The impact of sexual abuse in childhood on the risk of suicidal and homicidal behavior in adulthood

Vaikystėje patirtos seksualinės prievartos pasekmės – suicidinio elgesio ir polinkio į žudymą rizika suaugus

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SUMMARY

Sexual abuse is lifetime experience. Psychiatrists become involved in managing the problem through the effects on development and psychological functioning through the lifetime course. There is strong evidence confirming clinical impression of wide range of psychopathology associated with child sexual abuse appearing in adult life. Many survivors only break the silence in adulthood, while some never do [1]. As an adult the survivor's inability to trust anyone prevents them from seeking help, which in turn leads to feelings of isolation. To a certain degree statistics reveal how many survivors are abused; but they cannot show how individual cases are affected. The pain and legacy of abuse do not diminish over time – each survivor always carries the hurt and loss within. Society still expects them to have come to terms with it and put it behind [2]. The psychological and physical effects of sexual abuse can be devastating and long lasting [3]. Depressive symptoms are commonly reported. The depressive feelings are usually combined with shame, guilt, and a sense that victim has been permanently damaged. Poor impulse control and self-destructive and suicidal behaviors are reported to be high. Posttraumatic stress disorder and dissociative disorder are seen in some patients who have been sexually abused. Sexual abuse is a common preexisting factor in the development of dissociative identity disorder (also known as multiple personality disorder), increased risk of suicidal behavior, violent acts, and substance abuse [3–5]. Two cases of sexual abuse in childhood and its impact of the development of psychopathology in adult age are being presented. One was met during the clinical practice in the United Kingdom, and demonstrates numerous symptoms of acute psychopathology with high risk of suicide, bearing a history of sexual abuse, which started at the age of four, by her father; another case is of Lithuanian patient, who was sexually abused by her grandfather at the age since eight up to thirteen, with social phobia developed and social integrity damaged, inability to built both social and interpersonal relations, high risk of suicide and attempts, and homicidal fantasies.

Key words: childhood sexual abuse, adult survivors, psychopathology, suicide, homicide.

SANTRAUKA

Seksualinės prievartos pasekmės jaučiamos visą gyvenimą. Psichiatrai ėmėsi spręsti šią problemą per jos poveikį asmenybės vystymuisi ir psichologiniam funkcionavimui gyvenimo eigoje. Yra tvirtų įrodymų apie plataus spektro psichopatologiją, kuri išsivysto suaugusiems, vaikystėje patyrusiems seksualinę prievartą. Dauguma seksualinės prievartos aukų prabyla tik kai suauga, o kai kurie niekuomet neprabyla. Aukos negalėjimas niekuo pasitikėti neleidžia jai ieškoti pagalbos, kas savo ruožtu veda prie izoliacijos jausmo atsiradimo. Tam tikru laipsniu statistika rodo, kiek yra aukų, tačiau ji neatskleidžia, kokios pasekmės yra konkrečiais atvejais. Prievartos skausmas ir prisiminimai neblėsta laikui bėgant – kiekviena prievartos auka savo viduje nuolat nešiojasi nuoskaudos ir praradimo jausmą. Visuomenė gi mano, kad auka su tuo susitaikė ir paliko praeityje. Seksualinės prievartos psichologinės ir fizinės pasekmės gali būti itin destruktyvios ir ilgai išliekančios. Paprastai pastebimi depresijos simptomai. Depresija dažnai sumišusi su gėdos, kaltės jausmu ir pojūčiu, kad žala padaryta visam laikui. Būdingas nevaldomas impulsyvumas, polinkis į autodestrukciją ir savižudybę. Kai kuriems pacientams, vaikystėje patyrusiems seksualinę prievartą, atsiranda potrauminio streso sindromas ir disociacija. Seksualinė prievarta – įprastas faktorius, lemiantis disociatyvų tapatumo sutrikimą (taip pat žinomą kaip daugybinis asmenybės sutrikimas), padidinto polinkio į savižudybę, smurtą ir piktnaudžiavimą narkotinėmis medžiagomis riziką. Pateikiame du seksualinės prievartos vaikystėje ir jos poveikio psichopatologijos išsivystymui suaugus atvejus. Apie vieną atvejį sužinojau klinikinės praktikos Jungtinėje Karalystėje metu – buvo akivaizdūs sunkios psichopatologijos simptomai, didelė savižudybės rizika. Viso to priežastis – seksualinė prievarta nuo ketverių metų iš aukos tėvo pusės. Kitas atvejis – lietuvė pacientė, kurią seksualiai išnaudojo jos senelis nuo aštuonerių iki trylikos metų, ko pasekmėje išsivystė socialinė fobija ir buvo pažeista socialinė integracija, atsirado nesugebėjimas kurti visuomeninius ir asmeninius santykius, didelė savižudybės ir bandymų ją įvykdyti rizika bei su žmogžudyste susijusios fantazijos.

Raktžodžiai: seksualinė prievarta vaikystėje, suaugusios aukos, psichopatologija, suicidas, homicidas.

INTRODUCTION

Finkelhor (1994) defines child's sexual abuse as sexual activities which involve a child and an adult, or significantly older child. There are two elements: the sexual activities and the abusive condition. Contact sexual activities include penetrative acts (e.g. penile, digital, or object penetration of the vagina, mouth, or anus) and non-penetrative acts (e.g. touching or sexual kissing of sexual parts of the child's body, or through the child touching sexual parts of the abuser's body). Non-contact sexual activities include exhibitionism, involving the child in making or consuming pornographic material, or encouraging two children to have sex together [6].

The abusive condition is founded on the premise that children cannot generally give consent to sex, because of their dependent condition.

Half the sexual abuse cases coming to the attention of welfare agencies involve penetration or orogenital contact. The proportion is less in community samples, because reported cases tend to be more serious in nature.

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Abuse perpetrated by a caretaking adult normally consists of increasingly severe sexual contact over time, with parallel increases in coercion and threats to the child if the 'secret' is disclosed. As the physical acts and psychological climate worsen, so the child's reluctance to disclose the predicament deepens.

According Jones (1996) the prevalence of child sexual abuse range from 5-30%of the population (in the United Kingdom), principally because of differences in sampling, interview, and definitions (e.g. inclusion of non-contactabuse). Nevertheless, it is that higher rates are found in subsections of the community, including those in contact with psychiatric services [7].

In the United States each year 150,000 to 200,000 new cases of child sexual abuse are reported. An estimated one of every three to four girls will be sexually assaulted by the age of 18 years, and an estimated one of every seven to eight boys will be sexually assaulted by the age of 18 years. The actual occurrence rates are likely to be higher than those estimates, because many maltreated children are go unrecognized, and many are reluctant to report the abuse [8].

The effects of sexual abuse are inextricably linked with two other important dimensions which are often impossible to separate from sexual trauma itself. These are the context within which sexual abuse occurs, and subsequent life events [9-14].

Sexual abuse in childhood brings the signs of this traumatic experience into the adulthood life [5]. Mental health professionals, psychiatrists included, must be alert in reading the signs of this experience, interpreting clinical symptoms, conducting interview, constructing help and management plan. Two cases I present differ in their management. The first one represents country (the United Kingdom), where services for management of child sexual abuse and adult survivors of sexual abuse in childhood, are very much developed and have a lot to offer. Lithuanian case, demonstrates high stigma, "non existence" status, occasional seeking for private help. Professional supervision should be essential, what was available in the United Kingdom, but not in Lithuania. Helping for survivors of sexual abuse is not only professional duties, but very hard emotional work, as well. It is impossible to remain indifferent to patients. Each session could become explosion of survivors emotions [15]. Symptoms discovered require immediate management. Dealing with dissociated personality demands from psychiatrist very high sensitivity as well as professional knowledge. Khan (1971) states the necessity to hear with eyes, as impression is the same, as one does looking at a phased image on the television screen [16]. Schwartz states that dealing with such cases becomes a potent integration for all psychotherapists of where they have been, where they are, and where they are going [17]. Bloom (1997), during her work with survivors of childhood sexual abuse, confesses: "As a result, we have learned a great deal about what is important to human beings-and some important lessons about how human systems succeed and how they fail. My world view has changed almost entirely as a result of what I have learned about what happens to human beings who are exposed to overwhelming stress …" [18]. Lives of survivors she viewed as broken into pieces [18].

A traumatic event threatens the person's view of the world, the self, and the future. Rich psychopathology is found in the presentations of adult survivors of past sexual abuse in their childhood.

METHOD

Episodes of two cases of sexual abuse in childhood and its impact on the development of psychopathology in adult age are being presented. One was met during the clinical practice in the United Kingdom, and demonstrates numerous symptoms of acute psychopathology with high risk of suicide, bearing a history of sexual abuse, which started at the age of four, by her father; another case is of the Lithuanian patient who was sexually abused by her grandfather at the age since eight up to thirteen, with social phobia developed and social integrity damaged, inability to built both social and interpersonal relations, high risk of suicide and attempts, and homicidal fantasies. Names of the patients have been changed, as well as some personal details. Their permission was given in the context "to tell and educate others, and maybe help other similar victims".

1. Tracey was my English patient, seen four times by myself, during my 10 months Locum clinical practice in General Adult Psychiatry in the United Kingdom. She was first referred to me by her care co-ordinator, for medications review, as she started experiencing both visual and auditory hallucinations. She was a lady in her late forties, she lived on benefits with her husband; their adult children lived separately. She began seeing a huge image of an Angel, with big wings, who was telling her to go to the mall and take away a coat. She was responding to him that this was not correct, but he answered "correct, otherwise you'll get cold". She tried asking her husband for assistance and requested him to say to the Angel that she was not willing to steal things, but her husband answered he did not see anything, and did not hear, and asked Tracey to leave him alone. Tracey became even more upset as she decided maybe they both were against her. She told her husband: "How couldn't you see, if he is so huge, hardly fits in the room, and his wings are so big." Tracey told me: "I saw him, as I see you now". She also started getting agitated during the interview and was almost to cry. She added saying to me:" I am scared", "I am so scared that I do not want to live. I am very much alone, no one trusts me", "I prefer to dye, as this is very painful, I have no strength to suffer anymore".

2. Anna was a young good looking lady, 36 years old, always dressed extravagant way, with a scarf, like turban, on her head, divorced tree times, currently living on her own. She was educated in one of the world capital's university, back to Lithuania. She was a lecturer at a high school. She developed social phobia and was feeling restless among the students during her lectures. She started avoiding lectures, meeting students and colleagues, became scared to enter the classroom at all. She began to abuse alcohol at home in order to get a release. She was taken to me by her mother who was a doctor herself. Anna did not want to speak in front of her mother, and asked her to leave my office. Anna knew that I was working with survivors of childhood sexual abuse, so she started talking to me formulating her problems at the very first interview." I know the reason of my damn state and my spoiled life". Anna was rude, full of sarcasm, she spoke with voice raised. Anna demonstrated the feelings of being angry, did not want me to interrupt her and demanded me to listen.

She told me she had been sexually abused in childhood by her grandfather. "My mother was taking me to the village, to spend my summer holidays with my grandmother and grandfather. I had to sleep in one bed with them, in the middle. He started to please himself in the mornings when my grandmother awaked first and went away to take care of animals. He was touching me under my night wear and ejaculating on my naked body. He was laughing and saying I was good, and leaving me alone in a bed, following grandmother. This lasted several summers, since my age of eight, but when I was thirteen I resisted him. He used force. I told I would tell grandmother, but he laughed rudely saying that grandmother would not trust. And this was true. My grandmother got very angry at me and began to shout how such a big girl could tell such nasty nonsenses. My mother told the same. I wanted to tell everybody during some family gathering in the village and warned my mother I would do so, then she locked me and did not allow to attend the event at all. I ran away, and never ever was back to that village. This is a hell place. My mother began to dislike me. Since then we only argue, for any reason, until now. I never phone her, I do not want to visit her. During all my life my hottest desire was to kill him, and I had very sweet fantasies killing him in my mind. My happiest day was when he died several years ago. I did not attend the funeral, but drank champagne in privacy for that occasion, saying: "Go to hell, there is your place!" All my three husbands I left when only I got pregnant from each of them, I aborted children of every of them. I hate all men. I hate my mother. I am very much alone, and want to remain alone. I have no life. I hate myself. I am all dirty. Both my body and my inside. I am not sure what I am doing in this cruel world. Still when I sleep at night I see dreams how he urinates on me. I will never get rid of that devil. And my mother is a disaster, too. I will never give a birth to any children, as they could be born with damaged genes. Whenever I start doing anything like other people do, that devil comes and takes my breath away. I think that my students are aware, they laugh at me."

DISCUSSION

Two cases presented demonstrate psychopathology, which were brought in for the help of mental health services by survivors of child sexual abuse. The first one is more associated with acute psychopathology, thought disorder, and symptoms of severe depression. The second one demonstrates dissociated personality with social phobia developed. In both cases suicidal thoughts are present, the risk of suicide is high; both clients do not see the meaning in their lives. Symptoms of PTSD (posttraumatic stress disorder) are present in both cases, too.

Tracey was referred by her care coordinator because of sudden relapse, arguments at home, agitation, visual and auditory command and comment hallucinations. Symptoms of anxiety and severe depression were present too. She was at a high risk of suicide; her mind was preoccupied with thoughts of suicide. Tracey experienced a tremendous sense of guilt, she was blaming herself for he son's drug abuse, for her husband having psoriasis, for being not a perfect parent. She feared something dreadful would happen to her husband and children.

I learnt about Tracey's sexual abuse from her medical records, and could talk about this experience during the first time I saw her. She told me her father started to abuse her sexually when Tracey was 3-4 years old, he abused her older sister too. He was taken to prison, as he abused other children too, boys and girls. Tracey was told that her father died. But she explained to me that she did not attend his funeral, so she could not be sure about his death. "I never saw him in coffin, so may be he could be alive and he could come and kill me". Tracey was sure that the Angel she saw was her dad, that's why he taught her to steal the coat. She had recently seen Father chiselling at the bedroom door frame. Believed he was really there, was not sure anymore he was actually dead. Asked husband for reassurance and confirmation but this did not convince Tracey, she got out of bed to touch the door frame; she believed she could feel that the wood had been chiselled. Tracey reported poor sleep, she told me she was afraid to go to bed in order not to see bad dreams and nightmares. She reported that the male voice who was "actually him" told her that in 2012 the world would come to an end. She avoided going out in order people would not be strange about her, as they probably knew who her farther was – they also were able to read her mind.

She hardly responded to administered high doses of antipsychotics and antidepresants. I referred Tracey, parallel to psychopharmacotherapy, both for individual and group psychotherapy, SAGE course (sexual abuse group's education), and to crisis intervention group, who was seeing Tracey twice per day. She wanted to see me soon again, as she told to her care co-ordinator that she felt better after talking openly about her childhood experience. She also expressed willingness to see a priest and to discuss with him where could be her any possible fault, sin or punishment, if she was put into such a position while being an innocent child. Her care co-ordinator referred Tracey to pastoral counselling, too.

Lastly, later on, she was found in the street in night wear (in January), as the voices told her to go and "never come back again" and Tracey automatically followed the command.

Pastoral counselling is very helpful in healing survivors of childhood sexual abuse, especially if patient is a religious person and holds personal religious beliefs. Fact of child sexual abuse brings a lot of confusion into existence, and raises essential question and concerns, such as Tracey expressed: about possible punishment, sin or fault. Psychiatrist and a priest could share their competencies at this point. Parallel to the input of psychiatrist's, the contribution of pastoral counselor to the entire problem of sexual abuse is significant because childhood sexual abuse raises many issues of faith. Secular counselors may address well the issues of sexual abuse, but they often ignore the faith dimension so critical to the healing process, which must integrate the various personal dimensions: intellectual, physical, social, emotional and spiritual [19, 20]. For a victim to heal, her faith must be an issue that is brought into the therapeutic process.It means that the life assumption, faith in a supreme being, the meaning of life, and the role of evil must be food for discussion and growth if the patient is going to move toward health [20]. The case of Tracey is very good illustration of it. Tracey's even acute psychopatology holds a content of religious background: she is seeing visual hallucinations of Angel, and is ambivalent of his true presentation. The clinical psychologies try to interpret individual lifes; theology tries to interpret life – life as a whole,

in its entirety. And if this is so, both disciplines must face the question of the framework of meaning from which they make their interpretive judgments [21]. In our case, Tracey wanted to be seen by priest, and she also wanted to be referred to him by mental health services providers, in order the responsibilities should be shared and explanations given to her.

Anna was seeking for help as she felt she could lose her job because of alcohol abuse and social phobia, which was not compatible with duties of a lecturer. I saw her several times until she did not come back some time. She was extravagant, arrogant, but during sessions she was becoming weak and dependent, crying, shouting, and then saying she hates me for making her express herself in such a way. She was never performing the homework recommended by me. She was not willing to take medications, but I was happy with that because I was not sure she would not commit suicide by overdosing. As our sessions proceeded, she became slightly gentle, her voice became more soft and gentle, and her eye contact became more prolonged. That's all positive I was able to achieve with Anna before she disappeared.

Anna's case, her disappearance from therapy, demonstrates, she did not want to get rid of her traumatic experience. Pathological pattern of her reactions, she learnt in childhood and was using all her life, had become normal for Anna, the way she was able to express herself. Normal life was not normal for Anna, scared and confused her. I also predicted difficulties for positive dynamics, as Anna was really very much alone. She could get a support only attending psychiatric office, but no comfort in her own private life she was not able to achieve, no understanding, no trust, no one she could share her feeling openly and would be believed [5, 15, 16, 18].

Adult survivors of childhood sexual abuse often suffer from the posttraumatic stress disorder. Both our presented patients meet criteria for PTSD. They both experienced an event that involved actual threat to their development, integrity of self; their response involved intense fear, helplessness, even horror; this traumatic event (sexual abuse by father in Tracey‘s case, and sexual abuse by grandfather in Anna‘s case) is being persistently reexperienced in intrusive recollections of the event, thoughts, perceptions, desires, drems, intense psychological distress at exposure to internal or external cues that symbolize an aspect of the traumatic event, restricted range of affect (unable to have loving feelings , described by Anna), irritability or outbursts of anger. [22, 23].

Recent studies indicate, that with untreated PTSD we have a dysfunctional individual that has the potential to have an extremely adverse impact on themselves and others [24]. Because of high stigma in Lithuania, it is very hard to monitore help to such cases as Anna's presented, and similar cases of adult survivors of childhood sexual abuse. We should also have in mind these cases, who never seek for help, and continue live between us untreated [1].

CONCLUSION

We have found rich psychopathology, when dealing with cases of adult survivors of sexual abuse in their childhood: severe depression, anxiety, poor sleep, visual and auditory hallucinations, thought disorder, pathological guilt, PTSD symptoms, social phobia, suicidal thoughts and intentions, homocidal fantasies.

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