PSYCHIATRIC TREATMENT OF VICTIMS AND SURVIVORS OF SEXUAL TRAUMA

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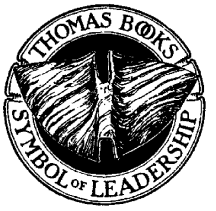
PSYCHIATRIC TREATMENT OF VICTIMS AND SURVIVORS OF SEXUAL TRAUMA

A Neuro-Bio-Psychological Approach

Edited by

JAMSHID A. MARVASTI, M.D.



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I dedicate this book to the late Myron (Mo) Hurwitz, M.D., a brilliant and forward-thinking psychoanalyst, who was professionally ahead of his time. His life was abruptly taken by cancer at age 64, without allowing him to have a "closure session" and an opportunity to say "good-bye" to his analysands.

Mo—your optimism, your laughter, and your endless love for life will remain in our hearts forever.

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meetings in the Middle East, Europe, Canada, and the United States. He also edited the book *Child Suffering in the World* in 2000. Dr. Marvasti was previously as associate clinical professor of psychiatry at the University of Connecticut, School of Medicine.

Barbara Pascal A.P.R.N., M.S., C.S., is the Director of Child and Adolescent Behavioral Health Services at Manchester Memorial Hospital (Manchester, Connecticut). For the past 30 years, she has worked with children, adolescents, and families in a variety of settings and roles. Ms. Pascal worked as a pediatric nurse for 17 years before earning a Master's Degree in Nursing and certification as a Clinical Nurse Specialist in Child and Adolescent Psychiatric and Mental Health Nursing as well as licensure as an APRN. In her current role as a Director, she provides therapy, medication evaluations, and medication management for children and adolescents. Ms. Pascal specializes in treating children and adolescents with ADHD and also provides consultation services to community agencies and schools.

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FOREWORD

This book is unique in my experience. First, it actually delivers what is promised in the title. Most authors who write about sexual trauma focus on psychopathology and psychotherapeutic interventions. A smaller number focus on the neurological and endocrinological sequelae of psychic trauma. But it is extremely unusual to find a professional book that manages to link the neurobiological and clinical sequelae of sexual trauma with updated and innovative treatment approaches. Readers will find this rare combination herein.

Dr. Marvasti and his co-authors have accomplished their goal remarkably well. The book offers a balance between empirical and clinical information and manages the difficult task of being as up-to-date as exhaustive and zealous research will allow. As a result, it offers practical clinical approaches and guidelines for working with victims and survivors within the context of presenting the latest theoretical and scientific data. Readers will find particularly helpful the detailed and extensive sections on psychopharmacology for trauma patients. The innovative chapter on addicted trauma victims (with dual diagnoses of substance abuse and sexual trauma) should be required reading for all clinicians.

The comprehensive and scholarly nature of this work, as well as its humor and clinical applicability, will not surprise anyone who is familiar with the principal author. I have had the pleasure of knowing Jami Marvasti for 25 years, as a professional colleague, consultant, and a friend. He has a voracious appetite for knowledge about all aspects of psychiatry and humanity, with a particular focus on sexual trauma. He also is a tireless worker, devoted and compassionate clinician, and generous friend.

For more than 20 years after founding a sexual trauma center within his private office in Manchester, Connecticut, Dr. Marvasti com-

bined a busy clinical practice with extensive study of the research and clinical literature. During this period, he contributed many scholarly articles and chapters to the field of knowledge about sexual trauma. In addition to serving as an adjunct professor and permanent faculty member for the Saint Joseph College Institute for Child Sexual Abuse Intervention in West Hartford, Connecticut, he has lectured extensively on sexual trauma to professional groups across the country. In 2000, he edited and published a ground-breaking book on a related subject, *Child Suffering in the World.*

Some female survivors of sexual trauma, especially incestuous sexual abuse, would deem it unthinkable to choose a male physician for psychotherapy. Despite this sociocultural barrier, Dr. Marvasti has been able to treat countless girls and women for sexual trauma issues. His success has been due to the genuine respect, compassion, sensitivity, and humor coupled with the superb diagnostic acumen and treatment skills that he brings to psychotherapy with traumatized females and males. Few, if any, other psychiatrists can match his capacity to combine pharmacotherapy with psychotherapy for sexual trauma. His knowledge and clinical experience in this field can only be described as voluminous and still growing.

Therefore, *Psychiatric Treatment of Victims and Survivors of Sexual Trauma* represents a particular stage of a work in progress. I have no doubt that clinicians who wish to learn more about this subject will be able to read more enlightening contributions from this author and his collaborators. Meanwhile, read *this* volume! Learn! Enjoy!

Suzanne M. Sgroi, M.D.
Director, Saint Joseph College Institute
for Child Sexual Abuse Intervention
Editor and principal author of
Handbook of Clinical Intervention in Child Sexual Abuse;
and *Vulnerable Populations,* Volumes I and II

PREFACE

We have conceived this book on the basis of our clinical observations. These findings point toward the "holistic" aspect of human beings and challenge the artificial dichotomy of "psych" and "soma." In this text, we aim to integrate the psychosocial and bio-neuro-endocrine aspects of human experience, including trauma. "Psychological trauma" is a multifaceted phenomenon, with extensive involvement of biochemical and neurological changes. The result may be considered the classic form of the "psychosomatic" disorder. We believe that "trauma" is the region in which "psych" and "soma" meet each other and integrate, becoming a single entity. By way of analogy, if one adds a drop of water to a glass of ink, shortly thereafter, one cannot differentiate between water and ink; the two have become one.

In accordance with this theory of integration, we believe that victim/survivor psychopathology should be targeted for intervention from every corner simultaneously; that means a combination of psychotherapy, milieu therapy, and pharmacotherapy. For example, in our chapter on the psychopharmacology of trauma, we suggest using medications even if the patient's presenting problem is a "normal reaction" to an abnormal event, such as rape or incest. However, we also suggest long-term psychotherapy for such victims and survivors.

As we consider these current therapies, it is appropriate to reflect upon changes that have occurred in the field. It is worth noting that when I began my practice with child and adult survivors of sexual abuse in the late seventies, no guidelines in clinical literature existed for treating such victims. At that time, it was not customary to prescribe medication for adult survivors. In addition, it was not common knowledge that psychological symptoms are associated with, or possibly caused by, neurotransmitters (or neuromessengers) which convey messages of emotion and behavior (e.g., depression, aggression, anxi-

ety). Managed care/HMO companies had not yet arisen either, with their insistence on short-term therapy and heavy use of medications, such as selective serotonin reuptake inhibitors (SSRIs), used now to alter the "message" system.

At that time, I established with Karen Prewo, LCSW, and Sebastian Mudry, Ed.D., the Sexual Trauma Center of Manchester (in Connecticut) and treated children and adults who were victims of sexual trauma. We should declare that we achieved our most successful results at that time–when we were able to treat patients on a long-term basis, that is, weekly, for several years. We had an opportunity then to see the process of change through "talk therapy," with no substantial use of medication. Now, after more than two decades, we have a number of novel medications and increased knowledge about PTSD and trauma, but we miss that long-term psychotherapy that was not only curative for our clients but also inspirational for us as therapists.

The content of this book is divided to nine chapters:

The First Chapter provides a psychobiological perspective of incest and sexual abuse. Drs. Marvasti and Dripchak define *incest* and consider the stages of and reactions to incest that trauma clients have experienced. Emphasizing the diversity of possible reactions to traumas, the authors include descriptions of the overstimulation syndrome, delayed psychological puberty, and alexithymia–all as negative consequences of sexual abuse. Also discussed is the subject of homosexuality vs. homo-sensuality. The writers reveal that some homosexual tendencies in females may be more appropriately termed *homo-sensuality,* in that the original and primary sexual orientation is heterosexual. Yet, because some of these victims have been brutally abused by men, they have developed an aversion to male genitalia.

In Chapter Two, Drs. Marvasti and Dripchak focus on trauma-related syndromes associated with survivors of sexual abuse. Discussion centers on relational, cognitive, affective, and spiritual consequences. Included is a brief description of the phenomenon of revictimization. The writers also consider specific theories about the impact of sexual abuse on victims, such as the dysfunctional mothering patterns of incest survivors. The relationship between the trauma and comorbid disorders such as alcohol abuse, depression, suicidal behavior, dissociation, and anxiety is explained.

Chapter Three continues the theme of the second chapter, providing further discussion of the link between sexual trauma and somatic

sensations of discomfort and pain. The specific psychopathologies of self-mutilation, trichotillomania, restless leg syndrome, obsessive-compulsive behavior, and anorexia nervosa are examined by Drs. Marvasti and Dripchak in terms of theory, motivation, and family characteristics.

In Chapter Four, J. Marvasti, M.D. and Charlotte Pinto, L.C.S.W., describe their frustration in treating drug/alcohol addicts and the discovery that these addicted individuals have a history of hidden trauma which haunts them and prevents recovery. Dr. Marvasti refers to this dually-diagnosed group as Addicted Trauma Victims (ATV). The relationship between childhood traumatization and the subsequent abuse of alcohol or drugs in adolescence and adulthood is examined. This chapter also includes an overview of current clinical literature and therapeutic approaches used to treat members of this notably intractable patient population. In exploring the neurobiological aspects of childhood emotional trauma, the writers discuss indications for new treatment approaches, such as Harm Reduction Therapy and Motivational Enhancement Therapy.

In Chapter Five, J. Marvasti, M.D. and Karen Colt, M.Ed., explore the victims' response to trauma and examine nontraditional treatment models for psychological trauma. The TARGET model of treatment focuses on current symptoms. Treatment is aimed at helping the victim move from maladaptive patterns of thought and behavior toward healthy ways of managing life. TREM was created to assist disempowered female victims of trauma to develop self-esteem and coping skills. EMDR is a set of protocols designed to decrease the symptoms of traumatic stress by use of rhythmic movements and cognitive restructuring.

In Chapter Six, Drs. Marvasti and Dripchak present psychotherapy practices used with incest survivors. The authors discuss treatment principles and goals and explain new treatment options. The importance of transference and countertransference issues within the context of psychotherapy is detailed.

In Chapter Seven, Dr. Marvasti and Barbara Pascal, A.P.R.N., explore the practice of pharmacotherapy in treating trauma-related disorders. The authors focus on the use of a variety of psychiatric medications for the treatment of PTSD. Included are discussions of SSRI antidepressants, tricyclic antidepressants, monoamine oxidase inhibitors, anticonvulsants, mood stabilizers, anxiolytics, beta-adren-

ergic blocking agents, alpha-adrenergic agonists, opioid antagonists, and antipsychotics.

In Chapter Eight, J. Marvasti, M.D. and Maja Florentine, ORT/L, present creative and rehabilitative practices for treating victimized children and adolescents. The writers point to the importance of art therapy in the recovery process of traumatized individuals, particularly for "Those who either talk little and distrust words, or those for whom talk has become a way to escape and hide" (Rubin, 1978). Practical issues that often arise during creative therapy sessions are also discussed. Marvasti and Florentine describe occupational therapy in treating traumatized patients and demonstrate its uses in a case vignette. Similarly explored and illustrated is psychodrama, a strategy used to re-create trauma in order to discover solutions and alternatives.

Chapter Nine provides an overview of play therapy/cognitive-behavioral therapy for sexually abused children and adolescents. Drs. Dripchak and Marvasti discuss the types of trauma, assessment, and the impact of disclosure in the context of such treatments. The authors include two case vignettes to illustrate these approaches. A brief discussion follows on the uses of metaphor and storytelling in play therapy with traumatized children.

J.A.M.

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I am thankful to the many professionals and friends who have helped me in the accomplishment of this book. First, I thank Professor Ralph Slovenko, who inspired me to write this book, and Suzanne M. Sgroi, M.D., who sustained that inspiration with her professionalism, advice and countless hours of review.

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CONTENTS

PSYCHIATRIC TREATMENT OF VICTIMS AND SURVIVORS OF SEXUAL TRAUMA

Chapter 1

THE TRAUMA OF INCEST AND CHILD SEXUAL ABUSE: PSYCHOBIOLOGICAL PERSPECTIVE

JAMSHID A. MARVASTI AND VALERIE L. DRIPCHAK

> Society reaps what it sows in the way it nurtures its children. Stress sculpts the brain . . . stress can set off a ripple of hormonal changes that permanently wire a child's brain to cope with a malevolent world. Through this chain of events, violence and abuse pass from generation to generation as well as from one society to the next . . . we see the need to do much more to ensure that child abuse does not happen in the first place, because once these key brain alterations occur, there may be no going back.
>
> M. TEICHER (2002)

DEFINITION OF INCEST

Incest has been defined in the past as any sexual activity between children and parents or siblings. This definition was extended to sexual activity or sexual contact including visual contact between the child and anyone who is in a position of parent surrogate. Therefore, sexual contact between a child and the mother's boyfriend is also considered incest. Mudry (1986) determined that sexual activity between a student and a professor is a kind of incestuous relationship.

Incest is forbidden in almost all cultures including primitive cultures. This strong taboo and prohibition may indicate that there may have been a strong desire to commit incest in these cultures. In gen-

eral, incestuous sexual abuse may be defined as any kind of sexual activity between a child and parent surrogate or older sibling, which is for the purpose of sexual gratification and sexual needs of the offender. For example, if a father watches his child while she is taking a shower through a hole he made in the shower room wall, and the child is not aware of it, it is still considered incest. However, as far as the child is not aware of her father's action, there is no indication that the child is being victimized or harmed.

Incidents of child sexual abuse and incest have occurred through the years. However, the "discovery" of these events and the talking about this taboo began only in the 1970s. One of the reasons that the professionals neglected this important aspect of child victimization was as Sgroi (1975) stated, "A prerequisite for the diagnosis of sexual abuse in children is the willingness of the healthcare professional to consider the possibility that such abuse may happen."

In general, incestuous relationships between parents, or parent surrogates, and children are considered more the misuse of power rather than an issue of sexuality, and are connected to the adult's desires to satisfy their nonsexual needs as well as their sexual needs. However, the nonsexual needs may have priority. Sexual contact between siblings may also be considered abusive and result in the victimization of the child if the element of power and authority were present. Some professionals concede that if a sibling is a few years older than his or her partner in sexual activity, the element of exploitation and possibly abuse is present. These professionals speculate that the age difference itself generates a power imbalance and creates difficulties for a younger child to refuse, avoid, or protest.

STAGES OF SEXUAL ABUSE

Sgroi et al. (1982) suggested a five-stage sequence, which may characterize child sexual abuse:

1. *Engagement:* The offender engages the child around nonsexual issues and becomes a friend or a person who provides material rewards and satisfies the child's need for closeness and socialization. This relationship allows the offender to acquire access to the child and to develop trust and emotional connection.
2. *Sexual Interaction:* In this phase, the offender engages the child

in age-inappropriate sexual activity. This sexual contact may progress from exhibitionism, to erotic kissing and fondling, to actual intercourse.

3. *Secrecy:* This element ensures access to the child and maintains sexual activity. Secrecy may be maintained through threat or bribery. The threat may at times be very subtle.
4. *Disclosure:* Generally, disclosure may be accidental or purposeful. At this time, the inappropriate equilibrium of the family is shaken, and universally all the family members may try to rebalance the shakiness of the family equilibrium.
5. *Suppression:* Once disclosure happens, the caregivers may not want to deal with the reality of this taboo and resort to denial and minimization. Most likely, due to the dynamic of guilt feelings and fear of family disruption, the entire family may enter into a suppression phase. Every family member may perceive pressure and impose pressure on the child to retract his or her account of the incest.

Many professionals consider the stage of recanting in intrafamily child sex abuse as very typical. In fact, professionals have identified a so-called syndrome, which is called "no/maybe/sometimes/yes syndrome." This "syndrome" suggests that the child initially may not disclose any information about the sexual abuse ("no"), and then gradually feels comfortable enough to begin to talk about some of the factors related to the incest ("maybe/sometimes"). Finally, the child becomes free to arrive at full disclosure ("yes"). In some incest cases, the reversed syndrome may also be present as many children may recant their account of sexual abuse due to the excessive negative events that happen to the child and the family, including the removal of the offender, disruption of family, publicity, and eventually, testimony against the offender in the justice system.

Summit (1983) described the existence of another syndrome, which is called "child sexual abuse accommodation." He described five stages that children who are sexually abused go through. These stages are: secrecy, helplessness, entrapment, accommodation, delayed, conflicted and unconvincing disclosure, and lastly retraction. In this syndrome, Summit explained that the child would initially feel trapped and helpless. The feelings of helplessness lead to accommodative behaviors because the victim fears that no one will believe the story if he or she does tell. The failure of protective services and

the family to support the child after disclosure only serves to reinforce the child's initial feelings of helplessness and powerlessness (Summit, 1983).

DIVERSITY OF REACTION TO INCEST TRAUMA

The diversity of reactions and symptom formation to trauma is evidenced when one compares the symptomatology in the following two female survivors of sexual abuse. One is a woman who developed anxiety and panic attacks while watching sexual encounters on television. The other is a woman who compulsively watches pornographic movies with no anxiety or agitation. The life histories of these two women revealed that in many aspects, they showed diverse reactions. Both women were asked what they would do if they discovered a fire in the theater. The first woman said, "I would close my eyes and scream," and the second woman said she would attempt to extinguish the fire by running toward it and throwing her jacket over it. As is evidenced in these two reactions, one has a tendency toward avoidance and flight, and the other meets the problem head-on in the hope of overcoming it.

Similar symptoms in individuals may be caused by the interaction of different dynamics. Generally, considering only one factor as pathogenic for complex symptoms may be an oversimplification. For example, Finkelhor and Brown (1985) attributed possible alcohol abuse in victims due to the trauma of stigmatization. However, in our cases, some teenagers used alcohol as a sedative and tranquilizer to decrease their anxiety due to overstimulation of incest. In some of our adult survivors, especially those who presented posttraumatic stress disorder (with flashbacks, nightmares, and insomnia); alcohol was used to decrease these symptoms. It is known that alcohol decreases the REM (rapid eye movement) stage of sleep, which is the stage that presents the most terrifying nightmares. Traumatic experiences may produce a memory engram, which may be recalled during REM sleep as a nightmare (Bishay, 1985). When alcohol is consumed, nightmares disappear (due to a decrease in the REM stage of sleep) and sleeping improves. The next day the patient feels "better," and eventually, this individual will associate the alcohol consumption with feeling better.

Therefore the issue of alcohol abuse may not be simply explained

and attributed to a stigmatization trauma as its cause; rather, it may be a "solution"–a coping mechanism or a secondary symptom due to the interaction of multiple factors (for example, genetic structure, family values, life style and sexual abuse).

The individualization of reactions, symptom formation, and resolution of trauma prevent any generalization of the effects of incest. For example, the sexual dysfunction of adult survivors is reasonably attributed to the sexual nature of their abuse in childhood. However, many of these survivors are also having posttraumatic stress disorder (PTSD) due to the trauma of incest. Reviewing the literature on patients with PTSD with no past history of sexual trauma, reveals that the majority of them are also suffering from sexual dysfunction. In a study of the survivors of the Nazi Holocaust, Krystal (1968) stated: "Many of the male survivors tend to be permanently inhibited in their ability for sexual initiative and potency." In other observations of survivors of accidents and veterans of war with PTSD, sexual potency and desire are substantially decreased. For example, Cosgrove et al. (2002) researched sexual dysfunction in combat veterans with PTSD and found that they experienced significantly higher rates of sexual dysfunction than did veterans without PTSD.

Clinicians who work with incest survivors frequently consider promiscuity related to the sexual nature of abuse. However, studies on disturbed teenagers with presenting problems such as promiscuous sexual behaviors revealed that promiscuity was connected to a disturbance in the mother/daughter relationship (Gianturco, 1974). Concerning the shame that has been associated with the sexual nature of rape and incest (Nadelson and Rosenfeld, 1980), Terr (1985) pointed out that it "now appears to be a more general posttraumatic finding," related to the child's temporary loss of all personal choice and autonomy. The presence of shame in nonsexually traumatized youngsters is documented in the clinical literature (Terr, 1983).

OUR CLINICAL EXPERIENCE WITH SURVIVORS OF ABUSIVE INCEST

Our experience with incest victims and adult survivors over the last twenty years has led us to several clinical findings that are described in the following pages.

Overstimulation Syndrome

Many of our incestuous families had multiple psychopathologies and were dysfunctional families. Due to the multiple variables–any of which may have an impact on child development–it is difficult to make a direct cause/effect theory about incest. In our experience, we have observed one common point among these children who were seduced and sexually abused. The commonality may be described in terms of *overerotization* and *overstimulation*. The anxiety resulting from the overstimulation, which the child cannot control, may contribute to the child's poor self-confidence, low self-esteem and delay of the developmental process. The excessive anxiety and overstimulation required an extensive amount of mental energy, leaving less mental energy for emotional growth and development. In our patients, we speculated that the sexual overstimulation by parents might interfere with the child's ability to progress into and enjoy the latency stage of his or her development. This is the stage in which the child apparently represses sexual conflicts and feelings toward family members (if any) and displaces them on an outsider. Although the latency stage is not free from sexual preoccupation, the child enjoys a certain amount of relaxation and peace of mind, which he or she did not have in the previous state (Oedipal) and will not have during the storminess of adolescence. We speculated that children whose incestuous sexual abuse continued during the latency stage may not experience the tranquilizing characteristics of latency, consequently their psychosexual development differs from other children and their emotional problems may increase. These children may miss the latency stage and its developmental task of displacement and repression of sexual/aggressive conflicts. Anna Freud (1967) may have indirectly referred to these issues by emphasizing that the Oedipal fantasies should remain just what they are, namely unrealities. Frustration of these fantasies leads to the overcoming of the Oedipus complex, "which initiates entrance into the latency period with its inestimable benefits for ego advancement, superego formation and personality development." In a study of girls who had early menstruation, it was found that they have more psychopathology than girls whose menarche starts later. In another study on boys with true precocious puberty, a high prevalence of behavioral problems and aggression was noticed. One explanation is that when puberty and menarche start early, the latency stage is short-