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Child Sexual Abuse: Changes in Psychoanalytic Perspective and Countertransference Denial

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Annie Katan (1973) in her landmark contribution, "Children Who Were Raped," calls attention to the fact that child analysts rarely have the opportunity to analyze children who at a very early age experience sexual molestation by an adult. Katan vividly reconstructs sexual abuse in the lives of two women patients. She convincingly portrays the tragic drama of their childhood traumata. These analysands had done poorly with their male analysts because of their provocative aggression which masked deep underlying anxiety. One of the patients had told Katan that she could not stand being alone with a man especially if he sat behind her. This led the analyst to suspect that the patient had been seduced by a man who approached her from the rear. The woman then recalled exciting games played with her father, when he bit the child on the cheek and upper arms while caressing her, his hands in her underpants, her legs spread apart, and his genitals touching hers. His excitement would mount until he bit her. After he hurt her he would give her a chocolate bar. When Katan inquired about the patient's

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The original version was presented at the 20th anniversary of the Workshop on the Vulnerable Child in San Francisco, May 4, 1989, at the meetings of the American Psychoanalytic Association.

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pp. 199-213 Vol 2, 1993

Published in: The vulnerable child, vol 2.
Ed. by Theodore B. Cohen, M. Hossein Etezady, + Bernard L. Pacella.
Madison, Conn.: Int'l Universities [illegible], [illegible]3

feelings, a further memory emerged of being molested by a stranger.

SHIFTS IN ATTITUDES

Over time attitudes toward the significance of sexual abuse have undergone marked shifts. Freud (Breuer and Freud, 1895–1897) attributed the hysteric symptoms of twelve female and six male patients to sexual molestation in childhood. After he abandoned the seduction theory, literature involving these events became sparse, and were no longer recognized as major factors in emotional illness and character pathology. Ferenczi (1933) was not taken seriously when he reminded the analytic community of the importance of actual sexual seduction. The Kinsey report, (Kinsey, Pomeroy, and Martin, 1948) while indicating that 20 to 30 percent of women college students had been raped in childhood brought about little change in psychiatric concepts of etiology.

Where twenty years ago not much was written on the subject and the public was unaware of the frequency of sexual molestation, we now have a burgeoning interest in the subject. Analysts too have begun to deal with sexual abuse in papers and workshops. The women's movement should be credited with raising our consciousness first to widespread physical abuse of women in childhood, and ten years later to child sexual abuse (Summit, 1983). The public has become aware of the astonishingly widespread frequency of sexual molestation. A door-to-door survey in San Francisco in 1983 of 930 women showed that 28 percent had had sexual encounters before 14 years of age (Russell, 1983.) A *Los Angeles Times* poll in 1985 of 2,627 U.S. adults chosen randomly by telephone showed that 27 percent of the women and 16 percent of the men were molested as children. Two-thirds of the abused were girls and 93 percent of their abusers were men. Since we usually assume that sexual abuse is more likely to occur in emotionally neglected children, it is of interest to note that in this survey, victims were only slightly more likely than nonvictims to come from unhappy, broken homes, or not to have been close to

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their mothers. Fewer than half told a parent or relative within a year of its occurrence. Usually no effective action was taken. Most people did not tell anyone because they were ashamed, afraid, or did not consider the abuse serious.

More credence is given by psychiatrists today to the history of sexual abuse in childhood. However, there remains a frequent failure to explore the relation between the abuse and the presenting pathology. In order to understand and search for these connections one has to be familiar with the practices of the abusers and pursue what the sexual seduction represented internally to the patient at the time it was experienced. A thorough grasp of child development and the effects of sexual abuse at each stage is extremely helpful.

TRANSFERENCE AND COUNTERTRANSFERENCE

One of the most important aspects in the diagnosis and treatment of child sexual abuse is countertransference denial. The following vignettes are but a small sample of what I have come across in recent years in my practice and in supervising psychiatric residents and psychoanalytic candidates.

In "Resistances In the Treatment of a Sexually Molested 6 Year old Girl" (van Leeuwen, 1988; see p. 00) I examined the young patient's desperate attempts to cover up what happened and my reactions to this. The frustration I experienced in following up clues with the child, ran parallel to those of one of my students encountered with an adult patient.[1]

In spite of repeatedly pointing out what these abrupt changes indicated, the supervisee was not able to connect them with the patient's forbidden oedipal impulses. Later he came to recognize that his countertransference denial was due to the fact that the woman reminded him of his mother and he feared that any mention of sexuality might be taken as a seductive overture.

Thus, a depressed woman patient presented at a Continuous Case Seminar, revealed that she had been sexually abused

[1]Play activity disruptions in children probably are the equivalent of sudden shifts in the verbal associations of adults.

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as a child by her father and older brother. Though the therapist accepted what the patient said there was no attempt to connect the symptoms of estrangement, low self-esteem, and fear of completing her career plans, to her feelings about the abuse. Again in this example, the trainee could not make use of my efforts to help him understand why the abuse was important to the dynamics of the case.

Reluctance to explore incestuous fantasies is commonly experienced by those who do therapy with the sexually abused regardless of the age of the patient. One psychiatrist noted that interviewing court-assigned children presented no problem for him, while his approach differed markedly in private practice. In the latter he noted his avoidance of sexually tinged material.

The reluctance to pursue leads is present even in very experienced analysts. At a case conference, the presenter gave a cohesive picture of the analysis of a 3-year-old boy. Data were presented about the child suddenly beginning to expose his genitals and pull down his pants, which made me suspect molestation. The reporting analyst glanced at me but continued the discussion without mentioning the possibility of sexual abuse. After the presentation, the speaker confided to me that he now saw he had unwittingly avoided this exploration.

Five-year-old Helen had been in therapy because of biting and kicking in school. After several months the child began to report nightmares to her mother which, however, she hid from her therapist. At the same time, Helen began to complain of itching and a rash in the rectal area. The pediatrician treated her for pinworm but the complaint persisted and was aggravated each time the child spent the night with her father who lived separately. She pulled down her panties in the waiting room, and in great agitation wanted to bite the therapist's buttocks. Helen had sustained a disfiguring scar on her face at age 2 from a dog who attacked her, and she underwent a number of operations to improve her appearance. A personality change had taken place at that time, and the child turned from being a sweet, compliant little girl into one who angrily attacked her mother. The question arose whether Helen's new symptoms were due to the dog bite or to sexual abuse. The therapist who

had been doing excellent work with the child became completely paralyzed when the question of molestation arose. She feared having to report the event to the authorities, as is the law, and thus aggravate the already tenuous relationship between the parents. All manner of rationalizations were utilized such as precipitation of suicide in the mother, psychosis in the father, or that the child already had too much to cope with.

When the rash cleared up spontaneously because Helen no longer slept at her father's house, the therapist relaxed somewhat, convinced now that her supervisor had been wrong. Nevertheless, she felt compelled to inquire further about the possibility of sexual abuse and did so hesitantly. She reported her findings in a high-pitched, childlike voice quite different from her usual confident tone. Upon recalling that she herself had been accosted as a child, and how hysterical and reproachful her mother had become on hearing the story, obstacles to treatment were removed. Over time with great skill the supervisee was able to analyze the many ramifications of the sexual abuse as it was revealed in the child's dramatic play and behavior. The therapist supported the family through many complicated situations including legal involvements.

Awareness of the possibility of child sexual abuse does not necessarily result in analysis of the symptoms, partly because of the strength of the patient's fears. After a brief illness 9-year-old Marilyn developed a sleep phobia which required mother's presence in her bedroom. The child was afraid to spend the night away from home. A clue to her behavior came from a dream reported at the first session in which Marilyn vomited because of "something very disgusting." At the next session obviously afraid to tell more, the dream was denied. Subsequently whenever the dream was mentioned, the child cried. Other themes were worked through without much difficulty, particularly her struggle with an older brother, and her fear of standing up to him. Disgust was displayed in relating an incident where she observed cats being cut up in a laboratory. Ultimately she expressed feelings of loneliness, and identification with a neglected, deserted kitten.

Occasionally she suddenly would speak of a "freaky" thought about seeing a naked man in a tree looking at her.

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However, as soon as she was asked to elaborate, she warded off the entire matter. Improvement took place in spite of her developing a phobia about therapy. She became more assertive and friendly with her brother, performed better in school, made new friends, and no longer needed mother to stay in her room at night. Throughout treatment the therapist experienced frustration and found it difficult to work with the reluctant child. It seemed that the analyst failed to interpret the defenses against the intense affect experienced, and felt put off by the patient's withdrawal and crying whenever she was confronted.

Difficulties may be present in the analysis of child sexual abuse because the experiences are repressed, acted out, or split off. Thelma G, an efficient professional woman, sought help in dealing with a work situation. The patient expected to be fired because of abrasive behavior. Furthermore her marriage was suffocating. Resentment about being unable to assert herself had led to many affairs to get even with her husband. She was consumed by anger. When Mrs. G was 4½ years old, her father died after a lingering illness. Much to her dismay she was left to the care of her grandparents. Painfully ambivalent toward her longed-for mother, whom she fantasized had murdered father, the distraught little girl decided to repudiate mother by extremely negative behavior. At age 7 she was molested by a handyman.

Mrs. G escaped from home at 16 by marrying a severe, demanding, much older man, about whom she experienced childlike ambivalence. She recalled manipulating her husband into abusing their daughter sexually at the same age that this had happened to her. The daughter never forgave the mother. Interestingly, Mrs. G's son married a woman who had also been molested and this young woman confided in Mrs. G her concern that she might sexually abuse her own infant. Mrs. G ended her first session by relating that her brother had committed suicide several years earlier, and that she too had suicidal fantasies. If she did succeed, her husband would be undone, and on further analysis, so would her therapist.

Based on the unconscious compulsion to repeat, the patient was alternately compliant and rebellious. Mrs. G acted out her

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childhood experiences of sexual abuse, abandonment, neglect, and anger. She confounded her psychiatrist with numerous upheavals including an extramarital affair followed by a homosexual liaison. The patient displayed pride at being able to voice angry criticism of her homosexual partner without the intense fear experienced with her husband. Upon being followed by a man on a weekend outing, she recalled how as a child she attempted to seduce her uncle, and her dismay when he would not have any part of this. The stormy therapy soon came to an end without much insight being accomplished. Reluctance to intervene after the act paralyzed the psychiatrist and kept her from confronting the patient with her acting out behavior in the transference.

Responding to the media's current interest in childhood sexual abuse, Barbara E wondered if her sudden disgust with a man to whom she had been very attracted could be related to similar events in her own childhood, though she could not recall any such episodes. Her symptomatology included intense self-loathing, gastrointestinal symptoms, premenstrual complaints, and headaches.

Over time the story emerged in bits and pieces. Mrs. E was her father's favorite and was made to feel that she was very important, easily outstripping her mother whom she thought took little interest in her. At the same time the daughter resented her father's "exploitative" attitude, which put her on display. Father often drank to excess, frequently falling down. The child would take care of him as he lay nude on the floor. These episodes were never mentioned in the family, and Mrs. E too acted as if nothing had happened. One of her early childhood memories was of being on a swing, with her panties exposed, while father watched. She concluded that she must have been an oversexed little girl.

In the therapeutic situation Mrs. E dramatized her symptoms while omitting themes which she found too difficult or embarrassing to deal with, seducing the therapist into admiring her tenacity and wish for discovery. Unconsciously Mrs. E submitted to what she thought her psychiatrist expected from her. She was in a state of perpetual fury over slights and impositions committed by her friends.

Inability to establish the validity of her feelings and the veracity of her memories was a significant feature. As this tendency was interpreted she recalled being molested by a friend of the family. Later in the analysis when it was brought to her attention that she often used swear words, she revealed the pressure of constant sexual images. Pursuit of the specific expressions led to further details.

DISCUSSION

These vignettes illustrate the vicissitudes of the diagnosis and treatment of sexual abuse. Where in the past I was aware that the children I saw in treatment had been sexually stimulated, I had not necessarily considered the possibility of sexual abuse. However, I did not assume that adult patients telling me of incestuous relationships were fantasizing. Nevertheless I did not thoroughly analyze how the symptoms of anger and distrust of men were related to early sexual violation.

Alertness to the possibility of sexual abuse definitely has enlarged the scope of my inquiry. The experience is frequently central and clearly recalled, though without accompanying affect. Issues of emotional abuse, neglect, or lack of protection by the mother, and other narcissistic hurts, may be present. There are threats of violence, and major demands for secrecy. These patients feel deeply guilty and want their participation kept secret. They experience self-loathing, shame, and unconsciously punish themselves. A thorough analysis should include the uncovering of the most critical fantasies and affects surrounding the traumatic events. If the trauma continues to be denied, repressed, split off, or acted out, then we may never uncover the full extent of the associated unconscious fantasies and thus place the treatment in jeopardy of remaining anemic and speculative.

There are many gradations of abuse from actual penetration to fondling, exposure to nudity of adults, suggestive remarks (Weil, 1989). If it is so omnipresent, we need to examine how the ubiquitous sexual fantasies of parents about their children are either warded off or acted upon. Lowering of defenses

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against incestuous fantasies are frequent when men are alcoholic, on drugs, or sexually frustrated. Sexual abuse by the previous generation is reenacted with offspring. Basically, children are considered the parents' property to treat the way they see fit. Experiencing them as separate human beings with their own needs and rights is a recent development in the history of mankind.

It is the analyst's function to ferret out as well as possible the effects of exposure to sexual stimulation, including sexual assault. There is much yet to be learned in terms of detection and technique. What is evident is that we are easily thrown off the track, we do not always follow leads, and there are reasons for this.

The differentiation between actual and fantasied seduction is crucial to our understanding and effectively dealing with patients. When actual seduction takes place, the pathology is far more severe, all other factors being equal. Interpretations are only partially effective in overcoming a patient's reality. Differentiating factors include abrupt, sudden motions, or explosive swearing, or sexualized images indicative of the overwhelming quality of the traumatic situation. The unconscious purpose is both to turn passive into active, as well as to shock, frighten, and seek revenge against the abusing parent via verbally attacking the analyst. Some act our considerably and unconsciously manipulate reality crises in the service of resistance purposes. Abrupt premature termination of treatment by the patient is frequent. The features in an analysis which result in successful therapeutic outcome need to be carefully studied.

There is nothing so humbling and instructive as paying close attention to aspects which are difficult to pursue. But to tune into areas in which one feels frustrated, confused, or reluctant, may help us gain access to the patient's unconscious. This is true in the treatment of adults and even more so with children and adolescents with their sudden manifestations of instinctual drives and prohibitions against them. Of course one has to use caution so as not to assault the patient or move too fast in therapy.

All of this becomes much clearer in the supervisory process as the supervisor has more distance from the patient. If one

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considers the strength of resistance in patients to emergence of their sexual secrets, it becomes easier to understand why there are widespread resistances to discovery in the psychoanalyst as well. This is so partly in response to the patient's transference, and partly originating in the therapist's unconscious conflicts. Some of the difficulties are the result of unfamiliarity with what can happen to an abused child. Though I experienced much frustration early on, more knowledge has resulted in an increased capacity to recognize the special qualities and behaviors within the transference. I don't find myself as lost and am now more able to overcome my own concerns.

Everyone has blind spots and defenses against voyeuristic and incestuous impulses. There is a reluctance to penetrate what the patient is intent on hiding. No one wants to believe that these unmentionable things happen, and patients of every age tend to reveal, and then retract, bits of information leading to exposure of their humiliating plight. Psychiatrists may not be able to follow leads or are thrown off the track, aiding the patient's denial and colluding in their doubts. There is an unconscious fear of being drawn into a projective identification with the patient's panic state, and the extent of their depression. Seductiveness may be difficult to deal with, and the psychiatrist is concerned both about being seduced or being seductive in turn. Questioning or even listening may be experienced as a repetition of the trauma.

To analyze these patients with good results, one needs to be in touch with and overcome one's hesitancy, and be convinced that making connections with feelings about the sexual seduction is helpful. Be alerted by peculiar remarks, idiosyncratic comments, reenactments, repetition in daily life and in the transference, screen memories, etc. When therapists feel frustrated or at a loss they should suspect child sexual abuse. One could speculate that therapists who have themselves been sexually abused are handicapped in special ways in dealing with sexual abuse unless they have worked through these situations. Those who permit themselves to follow up leads may be rewarded with success. I believe this was the reason for Katan's ability to analyze the women patients mentioned in her article where her predecessors fell short. De Wald (1987) successfully

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analyzed a patient who had been in treatment with four previous therapists. Weinshel (1986) became suspicious of sexual abuse when a patient fantasied that he was masturbating behind her and that she saw his penis. Others may analyze many areas but back away from indications of sexual abuse.

CONCLUSIONS

Psychoanalysts are prone to the same sexual conflicts and traumas as everyone else. Our defenses against forbidden impulses and fear of incestuous wishes make treatment of the sexually abused more difficult. It is important to follow up on every lead and not be deterred by evasive maneuvers. We can delay our inquiry but return at a propitious time, always dealing with the mechanisms of defense first and getting in touch with the prevalent affect, whether it be anxiety, the wish to be understood and loved, the fear of loss of support, or of threats. A proper balance between the need to provide reparative care and understanding connections is important, as is giving the analytic process sufficient time to work through the traumas.

Failures of therapy can be due to failure to understand the connection between the sexual events and presenting psychopathology, much as in the treatment of Holocaust victims where we experience horror and therefore are hesitant to fully explore. If 20 to 30 percent of the population has been sexually abused, the same statistics must hold true for those involved in doing therapy. The large number of papers now being published and the focusing of interest on the topic of child sexual abuse may bring forth more knowledge for the future.

REFERENCES

Breuer, J., & Freud, S. (1893–1895). Studies on Hysteria. *Standard Edition* 2. London: The Hogarth Press, 1955.

DeWald, P. (1987), Effects in an adult of incest in childhood—A case report. Paper presented at American Psychoanalytic Association Meetings.

Ferenczi, S. (1933), The passions of adults and their influence on the sexual and character development of children. *Int. Z. fur Psa.*, 19:5–15.

Katan, A. (1973), Children who were raped. *The Psychoanalytic Study of the Child*, 28:208–224. New Haven, CT: Yale University Press.

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Kato van Leeuwen article
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Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948), *Sexual Behavior in the Human Male*. Philadelphia: W. B. Saunders.

Summit, R. (1983). Recognition and treatment of child sexual abuse. In: *Coping with Pediatric Illness*, ed. C. Hollingworth. New York: Spectrum Publications.

Russell, D. E. H. (1983), The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children. *Child Abuse & Neglect*, 7:133–146.

Weil, J. L. (1989), *Instinctual Stimulation of Children: From Common Practice to Child Abuse*, Vols. 1 & 2. Madison, CT: International Universities Press.

Weinshel, E. (1986), The effects of sexual abuse in childhood as observed in the psychoanalysis of adults. Presentation to panel of the American Psychoanalytic Association.

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