

# Childhood sexual abuse. Women's Mental and Social Health Before and After Group Therapy

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# The influence of childhood sexual abuse factors on women's health

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A history of childhood sexual abuse has been shown to be common among adult women, 15–30% in prevalence studies. The childhood sexual abuse variables taken into account are commonly age of onset, duration, abuse forms and relationship between the child and the perpetrator. Within the Department of Psychiatry at Lund University Hospital, 45 women with experiences of childhood sexual abuse were offered a 2-year long trauma-focused group therapy. Half of the women had been sexually abused during childhood in pre-school ages and half by a perpetrator who was the biological father. Two-thirds had been abused for more than 5 years and half through penetration. There was a statistical significance between age of onset (0–6 years) and psychiatric symptoms including eight of nine subscales, according to results from use of the questionnaire Symptom Check List (SCL-90). According to the same questionnaire, there also was a statistical significance between the perpetrator (male relative) and the subscale interpersonal sensitivity. According to the Interview Schedule of Social Interaction, there was a statistical significance between the abuse form penetration and the social integration in the subscale availability of attachment. Thirty-five women (78%) had not told anyone about the sexual abuse when it happened, and the most common reason for this was fear of not being believed.

• *Childhood, Health, Influence, Sexual abuse.*

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In prevalence studies outside Sweden, the frequency of childhood sexual abuse among adult women is estimated to be 15–30% (1). In Sweden, the prevalence is shown to be around 10% in several studies (2, 3). In approximately 10% of all sexual abuse cases (6–32%) the perpetrator is a family member – a parent, a step-parent or a sibling (1). The psychosocial consequences of sexual abuse are considered worse if the perpetrator has a close relationship to the victim, as for example a father or a stepfather (4).

In both community and clinically based studies, adult women who have been sexually abused as children report suffering from depression, anxiety, eating disorder, phobias, post-traumatic stress disorder, substance abuse, sexual disturbances and difficulties in relationships with both men and women. These women often make suicide attempts and display self-destructive behaviour (5).

Considering the sexual abuse variables can provide understanding for relations to psychosocial problems in adulthood. The sexual abuse variables usually mentioned are the child's age of onset of abuse, the abuse forms, the duration and the relationship between the child and the perpetrator (1). The abuse forms are often categorized into three groups: penetration, physical contact and any other sexual contact. The perpetrator is defined as a person within the family, another relative, an acquaintance or a stranger (1). How each sexual abuse variable can affect the adult woman's health is difficult to say. In the literature, the abuse variables are usually treated together, but some results from studies examining single abuse variables have been found.

### *Summary of the effects of different sexual abuse variables*

There are statistically significant relations between age, duration, serious abuse, close perpetrator relationship and more than one perpetrator in relation to psychiatric symptoms (depression, anxiety, phobia, obsessive – compulsive disorder, deliberate and repeated deliberate self-harm, self-mutilation, overdose, suicide attempts, drug use and somatization, measured by, e.g., SCL-90, QSL and GAF) (6–12). Age, duration and serious abuse seem to significantly relate to post-traumatic stress disorder (6, 9, 13). Age, serious abuse and more than one perpetrator occur significantly together with personality disorder (6, 11), and serious

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abuse, duration and more than one perpetrator together with dissociation (7). Serious abuse and more than one perpetrator have significant connections with sexual problems (9, 11, 12). One study, which investigated relationships between different sexual abuse forms and psychiatric disorder including symptoms, showed that penetration had an odds ratio ranging from 3.3 for alcohol abuse to 11.8 for suicide attempt (14). Santa Mina & Gallop found, in their review study, strong links between self-harm or suicide attempt/ideation and duration, and between penetration and known perpetrator (15). Concerning sexually abused children, a review of 45 studies from the fields of medicine, social work, psychology and sociology showed significant relations between penetration and increased symptoms, between longer duration and increased symptoms and between perpetrator and increased symptoms if there was a close relationship between perpetrator and child (16). However, there are also studies that report no connections between the age of onset and symptoms (7, 10). Beitchman et al. (4) concludes in his review that there is a high prevalence of sexual disturbances when the abuse form is penetration or when the perpetrator is a father, and that there is a connection between duration and greater impact.

### *The influence on the child's psychological development*

The psychological developmental injury of sexual abuse against a child has to be considered in the light of the fact that the child is not a completely developed psychological individual. The younger the child is at the time of the sexual abuse, the more incomplete is the psychological personality structure. Finkelhor & Browne (17) have organized a model of traumagenic dynamics, which make it possible to understand why some children can manage sexual abuse but others are psychologically hurt. The model comprises *traumatic sexualization*, *betrayal*, *powerlessness* and *stigmatization*. The model states that the consequences of sexual abuse could be that "a child's sexuality is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion". This can lead a child using sexual behaviour for developmental needs. The child experiences betrayal when an adult, with whom the child has a deep and trusting relationship, uses the child for sexual purposes. For the child, this can lead to mistrust, not only for the perpetrator but for all adults, and also to difficulties in developing deeper relationships later in life. Because the child feels trapped and unable to affect the perpetrator or to tell other adults, the experience of powerlessness is all-embracing. The child risks developing as an adult an identity of being a victim and because of that has a greater tendency to being exposed to revictimization. Stigmatization means a communication to the child of negative meanings like shame, guilt and badness. The child incorporates all stigmatization in a negative self-image. As an adult, this experience can be developed into low self-esteem, which can lead in turn to self-destructive behaviour, including suicide attempts.

Briere et al. (18) describe in the "Self-trauma Model" that a child's psychological development through sexual abuse can be damaged concerning *identity*, *personal boundaries* and *affect regulation*, comprising affect modulation and affect tolerance. The self-capacities and self-functions are developed during childhood. If aversive events happen, the child does not develop the necessary "sense of internal stability" to be able to interact with the world. The parent – child attachment is disrupted and the child protects itself by avoiding close relationships with others.

Children who have been sexually abused within the family usually do not reveal this. According to Summit (19) this may be understood from the model of "child sexual abuse accommodation syndrome". The sexual abuses happen in *secrecy* and the child is threatened or persuaded to keep quiet. This brings an experience of *helplessness* to the child, who feels *entrapped* in a dependent relationship to a perpetrator, who abuses the child again and again. The child has to *accommodate* to the abuse situation. The longer the child is quiet, the more difficult it will be to *reveal* what is happening. When the child at last tries to say something it will be met with *distrust*, because the adult has difficulties in understanding why the child has not said anything before. The adult, often the mother, accuses the child of wanting to send the perpetrator, maybe the father or stepfather, to prison and disrupting the family. In the end, there is a high risk that the child will *retract* the story.

### *Aim*

The aim of the present study was to determine the influence of the four sexual abuse variables – the age of the child at the onset of the sexual abuse, the type of the sexual abuses, the duration of the sexual abuse, and the relationship between the child and the perpetrator – on the adult women's health at the time they started in group therapy. The second aim was to gather information about why the child did not reveal the sexual abuse when it happened.

## Material and Methods

### *Subjects*

Between 1993 and 2001, forty-five women were treated in 10 different 2-year long, phase-divided therapy groups, focused on childhood sexual abuse. The inclusion criteria were to have a memory of the childhood sexual abuse and to know who the perpetrator was. *Sexual abuse* was defined as:

All physical contact and visual or verbal interaction between a child/teenager up to 18 years old, and a family member, a relative or a person who in the place of a relative has a position of trust in the family, in which the child/teenager is used to sexually stimulate the perpetrator or someone else (20, 21).

Exclusion criteria were diagnoses of psychosis or ongoing substance abuse.

### *Methods*

A 2-h interview at the time of admission was done by the group leaders with each woman about her present life, the sexual abuse history and the family of origin. At the end of the interview, a questionnaire was completed to provide socio-demographic data, and to answer questions about health, relationships, earlier psychiatric contacts and history of sexual abuse, including the four sexual abuse variables. Each of the sexual abuse variables was subgrouped for statistical analyses.

Before and after group therapy, questionnaires were answered. In this paper, three instruments are presented.

The *Symptom Check List* (*SCL-90*), a self-rating scale with 90 questions measuring present psychiatric symptoms reflects nine dimensions of psychiatric symptoms and a total score, Global Severity Index (GSI). The nine subscales are somatization, obsessive – compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism. The answer alternatives are from "not at all" (0 points) to "very much" (4 points). In each subscale, the scores for the included questions are added and then divided by the number of questions. For the GSI, the scores for the 90 questions are added and then divided by 90. A low score shows good psychiatric health. This scale is a commonly used scale with high validity. In a Swedish general population, the instrument has shown Cronbach's alpha 0.73–0.91 for the subscales and 0.97 for the GSI (22–25).

The results from the study group with age of onset $\leq$6 years are compared with the results from the study group age of onset 7–18 years, and the results from a general group and a clinical group. The general group comprises a population of 707 women with mixed ages (25). The age range is 18–63 years and the women are mostly students at a university or college, or are working within the healthcare system. The clinical group comprises 162 female outpatients with mixed ages who had all been sexually abused as children. The mean age is 33.2 years (26).

The *Interview Schedule of Social Interaction* (*ISSI*) is an instrument with 30 items measuring social integration and attachment. The scale is subdivided into four subscales: availability of social integration (AVSI) 0–6 points, availability of attachment (AVAT) 0–6 points, adequacy of social integration (ADSI) 0–8 points and adequacy of attachment (ADAT) 0–10 points. This allows for a maximum total score of 30 points. A high score shows good social integration and attachment. The reliability, measured with Cronbach's alpha, has been shown to be 0.67–0.79 for the four subscales. The validity of this scale is found to be satisfactory (27–29).

The *Social Adjustment Scale* (*SAS-SR*) is a self-rating scale with 54 variables measuring social situation and adjustment overall and within the subscales work/studies/homework, social and leisure, family unit, marital, parental and extended family. The answer alternatives range from "manage very well" (1 point) to "manage very badly" (5 points). In each subscale, the scores for the included questions are added and then divided by the number of questions, and the same is done for the overall scale. A low score shows good social adjustment. The reliability, measured with Cronbach's alpha, has been shown to be 0.74. The validity is found to be satisfactory (30–32).

After having terminated the group therapy, the women were given a semi-structured interview by an independent evaluator. Among other things, the women were questioned about their reasons for not having told anyone of the sexual abuse when it happened. The results are reported in this paper.

### *Ethics*

The study was carried out at an outpatient treatment unit at the Department of Psychiatry at Lund University Hospital, and was approved by the Ethics committee of the Lund University Hospital (LU 274-92 and LU 398-97).

### *Statistics*

The statistic programme SPSS was used. The material was described with frequencies, percentages, means and standard deviations. Group comparisons were made with unpaired *t*-tests. Stepwise regression analysis was made with the abuse variables in relation to psychiatric symptoms (SCL-90), to social interaction (ISSI) and to social adjustment (SAS-SR).

## Results

### *Sexual abuse variables*

The nature of childhood sexual abuse was assessed with references to four variables (Table 1). Half of the 45 women were in pre-school years (51%) when they were sexually abused, and half were abused through penetration (53%). About two-thirds were abused during a period lasting more than 5 years (67%) and nearly half by a biological father (45%). Thirty-six women (80%) were sexually abused in more than one way. Sexual abuse by more than one perpetrator had occurred for 15/45 women (33%), and these second perpetrators mostly were brothers (six persons) or stepfathers (five persons).

*Table 1.* Description of sexual abuse in childhood, different variables ($n = 45$).

| | *n* | (%) |
|---|---|---|
| Child's age of onset of sexual abuse | | |
| ≤6 years | 23 | (51) |
| 7–18 years | 22 | (49) |
| Sexual abuse forms | | |
| Penetration (oral, anal, genital) | 24 | (53) |
| Physical contact (not penetration) | 18 | (40) |
| Any other sexual activity (not physical) | 3 | (7) |
| Duration of sexual abuse | | |
| 0–5 years | 15 | (33) |
| 6–11 years | 16 | (36) |
| 12–31 years | 14 | (31) |
| Perpetrator of sexual abuse: | | |
| The first perpetrator | | |
| Biological father | 20 | (45) |
| Stepfather | 11 | (24) |
| Foster father | 2 | (4) |
| Relative, male | 12 | (27) |
| The second and third perpetrator | | |
| Stepfather | 5 | |
| Relative, male | 4 | |
| Biological mother | 2 | |
| Brother | 6 | |
| Relative, female | 2 | |
| Known male | 2 | |

### *Sexual abuse variables and psychosocial ill-health*

#### Age of onset

The different sexual abuse variables were related to psychiatric symptoms (SCL-90), to social interaction (ISSI) and to social adjustment (SAS-SR).

A high score for psychiatric symptoms (SCL-90) shows poor psychiatric health. A statistically significant difference was found between an early onset ( ≤6 years of age) and a later onset (7–18 years of age) in the study group concerning the total psychiatric symptom score GSI ($P < 0.01$) and also concerning eight of the subscales (all $P < 0.05$) (Table 2). When comparing this early age of onset of the study group with the general group, there was a statistically significant difference ($P < 0.001$) but not when comparing with the clinical group. There were no statistically significant differences between the two groups of ages of onset when measuring social interaction (ISSI) or social adjustment (SAS-SR).

#### Relation to the perpetrator

Concerning perpetrators, there was a statistically significant difference for male relative in comparison with the other perpetrator groups for the psychiatric subscale (SCL-90) interpersonal sensitivity ($P < 0.05$). No statistically significant difference was found between the perpetrator groups when measuring social interaction (ISSI) or social adjustment (SAS-SR). Being sexually abused by more than one perpetrator showed a statistically significant difference on the psychiatric subscale (SCL-90) anxiety ($P < 0.05$) compared with being abused by a single perpetrator.

#### Type of abuse

The abuse form penetration showed a statistically significant difference for a poorer social interaction (ISSI) in the subscale availability for attachment ($P < 0.05$) compared to non-penetrative sexual abuse. No other statistically significant differences were found between the abuse forms.

#### Duration

There were no statistically significant differences between the duration groups when measuring the three scales SCL-90, ISSI and SAS-SR.

#### All sexual abuse variables

In a regression analysis, 15.5% of the variation in psychiatric symptoms according to SCL-90 could be explained by the four sexual abuse variables but only age of onset had a significant relation with SCL-90, $P < 0.01$. For the scales ISSI and SAS-SR, no statistically significant relations to the sexual abuse variables were found.

### *Years of silence*

Of the 45 women in the study, two women dropped out and two did not come to the evaluation interview. Of the 41 who came to the interview, three women had as a child told an adult of the sexual abuse and three did not answer the question. Thirty-five women had not told anyone about the sexual abuse when it happened, and these women answered the question. Thirty-four of the thirty-five women reported several reasons for keeping quiet. The most common reasons for not telling anyone were that the children were fearful that they would not be believed (71%), or were fearful that they themselves would be accused for having taken part in the sexual abuse (46%). Forty-six per cent also said that they feared for being physically punished by the perpetrator (Table 3). Ten women (29%) said they could not reveal the sexual abuse owing to loyalty to the perpetrator. Fearing being accused for having taken part in the sexual abuse showed a higher total psychiatric symptom score GSI ($P < 0.05$) and higher scores on the four subscales depression, anxiety, paranoid ideation and psychoticism ($P < 0.05$ for all four subscales). Fear of being physically punished by the perpetrator revealed a higher score on the psychiatric subscale hostility ($P < 0.05$) and the SAS-SR ($P < 0.01$).

## Discussion

Women who experience sexual abuse in childhood have a high likelihood for developing mental illness and

*Table 2.* Psychiatric symptoms in comparison between ages of onset of the study group, a general group and a clinical group.

| | Study group,† age at onset | | | |
|---|---|---|---|---|
| | ≤6 years (I) ($n=23$) (M±$s$) | 7–18 years (II) ($n=22$) (M±$s$) | General group,‡ ($n=707$), (M±$s$) | Clinical group,§ ($n=162$) (M±$s$) |
| SCL-90, Total score (GSI) | 1.86±0.78 | 1.29±0.56** | 0.49±0.44*** | 1.81±0.82n.s. |
| Somatization | 1.87±0.86 | 1.35±0.63* | 0.49±0.48*** | 1.51±0.93n.s. |
| Obsessive-compulsive | 1.87±0.86 | 1.35±0.63* | 0.65±0.61*** | 2.04±0.98n.s. |
| Interpersonal sensitivity | 2.00±1.00 | 1.53±0.78n.s. | 0.55±0.57*** | 2.08±0.94n.s. |
| Depression | 2.45±0.81 | 1.84±0.81* | 0.72±0.74*** | 2.24±0.93n.s. |
| Anxiety | 1.97±0.95 | 1.37±0.71* | 0.56±0.54*** | 1.90±1.04n.s. |
| Hostility | 1.39±0.91 | 0.91±0.61* | 0.39±0.50*** | 1.61±1.02n.s. |
| Phobic anxiety | 1.39±1.22 | 0.70±0.66* | 0.16±0.40*** | 1.22±1.07n.s. |
| Paranoid ideation | 1.82±0.93 | 1.23±0.69* | 0.41±0.54*** | 1.91±0.90n.s. |
| Psychoticism | 1.43±0.86 | 0.97±0.64* | 0.23±0.37*** | 1.43±0.94n.s. |

†Female outpatients, sexually abused in childhood, $n=45$.
‡Women, general population with mixed ages, $n=707$ (25).
§Female outpatients, sexually abused in childhood, $n=162$ (26).
T-test study group (I)/study group (II), study group (I)/general group and study group (I)/clinical group: statistically significant level: *$P<0.05$, **$P<0.01$, ***$P<0.001$, n.s., no statistical significance (33).
The age of onset was divided into two categories based on the median, ≤6 years ($n=23$) and 7–18 years ($n=22$).
$s$, standard deviation.

problems in their social lives (1). This can both be understood from the model of Finkelhor & Browne (17) comprising powerlessnes and stigmatization, and from Briere's self-trauma model (18), which points out the damage to identity, personal boundaries and affect regulation. It is shown that between 25% and 77% (5) of the female psychiatric in- and outpatients have been sexually abused in childhood. The childhood sexual abuse variables usually mentioned in the literature are the child's age of onset, the duration, the abuse forms, and the relationship between the child and the perpetrator.

In our study of clinical cases, half of the women (51%) were abused for the first time when they were younger than 7 years of age. This can be compared with peak ages of risk occurring between 10 and 12 years in community studies (1). The most common childhood sexual abuse forms in the study were penetration (53%) and physical contact (40%). Fergusson (1) reports in community studies considerably less penetration than physical contact (relation 10.1% to 19.2% in weighted average rates). If the perpetrator has a close relationship to the victim, the psychosocial consequences are considered worse (4). In our study, all the perpetrators were close to the children, even if there were not only biological fathers (45%) and stepfathers including foster fathers (28%) but also other relatives (27%). The assumption was that all the women were abused by a perpetrator in a position of trust. In community studies, these groups of perpetrators represent about 29% of all perpetrators (1). In our study, the mean value of duration was 9 years. A comparison study of 404 women who had been sexually abused in childhood, shows a mean value of duration of 6 years (7). The duration in our study is obviously very large and this long duration is likely to have a worsening effect on health.

*Table 3.* The reasons for not revealing the sexual abuse ($n=35$).

| | $n$ | (%) |
|---|---|---|
| Fear of not being believed | 25 | (71) |
| Fear of being accused for having taken part in the sexual abuse | 16 | (46) |
| Fear of being physically punished by the perpetrator | 16 | (46) |
| Fear of meeting anger from the receiver | 10 | (29) |
| Loyalty with the perpetrator | 10 | (29) |
| Fear of the perpetrator hurting someone else | 7 | (20) |
| Fear of loosing attention/kindness | 5 | (14) |
| Fear of loosing favours/rewards | 3 | (9) |
| Fear of being sent away from home | 3 | (9) |
| Fear of the perpetrator being put in prison | 2 | (6) |
| Fear of the perpetrator hurting himself | 1 | (3) |
| Sexual satisfaction | 1 | (3) |

When interpreting the results of this study, one has to keep in mind that this is a very select group of women seeking treatment in psychiatry for the long-lasting consequences of childhood sexual abuse. This suggests that we are studying a more traumatized group than a group chosen from a community-based sample.

The women in our study often had been abused very early in life, they were to a higher proportion abused by penetration with a long duration and they were abused by a perpetrator close to them. These are all factors known to predict a more negative outcome (16). This selected clinical population can, in other words, confirm

these findings that community studies have shown and in a way serve as a validation for these studies.

Why do women become stigmatized by the abuse? Through group therapy, we know that many of the victims told of mistrust of both the male perpetrators and the mothers of the victims. Feelings that the mothers were unable to protect their daughters or did not care enough were recurrent elements in the stories told by the victims. In a way, these mothers were not "good enough" (34) to be able to create a confiding relation with their daughters or to give them a safe childhood. Because of this, the child may experience attachment deprivation (18). Feelings of being guilty and ashamed put extra burdens on an already fragile child meeting the description of stigmatization (17), and developing a low self-esteem as adults was complemented with a strong feeling of being dirty and bad. The women also had so little trust and confidence as children that they did not dare to reveal the sexual abuse to any adult. This could also be understood from the child abuse accommodation syndrome (19), where the child feels trapped in a dependent relationship to the perpetrator and accommodates to the abuse situation. It is not so difficult to trace the pathway leading to mental illness.

In this study, the abuse factor age of onset ( $\leq$6 years of age) was the factor most consistently related to psychiatric symptoms findings. This was evident in relation to psychiatric symptoms, measured with SCL-90, both total (GSI) and for eight of nine subscales. This supports the assumption that an early start of abuse may negatively influence many developmental tasks that are so important during childhood. This finding is confirmed in a Swedish female general population study of associations between childhood sexual abuse and lifetime alcohol dependence or abuse (3). In that study, there were statistically significant relations between sexual abuse before the age of 13 years and an increased risk of lifetime anxiety diagnosis and alcohol dependence or abuse. A study of McClellan et al. (35) found, in a gender-mixed sample of seriously mentally ill youths, a significant relation between onset of sexual abuse prior to 7 years of age and inappropriate sexual behaviours. They also found relations between an early onset of sexual abuse and both chronic sexual abuse and sexual abuse by a parent/step-parent.

Male relative compared to other perpetrator groups gave a statistically significant difference for the subscale (SCL-90) interpersonal sensitivity. Abuse form groups and duration groups gave no statistically significant differences to psychiatric symptoms. This could probably be explained by the very homogenous sample of clinical cases.

Concerning social interaction, measured with the ISSI, there was a statistically significant difference for the abuse form penetration and the subscale available attachment. No other study measuring social interaction has been found, but there is a study reporting higher degree of loneliness and lower level of network orientation among sexually abused women (36). Furthermore, several studies are underlining existence of social isolation in incestuous families (37–39).

The social adjustment, measured with SAS-SR, gave no result for any of the abuse variables. Jackson et al. (40) reported a statistically significant relation between social adjustment and childhood sexual abuse, but no single abuse variable was mentioned in this study.

As many as 35 women of 45 in our study had not told anyone of the sexual abuse. Of them, 71% feared that they would not be believed, 46% that they would be accused of having taken part in the sexual abuse and 46% that they would be physically punished by the perpetrator. These results are partly confirmed in a national survey from the USA (41) about delay in disclosure. There, the result was that younger age at the time of rape, family relationship with the perpetrator and repeated rapes were associated to disclosure latencies longer than 1 month. Fear of being blamed for participation and fear of being physically punished by the perpetrator for telling anyone of the abuse were significant reasons for not disclosing abuse. These findings are in line with the results from the study of Sas &Cunningham (42), in which children who delayed their disclosures by more than a year revealed that the most common reason (27%) for this was fear of harm to self or others.

Finally, the overwhelming importance of information about these women's difficulties in helping them and others in breaking the silence and telling about abuse during childhood must be highlighted. Sometimes this lack of information has contributed to the children not having had treatment as children. Therefore, better knowledge about symptomatic behaviours, early signs and, most of all, knowledge of "how to talk to children" must be obtained. In addition, efforts to distribute this information once it is obtained must be strengthened. In the interviews with these women, we have gained the impression that this seems to be the best way to ensure early intervention.

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