The Survivor SYNDROME

Childhood sexual abuse leaves a controversial trail of aftereffects

Second of two articles

By BRUCE BOWER

Carol Tavris, a psychologist with a private practice in Los Angeles, welcomed the new year with a bang that reverberated throughout the mental health field. In a Jan. 3 NEW YORK TIMES BOOK REVIEW article titled "Beware the Incest-Survivor Machine," she argued that a number of self-help books for victims of child abuse encourage a growing tendency to portray nearly all psychological problems – and particularly those of women – as consequences of incest.

"The evidence that [sexual] abuse is more common than we knew is being trivialized by unvalidated claims made by pop-psychology writers that abuse is nearly universal, and that if you can't actually remember the abuse, that's all the more evidence that it happened to you," Tavris argued. "The problem is not with the advice [self-help books] offer to victims, but with their effort to create victims."

Her assertions sparked numerous angry responses, including condemnations that her view supports a backlash against legal and social gains recently made by those who have suffered sexual abuse as children.

Although debate rages, scientists lack a comprehensive model of the damage wreaked by sexual abuse. Such a theory might address the interplay among responses to specific abusive acts, a child's prior emotional condition, family psychological health or disturbances, and adult responses to the discovery of the abuse.

Self-help books cited by Tavris – such as the best-selling *The Courage to Heal* by Ellen Bass and Laura Davis (1988, HarperCollins) – offer checklists that identify purported symptoms spawned by incest. These signs of past abuse include feeling bad or ashamed, feeling powerless, always needing to be perfect, low self-esteem, lack of motivation, phobias, having problems with sex and relationships, arthritis, and the desire to change one's name. Even researchers and clinicians who welcome the support and information self-help books bring to survivors generally take a dim view of such sweeping checklists.

"Symptom checklists cannot establish that someone was sexually abused," says Lucy Berliner, a social worker at Harborview Sexual Assault Center in Seattle. "But I'm not persuaded that therapists commonly diagnose sexual abuse with checklists or engage in a wholesale tendency to talk people into recalling childhood abuse."

In a way, symptom checklists that draw on a grab bag of miseries and distress run parallel to a trend noted in much research on the aftereffects of sexual abuse. Corroboration of adult reports proves difficult, but many researchers assert that the frequency of childhood sexual abuse rises significantly in conjunction with many psychological problems, including borderline personality disorder (marked by volatile relationships, moods, and self-image), multiple personality disorder, substance abuse by women, eating disorders, and somatoform disorders (such as pseudoseizures, pelvic pain, and gastrointestinal disturbances with no known physical cause).

Some investigators further argue that severe, repeated sexual assaults often produce post-traumatic stress disorder (PTSD), a cluster of symptoms including persistent sadness, feelings of unreality, social isolation, and either amnesia for or constant reliving of traumatic events.

Yet no consensus exists regarding how childhood sexual abuse might induce bulimia in one person, multiple personalities in another, and cocaine addiction in a third. In fact, considerable debate centers on whether sexual abuse by itself, or as a relatively small part of much broader family upheaval, incites the slew of psychological troubles observed by researchers, mainly in studies of women.

It is a controversy that currently envelops the mental health professions, encompassing the highly publicized issue of whether some adults harbor repressed memories of child abuse that suddenly step out of the shadows if nudged by an inspirational book or a concerned therapist (SN: 9/18/93, p.184). But at its core, the dispute hinges on how best to conceptualize the still poorly understood legacy of child abuse in adults' lives.

A report issued this month by the National Research Council in Washington, D.C., concludes that "we do not yet understand the consequences on children of particular types or multiple forms of abuse." Researchers have yet to clearly distinguish the effects of child maltreatment from those of poverty, drug abuse, and other social problems, according to the 16-member panel of child-abuse researchers and clinicians.

The effects of various types of mistreatment – sexual abuse, physical abuse, neglect, and emotional abuse – at specific ages and points in development remain largely unexplored, the panelists contend in their report. Few studies have addressed possible differences between boys and girls in their responses to child abuse, they note.

No evidence exists for a characteristic psychological response or "survivor syndrome" in sexually abused children, according to a review of the most rigorous studies on this issue published in the past decade. Three psychologists – Kathleen A. Kendall-Tackett of Wellesley (Mass.) College and Linda Meyer Williams and David Finkelhor, both of the University of New Hampshire in Durham – conducted the review.

"Because the effects of abuse can manifest themselves in so many ways, symptoms cannot be easily used, without other evidence, to confirm the presence of sexual abuse," they conclude in the January PSYCHOLOGICAL BULLETIN.

The three researchers compiled data from 45 studies that examined a total of nearly 3,000 sex-abuse victims ranging in age from 2 to 18. Half the studies included comparison groups of nonabused children.

Slightly more than half of the victims displayed PTSD in the first 12 to 18 months after police or other authorities documented their abuse; the percentage of children with any other symptom

usually fell between 20 and 30 percent.

For preschool-age survivors of abuse, the most common symptoms consisted of anxiety, nightmares, PTSD, fearfulness, aggression, and inappropriate sexual behavior. According to the researchers, inappropriate sexual behavior includes seductiveness, requests for sexual stimulation from adults, and public masturbation.

School-age children most often displayed fearfulness, aggression, nightmares, school problems, hyperactivity, and regression to behaviors typical of much younger children. For adolescents, the most common symptoms included depression, withdrawal, suicidal or self-injurious behavior, physical complaints, delinquency, running away, and drug abuse.

Approximately one-third of all victims had no symptoms, a finding that the psychologists cannot easily explain. The studies may have failed to measure some effects of abuse; apparently healthy survivors may have suppressed their symptoms and may develop serious problems as they get older; or symptom-free youngsters may have suffered the mildest abuse and received more support or treatment to bolster their resilience.

A new study, published in the April JOURNAL OF CONSULTING AND CLINICAL PSYCHOLOGY, indicates that many of the psychological problems observed among women who were sexually abused as children stem from their profoundly disturbed family lives rather than from isolated instances of abuse.

Michael R. Nash, a psychologist at the University of Tennessee in Knoxville, and his colleagues studied 56 women who had been sexually abused before age 17 by an adult and 49 nonabused women. Each participant completed a questionnaire on her family environment, several tests measuring susceptibility to hypnosis and the related trance-like state known as dissociation, and two assessments of anxiety, depression, and other symptoms of psychological distress.

Adult psychological problems appeared about as often among abuse survivors as they did among nonabused controls, Nash's team reports. About half of each group attended regular psychotherapy sessions. But women who reported both abuse and a highly disturbed family life while growing up exhibited the most pronounced symptoms of psychological distress, the researchers maintain.

Sexually abused women showed no predisposition for hypnosis, they add. Many clinicians have asserted that sexually traumatized children often retreat to altered states of consciousness (a process known as dissociation) and later prove more susceptible to hypnosis.

In contrast, another study described in the same issue of the journal suggests that sexual abuse carried out by a parent or older sibling may indeed cause adult PTSD, physical complaints, sexual problems, and other symptoms of trauma, regardless of overall family problems. Trauma reactions occur much less often if more distant family members or strangers commit the abuse, the researchers assert. The study was conducted by John Briere of the University of Southern California School of Medicine in Los Angeles and Diana M. Elliott of Harbor-University of California, Los Angeles, Medical Center.

A disturbed or chaotic family life may heighten the impact of childhood sexual abuse, but conversely, sexual abuse may produce or worsen family conflict, Briere and Elliott maintain.

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They base their argument on a study of 2,964 women holding professional jobs. More than 700 of these women reported having experienced childhood sexual abuse either within or outside their immediate families. Participants completed a questionnaire inquiring about 40 current trauma symptoms.

Some agreement exists between these findings and those of Nash. In the Tennessee study, early sexual abuse by itself rendered women more vulnerable to perceiving themselves or their bodies as "fundamentally damaged and painfully inadequate," regardless of other family problems. A deeply ingrained "disturbance of the self," often heralded by complaints of pelvic pain and other physical symptoms, may haunt many women with a history of sexual abuse, Nash and his co-workers suggest.

Frank W. Putnam, a psychiatrist at the National Institute of Mental Health in Bethesda, Md., makes a similar point. He theorizes that young incest victims suffer setbacks in their attempts to regulate emotions, impulses, and other aspects of the "self" as they grow up. In addition, sexual abuse by a parent destroys the trust needed for nurturing healthy relationships during adulthood, he maintains.

A fragmented sense of self and mistrust of others underlie the many mental disorders noted among incest victims, Putnam holds. For instance, multiple personality patients feel as if they inhabit separate selves, often act impulsively and self-destructively, and cannot form stable relationships; drug abusers report entering a separate drug or alcohol identity, undergo extreme mood shifts, and maintain a suspicious, withdrawn stance toward others; and bulimic women report distorted body images, binge-eat and purge, and avoid sexual relations.

Yet some investigators see no clear connection between childhood sexual abuse and these mental disorders.

At the American Psychiatric Association's annual meeting in May, James I. Hudson, a psychiatrist at McLean Hospital in Belmont, Mass., argued that the overall frequency of childhood sexual abuse among bulimic women participating in 12 recent studies conducted by different research teams reaches about the same level as that estimated for the general population.

Moreover, a study presented at the same meeting by Joel Yager, a psychiatrist at the University of California, Los Angeles, found that childhood physical and psychological abuse — but not sexual abuse — typified bulimic and formerly bulimic women (SN: 6/5/93, p.366). Unrelenting psychological assaults within the family, rather than incest, may undermine self-image and contribute to bulimia, Yager contends.

Lenore C. Terr, a psychiatrist at the University of California, San Francisco, takes another approach to the aftermath of childhood sexual abuse and other traumas. She distinguishes the effects of unanticipated, single shocks, which she calls "type I trauma," from the effects of repeated, severe trauma, or "type II."

Children who experience a single, terrible event — such as witnessing a murder — retain vivid memories of the incident, devote much energy to explaining why it happened and how the disaster could have been averted, and often report hallucinations or perceptual illusions related to the trauma. In contrast, type II trauma — such as repeated incest — produces amnesia for the events, denial of any past problems, emotional withdrawal, self-hypnosis, dissociation (such as feelings of physical numbness or

invisibility), and self-mutilation or other aggressive acts.

These two brands of psychological trauma in childhood can potentially lead to various adult mental disorders noted by researchers, Terr contends in the January 1991 AMERICAN JOURNAL OF PSYCHIATRY. She also describes four responses common to almost everyone exposed to extreme terror as a youngster: trauma-specific fears, such as avoidance of any sexual posture similar to that assumed during incest; visualizing or reexperiencing feelings associated with the trauma, often in response to reminders of the event; reenacting traumas in childhood play or through repeated behaviors; and a sense of having a severely limited future, often accompanied by distrust of others.

Researchers have yet to take a close look at these central symptoms of trauma in adult survivors of childhood sexual abuse, Terr notes.

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—Andrew Levin

In the meantime, debate over the advice about incest purveyed by self-help books contributes to a "terrible polarization" among mental health professionals regarding sexual abuse and its consequences, Carol Tavris asserts.

Consider two responses to her criticism of symptom checklists for potential incest survivors.

Although self-help books often contain "errors, exaggerations, and just plain sloppy thinking," they bring crucial help to people who feel isolated and ashamed, contends psychiatrist Judith Lewis Herman of Harvard Medical School in Boston, who specializes in treating trauma victims.

"Most survivors complain far too little, not too much," Herman holds. "False complaints are rare indeed. Most survivors unfairly blame themselves, not others."

Yet Andrew Levin, a psychiatrist at Holliswood Hospital in New York City and director of a treatment center for incest survivors, says Tavris takes an "evenhanded approach." Many genuine cases of child sexual abuse indeed exist, he asserts; survivors (who in his experience usually have attempted suicide, committed self-mutilation, abused drugs, entered abusive relationships, had frequent nightmares, or exhibited multiple personalities) often improve when they explore their history of abuse.

"We are also familiar with [nonabused] patients who desperately hope to discover survivorship, a quest inspired by the incest-survivor juggernaut," Levin argues.

To further complicate matters, surviving a childhood trauma of any type may make some people more open to "the facile formulations of the self-help literature and its followers," he contends.

Perhaps the bitter division over this issue will spark what John Briere calls "the second wave" of abuse research. Briere hopes such work will feature sophisticated, longitudinal projects that address the causes and ultimate impacts of sexual abuse. If investigators fulfill this vision, the debate over the legacy of childhood sexual abuse may take some fascinating new turns. ❑