THE VICTIMS OF ABUSE

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In recent years a fuller understanding of the impact of childhood sexual abuse has begun to emerge, partly as a result of decades of sustained clinical and statistical research by psychologists, psychiatrists, sociologists and others who work with victims of abuse and survivors of abuse (Herman, 1992; Marshall et al. 1990; Pilkington and Lenaghan, 1998). These research findings have been enhanced by writings on the impact of abuse by those who have been victimized (Bass and Davis, 1988). Research and clinical experience highlights the fact that abuse can and does have both short-term and long-term damaging effects on those who have been victimized by it. At the same time, findings reveal the possibilities for surviving and coping with the damaging effects of abuse. This research also provides a fairly complex picture of patterns of abuse and of the factors which influence the impact of abuse and the possibilities for recovery.

Acknowledgement of the impact of abuse had been hampered in the earlier decades of the twentieth century by the blanket of secrecy and silence which surrounded abuse (Masson, 1984; Pilkington and Lenaghan, 1998). The use of phrases such as 'breaking the silence' and 'it couldn't happen' in early work on the topic are indicative of the difficulties that clinicians and researchers faced in attempting to bring the reality of abuse into the public domain, even in medical and scientific circles (Herman, 1992). The failure to acknowledge abuse in medical and scientific circles was partly related to the influence of psychoanalysis, which held for many years that children fantasized about sexual contact with parents, and which interpreted adult reports of childhood sexual abuse as fantasy (Masson, 1984). It became commonly accepted in medical circles that adult women fabricated memories of childhood sexual abuse, a view that has resurfaced in recent debates on 'False Memory Syndrome'. It should now be noted that it is argued that therapists have induced false memories of abuse in adults; while this may be possible, it should be noted here that the vast majority of victims of childhood sexual abuse do not 'forget' the experience of abuse, though they may have repressed certain aspects of it (Herman, 1992).

Debates about the reality of childhood sexual abuse continue (Marshall, et al. 1990). These debates centre primarily on whether sexual abuse of children, particularly by family members, actually occurs (occurrence), how frequently it occurs (prevalence), and whether it has a damaging effect (impact). In the past, the tendency was to deny that it occurred at all, or to argue that it was most infrequent and involved only pathological individuals (Sgroi, 1978).

Little attention was paid to the impact of abuse on victims, with the result that this was underestimated and misunderstood. The secrecy and silence surrounding abuse derives partly from the impact of psychoanalysis, but also from society's taboo. The exposure of abuse causes major disruptions in families, communities and institutions. Thus perpetrators are strongly motivated to conceal the crime.

Additionally, perpetrators often have exceptionally strong resources for concealment. First of all the adult perpetrator is in a position of considerable power *vis-à-vis* the child victim of abuse. In a family situation, this involves parental power or other forms of emotional power. The adult is able to intimidate the child with threats of physical assault and even death, damage to the child's mother or other members of the family, or the break up of the family. In an institutional context, threats of severe consequences, but most importantly, loss of security, abandonment and other emotional threats act as severe impediments to children taking action against the perpetrator of abuse.

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The general climate of secrecy and denial surrounding abuse makes it more difficult for family members and others to consider its possibility, to identify indicators that abuse is taking place, and to take action to verify its existence. Abuse, as Keenan (1999) points out, involves a web of relationships, all of which will be disrupted by revelations.

In a family setting fear of disruption of the family acts as a deterrent both to observers and to victims of abuse, who often prefer to remain silent even as adults rather than risk the disruption and possible rejection which are likely to follow disclosure. In institutional settings, disclosure by a victim may involve severe punishment or removal from the institution, and adults who report abuse also experience sanctions of various kinds.

Research on the prevalence of child sexual abuse relies on a number of methodologies ranging from crime surveys to health board statistics to clinical studies. Most of these studies have been carried out in North America and Britain, and there is considerable variation in the results, including variation by region. It is clear that there are more female than male victims of child sex abuse, with the ratio varying from 2:1 to 4:1 in community studies (Pilkington and Lenaghan, 1998). It is also clear that child sex abuse is more prevalent than is generally admitted, with Marshall et al. (1990) reporting that up to 25% of girls and up to 12% of boys may have been sexually molested in childhood, with a smaller percentage being subject to systematic sexual abuse over a period of time. Sexual abuse ranks as one of the most underreported crimes - it is estimated that less than 10% of cases reach the courts.

Obviously the term sexual abuse or sexual molestation may be used to refer to a variety of behaviours. The term sexual abuse is most often used to refer to penetrative sex or genital contact, while sexual molestation may be used to refer to non-genital sexual contact, exposure, arousal, harassment and other inappropriate sexual behaviours directed at children. Child sexual abuse often includes violence or the threat of violence, and in some instances extreme violence is used. Verbal abuse, blaming the victim and undermining the victim's self-esteem and perceptions are also part of abuse. Abuse is, as noted above, accompanied by threats regarding disclosure and also by rewards and other emotionally manipulative behaviours designed to ensure co-operation and prevent disclosure.

The majority of child sexual abuse occurs in the context of a relationship usually marked by power differentials; indeed there is general agreement that child sexual abuse "is above all a power-based phenomenon, involving the inappropriate use and expression of power in a sexualized form and manner" (Pilkington & Lenaghan, 1998, p. 185). The vast majority of child sexual abuse is perpetrated by men, with estimates of male perpetrators varying from 95% to 80% of offenders. A considerable amount of research in clinical and epidemiological settings indicates that perpetrators of abuse are almost always - in over 90% of cases - known to the victim. It is estimated that half of abusers are family members, with most of the remainder being in positions of power - teachers, religious and youth leaders - in relation to the victim. Many - up to one third - of abusers are adolescents, and the vast majority regard themselves as heterosexual (Marshall et al., 1990).

It is clear from this brief statistical survey that the sexual abuse of children is more common than is generally recognized. It is also clear that the social stereotype of the 'paedophile' as an isolated stranger is incorrect; child abusers are most likely to be found in families and communities, and to have an ongoing relationship with their victims.

While there has been little research on the prevalence and pattern of abuse in institutions, it is clear that under certain circumstances abuse may be more likely to occur in extremely hierarchical institutions, especially where there is a lack of acknowledgement of the occurrence of abuse and its damaging effects (Ferguson, 2000; Moane 2000; Raftery and O'Sullivan, 1999). Specific factors of sexual abuse in institutions include the likelihood that perpetrator-access to victims and the maintenance of secrecy may be facilitated - making detection less likely. For victims, the prospect of disclosing entails institution-specific threats to their future: authority, physical abuse and possible destitution outside the institution all lead to an experience of greater isolation.

While epidemiological studies have provided an overall picture of prevalence and patterns of abuse, insights into the impact of abuse are more likely to be based on clinical research. In discussing the impact of abuse, Keenan (1999) contrasts earlier views - which tended to blame children for

abuse, often seeing them as complying with, enjoying or even provoking abuse - with some contemporary views which regard victims of abuse as damaged for life. She argues that both views are incorrect, and calls for a more complex understanding of the impact of abuse.

The view that children benefit from abuse has been completely undermined by the absence of any evidence of positive effects, and indeed by the overwhelming evidence regarding the damage. On the other hand, as Keenan and others point out, it must also be acknowledged that not all victims of abuse suffer in the same way or experience similar damage (Bass and Davis, 1988; Herman, 1992; Keenan, 1999). It is generally accepted that the damage associated with abuse will be greater where there is a close relationship between the abuser and the victim, where there is more severe abuse, and where the abuse continues over a long period of time.

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There can be little doubt that for a child the experience of sexual abuse is intensely traumatic, with pain and terror being the most immediate reactions. Pain is obviously related to the physical trauma of many forms of abuse, while terror is associated both with fear of further pain and even of death and also with fears instilled by the threats used by the perpetrator to prevent detection. Fear involves activation of the autonomic nervous system, which as Herman (1992) and others point out, continues in a state of hyper-vigilance in situations of continuing abuse. This hyper-vigilance, the opposite of relaxation, may become a long-term chronic reaction on the part of the abused child, continuing into adulthood and resulting in psychological and physical problems such as hypertension (Green, 1993; Kendall-Tackett et al., 1993).

Abuse obviously involves profound disruption in any relationship of trust, and in the area of intimacy and connection with others. Herman (1992) argues that this disruption - the feeling of being connected with others - is a central feature of trauma, and it creates an inner tension between the need and the desire for closeness and connection with others, and the fear that such closeness will result in further abuse: 'Trauma impels people both to withdraw from close relationships and to seek them desperately. The profound disruption in basic trust, the common feelings of shame, guilt and inferiority, and the need to avoid reminders of the trauma that might be found in social life, all foster withdrawal from close relationships' (Herman, 1992, p. 56). In this passage Herman also highlights the emotional reactions to trauma, which include fear and terror as discussed above, but also guilt and shame.

These reactions are clearly understandable immediate reactions to the experience of abuse, and have been well documented in clinical studies and in

writings on abuse. The longer term implications of abuse are not as clearly understood, partly because there are considerable differences between individuals in their experiences of abuse, in their reactions to it, and in the supports they receive as they disclose it and learn to survive the impact (Herman, 1992; Pilkington and Lenaghan, 1998).

There is general agreement that the experience of abuse creates long-term inner tension and confusion which, before being alleviated, may require experiences of disclosure and acceptance. Herman (1992) writes that survivors are caught in tension between remembering and reliving the abuse - and with it the pain - on the one hand, and, on the other hand, setting these memories aside and keeping them out of consciousness. Another source of tension arises from the desire on the one hand to disclose the experiences of abuse, and the fear on the other hand of the blame and rejection that may follow such disclosure. A second area of difficulty is problems with intimate relationships and with sexuality, which are experienced by many survivors of abuse, though again these may be worked through in the context of loving and supportive relationships. A legacy of self-blame and therefore of low self-esteem is a third recurring long-term effect. Other emotional legacies include fear, anger, anxiety, isolation and depression. Many survivors of abuse may become dependent on alcohol or other drugs (Keenan, 1999; Pilkington and Lenaghan, 1998).

It is possible for victims to experience considerable healing, which is facilitated by acknowledgment of abuse and by close and supportive relationships.

It is important to acknowledge that while abuse may create severe difficulties for victims in the areas reviewed above, it is also the case that victims of abuse find many ways of surviving abuse, and many go on to live their lives with vitality and joy. Indeed, it is difficult to get a clear picture of the strategies which survivors of abuse develop outside of the clinical literature, which can provide only a limited view, as many survivors may never be seen by clinicians and therapists. Personal testimony and the literature produced by survivor groups all testify to the strength and courage of many, and to their success in coping with the difficulties created by their experience of childhood sexual abuse. It is also the case that victims can bear the burden of abuse throughout their lives, and suffer ongoing difficulties in relationships and in life generally.

The severity of these symptoms and the capacity to cope effectively with them depends on the experience of abuse as noted above. The long-term implications of child sexual abuse are also related to the reactions of those with whom the survivor has close relationships, and to the amount of love and support which the survivor receives (Herman, 1992; Keenan, 1999; Pilkington and Lenaghan, 1998). This is partly because disclosure of abuse is an important step in recovery. If this disclosure is met by rejection or

disbelief, such reactions may further exacerbate the impact of abuse by increasing the feelings of shame, isolation and fear. Close, supportive and trusting relationships are also of vital importance in surviving abuse because much of the damage is in the areas of self-esteem, intimacy, trust and sexuality, all of which can be profoundly influenced by the relationships which the survivor forms in adulthood. Herman (1992) makes the important point that surviving abuse is also related to the general social context in which the survivor lives. More specifically, in a context where there is denial of abuse or a tendency to blame the victim it is obviously harder to disclose and receive the required support. On the other hand where abuse is acknowledged and perpetrators are held responsible, there is greater likelihood of disclosure.

The phrase, 'healing journey', is often used in the context of abuse to highlight the way in which healing or recovery from abuse is a process which happens over time. This process may be distinctive to each individual - individuals will vary in their commitment and interest in engaging in a healing process, and in the opportunities and support they receive. It would seem from the available literature that while few individuals would regard themselves as undamaged by abuse, many have experienced a great deal of growth and development and see themselves as being on a healing journey. Bearing in mind the individual uniqueness, it may be possible to identify some common elements in the healing journey.

The creation of a safe environment is a prerequisite for recovery from abuse, as obviously any further experience of abuse can exacerbate the damaging effects. The need for the experiences of abuse and trauma to be spoken out and to be acknowledged is another commonly occurring theme in the writings of both survivors of abuse and of those who have worked with them (Bass and Davis, 1988; Herman, 1992). A third commonly recurring theme is that survival and recovery are difficult if an individual remains isolated. What is important is for the survivor to make connections with others who have been abused, and see herself or himself as part of a wider group (Herman, 1992).

These elements of recovery may be found in counselling and psychotherapy settings, and the role of counselling and psychotherapy in survival and recovery has been well documented, and also, it may be added, criticized (Bass and Davis, 1988; Fox and Prilleltensky, 1997). There are also many examples from community psychology and from liberation psychology of programmes for recovery, survival and empowerment among groups who have been victimized (Butler and Wintram, 1991; Prendiville, 1995; Rapaport, 1977; Serrano-Garcia and Bond, 1994). These include lone parents, lesbian and gay groups, those in recovery from addictions (AA) or suffering from mental health problems (e.g. AWARE). Other examples of programmes which may play a role in enhancing survival include assertiveness training and personal development, drama and creative writing,

and cultural and educational projects (Moane, 1999; 2000). Involvement in survivor groups or in the survivor movement more generally may offer an example of what Herman (1992) calls a 'survivor mission', where survivors feel they are playing a role, however small, in the prevention of abuse.

A review of the clinical and statistical literature on childhood sexual abuse emphasises not only the fact that sexual abuse of children is more prevalent than is generally recognized, but also dispels a number of myths - such as that abuse is perpetrated most often by strangers and that children are not damaged by abuse. On the contrary, the evidence shows with great consistency that abuse is most often perpetrated by someone known to the child who is being victimized, and that children are terrified, hurt and humiliated by the experience of abuse. There is general agreement that abuse involves damage in the areas of self-esteem, trust, intimacy and sexuality, and in other areas which are more specific to the experience of abuse and to each individual. The clinical literature and the writings of those who have survived abuse also indicate that it is possible for those who have been victims to experience considerable healing, which is facilitated by acknowledgement of abuse and by the experience of close and supportive relationships.

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