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Repressed and silent suffering: consequences of childhood sexual abuse for women's health and well-being

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Research results indicate that psychological trauma in childhood caused by child sexual abuse can have serious and widespread consequences for health and well-being. The purpose of this study was to examine the consequences of childhood sexual abuse for women's health and well-being. The research methodology was phenomenology. Seven women with a history of childhood sexual abuse were interviewed twice with 1–6 months interval. For all the women, the abuse started when they were between 4 and 5. All of them were repeatedly violated and traumatized ever since then and were even still being victimized at the time of the interviews. The main result of the study is that time does *not* heal all wounds. All the women described great repressed and silent suffering in all aspects of life, and the abuse is still seriously affecting them and their loved ones. As children, they had learning problems, experienced bullying and had unexplained physical symptoms. In adulthood, they have been suffering multiple physical and psychological symptoms: five of them have fibromyalgia; all of them have been suffering chronic and widespread pain; they have all been dealing with depression and difficulty with close connections, and they all have trouble trusting others. Because they were kids, they have been using the health service to a great extent but without adequate help. It is important for health professionals to know the symptoms and consequences of childhood sexual abuse to be able to respond to adult survivors in a supportive and caring way. More effective therapeutic measures have to be developed to decrease their suffering.

Keywords: sexual abuse, women's health, child abuse, suffering, lived experience, mental health, repression.

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Introduction

Child sexual abuse (CSA) is a form of child abuse in which an adult or older adolescent uses a child for sexual stimulation. It includes asking or pressuring a child to engage in sexual activities, indecent exposure with intent to gratify the adult's own sexual desires or to intimidate or groom the child,[1] physical sexual contact with a child, using a child to produce child pornography or exposing one's genitals to children or pressuring them to expose themselves (2). Research results indicate that psychological trauma in childhood because of CSA can have widespread and serious consequences for health and well-being (3, 4). The consequences of such trauma are great fear, helplessness and terror, and in all forms of violence, it seems that the damage is likely to have the deepest and most serious consequences when the perpetrator is a close friend or a relative (4). In psychological trauma, the body reacts with a *fight, flight or freeze* response. Levine and Frederick (5) point out that when individuals 'freeze', they often experience shame and guilt afterwards, because they could not do anything to protect themselves. They further state that freezing is an emergency response of a person experiencing trauma to survive the trauma; individuals enter a state of mind where they do not feel any pain and approach a feeling of dying.

Long-term trauma can develop into post-traumatic stress disorder (PTSD), with myriads of psychological and physical symptoms (6). PTSD is a severe anxiety disorder that can develop after exposure to any event which results in

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[1]*Grooming* is the process by which an offender draws a victim into a sexual relationship and maintains that relationship in secrecy. Three types of sexual grooming have been identified: self-grooming, grooming the environment and significant others, and grooming the child (1).

psychological trauma. It may involve the threat of death to oneself or to someone else, or to one's own or another person's physical, sexual or psychological integrity, overwhelming the individual's ability to cope. Symptoms include re-experiencing the original trauma(s) through flashbacks or nightmares, avoidance of stimuli associated with the trauma and increased arousal – such as difficulty falling or staying asleep, anger and hypervigilance (7). PTSD is especially common after CSA (3, 8, 9); and PTSD and attention deficit hyperactivity disorder (ADHD) were the most common symptoms experienced by children following CSA (10). However, not all those who suffer CSA develop PTSD or ADHD (10). Positive defence mechanisms such as the person's maturity, faith, experience, inner strength, adaptation and support from family and community can hinder or prevent PTSD (6). In Table 1, the known consequences of CSA are highlighted. They can be categorized into physical, psychological, social consequences and those affecting sexuality. The consequences of CSA have largely been examined through quantitative studies, but more qualitative studies are needed, as some research questions, for instance, with respect to the lived experience, cannot be answered within the quantitative paradigm.

Table 1 Known consequences of child sexual abuse (CSA)

Physical symptoms
Widespread and long-term pain (11–13)
Sleeping problem, tremor and numbness (11, 13)
Eating disorders (14, 15)
Fibromyalgia (16)
Long-term fatigue, heart and coronary problems, as well as diabetes (17)
Psychological symptoms
Depression, anxiety, phobia, low self-esteem, shame, self-destructive behaviour, alcohol and drug abuse (18–20)
Serious suicidal thoughts (21–23)
Anger, grief, sorrow, sadness, disappointment (24)
Personality disorder, post-traumatic stress disorder and social phobia (25–27)
Social symptoms, sex and relationships
Difficulties in sex life and in connection with spouse (28)
Difficulty trusting men (29, 30)
Marriage problems (31)
Defencelessness against all kinds of violence in adulthood (8, 32, 33)
Repeated physical, psychological and/or sexual violence in relationships or rape (34)
Anxiety and stress as parents and adolescent motherhood (35, 36)
In more danger of being violent towards own children (37)
Frequently seeking help in the health care system but do not mention the abuse (38)
Get little or no support in the healthcare system but ample medication (24)
Health care cost is twice the amount for people with no CSA (39) … With meagre success (38)

The purpose of this study was to examine consequences of childhood sexual abuse for women's health and well-being. The research question was what are the consequences of childhood sexual abuse for women's health and well-being?

Research methods

The methodology chosen to answer the research question was the Vancouver School of doing phenomenology, a unique blend of phenomenology, hermeneutics and constructivism (40). As applies to most studies based on phenomenological traditions, this study is based on the philosophy of holism and existential psychology, as well as on the premise or theory that reality is individually constructed as a result of lived experience (41). Within the Vancouver School of doing phenomenology, emphasis is placed upon seeing all individuals in their context, as well as the understanding that each person perceives the world in a unique way and that their perception is moulded by former experience and their own interpretation of that experience. The method is thus person centred. The Vancouver School of doing phenomenology stands for moderate realist ontology, a transactional epistemology, and a hermeneutic, dialectical methodology (40). The inquiry aims are oriented to the production of reconstructed understandings from the point of view of the interacting individual. Spiegelberg (41) has asserted that the common concern of phenomenology is that of giving the phenomena a fuller and fairer hearing than traditional empiricism has accorded them. It involves believing, with the constructivist and the interpretivist, that to understand the world of meaning one must interpret it and that the data in any study do not speak for themselves as such. The researcher must make sense of the data in a meaningful way, along with research participants, who are seen as dialogue partners and coresearchers (40). Finally, the stated aim of the Vancouver School of doing phenomenology is to increase knowledge and deepen the understanding of certain phenomena to improve a human service, for example, a certain field of health service (40). This aim corresponded with our ideas of the importance of the dissemination of new knowledge and the utilization of findings in clinical practice.

Sample

Seven women who were sexually abused in childhood participated in the study. They were chosen through a purposeful sample with the assistance of an expert in the field (four women) and from two education and counselling centres for survivors of sexual abuse and violence *Stigamot* (http://www.stigamot.is) in Reykjavik (the capital) and *Aflid* Akureyri (http://www.aflidak.is) in North Iceland (three women). Requirements for participation in

the study were to be over 25 and have experienced childhood sexual abuse. The women were between 30 and 65 years of age at the time of the interviews. The abuse started when they all were between 4 and 5 years old (so far as they can remember). They have all experienced repeated trauma and violence ever since, and for some, that was still the case at the time of the interviews. Three of the women have lived with their husbands and the father of their children since they were teenagers. Four of the women have divorced many times and do not live with the father of their children. They are all cohabiting today. Each of the women has 2–4 children, and they all live in urban areas. None of the women went into high school education; two did not complete their compulsory schooling (age 6–16) because of difficult family situations. All the women have sought professional help within the healthcare system, one of them since she was a child, some of them since they were teenagers and still others in adult years. They have sought help from GPs, medical specialists, nurses, pastors, psychiatrists and psychologists, but have not received adequate or proper help.

Data collection and data analysis

Each woman was interviewed twice by the first author. The interviews were held in places that were chosen by the women. All the women had professional support at the time of the interviews. The research process in the Vancouver School involves 12 main steps, and in Table 2, these steps are delineated, as well as how they were followed in this study.

All interviews were conducted in Icelandic, taped and transcribed verbatim. The transcriptions were analysed for main themes and subthemes. The findings from each interview were constructed into an analytic framework, in accordance with steps 3–6 of the Vancouver School. The first author repeated this procedure for each participant, constantly repeating steps 1–6 until a holistic understanding of the participants' experience was constructed. Each of the seven analytical frameworks was verified with the relevant participant, to ensure that the researcher had understood her words correctly (step 7). Both researchers were involved in the data analysis, synthesis and interpretation. At every step, the researcher/s went through the research process of the Vancouver school: silence, reflection, identification, selection, interpretation, construction and verification (see Fig. 1).

Validity of the study

Each interview was analysed thoroughly, with emphasis on critical assessment of the quality of the data collection, data analysis and presentation of findings, to enhance the validity of the study. The research process of the Vancouver School has some in-built strategies designed to enhance validity, particularly 'member checking' in steps 7

Table 2 The 12 research steps of the Vancouver School and what was performed in this study

Steps in the research process	*What was performed in this study*
Step 1. Selecting dialogue partners (the sample)	Seven women were selected through purposeful sampling
Step 2. Silence (before entering a dialogue)	Preconceived ideas were deliberately put aside
Step 3. Participating in a dialogue (data collection)	Two interviews with each participant, total of 14 dialogues. The first author conducted all the interviews
Step 4. Sharpened awareness of words (data analysis)	Data collecting and data analysis ran concurrently
Step 5. Beginning consideration of essences (coding)	Trying repeatedly to answer the question: what is the essence of what this woman is saying?
Step 6. Constructing the essential structure of the phenomenon from each case (individual case construction)	The main factors in each woman's story were highlighted, and the most important factors were constructed into an analytic framework
Step 7. Verifying each case construction with the relevant participant (verification)	This was carried out with each participant
Step 8. Constructing the essential structure of the phenomenon from all the cases constructions (meta-synthesis of all the different case constructions)	Both researchers participated in this final data analysis process and made sure the model and framework constructed were based on the actual data
Step 9. Comparing the essential structure of the phenomenon with the data (verification)	To ensure this, all the transcripts were read over again
Step 10. Identifying the overriding theme that describes the phenomenon (construction of the main theme)	*Time does* not *heal all wounds*: Short-term and long-term consequences of childhood sexual abuse to women's health and well-being
Step 11. Verifying the essential structure with some research participants (verification)	The results and the conclusions were presented to and verified by each participant
Step 12. Writing up the findings (multivoiced reconstruction)	The participants are quoted directly to increase the trustworthiness of the findings and conclusions

Based on (40: 57).

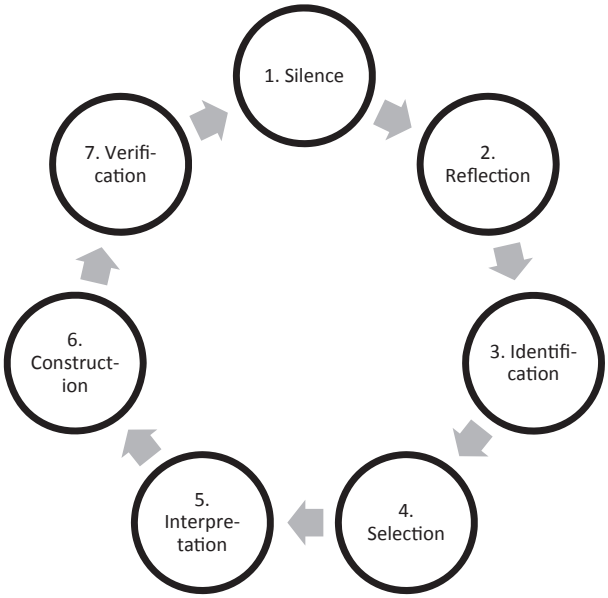

Figure 1 The process of doing phenomenology in the Vancouver School. Based on (40: 56).

and 11 (see Table 2). The 'researcher triangulation' in this study proved fruitful, especially in steps 8, 10 and 12, where the expertise of two professionals, one expert in the subject area and one expert in the methodology, were combined. Triangulation is one of the strategies designed to enhance validity and reliability in qualitative research (40). 'Peer debriefings' and 'thick description' were also used as strategies to enhance validity. Because of the effects of constructivism within the Vancouver School, 'reflexivity' is a given. The findings are a construction of the researchers, based on the data. A 'reflective diary' was used at all stages of the research process as required by the Vancouver School (40).

Ethics

The four basic principles of biomedical ethics – respect for autonomy, nonmaleficence, beneficence and justice – were the ethical ideals followed in the study and explained to the participants, to ensure that the rights of the participants were safeguarded, for example, confidentiality, and the right to waive or suspend (42). Ethical clearance was obtained from the Icelandic Bioethics Committee (VSNb 2005030020/03-7), and the study was reported to the Data Protection Authority (S2478/2005/EB/-). Because the study involved a group of vulnerable women, we made every effort to protect the women ethically. A nurse working in pain and obesity teams within rehabilitation pointed out four women whom she had worked with as clients within these teams. These four all agreed to participate and pointed out other women with similar experience whom they knew. The nurse contacted the women and asked for permission for the first author to contact them by phone. Initially, the first author contacted all the women by phone and introduced the study to them. Then, before the first interview commenced, each woman was given an introductory letter in which all the main ethical aspects were addressed. The first author also gave an oral presentation of the study before the interview started, and the women all signed an informed consent. The letter of introduction and the oral presentation included names of a psychologist and other therapeutic professionals who all had signed a consent to be available for the women if difficult emotions emerged during the interviews. The first author chose 'research names' (pseudonyms) for all the women to be used only in this study.

Results

All the women suffered repeated childhood sexual abuse from a close family member before they reached the age of 12 years and from more than one person. Table 3 gives an overview of the answer to the research question about the consequences of childhood sexual abuse for women's health and well-being. The women have all lived in repressed and silent suffering with negative physical, psychological, relational and sexual health consequences.

Experiencing the trauma

Experiencing the trauma had a negative impact upon the women's emotional health and well-being. Some of the women have always remembered the details of the traumas, while others shut out the painful memories and remembered nothing until years later. All of them have had severe feelings of self-reproach. Heather recalls her feelings from the time of the abuse:

> I experienced it as theft of the soul. When you are being abused, the pain gets so tremendous and the stress and the desperation, that what you experience can only be that you've died, the pain is so great … how is it possible only to keep on breathing? … it hurts so much there are no words to describe it. It's so overwhelming [breaks into tears], it's like experiencing your soul dying … everything dies, all sense of security, self-respect and self- love and all belief that you're worth anything.

The women felt that their 'personal protective line', which they saw as part of their 'psychological defence system', was violated. Their 'personal line was broken' by the violator, and that rendered them defenceless and vulnerable to repeated violence and abuse. In the situation of CSA, all the women experienced 'secrecy', 'menace' and 'humiliation'. Most of the women spoke of their mothers having been victims of violence themselves, and not being able to help them or protect them. Heather remembers one time when her mother came into her room at night and took her father away:

Table 3 Consequences of child sexual abuse for the health and well-being of the women who participated in this study – main themes and subthemes

Experiencing the trauma	*Lack of well-being as a child and as a teenager*	*Adult physical symptoms*	*Adult psychological symptoms*	*Relation and sexual health consequences*	*The shadow is still hanging over*
Self-blame Guilt Sleeping problems	Psychological problems. Fear. Problems in school. Being bullied	Pelvis problems Vaginal problems	Depression. Anxiety. Postpartum depression	Trouble connecting with men	'I am what I am today' I can't get rid of 'the shadow'
'Soul theft', 'soul death' Psychological pain. Despair. Stress. Agony	Multiple physical symptoms	Complex physical problems	Self-destructive thoughts Self-destructive behaviour Suicidal thoughts	Trouble trusting other people	Importance of the will to live
Defencelessness Broken defence wall	Pain	Fibromyalgia Muscle pain Sleeping problems	Feeling rejected	Trouble with touching and in sex life	Permanent damage Hidden pain inside
Secrecy. Threat. Humiliation Remembering Flashbacks	Domestic violence Sexual abuse Self-destructive behaviour Suicidal thoughts Suicidal attempts	Eating disorders Alcoholism	Fear and panic Remembering the abuse	Trouble connecting with the children Trouble touching the children	Giving up Hopelessness The need for peace in the soul
Leaving the body Dissociation			Escape. Phobia. Isolation		Heavy work ahead to reach healing of the heart of the heart

> When I think back to when she came into the room – she sees the child crouching in a corner with nothing to cover her, something is wrong here. Mum must have been a victim too. It's just enormous pain.

Four of the women were raped later in their lives, and at that point, they experienced the abuse all over again, as Susan described:

> When I was lying there afterwards, I experienced everything I had gone through all over again, and my feelings just died again. I was more in the past when I was a little girl, than the rape itself, and I experienced it all over again.

Audrey started to gain weight after the abuse and has since then used food to cope with difficult feelings and emotions: 'After an incident I would go straight to the sugar bowl and get myself something to dull the pain'. Four of the women recounted how they managed to cope by leaving their bodies, as Kate describes:

> I always left my body. I remember looking at myself from outside and it was just the body suffering. Then the soul returned. I went out of my body and watched the body suffer. I still sometimes use this way to escape.

Lack of well-being as a child and as a teenager

Great distress dominated the women's childhood and teenage years; they were unhappy at school, were bullied and lived in fear. They had various psychological and physical symptoms. They feel that people should in most cases be able to tell from children's behaviour if something is seriously wrong. They were gravely depressed as children; one of them was abnormally well behaved and good and always afraid. Audrey dealt with learning disabilities and psychological problems: 'I had ADHD, was put in special education and just gave up. I could not learn'.

All the women except one said they were repressed in childhood, tried to hide and be invisible. Audrey, however, was rebellious, obeyed no one, used alcohol, smoked and lied. At 13, she started having sex with many much older men, and was sexually abused on many occasions although she claims she was a willing participant. All the women dealt with various physical problems during childhood which were never connected to their psychological trauma. They saw many doctors, but were never given any diagnosis or support, although they received plenty of medication. Jane was 13 when she had an operation for appendicitis, which turned out to be gastric ulcers caused by severe stress. She always developed a fever when she was sent to stay with her abusive father. When Heather was 10, unexplained back pain put her to bed for days:

> I regularly wet the bed until I was 11, just a symptom of fear, and then there was the pain: the legs at 9; the back at 10 and at 11 the hips. I was only a teenager

> when they started talking about myositis and arthritis starts. By the time I was 16 or 17 it had become a part of me, chronic pain, and I experience a lot of pain.

The summer when Jane turned 12 she almost lost her sight and had a severe inflammation of her ears, and both ear drums ruptured in 2 days, as she herself said: 'Just stress, like giving up on watching and listening to life'. One doctor said to her that if she wanted attention she should look for it at home, not from him.

After Audrey was abused, she started to gain weight and that led to side effects such as diabetes, myositis and pain. All the women had suffered headaches, digestive problems and dizziness as children. Only one of them, Heather, told of the abuse when she was a child: 'I was 5 when I told Mum what my grandfather was doing to me. She just slapped me. It was shocking, and it made me so confused and it was at that time even worse than the abuse itself'. As children, all the women had had suicidal thoughts, and most of them had attempted suicide.

Adult physical symptoms

All the women have had uterine problems and severe unexplained pain; they have even been hospitalized and given strong painkillers. Five of the women had hysterectomies around the age of 30 and felt it was a great relief to get rid of what had been causing them so much pain. Some of the women have had miscarriages and/or ectopic pregnancies. In adulthood, all the women had serious physical problems in relation to puberty, sex life and childbirth: urinary infections, severe menstrual pain and diverse infections in the pelvic region. In some cases, it led to repeated abdominal operations, as Jane recounted: 'At the age of 16–17 I started to get cysts on my ovaries and I must have had 8 or 10 abdominal operations to fix all sorts of problems'.

The women have been plagued by complex physical symptoms without medical explanations, such as stomach ache, colon cramp, digestion dysfunction and infection, cardiac arrhythmia, angina and hypertension, dizziness and fainting, glandular dysfunction, problems with the lymphatic and nervous systems, and chronic fatigue. They have had problems with sleep since childhood, and six have been diagnosed with fibromyalgia/ME. All the women have suffered from unexplained pain and myositis in various parts of the body. All have some kind of eating disorder, and some of them have used alcohol to try to ease their emotional pain. Heather has often been very ill and has had many of the symptoms of a dying person; her oxygen level fell, the lungs were not functioning well, there were disturbances in nerve function and the heart, as if all bodily functions were slowing down. Extensive medical examinations yielded no result. Having a panic attack, Gwen experienced all the symptoms of a stroke and lay in bed for about 2 months, without being able to stand on her feet. She was numb above the mouth and on one side of her body and had a feeling of paralysis, with panic attacks, severe weakness and nausea: 'I was certain I was never going to be happy again, and had started to think that the best way out of this pain would be simply to die, I just felt so awful'.

Adult psychological symptoms

All the women have experienced periods of depression in their lives; in some cases, this has been a constant. Jane was raped when she was 18 years old, shortly after giving birth to her first child, and this was followed by severe depression. When Heather was 23 years old, her parents came to her home to ask her whether her grandfather had done something to her in childhood. At that time, other victims of his abuse had come forward:

> I completely lost it and screamed so painfully. It was not just like normal crying, it was like an injured animal. I screamed and I cried … but then my mother grabs my hand and says: 'but we're not going to tell anyone about it, the family must stick together'. It hurt so much that I cried for a whole day, and the next day my husband called a doctor. He had to give me an injection to calm me down. I just cried with pain.

Some of the women have tended to react in a similar way to such times of pain and unhappiness to seek some kind of inner peace: they adopt a foetal position and sit quite still, with 'the stare', as Jane recounted:

> The kids were always saying: 'Mum, stop staring like that'. I sometimes did it when I had that feeling, and got into thoughts that hurt so much, I would sit down in some corner and just stare into space. It was some kind of escape because it was connected to the abuse and the violence.

The women speak either of postnatal depression, 'never experiencing the joy of bringing a child into the world', or a tendency to isolate themselves and the children, overprotect them and an inability to trust anyone else to take care of them. They have all had some self-destructive tendencies, self-harming or having suicidal thoughts. Heather has thought seriously about taking her own life for a long time and had it all planned:

> As a getaway I used to leave my body, just stepped out and watched the body suffer. I had been planning to drown myself in the sea and to use this same way to fight the cold. You feel so bad that you don't believe anyone would miss you, you really feel you're just dirt… that's the way you see yourself.

All the women have had strong feelings of rejection which have affected their thoughts, actions and general well-being. They constantly fear more rejection, and that has had an impact on their self-image. They often speak of 'fear', 'running away' and 'isolation'. They find it difficult to be in a crowd, and avoid close encounters and

heavy demands which they feel have always been made on them. They want to be alone, not to mingle with other people. At a certain time in her life, Heather saw her grandfather's face everywhere and felt that he was around when she least expected him, and it reminded her constantly of the abuse: 'If my husband walked towards me I just saw the face of my grandfather, and if my husband put his hand under the quilt I felt it was my grandfather's hand. It was so hard'. The women who repressed their painful childhood experiences experienced flashbacks later in life; certain moments in their life brought it back into memory, such as giving birth to their first child.

Relational and sexual health consequences

The women all have difficulty in relationships with men; their self-image is shattered, and they feel they deserve nothing good. They find it difficult to trust anyone and feel that all trust has been broken, because someone they trusted as children betrayed them. The women have problems with touching. They are uncomfortable being touched by male partners, and this gives rise to problems in their intimate relationships. They feel that the consequences of the abuse will never disappear. They find it difficult to enjoy sex life with their partners, but usually put up with sex for the partner's sake, as they feel it would not be fair to deny, as Jane states:

> Of course it's been a heavy cross to bear all this time, and really you're no kind of lover… It has just been a bit hard, and something I am, today, not capable of doing. Sometimes you have this sexual desire and then you try to make the most of it. I often think about that sexual side, what I've been missing not being able to enjoy it [breaks into tears] but I just can't, and I believe that's what I regret the most.

They believe that their painful childhood experience, together with postpartum depression later in life, has greatly influenced how hard it has been for them to bond with their children and be affectionate towards them. Kate is certain that her emotional state has had a damaging effect on her children's well-being. The women also have problems with touching and hugging their children and with being touched by them. Problems may have begun just after birth, or when the children were the same age as their mothers when abused, or at puberty. Jane describes this:

> I have always had to fight myself, always trying to convince myself that I know the difference between right and wrong touching, that I will not touch them in a wrong way. I've had a really hard time bringing them up, and felt that all touching was wrong… you wonder how many generations it takes to eliminate this kind of behaviour.

The shadow is still hanging over

All the women have repeatedly sought help within the health service, but have never received adequate or proper help. They have also used various alternative treatments and massage, which they feel was one of the few things that have helped them. They talk about feeling bad and ill and being unhappy. They feel they will never be rid of the 'shadow' that hangs over them, but they try to see the bright side of themselves and their life. Some find it most difficult to always be on their guard, unable to trust anyone, and they feel that is one of the reasons why they cannot give of themselves. For Heather, it is a constant struggle to keep going from one day to the next. She is afraid of people and finds it hard to wrestle with her feelings and is always expecting the unexpected from people: 'I need to remind myself many times a day that my will to live is all right. I just have to learn to live with it. Time does *not* heal all wounds'. She sometimes feels that she cannot go on, with so much despair and inner anguish, trying to get out. She feels a constant sense of disappointment.

Rose has been working extensively on her inner life and her feelings, but now close to giving up. When she consults doctors about her physical symptoms, they can give her no answers, and she asserts that childhood sexual abuse is 'murder of the soul', from which she will never recover. She has never been able to cry and is so tired of not finding any way out or attaining any inner peace:

> It doesn't matter what I do, there is always something inside me that is bothering me. Being as old as I am and not being able to feel good after all I have been through. Sometimes I feel that I am giving up, ready to go. I feel my role here is finished. I'm so tired from this pain that can't find a way out.

Susan has tried all the help she could find, and she says it is important that people open up about the abuse, because the longer they keep it inside the more damage will be done, for their partner, their children and themselves:

> You always have to go all the way inside yourself… to the bottom of your heart. I would like to rewind to the beginning and start my life again… nobody else can make it go away… you have to find the way yourself. Nobody else can put peace into my heart. The hate is the worst thing for us.

Discussion

We found that this methodology fits well within healthcare research, not least when researching sensitive subjects and vulnerable groups, because this phenomenological school emphasized meeting the participant as an expert in the phenomenon being researched and hence with a certain level of modesty and unobtrusiveness. We believe that this approach made it easier for us to recruit survivors of sexual abuse and gain their confidence to participate in

this study and positively affected the level of candidness and earnestness we witnessed in the study. The research results indicate that CSA can have vast and long-term consequences for women, physically and psychologically. The symptoms appeared at different stages – immediately after the trauma or even many years later – and developed into PTSD with complex symptoms, and the women were defenceless against repeated trauma later in their lives. The results of this study are in harmony with research results from many other studies (see Table 4).

The results of this study where we did *not* find comparable results in other studies were mainly the following:

- All the women had experienced multiple physical problems in their childhood that were never connected to their psychological trauma.
- All the women have had uterine problems and severe unexplained pain. They have even been hospitalized because of this. Five of the women had a hysterectomy before the age of 30. A few of the women had miscarriages and/or ectopic pregnancies, cysts on their ovaries, urinary tract infections, severe menstrual pain and diverse infections in the pelvic region.
- All the women have suffered from unexplained pain and myositis in different parts of the body from childhood.
- All the women experienced postpartum depression.
- All had difficulty bonding with their children and showing them affection and tenderness. They worry constantly about their children and have a hard time trusting others to care for them, tending to isolate and overprotect them.

No research results were found that gave such detailed insight into the short- and long-term consequences of CSA, and we are of the view that this study is therefore important, as it gives a fuller picture of the consequences of CSA than the previous studies.

When we discuss the enormous consequences that CSA has had for these women, to what can we compare to the crime committed against them? The consequences are similar to what we see in people who have lived through torture and serious war crimes. When a little girl is subjected to sexual abuse, her life is destroyed in so many ways. From these research results, we can see how her body and soul are broken for a lifetime. We see this especially with regard to the pelvic area. All of them agree that they have sustained permanent damage and that their lives have been a constant catalogue of struggle and suffering, a thorny path they have trodden from childhood until the present day.

What can help us understand this massive destruction? They describe the trauma in childhood as a 'theft of the soul', 'murder of the soul' and 'death of the soul'. They recount how their soul actually leaves their body. They explain the child's pain, how the desperation follows them, how their protective wall was broken down and their defencelessness was complete. We can compare this utter collapse to the impact of war crimes; however, in that case, we are usually talking about grown men, but here about the defencelessness of a little girl. Even the 'stare' is known by soldiers who have been active in war and who have been through too much and seen too much. Known as the 'thousand-yard stare', it is one aspect of 'combat fatigue' or 'combat stress reaction', seen in military personnel who have been engaged in life-threatening combat in the front line.

Table 4 Main results of this study consistent with other research results

Findings of this study which are consistent with other studies
Some of them have remembered the abuse all the time, and others shut it down and remembered it many years later (4, 5)
All the women except one had feelings of heavy self-blame and guilt (4, 5)
Lack of well-being in childhood. Always felt different. Could not sleep at nights and had psychological problems (23)
One of them had attention deficit hyperactivity disorder (ADHD), and others had symptoms of attention deficit disorder (9)
All of them experienced difficult teenage years, and one of them started to have unlimited sex before the age of 13 and used a lot of alcohol (32)
All of them had some kind of eating disorders. All had suicidal thoughts, self-contempt, self-destructive instinct from very early on and suicidal attempts (17, 22, 41)
All of them have suffered long-term and widespread pain since childhood, especially in the pelvic area (10, 12, 15)
Five of them have fibromyalgia (15)
All of them have suffered depression, lost their will to live, had trouble regarding mood, always tired and had no energy (16, 24)
They have all had feelings of rejection all their life (20, 26)
They have had feelings of escape, phobia and isolation (12, 21)
Some of them have used alcohol to numb their bad feelings (13, 14)
All of them have had problems with close connection and to have normal relations. They have marriage problems and difficulty trusting (28, 29)
Most of them had been through repeated physical, psychological and/or sexual violence from a spouse or were raped (7, 31)
They all have had trouble touching their children, feel like all kind of touching is wrong (34)
All of them have repeatedly sought help in the health care system. They feel that nobody listens to them and that they do not have appropriate support and no cure for their physical problems but plenty of medications (23, 37, 38)

Once again, we may compare the impact of CSA with that of war; in that, CSA does not only break down the defences: the invader, the enemy, breaks in and occupies all the little girl's private space and seizes power over her life, and throughout her life the 'vanquished' is striving to expel the enemy, the monster, from her private space (43).

The characteristic feature of 'conquerors' is often to destroy, vanquish, compel and oppress. As in a country defeated by war, the horror of the destruction is in front of us, and reconstruction is not an easy task. It can take a long time and needs a lot of patience. The main problem is that the healthcare system is not meeting the needs of these women. The breakdown they experience is like no other. Few of those who seek help within the healthcare system are so totally devastated, both physically and mentally.

The latest research results from psychoneuroimmunology have an important contribution to make to our understanding of this drastic collapse. These studies indicate that every human being must be seen as one whole, body and soul (44). That which breaks down the soul also breaks down the body, and *vice versa*. The soul, the nervous system and the immune system are all closely connected. When we respond to an incident or situation, we do it as one whole, body and soul (44, 45). The latest research results indicate that there is no real distinction between soul and body, because of the communication between the brain and the nervous system, endocrine and immune systems (45, 46). All the women have been living under enormous stress, and it is known that stress is highly immunosuppressive (46), and long-term stress can increase the risk for many diseases (47). Negative emotions, such as those experienced by all the women, can be very damaging to health and can lead to long-term infections, delayed healing of wounds and long-term inflammation (48). It is also known that if a person feels that she/he does not have control over the situation that causes the stress – as is true of all the women in this study – that can have even greater negative impact than the causes of the stress itself (49). Furthermore, the physical symptoms can be connected to the defence response of 'freezing', as Levine and Frederick (5) and Rothschild (6) have stated. It is also known that depression, experienced by all the women, has multiple negative effects on the immune system (47). The women's experience may be likened to a tsunami for their soul, body, mind and their whole consciousness.

What these women experienced was repeated psychological trauma without any crisis counselling; on the contrary, they were silenced. Researchers who have been studying suffering, emotions and emotional relief have found that expressing emotions can have very positive effects on the immune system (50). This should be kept in mind when developing treatment to relieve the pain of people suffering because of CSA. Emotional expression is also connected to revitalization (51). Furthermore, it is important to mention that social support is a stress buffer (52), and awareness of having support from family, friends or professionals has statistical correlation to positive effects on the immune system (44). Finally, researchers also point out that support is one of the most important treatments for women suffering long-term PTSD because of CSA (53, 54).

Study limitations

All the women who participated in this study have been working very hard to recover, with professional assistance. Hence, they are not typical of women affected by CSA. Care should be taken not to generalize from this study, as its purpose was to increase knowledge and deepen the understanding of the consequences of CSA for women's health and well-being, but not to generalize from it to all women who suffer the effects of CSA.

Conclusion

This study adds critical dimensions to the current research findings. The results of the study indicate that CSA can have enormous, widespread, long-term and grave social, psychological and physical consequences. All the women have suffered intensely, and their emotional pain is deep. It is cause for concern that the healthcare system does not seem to offer a treatment solution for women suffering because of CSA; all the women have sought help from the healthcare system, without receiving satisfactory help for the root of their problems, the CSA. This has to change. An effective treatment solution for victims of CSA has to be developed. Finally, it is important that all women who have experienced CSA encounter care and support when they seek help from the healthcare system; and healthcare professionals need to listen with attention to what they have to say. It can make a crucial difference to their health and well-being.

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Author contributions

Sigrun Sigurdardottir conceived the study. Sigridur Halldorsdottir and Sigrun Sigurdardottir designed the study. Sigrun Sigurdardottir collected data. Sigrun Sigurdardottir and Sigridur Halldorsdottir analysed the data. Sigrun Sigurdardottir drafted the manuscript. Sigridur Halldorsdottir

and Sigrun Sigurdardottir critically revised the important intellectual content. Sigridur Halldorsdottir supervised.

Ethical approval

Ethical clearance was obtained from the Icelandic Bioethics Committee (VSNb 2005030020/03-7), and the study was reported to the Data Protection Authority (S2478/2005/EB/-). Because the study involved a group of vulnerable women, we made every effort to protect the women ethically.

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References

1 Craven S, Brown S, Gilchrist E. Sexual grooming of children: review of literature and theoretical considerations. *J Sex Aggress* 2006; 12: 287–99.
2 Child Sexual Abuse. *Medline Plus. U.S. National Library of Medicine*. http://www.nlm.nih.gov/medlineplus/childsexualabuse.html (last accessed 18 July 2012).
3 Fagan N, Freme K. Confronting posttraumatic stress disorder. *Nursing* 2004; 34: 52–64.
4 Scaer RC. *The Body Bears the Burden*. 2001, The Haworth Medical Press, New York.
5 Levine PA, Frederick A. *Waking the Tiger, Healing Trauma*. 1997, North Atlantic Books, Berkeley, CA.
6 Rothschild B. *The Body Remembers*. 2000, W.W. Norton, New York.
7 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV*. 1994, American Psychiatric Association, Washington, DC.
8 Hetzel MD, McCanne T. The role of peritraumatic dissociation, child physical abuse and child sexual abuse in the development of posttraumatic stress disorder and adult victimization. *Child Abuse Negl* 2005; 29: 915–30.
9 Norris FH, Murphy AD, Baker CK, Perilla JL, Rodriguez FG, Rodriguez JJG. Epidemiology of trauma and posttraumatic stress disorder in Mexico. *J Abnorm Psychol* 2003; 112: 646–56.
10 Weinstein D, Staffelbach D, Biaggio M. Attention-deficit hyperactivity disorder and posttraumatic stress disorder: differential diagnosis in childhood sexual abuse. *Clin Psychol Rev* 2000; 20: 359–78.
11 Otis JD, Keane TM, Kerns RD. An examination of the relationship between chronic pain and post-traumatic stress-disorder. *J Rehabil Res Dev* 2003; 40: 397–406.
12 Walsh CA, Jamieson E, MacMillan H, Boyle M. Child abuse and chronic pain in a community survey of women. *J Interpers Violence* 2007; 22: 1536–54.
13 Woods SJ, Wineman NM. Trauma, posttraumatic stress disorder symptom clusters and physical health symptoms in post-abused women. *Arch Psychiatr Nurs* 2004; 18: 26–34.
14 Jia H, Li JZ, Leserman J, Hu Y, Drossman DA. Relationship of abuse history and other risk factors with obesity among female gastrointestinal patients. *Dig Dis Sci* 2006; 49: 872–7.
15 Striegel-Moore R, Dohm FA, Pike KM, Wilfley DE, Fairburn CG. Abuse, bullying and discrimination as risk factors for binge eating disorder. *Am J Psychiatry* 2002; 159: 1902–7.
16 Finestone HM, Stenn P, Davies F, Stalker C, Fry R, Koumanis J. Chronic pain and health care utilization in women with a history of childhood sexual abuse. *Child Abuse Negl* 2000; 24: 547–55.
17 Romans S, Belaise C, Martin J, Morris E, Raffi A. Childhood abuse and later medical disorders in women: an epidemiological study. *Psychother Psychosom* 2002; 71: 141–9.
18 Edgardh K, Ormstad K. Prevalance and characteristics of sexual abuse in a national sample of Swedish seventeen-year-old boys and girls. *Acta Paediatr* 2000; 88: 310–9.
19 Nehls N, Sallman J. Women living with a history of physical and/or of sexual abuse, substance abuse, and mental health problems. *Qual Health Res* 2005; 15: 365–81.
20 WHO. *World Report on Violence and Health 2002*. 2002, http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf (last accessed 18 July 2012).
21 Gutierrez PM, Thakker RR, Kuczen C. Exploration of the relationship between physical and/or sexual abuse, attitudes about life and death, and suicidal ideation in young women. *Death Stud* 2000; 24: 675–88.
22 Horwitz AV, Widom CS, McLaughlin J, White HR. The impact of childhood abuse and neglect on adult mental health: a prospective study. *J Health Soc Behav* 2001; 4: 184–201.
23 Martin G, Bergen HA, Richardson AS, Roeger L, Allison S. Sexual abuse and suicidality: gender differences in a large community sample of adolescents. *Child Abuse Negl* 2004; 28: 491–503.
24 Jonsdottir G. *Surviving Incest: Icelandic and British Incest Survivors'* Experiences of Incestuous Abuse. 1993, University Press, Reykjavik.
25 Chen J, Michael P, Dunne BA, Ping H. Child sexual abuse in Henan province, China: association with sadness, suicidality and risk behaviors among adolescent girls. *J Adolesc Health* 2006; 35: 544–9.
26 Golier JA, Yehuda R, Bierer LM, Mitropoulou V. The relationship of borderline personality disorder to posttraumatic stress disorder and traumatic events. *Am J Psychiatry* 2003; 160: 2018–24.
27 Ystgaard M, Hestetun I, Loeb M, Mehlum L. Is there a specific relationship between childhood sexual and physical abuse and repeated suicidal behavior? *Child Abuse Negl* 2004; 28: 863–75.
28 Lemieux SR, Byers ES. The sexual well-being of women who have experienced child sexual abuse. *Psychol Women Q* 2008; 32: 126–44.
29 Colman AR, Widom CS. Childhood abuse and neglect and adult intimate

relationships: a prospective study. *Child Abuse Negl* 2004; 28: 1133–51.
30 Whiffen VE, Thompson JM, Aube JA. Mediator of the link between childhood sexual abuse and adult depressive symptoms. *J Interpers Violence* 2000; 15: 342–51.
31 Yehuda R, Friedman M, Rosenbaum TY, Labinsky E, Schmeidler J. History of past sexual abuse in married observant Jewish women. *Am J Psychiatry* 2007; 164: 1700–6.
32 Coid J, Petruckevitch A, Feder G, Chung W-S. Relation between childhood sexual and physical abuse and risk of revictimisation in women: a cross-section survey. *Lancet* 2001; 358: 450–4.
33 Steel JL, Herlitz CA. The association between childhood and adolescent sexual abuse and proxies for sexual risk behavior: a random sample of the general population of Sweden. *Child Abuse Negl* 2005; 29: 1141–53.
34 Fleming J, Mullen PE, Sibthorpe B, Bammer G. The long-term impact of childhood sexual abuse in Australian women. *Child Abuse Negl* 1999; 23: 145–59.
35 Douglas AR. Reported anxieties concerning intimate parenting in women sexually abused as children. *Child Abuse Negl* 2000; 24: 425–34.
36 Erdmans MP, Black T. What they tell you to forget: from child sexual abuse to adolescent motherhood. *Qual Health Res* 2008; 18: 77–89.
37 Freysteinsdottir FJ. *Risk Factors for Repeated Child Maltreatment in Iceland: An Ecological Approach*. 2005, University Press, Reykjavik.
38 Wijma B, Schei B, Swahnberg K, Hilden M, Offerdal K, Pikarinen U, Sidenius K, Steingrimsdottir T, Stoum H, Halmesmaki E. Emotional, physical and sexual abuse in patients visiting gynaecology clinics: a Nordic cross sectional study. *Lancet* 2003; 361: 2107–13.
39 Tang B, Jamieson E, Boyle M, Libby A, Gafni A, MacMillan H. The influence of child abuse on the pattern of expenditures in women's adult health service utilization in Ontario, Canada. *Soc Sci Med* 2006; 63: 1711–9.
40 Halldorsdottir S. The Vancouver school of doing phenomenology. In *Qualitative Research Methods in the Service of Health* (Fridlund B, Hildingh C eds), 2000, Studentlitteratur, Lund, 47–78.
41 Spiegelberg H *The Phenomenological Movement: A Historical Introduction by Herbert Spiegelberg,* 3rd enlarged edition. 1984/1965, Maritinus Nijhoff, The Haue.
42 Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*, 4th edn. 1994, Oxford University Press, New York.
43 Heche A. *Call Me Crazy*. 2001, Washington Square Press, New York.
44 Ader R. Psychoneuroimmunology. *Curr Dir Psychol Sci* 2001; 10: 94–101.
45 Brower V. Mind-body research moves towards the mainstream. *EMBO Rep* 2006; 7: 358–61.
46 Kemeny ME, Gruenewald TL. Psychoneuroimmunology update. *Semin Gastrointest Dis* 1999; 10: 20–29.
47 Brosschot JF, Godaert GL, Benschop RJ, Olff M, Ballieux RE, Heijnen CJ. Experimental stress and immunological reactivity: a closer look at perceived uncontrollability. *Psychosom Med* 1998; 60: 359–61.
48 Kiecolt-Glaser JK, McGuire L, Robles TF, Glaser R. Emotions, morbidity and mortality: new perspectives from psychoneuroimmunology. *Annu Rev Psychol* 2002; 53: 83–107.
49 Pert CB, Dreher HE, Ruff MR. The psychosomatic network: foundations of mind-body medicine. *Altern Ther Health Med* 1998; 4: 30–41.
50 Pennebaker JW, Zech E, Rime B. Disclosing and sharing emotion: psychological, social, and health consequences. In *Handbook of Bereavement Research: Consequences, Coping and Care* (Stroebe MS, Hansson RO, Stroebe W, Schut H eds), 2001, American Psychological Association, Washington, DC, 517–43.
51 Bergsma J. Illness, the mind, and the body. *Theor Med* 1994; 15: 337–47.
52 Maier SF, Watkins LR. Cytokines for psychologists: implications of bidirectional immune-to-brain communication for understanding behaviour, mood, and cognition. *Psychol Rev* 1998; 105: 83–107.
53 McClure FH, Chavez DV, Agars MD, Peacock MJ, Matosian A. Resilience in sexually abused women: risk and protective factors. *J Fam Violence* 2008; 23: 81–88.
54 Putman SE. The monsters in my head: posttraumatic stress disorder and the child survivor of sexual abuse. *J Couns Dev* 2009; 87: 80–89.