THE EFFECTS OF CHILDHOOD SEXUAL ABUSE ON FEMALE SEXUALITY : A MODEL OF INTERVENTION

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Literature supports the fact that childhood sexual abuse impacts negatively on many women's experiences of sexual contact. Victims of childhood sexual abuse often have associations, flashbacks and memories related to the specific aspects of the sexual abuse. This can be reflected in both psychological and physiological responses. Difficulties can range from psychological abhorrence or fear of any intimacy associated with sexual activity to physiological symptamology such as vaginismis and orgasmic disorders. These sexual difficulties can have a severe impact on the woman's ability to sustain long-term relationships. The intervention discussed throughout this paper combines sex therapy with the theory of trauma and includes assisting the couple to provide a safe environment in which the woman can explore a sexual experience which is trauma free.

Sexual difficulties among survivors of childhood sexual abuse has been largely ignored or is often treated as an issue that requires little intervention. Therapists who have addressed the issues of sexual difficulties among survivors of childhood sexual abuse rarely account for the unique dynamics of sexual abuse in their treatment. As more therapists grapple with the dynamics of childhood sexual abuse; and more women identify that sexual difficulties affect their ability to maintain a relationship, it has become obvious that providing interventions that address sexual abuse and the subsequent sexual difficulties, requires a comprehensive approach.

The impact of sexual abuse on sexual functioning began to be reported in the late 1970's. Courtois (1979) found that 80% of victims of childhood sexual assault surveyed reported sexual problems in adulthood. Further studies have been conducted by Bageley and Ramsay (1986), Becker et al. (1982) and Briere and Runtz (1987). These studies concluded that a relationship exists between childhood sexual abuse and adult female sexual problems. Several studies have identified a range of sexual problems. These include an inability to enjoy sex or relax during sex and a lack of interest in sex. (Coutis 1981, Watts 1991) McGuire and Wagner (1978) found women in their study experienced an avoidance of sex, an inability to initiate sex, difficulty in mutual masturbation and a feeling of revulsion about their sexuality. Further studies have identified women experiencing difficulties in reaching orgasm and experiencing vaginismus. The women in Shearer and Herberts (1985) study also reported trust was an issue. These women were either unable to trust men or were overly trusting in their relationship closeness in their relationship with men. Sawers and Durlarks' (1995) study found that 63% of the women in their study experienced sexual dysfunction. Their study concluded that sexual abuse is a predictor of sexual dysfunction and predisposes the individual to a greater likelihood of sexual problems. Sawer and Durlark (1995) extended their research findings by acknowledging particular elements of sexual abuse, such as sexual penetration were specifically related to adult sexual dysfunction and predicted the increased likelihood of sexual dysfunction. In Mullins et al (1994) study, they found that the victims of child sexual abuse expressed dissatisfaction with their sex life and were more likely to experience difficulties with their own sexuality than a control group, that consisted of women who had not been sexually abused. The victims of sexual abuse in this study reported a disruption of intimacy, which was related to their sexuality, and to the caring and emotional closeness in their relationship. Mullins et al (1994) also found that child sexual abuse impacted on a number of important strands in the development of the child. "It puts at risk the emerging sexual identity. It puts at risk the acquisition of a sense that the world is a reasonably safe and essentially benign environment. It puts at risk trust in others, particularly those on whom they are critically dependent. It puts at risk children's emerging sense of themselves as active agents with some control over their world; and finally, it puts at risk their developing self-esteem." (p.43). Mullins et al (1994) concludes their study by reporting that the women who continued to be affected by childhood sexual abuse nominated a fear and distrust of men and sexual problems as the most frequent long term sequelae of the abuse.

A review of the above studies highlights many similarities that exist in the relationship between sexual assault and sexual difficulties. The women in these studies have been described as having a diminished interest in sex and an avoidance of sexual encounters. On the other hand, they may also exhibit an adolescent history of sexually promiscuous behaviour that often led to poor sexual satisfaction within these brief relationships. The above studies support the view that there is a strong correlation between childhood sexual assault and sexual difficulties. An examination of the results of these studies has not necessarily led to more effective treatment approaches because the clinical picture is often extremely complex and the treatment protracted.

Our clinical experience in working with women who have been sexually abused in childhood supports the findings of these studies. We have also found that a majority of women who are reporting sexual difficulties experience a lack of sexual desire. It is our contention that a lack of sexual desire can be directly attributed to the effects of child sexual abuse. The area of inhibited sexual desire in victims of sexual abuse has been recognized by clinicians as well as by researchers. McCarthy (1995) stated that sexual dysfunction, especially inhibited desire can be directly linked to childhood sexual abuse.

Maltz and Holman (1987) state "the lack of sexual desire is a common complaint of incest survivors." (p.75) Sexual desire is an important precursor to the mechanics of sexual arousal, thus without sexual desire; any form of sexual contact can be problematic.

To address the difficult nature of sexual difficulties in survivors of childhood sexual abuse, a more comprehensive understanding of the effects and dynamics of the original abuse and its resulting impact on the survivor is needed to help develop a more relevant and appropriate treatment response.

In exploring the dynamics that existed within the relationship between the child and the person who sexually abused them, we have found that many of these dynamics often exist within the adult woman's' relationship with her partner. The dynamics that are often displayed within the abusive relationship are - the offender being either a member of the child's' immediate family or extended family; the sexual abuse having a seductive nature, ie. the child is groomed carefully and the sexual abuse is carried out seductively with some degree of caring or affection; and, the offender usually being a trusted person in the child's life.

Paralleling the abuse experience, the dynamics within the woman's current relationship, often lead her to believe her partner has taken on some of the characteristics of the offender. For example, a partner is a member of the woman's' immediate family; sex between people who love each can have a seductive nature about it; and, the male partner is someone who the woman is expected to trust. McGuire and Wagner (1978) support the parallel process between the childhood sexual abuse and the adult woman's sexual relationship."The woman is often unaware of the fact that she is responding to her current relationship in terms of the parental sexual milieu, … her perception of a sexual threat or approach in virtually all affectionate movements of her partner stemmed from a transferred fear of her father's approach. There can be a considerable lack of insight into the relation of the present dysfunction to past experiences." (p.13) Although our work supports this view, we have found that it is not necessarily only the parental milieu but also other significant trusted people in the child's life who have a similar impact. Anna Salter (1995) discusses the child internalizing the messages from the offender. These messages usually remain unconscious in the child's mind but the impact is felt when triggered by a situation that in some way replicates the abuse situation. An example of this would be the grooming process that is used by the offender could often be replicated by the sexual seduction in an adult relationship.

As mentioned throughout this paper, the repercussions of childhood sexual abuse can hinder the development and expression of sexuality in a couple relationship. It often surprises some survivors when they discover that despite their commitment to their partner, sexual intimacy becomes more difficult. The emotional closeness of a committed relationship can be frightening and uncomfortable as these women struggle to engage in sexual encounters. Sex becomes repulsive and their partners dangerous. In an effort to establish an environment in which the woman can be secure, safety needs to be established. This is an essential part of working with women who have been sexually abused as children who consequently experience sexual difficulties. Briere (1996) acknowledges the need for safety in the treatment of all survivors of childhood sexual abuse. Briere (1996) states, "most good therapy must acknowledge and honour the survivors competing needs to maintain safety and internal stability while at the same time be open to information and experience so that he or she may grow." (p.133) Maltz (1991) supports Briere's view, she states that victims of sexual abuse need to feel physically safe, in control and relaxed before they can begin to rebuild their sexual relationship. In our clinical experience, we have found that survivors of childhood sexual abuse often try to establish safety in their relationship by 'avoidance' – ie., they try to avoid all emotional and physical contact with their partner. By avoiding contact, the woman is also avoiding intimacy and this protects her from any likelihood of sexual contact. Maltz and Holman (1987) found that "often survivors and partners end up in an unfortunate cycle. For example, a female survivor begins to withdraw sexually because of unresolved trust issues and sexual problems from the child sexual abuse. Her male partner takes this as a personal rejection and stops expressing loving feelings; he may also become angry and sexually demanding. … The survivor then feels guilty and pressured. She interprets the reactions of the partner as proof that he is unresponsive to her emotional needs. The survivor pulls back emotionally and physically even further. The cycle continues with emotional and physical distance increasing." (p.89)

It is our experience that women avoid intimacy in various ways, including not going to bed until their partner is asleep, not being alone with their partner in case the subject of sex is brought up, wearing clothes to bed and sleeping on the couch or in another room. Women also become "too busy" to spend any time with their partners by doing excessive amounts of housework and by always finding an excuse to avoid their partners attempts at establishing some intimacy between them.

A further strategy in maintaining safety is the woman's use of hypervigilance. Briere (1996) talks about sexual assault survivors experiencing difficulties around sleep disturbance, difficulties in maintaining concentration, hyperalertness and irritability. "Such autonomic hyperarousal often presents cognitively as extreme alertness to the possibility of danger. This hypervigilance may, paradoxically, coexist with an inability to concentrate for extended periods, producing an individual who is constantly scanning the environment but who may have difficulty focusing her or his attention when needed."(P.13) Hypervigilance keeps these women safe in all areas of their lives, including their sexual lives. It allows the woman to pick up any nuance in her partner's behaviour that indicates his desire for sexual contact. In counselling sessions, women have reported their need to be aware of the signals their male partner's employ to indicate their desire for sexual contact. For example, one woman knew that when her husband brought home a video and chocolates, he was expecting sex that night. The woman would then cause an argument with her husband in order to create an emotional and physical distance between them. Another woman reported she knew that when her husband did the dishes at night, he was expecting sex. She would then spend all evening working on strategies to keep herself safe by avoiding the possibility of any sexual contact.

Clinical work with survivors of childhood sexual abuse, has led us to support Maltz's proposition of firstly establishing safety. This can be achieved by the couple agreeing that no sexual contact should occur for an agreed amount of time, unless the woman initiates the contact. Maltz (1991) describes this process as the woman "taking a healing vacation from sex." Maltz's (1991) concept of a 'vacation from sex' allows the woman to explore her sexuality in an environment that is free from sexual pressure. Talmadge and Wallace (1991) support the notion of relieving the pressure for sex. They state "the therapist works to back the pursuing partner off the reluctant one." (P.174)

Once safety has been established, the couple is able to explore and begin to work on the sexual difficulties. It may be that the beginning stage for the woman is to feel comfortable with her own body prior to any physical contact with her partner. This may include homework assignments such as having the woman massage herself, excluding her genitalia. In our clinical experience we have found that some women are so repulsed by their bodies that it may take several months for them to move from repulsion to acceptance. For example, one woman reported that she was so disgusted by even self-touch that she washed her body using a sponge. The idea of washing her body with her hands became a major focus of the therapeutic work. We have found that to include masturbation at this stage is far too confronting and can jeopardise the woman's progress.

Once the woman is more accepting of her body, she may move onto couple massage. Again, this process needs to be introduced carefully and the massage may include clothes being left on and then, perhaps without clothes. We may encourage the woman to familiarise herself with her partner's smell and physical appearance. This has the affect of differentiating her partner from the abuser. It is crucial to allow the woman to feel a sense of control over where her partner touches her and where she touches him. These assignments often allow the woman to test how safe her relationship is and how responsive her partner is to her needs. During this phase issues of trust and betrayal arise for the survivor of childhood sexual abuse. "Even though she may be in charge, it is difficult for her to believe her partner will acquiesce to the instructions and not violate the limits." Talmadge & Wallace (1991) (p.177) This process can be likened to what Briere (1996) calls 'systematic desensitization'. Briere (1996) discusses systematic desensitisation in the context of the person processing their traumatic memories. He describes it as " … careful gradual exposure to various aspects of the abuse memory." (p.129) Briere (1996) talks about starting with the least traumatic or painful memory and sequentially working through the rest of the memories. In support of Briere's (1996) concepts, we work in much the same way by having the woman complete assignments that sequentially become more difficult. By using systematic desensitization the woman is gradually increasing her tolerance of intimacy, building a trusting relationship with her partner and learning to be comfortable in initiating sex. This process directly contrasts with her childhood sexual abuse experience.

If safety within the relationship has been maintained through this process, a more challenging task can be presented to the couple. It is at this stage the woman must feel she is in complete control of the process. It has been our experience that if the woman does not feel that she is safe and in control then further progress is hindered. Depending on the couple's progress, it is at this point we would explore self masturbation and Masters and Johnsons' sensate focus treatment techniques. The use of any form of sensate focus assignments needs to be carefully introduced. McGuire and Wagner (1978) support this view. They suggest that "when introducing sensate focus, the pacing is of prime importance and should be initiated and controlled by the woman. This is a deviation from the typical sensate focus assignments

where both partners alternate the initiation of the sexual contact. By allowing the woman to set the pace of sexual contact, she is able to feel a sense of control and thus increase or decrease the pace according to her comfort level."(p.14) It is critical that the partner fully understands the dynamics of childhood sexual abuse that not only allows him to support the woman but also to feel a part of the process.

Throughout the process, the effects of past abuse can be triggered and subsequently need to be explored. The surfacing of the effects interferes with any further progress. The woman is often not aware of why she is feeling overwhelmed and careful exploration is needed to uncover these obstacles. For example, one young woman reported feeling a sense of revulsion whenever her husband became sexually aroused. The sense of revulsion was so severe it prevented her from continuing any further sexual contact. In exploration it became apparent that the young woman experienced a flashback which in turn caused a dissociative experience. She described a memory of being sexually abused by her father and her repulsion at her fathers heightening sexual arousal. The young woman was able to make the connection between her fathers' arousal and that of her husbands. "Dissociative experiences can occur. Dissociation in all of its forms served the incest survivor well as a coping mechanism for her survival. When flooded with overwhelming emotional or physical trauma, dissociation became an adaptive way for the child to deal with the experience." Talmadge & Wallace (1991) (p.179) The aim of therapy at this stage is to help the survivor to tolerate and move beyond these traumatic feelings. It may mean that for a time any further sex therapy may be halted until the traumatic memory can be explored. At times, the halting of progress is often frustrating for the couple and can feel as though the woman is regressing. This can cause conflict in the relationship and needs to be dealt with sensitively by the therapist and the couple.

The aim of working with survivors of childhood sexual abuse who experience sexual difficulties is to explore the notion of the couple reaching their sexual potential. Often the partner has an unrealistic view of sexual fulfilment and this can lead to frustration and blame. It is our experience that the woman often becomes the focus of the problem in the relationship and to avoid blaming and further victimisation, the partner needs to take responsibility for their own issues in the relationship. The couple may need to let go of fantasies and re-acquaint themselves with intimacy and acceptance of the progress they have achieved.

In working with women who have sexual difficulties as a result of sexual abuse as children, the process is often a long and torturous journey for the therapist, the woman and her partner. This process can be hindered by a woman's lack of sexual knowledge, her lack of understanding about the impact of sexual abuse on her current relationship and fear of her own sexuality. Often these women are resistant to change given that change can be the unknown and the unknown can represent fear, distrust and confusion. To intervene in this process, the therapist must have knowledge and experience working in the area of sex therapy as well as be well versed in trauma theory. Our model of intervention allows the dovetailing of traditional sex therapy with trauma work. The process of entwining these two models allows the woman to establish safety within her relationship and to regain control of her sexuality.

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