According to Miltenberg & Singer (1997) the literature is full of reports of 'the deep despair, the depressions, suicidal behaviour and aggressive outbursts of the clients during their treatment. But this is supposed to be only a phase that the client has to work through. All authors state that an unspecified number of clients are unable to cope with the exacerbation of their problems, abandon hope of improvement and stop therapy. The authors also note that sometimes during therapy, though they rarely specify how often,

psychiatric hospitalisation may be necessary. Shengold (1989) states that clients 'must again bear the unbearable, and their constitution may not be up to it.' (p. 300) Nevertheless, Shengold and many other therapists continue to be convinced of the therapeutic power of reliving past suffering.' (ps. 616-617).

Stevenson (1999) notes the paucity of well designed studies of therapeutic outcome. However he echoes the conclusions of Oates and Bross (1995, p 471):

"We know that the treatment of an abusive family is complex. We know that it is not like a lotion that can be rubbed on, or a medicine that can be taken for a short time. When one realizes that the abusive behaviour has often been learned by the parents over several years in their own childhood, it becomes clear that treatment, even if the intensity of treatment becomes less, most likely it will have to take place over several years as well. This means that with a problem as large as child abuse, with only a relatively small number of people available to provide treatment, only a small proportion of families will be able to be properly treated. However there is great value in some clinical insights that can be derived through careful treatment, insights that might generate ideas for better prevention as well as treatment programs. Even for the relatively small number able to be helped, the investment of time is worth it if the cycle of abuse can be prevented from appearing in the next generation."

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