

Traumatic Sexuality After Intrafamilial Sexual Abuse: a Case Report With Compulsive Sexual Behaviour

Yavuz Selvi¹,
Pinar Güzel Özdemir²,
Abdullah Atli³,
Songül Gündoğdu Kiran⁴

¹Asist. Prof. Dr., ²Psychiatry Trainee, ³Psychiatrist,
⁴Psychologist, Yüzüncü Yıl University Medical School,
Department of Psychiatry, Van - Turkey

ABSTRACT

Traumatic sexuality after intrafamilial sexual abuse: a case report with compulsive sexual behaviour

Intrafamilial child sexual abuse is one of the most difficult issue to be talked over and studied. All instances of abuse are not recognized or reported because of shame and guilt feelings, or hidden from other family members. It can lead to both immediate and long-term adverse behavioral and psychological effects that carry over into adulthood. A causal model identifying relationship among sexual abuse situation characteristics, based on Finkelhor and Browne's traumagenic model of childhood sexual abuse has four traumatic dynamics, including traumatic sexuality with abuse, feeling of betrayal, weakness and stigmatization. Traumatic sexuality can be defined as deviation of the development of sexual feelings and attitudes from normal. The documented long-term effects of childhood sexual abuse on adult functioning include affective disorders, self destructive behaviors, posttraumatic stress disorder and disturbed interpersonal relationships. In this article, we present a case with sexual obsessions and compulsive sexual behaviours, which developed after intrafamilial sexual abuse.

Key words: Sexual abuse, sexual behavior, compulsive behavior, trauma

ÖZET

Aile içi cinsel istismar sonrası zedelenmiş cinsellik: Kompulsif cinsel davranışları olan bir olgu sunumu

Aile içi cinsel istismar, sebep olduğu utanç ve suçluluk duygularının yanı sıra, aileden ve yakın çevreden gizlenmesi nedeniyle tespit edilenden daha sık olarak yaşanan, istismara uğrayan bireyin şimdiki ve gelecekteki yaşantısını olumsuz etkileyen, bu konuda çalışanları oldukça zorlayan bir durumdur. Çocukluk çağı cinsel istismarı, Finkelhor ve Browne'nin travma modelinde ifade edildiği gibi, 4 ana başlık altında incelenen ciddi sorunlara neden olur. Bunlar, zedelenmiş cinsellik, ihanet duygusu, acizlik ve damgalanma şeklinde sıralanabilir. Zedelenmiş cinsellik, cinsel duygu ve davranışların normal gelişiminden sapması olarak tanımlanabilir. Cinsel istismar ve sebep olduğu zedelenmiş cinsellik bireyin cinsel kimlik gelişiminde, çocukluk ve ergenlik dönemi boyunca belirgin bozulmalar şeklinde ortaya çıkar. Cinsel istismar, psikopatolojik anlamda duygudurum bozuklukları ve travma sonrası stres bozukluğuna sebep olabileceği gibi, tekrarlayıcı, rastgele kompulsif davranışlar da ortaya çıkarabilir. Bu olgu sunumunda, çocukluk döneminde maruz kaldığı cinsel istismarın uzun dönemdeki etkileri arasında sayılabilecek cinsel obsesyonlar ve kompulsif cinsel davranışlar sergileyen bir olgu sunulmuştur.

Anahtar kelimeler: Cinsel istismar, cinsel davranış, kompulsif davranış, travma

Address reprint requests to:
Asist. Prof. Dr. Yavuz Selvi, Yüzüncü Yıl
University Medical School, Department of
Psychiatry, 65200, Van - Türkiye

Phone: +90-432-215-0470

Fax: +90-432-216-7519

E-mail address:
dryavuzselvi@yahoo.com

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INTRODUCTION

Childhood sexual abuse is an important sub-group of all sexual abuses and covers all behaviors done by adults such as deceiving, convincing, perverting, obliging or forcing children for their sexual satisfaction (1). When sexual abuse is experienced within family, it becomes difficult to disclose it due to reasons such as fear of family separation and unacceptability by society and it may be hidden for several years (2). Previous research showed that girls are exposed 3-4 times more than boys to this

condition and disclosing of child abuse of boys are less prevalent than girls (3).

It was proposed that sexual abuse creates 4 important effects on the individual (4):

1. Traumatized Sexuality: This condition is highly prevalent among sexual abuse cases and means deviation from normal in every domain of sexual development and is the main concept which we emphasized in our case.

2. Feeling of Betrayal: People who sexually abuse children are generally people that they love and know closely. For this reason, feeling of betrayal occurs in the

child and depression with fear, sadness and loss of confidence can be seen.

3. Powerlessness: Child will feel him/herself weak and helpless due to sexual abuse without his/her consent. This causes anger, anxiety, nightmares, somatic complaints, learning deficits, criminal tendencies and feelings of revenge in both childhood and adulthood.

4. Stigmatization: Concepts such as evil, shame and guilt accompanying sexual abuse may alter the ego perception of the child in time and may cause to perceive himself like this. A great isolation feeling can be experienced when all of the effects of sexual abuse are combined with stigmatization (4,5).

It is already known that people who were sexually abused by one of their family members in their childhood carry the serious and chronic effects of this living throughout their lives. Also, if the child is smaller and harassment is longer, it is correlated with the severity of psychological injury (6,7). Moreover, it was reported that effects of sexual abuse on the individual depend on the relationship of that individual with the abuser, type of the sexual activity, presence of violence and physical harm, cooperativeness, age, level of development and pre-traumatic psychological development of the child (8).

In studies which adult mental disorders were investigated in people who were sexually abused in their childhood, borderline personality disorder, alcohol and substance abuse, major depression and suicide, bulimia nervosa, agoraphobia and panic disorder were found significantly more prevalent in abused individuals (9,10).

In this report, we aimed to discuss traumatized sexuality of a patient who applied to our outpatient clinic due to sexual behavioral problems and were sexually abused by his brother at the age of 9.

CASE REPORT

F.F. was a housewife who was 21 year old and a high school graduate. Patient was the third of 5 children of parents who were primary school graduates, having medium socio-economical status and limited social interaction. She was married 4 months before applied to our clinic and was living at the same house with his husband's family.

Her main complaints were obsessions, distress and nervousness. Her obsessions mainly occurred in social environments and could not keep herself from thinking of taking off her clothes in the public, looking at erotic body parts of others and disturbing sexual thoughts and behaviors. In order to cope with these thoughts and not being thought that she looked erotic body parts of others, she goes out by wearing big black glasses and a hat. She had very disturbing thoughts as taking off her clothes in the public and was afraid of doing this. In order to prevent herself from looking other people's special body parts, she closed her face with various objects. Moreover, she continuously watched pornographic films during the day, randomly made phone calls and talked sexual subjects with other people, always pre-occupied with sexuality and told that this condition disturbed her too much.

Our case was raped by her 16 years old brother 3-4 times when she was 9 years old and could not tell this event to anybody due to fear of being found guilty. This sexual abuse continued for 1,5 years and ended due to her resistance and non-permittance. After this period, her interest on sexual subjects began increasing. He spent most of the day by watching pornographic films and excessively masturbated. This condition steadily increased to a level which affected her school life after 11 years old. During her adolescence and sexual development period sexuality became an important part of her life. She could not continue her education after high school and started to spend her life mainly at her room and isolated herself from her environment. She watched pornographic films so excessively that this affected her social life, made random phone calls and talked sexual subjects with people she did not know at all and masturbated daily. However, she never sought for psychiatric help. She met her husband through one of her friends and married him after a short period of time with long phone calls 3-4 times daily having intense sexual content and voluntary sexual intercourses. During her marriage of 4 months, she continued watching pornographic films and making random phone calls with others having sexual content and requiring disturbing sexual desires from her husband which took a long time of him. She told that she could not prevent herself from doing these and got relieved after performing these acts.

There was nothing in her medical and family history of note including any disease, accident or surgery. In her psychiatric examination; she looked at her own age, her weight was consistent with her height and she wore clothes consistent with her socio-economic status. Her hat and black glasses which she did not take off for more than a year were noticed. When her memories about the trauma she experienced were interviewed, she talked about the events monotonously and like ordinary events. She had a normal IQ clinically and her thought content was consisted of intense sexual obsessions about intersexual relationships.

Her physical and neurological examination was within normal limits. Her biochemical values and EEG were normal. Results of the Minnesota Multiphasic Personality Inventory (MMPI) were as follows: "Low confidence and guilt feelings, reflecting her hostility inappropriately, thought style was autistic, defragmented and weird, general life style was schizoid". Yale-Brown Obsession and Compulsion Scale (Y-BOCS), obsession sub-scale total score was 15, compulsion sub-scale score was 16 and total score was 31. Childhood Traumas Scale score was high and significant.

Clinical Follow-up: Due to sexual obsessions, compulsive sexual behaviors and depressive symptoms of the patient, escitalopram 20 mg/day was started and insight gaining and supportive interviews were performed. Firstly, her depressive mood was improved and also reported a decrease of her obsessions beginning from 6th week of treatment but her exaggerated and compulsive sexual behaviors improved only a little. Risperidone 1 mg/day was added to treatment to reduce impulsivity. Patient took off her hat and black glasses afterwards. Her husband was also included in the interviews in order to control her uncontrolled behaviors by adding family support and idea of contributing to therapeutic process. Her compulsive sexual behaviors partially improved after the 12th week of treatment.

DISCUSSION

When looked at from a diagnostic point of view, our patient was diagnosed as Obsessive Compulsive Disorder (OCD) due to presence of unintentional and repetitive

thoughts which could not be willingly prevented, involuntary compulsions to eliminate these thoughts and acceptance of the excessive and meaningless nature of these thoughts and impaired functionality. However, we thought that childhood sexual trauma was responsible of her compulsive sexual behaviors and was evaluated as "a case with compulsive sexual behaviors due to long-term effects of childhood trauma".

Finkelhor and Brown developed "Traumagenic Dynamics" model to make effects of sexual abuse understood (4). According to this model, sexual and emotional developmental problems may occur in the child due to finding him/herself suddenly in adult sexuality when not being ready for that. Defects of sexual identity and norms can be seen due to traumatic sexual development. This condition may cause repetitive and random compulsive behaviors in early and late periods, impairment in interpersonal relations, wrongly re-treatment, sexual violent behaviors, powerlessness and self-stigmatization.

In children exposed to sexual abuse, intense anxiety, distress, fear reaction and preventive behavior towards objects which remind the event can be observed but also increase in sexual behaviors, masturbation, playing sexual games and sexual identity and functional disorders may be seen conversely (11). In our case, there were disturbing and unavoidable sexual behaviors such as early-onset masturbation which were so intense to disrupt daily activities. These behaviors were described as compulsive sexual behaviors by several authors and relationship with OCD was referenced (12).

Although compulsive sexual behavior (CSB) is a concept which has recently gained attention, there is much debate about its main clinical characteristics and relationship with other psychiatric disorders. Common opinion is that CSB is inappropriate or excessive sexual cognition or behavior which causes subjective discomfort or impaired functionality in some important domains (13). CSB is a progressive, multi-phasic and deteriorating condition unless treated. At the first phase, mental occupations and desires with intense sexual contents occur and at the second phase ritualization and habits generating sexual behavior occur. Third phase is the satisfaction phase and sexual behaviors became too

intense. Fourth phase is the desperation phase and characterized by development of guilt, hopelessness and isolation. This condition fires the tension which develops CSB and same cycle starts again (14,15).

There are several things to be done for sexual traumas in our country. First of all, sexual abuse in childhood and different psychiatric conditions which can develop in the following years should be paid more attention.

REFERENCES

1. Russel D. *The Secret Trauma: Incest in the lives of girls and women*. Basic Books, New York, 1986, 81–87.
2. Şahin F, Beyazova U: Çocuğun cinsel istismarında adli bildirim. Hekimin İkilemi. Adli Tıp Dergisi 2003; 17:47-51 (Article in Turkish).
3. Ovayolu N, Uçan Ö, Serindağ S. Çocuklarda Cinsel İstismar ve Etkileri. Fırat Sağlık Hizmetleri Dergisi 2007; 4:14-22 (Article in Turkish).
4. Finkelhor D, Brown A. The traumatic impact of child sexual abuse: a conceptualization. *Am J Orthopsychiatry* 1985; 55:530–541. 
5. Davis JL, Petretic-Jackson PA. “The impact of child sexual abuse on adult interpersonal functioning. A review and synthesis of the empirical literature”. *Aggress Violent Behav* 2000; 5:291-328. 
6. Jackson J, Calhoun K, Amick A, Maddever H, Habif V. Young adult women who report childhood intrafamilial sexual abuse: subsequent adjustment. *Arch Sex Behav* 1990; 19:211–221. 
7. Gordy P. Group work that supports adult victims of childhood incest. *Soc Casework* 1983; 64:300–307.
8. Eliot AJ, Peterson LW. Maternal sexual abuse of male children: When to suspect and how to uncover it. *Postgrad Med* 1993; 94:169-172.
9. Fassler IR, Amodeo M, Griffin ML, Clay CM, Ellis MA. Predicting long-term outcomes for women sexually abused in childhood: Contribution of abuse severity versus family environment. *Child Abuse Negl* 2005;9:269-284. 
10. O’Leary P, Cooney C, Easton SD. The effect of severe child sexual abuse and disclosure on mental health during adulthood. *J Child Sex Abus* 2010; 19:275-289. 
11. Beitchman JH, Zucker KJ, Hood JE, DaCosta GA, Akman D. A review of the short term effects of child sexual abuse. *Child Abuse Negl* 1991; 15:537-556. 
12. Black DW, Kehrberg LL, Flumerfelt DL. Characteristics of 36 subjects reporting compulsive sexual behavior. *Am J Psychiatry* 1997; 154:243-249.
13. Black DW. The epidemiology and phenomenology of compulsive sexual behavior. *CNS Spectr* 2000;5:26-35.
14. Carnes P. Addiction or compulsion: politics or illness? *Sexual Addiction & Compulsivity* 1996; 3:22. 
15. Bergner RM. Sexual compulsion as attempted recovery from degradation: theory and therapy. *J Sex Marital Ther* 2002; 28:373-387. 