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Consequences and Treatment of Child Sexual Abuse

by Jessica Otto-Rosario

(English 1105)

Childhood is often marked as a significant period of people's lives, in which they begin to develop both biologically and psychologically into who they will be later on in life. Childhood is also a cherished phase of human life, a phase that is absent of the stresses associated with adult life. However, some children are not fortunate enough to endure happy childhoods and instead undergo experiences that may hinder or dramatically affect their development. Consider the case of Julio, a man who was sexually abused throughout his childhood. Julio was raped on various occasions by his uncle when he was only five years old. As a result, Julio experienced a great deal of adversity in recovering from this trauma. In the years that followed the abuse, Julio had the burden of hiding this tremendous secret from his family. He was ashamed of what had happened and constantly blamed himself for the abuse. Holding all of this guilt and shame inside, Julio fell into a deep depression. Eventually, he became so depressed that his feelings of hopelessness and worthlessness caused him to attempt to end his life. Julio's suicide attempt landed him in the psych ward, where he finally opened up to his family about his childhood trauma.

This story demonstrates the wide range of effects that child sexual abuse can have on its victims. Furthermore, it shows that many of these effects cannot be alleviated until victims tell people about the abuse that occurred, so that they can begin the trauma recovery process. Child sexual abuse causes high levels of anxiety and depression within its victims, which has various effects including substance abuse, self-mutilation, suicide, and eating disorders. Since child sexual abuse has potentially far-reaching effects, it is important for survivors to undergo treatment so they can recover from the trauma.

As child sexual abuse creates large amounts of anxiety and depression in its victims, these victims may utilize self-destructive behaviors like drug and alcohol abuse, self-mutilation, and suicide as a means of managing their resulting pain. "Survivors may interweave . . . drugs, alcohol, self-mutilation, and suicidality so artfully and automatically that they could not name any of these coping strategies" (Salter 220). This inability of survivors to identify these behaviors as tools they use to cope with the pain from child sexual abuse often causes the behaviors to be misidentified as the issue rather than as their solutions to the underlying issue of child sexual abuse. In order for survivors to discontinue self-medicating the pain of child sexual abuse, they must first recognize that their self-destructive behaviors are a result of their attempts to treat the pain they are in from the abuse.

One way child sexual abuse survivors may self-medicate is by abusing substances like drugs or alcohol. According to Rodriguez-Srednicki and Twaite (2006), "individuals who are abused as children are at increased risk for developing substance use disorders" (p. 132). Victims of child sexual abuse experience a substantial amount of pain and anxiety and may use alcohol or other substances to numb themselves from these emotions. In this way, child sexual abuse victims use substances as "a mechanism to cope with or escape from the trauma of childhood victimization and the related depression" (Widom and Hiller-Sturmhofel, 2001). In addition, survivors of child sexual abuse may abuse substances as a means of reducing feelings of loneliness and isolation. They may also use substances to alleviate guilt associated with the abuse (Rodriguez-Srednicki and Twaite, 2006, p. 112). Substance abuse is just one way child sexual abuse victims can attempt to relieve the distressing emotions that result from their trauma.

In addition to drug and alcohol abuse, victims may also utilize self-mutilation to deal with resulting pain from the abuse. A history of trauma and sexual abuse has been recognized by many experts as the most common causal factor related to self-mutilation (Plante, 2007, p. 17). Victims of child sexual abuse will often dissociate from the experience, or disconnect from the experience both emotionally and physically. Consequently, victims may self-injure, which reenacts the sensations and punishment that occurred throughout their traumatic history (Plante, 2007, p. 18). Child sexual abuse victims may self-mutilate for a variety of reasons. First, they may self-mutilate as a means for relieving the pain and suffering they experience from the abuse. Self-mutilation can produce endorphins that successfully medicate pain. However, this effect is only temporary and overindulging in this habit increases the unhappiness in victims, which results in their need for more pain relief (Salter, 1995, p. 242). Another reason victims may self-mutilate is to gain nurturance and attention from significant others. "Many survivors have an unconscious belief that others could reduce their dysphoria if they chose . . . Thus survivors sometimes escalate the behavioral messages they send in the hope of eliciting the help they believe is available, but withheld" (Salter, 1995, p. 242). In this type of situation, survivors are not only seeking to elicit attention from others but also to compel rescue. Yet another reason survivors of child sexual abuse may self-harm is to purposely punish themselves. A survivor may experience anger toward the self that he or she believes could be relieved by releasing this anger through self-mutilation (Salter, 1995, p. 242). Self-harm is employed by child sexual abuse survivors for various reasons, demonstrating that it is a flexible method of pain control. These survivors use such a method in order to manage the resulting pain from the abuse they experienced.

Along with substance abuse and self-mutilation, a final self-destructive behavior that child sexual abuse survivors may use in an attempt to cope with pain from the abuse is suicide. This pain control method is the most severe of the self-destructive behaviors described and is manifested through both thoughts of suicide and suicidal attempts. Suicidal ideation is more common among child sexual abuse survivors than among people without a history of sexual abuse. For survivors that fantasize about suicide, suicidal thoughts comfort them by reminding them that they are not trapped in a world they believe they cannot endure (Salter, 1995, p. 245). Rather, they have the option to end their—or what they consider—unbearable lives. Salter (1995) describes how suicidal thoughts become comforting for child sexual abuse survivors:

> Where there should be an internalized soothing introject—an image of parental warmth and loving—there is none, either because poor parenting early in the survivor's life failed to provide a model that could be internalized, or because trauma disrupted the sense of basic trust that had developed . . . instead of going back to scenes of early nurturance for images of soothing and pain cessation, the client without any such images goes forward to the end of her life, and can imagine no greater soothing than being without pain. (p. 245)

Survivors with this mentality view suicide as a means of stopping the pain they experience completely. In order for survivors to recover from the pain associated with the abuse they experienced, they must learn to deal with that pain in a constructive way.

In addition to self-destructive behaviors, child sexual abuse victims may resort to disordered eating behaviors as a way to cope with the pain from the abuse. The trauma of child sexual abuse is most likely to result in "eating disorders in women, because 'rigid social expectations define women through their appearance,' and because 'a person with no outside source of gratification and control can still manipulate her food intake'" (Rodriguez-Srednicki and Twaite, 2006, p. 93). Three eating disorders that are linked to child sexual abuse are anorexia, bulimia, and compulsive overeating. Of these three eating disorders, bulimia is the most prevalent among child sexual abuse victims. Like

self-mutilation, engaging in eating disordered behavior can aid victims in dissociating from their traumatic experiences “by interfering with the normal storage, retrieval, and integration of thoughts, feelings, sensations, and memories” (Rodriguez-Srednicki and Twaite, 2006, p. 102). Victims are able to temporarily avoid feelings that arise from a victimization experience by abusing food. However, since abusing food is only a temporary means of evading emotions and eating disordered behaviors are addictive, child sexual abuse victims may become dependent on such behaviors to cope with their trauma.

Not only are eating disordered behaviors used by victims of child sexual abuse to deal with pain, but they are also used to manage bodily shame and body disparagement that victims may experience. It is common for victims to blame themselves for the abuse they suffered, causing them to feel guilt and shame. Shame can be manifested as intense bodily shame, and this shame consequently leads to body disparagement. Body disparagement is “defined as ‘the diffuse experience of body degradation or body loathing endured by the sexually abused individual’” (Rodriguez-Srednicki and Twaite, 2006, p. 100). Body disparagement encompasses the subjective evaluation of appearance and body shape, as well as both attitudinal and affective components toward one’s body. The more body disparagement a child sexual abuse victim experiences, the more likely he or she is of developing eating disordered behaviors and attitudes. To better demonstrate how bodily shame and disparagement can lead child sexual abuse victims to engage in eating disordered behavior, let’s consider an example. A woman suffering from a trauma history desires to decrease her breast size so that she appears less feminine and consequently, less appealing to men due to her past sexual abuse. In this instance, the woman may experience bodily shame because her breast size attracts men to her, which she could associate as the cause of being abused. This shame leads to body disparagement, as the woman evaluates her appearance negatively, which further results in her engaging in eating disordered behavior in order to decrease her breast size.

With such a vast amount of potential consequences of child sexual abuse, including substance abuse, self-mutilation, suicide, and eating disorders, it is pertinent that survivors seek treatment in order to mitigate these effects. Fortunately, survivors have a wide variety of treatment methods available to them. Thus, if one method does not work for them, they have other methods they may benefit from. Among these treatment methods are group therapy, individual treatment, dyadic treatment, family therapy, and multiple therapists. “Group therapy can promote the development of self-capacities such as the ability to connect with others and the ability to regulate affect” (Rodriguez-Srednicki and Twaite, 2006, p. 300). Group therapy can also facilitate the process of reworking trauma from childhood experiences to lessen the disruptive effect of intrusive memories. Groups in this type of therapy may be comprised of victims, parents of victims, siblings of victims, adult survivors, and even generic groups that include parents of victims, survivors, and offenders (“Treatment of Child Sexual Abuse”). Groups can last for specific periods of time—long or short—or they can be open-ended. They can deal with either a wide range of issues or with specific issues like relapse prevention or sex education.

Though group therapy is usually referred to as the treatment of choice for child sexual abuse, there are other types of treatment that are effective, as well. Individual treatment refers to one-on-one therapy, which functions to build an alliance between victims and therapists (“Treatment of Child Sexual Abuse”). Victims must learn to trust their therapists, and they have to believe that change is not only possible but also desirable. According to Rodriguez-Srednicki and Twaite (2006), in order for individual therapy to be successful,

> interventions aimed at altering dysfunctional schemas, procedures designed to decondition emotional responses to trauma-related cues, and efforts to build skills to replace dysfunctional behavior patterns must all be planned and executed individually and specifically, while maintaining overall sensitivity to the diverse areas of

> dysfunction that may have been created by the experience of childhood trauma. (p. 282).

Another type of treatment is dyadic treatment, which is utilized to either repair damage to or enhance mother-daughter, husband-wife, and father-daughter relationships. Dyadic treatment is also used to cope with issues that are addressed initially in individual treatment ("Treatment of Child Sexual Abuse"). Similar to dyadic therapy, family therapy involves therapy with various members of the family and serves to work through issues that may have resulted from the sexual abuse. A final type of treatment involves multiple therapies. This method of treatment may include any combination of individual, group, dyadic, and family therapy.

Each of the treatment methods of child sexual abuse should address various issues for victims, including trust, protection from future victimization, and emotional, behavioral, and cognitive reactions to the abuse. Since child sexual abuse can negatively impact victims' abilities to trust others, therapists are responsible for creating "circumstances in which the child has positive experiences with trustworthy adults in order to ameliorate the damage to the child's ability to trust" ("Treatment of Child Sexual Abuse"). Therapists may accomplish this by generating opportunities for appropriate relationships with adults or by rehabilitating the parents. To build a trusting atmosphere, therapists must be dependable and honest. Along with trust, another issue that must be addressed is protection from future victimization. Therapists must teach victims strategies for future protection, like how to say no and how to report inappropriate sexual behavior.

In regard to emotional responses to sexual abuse, three common consequences are a sense of responsibility for the abuse, an altered sense of self, and fears and anxiety. Victims may feel responsible for the offender's well-being, for the abuse, or for the consequences of reporting the abuse, as a result of offenders placing guilt on them. "Victims may also feel guilty for not having stopped the abuse as well as for any positive aspects of the abuse, such as physical pleasure, the special attention given by the offender, or an opportunity to have control over family members because of 'the secret'" ("Treatment of Child Sexual Abuse"). In working with victims experiencing such guilt, therapists must aid the child in accepting emotionally and understanding intellectually that the child bears no responsibility for the abuse. Both feelings of guilt and the intrusive and invasive nature of the sexual abuse negatively affect victim's sense of self and self-esteem. The effect is psychological (victims may view themselves as different from their peers) and physical (victims have an altered impression of their bodies). ("Treatment of Child Sexual Abuse"). To mitigate these effects, therapists must help victims to regain a positive self-esteem. It is helpful for therapists to address the issue of self-blame, as well as to have interventions that assist survivors in viewing themselves as more than just victims of sexual abuse. A final emotional consequence is anxiety and fear, where victims acquire phobic reactions to the abuse, the offender, and to other facets of the abuse. Victims may experience anxiety if they encounter experiences that elicit recollections of the abuse. Prior to treating fears and anxiety within victims, therapists must ensure that the victims are no longer experiencing sexual abuse. Therapists can then engage "the victim in a series of interventions that allow him/her to gradually deal with the abuse and related phobias and anxiety in ways that usually avoid excessive stress and avoid mastery" ("Treatment of Child Sexual Abuse"). These include play therapy, discussions, or interventions in the victim's environment.

In closing, victims of child sexual abuse experience high levels of depression and anxiety, which can lead them to engage in various self-destructive behaviors like substance abuse, self-mutilation, suicide, and eating disorders. With all of the negative consequences that may result from child sexual abuse, it is important for victims to utilize the many treatment methods available to them, such as individual treatment, group therapy, dyadic therapy, and family therapy. Treatment for child sexual abuse should address various issues including trust, protection from future victimization, and emotional, behavioral, and cognitive reactions to the abuse. In reference to Julio's story, he was

able to recover from the sexual abuse he endured after undergoing extensive therapy that followed his stay in the psych ward. Since his stay in the hospital, Julio has graduated from college, toured around the country with his dance company, and has recently gotten engaged. He is just one victim of a tragedy that occurs frequently, but he is a model for other victims, demonstrating that victims can recover from sexual trauma and live fulfilling lives.

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