SHAME AND DISSOCIATION: A RESULT OF CHILDHOOD SEXUAL ABUSE

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Abstract

It is sad to say that childhood sexual abuse is not a foreign concept to the world population. Though many are aware of its occurrence, few are educated on its effect on the victim, whether at the onset or into adulthood. In the last 10 years, there have been many studies on the effects of CSA on the victim. There are studies that examine physical and mental functioning, and the quality of sexual relationships. There are studies that focus solely on the effects on men or women and many more. However, the following will be discussing the occurrence of shame because of CSA and how shame can lead to dissociative disorders in victims. We will discuss the prevalence of non-disclosure and the reasons thereof. Lastly, we will discuss treatment therapy settings such as individual and group settings and Acceptance and Commitment Therapy (ACT) and Dialectical Behavioral Therapy (DBT) as effective treatment modalities.

Keywords: Childhood Sexual Abuse, Non-disclosure, Shame, Dissociation, DBT, and ACT

Shame and Dissociation: A Result of Childhood Sexual Abuse

Unfortunately, childhood sexual abuse is not a foreign occurrence in the world, certainly not in the United States. Between 2009 to 2017, the Behavioral Risk Factor Surveillance System yielded results of 16.1% of women, and 6.2% of men disclosed experiencing CSA (Henkhaus, 2022). Moreover, 50% of rapes focused on women were experienced during childhood (Melmer, 2022). Often no form of sexual abuse is reported to the police. Thus, the ratio of occurrences is never entirely accurate (Melmer, 2022). As a result, there is no clear understanding of the magnitude of the offense. Exposure to CSA leads to many problems for the victim, including the onset of shame, which propagates into mental and behavioral disorders such as dissociation.

Shame

The defining and understanding of shame are based on the individual development of self. This unique development is shaped by personal and attachment experiences from birth to the present (MacGinley, 2019). Thus, each person's definition or boundaries around shame are different. While shame can occur through other means of individual development, as referenced above, it is also introduced by trauma such as childhood sexual abuse (CSA).

Early work by Finklehor and Brown suggests that the onset of shame and guilt by the victim occurs during the act of CSA (MacGinley, 2019). The offender perpetuates it and begins to change the self-image of the victim. Studies years later continue to substantiate these beliefs; however, shame cannot only result from CSA but also affects other aspects of the victim's life in later years, including adulthood (MacGinley, 2019). Though many studies are available regarding childhood trauma and its effects, such as shame, very few studies focus on why children are symptomatic. Studies concentrate on resulting occurrences rather than why they

occur (Feiring, 1996). This allows for lack of agreement and understanding regarding the entire process of shame, which leads to stigmatization and adaptation by the CSA victim.

The shame of a CSA victim is very much tied to the possibility of others seeing their perceived flaws and brokenness. Victims see themselves as unfixable and flawed beyond repair (Sims, 2014). They see themselves as unclean, ugly, and displeased with their appearance (Radmanovic, 2020). Their perception is that they are not acceptable by the current societal norms. This includes not being accepted by their family's cultural beliefs and measures of being proper. Shame interrupts establishing individual identity and thus prevents foundational attachment formation (Sims, 2014).

It is that same shame that prevents disclosure of CSA even in adulthood. A CSA study of 47 participants from the ages of 15 to 25 explored CSA disclosure. All participants were current CSA clients of a community-based CSA center or had been clients previously. There were two types of disclosures from the group: implicit and explicit. Clients who were comfortable disclosing CSA spoke of the incident with specific happenings and emotions and words to detail the event. Those uncomfortable with disclosure spoke implicitly regarding the CSA event and used other words to articulate the negative self-reflection and shame they felt regarding the event(s) (McElvaney, 2022). In either case, the act of disclosure reduced the level of shame the individual was experiencing (McElvaney, 2022).

Another study of 246 mixed populations of women (74 heterosexuals, 88 lesbians, 84 bisexual) was conducted by means of questionnaires and qualitative interviews to investigate the occurrence of sexual violence, disclosure, and coping patterns. Of the 246 women, it was found that there were more occurrences of childhood sexual abuse among minority women. Most of those events were perpetrated by males (Hequembourg, 2021). The two major reasons for non-

disclosure were due to feelings of shame and reducing the focus on the event by minimalizing its importance (Hequembourg, 2021). Disclosure of the specific details of CSA events experienced by the victims to clinicians, sexual partners, and others is extremely difficult. It is difficult for the victims because their self-images are clouded by shame (Sims, 2014).

Yet another study encompassed eleven adults between the ages of 20-25. The participants were invited to volunteer through social media to participate in a study regarding the disclosure of CSA. Each participant was interviewed via telephone. The information was collected using the interpretative phenomenological approach (IPA). The youth that volunteered were Indian and had experienced CSA. The participants were interviewed and found to have five predominant factors in non-disclosure of the events: mistrust, confusion, relationship deficiencies, helplessness, and shame (Fayaz, 2023). Some of the respondents reported feeling shame even at reflecting on the event. In other cases, respondents described the shame as “crushing” (Fayaz, 2023). Respondents expressed that the shame from CSA is always present. They also communicated the belief that their feelings of shame will never go away (Fayaz, 2023). The common theme in these three studies is the existence of shame as the result of CSA and attributed to non-disclosure.

Mental and Behavioral Disorders

Shame is a catalyst for other maladaptive behaviors and thought processes, such as isolation, self-doubt, inadequacy, and feelings of inferiority (Sims, 2014). CSA has a prominent relationship not only with shame but with advanced diagnoses of depression, self-harm, suicide, anxiety, dissociative disorders, and sexual and relationship problems (Radmanovic, 2020). These mental disorders and behavioral issues can either manifest in childhood or adulthood.

Dissociative Disorder

One of the advanced diagnoses given above was dissociative disorder. There is a direct relationship between shame and dissociation. Dissociation is commonly linked to CSA because the brain involuntarily protects the individual's mental, emotional, and physical stability (Belli, 2012). When a victim is diagnosed with dissociation disorder, they can experience various symptoms such as detachment from thoughts, memories, surroundings, individual actions, and even themselves. Dissociative disorders include dissociative identity, depersonalization/derealization disorder, dissociative amnesia, and dissociative fugue. Any diagnosis of dissociation that does not fit into the symptoms of the above disorders is considered a dissociative disorder, unspecified (Belli, 2012).

A study of shame and dissociation found that shame increases after a dissociative experience (Dorahy, 2021). The presence of shame existed from a CSA event; however, it intensified after a dissociative event. The individuals shared that their shame increased from feeling exposed and broken. The levels of shame were measured by regression analyses (Dorahy M. J., 2021).

Unlike the study above, an experimental study was performed to investigate shame-provoked dissociation. The study consisted of 50 female participants gathered from the local community. Using script-driven imagery technique and mirror tasking. Each female was to recall two shame-related memories and two general life memories, which were recorded. After completing the tasks, the participants were to listen to the recordings of themselves while staring into a mirror or black background. This study found that shameful memories lead to higher levels of dissociation than neutral memories (Kouri, 2023). Examining both the studies and their

results, shame and dissociation feed off one another. Shame can lead to dissociative disorders, and dissociation occurrences increase the magnitude of shame.

Treatment

What can be done to eliminate or reduce shame as the catalyst for dissociative disorders? Both individual and group therapy are effective methods for assisting clients with resolving issues from CSA. However, incest resolution groups are now more common as they have been effective in diminishing the sense of shame in the victims of CSA (Sims, 2014). This is because the group forum requires the victims to participate and share their detailed experiences while also allowing them to see that they are not isolated or alone in their experiences, creating a platform for reality and self-accepting rather than isolation and stigmatization (Sims, 2014). While group therapy works to alleviate the feelings of shame and its effects on CSA victims, as adults, it has not effective when dealing with relationships between the victim and their sexual partners (Sims, 2014).

While there are same-gender groups (men or women), mixed-gender therapy groups have value as they help lift the feelings of shame and stigmatization as the participants realize they have a commonality in how they responded or felt about the CSA event (Morely, 2022). This commonality takes the focus away from the gender differences of the group. It also decreases the unwillingness to disclose and neutralizes the feelings of shame and desire to isolate. However, it does not mitigate other differences within the groups, such as CSA occurring at a different age than others (Morely, 2022).

In addition to the type of therapy, individual or group, interventions used within therapy are critical in whether therapy is effective. Dialectical Behavioral Therapy (DBT), in conjunction with Acceptance and Commitment Therapy (ACT), are a practical, efficacious tool in treating

shame and guilt associated with CSA. DBT accepts the client's thoughts and does not deem a thought or behavior as adaptive or maladaptive. With DBT, a thought is just a thought, and a belief is just a belief. The clinician accepts thoughts and beliefs shared by the client at face value without judging or labelling them. Acceptance allows the client to relax, expand on feelings, and grow to trust the clinician with his or her thoughts and feelings. This process does not push the client toward change but allows the client to set his or her boundaries and enter self-reflection as he or she is willing and able (Meltzer, 2015).

Like DBT, ACT is an empirically supported form of psychotherapy. ACT prompts the client to embrace their thoughts and emotions instead of rejecting them or attempting to suppress them, to accept the concept of self and identity, understand personal values then chart a plan of action for desired change. ACT removes the barrier of stigmatism and incorporates acceptance, thus reducing the individual's anxiety. Many studies within the past ten years have focused on the efficacy of ACT in reducing shame and stigmatization (Luoma, 2015). One of the initial studies employed ACT in a 6-hour group therapy focusing on mindfulness, self-acceptance, and personal values. The session result showed that using ACT significantly reduced shame and stigmatization levels among clients (Luoma, 2015).

Conclusion

While there have been many studies regarding CSA, shame, and their association with dissociative disorder, there are yet more studies to conduct. One of the most significant variables in the quality of data being gathered is the lack of individuals disclosing victimization by CSA. This prevents societal awareness of the size of the CSA population and all its effects. Moreover, disclosure is more likely to introduce additional variables to consider when examining shame leading to dissociation, as each person's experience is different. Individuals do not realize that

non-disclosure does not mitigate or erase shame, it exacerbates it. Non-disclosure doesn't prevent the occurrence of dissociative disorders, relational problems, and other mental disorders. It simply prolongs the need for treatment.

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