

## **SEXUAL ABUSE AND PHYSICAL SYMPTOMS**

**By: Morella Yopez-Millon**

Sexual violence is one of the more devastating forms of violence practiced in every society and culture with women and children as the recurrent victims. Sexual abuse is so poisonous because it is perpetrated against vulnerable individuals who can not protect themselves resulting in painful life lasting effects. Sexual abuse is a form of oppression based in societal inequities that reflects the expression of a power imbalance in which someone powerful, and capable of producing physical harm or death imposes him/herself upon a defenseless individual. There are different types of sexual abuse i.e., date rape, partner abuse, assault by a stranger, sexual harassment, childhood sexual abuse, gang rape, warfare, etc. Statistics from the Montreal Health Press (1997) show that 80 % of the time the abuse happens at the hands of a person who was known and trusted by the victim. This is usually the case of childhood sexual abuse.

Furthermore, it is well accepted that childhood sexual abuse commonly occurs in the presence of other types of child maltreatment (Briere, 1992). Sexual abuse is also a situation in which disconnection from others, captivity, threats of being harmed or the harming of significant others is perceived as a constant risk (Herman, 1992). This further isolates victims, severing already tenuous bonds and relationships. Healing from sexual abuse frequently means going through feelings of overwhelming loss, grief, abandonment, neglect, anger, and an intense sense of badness which are all sequels of the mistreatment or abuse.

### **Prevalence of Sexual Abuse**

The statistics on sexual abuse are quite high with the constant of sexual and other types of abuse usually being underreported (Breire, 1992; Jacob & DeNardis, 1998). As much as 98% of sexual abuse is underreported (Russell, 1986, as cited by Jacob & DeNardis, 1999).

- Psychiatric samples usually reveal higher rates of sexual abuse survivors. Six studies of female inpatients or outpatients report sexual abuse rates where between 36% and 51% (Breire, 1992).
- In Ontario, 12.8% of females and 4.3% of males in the general population report being sexually abused during childhood (MacMillan et al., 1997).
- Finkelhor (1994, as cited by Jacob & DeNardis, 1998) found that at least 20% of American women reported being sexually abused as children.
- Finkelhor's previous review also notes that 90% of abuse is perpetrated by men, 70% to 90% of the perpetrators are known to the child, and 33% to 50% of girl victims are assaulted by family members.
- Retrospective surveys of adults suggest that 16% to 27% of girls and 15% of boys are abused, usually by family members, by their 18<sup>th</sup> birthdays (Finkelhor et al., 1990, as cited by Jacob & DeNardis, 1998).
- Over 900 women, chosen by random sampling techniques were interviewed in depth about their experiences of sexual exploitation. One woman in four had been raped (Russell, 1980, as cited by Herman, 1992).

In Canada statistics from "Women's Safety Project" (1993) show the following

highlights:

### **Childhood sexual abuse**

Briere (1992) defines childhood sexual abuse as a sexual contact that ranges from fondling to intercourse between a child in mid-adolescent or younger and a person at least five years older. "Sexual abuse may be intrusive and violent, as opposed to the harmless affair sometimes assumed" (p. 4). In a clinical example of 133 women with sexual abuse histories 77% had been penetrated orally, anally, or vaginally, and 56% had also been abused physically. Ritual

victimization was reported by 17% of the same sample (Briere, 1992). Here we have some statistics regarding sexual abuse:

- 54% of women had experienced some form of unwanted or intrusive sexual experience before reaching the age of 16
- 24% of cases of sexual abuse were at the level of forced or attempted forced sexual intercourse
- 17% of women reported at least one experience of incest before age 16
- 34% of women had been sexually abused by a non-relative before age 16
- 96% of perpetrators of childhood sexual abuse were men

### **Sexual abuse of women**

- 51% of women have been victims of rape or attempted rape
- 40% of women reported at least one experience of rape
- Using the Canadian Criminal Code definition of sexual assault (this includes sexual touching): **two out of three women** have experienced what is legally recognized to sexual assault
- 81% of sexual abuse cases at the level of rape or attempted rape reported by women were perpetrated by men **who were known to the women**

These figures show that frequently sexual abuse cannot be separated from other types of abuse, mainly physical abuse. Both forms of abuse and the feelings and emotions that accompany them are pervasive and endemic problems of many patriarchal societies due to its transferal of abuse as victims or perpetrators to upcoming generations. Another sad statistic that links together different types of abuse is that “the adult survivor is at great risk of repeated victimization in adult life. The data on this point is compelling, at least with respect to women. The risk of rape, sexual harassment, or battering, though high for women is approximately doubled for survivors of childhood sexual abuse” (Herman, 1997, p. 111).

## **Sexual Abuse, Trauma, and Stress Response: Post Traumatic Stress Disorder PTSD**

Traumatic reactions occur when neither defense nor escape is possible and the system of defense becomes useless and disorganized (Herman, 1997). This is the “Flight or Fight” response in which no action is opposed to the threat. Therefore, psychological trauma is caused when the individual is rendered helpless by overwhelming force that inspires terror. The individual is left experiencing intense fear, helplessness, loss of control, and dread of being seriously harmed or killed.

Following Breire (1992) the result of a traumatic event is called posttraumatic stress which, according to DSM-III-R, requires:

- An aversive event severe enough that it would evoke similar disturbance in almost anyone
- The event is frequently re-experienced through flashbacks, intrusive thoughts, and nightmares. Traumatic memories are frequently experienced as body experiences as these memories “lack verbal narrative and context; rather they are encoded in the form of vivid sensations and images (Herman, 1997, p. 38).
- The individual presents numbing of a general responsiveness. This is a constriction of the field of consciousness in which experiences can be perceived as detached states of consciousness. These constrictive symptoms “apply not only to thought, memory, and states of consciousness but also to the entire field of purpose and initiative” (Herman, 1997, p. 46).
- There are persistent symptoms of arousal such as sleep disturbance, heightened startled response, and poor concentration. There is also reactivity to events that resemble or symbolize the traumatic event.

Post Traumatic Stress has been lately scientifically validated by recent research which clearly exposes the lasting alterations in the endocrine, autonomic, and central nervous systems (van der Kolk, 1996, as cited by Herman, 1997).

PSTD accounts for reactions such as the ones mentioned in SACL brochure:

- fear, terror and anxiety
- confusion
- feeling frozen or numb
- overwhelming grief, unable to stop crying
- unable to believe it happened
- depression, despair, suicidal thoughts
- rage
- guilt and self blame
- shame
- inability to sleep, nightmares, night terrors
- reliving the assault or flashbacks
- inability to eat or keep food down
- hyper alertness, nor feeling safe to relax
- embarrassment
- feeling disempowered
- feeling of isolation and alienation, even from family and close friends
- overwhelming feelings of loss
- erratic mood swings

Sadly childhood sexual abuse occurs mainly over a period of time in which repeated trauma has been a way of life for sexual abuse survivors. It is known that the presence of trauma is not only precipitated by a major traumatic event. Trauma is not only considered in the presence of a gross traumatic event such as physical and sexual abuse. Trauma is also the presence of 'minor' but continuous, repetitive emotional injury related to an unresponsive environment that does not acknowledge a child's emotional cues (Briere, 1992; Grodin, Groot, and Spivak, 1998).

Therefore, repetitive subtle trauma specifically related to attunement and responsiveness to the emotional and developmental needs of the child can shatter normal processes such as cognition, memory, identity formation, and affect integration (Grodin, Groot, and Spivak, 1998). This notion of trauma provides an idea of the seriousness of repetitive injuries that can be vastly made up by a composition of intrusive, traumatizing, overwhelming events that did not consider the vulnerability level, defenseless position, or developmental stage of a victim. This is the panorama for the formation of dissociation as a defensive mechanism. It is also important to mention that the starting point of sexual abuse necessarily increases the deepening and harmful effects of the wound taxing seriously possibilities for recovery. The experience of repetitive trauma is contemplated in the complex version of PTSD (Herman, 1997).

### **Trauma and Dissociation**

The concept of dissociation was initially defined by Janet (1889, as cited by Herman, 1997) as an essential part of hysteria. Hysterics “had lost their capacity to integrate the memory of overwhelming life events” (p. 34). Newer versions of the concept defined it as a psychological mechanism that deflects information from distressing, intense, disturbing reality, which is not integrated into consciousness. The divergent information is related to the experience of trauma and presents itself in complicated alterations of consciousness in which “information –incoming, stored, or outgoing- is deflected from integration with its usual or expected associations” (Rodin, et al., 1998, p. 161). We all use dissociation, however, it is the predominant use of this psychological mechanism what makes it pathological. The recurrent or massive disruption of the usual process of integration affects not only mental processes such as consciousness, memory, affect, identity, but also planning, purpose, and initiative (Rodin, et al., 1998; Herman, 1997). Different authors accept that affect integration has been considered the hallmark of dissociative pathology.

Nevertheless, the protective action resulting from dissociation, as a way of escaping unbearable stimuli, has been lately reconsidered. “This respite from terror is purchased at far too high a price” as “people who reported having dissociative symptoms were also quite likely to develop persistent somatic symptoms for which no physical cause could be found. They also engaged in self-destructive attacks on their own bodies” (Herman, 1997, p. 239). The transformation of dissociated emotional pain and suffering in physical symptoms is what is called *somatization*.

There are obvious similarities between the concepts of dissociation and repression. The latter being a less acute version on a continuum of awareness ranges in which dissociation is the strongest defensive measure to deal with extreme distress (Vermetten, Bremner, Spiegel, 1998).

### **Trauma and Somatization**

Psychodynamic approaches have been instrumental in the understanding of these complex concepts. As previously mentioned *somatization* is the tendency to experience oneself and express distress in physical terms, bodily preoccupation, and illness related worries (Rodin, et al., 1998). It reflects a disturbance in the sense of self in the way that affect integration is not achieved. Psychological aspects of an experience are deflected and stored out of conscious awareness to be reflected in somatic terms. Freud referred to the term *conversion* to explain links between defensive operations and subsequent development of somatic symptoms while presenting the connection between trauma, dissociation, and somatization (Rodin, et al., 1998). As mentioned above trauma is not only a gross impact that destroys safety, trust, and meaning in a victim. Trauma is also repetitive, subtle, traumatic experiences that may be the result of compound abusive experiences. Furthermore, “ somatization, like dissociation, may reflect a failure to develop the capacity to integrate emotion into the ongoing flow of subjective experience” (p. 162). This happens as a result of parental inability to modulate and elaborate emotional experience to facilitate its integration into conscious awareness. Somatization is found

in the so-called somatoform disorders, in anorexia nervosa and bulimia nervosa, in factitious disorders in which illness is simulated or induced, and in other major psychiatric disorders such as depression and schizophrenia.

### **Somatoform Disorders**

Somatoform disorders “are characterized by physical complains lacking known medical basis or demonstrable physical findings in the presence of psychological factors judged to be etiologic or important in the initiation, exacerbation, or maintenance of the disturbance” (Stoudemire, 1994, as cited by Bashford, 1998, p. 278). Usually this condition is associated with impairment in social, occupational, or other areas of functioning (American Psychiatric Association, 1994). Somatization disorder is related to chronic, severe, conditions with symptoms occurring over years, beginning before 30, and involving multiple organs and symptoms (Rodin et al., 1998). Pribor et al. (1993, as cited by Rodin et al., 1998) “found that 90% of women with somatization disorder reported a history of emotional, physical, or sexual abuse and 80% reported some type of sexual abuse” (p. 164). Saxe et al., (1994, as cited by Rodin et al., 1998) found that in psychiatric inpatients there was a correlation between somatization disorder and dissociative disorder, and that the degree of dissociation correlated with the degree of somatization. Following Bashford (1998) this condition is encountered in most medical fields. Some examples are,

- neurology: paresthesias, dyskinesias, hysterical seizures
- otorhinolaryngology: swallowing difficulties or aphonia
- ophthalmology: tunnel vision

Survivors of child sexual abuse usually appear with a staggering list of symptoms and their general levels of distress are higher than those of other patients (Herman, 1997).

## **Chronic pain syndrome**

As previously mentioned, traumatic experiences have been related to PTSD, which has been shown to have relevance to clients who are injured in a traumatic manner and also related to chronic pain patients (Geisser, Roth, Bachman, & Eckert, 1997, as cited by Robinson & Riley III, 1999). Furthermore, women account for the majority of chronic pain patients. This gender imbalance means that women face greater risk of chronic pain and possibly that they use health care services more often (Morris, 1999). This assertion seems logical as physical symptoms are more readily perceived, socially accepted, and treated through the medical system that is more easily available and sanctioned in most modern societies than other therapeutic methods.

There are asymmetries between men and women in the experience of pain. For example, kappa-opioids work twice as well in women as in men. And 15% to 18% of women suffer from the effects of migraines compared to 6% of males. However, biological differences do not completely account for these types of asymmetries (Morris, 1999). Unruh (1996, as cited by Morris, 1999) concluded in a major review that “women are more likely than men to experience a variety of recurrent pains, to report more severe levels of pain, more frequent pain, and pain of longer duration. The presentation of pain in a health care setting, the study contends, “is affected in multiple and complex ways by ‘gender differences in the construction of meaning” (p.126).

Following Block (1999) there is a high correlation between chronic pain syndrome and physical and sexual abuse recognizing abandonment and abuse as widespread scourges of modern society. Linton (1997, as cited by Block, 1999) also found scientific evidence that suggested that experiences of physical and sexual abuse may predispose individuals, especially women, towards chronic pain. This study surveyed nonpatients, as well as chronic pain patients, about their history of physical and sexual abuse. For nonpatient women reporting no pain, physical abuse was reported as 2% and frequency of sexual abuse was 23%. The nonpatient women reporting pain had an 8% of physical abuse with a 46% frequency of sexual abuse. The

female chronic pain patients had a 35% of sexual abuse history. This study showed that the likelihood of developing chronic pain was increased fivefold by physical abuse and fourfold by sexual abuse. “Among men, there appeared to be little association of abuse with pain” (Block, 1999, p. 397). The same author informs that sexual and physical abuse has become a risk factor for the spine surgery candidate. Schofferman et al. (1992, as cited by Block, 1999) found an 85% failure rate from spine surgery among patients with a strong history of childhood sexual abuse and abandonment, compared with 5% of failure among patients lacking such history.

We can not forget that meaning is intrinsic to human pain which implies continuous processes of nonconscious and conscious interpretation (Morris, 1999). This is a controversial point since pain has been understood as a physiological mechanism whose main goal was to warn us from danger; and understood as lacking meaning (Tallis, 1991, as cited by Morris, 1999). Recent research challenges the belief that pain is the result of merely neural response, presenting consistent evidence that emotion, perception, and meaning are a significant part of the experience of pain, as shown through the placebo effect. Numerous recent studies explore cognitive and emotional influences on pain suggesting that paying attention to meaning and beliefs can have therapeutic benefits for helping individuals (Morris, 1999). Therefore, recent research in pain implies the need for additional therapeutic support that can help client to discover meaning and beliefs engrained in their physical dysfunction.

### **Chronic pelvic pain (CPP)**

It has been noted that women with a history of sexual abuse may be overrepresented in the population of women with CPP; this may also be true of women with a history of physical abuse (Jacob & DeNardis, 1998). This correlation has been implied from studies as follow:

- In a study of 36 women with CPP it was found that 53% reported a history of sexual or physical abuse during childhood (11%), adulthood (17%), or both (25%) (Toomey et al., 1993, as cited by Jacob & DeNardis, 1999).

- 25 women with CPP were compared with 30 women needing laparoscopy for other reasons. They found that 64% of the women with CPP experienced sexual abuse by age 14 years and 48% experienced sexual abuse after age of 14 (Walker et al., 1988, as cited by Jacob & DeNardis, 1999).
- A study of 106 women with CPP with no identifiable organic cause found that 48% reported a history of “major psychosexual trauma” (Reiter et al., 1990, as cited by Jacob & DeNardis, 1999).

There is also relevant to know that

- In 1960 researchers studied 40 women with CPP and postulated that these women were unable to fulfill their female roles without conflict (homemaking, relating affectionately to a husband, performing sexually, menstrually, and gestationally); and that only repression and denial allowed them to enter into marriage. When those defenses failed, pelvic pain was thought to develop (Gidro-Frank et al., 1960, as cited by Jacob & DeNardis, 1998).

These studies have emphasized the unconscious but symbolic nature of the pain arguing that physical pain was an unconscious expression of psychic pain resulting from the abuse. In this manner CPP has a function which is to remove a woman from traditional female tasks and responsibilities (Jacob & DeNardis, 1998).

### **Sexual Abuse and Other Psychiatric Symptoms**

Following Herman (1997) survivors of childhood sexual abuse are often misdiagnosed and mistreated in mental health systems. This occurs because of the number and complexity of their symptoms accumulating “many different diagnosis before the underlying problem of a complex post traumatic syndrome is recognized” (p.123). Three particular diagnoses pejoratively viewed are frequently applied to survivors of childhood abuse: Somatization disorder, borderline personality disorder, and multiple personality disorder. These conditions have many common

features clustering and overlapping with each other. Some of the shared symptoms are major depression, panic disorder, agoraphobia, numerous physical concerns, substance abuse, self-injury, gastrointestinal disturbances, headaches, and hysterical conversion symptoms (Herman, 1997). It is out of the scope of this paper to study the particular characteristics of psychiatric conditions related to sexual abuse. However, it is important to mention that due to survivors' particular difficulties with close relationships they are particularly prone to revictimization in their interaction with caregivers, where medical or mental health systems reenact situations already lived within the abusive family (Herman, 1997).

As already mentioned sexual abuse survivors will approach medical health care services due to their physical, mental, and psychological symptoms. The complexity of their symptoms go far beyond the initial physician-related health service easily available in the Canadian system. More specialized assistance such as psychiatric services are neither readily available nor necessarily suited to meet these clients needs as it is based in a medical model that has an imminent focus on medication providing no real connection for the survivor. This type of service is needed; yet, not enough for clients with such as enormous needs. These needs are possibly increased by clients financial restrictions, as they might not be consistently integrated in job related activities. Cuts everywhere in Social Services do not make things easier for this type of clients. Physicians whose medical knowledge is incremented by an understanding of childhood abuse and its effects, may provide better services by referring clients to survivors based, feminist counselling services in which connection, understanding, and meaning making can finally start to happen.

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