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Impacts of Childhood Sexual Abuse on Adult Psychosocial Functioning

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Impacts of Childhood Sexual Abuse on Adult Psychosocial Functioning

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CERTIFICATE OF APPROVAL

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IMPACTS OF CHILDHOOD SEXUAL ABUSE ON ADULT PSYCHOSOCIAL FUNCTIONING

This is to certify that the Capstone Project of

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Impacts of Childhood Sexual Abuse on Adult Psychosocial Functioning

Over the past several decades, a proliferation of studies has pointed to the significant and enduring effects of childhood sexual abuse (CSA: Finkelhor, 1985; Godbout, 2013; Hall & Hall, 2011; Horowitz, Spatz Widom, McLaughlin, & Raskin White, 2001; Ratican, 1992).

Ratican (1992) describes CSA as "Any sexual activity, overt or covert, between a child and an adult, or older child where the younger child's participation is obtained through seduction or coercion" (p. 33). The World Health Organization (1999) defines CSA as the following:

> Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to: 1) the inducement or coercion of a child to engage in any unlawful sexual activity; 2) the exploitative use of a child in prostitution or other unlawful sexual practices; 3) the exploitative use of children in pornographic performance and materials. (p. 15-16)

Because CSA is not uniformly defined and is often not reported, prevalence statistics may vary (Finkelhor, 2009). In 2012, 62,939 cases of CSA were reported within the U.S. (U.S. Department of Health and Human Services, 2012). According to the National Center for Victims of Crime (2012), one in five girls and one in 20 boys is a victim of child sexual abuse. The World Health Organization (WHO, 2017) reports even more dire numbers, indicating one in five women and one in 13 men have been sexually abused as a child.

Unlike adult sexual abuse, CSA is most often inflicted by adult caregivers who manipulate the victim's trust, and interfamilial abuse accounts for one third of all CSA cases (World Health Organization, 2003). The U.S. Department of Justice (2000) National Incident-based Reporting System shows adults were the offenders in 60% of the sexual assaults of youth under age 12. Strangers were the offenders in just 3% of sexual abuse victimizations against victims under age six, and in 5% of the sexual abuse cases of youth ages six through 11.

There is no single cause of CSA, and family, child, and environmental risk factors may increase likelihood of occurrence (Finkelhor, 1985; World Health Organization, 2003). Child characteristics such as intellectual and physical disabilities have been shown to increase vulnerability to CSA victimization (Crosse, Kaye, & Ratnofsky, 1993). Parent and caregiver risk factors include low self-esteem, poor impulse control, depression, substance abuse, anxiety, and antisocial behavior. Family structure influences CSA risk, and risk is lowest for children who live with their biological parents. Children who live in foster care are ten times more likely to experience CSA than children who live with their biological parents. Risk of CSA is highest for children who live with an unmarried parent who has a live-in partner. These children are 20 times more likely to be victimized than children living with both of their biological parents (Sedlak, et al., 2010).

Through a survey of the research literature, this paper will examine the impact of CSA on adult psychosocial functioning as manifest through attachment (Dimatrova et al, 2010; Markese, 2008), self-esteem (Briere and Runtz, 1993; Feinauer & Hilton, 2003; Gold, 1986; Ratican, 1992; Zupanic & Kreidler, 1999), shame (Black, Curran, & Dyer, 2013; Dorahy, 2011; Feinauer & Hilton, 2003; Feiring, Simon, & Cleland, 2009; Finkelhor, 1985; Hall & Hall, 2011; Lutwash, Panish, & Ferrari, 2003; Ratican, 2002; Zupanic & Kreidler, 1998), intimate relationships

(Berzoff, 2008; Briere and Runtz, 1993; Finkelhor & Browne, 1985; Godbout, 2013; Ratican, 1992), sexuality (Beitchman et al., 1992; Frias, Brassard, & Shaver, 2014; Godbout, 2013; Maltz, 2002; Ratican, 1992; Whisman & Snyder, 2007), and mental health (Alvarez et al., 2011; Baldwin, 1990; Bebbington et al., 2011; Beitchman et al., 1992; Hall and Hall, 2011; Horowitz, Widom, McLaughlin, & White, 2001; Spataro, Mullen, Burgess, Wells, & Moss, 2004; Perry & Wright, 2006; Ratican, 1992).

The extremely high prevalence of CSA may indicate that many clients seeking counseling services may have disclosed or undisclosed histories of childhood sexual abuse. To improve counseling outcomes with adult clients, counselors should be educated on the symptoms and profound, enduring impacts of CSA. With an understanding of the long-term effects of CSA, counselors may better help clients address areas of functioning impacted and impaired by their experience of CSA.

Literature Review

Erikson's Theory of Psychosocial Development

Erik Erikson's (1963) model of psychosocial development consists of eight stages spanning from birth to death. In this life cycle approach, Erikson (1963) argued that development is influenced by biological forces, social demands, and an individual's success in resolving developmental, age-specific 'crises' associated with each stage. Each crisis can be viewed as a turning point with potential to advance or hinder development. Resolution of each psychosocial crisis fosters growth, increases interconnections, and develops equilibrium between self and environment. Failure to meet the psychosocial challenge of a particular stage may lead to regression or fixation within a particular stage of development, and impede development in subsequent stages (Corey & Corey, 2014).

Erikson (1963) emphasized that psychological outcomes occur along a continuum between the two polarities of each stage: mistrust versus trust (birth–18 months), autonomy versus shame and doubt (2–3 years), initiative versus guilt (3–5 years), industry versus inferiority (6–11 years), identity versus role confusion (12–18 years), intimacy versus isolation (19–35 years), generativity versus stagnation (35–65 years), and integrity versus despair (65–death). In healthy development, a balance between each pair of ego qualities is achieved. For example, a measure of mistrust may be adaptive in situations involving threat of harm. However, optimal development occurs when psychosocial strengths (trust, autonomy, initiative, industry, identity, intimacy, generativity, integrity) outweigh corresponding vulnerabilities (Erikson, 1963).

Erikson's (1963) psychosocial model is epigenetic. Each stage builds on previous stages, and impacts later stages. This model, however, represents a typical process of development. Personal experience and environmental influences may account for variations in the timing of stages. Erikson (1963) believed earlier stages may be visited later in life, and later stages may be addressed earlier in life. Hamachek (1990) contends, "Ego qualities are not achieved once and for all, nor are they gained by forever overcoming challenges" (p. 679). The process of human development is life-long and conflicts remain throughout the life cycle. Being psychologically alive requires the resolution of psychosocial conflicts unceasingly across the lifespan (Hamachek, 1990). Successfully navigating conflicts from birth to adolescence positions a person to function successfully in adulthood (Sigelman and Rider, 2012).

Once adolescent identity is established, an individual may be prepared to develop intimate relationships in early adulthood. The experience of CSA, however, creates a precarious foundation for subsequent personality development and relationships. Survivors in early adulthood often struggle to develop identity and intimacy, as they have often not yet established

necessary ego strengths of trust, autonomy, initiative, industry, and identity in previous developmental stages.

Attachment Development and CSA

Attachment involves connecting with an individual who is a perceived source of security (Bowlby, 1973). Intimate relationships in adulthood are informed by attachment style learned in early childhood. When infants experience a sense of security within their primary relationship, they tend to feel secure and emotionally attached in their adult relationships. Adults with secure attachment styles view themselves as worthy of love and support. These adults view significant others as supportive, trustworthy and well intentioned (Dimitrova et al., 2010). When infants do not experience a sense of security within their primary relationships, they may also feel insecure and emotionally unattached in their adult relationships. Corey and Corey (2014) assert, "The quality of an infant's attachment pattern is related to the quality of relationships in later life" (p. 45). Research indicates that early abuse by caregivers is linked to insecure, disorganized attachment in infants (Markese, 2008). Disorganized attachment is characterized by an infant's confusion over whether to approach or avoid an unreliable or unsafe caregiver (Sigelman & Rider, 2012).

Additionally, the experience of CSA often compromises survivors' capacity to trust people, which can lead to a sense of isolation and difficulty forming secure attachments (Larsen et al., 2011). Individuals with history of CSA often struggle to trust others and form stable and secure relationships (Dimitrova et al., 2010). Corey and Corey (2014) assert that disconnection resulting from insecure attachments "inhibits learning the essential emotional habits that will enable them to care about others, to be compassionate, and to form meaningful connections with others" (p. 45).

Self-Esteem Development and CSA

Intimacy and connection require self-esteem, a sense of autonomy, and establishing a sense of one's unique self in relation to others (Corey & Corey, 2014). Low self-esteem is expressed in victims of CSA through lack of self-respect. Because survivors of CSA have often disowned or depersonalized their bodies, they often exhibit difficulty with self-care (Ratican, 1992). Zupnanic and Kreidler (1999) state, "Quite typically, survivors of abuse have great difficulty giving themselves support even in the simplest ways" (p. 33). Through the experience of abuse, victims often develop the perception that the needs of others are primary. The survivor learns his or her needs are unimportant compared to the needs of others (Zupanic & Kreidler, 1999). With this template forged by sexual trauma, the survivor often struggles with identifying and expressing his or her own needs or having a healthy sense of self-worth.

Negative cognitions related to self and environment are common in CSA survivors and survivors tend to overestimate danger and underestimate one's sense of worth (Briere and Runtz, 1993). A sense of helplessness may arise from a child's physical or psychological inability to stop the abuser. Gold (1986) found adult women with CSA history more often attributed negative events to internal factors, and positive events were more often attributed to external factors. Feinauer and Hilton (2003) assert that sexual abuse "corresponds with a sense of shrinking, or being small, and being worthless and powerless" (p. 66). Survivors of childhood sexual abuse may lack self-efficacy, empowerment, and self-esteem, which are necessary components for developing and maintaining intimate relationships (Ratican, 1992).

Ratican (1992) contends, "sexual abuse survivors are deeply and seriously alienated from the one piece of territory that they own: their own bodies" (p. 34). Finkelhor (1985) asserts, as a child's body and personal space are repeatedly invaded, his or her sense of self-efficacy is

contravened. Additionally, if a victim discloses the abuse and is not believed, his or her sense of powerlessness may increase (Finkelhor, 1985).

Shame and Guilt from CSA

Guilt and shame are related feelings and often occur conjunctively in victims of CSA (Hall & Hall, 2011). Guilt can be understood as a feeling that results from doing something wrong or bad. Shame is the internalization of guilt resulting in feelings of being inherently wrong or bad and is an emotion characterized by the perception of the self being profoundly flawed, incapable, and unacceptable (Black, Curran, & Dyer, 2013). Black et al. (2013) go further to describe shame as "a complex self-conscious emotion that is characterized by…an affective desire to be unseen" (p. 646). Eisenberg (2000) states, "When a person experiences shame, the entire self feels exposed, inferior, and degraded" (p. 667). The connection between shame and CSA is well documented (Feinauer & Hilton, 2003).

Survivors of CSA experience guilt and shame on multiple levels. Adult survivors of often feel that they did something wrong and hold themselves responsible for allowing abuse in being passive or silent. The survivor may also feel guilty for receiving emotional, physical and material benefits from the abuse (Ratican, 2002). As a coping mechanism, sexually abused children may believe they are flawed, rather than acknowledge a primary source of security is unsafe and capable of great harm (Finkelhor, 1985; Ratican, 1992). Children often accept blame for their abuse due to the stigma and secretive nature of CSA, condemnation of the victim by the perpetrator, and the illegal nature of CSA (Feiring, Simon, & Cleland, 2009).

At typical levels, shame may promote social and moral development (Black et al., 2013), amplify awareness, and protect one's humanity (Zupanic & Kreidler, 1998). Childhood sexual abuse survivors often experience excessive levels of chronic, intense shame, which Zupanic and

Kreidler (1998) identify as pathological or toxic shame. Toxic shame can restrict emotional expression, inhibit interpersonal connection, and "create unparalleled misery" (Zupanic & Kreidler, 1998, p. 30).

Because the motivations and implications of shame and intimacy are antithetical, survivors of CSA are often conflicted and experience difficulty in developing intimate relationships. The process of developing intimacy requires emotional vulnerability, exposure, and connection (Brown, 2012) which may be incomprehensible and fear-provoking to CSA survivors. Additionally, shame is characterized by avoidant behaviors, which have a severing impact on interpersonal relationships (Dorahy, 2011). Black et al. (2013) assert, a sense of shame produces "feelings of anxiety about negative evaluation from others" (p. 647). Due to concern about undesirability, people who experience shame, such as adults who experienced CSA, may have trouble developing relationships.

Because survivors experience high levels of shame, they tend to isolate themselves in fear that others might discover how bad they are. As Lutwash, Panish, and Ferrari (2003) explain, "shame elicits strong self-deprecating reactions of the entire self" (p. 910). Thus, survivors may feel so ashamed of their history, that they may conceal it. Furthermore, concealing may reinforce the survivor's misperception that in order to be accepted he or she must not disclose experiences of childhood sexual abuse. Survivors of CSA often feel intrinsically bad to deserve the treatment they have received. In attempt to preclude negative perceptions and censure, survivors may maintain emotional distance in relationships (Ratican, 2002, Hall & Hall, 2011). Adult survivors commonly experience pathological levels of shame and are consequently reluctant to disclose their experiences of childhood sexual abuse. Further, intentionally withholding personal information in close relationships may inhibit intimacy and perpetuate

shame (Zupanic & Kreidler, 1998).

The Effects of CSA on Intimate Relationships

CSA results in dysfunctions that create barriers to intimacy and healthy development. Sexual abuse survivors often demonstrate patterns of mistrust and estrangement, and numerous studies correlate history of CSA with impairment of interpersonal functioning in adulthood (Berzoff, 2008; Briere and Runtz, 1993; Finkelhor & Browne, 1985; Godbout, 2013; Ratican, 1992). These impairments include insufficient identity development, discomfort in forming close relationships, distrust of self and others, and distorted sense of self-worth.

Establishing a healthy identity is necessary for engagement in intimacy and long-term relationships (Berzoff, 2008). Avoidance of intimate relationships, substance abuse, social isolation, problems of self-confidence and confidence in others, dysfunctional anxiety-reducing behaviors (self-mutilation), and severe psychological distress are correlated with childhood trauma survivor's difficulty developing and maintaining marital relationships (Godbout, 2013).

If an individual's sense of identity is insufficiently developed, he or she may struggle to develop and maintain intimacy. An individual must achieve an independent identity in order to create a shared identity with another person. Without a clear sense of self, a person may fail to create intimacy, experience fear of commitment, and establish over-dependence (Sigelman & Rider, 2012).

Hamachek (1990) suggests that developing intimate relationships requires mutuality, compromise, and expanding the self to include others. Berzoff (2008) contends that mutuality "requires the ability to lose oneself and find oneself in another, without losing one's identity" (p. 112). Because survivors of CSA struggle with identity and are highly self-protected, they often find difficulty in developing mutuality (Berzoff, 2008).

CSA is associated with the development of cognitive distortions, including overestimation of danger and underestimation of self-worth, that may impair relationships (Briere & Runtz, 1993). Many survivors of CSA report duality of thinking. In reflecting on abuse experiences, survivors often report feeling they could have prevented the abuse. At the same time, they report feeling powerless, weak, and shameful. Survivors of CSA have often been betrayed and deeply wounded by perpetrators professing to love them. This dissonance causes distorted perceptions about loving relationships that often hinder intimacy (Briere & Runtz, 1993; Zupanic & Kreider, 1999).

Dimitrova et al. (2010) assert, the experience of CSA may deteriorate the quality of subsequent relationships, particularly if the survivor is uncomfortable forming intimate and close relationships. Larsen, Sandberg, Harper, and Bean (2011) contend, the experience of CSA is related to adult relational impairment and difficulty in forming healthy relationships. In adulthood, this lack of relationship may accentuate the risks of psychopathology (Dimitrova et al., 2010). Godbout (2013) states, "Experiences of abuse or neglect can also elicit fears of intimacy, which, when added to the coexisting need for connecting, lead to intimate relationships that are ambivalent, chaotic, or short-lived" (p. 15).

Sexuality in CSA Survivors

Through the experience of CSA, a survivor may associate trauma, force, coercion, danger, and fear with sexuality. Sexual intimacy requires openness and a willingness to trust a sexual partner. Victims of CSA are often unwilling to assume this degree of vulnerability. As a means of self-protection, victims may close themselves off emotionally and physically, thereby limiting the development of intimacy (Maltz, 2002). Studies indicate that sexual abuse causes long-term, serious, and chronic problems with sex and intimacy (Beitchman et al., 1992;

Godbout, 2013). These include arousal disorders, premature ejaculation, erectile dysfunction, low levels of sexual satisfaction, and low desire to experience sexual activity. Survivors often experience a sense of disgust with touch, emotional distance and intruding thoughts during sex, and compulsive or inappropriate sexual behaviors (Maltz, 2002). Fear of sex, arousal dysfunctions, and orgasmic difficulty are the most commonly reported dysfunctions among women survivors. Men with a history of childhood sexual abuse also often struggle with arousal and desire, and are more likely to express aggression in sexual relationships (Ratican, 1992).

Adult survivors often report being frigid or promiscuous (Beitchman et al., 1992). and engagement in extradyadic affairs is associated with experience of CSA. A study by Whisman and Snyder (2007) found women with CSA history were four times more likely to engage in extradyadic affairs. CSA is also related to sexualized relationships, promiscuity, and seductive behavior (Ratican, 1992). Individuals who have been sexually abused have difficulty maintaining appropriate boundaries and rejecting unwanted sexual advances (Ratican, 1992). Additionally, the experience of sexual relations with family members may lead to other inappropriate sexualizations of friends, coworkers, and other nonromantic relationships (Finkelhor, 1985; Frias, Brassard, & Shaver, 2014).

Impacts of CSA on Mental Health

The association between CSA and adverse impacts on adult mental health is well-established. Research indicates a strong correlation between childhood sexual abuse and severe mental disorders including anxiety disorders, depressive disorders, posttraumatic stress disorder, eating disorders, sexual disorders, personality disorders, and substance abuse. (Horowitz, Widom, McLaughlin, & White, 2001; Spataro, Mullen, Burgess, Wells, & Moss 2004). CSA is also found to be a major cause in borderline personality disorders, and a contributing factor

paranoid and obsessive-compulsive disorders (Ratican, 1992). A study by Spataro, et al. (2004) indicates CSA survivors have twice the rate of major affective disorders, with anxiety disorders being the most frequent, and a "nearly fourfold increase in contacts with mental health services…compared with the general population" (p. 419).

Hall and Hall (2011) report depression as the most commonly reported symptom of childhood sexual abuse. Depression may result from chronic negative self-thoughts, feelings of worthlessness, and avoidance of relationship and connection with others. Depressive symptoms of CSA survivors include a sense of being down most of the time, suicidal ideation, sleep disturbances, and eating disturbances (Ratican, 1992). Beitchman et al. (1992) assert, "Women with a history of contact childhood sexual abuse were significantly more likely than victims of noncontact abused on non-abused controls to have experienced a major depressive episode and to have had more depressive episodes" (p. 106). Also, compared to non-abused controls, women childhood sexual abuse survivors were more likely to seek treatment, most often for depressive disorders (Beitchman et al., 1992).

Baldwin (1990) cites that in a study of 100 cases of multiple personality disorder, 83% were found to have experienced childhood sexual abuse. The development of dissociative disorders is also strongly related to childhood sexual abuse. Sexual abuse victims may cope with the psychological pain of the abuse by compartmentalizing or "splitting off" a part of the self in the psyche. Some survivors report having the sense of a young child stuck inside, hearing voices, and having conversations with fragmented aspects of themselves (Ratican, 1992).

Dissociative identities are formed within the most extreme and violent cases of childhood sexual abuse (Ratican, 1992; Baldwin, 1990). Baldwin (1990) suggests the 'double-bind phenomenon' is a primary marker for the development of multiple personalities. In these cases

of abuse, a child receives contradictory injunctions from primary caregivers, and receives nonverbal messages that he or she is not allowed to discuss the conflicting messages and expectations. For example, a father may be brutally raping his daughter, while telling her it is for her own good. If the daughter tells her mother about the abuse, the mother may accuse her of lying and call her a 'bad girl' for saying terrible things about her father. In double-bind cases, the child is betrayed and abandoned by primary sources of security, and also not allowed to self-advocate. The child is left with his or her feelings of fear, abandonment, despair, and humiliation, which contrast sharply with a child's strong desire for safety and affection. Baldwin (1990) states, "Brutality from a stranger would in itself be traumatic, but coming from a loved one, it has the bizarre quality of combining intense and longed-for attention from the parent with pain and humiliation" (p. 980). In cases of frequent abuse a personality may be forced to split to adapt and protect itself from an irrational environment. If one struggles to manage his or her own personality in adulthood, it may be assumed that developing intimate relationships may likely pose significant challenges (Baldwin, 1990).

Research shows the development of psychosis in adults is linked to the experience of CSA (Alvarez et al., 2011). A 2011 study by the British National Survey of Psychiatric Morbidity found a strong relationship between CSA and psychosis in adults. Findings determined that those who were sexually abused in childhood were fifteen times more likely to develop a psychotic disorder (Bebbington et al., 2011).

Mental illness is correlated with lack of intimacy in relationships (Perry & Wright, 2006). Intimacy and social functioning may be hindered by certain features of mental illness, and by the side effects of psychiatric medications. Perry and Wright (2006) found that relationships of people with serious mental illness were characterized by less commitment and intimacy than

those of the general population. Additionally, multiple studies have shown people with serious mental illness have an increased tendency to engage in concurrent and short-term sexual relationships, which may indicate lack of intimacy (Perry & Wright, 2006). Since victims of CSA are more likely to lack intimacy in relationships, they may be at higher risk for mental illness. All of the aforementioned diagnoses associated with CSA may affect the long-term quality of life in adults who have experienced sexual abuse as a child.

Conclusion

Because psychosocial development is epigenetic, with each stage building on subsequent stages, the trauma of sexual abuse in childhood often produces a highly unstable foundation for subsequent psychosocial development. Adult CSA survivors often face profound challenges in developing and maintaining secure attachments, healthy identity and self-esteem, strong relationships, healthy sexuality, and mental health. To better address client needs, develop empathy, and accurately conceptualize CSA clients' problems, it is imperative for counselors to expand their knowledge on the dynamics and enduring impacts of childhood sexual abuse.

While CSA survivors may have awareness of their abuse and their current dysfunction, they may not understand the devastating impacts of CSA, and thereby attribute their negative experiences to internal factors (Gold, 1986). Therefore, counselors should advocate for clients in providing psychoeducation on the effects of CSA to clients. With knowledge of the effects of CSA on psychosocial functioning in adulthood, counselors may help CSA clients identify current impacts of early abuse and empower clients to overcome long-term effects of sexual abuse in childhood.

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