

Child Victims of Sexual Abuse

Development and Symptomatology

As we consider the child who is being sexually abused, we must look first at what is normal sexual development throughout childhood and then at how sexual abuse affects children of different ages.

HEALTHY SEXUAL DEVELOPMENT _____

The healthy sexual development of children differs based on a variety of variables, including societal expectations and the culture in which a child is raised. For example, several generations ago, children were not expected to be sexually active as early as they are today. But exposure to sexually explicit information through the media and other factors has increased the knowledge of youth today at earlier ages. In addition, some cultures expect that young children should be shielded from sexual information until later in childhood or adolescence. Still other cultures expose their young people to sexual relations and birth as normal parts of life.

Recently, a number of organizations in collaboration produced the *National Sexuality Education Standards* (Future of Sex Education Initiative, 2012) that outlined what these organizations believe are the current needs of children in grades K–12 for sexuality education. From this document, as well as other contemporary sources, it is possible to put together a very generalized picture of the sexual development of children (see Table 4.1).

These assumptions about children's sexual development give us some perspective as we continue the discussion of how children are impacted at specific ages by being sexually abused. But again this must be tempered by the recognition of an individual child's life construct and culture.

AGE AND THE IMPACT ON DEVELOPMENT _____

Age as a Factor in Symptomology

The age of the child at the onset of the abuse will have a significant effect on his or her symptomology. A common myth is that very young children, especially those who are preverbal, will not be as affected by the abuse. In fact, this is not the case. The difference is that children who are abused before they are verbal may not have the words to explain what has happened to them. However, memories are often

Table 4.1 Healthy Sexual Development

Age	Phase or Task
Birth to 1 year	<ul style="list-style-type: none"> Primary center of stimulation is mouth Becoming aware of body Touching genitals just as another part of body Touching mother's breasts, especially when nursing May have erections or vaginal lubrication
1–4 years	<ul style="list-style-type: none"> Touching or rubbing genitals may feel soothing (beginning masturbation) Early recognition of gender differences Curious about bodies Showing genitals to others is common Removing clothes and wanting to be naked Attempting to view others when dressing or naked Asking questions about bodies and bodily functions Talking about poop and pee especially with peers
4–6 years	<ul style="list-style-type: none"> Purposefully touching genitals, masturbating, sometimes in front of others Attempting to see others (especially adults) naked or using the bathroom Very curious about bodies Imitating dating behaviors as seen (e.g., holding hands, kissing) Talking about genitals and sexual actions as "dirty" (no comprehension of meaning) "Playing doctor" (sexual play) or exploring sexual parts with same-age peers Might ask questions about reproduction ("Where did I come from?") Learning words related to sex and using them, not always appropriately Mimicking adult sexual behaviors if seen on TV or in person
6–9 years	<ul style="list-style-type: none"> Developing definite ideas about male and female roles Gender identity becoming more clear Beginning to understand sexual orientation Developing strong friendships with children of same gender May masturbate May continue sexual play or exploration with others Beginning to be modest about nudity and bathroom time May begin to use sexual terms to insult peers Talking about sexuality with friends, comparing notes on what they have heard
9–12 years	<ul style="list-style-type: none"> Masturbation may continue but in private and secretly Playing games with peers that involve sexual behaviors (e.g., boyfriend–girlfriend, truth or dare) May experiment with dating behaviors (e.g., kissing, petting, masturbating to orgasm) Having romantic feelings toward same and/or opposite sex Attempting to see others naked or dressing Attempting to view or listen to media, books, and so on with sexual content Very interested in details of reproduction and sexual behaviors and seek information Expressing concerns about being normal socially or sexually Having strong sexual feelings

Age	Phase or Task
	May be beginning puberty (more likely for girls) Developing secondary sexual characteristics (e.g., pubic hair, enlargement of breasts) and feeling embarrassed about these changes
13–18 years	Experiencing bodily changes of puberty Emotional responses to growth and hormones Exploring and developing independence Having increased sexual feelings Wanting physical closeness with chosen peers, “falling in love” Sexual and romantic fantasies Developing preference for romantic relationships over friendships May face peer pressure to be sexually active May become sexually active Facing decisions about contraception May be exposed to violence in relationships (e.g., date rape, sexual harassment)

held in the psyche and are manifested through nonverbal behaviors.



Misty does not remember much of her early childhood. She remembers little of her mother who committed suicide when Misty was 3. Nor does she remember that her father’s alcoholism became so problematic that he was no longer able to care for his children. When Misty was 5 and her brother Gray was 12, they were removed from the home and placed in a foster home by children’s protective services. Misty did well in her new home initially, but for Gray, the adjustment was more difficult. He was frequently in trouble and after 18 months, Gray was placed in residential treatment after he molested another foster child in the home. Misty missed her brother whom she saw as her protector. She began having nightmares about his being taken away. In her nightmares, she frequently felt that she could not breathe. Soon this feeling punctuated her daytime hours as well. The child gasped for breath and had difficulty being calmed. A medical evaluation uncovered no organic cause. It was Gray’s therapist who finally was able to shed light on

the changes in this little girl who had become fearful and sickly almost overnight. In therapy, Gray disclosed memories of watching his father sexual molest infant Misty.

“He’d put his [penis] in her mouth and get her to suck on it,” the boy told his therapist. “I tried to stop it, but he’d beat me and shut me out of the room.”



It seemed while big brother Gray had been near Misty, safely holding the memory of her abuse in his own consciousness, she was free of symptoms. Once he was no longer there, the symptoms emerged behaviorally as she had no words with which to remember. It is not uncommon for such traumatic memories to be repressed and be manifested in behaviors (Fredrickson, 1992; Johnson, 2010). Children who have verbal skills at the onset of the abuse may have the tools to discuss it at some point. However, children of any age may repress the fact that they have been abused and the feelings around the abuse.

Beyond the usual inability of preverbal children to express their trauma in words, it is difficult to attach specific symptoms to abuse at certain ages. When abuse begins at a particularly young age, there are certain factors that must be

considered. The less control the child perceives that he or she has, the greater the trauma that may occur. If force is used, the trauma can be intensified. If the abuse began when the child is young and is not discovered until the child is older, the opportunity for multiple incidents over time and even for multiple perpetrators is greater (Finkelhor, 1984; Herman & Hirschman, 2000; Whetsell-Mitchell, 1995).

Developmental Considerations

Child development is influenced not only by the genetic makeup of the child but also by environmental influences, both positive and negative. Development can be broken down into three categories: physical, cognitive, and social or emotional. In addition, there is a moral component to development that can be affected by sexual abuse. And when related to sexual abuse, theorists often look at sexual development to help them recognize symptomatic behavior that falls outside the normal range. In turn, each developmental stage can be impacted by sexual abuse.

The onset of sexual abuse will vary. Most clinical studies found children who were sexually abused to be between the ages of 7 and 12 (Ferrara, 2002; Finkelhor, 1984; Scannapieco & Connell-Carrick, 2005). However, some experts suggest that younger children are more at risk because of their inability to report the abuse or their failure to recognize the touch as abusive (Hewitt, 1999). It is useful to think of sexual abuse within a developmental context and how the child may be impacted if he or she is abused during each developmental stage.

Infancy and Toddlerhood

In infancy, healthy development is dependent upon an environment that fosters this development. The child must be sufficiently stimulated,

nurtured, fed, and protected. In abusive homes, parents are sometimes unable to provide such environment. For example,



Henry was born to a teen whose family had responded to her pregnancy by telling her to “find another place to live.” At 15, Annette had few friends and no place to go. Living in one shelter after another, Annette spent her evenings in bars where she met Jerome, a 34-year-old man who agreed to let the obviously pregnant girl move in with him. Jerome was an alcoholic who had lost his own wife and family years earlier. He was on disability and assured Annette that he would help with the baby. But soon after Henry’s birth he demanded that Annette keep house while he spent all his time with the baby. This resulted in numerous fights, some of which became physical. During these, Henry’s cries often went unheeded. In addition, Jerome’s attention to the baby included fondling his genitals. Thus, when his cries were attended to, the baby was often soothed by sexual abuse.

Sometimes the fights between Annette and Jerome sent him out on a drinking binge and the mother and baby were left alone in an uncomfortable relationship that met the needs of neither. Annette was ill equipped and unwilling to care for a baby while Henry, who had never fully bonded with her, met her inept attempts with frustrated cries which further alienated her from him. This neglect, interspersed with Jerome’s returns and sexual abuse, continued until children’s protective services learned of the situation and intervened.



The result of this early environment for Henry was that he was slow to reach any of the typical developmental milestones—rolling over, sitting up, crawling, developing a differentiated cry—which are the tasks of the first year of life.

Children who are sexually abused during infancy or during the toddler years may fail to master the physical tasks of the stage. For example,

crying is the first mode of communication that the infant uses with his or her world. Infants develop a different cry for each need that they have. If you have ever been in the presence of a mother or father who is in tune with her or his infant, you may have heard her or him respond to a cry by “Oh, he’s hungry” or “She’s just tired.” When the connection with the outside world is distressing or unfulfilling to an infant, that differentiated cry may not develop as in Henry’s case. Some abused infants become passive, having learned that those in their environment will not meet their needs. The far end of the continuum of passivity is nonorganic failure to thrive, when an infant turns inward, often refusing to eat to the point that he or she might actually die.

Abused infants also fail to develop the motor skills appropriate for their age. Eating difficulties, hyperactivity, anxiety, frequent crying, and head banging may also be manifestations of some type of distress or disturbance and could be associated with sexual abuse (Berk, 2012; Scannapieco & Connell-Carrick, 2005; Woody, 2003). The brain is also impacted by traumatic events such as sexual abuse. Memories of the abuse may alter the child’s perception of his or her environment and therefore the way in which he or she interacts with it (Hilarski, 2008a; Perry, 2003; Scannapieco & Connell-Carrick, 2005).

Scannapieco and Connell-Carrick (2005) suggest that very young infants may not suffer effects from sexual abuse. However, as stated earlier, some may be traumatized but not have access to the verbal memory of this trauma. Perry (2003) postulates that

the earlier in life, the less “specific” and more pervasive the resulting problems appear to be. For example, when traumatized as an adult, there is a specific increase in sympathetic nervous system reactivity when exposed to cues associated with the traumatic event. With young children, following traumatic stress, there appears to be a generalized increase in autonomic nervous system reactivity in addition to the cue-specific reactivity. Due to the sequential and functionally interdependent nature of development, traumatic

disruption of the organization and functioning of neural system can result in a cascade of related disrupted development and dysfunction. (p. 1)

This may account for disturbances in the motor and language development in young children as well as behaviors (e.g., hypervigilance), which requires the child’s energy and may prohibit him or her from the natural exploration necessary to develop in a healthy manner (Berk, 2012; Gaskill & Perry, 2012; Hilarski, 2008a; Perry, 2003, 2009; Johnson, 2010). The way in which information about the abuse is encoded also means that later retrieval will tend to be based on nonverbal behaviors rather than verbal skills.

Infants and toddlers who are sexually abused may associate genital touch with that abuse, inhibiting normal developmental processes such as normal masturbation (Perry, 2003). The child may also not develop trust in the caretaker’s ability to nurture and keep him or her safe. Earlier in this chapter, we discussed the impact of the failure to bond with and therefore to trust the caretaker, disrupted attachment, and its effect on the child’s later life.

There is increased emphasis in the field of child maltreatment on the assessment of not only the risk for and the effects of child abuse but also the *protective factors* that reduce the risk of the abuse or at least the trauma resulting from it. For sexually abused infants, the most significant protective factor would be to have a healthy relationship with one of the parents.



Eugene was determined that he would be a better father than his father had been to him. When Michael was born, it was in the middle of tax season and as an accountant, Eugene had little time to spend at home. His wife, Georgia, had always been a moody person subject to changeable behavior and moods. He also knew that she was very insecure and hoped that a child would help her to feel more needed.

Once tax season was over, Eugene was home more. He encouraged Georgia to get out more. But she was so attached to the baby that she resisted. She didn't want him to care for the baby either and that really upset him. It was the fodder for many a fight. Baby Michael was not a secure child. He cried a great deal, and Eugene worried about him. He asked Georgia if she took him for his regular doctor visits which she insisted that she had.

The more Eugene tried to involve himself with the baby, the more Georgia pushed him away. She even closed the door on him when she changed Michael on the changing table in the bathroom. One day, Eugene came home from work early and pushed open the partially closed door, about to insist that he be the one to change the baby. What he saw was his wife fondling their infant son and putting his small penis in her mouth. Horrified, he grabbed the baby and left the house with him. At his mother's house, Eugene discovered that the baby's genitals were red and his anus showed signs of having been torn. Michael shrank from his touch when his father or grandmother tried to put ointment on him. Distressed, Eugene called the pediatrician who, after examining the baby, reported the situation to child protection. An investigation uncovered that the unstable mother had been abusing her baby almost since the time of his birth.



The intervention and later the nurturing of baby Michael by his father gave Michael the chance for a healthier life after his mother's abuse. Other protective factors might include the child's own temperament or a social or cultural support system for the family (Fontes, 2008; Fontes & Plummer, 2012; Scannapieco & Connell-Carrick, 2005).

Preschool-Age Children

During the preschool years (3 to 6) children are expanding their language and understanding of their world. They are often engaging with peers

and developing socially. They are also beginning to understand issues of gender and the beginnings of sexuality.

Most well-nurtured children at this age have a fairly optimistic opinion of themselves believing that they can "win" in most situations (Scannapieco & Connell-Carrick, 2005). In addition, they have developed a rudimentary understanding of how the body works and may have an inkling that boys and girls are different. Abused children may not feel as good about themselves. But perhaps the most obvious sign that preschool children are being sexually abused is precocious sexual knowledge. These children may be aware of sexual practices that are far beyond their developmental age. Some children simulate behavior that they have seen such as "humping." Their play with other children may become sexualized, mimicking what they have experienced. These children might also become preoccupied with sexual behaviors, masturbate to excess, and appear overly seductive. A note of explanation is necessary here. The years between 3 and 6 are a time when some children, especially females, can appear to some as especially coquettish. But if this behavior is looked at for what it is, the beginning of the children's recognition of their gender and what that means, the usual conclusion is that it is not seductive. Sexually abused children, on the other hand, have learned that sexual behavior is a way to relate to others, especially adults. Therefore, their behavior takes on a recognizably seductive tone.

Young children who have been abused may manifest their stress in other ways as well. Anxiety, nightmares, hyperactivity, depressions, excessive guilt, aggressions, tantrums, and difficulty separating from caretakers can be other indicators of abuse at this age.

Physically and sexually abused children may have genital tears (from insertion of a penis, an object, or fingers); may bleed from the genital area; have difficulty moving, walking, or sitting; wet the bed (enuresis); or

soil themselves (encopresis). Genital itching, pain, or odor may be indicative of some type of infection or even venereal disease (Faller, 2003; Ferrara, 2002; Hewitt, 1999; Sgroi, 1982; Johnson, 2010). Children of preschool age and school age may also somatize their anxiety through developing headaches, stomachaches, and asthma.

Sexually abused children may also not relate to their peers in a comfortable manner. In addition to the antisocial or sexual behaviors that they might exhibit, they may also isolate themselves feeling somehow that forming relationships with others will uncover the secret of their abuse. Abused children have internalized a sense of shame and badness that makes them hesitant to engage in interactions with others (Berliner, 2011; Scannapieco & Connell-Carrick, 2005).

There are also similar protective factors that impact the child between 3 and 6 years such as the child's temperament, the presence of one or more nurturing caretakers, secure attachment, and cultural or environmental support systems. In addition, the preschool child can be somewhat protected from additional trauma from sexual abuse if he or she has had a positive experience in nurturing prior to this age (Scannapieco & Connell-Carrick, 2005).

School-Aged Children

Children between the ages of 7 and 11 years are involved in school life and the acquisition of new cognitive as well as physical and social skills. This is a time when children who are not abused will think little of sexuality and will devote their time toward learning and making new friends. The failure to accomplish these tasks or difficulty doing so may be the first clue to an interruption in development that may have sexual abuse at its core.

When sexually abused children reach school age, their distress over being abused is often seen in school-related activities. Poor school performance or conversely obsession with "getting things right" may exist along with poor peer

relations. Learning difficulties are often how such children come to the attention of school personnel. They may have difficulty with concentration and fail to attend to what is being taught. Low self-esteem and self-degradation enhance this already-negative picture. And children trying to cope will often exhibit regression or immaturity. Or children may act out through exhibiting conduct disorders: lying or stealing (Berliner, 2011; Crosson-Tower, 2002; Scannapieco & Connell-Carrick, 2005).

The symptoms relating to sexual disturbance mentioned earlier may also be present, such as precocious sexual knowledge, sexualized behaviors or preoccupation, excessive masturbation, genital exposure, and seductive behavior. Children who exhibit these symptoms may have begun to act out sexually against others (Erooga & Masson, 2006; Faller, 2003; Lundrigan, 2001).

In addition, this age group may also experience the genital distress at being abused complete with the enuresis, encopresis, and risk of infection or venereal disease. This is also an age when fears, nightmares, obsessions, undue anxiety, and phobias are most likely to be seen (Silva, 2004). These may lead to tics, or children may turn inward or outward in hostility, anger, and rage. Suicidality may also be observed. The guilt and shame that they feel at their own perceived culpability is often an underlying cause (Sgroi, 1982; Silva, 2004).

In addition to the protective factors mentioned for earlier age groups, these children may develop a peer group to whom they might go for support. They might also develop social networks through which they might get help. They are more mobile and have access to more community supports even though all children might not feel able to use them. And again, healthy development in the previous stages will be important as a factor in minimizing trauma.

Adolescence

Adolescence is a bridge between childhood and adulthood with a myriad of resulting tasks. As a

period of transition and transformation, it represents a time when it may be somewhat difficult to discern if some behaviors are the result of sexual trauma or are peculiar to the adolescent's attempts to forge his or her way through this developmental stage. Developmental delays may have been present for some time but become more obvious when the adolescent is expected to begin to assume adult responsibilities. It may be difficult as well, in an age when sexual mores are diverse and often unclear, to determine if a sexually acting out teen is behaving in an age-appropriate manner or has been exposed to sexual abuse.

Adolescents who are being sexually abused often assume that they are transparent and that everyone knows their secret. They also reason that if people know, they are doing nothing to stop the abuse. The typical response for the sexually abused adolescent is to withdraw or act out in disillusionment, anger, and rage. Adolescents often become seductive, having learned that sexuality is one form of barter to get their needs met. This seductiveness may be acted out through promiscuity or other sexualized behaviors. It is difficult to determine in a highly sexualized culture like the United States how adolescents learn sexual behaviors. Sexually abused teens may have learned them through experience (Berliner, 2011; McGee & Holmes, 2012; Scannapieco & Connell-Carrick, 2005; Silva, 2004).

Sexually abused adolescents often act out their anxiety either passively through somatic complaints, eating disorders, or sleep problems or aggressively through delinquent acts, aggressive behaviors, running away, truancy, leaving school, early marriage, early pregnancy, or prostitution (Crosson-Tower, 2014; Scannapieco & Connell-Carrick, 2005; Sgroi, 1982). There is a high correlation between the incidence of self-mutilation and eating disorders with sexual abuse in adolescents. The purpose of self-mutilation—cutting, scratching, branding, and picking—is to reduce both the psychological and physiological pain (McGee & Holmes, 2012; Scannapieco & Connell-Carrick, 2005). Abused adolescents feel

helpless and out of control, and eating disorders give them a sense that they are controlling, to some small extent, what is being done to their bodies. Eating disorders either surround the teen with a protective layer of flesh (obesity) or are an attempt to purge the badness (bulimia). Not eating (anorexia) also exerts a form of control (though ironically the teen becomes out of control) and may be a wish to “fade away” and therefore not be available to be abused (Jaffa & McDermott, 2006; McGee & Holmes, 2012; Scannapieco & Connell-Carrick, 2005).

Protective factors for adolescents include those mentioned earlier, as well as an increased mobility and the ability to move within the community offer the possibility of more protective allies.

Attachment

Although mentioned earlier, attachment deserves a special section given the fact that it has become clear that the impact it has on abused children is significant. The role of attachment and how it is affected by sexual abuse has been widely studied especially in the last decade. *Bonding* refers to the initial connection between parent and child and begins at birth or even in utero. *Attachment* is a life-long process that an individual experiences, which is often based upon the initial bonding experience (Hewitt, 1999). Caretakers who are dependable, nurturing, and responsive and meet the child's needs in a prompt and caring manner help the child to develop a *secure attachment* style that prepares that child for healthy relationships built on trust, positive belief systems, and the ability to become independent and to cope with most situations (Anderson & Alexander, 2005; Bacon, 2001; Brisch, 2012; Hewitt, 1999; Levy & Orlans, 1998).

Children who are sexually abused may not have the parent-child relationships that foster secure attachment. If the abuse takes place in the home, dysfunctional family patterns have already

developed. The child's primary attachment figure may be the one who is sexually inappropriate. Or the correlation between domestic violence and sexual abuse suggests that a mother might be fearful for her own safety and not fully emotionally available for her child. Other family issues or the fact that a parent is sexually abusive and perhaps attempting to hide the fact creates an atmosphere that may not allow the child to develop secure attachment.

There are three other patterns of attachment in addition to secure attachment: anxious resistant attachment, anxious avoidant attachment, and disorganized or disoriented attachment. *Anxious resistant attachment* develops when caretakers are not consistent in their relationship with the child, not meeting the child's needs, not able to adequately soothe the child who is in need of calming, and perhaps even stimulating him or her. Although these children continue to seek comfort from their caretaker, they do not see her or him as a secure base. Somewhat paradoxically they may also cling to that caretaker in the fervent of hope of their needs finally being met. They may exaggerate their style of demanding, appearing fussy, difficult, or demanding, which may further alienate the caretaker. These children appear insecure and hesitant to explore the world around them. Later in childhood, these children will appear babyish, be angry, and see themselves as unworthy of the attention of others. Thus, they may seek attention in a variety of needy and sometimes irritating ways (Anderson & Alexander, 2005; Bacon, 2001; Brisch, 2012; Hewitt, 1999; Levy & Orlans, 1998).



Malcolm was the third child born to Tasha and was fathered by her new boyfriend, Zak. While Zak was thrilled with the birth of a son, Tasha was not as sure. Her girls, products of a previous relationship, had been little trouble and at 8 and 10, she saw them as fairly self-sufficient. She did not want to be pregnant again but had done little to prevent it. Zak's enthusiasm about having a son did not curb

his staying out late after work, however. Alone during the day with baby Malcolm, Tasha found him cranky and annoying. It was easier to leave him in his crib or play pen. Sure he cried, but he got over it. When the girls and Zak got home, the baby got plenty of attention anyway. Then Tasha would pretend that she had tended to Malcolm all day. Since he was everybody's pet, anything less would not be tolerated. And when there were other people around to pick up some of the responsibilities, she figured that Malcolm wasn't that bad.

Malcolm was a clingy baby as he got into his toddler years. He cried a lot and was sometimes difficult to soothe. When the child was 2, Tasha discovered that Zak was having an affair. They fought, and Zak would leave for days at a time. At night, Tasha found that if she brought Malcolm into her bed, he would quiet down. She sometimes stroked him, fascinated at his small body. She was surprised that boys so young got erections and she started playing with his penis to see how it would respond. A few nights later, Zak would return and Malcolm would be left to cry in his own crib until the pattern of his parents' relationship repeated itself. Eventually, Zak left altogether and Tasha has a string of boyfriends in his place. When she was alone, she kept Malcolm in bed with her, evicting him only when there was another male to take his place.

Malcolm grew to be a moody child who clung to Tasha and isolated himself when she had no time for him. He frequently complained of a variety of ailments and was prone to severe temper tantrums. Tasha described him as a "tough kid who could be nice sometimes, but a real pain at others."



Some children exhibit *anxious avoidant attachment* when their parents are emotionally unavailable or rejecting when they seek contact. They blunt their negative emotions and avoid the parent during times of emotional distress. These children are not likely to protest when the caretaker leaves them, seeming indifferent and later relatively self-reliant. They often turn to

toys rather than people giving an impression of isolation, which may appear hostile or antisocial (Anderson & Alexander, 2005; Bacon, 2001; Brisch, 2012; Hewitt, 1999; Levy & Orlans, 1998).



Barbie was a quiet, serious child. Her mother, Irene, described her as being "little trouble." It was a good thing, Irene explained, as when Barbie was a baby, life was total chaos. Irene's husband was abusive, she explained tearfully.

"He used to beat me up at least once a week! I was afraid for Barbie but she just sat in a corner and never got in the way. But when I found out he was messing with her and my other girls too, that was it. He was gone!" Irene talked about how she had always worked two jobs to make ends meet and thought that it might have been Barbie who got the worst of it between witnessing the abuse and Irene's emotional and physical unavailability.

Barbie had little affect. In fact, although Irene spoke of her fondly, the child seemed to have little attachment to her mother. During the interview, 7-year-old Barbie sat quietly in the floor apparently intent upon whatever toy she had brought with her. Once she fell and hit her chin on the table. There were no tears despite the bleeding cut that resulted. Barbie found tissue to put on it and went stoically back to her isolated play, quiet and eerily self-sufficient.



Disorganized or disoriented attachment occurs when there have been more blatant interruptions in parent-child relationships. When parents are physically abusive or overtly or indirectly threatening resulting from their own unresolved abuse or trauma, they may not enable their children to attach properly (Hewitt, 1999).

Levy and Orlans (1998) explain that

disorganized infant attachment is transmitted intergenerationally: Parents raised in violent, frightening, and maltreating families transmit their fear and unresolved losses to their children through insensitive or abusive care, depression,

and lack of love and affection. The infant is placed in an unresolvable paradox: Closeness to the parent both increases the infant's fear and, simultaneously, need for soothing contact. (p. 62)

When children exhibit a disorganized or disoriented attachment style, they lack the organization to respond consistently to their environment and demonstrate confused, unpredictable, and contradictory behaviors. For example, a child might reach for the parent in a demanding angry manner that appears to indicate attachment, but suddenly retreat or freeze. Or the child might be extremely fearful of the parent or display confused reactions when reunited with a parent.



Polly was a 2-year-old child who had been hospitalized with a broken leg. There was also some question of sexual abuse in the home. Her mother had taken out a restraining order against Polly's father, and the father was prohibited from hospital visitation. Polly spent her time rocking or banging her head in her hospital crib. When mother came to visit, she was at first anxious and reached out her arms for her. Then Polly would shrink away and move as best she could to one side of her crib. Her interactions with her mother seemed to be characterized by this push-pull behavior.



Not all sexually abused children demonstrate attachment disorders, but a significant number do. Because the ability to develop a positive and safe relationship is so much a part of healing for sexually abused children, the presence of a disrupted attachment style compounds the trauma. Each attachment style brings with it different types of behaviors.

The style of attachment that a child develops may also be influenced by culture. Northern European cultures demonstrate higher incidences of insecure avoidant attachment, whereas Asian cultures that attempt to minimize anxiety for their children produce fewer children with disrupted attachment patterns. Societies that stress

community and provide close relationship for children with multiple adults (e.g., Hispanic cultures) tend to produce more emotionally enmeshed relationship patterns (Bacon, 2001; Hewitt, 1999).

THE WORLD OF THE SEXUALLY ABUSED CHILD

It may be hard to imagine what it is like to live in the world of a child who is sexually abused. The ideal is for children to grow up in families where they are nurtured and protected from harm. This develops in them a sense that the world is benevolent and predictable and that they have some worth. According to researcher Ronnie Janoff-Bulman (1992), trauma develops when children are exposed to an environment that does not allow them to develop these important assumptions.



The most striking thing as I look back on my childhood is the unpredictability of our home. You never knew what would happen. There weren't any real rules—at least rules we knew about in advance. The rules seemed to emerge after we had been punished for something that we "knew we weren't supposed to do" according to our mother. My sister Dinah and I just tried to keep out of everyone's way. My father's temper was legendary. He never hit us, but he broke things a lot. We never knew when he'd be home, and I never knew when he would come into my room and start stroking me. He used to tell me that my mother "never gave him any lovin'" and it was up to me to do so. I never knew until we were adults and Dinah tried to commit suicide that he did the same to my sister.

Dinah and I weren't even sure what my mother did, but she would go out of the house for some reason each day—but not at predictable hours. The only thing we could count on was school when we went. Sometimes mother would keep us out to do chores until someone visited

from the school and we had to start going again. When I was 10 and Dinah was 8, my father just stopped coming home. I remember being kind of relieved. But then my mother started having her "gentlemen friends" come to the house. They were no gentlemen and more than one of them came into my room after they'd been drinking and my mother passed out. But I was used to it by then. They just wanted what Daddy had wanted. I knew all those rules.



Although not every home is as chaotic as Dinah and her sister's, the unpredictability is apparent. One woman remembered that during her childhood her father was the nurturer. When he came into her room and forcibly raped her one night, she was not sure that she had not imagined it. For many years, she denied that her loving father could have done this to her. Only in adulthood when she learned from her sister that the same thing had happened to her did this woman believe in her memories of childhood.

Symptoms and Indicators of Child Sexual Abuse

It is not uncommon for children to be sexually abused through several developmental stages. Therefore, it is important to become familiar with generalized symptoms associated with child sexual abuse.

Physical Indicators

The physical indicators of child sexual abuse may be more obvious than behavioral ones. Some of these symptoms might include (Adams, 2010; Berkoff et al., 2008; Berliner, 2011; Muram & Simmons, 2008; Saunders, 2012; Sgroi, 1982)

- bleeding, bruising, or tears around the anus or vagina;
- labial adhesions;
- hymenal perforation;

- difficulty walking or sitting;
- semen in the vagina or anus of a young child;
- injury to the penis or scrotum;
- vulvovaginitis or yeast infection;
- chronic urinary tract infections or painful urination;
- frequent urination;
- evidence of enuresis or encopresis;
- evidence of venereal disease symptoms (e.g., from syphilis, gonorrhea, trichomoniasis, chlamydia) such as vaginal or penile pain or discharge, genital or oral sores, genital warts;
- gonorrhea of the throat as a result of oral sex;
- presence of HIV/AIDS virus;
- evidence of excessive masturbation;
- pregnancy at a very early age;
- frequent psychosomatic illnesses; and
- symptoms associated with post-traumatic stress disorder (PTSD).

Although such symptoms should raise concern about sexual abuse, others could be attributed to other causes (Adams, 2010). For example, urinary tract infections and vaginitis may be caused by bubble bath, antibiotics, or other factors upsetting the natural balance of the body. Excessive masturbation may be indicative of other types of anxiety. Likewise, bruising of the scrotum, labia, or rectum might be contracted through injury. The HIV virus can be transmitted through contact with other bodily fluids or in utero. However, without clear knowledge of the cause, sexual abuse should not be ruled out when the aforementioned symptoms are present.

Behavioral Indicators

Children may respond to being sexually abused in a variety of ways: some obvious as to their origin and others that might be attributed to a variety of causes. The following are a few such indicators:

- Exceptionally secretive
- Demonstrating sexual knowledge that is beyond the child years

- Preoccupation with sexual talk or body parts
- In-depth sexual play with peers that appears to go beyond mutual exploration
- Sexually acting out against other children or animals
- Sexually explicit drawings
- Appearing much older and more seductive than appropriate
- An inordinate fear of males (or females)
- A sudden drop in school grades or sudden desire not to participate in peer-related activities
- Sudden phobic behavior
- Gagging or difficulty breathing with no apparent organic reason
- Crying without provocation
- Regressive behavior
- Sleep disturbances including nightmares
- Eating problems or disorders
- Depression
- General social withdrawal
- Feeling damaged
- Fear of being alone
- Cruelty to animals (especially those that would normally be pets)
- Setting fires and enjoying watching them burn
- Self-mutilation (cutting, scratching, burning self)
- Obsessive-compulsive behavior
- Desire to or act of running away excessively
- Substance abuse
- Suicidal ideation or attempts

Many of these indicators are obviously connected with abuse, but others may not seem as obvious. Sexual acting out against other children, adults, or animals may be the victim's attempt to put into perspective what has happened to him or her. It is also a way to gain control over what seemed like an out-of-control situation. There are victims and victimizers. The victim feels out of control, whereas the victimizer takes control.

Because sexual abuse is very much about control, other behaviors in victim symptomology that are about controlling are evident. For example, when children set fires they feel in control as they watch the adults around them strive to gain

control, often without success, of the fire. Eating disorders are about taking control, in a negative manner, of one's own body. As one teen victim put it, "If I did not eat and got really thin, maybe I would just disappear and he could not find me to sexually abuse me!"

Victims of sexual abuse feel intrinsically damaged. Sgroi (1982) uses the term *damaged-goods syndrome* to describe how victims perceive themselves. Suicide is the ultimate control of one's own destiny. It also feels to some victims like the only way to end what seems to them to be an inescapable situation.

Victims of sexual abuse may also demonstrate symptoms that might not seem related to what has happened to them unless the deeper psychological significance is understood. Obsessive-compulsive behavior may be another attempt to control the environment. Ten-year-old Renee could not control the fact that her stepfather was abusing her, but she took control of other aspects of her life. Rigid routine became her escape. Every toy and piece of clothing must be in a specific place in order for Renee to feel at all secure. These were parts of her life that she could predict. When her stepfather came to her room to molest her, his behavior was out of her control.

Some victims experience physiological responses to their abuse. Enuresis, or wetting the bed or one's pants, and encopresis, or soiling, are behaviors that may not be entirely voluntary. They are instead psychological reactions to being violated in those bodily areas. There may also be an unconscious recognition that to wet or soil may make one undesirable, and the wish is that the abuse would cease.

Some children and many more adult survivors complain of difficulty in breathing or swallowing. Difficulty breathing may be related to a body memory of having an adult on top of them when their small bodies feel crushed. This response becomes embedded in the sensual memory and may plague them for years to come. Gagging or difficulty swallowing is often related to being orally violated. The presence of an adult

penis in a child's mouth may make the child feel like he or she cannot swallow or must gag. This response too may continue after the penis has been removed.

Learning may be difficult for children who are being sexually abused. Trying to deal with the conflict of what is happening to them that they may not understand saps the psychic energy necessary to concentrate and conceptualize. Schoolwork may suffer, and grades may drop. On the other hand, there are children who use school and learning as an escape in order to cope with what they are experiencing. It is often even more difficult for teachers to recognize trauma when children excel at school. And yet, these children are often obsessive and are perfectionists, falling apart if they do not achieve.

The behavioral symptoms of child sexual abuse can also point to other types of problems as well, especially when emotional upset is at the root. It will be important for parents and helpers to screen out the possibility of sexual abuse before assuming that these behaviors are indicative of other disturbances.

EFFECTS OF CHILD SEXUAL ABUSE ON VICTIMS _____

Finkelhor and Browne (1985) postulate that the effects of child sexual abuse can be divided into four main categories: trust and betrayal, traumatic sexualization, stigmatization, and powerlessness.

Trust and Betrayal

Developing trust is the first task for a child. As early as infancy, children must learn to trust the predictability of their caretakers in order to develop in a healthy manner. Trust is the foundation on which children build the future of their relationships and their approach to the future. That trust is twofold. As children begin to trust caretakers and therefore their

environment, they in turn learn that they can trust themselves and their responses. When the trust of others is undermined, the betrayal for the child can feel profound. As a child begins to lose trust in the environment, trust in the self and in his or her own perceptions may also be shattered.



"I was alone a lot," Darren explained. "I thought that I was pretty self-sufficient. My Mom was an okay mom I guess, but she raised me and my brothers alone and had to work long hours. We'd spend a lot of time at the ball field. There was one coach I really liked. He spent a lot of time with me, and I began to feel like he was almost like a dad. And then one day he asked me to do some things to him—some sex stuff. I wasn't really into that, and I said 'no.' The next thing I know he had pinned me down and was raping me. I was crying, and I couldn't believe what was happening. I trusted him. Afterward, he told me that after all we'd meant to each other, letting him do me was the least I could do. I left the ball field that day, and I didn't want to go back. But I did, because it was the only place that I had to go. And he made me do it again—touch him and he'd touch me. After a while, I didn't even care. I began to hate him and yet want to spend time with him. I began to wonder who I could trust. Could I even trust myself?"



Victims become unsure of whom to trust, and this may carry into their adult life. In addition, they wonder about their own judgment in discerning who is worthy of trust. This creates an isolation and feeling of vulnerability that further intensifies their problems and makes them vulnerable for future victimization (Finkelhor & Browne, 1985; Russell, 1999; Sonkin, 1998). For racial minorities this sense of betrayal is often intensified when the system that they may look toward to help them further victimizes them through racially biased attitudes (Fontes & Plummer, 2012).

Traumatic Sexualization

The realm of adult sexuality is one that most children enter only when they become teens or adults. Sex is usually something one learns about gradually, in age-appropriate increments. But sexually abused children are thrust prematurely into a sexual world that they may not fully understand. Often the perpetrator equates sex with affection and rewards the child for sexualized behavior. The child learns to barter for such favors through using sexuality. The result is that the victims become confused between sex and affection and see sex as a tool to get their needs met. They may develop a distorted perception of sexual norms assuming that what they have been taught is normal. They often compensate through promiscuity or survive through prostitution.

In addition to being learned behavior, promiscuity is also a form of self-destructive repetition compulsion—something that victims do over and over in an attempt to make sense of it. The original pain of betrayal combined with bodily sexual pleasure makes them repeat the sexual act again and again for recognition or attention (Maltz, 2012).

Although survivors of child sexual abuse do not necessarily become professional prostitutes, they do often use sexuality as a way of getting their emotional needs met. It may not be surprising given this fact that an extremely high percentage of professional prostitutes were victims of sexual abuse in childhood. Some theorists suggest that both promiscuity and prostitution are a combination of anger, feelings of worthlessness and futility, and the mind-body split that allows sexual abuse victims to separate themselves from what is happening to their bodies (Courtois, 2010; Maltz, 2012; Russell, 1999).

Some victims of child sexual abuse develop an aversion to sex, and as adults, they seek out therapy for such issues as arousal dysfunction, desire dysfunction, or difficulty achieving orgasm (Courtois, 2010; Maltz, 2012). Still others grow

up confused about their sexuality or when adults choose partners of the same sex because they have learned in childhood that those of the opposite sex cannot be trusted (Courtois, 2010; Maltz, 2012; Sonkin, 1998).

Stigmatization

Children who are sexually abused feel that they have been damaged. In fact, society lets them know this at almost every turn. They are spoken about in hushed tones, and adults are unsure how to deal with children who have prematurely entered the world of adult sexuality. This sense of being different or damaged heightens the feelings of isolation inherent in being abused. They do not feel like their peers and may isolate themselves socially.



When we read the *Scarlet Letter* in high school English class, I began to identify with the character. That's what I felt like knowing that my Dad had abused me since I was 10. I felt like I had this big red letter on me, telling everyone what an evil, dirty person I was.



Children who have been sexually abused often believe that their bodies are evil, unclean, or distorted. Those who recognize what is being done to them become confused by the physiological pleasure that they feel. As a result, they may feel anger toward their bodies and punish them through eating disorders or self-mutilation. Some children somatize their conflicts through developing headaches, nausea, menstrual or vaginal problems, or even asthma (Maltz, 2012; Russell, 1999; Sgroi, 1982).

Powerlessness

Children recognize that they have no power, but children raised in healthy environments begin

to develop a sense of power over themselves and eventually their environment. But being sexually abused can rob children of this ability. Continued powerlessness becomes a major problem for victims of sexual abuse, and these feelings follow them into adulthood. This feeling of being powerless in almost any situation actually puts the victim at risk for future victimization.

These feelings of powerlessness may also have gender-specific variations in the way these feelings are manifested. Women have been socialized to accept powerlessness. Even though many women today strive to be in control of their lives, social messages that they have little power usually feel familiar. Men, on the other hand, are expected by society to have some power. Thus, when a boy grows up feeling powerless, the guilt over this powerlessness compounds his feelings of inadequacy. He may therefore withdraw, become a victim again, or have sexual adequacy issues. Some boys as they develop overcompensate by becoming overly aggressive, violent, or even abusive (Dorias, 2009; Hunter, 1990; Lew, 2004; Sonkin, 1998).

Once again, cultural identity plays a part in how a child is affected. The sense of powerlessness may become intensified for minority children who already struggle with feelings of being robbed of their power.



Krystal's family was the only African American family in their neighborhood. She was raised by her grandmother who cooked for one of the wealthier families. Her mother had died when she was an infant, and her father also worked for the family.

"I went to the neighborhood school, but there was no question about who I was," she explained. "I was the hired help's kid, and everyone let me know it. When an older white man who used to come to the house started abusing me, no one seemed to know what to do, so no one did anything. And I was so caught up with the way everyone saw me—a nobody who didn't dare criticize the

'white folks'—that I just figured that was the way things were. But the anger grew into rage at how powerless I felt."



Post-Traumatic Stress Disorder

PTSD is common in both children and adults who have been sexually abused. This condition is described in the *Diagnostic and Statistical Manual of Mental Disorders* as characteristics of individuals who have experienced extreme traumatic stressors through direct personal experience. PTSD has recognizable characteristics: problematic behaviors including fear or horror, feelings of helplessness, agitation, or general disorganized behavior. Often the individual reexperiences the trauma, suffering from flashbacks, anxiety, and a sense of increased arousal. Any people or situations that might remind one of the traumatic events are avoided. These symptoms persist over time and impede the individual's functioning (Briere, Kaltman, & Green, 2008; Courtois, 2010; Saunders, 2012; discussed more fully in Chapter 13).



Eight-year-old Edgar's school recommended that he be seen for evaluation. For the last several months, he had been exhibiting behavior that

concerned his teachers. When approached by the teaching aide, Edgar began crying uncontrollably and hid under a table. The teacher's aide, Joel, a very gentle but large man, at first tried to talk with him, but Edgar's behavior intensified. Once the aide left the room and Edgar could be coaxed out from under the table, he remained agitated and unable to return to his work. He whimpered softly, but if anyone approached him, Edgar would begin to cry again in earnest. Eventually, he was calmed, but when Joel returned to the classroom, Edgar began to cry once more. His teacher finally realized that the child's agitated behavior occurred only when Joel was in the classroom. Knowing that the aide had in no way harmed Edgar, the teacher asked the parents if there was another cause. His parents admitted that he had been having nightmares lately. It was finally discovered that while at a friend's house, Edgar had been raped by an older boy in the neighborhood—a large boy who resembled Joel.



The intensity of trying to push aside the memory of the rape and his inability to tell anyone what had happened had caused Edgar the intense emotional distress. Fortunately for this child, a competent therapist was able to gain his trust and eventually help Edgar to face the abuse and heal.

Summary

Child sexual abuse affects victims in a variety of ways. Developmentally, being abused during a particular stage puts the child at risk for symptoms related to the tasks of that developmental period. There may also be factors that serve to protect the child from experiencing these reactions (protective factors). One of the most significant risks for children who are abused at home is that there may be an interruption in their attachment to caretakers. Anxious resistant attachment, anxious avoidant attachment, and disorganized attachment can create problems for children in their later lives.

There are a variety of symptoms that are often indicative of childhood sexual abuse, although some of these may also denote other problems. These symptoms fall into the categories of physical indicators and behavioral indicators.

The effects of child sexual abuse are myriad. Finkehor and Brown (1985) suggest that these can be categorized into four main categories: betrayal, traumatic sexualization, stigmatization, and

powerlessness. Victims may also suffer from post-traumatic stress disorder. In addition, children may act out their trauma either behaviorally or sexually, or exhibit somatic symptoms. It will be important to rule out sexual abuse if these symptoms are observed.

Review Questions

1. What influence does age have in the study of child sexual abuse?
2. What impact does sexual abuse have on infants and toddlers?
3. What influence does sexual abuse have on school-age children?
4. What impact does sexual abuse have on teens?
5. What influence does the study of attachment have on understanding child sexual abuse?
6. What are some physical indicators of child sexual abuse?
7. What are some behavioral indicators of child sexual abuse?
8. What are the four main categories of the residual effects of child sexual abuse?
9. What is the meaning of the phrase post-traumatic stress disorder?