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CHAPTER ONE

The emotional impact of abusive experiences in childhood, particularly sexual abuse

Judith Trowell

In the late 1970s and early 1980s, the occurrence of childhood sexual abuse began to be widely recognised. The Cleveland Inquiry report was published in the United Kingdom in 1988, and in this Lord Elizabeth Butler-Sloss confirmed that sexual abuse did indeed occur and existed. Until then, many in society did not believe this to be so. What is important is to ask whether it matters that sexual abuse actually happens to children. We know about the Oedipal conflict and the enormous power of the associated phantasies. But the actual physical enactment of the act of adult–child sexuality—masturbation, oral, anal, or vaginal intercourse, and then all the various other sexual acts some children experience—is a very different psychological trauma from the effect of phantasy. Violation of the actual body, and the accompanying threats to ensure silence and secrecy, are damaging in a way that differs from phantasies. The fear of violence and the actual violence that so frequently accompanies the abuse are also very different from the phantasy of destruction of murderous rage.

We have become much clearer about the problems and behaviour associated with childhood sexual abuse. Beitchman and colleagues have undertaken two extensive reviews. The first (Beitchman, Zucker, Hood, Dacosta & Akman, 1991) looked at forty-two different studies to

draw out the short-term effects; the second (Beitchman, Zucker, Hood, Dacosta & Akman, 1992) reviewed the long-term effects. These effects have been summarised by Cotgrove and Kolvin (1996) as four main long-term associations with child sexual abuse:

1. Psychological symptoms consisting of depression, anxiety, low self-esteem, guilt, sleep disturbance, and dissociative phenomena.
2. Problem behaviours including self-harm, drug use, prostitution, and running away.
3. Relationships and sexual problems—social withdrawal, sexual promiscuity, and re-victimisation.
4. Psychiatric disorders, particularly eating disorders, sexualisation, post-traumatic stress disorder, and borderline personality disorder.

We have also become increasingly aware, as the children and adults abused as children have been able to speak about their experiences and seek help, that the therapeutic work needed is very complex and difficult. In order to understand and think about the emotional impact of this abuse and how to work therapeutically, we have learned that it is vital to draw on the understanding of child development and of sexuality and aggression that is central in object relations psychoanalytic theory. Psychoanalytic theory has a significant contribution to make to the work—in particular, the understanding of transference, countertransference, and early mechanisms for trying to manage intense feelings such as splitting, denial, projection, and projective identification—because they are used so extensively by these individuals and their families.

Child sexual abuse

Sexual abuse is defined in the United Kingdom by the Department of Health (Schechter & Roberge, 1976) as "the involvement of dependent developmentally immature children in sexual activities that they do not truly comprehend and to which they are unable to give informed consent, and that violate the social taboos of family roles".

In this chapter, what is being considered is contact sexual abuse, which means that the child or the adult as a child has touched or been touched by the abuser. The acts have been kept secret and may involve bribery, threats, or violence, and some children may have been involved in multiple sexual abuse with groups of children and adults. The abuse

may have occurred once or lasted over a period of years with variable frequency.

It is important to always remember that sexual abuse is not a psychiatric disorder, it is a psychosocial event, and the mental health sequelae vary from individual to individual. What to us seems horrendous abuse may not profoundly impact on the survivor; lesser abuse may leave the victim very damaged.

Assessment

When we started work in this area, we mainly saw adolescent girls and women abused as children. Over the years, we have seen more and more younger children, down to 6/12, and more boys and men abused as children or adolescents.

The only definite diagnosis is made when semen or seminal fluid is found. So most abuse is diagnosed on the balance of probabilities. The child bleeding from the anus or vagina, or bruising in the area, are pretty clear signs. Colposcopy can be used and this may show signs invisible to the naked eye. However, most cases are diagnosed on the basis of the history and the interviews with the individual.

Adults can recall abuse, and often siblings or friends can corroborate events. A man in his fifties recently talked to me of abuse lasting several years by his older brother's best friend. The friend used to offer to read a bedtime story and abused him. But back then, he felt special, "the chosen one". Only later did he realise. Of course, there are no physical signs in these retrospective accounts, but often others can confirm.

One needs to be careful, given the "false memory syndrome", regarding an individual who has become convinced they were abused. Such individuals often have no corroborating details, and this arouses my suspicion. Survivors talk of gazing at the ceiling and describe the lights or the wall covering, the situations where it occurred, floating out of their bodies and looking down. There are usually some details that imply an authentic account.

Adolescents can be very vocal about what has happened but suddenly embarrassed to give precise details. They can sometimes draw or tell it in the third person—as a story. We have learned over the years that most assessments only reveal a small amount of what really happened; a fuller account emerges later in treatment.

Children and adolescents need to know that the therapist can bear to hear it. Often, we say, "other boys and girls have told us that bad things

happened to them, they were touched in private places, or made to do things they didn't want, has this ever happened to you?"

I have assessed many individuals, but also had to assist in Ireland in an extensive way in a case in which many children were involved. I also went to Orkney where there were fifteen children potentially abused, and have been leading teams working with boys from a church choir and two boys' special church residential schools.

Many of these young people have been terrified to talk, and most only allow glimpses of what has occurred. Later, they report it takes six months to a year before they really dare trust anyone.

However, one has to make some judgements, and generally we give up to four sessions and the individual can in that time convey enough. Often, when seen in a group, they can talk more. But if one is aware there may be court proceedings, group interviews are not permitted. Small children often need a "safe", trusted person with them or just outside the door, to speak. We have reasonable accounts from three-year-olds.

But one must always bear *not knowing* and that, for many, uncertainty remains. More and more assessment interviews must not be allowed. I use dolls (pipe cleaner), play dough, cellotape, felt tips and paper, small animals and string, whether with children or adults. They need to be doing something and cannot just sit and talk.

This whole internal ferment is going on for the child around each significant relationship. The child, not surprisingly, becomes very confused. They have to make sense of real experiences of loss and separation, and at the same time be trying to adjust to their present set of relationship standards, expectations, and do all the mental work of appraising their internal representations, real or fantasy. Not surprisingly, many of them do not have the mental or emotional energy to do this.

Identity is based on these internal representations. Older children, despite being relieved to be away from the external reality of their home, carry it with them in their minds. All of them may have to settle for either siding with and idealising the internal representations of mother or father, or rejecting them and living in fear of retaliation, retribution, and intense feelings of disloyalty.

Interventions

We concluded from our work that the individuals, children or adults, need a menu of treatments. Debriefing does not seem to be

helpful—the belief that it must be talked about. Some individuals need to talk—some flood one with it and have to be helped to slow down and reflect. Others do not want or cannot talk; to force them is wrong. Some need help to manage themselves and their behaviour, some need medication initially for depression or post-traumatic stress disorder. Art or music therapy may be helpful.

What is so important is, when they are ready, to offer help for the deep emotional pain, confusion, and distress. Psychoanalytic work is vital to help them recover, because the emotional impact of the abuse is like an intra-psychic abscess that poisons all aspects of the individual's internal life. We cannot *cure* them, they will be left scarred, but the wound can heal; it does not need to be a raw, suppurating wound.

Many such patients start once weekly, terrified of being in a room one to one. Gradually, frequency can be increased. Some manage a group, and from every group of six, then two or three need individual work. The families or partners of patients need help also, as there are consequences for them, and there may also be issues raised from their own pasts.

Psychological sequelae of sexual abuse

There is a persistent and frequently unresolved question: has abuse occurred, is it real—reality—or is it imagination, or is it some form of phantasy, conscious or unconscious? Is it possible to understand this? Trying to understand childhood trauma and its impact on thinking and memory, we have to consider post-traumatic stress disorder (PTSD), some features of which are applicable to child sexual abuse. In PTSD, there can be flashbacks, the person is awake, conscious, and is suddenly dramatically and vividly back, in the mind, in the very stressful situation, re-experiencing the events. Also they can have flashback dreams, in which they dream the re-experiencing, and if they awake during this "action-replay" dream, their confusion and distress is even greater than with the awake re-experiencing. Experiencing a flashback, being able to distinguish phantasy from reality when the phantasy had, in fact, been a real experience, is very distressing.

But there are other features of PTSD that also need to be considered and can be helpful in understanding why children, or the child inside the adult, function in the way they do after traumatic experiences. Part of PTSD is what is known as psychogenic amnesia—the memories are pushed out of consciousness. This may be done so successfully that

individuals are aware there are things that they cannot remember, but they do not know what those things are. Alongside this goes an inability to concentrate, a lack of emotional involvement, a loss of liveliness sometimes described as feeling of numbness. It is not surprising, therefore, that individuals appear to be confused and uncertain about what has happened to them. It is also not surprising that their emotional reactions may be rather flat, that they do not show the level of distress or anger that might be expected.

It is easy to understand how rather flat accounts that do not have great detail in them lead to questions about whether the abuse occurred or not. Why it is so difficult to confirm or refute abuse in the absence of physical signs begins to make sense; the difficulty of staying with the uncertainty as far as the legal system is concerned is a large part of the problem. Post-traumatic stress disorder also involves avoidance and dissociation. The abuse victim appears to be somewhat vacant or blanks out, will pause and then change the subject completely during an interview. This is partly conscious avoidance but also seems to be a process occurring in the preconscious or the upper levels of the unconscious. Memories and experiences that are too painful and distressing are blanked out, and the individual becomes very adept at doing this so that the interviewer may hardly notice the pauses and the switches in themes or diversions.

But PTSD does not explain why sexually abusive experiences cause so many difficulties. Psychoanalytic theory is needed to try to understand the persistent and long-term problems.

Childhood sexual abuse can be seen as the abusing adult's "madness" being forced into the mind of the child, and it penetrates deep into the unconscious: the child's mind is "raped". The mental mechanisms used to deal with the overwhelming trauma are splitting, denial, projection, projective identification, introjection (introjective identification), and manic flight. Experiences, thoughts, feelings are split off; they may then be projected or they may be denied. Understanding these processes and the phantasies that accompany them is crucial in the understanding of childhood sexual abuse.

One of the things that seems to happen in sexual abuse is that the split-off denied experience forms a bubble, which can become encapsulated. It may be a very small bubble if it was an experience that did very little damage, or it may be a very large bubble if there was major emotional/psychic trauma. This bubble may then sink—a denied split-off

fragment that, like an abscess, can give off undetected poison—and the person may be impaired in a number of ways: their learning capacities, their capacity to make relationships, or their complete hold on reality. Alternatively, the split-off experience, the encapsulated bubble, may be quite large and encompass quite an area of mental life and functioning and cause considerable impairment. The impairment may be significant in the area of learning, in developing relationships, or on the individual's hold on reality, but for all of them there is impairment, a block on their normal development.

If the individual has had good-enough early experiences and their development had been proceeding satisfactorily, then the abuse and its resulting split-off and denied aspects can be dealt with using displacement, disavowal, or dissociation; in a way, the child gets on with their life, and it is as if the abuse never happened. But the protective processes may fail at some point, and then awareness re-emerges: for example, when trying to make intimate relationships, when pregnant or giving birth, when their child is the age they were when the abuse took place, or during the course of seeking help for something altogether different.

Where the abusive experience was extensive and early childhood experiences were not good enough, then the split-off, denied abusive experiences seem almost to take over the whole person, leaving very little mental or emotional energy available for current life. Unconscious phantasies dominate and spill out in bizarre and disconcerting ways, for the individual and for those around them. It appears that the individual is using projection and projective identification as a means of struggling to return to some psychic equilibrium. The individual can go on to become a borderline personality or to be overtly psychotic; the ability to establish relationships and the capacity to function can be very limited.

Some clinical examples to illustrate the therapeutic intensity of the work with an abused child

"Phillipa"

Phillipa, an early adolescent aged fourteen years, was referred by an outside psychiatrist for treatment; she was doing extremely well at school, spending hours there, and was reluctant to leave to go home.

She was very small and uncared for but was very friendly with teachers; child sexual abuse was discovered when she talked to the deputy head, saying her father came to her room at night.

She was the eldest of three children, with a younger brother and then a sister. Since her sister's birth, when Phillipa was five years old, mother and father had been having problems. Mother adored her younger brother and sister. Phillipa had to help in the house, run errands, and give father his meals as her mother was busy with the other two children. Phillipa was very fond of her father; her father began to cuddle Phillipa a lot, then to visit her bedroom for cuddles, then to get into her bed. They had intercourse; at the start, this was anal and was then vaginal for about the last three years.

The therapy

Phillipa was fostered by a teacher at school. She was very angry: "Why do I need to come? I only come because I'm made to. What do you know? What could you do—nothing. You haven't been abused—have you." I was totally useless, there was no point in her coming. In spite of this, I arranged to see her; the contempt, derision, sarcasm, denigration, went on and on. She knew more than I did about everything, was more intelligent than I was; she was relentlessly sneering and mocking. Then she began to flaunt her sexual knowledge and to be quite provocative. She talked in a very erotic and sexualised way, becoming excited and seductive so that sometimes it felt as though she could masturbate me with her words. I began to dread her visits, her words, to dislike her intensely. And yet here was this small, vulnerable child/woman who seemed desperately to need help. I felt ground down and useless. I learned that the foster mother felt that she couldn't get near her, and the foster father was extremely uncomfortable.

The feeling of hopelessness and despair led me to talk about her mother, and she became more and more repulsive. I felt that she resembled a poisonous snake. I began to talk about terror and fear and panic and feeling trapped. This later produced a dramatic response. She began to talk and talk about her terror and sense of being trapped in her family, in her bed, with her father. She had coped by pulling the sheets up to her chin, putting her arms and head out of the top, and not knowing what went on below. She insisted that she had completely cut off. She began to have terrifying night terrors—dreams that were a repetition

of the abuse. She talked about her father coming home drunk, how he hated himself, how she was left to get him undressed and into bed, how one day she couldn't support him and he fell and injured himself—she was very upset but relieved. In the room with me, she began to weep. For several weeks, she wept and wept through each session. Now, she was talking to her foster mother, but when Phillipa wept for three weeks almost continuously, I think everyone wondered what I was doing to her in the sessions.

Around this time, she started to have symbolic dreams, nightmares of her father in a coffin: either he was dead and it was her fault, or he was being buried alive and only she knew it. She wept for her father, finding it hard to be in touch with any anger or rage and her wish to kill her father. They were both victims, he should not have done it; but her hatred of her mother was intense, vitriolic.

She also still woke up frequently at night, screaming, having felt something hard pressing against her and feeling terrified, convinced that it was her father beside her and his erect penis, and that she "knew" intercourse would follow. We understood these dreams as "memories", whereas the other dreams were more usual symbolic dreams which we could struggle to understand. It now felt that she had become a person, not a walking mind; but the pain and despair were very powerful, and at times she raged at me for having done this to her, put her in touch with feelings, tortured her. Finally, she was able to rage at her father as well as show her pity for him. She had some compassion for her mother, whom she realised wasn't aware of the abuse and who had probably been quite depressed. We then had to work on her feelings of triumph over her mother and myself and how hard it was to be a teenage girl.

"Susan"

Susan, aged nine and a half years, was at primary school and was referred by the social services department. She was one of four children. Her mother had left when Susan was small. The elder two children were placed in a foster home. Susan and her youngest brother, about eighteen months old, were placed in another foster home; this was a family with six foster children, where the parents were fostering full-time. A short-term foster child, a girl, there whilst her mother was in hospital, when back at home told her own father about Mr X, the foster father, touching

her, Susan, and other girls; this child's father told social services. All the children were removed.

Mr X had begun touching Susan when she was small, soon after she arrived, initially masturbation of her, then mutual masturbation, then vaginal intercourse over the last few years.

Susan was in an ESN school and had been moved there after nursery class. No reason had been found for her quite serious learning difficulties.

Assessment showed a very flat, unresponsive child, and she had hearing problems—how much was she hearing, how much was subnormality or depression? Recurrent ear infections had left her virtually completely deaf in her right ear and partially deaf in the left. She was unable to cope in a group, unresponsive to counselling in school, and not speaking to her new foster parents.

The therapy

Susan was offered twice-weekly treatment. There were weeks of saying very little, with apparently no response from her to anything. Then I became aware of her eyes, which were quite alert, watchful, usually hidden by her hair; she never appeared to look at me and still looked stupid. I was aware of feeling more and more depressed and said this to her, and how hopeless it all felt.

She began to talk with rage and hatred about her ex-foster mother, the terrible food, the hours of slaving away doing work in the house and garden, the terrible pain in her ears, and never being taken to the doctor.

At times, she was very hostile and suspicious of me. She had further ear infections, and she told me that I was there in the night hitting her about the head, making her vomit, forcing burnt food, stale going-off food, down her, standing over her until she ate it. She had difficulty in sorting out me in her dreams and me at the clinic. It seemed I was seen as the cruel foster mother.

Material from a session after six months of therapy

Susan came in and sat opposite me across the room—she could not sit further away. She had come to the room rather reluctantly but had not resisted. She did not show any interest in the paper or plasticine

as she had previously begun to do. She sat without any eye contact and without saying a word. I caught her looking around the room, and her eyes seemed to be darting this way and that. I said: "It seems to be hard today." No reply. I said: "Is it horrid here today?" Susan said nothing but nodded her head. I said: "Why horrid?" Susan looked at me for a moment. I said: "I was puzzled. Was it horrid here in the clinic or outside, at school, in the foster home, before?" After quite a long pause, Susan said: "You hit me". I felt very shaken—what had I done, when, why couldn't I remember? I asked: "When do you think I hit you?" Susan said very firmly: "You hit me". "Tell me", I said. She said: "Night time, night time, you hit me, wake me up hitting me." She was now holding her head in both hands and thrashing in her chair from side to side. "You hit me, I wake up. Why, why you hit me? Pain, hurt." She began to cry and, with her heels on the floor, pushed her chair as far away from me as possible. She was looking at me with fear and rage. I said: "Susan is very afraid and very angry with Dr Trowell. But Dr Trowell is in the clinic, not in your house. Perhaps Susan had bad dreams." "No", she shouted: "You hit me, you hit me, you bad."

I felt worried and a bit panicky. What if outside people could hear, what if her foster parents or social worker thought I was abusing her? Had I hit her? What had I done and perhaps forgotten? I said: "Maybe Susan had a bad dream, a dream that was remembering bad things?" Susan paused and then said: "She hit me, like you hit me, she hit me." I said: "And in the night it all gets muddled up." Silence. Then I said: "It must be very scary not knowing, is Mrs X there, are you back there and she is hurting you, or is it me, Dr Trowell. Maybe because you missed Dr Trowell and wanted me to be there." "No", she said, "You hit me, you bad. You make me eat bad things. Don't take me to doctor's. Need doctor make ears better. Don't take me. Bad." I said: "I think Susan gets in a muddle. It all gets muddled up. Mrs X, myself, her new foster mum and her real mum. So much pain and hurt. Missing pain, earache pain, and then all the pain with Mr and Mrs X hitting and hurting. It was very hard to sort it out." She began to sob. After a while, I said: "Maybe the hardest thing could be sort of wanting to be hit, wanting the pain, because then Susan knew someone was there. Susan wasn't all by herself." She left tearful and down.

During this session, I had been very thrown. I needed to check with myself and reassure myself that I hadn't hit her as far as I could remember. I also felt briefly furious with her for disconcerting me. I wanted

to shake her and say, "Don't be so stupid. I never hit you. How dare you say that." Susan's conviction when she came in that I had hit her seemed fixed—or was it my anxiety that made it seem so? Certainly, it was very hard indeed to hold on to the capacity to think and not know the answers, to stay with uncertainty.

Towards the end of the first year, she began to talk about her foster father. She wept a great deal. He hadn't been cruel; she had felt bad, dirty, knew it was wrong, and it was also good, being held, being touched, stroked; no-one else did, except she and her brother, but hardly ever. The inside bit was awful and all the mess and the smell. She thought everyone could smell it, knew it, everyone at school. Now he was in trouble and she felt sad, glad it had all stopped, but she sort of missed him. He had a terrible time with Mrs X; she was a right cow.

Now she was sobbing for her natural mother—where was she, why had she walked out, and, to a lesser extent, why hadn't their natural father kept them (she still saw him)? At school, she began to learn, to ask questions; she started to try to write—for example, her name—and she drew. She began to read, about families and animals, and later to use small numbers and add up. Susan developed a real talent for drawing and painting and using clay, making animal models. She was a real star in the school kitchen and she loved cookery. She began to read in earnest—recipes and the instructions on the kiln at school.

We now went over and over the sexual abuse, her sexual feelings for girls and women and myself, her shame, her longing for babies. She wondered if she was normal—could she have them? Would she ever have normal relationships with men? My reactions were very powerful and at times difficult to cope with: despair, fear, guilt, anger, the seduction of being the good, idealised, abandoning mother—the ease with which I could have been the cruel, sadistic foster mother.

Thoughts about the development of sexual identity

In undertaking this work, an issue that has emerged is the development of identity, particularly sexual identity. At the start of treatment, very often the central issue appeared to be "are they a person and are they sane?". They have dreams, day-dreams, possibly hallucinations that involve terrifying fantasies. The processes of coping take all the psychic energy, using projective identification to get rid of the unbearable, the unthinkable, and then having to manage the terror of retaliation,

possible attacks, and persecution. But then, gradually, questions about sexuality and sexual identity come to the forefront and need to be thought about and understood.

Psychosexual development as understood psychoanalytically plays a very important part in this understanding (see Trowell, 1997a, 1997b). In particular, Melanie Klein's early papers (1932a, 1932b) are very helpful. She describes how baby boys and girls are aware of their bodies, their genitalia, as a source of pleasure very early on, boys with their penile erection and their wish to thrust forward, to penetrate, and girls with their sense of something precious inside. She suggests that alongside the Oedipal longing for the parent of the opposite sex and the reverse Oedipal longing for the parent of the same sex, there is for both small boys and girls a sense of the power and importance of "mother", the main female carer. Mother who cares and nurtures is also feared. (See Baker Miller, 1976; Freud, 1905e, 1931b; Jukes, 1993.)

This is a complicated and complex situation for the child. Mother is loved and longed for but is also hated for depriving, for failing to meet needs, and for involvement with others. The child then fears mother's retaliation for this hatred. But, in addition, mother who has the source of life inside her, all the babies, all the penises, is feared because she is expected to wish to attack. The boy child expects mother in her envy to wish to take over his penis, and the girl child expects mother in her envy to attack the child's "womb" as a potential rival to her own (see Klein, 1932a, 1932b; Heimann, 1951). These are all normal phantasies and fears that have to be worked through, and with a loving, caring mother, the envy, fear, and terror is slowly made bearable.

However, in abusive situations, there appear to be times when the child thinks that mother knew what was happening and wanted him or her to be damaged or, if not actually wanting damage inflicted, certainly failed to prevent it happening. This is an internal phantasy that becomes a thought and has nothing to do with the external reality of the circumstances of the abuse. During childhood and puberty, these issues are repeatedly reworked. Puberty for girls is particularly crucial, the onset of menstruation provoking considerable anxiety in the girl—"Have I been damaged inside?" The girl needs the "mother" to be particularly supportive and to take pride in the girl's emerging sexuality as she struggles with all the fantasies. Sexual abuse at this age, with the fantasy that mother's envy could not bear a rival and that she wanted

her daughter to be damaged, seems to be a crucial factor in why sexual abuse can be so damaging.

Slowly, then, in treatment, the sexual development, sexual identity, emerges as an issue (see Breen, 1993; Mitchell & Rose, 1982). Trying to understand the process is slow and difficult, but common themes have begun to emerge. Body gender seems to be the earliest to emerge; by this, one is considering physical gender based on genitalia and, later, secondary sexual characteristics such as breasts and fat distribution. This gives rise to an awareness that "I am a boy" or "I am a girl", maleness and femaleness.

Children usually know their body gender early on, probably before speech is well developed, although what exactly is understood is not clear. What follows next is an awareness of oneself as a boy or girl in one's mind: one's self as an internal object has a gender attribution. This gives rise to a sense of masculinity or femininity, one of which predominates in most people. Thus, a person may have a male physical body but could have either a male or female gender in the mind. The internal object "self"—one's awareness of masculinity or femininity, one's mind gender—is conveyed non-verbally as well as verbally. It is not clear how this develops, but it appears that it takes place largely in the context of interactions and relationships with those around, plus intra-uterine and hormonal factors. Alongside the relationships in the external world, the internal object relationships appear to be very significant—for example, the mother and father internalisation from the main carers, and their internalised carers from their childhood, all in interaction with unconscious phantasies.

Early on, at primary school, children are working through the Oedipal phase and are preoccupied with the possible choice of a partner—homosexual, heterosexual, or bisexual—at some time in the future. The sexual orientation fluctuates, and this fluctuation returns in adolescence (Limentani, 1989). Small children do not usually experiment in reality, although this may happen in adolescence. Childhood sexual abuse may influence this developmental phase.

Very closely linked with sexual orientation is object choice, but it is helpful for the girls and boys and the therapists to keep this as a separate phase. If a person decides that he or she is heterosexual, there is then a second stage, which involves the generational boundary. A man may have had as his sexual orientation female partners, but are they to be women or girls? A woman may settle on a homosexual

orientation: does she then want as her sexual partners girls or women? There is often an assumption on the part of therapists, patients, and citizens that homosexuality involves the choice of children as objects. This does not appear to be so, and it is important to keep this distinction. "Does this mean that they wanted sex with girls or with women?", is a frequent question. There are the issues of guilt, of shame, of not knowing, which need to be acknowledged, and it seems to be helpful to talk about the fear and anxiety about homosexuality and object choice so that this can be thought about and worked on.

If this phase can be negotiated, there is often a considerable step forward, with the emerging of creativity. Patients can discover a capacity to be in touch with feelings and have an active intelligence which arises from recognition of their internal parental couple (see Chasseguet-Smirgel, 1985).

In the final years at primary school and on into adolescence, these creative thoughts begin to link with the possibility of babies—real babies or intellectual babies, emotional babies, new ventures, new activities. Maternal or paternal feelings are then followed by thoughts of actual motherhood, fatherhood, and, if there is to be a real baby, child-care, parenting. Many individuals who were sexually abused as children find this whole phase very difficult. They may, in fact, by the physical act of intercourse, become pregnant and have a child, but the mental work to prepare for the care of a child is missing.

Thoughts on working through Oedipal issues

Are there particular problems, following sexual abuse for boys and girls, with the resolution of the Oedipal conflict? Boys abused by older boys or men are often initially in a state of turmoil and confusion, the violation of their body, penetration of the anus, has a profound impact. Many of them ask why they were chosen: did they invite the assault? Sadomasochism can be part of the abuse and, if this was part of their parenting, it easily becomes embedded in their personality structure. Turning to mother consciously becomes impossible: the shame, humiliation, and, for some, the excitement inhibits them. Unconsciously, the Oedipal conflict is not resolved unless previous parenting was good enough and there is a solid intra-psychic structure already. Many boys use splitting, denial, and projection, and some use disavowal. This can be more dangerous, as they know

abuse is wrong but then, when their needs surface, they act. So they can "believe" what they are doing is a consensual sexual relationship. Most boys we have seen have no internal creative parental couple, no sense of a combined parental object, no coming together of their male and female internal objects.

They may forcefully relinquish an attachment to mother, may reject father or be in identification with father. This does not mean they become paedophiles, and they may be straight or gay. It may leave them predatory in terms of seeking sex, with no concern for their male or female partner. Attunement and differentiation has been lost.

When phantasies become reality, the usual Oedipal resolution is lost—it has happened! This also applies to girls, but for girls whose abuser is male, there is the possibility of safety with mother. If mother is abusive, then they too have the betrayal and shame, but the disintegration usually turns inwards—"it must be my fault"—with the path leading to self-harm or mental health difficulties. It seems that physical abuse, sexual abuse, and neglect can have similar outcomes in the internal world, although sexual abuse often has more self-destructive sequelae.

Conclusions

Starting from the experience of working with traumatised girls, ideas have been developed about the impact of trauma on these individuals and on those trying to work with them. Post-traumatic stress disorder can follow abuse; it is partly a means of managing the unbearable thoughts and feelings but also, if there is frequent re-experiencing, seems to fixate the experience.

Understanding the intra-psychic phantasies and ways of dealing with these overwhelming experiences with current psychoanalytic ideas enable the individual to be helped with psychoanalytic psychotherapy and psychoanalytically informed case management. Similarly, the confusion and distress about their psychosexual development can be understood, relieved, and assisted.

What has become increasingly obvious in this area of work is that the therapy must be in stages. The post-traumatic stress disorder must be recognised and treated. The children need to be helped to give words to the sensations, the experiences they have been through—the smells, sights, sounds, physical sensations—and to talk about their feelings

about what has happened. But doing so leaves them with all the unconscious trauma, confusion, and distress untouched. This will need to be treated; it may be immediately, but some children may prefer to have a space and then begin the deeper psychoanalytic therapy work. Most, at some point in their lives, need the intra-psychic pain, conflicts, and confusion to be struggled with and resolved as far as possible, but in order to undertake this difficult and distressing psychoanalytic work, they need to be in a family or substitute setting that can support them through the work.

Different psychoanalytic theories have provided different concepts to try to make sense of this material and to try to help children understand what has happened to them. Trying to integrate some of these ideas in order to help these individuals and enable us to understand has been challenging and rewarding.

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CHAPTER TWO

"A soul in bondage": the treatment of an abused latency-age boy

Nick Midgley

Introduction

Recent work in the field of neuroscience, when linked to psychoanalytic and developmental research, has helped us to develop a better understanding of the impact of trauma upon both the mind and the brain of the developing child. In the previous chapter, Trowell has described some of the effects that traumatic experiences in childhood can have upon development, but in this chapter, I want to focus not so much on the impact of trauma *per se*, but more specifically on the ways in which a child's traumatic experience enters the consulting room, often in a state "far beyond words" (Lanyado, 2009).

At least since Freud's *Beyond the Pleasure Principle*, psychoanalysts have understood the powerful link between trauma and the "compulsion to repeat", and the way in which victims of trauma attempt to master the overwhelming experience by actively re-playing the experience, whether in the form of dreams, flashbacks—or re-enactments in the analytic setting. In the consulting room, post-traumatic states of hyper-arousal or dissociation—both of which may be highly adaptive to an environment that is chaotic, unpredictable, and dangerous—can quickly be triggered by apparently minor stressors, leading the patient