Indian J. Psychiat., 1992, 34(4), 388-391

PSYCHOTHERAPY AND CHILDHOOD SEXUAL ABUSE

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Childhood sexual abuse may have a significant impact on psychological well being in later life. In this report,we describe 5 women who had a variety of psychological symptoms that were related to childhood sexual trauma. These factors were explored during psychotherapy. Persistent feeling of depression, anxiety and problems in socio-sexual functioning, were prominent. Therapy varied from counselling and ventilation, to prolonged dynamically oriented therapy.

Restropective studies of the prevalence of sexual contact during childhood report prevalence rate of 6-62% in women. High rates of psychiatric morbidity have been reported in this population. Conversly, adults seeking treatment for various disorders report a high incidence of sexual abuse in childhood or adolescence (West, 1988). Childhood sexuality (real or fantasied) was an important source of symptoms and conflicts in adulthood, according to Freud. This view has been challenged forcefully recently, and it has been suggested that there was a wilful misrepresentation of facts to fit in with psychoanalytic theory (Masson, 1984). The use of dyanamic psychotherapy in this population has also been questioned (Masson, 1989). However, there is widespread agreement that some form of psychological support is important; and if delayed, is associated with greater distress (Stewart, 1987).

Sexual behaviour is quite often not discussed,even in psychiatric practice. There have not been any studies on the long term psychiatric sequelae of sexual abuse in childhood in our country. We have reported 5 cases who were seen as part of the psychotherapy training programme. This programme involves all postgraduate residents trainees and has been described earlier(Raghuram *et al.*, 1989). There was no specific report made to select these patients. The treating consultants felt that these individuals would benefit from therapy. Therapy was conducted by MV, VE and JR and supervised by SJ.

OBSERVATIONS

(Table on next page)

DISCUSSION

It is apparent that a wide variety of symptoms were present in this small group. The predominant symptoms were anxiety, depression and phobias, and personality disorder. High rates of these have been reported earlier (Duddle, 1991). It has also been reported that "casual sexual encounters" may be quite common in childhood and unreported.Three of these patients were adolescents, or young adults. They had significant difficulties in coming to terms with sexuality. Sexually provocative

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Table : CLINICAL DESCRIPTION OF THE CASES

		A	B	C	D	E
1.	Age	23	17	45	18	30
2.	Age at abuse	8-10	11	15	12	5
3.	Relation of abuser	Acquaintance, older male	Uncle	Uncle	Father's friend	Uncle
4.	Reaction of family	Pt. blamed for "inviting it", no overt sympathy	Ignored person continued to be a frqent visitor	Upset, forced to marry the person as a "cover-up", Pt's anger not considered.	Family unaware	Family covertly acquisced as person was supporting the family, abuse continued till adolescence
5.	Symptoms	Impulsive behaviour self harm, fantasies of violent sex, nicropsychotic episodes, romantic transference	Anxiety, avoids all contact with men, stopped going to college	Sad worrying, anhedonia, decreased libido	Poor academic performance, being aloof occ. provocative, rude to parents	Feeling sad, irritable, unable to concentrate, previous history of alcohol abuse, promiscuity, self harm.
6.	Duration	3-4 Years	2-3 years	2 years	2-3 years	Current symptoms 6 months Previous history 15 yrs.
7.	Diagnosis	Borderline pers. dis.	Anxiety Neurosis	Depressive Neurosis	Adol. Adj. Reaction	Depressive Neurosis

behaviour, including homosexuality were seen in A and C while B developed a phobic avoidance of all men. The other two were older woman, who, after several years still felt "guilty, sullied and resentful". An unusually large proportion of female patients taken up for psychotherapy at this hospital report previous history of sexual abuse. It may be under reported, or tacitly unacknowledged in our routine clinical work.

A significant factor that emerged in all the patients was a puritanical and cloistered family backgroud, and poor emotional support to the individual after the event. In two cases, families continued to be friendly to the person concerned without taking any explicit action; in one the patient was blamed for attracting attention; in another forced to marry the person, and the last tacitly made to yield, though she was labelled as "loose woman". There was significant effort made to "cover-up" the situation, and even a conscious playing down of the trauma and hurt experienced by the individuals. This may have had a significant effect of the symptoms. These issues were not handled in therapy, which was mainly individual oriented. It has been reported earlier that a significant number of victims experienced rejection by relatives and friends (Double, 1991). The psychoanalytic emphasis on the masochistic nature of female sexual behaviour was unfortunately fostered the concept of victim participation (Mezey, 1985). Social attitudes may further enforce this belief, as we see in this group.

Sexual abuse in childhood is tantamount to rape. Responses to rape are now considered asa post-traumatic stress disorder (Mezey and Taylor, 1988; Double, 1991). Chroncity of the rape trauma reaction is related, among other factors, to the age of victim, and support after the assault (Resik *et al.*, 1981).

Exposure to traumatizing sexual behaviour may thus have long lasting psychological sequelae. It is tempting to suggest that a specific attempt be made to look for evidence of this in women coming for psychiatric help. Some reports (Tsai *et al.*, 1979) do not find any pervasive differences between victims of childhood abuse and controls, except in socio sexual functioning. In a social context, where crisis intervention centre are nonexistent, and social support for victims questionable, psychological distress may be considerable. These 5 patients were amongst the 7 women patients seen by this group of trainees at random. It is obviously not a representative sample, but if it is the tip of an iceberg, it needs urgent attention.

ACKNOWLEDGEMENT

The authors are greatful to the member of the psychotherapy training group of the department of psychiatry, NIMHANS, for their support and discussions.

REFERENCES

Duddle, M. (1991). Emotional sequelae of sexual assault. Journal of Royal Society of Medicine. 84. 26-28.

Masson, J.M. (1984). Freud : The assault of Truth. London : Taber.

Mawson, J.M. (1989). Against psychotherapy. Harmondsworth: Penguin.

Mezey, G.C. (1985). Victimological and psychiatric aspects. British Journal of Hospital Medicine, 152-158.

Mezey, G.C. and Taylor, P.J. (1988). Psychological reactions of women who have been raped: a descriptive and comparative study. British Journal of Psychiatry, 152, 330-339.

Raghuram, R.; Girimaji, S.; Chatterji, S.; Jain, S.; Seshadri, S.; Shyamsunder, C.; Srinath, S.; Sriram, T.G. and Verghese, M. (1981). Client and therapy characteristics of a psychotherapy training programme. Presented at 39th Annual Conference, India Psychiatric Society, Chandigarh.

Resick, P.; Calhoun, K.; Atheson, B. and Ellis, E. (1981). Social Adjustment in Victims of sexual assault. Journal of Consulting and Clinical Psychology, 5, 705-712.

Stewart, B.D.; Hughes, C.; Frank, E.; Anderson, B.; Kendall, K. and West, D. (1987). The aftermath of rape. Profiles of immediate and delayed treatment seekers. Journal of Mental and Nervous Disease, 175, 90-94.

Tsai, M.; Feldman-Summers, S. and Edger, M. (1979). Childhood molestation : variables related to differential impacts on psychosexual functioning in adult women. American Journal of Abnormal Psychology, 88, 407-417.

West, D.J. (1988). Incest in childhood and adolescence : long term effects and therapy. British Journal of Hospital Medicine, 40, 352-260.