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Qual Health Res 2008 18: 77
DOI: 10.1177/1049732307309004

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What They Tell You to Forget: From Child Sexual Abuse to Adolescent Motherhood

Mary Patrice Erdmans
Central Connecticut State University, New Britain, Connecticut, USA

Timothy Black
University of Hartford, Hartford, Connecticut, USA

This study explores the relationship between child sexual abuse and adolescent motherhood, using a life story interview method. The sample consists of 27 mothers participating in a home-visitation parenting program for mothers at risk of child maltreatment. The failure to articulate the violation of child sexual abuse and to appropriately construct blame resulted in a range of self-destructive behaviors, some of which placed mothers at greater risk of teen pregnancy. Repressed feelings associated with the trauma often resurfaced with motherhood as victims reexperienced their innocence and vulnerability as children.

Keywords: sexual abuse; adolescent motherhood; life story methods

It was good memories [growing up] until one day my grandmother went to work. One of my youngest uncles, he’s almost my age, he seen me and he said, “Come on, come upstairs we’ll be together,” and he took me down in my grandmother’s room and raped me. I was 9. I ran out the room and went to the bathroom. I tried to use the bathroom but I couldn’t, so I ran to my grandmother’s job and she asked me what happened and I said nothing. To this day nobody knows, ‘cause everybody would think I’m lying.

Years passed and I was 12 years old and it happened again, my same uncle. He was 16. It was in the house, in my room, but it was at night and I didn’t scream, I didn’t yell, I didn’t do anything.

A week later, my grandfather came in the bathroom when I was taking a shower and he said that he was gonna sit down and make sure he sees me washing myself and he molested me. My grandfather! My grandmother didn’t believe that my grandfather did that to me. To this day, they still say it’s not true.

Then, when I graduated from sixth grade my baby sister’s father had also molested me—he offered me money to like show him my body, ’cause like I was 13, but I had the biggest breasts—they used to call me torpedoes. My mother never believed that [my stepfather] did that to me, ’til this day she don’t believe me—the oldest one, the one that made her a mom—she never believed me!

It’s like I blocked everything, ’cause if I don’t block it I won’t be able to live my life. I still think about it but I don’t stress it as much.

My social worker knows half of the stories but they tell me I need counseling because of what everything happened but I don’t know where and how, and I’m scared to go by myself so I haven’t called. Deep inside I know I need help.

—Deidre, 22, Puerto Rican mother of a 5-year-old

Like many victims of sexual abuse, Deidre became pregnant when she was a teenager. Victims of child sexual abuse are twice as likely to get pregnant as teenagers than nonabused adolescents (National Vital Statistics Report, 2003; Roberts, O’Connor, Dunn, Golding, & ALSPAC Study Team, 2004; Roosa, Tein, Reinholtz, & Angelini, 1997; Stock, Bell, Boyer, & Connell, 1997). Although childhood sexual abuse in

Authors’ Note: The authors would like to thank the state of Connecticut and the Children’s Trust Fund for funding this research. Of course, the views and opinions expressed are solely those of the authors.
the United States is estimated at 10%, studies have found as many as 60% of teen moms were victims of child sexual abuse (Boyer & Fineman, 1992; Finkelhor & Dzuiba-Leatherman, 1994; Gershenson, Musick, Ruch-Ross, Magee, Rubinio, et al., 1989; Martin, Bergen, Richardson, Roeger, & Allison, 2004; Putnam & Trickett, 1997). The path from sexual abuse to teen pregnancy tends to follow a well-trodden trajectory: sexual assault as a child, precocious and risky sexual behavior as an adolescent, withdrawal from school, abuse of alcohol and drugs, and finally pregnancy and adolescent motherhood.

Sexual abuse wreaks havoc on adolescent development, a period when young people are forming a core concept of self and developing healthy peer relations (Downs, 1993; Erikson, 1968). Victims of sexual assault often have negative self-images, which may evolve into a hypersexualized persona. As peer relations develop, precocious and frequent sexual activity is likely if they confuse sex for intimacy, if they see their body as something that is used by other people, or if they learn that sex is something to be exchanged. Because they have been physically violated, their boundaries, definitions of acceptable and appropriate sexual behavior, and attitudes toward men and sex can change in ways that make them more likely to have sex at an early age, with a series of partners, and without contraception, especially if they tell no one about the assault or receive no counseling (Downs, 1993; Finkelhor, 1986; Musick, 1993).

In addition to developing feelings of low self-worth, adolescent females who have been sexually abused are more likely to lack self-efficacy and to learn helplessness (Butler & Burton, 1990). Developmental psychologist Judith Musick (1993) wrote, "The victimized girl learns ways of thinking about men and sex that interact with emotional vulnerability to make her highly prone to repeated victimization. She learns patterns of passivity and helplessness in relation to men" (pp. 91-92). The sexual abuse is more likely to become a catalyst for learned helplessness if it is not reported or if the victim's report is not believed.

Negotiating sexual relations is difficult enough for confident, healthy adolescents. It requires a strong 15-year-old girl to initiate contraceptive use, to say "no" to unwanted advances, and at times, to go against her peer group. Child sexual abuse compromises her strength and undermines confidence (Polit, White, & Morton, 1990). "Children who are unable to defend themselves against sexual abuse are probably equally unable to protect themselves from pregnancy or venereal disease," wrote Moore, Nord, and Peterson (1989, p. 110). For example, in our study, LaRhonda, a 22-year-old mother of two children who was victimized in four different foster homes said, "I guess if you get raped too many times, they stop believing you 'cause they figure you can tell them no. Yeah, right," she added sarcastically. She had lost the capacity to fight back.

Quantitative studies have attempted to map the relationships between variables associated with sex abuse and adolescent motherhood, including sexual risk taking, early sexual relations (first coitus), and young teen pregnancies (Brown, Cohen, Chen, Smailes, & Johnson, 2004; Dunlap, Golub, & Johnson, 2003; Fergusson, Horwood, & Lynskey, 1997; Fiscella, Kitzman, Cole, Sidora, & Olds, 1998; Mason, Zimmerman, & Evans, 1998; Nagy, DiClemente, & Adcock, 1995; Noll, Trickett, & Putnam, 2000; Rainey, Stevens-Simons, & Kaplan, 1995; Raj, Silverman, & Amaro, 2000; Roosa et al., 1997; Stock et al., 1997; Widom & Kuhns, 1996; Wyatt, 1988). Rigorous tests controlling for intervening variables, like socioeconomic status, family dysfunction, and substance abuse, to name a few, have also found significant relationships between sexual abuse and adolescent pregnancy (e.g., Brown et al., 2004; Fergusson et al., 1997), and although there is a convergence in the rates of teen pregnancy and the extent and types of sexual activity between abused and nonabused adolescents when controlling for other variables, these differences remain statistically significant in several studies (Alan Guttmacher Institute, 1994; Luker, 1996; Roosa et al., 1997). Furthermore, in populations in which there is more economic and familial stability, sexual abuse explains more variance in adolescent pregnancy (Butler & Burton, 1990; Fiscella et al., 1998).

Still, there are conflicting findings from some studies, and a review of the literature by Blinn-Pike, Berger, Dixon, Kuschel, and Kaplan (2002) identifies several methodological limitations that make it difficult to establish a definitive causal link between sex abuse and teen pregnancy. These include the use of varying definitions of sexual abuse across studies; reliance on retrospective research designs with a traumatized population; the overuse of convenient governmental and social service data; and the failure to use theory to order the variables in many studies. The authors also argued that the absence of research examining relationships with men as well as racial and ethnic diversity restricts our knowledge.

Quantitative studies have documented the relationships between sexual abuse and other life course disruptions as well, some of which are also highly related to teen pregnancy. The effects of sexual abuse are influ-
enced by the severity of abuse, the duration of the abuse, the perpetrator’s use of force, the victim’s relationship with the perpetrator, and the age at onset of abuse (Friedrich, Urquiza, & Beilke, 1986; Putnam & Trickett, 1997; Wyatt, 1988). Victims of sexual abuse are more likely to develop social and emotional problems (Brown et al., 2004; Downs, 1993), depression (and suicide), mental illness and eating disorders (Chandy, Blum, & Resnick, 1996; Martin et al., 2004; Nagy et al., 1995; Pelekakis, Mykletun, & Dahl, 2004; Roberts et al., 2004; Romano, Zoccolillo, & Paquette, 2006; Stock et al., 1997), and substance abuse problems (Nagy et al., 1995; Stock et al., 1997). They are susceptible to sexual and physical violence (Boyer & Fineman, 1992; Briere & Runtz, 1987; Wolf, Weckerle, Reitsel-Jaffe, & Lefebvre, 1998) and tend to have older male partners (Rainey et al., 1995). Furthermore, many studies identify the link between sexual abuse and problems in high school (Boyer & Fineman, 1992; Musick, 1993), particularly disrupted cognitive development (Butler & Burton, 1990), lower grades and test scores, truancy, negative attitudes toward school, higher dropout rates (Chandy et al., 1996; Stock et al., 1997), and status marginalization among peers (Downs, 1993). Of course, many of these life course disruptions have other causes as well, just as sex abuse and teen pregnancy share similar risk factors (Blinn-Pike et al., 2002). Delineating these causal paths is difficult and challenging.

In our study, we listen to victims of child abuse tell their life histories to better understand the trajectories linking child sexual abuse to adolescent motherhood. Disclosures of shame, fear, denial, internalized blame, self-doubt, and isolation frame their narratives of untreated trauma and its consequences. Many of the mothers articulate where trust and boundaries were violated and distorted, where drugs and alcohol became antidotes for pain, and where silence or the need to forget led to life-threatening behaviors. Conversely, of few of the survivors showed how speaking about their trauma, especially with a therapist, lessened the hold of repression and helped them begin a process of reclaiming self-efficacy by appropriately placing blame on the perpetrators and gatekeepers of silence. Moreover, we listened to them talk about their pregnancies and their children and wrestle with narratives of childhood innocence that, in some cases, evoked an understanding of their own violated innocence as children and, in other cases, exposed unbearable anxiety and distant, fearful mothering. The depth and breadth of their stories further our understandings of how child sexual abuse is linked with teen motherhood.

Method

We used a life story method to understand vulnerability among participants in a statewide home-visitation program for first-time mothers as part of an evaluation strategy. Designed to support healthy parenting practices and reduce child maltreatment, the Nurturing Families Network program targeted mothers who were at risk of child maltreatment. The participants in the program were initially screened on a variety of risk factors, including socioeconomic measures, age, marital status, substance abuse, and mental health histories. If concerns were raised on the initial screen, the Kempe Family Stress Checklist was then administered to examine more thoroughly child abuse and neglect histories, current living circumstances, parenting attitudes, the pregnancy, and any criminal, substance abuse, or mental illness histories (Black & Damboise, 2007; Kempe, 1976). If mothers met a criterion for eligibility using the Kempe, they were offered program services. Participation in the program was voluntary.

The goal of the life story method is to get “descriptions of the interviewee’s life trajectories in social contexts, in order to uncover the pattern of social relations and the special processes that shape them” (Bertaux & Kohli, 1984, p. 215). Told in the person’s own words, life stories are often anchored around pivotal life events that shape the trajectory of and meaning given to the life story. In our study, we were interested in the social processes that shaped parents’ life trajectories and made them at risk of child maltreatment. For example, what were the mechanisms by which family instability and childhood poverty shaped their trajectories? What were their lives like before they became pregnant, what changed after they had the child, and what was the effect of the home-visitation program? Ultimately, the purpose of the evaluation was to be able to both assess program effectiveness and design ways to improve its implementation. The life story method allowed us to acquire a fuller picture of program participants and their needs and to better understand their lives from their own perspectives.

We asked home visitors to identify mothers who would represent different experiences in the program, for example, different stages in the 5-year program and different responses to program services. We then contacted these mothers and asked them to participate. We interviewed 171 mothers and 48 of their male partners; interviewers and interviewees were matched by race.
and ethnicity as well as gender. Each mother was interviewed twice, with each interview lasting 1 1/2 to 2 hours. Most interviews occurred in the mothers’ homes. Mothers and their partners gave their written consent to participate in the study and were paid 50 dollars at the completion of the second interview.

Topics were usually covered in a chronological order that included family background, school experiences, relationship histories, pregnancy and parenting experiences, work histories, experiences with state welfare services, and program experiences. We would start each section with a broad question (e.g., tell us what it was like when you were growing up) and follow with prompts to keep them talking about the topic. The interviewers were trained to encourage the mothers to narrate their own life stories, using questions only when necessary and allowing the order of the topics to emerge with the flow of the conversation. That is, rather than asking them a series of questions, the interviewers encouraged the mothers to tell us the story of what their lives were like before they got pregnant, how they became pregnant, and what their lives are like now. In between the two interview sessions, interviewers reviewed the recorded tapes and developed strategies, where necessary, for expanding on some of the areas covered in the first interview as well as for directing the second interview to discuss unexplored topic areas.

Interview tapes were transcribed and translated (where needed). We developed 60 codes, coded each of the transcripts, and input and organized the coded text using QSR Nud*ist software, version N6.5 The codes ranged from concrete topics (e.g., occupation, schooling, child care) to more abstract concepts (e.g., social support, school integration). We coded the transcripts independently and then met as a group to discuss the coding. Although much of the coding appeared straightforward, even standard categories like occupation and education became open to debate, when, for instance, we attempted to determine whether job training was a subcategory of one or the other (we coded it both ways). Other variables such as child care, school integration, social support, and sexual abuse were even more ambiguous and required us to think about how we were using and defining the concepts, as well as the boundaries of the concepts (Morse, 2004).

We then wrote a summary of each transcript that provided an overview of the life trajectory and identified the social processes that were salient to their vulnerability, including childhood abuse, poverty, incomplete schooling, young age, partner violence, drug and alcohol abuse, occupational history, and violent behavior. We met as a team to discuss each life story to identify emergent patterns. One important pattern that emerged was that a disproportionate number of the adolescent mothers had histories of child sexual abuse. Two thirds of the mothers (n = 108) gave birth to their first child between the ages of 13 and 19, and a quarter of these teen moms (n = 27) acknowledged in the interview that they had suffered child sexual abuse, many of them multiple times.

We defined the concept of child sexual abuse as molestation, attempted rape, or rape before the age of 16. We did not include statutory rape as a form of child sexual abuse. We also did not include date rape or cases where their partner was the sexual offender. Our definition of sexual abuse is between stringent and conservative definitions. A stringent measure includes only rape, whereas a conservative (and more common) measure was to ask whether someone touched you in places you did not want to be touched or did something sexually to you they should not have done, including noncontact assaults. See Nagy et al. (1995) and Chandy et al. (1996) for a discussion of measurements.

When we looked closely at these data, we found startling quantitative differences between the teen moms who had been sexually abused as children and those who did not report abuse. We found that abused girls were

- more likely to be victims of statutory rape (22% versus 5%),
- more likely to have abused alcohol or drugs (52% versus 16%),
- more likely to have abusive partners (63% versus 35%),
- more likely to suffer from a mental illness (56% versus 23%),
- more likely to have behavioral problems (56% versus 31%),
- less likely to be well integrated in high school (7% versus 25%),
- less likely to have played sports in high school (7% versus 28%), and
- more likely to drop out of high school before pregnancy (44% versus 33%).

In other words, when comparing apples to apples, we saw that child sexual abuse significantly exacerbated problems associated with poverty. We then decided to look more closely at the life stories of these 27 women to see how child sexual abuse was linked to vulnerability in general and to adolescent motherhood in particular. Moreover, we wondered what would be the effects of child sexual abuse on their own risk of child maltreatment.

Our sample of 27 teen moms is racially and ethnically diverse: 12 White, 9 Puerto Rican, 5 African

[...]

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American, and 1 biracial (White and Puerto Rican). The mothers lived in varying locations throughout Connecticut ranging from urban areas to rural towns. Mothers were, on average, 17 years old when they had their first child and 20 years old at the time of the interview. Nearly one half (44%) were sexually abused by more than one perpetrator. Pseudonyms are of course used in the text to refer to these mothers.

This article analyzes the varying trajectories that occur after the incidents of sexual abuse. Paths, of course, do vary, and our inductive analysis identifies the critical junctures that explain these variations among victims. Most important, we found differences between those who reported the abuse and received treatment and those who remained silent.

Narratives of Silence

The accounts of child sexual abuse were never the centerpiece of their narratives. More often, these stories appeared as asides and afterthoughts. We asked them to begin talking about their childhood—family, schooling, neighborhood—and it was usually at this point that droplets of sad stories fell into their narratives: “Oh yeah, and then I was raped.” We did not specifically ask them about sexual abuse, but we did require the interviewers to ask if they had “ever been abused by a man.” This probe, however, was designed to occur during their discussions about their partners.

Some mothers never said exactly what their uncle or stepfather did, only that “his behavior was inappropriate.” When this happened, the interviewer often asked the young narrator to elaborate. Unfortunately, however, was designed to occur during their discussions about their partners. Some mothers never said exactly what their uncle or stepfather did, only that “his behavior was inappropriate.” When this happened, the interviewer often asked the young narrator to elaborate. Unfortunately, however, they did not always ask, nor did all narrators elaborate. Even though interviews give people license to ask questions, some topics and behavior are still considered taboo, in which case probing can feel like a violation of the conventions of social discourse. Issues like sexual abuse, incest, and other heinous crimes are not topics we feel as free to pursue as child care or employment.

A few mothers, in particular those who had received some counseling, integrated the story of the abuse into their narratives in a matter-of-fact manner: “Oh, I skipped over the part where I told people about my being molested,” Michelle, a 20-year-old White mother with a 9-month-old child, said nonchalantly, and then went back to describe the abuse without a prompt. Her therapy had taken some of the edge off her pain and given her words to distance herself from the abuse.

For most of the women, however, the sexual abuse was not something they wanted to revisit—“that happened in my past, but I’m living in the future,” Tameka, a 17-year-old African American, made clear to us; “it’s just the fact that I have to survive,” and she does that by emotionally sealing off the past. Betsy, an 18-year-old White mother, does the same thing. When asked about the abuse, she said, “It just brings back really bad memories, and I’ve had a really rough morning and I kind of want it to get better. I don’t want it to get worse.” Others kept the memories repressed so effectively that they did not remember details. Iveselle, who had her first child at the age of 16, said, “Honestly, I wish I could tell you but... I tried to block it out. It’s like I put it to one side of my brain, decided I don’t want to be bothered with that section... . What I want to do is I want to forget.” They do not see value in remembering. “I talked to a couple of counselors about it,” 17-year-old Erica, a young rape victim, said. “It’s something I really don’t like talking about. I’d rather just kind of forget about it. I mean, it’s something that happened but there’s nothing I can do to change it.”

Given their reluctance to talk about these painful events, the limited resources that were available to them to deal with the trauma, and the intensity of the denial of those around them, the details of the abuse are often shadowy, oblique, and spotty. That many of them did not fully articulate narratives of abuse mimics what happened to them in their lives—they did not tell us much, but then, they did not tell many others about the abuse either. And unfortunately, when they did tell, they were often called liars or told to forget.

What They Tell You to Forget

In our study, 27 girls identified 48 sexual abusers (12 girls were abused by multiple perpetrators, 14 were raped). White mothers reported child sexual abuse the most (33%), followed by Blacks (28%) and Puerto Ricans (24%). As is the case for most sexual abuse victims, more than one half of the girls did not report the abuse at the time of the incident. Race and Hispanic origin did not play a role in whether they told.

They kept silent because of fear, shame, and guilt. Michelle reconstructed the feelings she had as a young child when she was abused but too afraid to tell anyone about it:

When I was 5 in my day care I got molested by the babysitter’s son for about a year and it was bad. [My
mom] didn’t know about it ’cause I didn’t tell her because, you know, when you’re young you don’t—
you’re scared that everyone will hate you. . . . I don’t remember his face or anything like that and I never
prosecuted him ’cause I didn’t tell anybody ’til I was like 12 ’cause I was so scared.

A few years later, a female neighbor molested her “for about a total of 9 months and never—I didn’t tell
anybody that, either.”

The younger they were, the less likely they were to report the abuse. They were also unwilling to tell if
they did not trust the authorities or if the perpetrator was someone they were supposed to trust such as a
family member or friend of the family. More than half of the perpetrators in our study had some familial
connection to the young girl (fathers, stepfathers, grandfathers, uncles, cousins, and a foster brother),
and another quarter were friends of the family. In these cases, the young girls did not tell because they
felt loyalty to the family—to both the offender and the relatives of the offender. Eighteen-year-old Jackie
said, “Well, I didn’t say nothing to nobody ’cause that’s my father’s brother. I didn’t want to start a big
problem so I kept my mouth shut.” And Trudy, a White mother who is cognitively impaired, was
molested by her stepfather from the age of 10 to 18. She never reported him because she was “afraid that
everyone is going to want me to talk to my mother and I don’t want to talk to her. I don’t want to hurt her
any more than she is.”

Some girls felt shame and did not want to admit to having been abused for fear they would be blamed.
Deidre, whose story opened the article, told her aunt she was raped by her stepfather but also told her “not to
say anything to the cops or anything ’cause I didn’t want the family to look at me like I did wrong.”

Adolescents are more likely to tell someone about the abuse if they have someone they trust—a parent,
guardian, or teacher (Chandy et al., 1996). In violent and unstable homes, however, where parents are neglectful
or abusive, the young girl is less likely to have an adult she can trust (Dunlap et al., 2003; Moore et al., 1989;
Stock et al., 1997). In these cases, the conditions that create the opportunity for the abuse are the same condi-
tions that would discourage the young girl from telling the people who are supposed to be protecting her.

More than half of those who told someone about the abuse were not believed or were accused of being responsible for what had happened. Of those who told and were not believed, 3 of them were African American and 4 were Puerto Rican. When the White girls told, they were believed.

Jesenia, a 25-year-old Puerto Rican mother who became pregnant with her first child when she was 18, told her family that she had been molested repeatedly by her 30-year-old cousin from the age of 3 until “like 9 years when one starts to, already starts to, you know [menstruate].” When she told them, “they didn’t believe me, so they left the thing like that, like I was a liar.” And Kim, a 21-year-old African American with a 2-year-old son, tried to convince her family that her cousin was molesting her, “but they was always, ‘Stop lying, you’re fibbing and telling stories,’ and now he’s in a worse situation where supposedly his daughter that he has, she’s about 7 or 8, he was, he’s been molesting her.” And when Deidre finally told her family that her uncle was raping her, they tried to convince her it was not true:

After it happened the second and third time then that’s when I opened my mouth and I told one of my
cousins and my cousin told my grandmother and then my father came down from New Jersey and they put me in the room and they asked me and I said, “Yes, it’s true, it’s true,” and they kept on telling me, “No, no,” and I said, “Okay,” and I just left it like that. To this day, they still say it’s not true.

And even in the following case, where the rape resulted in pregnancy, the young victim was not believed. When 13-year-old Carla became pregnant, the police first charged her boyfriend with statutory rape. When the blood work did not match, she then exposed her stepfather, who had been raping her for the past 5 years. Test results were positive—and still, “My mother didn’t believe me. She just kept saying that I was a liar.”

Why are these young girls not believed? First, sexual abuse is such a monstrous crime that people do not want to believe that one’s partner or brother or son or father is an offender. When Jackie finally told her parents about her abusive uncle, her mother believed her, but “my father didn’t believe me. He said I’m lying ’cause he didn’t want to believe the fact that his brother would do something like that, so he didn’t believe me.” Sexual abuse in families creates divided loyalties. Tamika, quoted earlier as saying she wants to live in the future and not the past, was first raped by her uncle when she was 6 years old:

I was staying with my grandpa and his son was over there sleeping for the weekend. It so happens he got into the room that I was in and he said it was a mistake. He didn’t know what he was doing. He just wanted to try something new on a baby. Okay, and the next morning I was bleeding and stuff. I knew he did something to me that night. I couldn’t get up.
was in shock, and when my aunt found me and I told my grandfather what happened, he didn’t believe me. To this day he don’t believe me. He think that I fell off the bed.

By refusing to believe his granddaughter, he protects his son.

Victims are less likely to be believed if the parents or guardians feel complicitous or responsible; if the adult fails to protect the child (e.g., he or she does not move out of a violent neighborhood or relationship), he or she has more incentive to deny or dismiss the abuse (Breckenridge & Baldry, 1997; Dunlap et al., 2003; McGuffey, 2005). If victims have a network of support outside the home or neighborhood, then it is easier to report the abuse and get help. But if they are isolated, they have few ties to begin with and may not want to sever them. Moreover, if the male is someone who provides support for the family—a father, stepfather, boyfriend, uncle—the mother may be reluctant to believe the hand that feeds her also abuses her daughter (Dash, 1989; Dunlap et al., 2003).

Even if they are believed, often nothing is done. One cognitively impaired young woman was sexually molested by a neighbor, and her father “wanted to take money from the guy to forget the whole thing.” Although somewhat extreme, this response nonetheless reflects a pattern. Only 5 of the 45 cases were prosecuted, despite the fact that 81% of the time, the victims knew their abusers. Alisha, a young African American mother, was raped by an older man in the neighborhood when she was 15 years old. She told her teacher, “and she told me that it happened to her when she was younger, so we kind of clicked there and we’re still friends to this day.” But no action was taken against this man who lived in her neighborhood (“I knew the house”), even though she “ended up having to go to the hospital and stuff, but I never told who he was.” Within a few months, she was raped again by another older man from the neighborhood who worked at a local store. This rape left her pregnant and she had the child. The rapist left the country.

Rather than prosecute, some mothers took action to protect their daughters by moving away from the perpetrator. This was more likely to be the response in White families. Diane, a 21-year-old White mother with a 2-year-old son, was molested by the father of her mother’s boyfriend from the age of 4 to 12. When she finally told her mother (who was simultaneously being abused by the boyfriend), “that was the final straw. She just packed everything up that next month and we moved. . . . I was just basically told to just forget about it. I was just told, you know, we’re not in the same state—don’t worry about it.”

The Silent Scream for Help

Hidden, denied, or not provided with adequate counseling, the young victims sometimes internalized the abuse and made direct connections in their stories between the abusive incident and self-destructive behaviors, such as self-mutilation, eating disorders, suicide, depression, and acute psychosis. Alisha said she “first started mutilating” after she was raped. Her depression, drug abuse, and abusive relations also began at this time. She tried to commit suicide four times and ended up in a state hospital:

They wanted me to stop mutilating myself [burning and cutting] and they figured if I went to a therapist, I would stop. . . . I haven’t done it since Valentine’s Day. . . . That was just me taking it out on myself instead of going to hurt somebody else. . . . I just did it, get it out of the way, get the anger off my chest.

Lilly, a Puerto Rican mother at the age of 16, was 10 years old when she was raped by an older boy in the neighborhood in the presence of others who did not help. After the rape she began “going crazy” and attempted suicide and spent the next years in and out of hospitals.

Delores, a 21-year-old Puerto Rican mother with a 2-year-old, was raped on a regular basis beginning when she was 10 by her cousin who was 17. She made an effort to forget about it, but the violence turned into an acute psychosis:

While I was being sexually abused, they had my baby brother—he was only 7 months. You know, the guy had a gun at his head to force me to make sure I wasn’t going to make no noise or I wasn’t going to say nothing, you know, but that’s just the past. . . . Well, I told [my parents about the abuse] the first time I tried to kill myself. I was 12, you know, but they really didn’t believe me. . . . I was just a child, you know, all that just affected me and affected me so bad where I developed a whole world inside of my head. You know, that I wouldn’t let nobody enter so nobody would hurt me.

Delores spent months in a psychiatric institution where she received the treatment that allowed her to talk openly and to put emotional distance between herself and the abuse. Three years later, she no longer suffers from psychotic symptoms or takes medicine, but her
story emphasizes the effects that silence and turning the pain inward can have: “That part of my life was just blocked,” she continues. “You know, where I didn’t even want to look inside that little box.”

For other women, the violence from the abuse is directed outward into a pattern of early and risky sexual behavior, delinquency, truancy, drug and alcohol abuse, and unhealthy violent relations with men. It is difficult to make direct connections between the abuse and some of these behaviors, but following the threads within these stories often leads back to the disruption that the abusive incident(s) created. Kate, an 18-year-old White mother, said that she started having “sex fiends” when she was 11 years old. She developed oppositional attitudes toward school authorities when she and her friends would “laugh in people’s face because we left school.” Kate eventually dropped out, and her mother tells us that Kate was having problems doing the schoolwork. Things began to change in junior high when she “started liking boys,” her mother said, “and the work became too difficult. She got wild on me and then you missed so many days and that was why you were expelled.” Kate admits she had problems in school, that she struggled with “ADD” and was in “special classes” in middle school, but also acknowledges that her problems in school were attributable to her sexual identity:

I was known to take girls’ boyfriends. That’s why I don’t have friends now, ‘cause I was, you know, I was pretty. I wasn’t that big then. Maybe in eighth grade I started getting a little bit chunky but I was not that big then and I was just known as either a whore or having sex with older men. . . . I was known to take girlfriends’ boyfriends.

Kate’s social marginalization—her problems in the classroom with school authorities and with other students, especially females—may not be entirely attributable to her sexual abuse; she does have a learning disorder. But she began falling behind in school at about the time she was molested. Her mother held her back in kindergarten—the same year she moved from Florida to Connecticut because she discovered that her husband was molesting Kate and her sister. When asked how the molestation affected her, Kate said, “It affected me in many ways, like school . . . education-wise I was just so messed up over it.” She was molested twice more before sixth grade, which is when she started having her “sex fiends.”

Laura, a White mother who became pregnant when she was 16 years old, had a similar path of poor school performance and abusive relations with men (her current boyfriend is in jail for participating in a gang rape and murder). Her destructive behaviors began after she was raped at the age of 13, which left her pregnant. She miscarried, but that year she was also held back in school because of poor academic performance. The next few years she was at a residential school facility where she was in smaller classes and received special attention. In 10th grade, she was mainstreamed back into the regular system and soon afterward became pregnant. This time, her boyfriend “gave me a miscarriage. Um, it was a fairly abusive relationship. . . . I got slammed into that wall and his shoulder was right in my stomach.” After she was raped a third time by a classmate at a school bonfire, she dropped out of school:

It was after that I did some tutoring at home and then it was like everything went into a tailspin. . . . I quit school. I ended up moving out, screwed around for a couple years, um, was into the whole drinking thing, getting into bars under age, getting served under age.

Again, we see that the tailspin begins with the first rape. Some girls became existentially fatigued by the sexual abuse and its aftereffects. At the age of 12, Tameka was raped for the second time while playing hide-and-go-seek in a park: “One of the boys found me right on the rocks by the water, bleeding, couldn’t talk, I just kept asking him to help me and I kept telling him don’t touch me, I’m scared.” She didn’t receive counseling for either rape, and soon after the second one, she dropped out of school, began abusing drugs, and became a stripper. By the age of 17, she felt as if she had lived “39 years. I’ve been through so much. I’ve done some things that older people haven’t even done yet. . . . I done try to escape from a rapist jumpin’ out of cabs on a highway. I been through a lot.” She was living on the streets at the time she hooked up with a boy in high school and became pregnant. The “condom broke” and she figured she was pregnant anyway so she continued having unprotected sex. The father of the baby denies paternity and avoids her in school; his parents think she “is a ho” and is “trying to trap” their son.

Alcoholism, drug abuse, and sexual assault clutter these stories as girls tell us how they used substances to help them forget. Bethany, a White mother pregnant with her first child at the age of 17, was molested by her alcoholic stepfather beginning when she was 3 years old, and it continued for a number of years. She never told her mom until years later. When she was
12, she was raped by two men on a footbridge. She thinks she might have gotten pregnant and then miscarried because at one point "there was a lot of blood." She was not sure who impregnated her, her 27-year-old drug dealer boyfriend who she was "totally in love with" but who turned out "to be a real jerk" or "one of the guys that did that to me on the footbridge." So "after that happened on the footbridge, through those years, I drank every weekend, I mean drink to the point where I couldn’t stand up." During this period, she was raped several more times. She never received any counseling: "I kinda had to just like forget about it. That’s pretty much what I did. I never went to counseling for it. I just stuffed it away and, you know, I was just extremely depressed." She became hooked on heroin and slid into two tumultuous years of addiction, prostitution, and criminal behavior. During this time, she gave birth to two children.

"Silence Like a Cancer Grows . . . ."

The trauma of sexual abuse, especially when repressed, can throw a victim into the chaos of substance abuse, violent relationships, withdrawal from school and family, and ultimately, teen pregnancy. In policy debates on teenage pregnancy, conservative leaders plead with young girls to abstain and liberal critics advocate for better access to birth control. What victims of child sexual abuse most need, however, are neither abstinence programs nor condoms but supportive venues where they can articulate and understand their victimization and engage in a process to recover their self-efficacy and power in relationships with men and institutional authorities. Of course, training caseworkers, teachers, and home visitors to recognize the symptoms of sexual abuse is an important step in creating safe networks of support, if not before they get pregnant, then certainly afterward so that the cycle is not repeated.

Victims may also recoup some of their lost power through more vigorous prosecution of offenders. Taking the offensive to punish the perpetrator allows for compensatory victimization that enables the victim to start placing the blame where it belongs. Furthermore, an institutional response allows the victim to receive power from within the community rather than trying to claim power through a tough street persona, an oppositional identity in the schools, or a highly sexualized presentation of self.

Developmental psychologist Judith Musick (1993) believes that talking about the abuse in support groups helps the victim break the offender’s "psychological hold over her, to loosen the grip of the unacknowledged pain of her past on her current thoughts and actions" (p. 72). By loosening the hold, the young woman regains some of the power lost as a result of the victimization. A confident, empowered woman is less likely to abuse drugs, drop out of school, and tolerate abusive partners. In addition, therapy helps to release the psychic energy needed to keep the images repressed. Repression drains cognitive energy and interferes with the ability to concentrate. Speaking out about the abuse, being believed, taking action against the perpetrator, and receiving treatment all help the victim regain power.

If the young victim is not believed, or worse, if she is blamed, then she is more likely to develop a distorted sense of self; feelings of powerlessness, betrayal, and stigmatization; and a victim identity (Musick, 1993). Moreover, if the perpetrator is still around, the feelings of helplessness are compounded—and real. She is not in a safe environment, so it is natural (and actually healthy) to mistrust people who are supposed to help her. The silence that accompanies the abuse intensifies the devastation of the crime.

Despite the fact that child sexual abuse is "a red flag for early sexual activity" and victims who receive counseling are less likely to have adolescent pregnancies, if most victims do not tell or are not believed, they are unlikely to receive treatment (Fiscella et al., 1998). In our study, only 3 women received counseling specifically related to the sexual abuse. Another 13 received some counseling in their lives for a variety of reasons, and most reported they did discuss the abuse with their counselors. Most who did receive counseling "didn’t get that much,” as Kate’s mom said, and it was often inadequate. Sixteen-year-old Mollie, raped by a stranger when she was 12, received 6 months of counseling. “It was free,” she said, but was it enough? "Is there enough time for anyone [laugh] for that?” she asked.

In our study, the few young women who received treatment described a process whereby they adopted more positive self-images and healthier, self-affirming understandings of sexual behavior. Michelle, who was first molested by her babysitter’s son when she was 5, talks about how she was unable to see sexual abuse as abnormal before she received treatment:

I told my cousin [about the abuse] and she like laughed at me so that was like really bad . . . and then she made me tell my mom, which is good. So we talked about it and she said, “Do you want to do anything?” I said, “No, whatever,” so then I did those drugs and whatever, had to get that out of my system.
... When I was 15 my friend and I went to this party with a drug dealer friend that I knew. So I went to this hotel party, which wasn’t safe for me to go to at all and I got raped by two men. I just think I was very vulnerable and that’s why all this stuff happened to me 'cause I wouldn’t like put a fight. It was just so normal, so normal—I know, it’s not normal, but to me. 

A few months later, she started a relationship with Mark, her 23-year-old boss at a fast food restaurant. “At that point I was getting old enough where I was like, hey, wait a second. This doesn’t happen to normal people.” With the support of Mark, she sought professional help:

I was about 16. I decided I wanted to go to therapy and he helped me and encouraged me into doing that because he knew I needed it. I didn’t really ever like totally tell everybody everything, you know. I just did drugs to like suppress it all in, whatever. I totally put it away in the box that we all have, until I was like 11 and it hit me one day when I was watching Oprah. I’m like, oh my God, and I started seeing all these pictures in my head and I’m like, is that me? So [Mark] kind of encouraged me to go to therapy and I was like, okay. The first session I didn’t really like it so I stopped going and then I went back like 3 or 4 months later and it was great. It totally helped me. It made me not so [pause] angry about everything. I knew it wasn’t my fault. I knew that all the people in my life must have had something wrong with them to do something wrong to me.

With therapy she stopped blaming herself for the abuse and acquired a different perspective for understanding sexual abuse. Even though she is a teen mom, she did not deliver until she was 19; she is in a long-term and committed relationship with Mark, the father of the baby; and she is in college.

Missed Opportunities, New Moments of Vulnerability

When victims of child sexual abuse never scream or when they scream and no one responds, the scream may turn inward and reappear as mutilation, suicide attempts, depression, and psychosis. Or the anger may become dislodged from its source and reemerge as drug abuse, oppositional posturing, and violence.

Examining misplaced self-blame and reclaiming self-efficacy through therapy and prosecution are important methods for victim recovery. However, most moms in our study did not report the abuse, and when they did, most were not believed. For many, this box is likely to remain closed until future events open it. In some cases, future events may be self-destructive, as described before. In other cases, they may reemerge in potentially healthier situations, such as the relationship that Michelle describes with Mark. They may also reemerge in motherhood.

Mothers who have not successfully dealt with their own trauma may become preoccupied with the memories of their unarticulated pain and subordinate the needs of their children. In a few cases, we saw that the experience of motherhood led to a process in which the mothers were able to reopen and readdress their pain. They reclaimed their innocence through the perceived vulnerability of their own children, and they worked vehemently to protect their children in ways they were not protected themselves. Through the parental responsibility of protecting their own children, they began to see that they were not to blame for the sexual abuse they had endured. Delores said,

Like for so many years in my life, it’s like I kept blaming myself but it’s like I stopped, letting that go when I had my daughter, because I have my daughter now and I can see that she can’t have nobody hurt her. A person could hurt them on their own and it’s not her fault, you know. I know that now that it wasn’t my fault, you know, but it’s like I still sit here and think about it. It bothers me a lot.

Some mothers became hyperprotective of their children. One mother said about her 2-year-old, “I got to start teaching her you can’t let nobody touch you.” They will not leave their children with child care providers who are not family, and they do not trust day care centers.

Reliving one’s own vulnerability through the child, however, is difficult to manage without professional help. Victims who have not received emotional support for the trauma can reproduce patterns of role reversal. Several of these mothers were forced to assume adult roles at a young age—caretakers to younger siblings, “friends” with their emotionally unstable moms, and sexual play toys for predatory older men. Now, as young adults, they tell us they “never had a childhood.” Robbed of their innocence and childhood, they talk about having babies so that they can be mothered. They want their children to grow up and take care of them. For example, asked about her hopes and dreams for her child, Alisha said
her 3-year-old son “just knows he got to protect me. But he does, he protects me.” Another mother hopes her child will “be making some money. Buy me a...”

But he does, he protects me.” Another mother hopes her 3-year-old son “just knows he got to protect me. “Another child knew how to play the VCR at the age of 3.”

Another reaction is to emotionally seal oneself off from the pain provoked by the child’s vulnerability. In these cases, mothers became emotionally unavailable to their children. Deidre admits, “I’m scared to go [to therapy].” She went once, but “didn’t feel comfortable.” In lieu of therapy, she did see a fortune-teller who “read her cards” and told her that she “needed to get help before they take her daughter away.” Cassandra, a 17-year-old Puerto Rican mother, received some counseling for anger management but not for her depression or the sexual abuse she endured at the hands of three different men when she was growing up. Emotionally blocked herself, she fails to emotionally engage her child. She believes her 1-year-old is manipulating her—a “child crying without no tears”—and her neglect is evident in a serious burn that her daughter sustained. Without counseling, it is harder for victims to recognize their own vulnerabilities and their children’s vulnerabilities. When they move the trauma to that little space in their brain and forget about it, when they do not deal with the damage to their own psyches, the damage is often recycled.

Becoming a mother creates a new set of choices—the damage can be repaired or the abuse can be reproduced. With counseling and support, a young woman is better prepared to set off down the first path. When she is not present to her own vulnerability, however, she is less able to repair the damage. This, however, underscores the dilemma—if victims of child sexual abuse are unlikely to tell or to be believed when they tell, how are they likely to receive therapy? As we have seen in this study, sometimes they ended up in therapy for other reasons and were able to address the abuse. But clearly more is needed.

The trauma associated with sexual abuse is much more likely to remain individually experienced and understood than viewed as a public issue. A sociological imagination, as described by C. Wright Mills (1959), that links personal troubles to public issues could provide a useful point of departure to more broadly address sexual abuse. Whereas the act of transcending the personal trauma by locating it within a set of larger social and familial dynamics may be an effective therapeutic strategy, limiting the work to the individual curtails public responsibility. This responsibility is twofold: It includes (a) reconceptualizing the problem of sexual abuse so that it is no longer seen as unique or rare but located within a set of sexual power dynamics more broadly characteristic of the culture, and (b) mobilizing a public campaign so that the institutions likely to interface with victims are better prepared to effectively address the myriad problems related to sexual abuse, even when it emerges years later, as in the experience of motherhood.

Although no public project has been described in exactly these terms, other researchers have clearly moved us in this direction. For instance, Teram, Schachter, & Stalker (2005) have found that one effective way of training professionals that also empowers clients is to elicit input from survivors to develop a handbook for professionals that would define appropriate practices and target needs. Ehrmin (2002) has demonstrated the importance of exploring “unresolved painful life experiences” in the context of substance abuse treatment to identify repressed incest and sexual abuse incidents (p. 790), and Nehls and Sallman (2005) have emphasized the need for public health professionals to adopt postures of deferential engagement in hearing the stories of victims. Similarly, Anderson et al. (2006) argued that engagement with sex abuse victims requires professional acknowledgement of and strategies regarding “their worldviews, priorities, and life experiences” (p. 939). These recommendations all attempt to diffuse the intensity of personal trauma and victimization through public rendering and institutional action, which shift more of the responsibility from the individual to the public, in much the same way that public responsibility for domestic violence has developed in the past 20 years.

Conclusion

The trajectories from child sexual abuse to teen pregnancy vary but are nonetheless patterned. As painfully described in this study, abuse is seldom articulated, and victims are rarely believed or likely to be treated professionally. Forgetting or repressing the trauma often intensifies the devastation of the crime and may result in self-mutilation, suicide attempts, depression, and acute psychosis. Similarly, misplaced anger may lead to substance abuse, delinquency, truancy, and unhealthy relationships with men, including early and risky sexual behavior resulting in teen pregnancies. Learning
to undo the emotional knots and the self-distortions around which their lives have been organized, a few of the women reclaimed self-efficacy and power through professional treatment.

With motherhood, many of the women reexperienced their innocence and vulnerability through their children. This provided a crossroads at which repressed memories and distorted perceptions of self-blame could be revisited and better understood, usually with professional help. However, missing this opportunity for professional intervention also leads to unhealthy consequences that reproduce conditions for child abuse and neglect, such as parental withdrawal or parent-child role reversal. Awareness of the ubiquity and consequences of child sexual abuse among health care professionals, home visitors, and early education and child welfare professionals can enhance needed interventions and reduce the likelihood of teen pregnancies. Supporting these efforts through more broadly defined public mobilization strategies can shift some of the burden of sex abuse from individuals to the public, exposing the essential link between personal troubles and public issues and responsibility.

Notes

1. We borrowed this title from a short story of the same name written by Fred Pfeil (1996), published in What They Tell You to Forget.
2. A few studies have also noted that the relationship between sexual abuse and teen pregnancy is considered stronger for boy victims than girl victims (see Pierre, Shrier, Emans, & DuRant, 1998; Raj, Silverman, & Amaro, 2000; Saewyc, Magee, & Pettingell, 2004).
4. Other research has not found a significant relationship between age of partner and a history of abuse (Harner, 2005).
5. This software was designed and developed in Australia in 2002 by QSR International.

References


Mary Patrice Erdmans, PhD, is a senior researcher at the Center for Social Research at the University of Hartford, Hartford, Connecticut, and a professor of sociology at Central Connecticut State University, New Britain, Connecticut.

Timothy Black, PhD, is the director of the Center for Social Research and an associate professor of sociology at the University of Hartford, Hartford, Connecticut.