Effects of Childhood Sexual Abuse on the Psychosocial Functioning of Adults

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As social workers study the many aspects of sexual abuse in childhood, one question that arises is the impact of that childhood sexual abuse on the psychosocial functioning of individuals in adulthood. Social workers are beginning to examine the relationship between adult problems in marriage, parenting, and work to sexual abuse experienced in childhood. Practitioners are attempting to assess diagnostically the impact of childhood abuse on adults with more finesse and also to offer more individualized treatment plans.

That sexually abused victims suffer into adulthood has been well documented in the literature. In a comprehensive review of existing studies, Fisher (1987) noted that many victims as adults have difficulty forming interpersonal relationships. Frequently, sexually abused children become asexual as adults and experience themselves as neuter beings. Many reject their own bodies and view pleasure in their bodies as taboo. Extreme self-hatred can occur; some deliberately burn or cut themselves. Obesity is a common symptom. Flashbacks, extremely distorted self-images, and even multiple personalities are not unknown. Nightmares are common, and attempted suicides are frequent.

Many adult victims have not confronted the roots of their sexual traumas because they have repressed the meaning of the abuse. Williams and Fuller (1987) reported that 88 percent of sexually abused adult subjects had repressed the memory of the abuse completely, for as long as 10 years. The subjects' recall may have been triggered by having a child of their own or by reading a newspaper story about sexual abuse. Subjects who did not repress or suppress traumatic sexual memories told no one of the incidents, or, if they did tell someone, they received little help or support.

Even repressed events exert a profound effect on psychosocial functioning (S. Freud, 1905). Severely abused children often repress memories of their abuse, but these individuals as adults frequently shun sex, avoid interpersonal relationships, and hate themselves (Wodarski, 1987).

Many victims of sexual abuse conclude that they were to blame—for starting the incidents, for not stopping them, or for feeling sexual excitement during the sexual encounters (Fisher, 1987; Freeman & Strean, 1986). If the victims were able to assign the major responsibility to the adult with whom they had the sexual encounters, the victims had to confront their grief and rage when they acknowledged that the adult was not a loving parental figure but instead was a disturbed, childish, exploitative individual. The pain of facing the extreme narcissism in a parent or parental figure activates repressive mechanisms, eventual sexual and interpersonal inhibitions, and self-loathing and masochism.

Gil (1987) found in her survey of 99 patients that 12 had been exploited by their therapists and had had sex with them. Although these patients often try to provoke their therapists to act out sexually with them, Gil emphasized that erotic behavior on the part of these clients does not mean that they seek sex but rather that they are relating to people in the only way they know. Such individuals also have trouble forming stable relationships because of the early message that "people who love you will hurt you." This perception can create an automatic dead-end for therapists, who by demonstrating that they genuinely care about their clients' welfare often may drive the clients away.

One of the major weaknesses of research on the impact of childhood sexual abuse on adult functioning is that few researchers individualize their subjects. Some careful questions can aid practitioners in more fully assessing sexually abused clients and in planning treatment with and for them: How often and under what circumstances did the sex take place? How old was the child when the sex was started? How long did it continue? What kind of sex took place? What happened to make it stop? What was going on in the family between the parents and siblings when the sex took place? Did the child see a sibling having sex? Of equal pertinence is the quality and quantity of subtle, less violent, sexual exploitation.

Studies of child development repeatedly have demonstrated that the variables that contribute to the formation of the adult personality are many, complex, and interdependent (Fine, 1982; Strean, 1982). Therefore, understanding feelings, attitudes, and behavior in an adult requires a careful assessment of the client's unique past and how it relates to current circumstances. Perhaps of more consequence, each individual constructs unique meanings for external events. Reality is subjective, and each client organizes it in his or her own idiosyncratic manner (Edelson, 1975; Fine, 1982). Consequently, there would appear to be no one-to-one correspondence between sexual abuse in childhood and a predictable *modus vivendi* in adulthood, regardless of whether the sexual encounters were violent or subtle, direct or indirect, frequent or few.

For example, many clinicians believe that childhood sexual abuse inevitably repeats itself in successive generations, and a large body of research tends to support that belief. However, after a closer look at the evidence with a focus on some variables—age of the child when sexually abused, frequency of abuse, family atmosphere of the victim, and the like—Kaufman and Zigler (1987) have concluded that for a variety of methodological reasons, many of these studies overestimate the risks of repeated abuse. Kaufman and Zigler's study suggests that, although the vicious cycle certainly

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occurs and is cause for concern, it is the exception, not the rule. Only about 30 percent of individuals who are sexually abused as children repeat the cycle with their own children. Instead of asking whether abused children become abusive parents, social workers should ask under what conditions the transmission of sexual abuse is most likely to occur. Two of the studies that Kaufman and Zigler reviewed show that the cycle is less likely to be repeated in individuals who, as children, had the loving support of a parent or foster parent and in those who as adults have a loving, supportive relationship with a spouse or lover and have relatively few stressful events in their lives. Experiencing sexual abuse as a child puts one at risk for becoming abusive as an adult, but becoming abusive is not direct or inevitable. Social workers therefore must individualize their assessment of clients.

Individualizing Assessment

To diagnostically assess and treat clients in the most effective manner, social workers need to discover how each sexually abused client views himself or herself, significant others, and the world. Of central importance is how the client perceives the sexual experiences with the parent or other adult. Other considerations include whether the client responds with acute distrust, particularly in sexual relationships; is full of rage and involved in power struggles, particularly with sexual partners; is promiscuous and feels that sex is the only way he or she can feel close to others; is masochistic or sadistic; or feels guilty and responsible.

As is true of any comprehensive psychosocial assessment, social workers not only should learn about the client's history and his or her interpretation of it but also should assess which ego functions work well and which functions do not (for example, judgment, reality testing, frustration tolerance, object relations, impulse control, defenses). Social workers also should assess the punitiveness or flexibility of the superego and how the client's past and psychic structure influences and is influenced by current circumstances. The nature of the client's current social context and current familial relationships and how they affect the client's current adaptive strengths and maladaptive mechanisms also should be assessed.

One of the most frequent diagnostic tasks in working with adults who have been sexually abused as children is to ascertain why some clients identify with the aggressor and some do not (A. Freud, 1966). The defense of identifying with the aggressor usually occurs in situations of helplessness and frustration, when a bigger, stronger, or more powerful individual controls the victim and the victim then tries to resemble the controlling individual. The use of the defense is eminently understandable when one has been sexually abused.

However, no one-to-one correspondence exists between childhood sexual abuse and parenting as an adult. Sometimes a sexually abusive parent is capable of some warm tenderness that is fused with the exploitations and molestations. Many sexual abuse situations are not reported at all because of occasional parental tenderness or because of the victim's fear of what such revelations will provoke. However, although such conflicts are complex and intense, some victims emerge in many ways into well-functioning, empathic, mature human beings who do not identify with the abuser but instead help others grow. For example, during the past 15 years, the author has treated more than 15 male and female social workers who were subjected to dramatic and intense sexual abuse as children. None became psychotic, and although most had some sexual and interpersonal inhibitions, all were warm, loving, altruistic, somewhat masochistic, but essentially mature human beings. In contrast, other victims do identify with the abuser and perpetuate the cycle of abuse. The author has observed severe pathology in some adults who were subjected to more subtle sexual abuse, such as parents' parading in the nude in front of their children, having overstimulating sexual conversations with them, or making frequent sexual references in nonsexual discussions.

In families in which a strong but latent hostility exists between the parents, the child frequently identifies with the parent of the opposite sex and demeans the parent of the same sex (Fine, 1979). If the parents do not resolve their mutual hatred, they concomitantly interfere with their children's freedom to love and to view sexuality as a loving experience. This is a form of subtle sexual abuse that eventually affects the adult's sexual and interpersonal relationships.

In clinical work with single adults who have difficulty forming relationships with the opposite sex and in work with individuals who are experiencing severe marital conflicts, the author has noted repeatedly that all of these clients have been subjected to one or more forms of sexual abuse. This definition of sexual abuse includes everything from mutual hatred between the parents (not necessarily overtly displayed), to more subtle kinds of abuse such as parading nude in front of the child or sharing a bedroom with the child, to more violent and more dramatic forms of abuse such as mutual masturbation between child and adult, mutual exhibitionism, cunnilingus, fellatio, or sexual intercourse.

Aspects of Treatment

After making a full assessment of a client, social workers then can decide how to proceed with treatment. Many sexually abused clients need a long-term relationship whereby they can learn to trust a parental figure who will not exploit, seduce, or abuse the client (Meyer, 1987). In this long-term relationship, distrustful clients constantly test the clinician to see whether he or she really is concerned about the client's welfare or instead is interested solely in his or her own narcissistic desires. Often these tests are of an indirect, subtle nature. A client might transfer certain responses from the abuser to a spouse and later to the therapist and might verbally compare the therapist with the narcissistic abuser.

For example, as one client, Marilyn, aggressed toward her therapist over a long period of time and was not censured or criticized, her self-esteem rose and her sexual and interpersonal relationships improved. When therapist and client took note of the improvement, Marilyn suggested that she was ready to terminate treatment. However, when the therapist explored the request—rather than gratifying or opposing it—it became

clear that Marilyn was testing the therapist to ascertain how eager he was to get rid of her, much the way she had experienced her father as eager to get rid of her after he got what he wanted from her sexually.

Because clients often relate to the therapist with their habitual defenses, anxieties, infantile wishes, and superego pressures, the transference of a sexually abused client often is an ambivalent one in which the client feels stimulated and cared for but also guilty and used. Such clients need help in seeing how they unconsciously recapitulate the dynamics of the abusive relationship with the therapist and others.

One of the most difficult issues for clients to accept is that regardless of how conflictual and unpleasant past experiences and relationships were, when the client repeats them with others the client has wishes to do so. These wishes usually are unconscious, and the therapist's task is to help the client discover what wishes are being gratified and for what purpose. Clients recapitulate relationships to continue their expression of revenge, to defend against loving feelings or sexual fantasies, to act out childish gratifications, or to receive punishment for forbidden sexual and aggressive fantasies and activities.

For example, Henry, a 40-year-old single man, was in treatment because he was not able to sustain a relationship with a woman. Henry described his mother as an engulfing woman who always tried to control him and he tended to experience most women as "controlling bitches." In his treatment with a female therapist, Henry initially enjoyed expressing himself freely without being judged. He began to feel less anxious and less depressed and could date women with more confidence and could receive more pleasure from his encounters with them. However, after his "honeymoon" with his dates and after his "honeymoon" with his woman therapist, Henry complained that all women were like his mother—"controlling and castrating." As his therapist listened to his complaints about her without censure, Henry brought in a dream in which he was kissing his therapist and hugging her. At first it felt very enjoyable to him but later in the dream the therapist grabbed him by the testicles and hugged him till it hurt him. When Henry eventually was helped to see that he wrote the script of the dream and therefore had some reasons to arrange to be engulfed and controlled by the therapist, he could gain some emotional conviction that he was arranging to keep the therapist and other women away from him. Once Henry could see that he was protecting himself from closeness and intimacy with women, he eventually could understand that he was terrified of his own incestuous wishes—wishes that stimulated him and frightened him and that he wanted to avoid.

In working with clients who have been sexually abused, social workers must remain in touch with and monitor their own childish wishes, particularly childish sexual fantasies and childhood experiences with parents and with significant others. If we cannot resolve old resentments or power struggles, we cannot help clients to do the same. If we cannot acknowledge incestuous fantasies and recall and understand sexually exciting experiences with parents or siblings, we will not be able to help clients to master these difficult experiences.

For example, every time Mary, a 33-year-old clinical social worker, was the object of an older male client's affections, she became very withdrawn or very active in her sessions with these clients. As she studied her countertransference feelings and fantasies as well as her own activity and inactivity in her sessions, Mary realized that she was preventing her male clients from forming a sexual transference toward her. Further reflection helped her to realize that she both wished and feared a relationship with a fatherly figure who reminded her of her "loveable, frightening, but seductive father."

In considering the impact of sexual abuse in childhood on the psychosocial functioning of adults, social workers need to expand the definition of childhood sexual abuse. Intervention requires a comprehensive assessment of the client's history, ego strengths and ego limitations, superego pressures, and a determination of how all of these variables relate to the client's current circumstances. Treatment with the sexually abused usually involves a long-term commitment on the part of both therapist and client so that the client can learn to trust and to see why he or she unconsciously arranges to hold on to maladaptive coping mechanisms. Treatment also involves an acute awareness and mastery by the therapist of his or her own sexual past, sexual interests, and sexual anxieties. When the social work clinician accomplishes that task, the clinican will be better able to help distrustful, frightened, and angry clients enrich their capacities to love and to have more satisfying sexual lives.

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