Sexual Abuse in the Preschool Years: Blending Ideas from Object Relations Theory, Ego Psychology, and Biology

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Abstract  This paper uses concepts from relational psychodynamic theories and findings from neurobiology to conceptualize a young child’s experience of sexual abuse. Selected developmental tasks are discussed using an integrated theoretical framework. Literature which highlights the importance of the child’s environment is reviewed. A case of a sexually abused 5-year-old girl demonstrates consequences of sexual abuse using ideas from psychodynamic theories and neurobiology. It is recommended that social work practitioners expand on the biology domain when conducting a bio-psycho-social assessment. Social work students may benefit from additional content on biology in social work curricula.

Keywords  Child sexual abuse · Preschoolers · Development

Introduction

The literature on child sexual abuse has expanded steadily over the last two decades. Nevertheless, there is still little social work literature devoted to sexual abuse of young children, which includes a biological viewpoint. According to Applegate and Shapiro (2005, pp. 202–203) “a central focus of social work education is the delivery of content that acquaints students with a biopsychosocial perspective for understanding the people they encounter.” Yet, according to the authors this is underdeveloped in social work curricula. The relative dearth of content in social work education addressing the biological dimension may, in part, reflect a lack of relevant social work literature.

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Published professional literature on sexual abuse of young children includes valuable research on disclosure (Campis et al. 1999; Mian et al. 1986; Sorenson and Snow 1991), behavioral symptoms (Adams-Tucker 1982; Lusk and Waterman 1986; Paolucci et al. 2001; Saywitz et al. 2000), and interviewing techniques (Faller 2005; Everson and Boat 1990; Sattler 1998; Shamroy 1987; Steinmetz 1995). However Waldinger et al. (2001, p. 43) state that research on child maltreatment has focused more on external behavior than on the inner world of the maltreated child. In addition, there is even less writing in this area incorporating theories of psychological, social, and emotional development with concepts from biology. A combined theoretical approach is significant because it offers a framework for understanding the behavioral disturbances frequently observed in sexually abused children.

According to Applegate and Shapiro (2005), the surge of published literature addressing neurobiology and mental health has been spear-headed by psychoanalytically focused authors. This is due in part to the natural fit between constructs from psychodynamic theories such as the unconscious, transference, countertransference, emotions, affect, object relations, and attachment, with recent models of neuropsychology. Neurological development and its associated aspects of brain functioning including cognition, emotion, and affect are consistent with the current relational emphasis of psychodynamic theory and reflect an epistemology of open systems, the individual in the environment. The person in the environment model has long been at the heart of social work practice. Therefore, blending ideas from these theoretical perspectives is a logical approach for clinical social work.

Every perspective and theory of human behavior has its limitations. Psychodynamic theory has been criticized for being Eurocentric and gender biased. Viewing some of the constructs put forth by psychodynamic theorists from a neurobiological perspective offers a more contemporary lens through which we may view psychological development. This integrated and multidisciplinary approach can extend and expand the meaning of some classic psychodynamic ideas. To the extent that we can further our understanding of such experiences as trauma, coping, adapting, and constructing relationships, we can offer more advanced interventions.

In light of the gap discussed above, this paper uses an object relations and ego psychology framework along with current ideas from neurobiology to conceptualize a child’s experience of sexual abuse, and the impact of such abuse on young children. Included herewith is an overview of selected developmental tasks of preschool age children, and the ways in which these tasks are compromised by sexual abuse. A case example of a 5-year-old female offers an example of behavioral indicators of abuse including ego regression, elements of disrupted object relationships demonstrated in her play and with the therapist, illustrations of affect dysregulation, and attachment difficulties.

**Overview of Sexual Abuse in Young Children**

According to the National Center for Juvenile Justice (Snyder 2000) one in every seven victims of child sexual abuse reported to US law enforcement agencies were
under 6 years of age (14% of all reported victims). In the categories of sexual assault with an object and forcible sodomy, 4-year-old children are the most frequently represented. Although females represent a larger percentage of victims, the NCJJS analysis by Snyder found that males are most at risk for sexual victimization at age 4. Further, according to research by Adams-Tucker (1982) molestations which began when a child was under the age of 6 years correlated with higher levels of anxiety, using standardized measures.

The effects of child sexual abuse are quite variable and are influenced by a number of factors including the extent and nature of abuse, age of child, relationship to the perpetrator, violence involved, and other aspects of the child’s life. Some of the symptoms noted repeatedly in the literature include affective consequences such as anxiety, anger, and depression; hyperarousal; psychosomatic effects such as sleep disturbance, headaches, stomachaches, and enuresis; interpersonal problems; sexualized behaviors; and aggression (Ferraro 2002; Finkelhor and Browne 1985; Lusk and Waterman 1986; Saywitz et al. 2000). Theoretically, the symptoms often expressed by children can be traced to problems with a sense of self, with mastery of tasks and body, problems with differentiation and individuation, and attachment difficulties.

In the 1980’s, mental health professionals focused their research on behavioral responses of sexually abused children. Researchers and practitioners identified the child’s response to sexual assault as, the Child Sexual Abuse Accommodation Syndrome (Summit 1983), and the Traumagenic Dynamics Model of Sexual Abuse (Finkelhor and Browne 1985) and The Sexually Abused Child’s Disorder (Corwin 1988). All of these models for conceptualizing symptoms and responses to abuse reflect coping mechanisms rather than pathology. Thus, they exemplify Hartmann’s theory of ego adaptation. The young child does what she can to survive mental and physical trauma. Social workers are now able to include in their assessments of young children the current research in neurobiology. Social workers should consider the research that indicates impulse control, aggression, and relationship problems are a result of the neuronal connections which form in the substructures of the young child’s brain when under severe stress such as abuse (Perry 1997).

Sexual Abuse and Selected Developmental Tasks of Preschoolers

Environment and Ego Development

The importance of the child’s environment to healthy development has long been considered a central factor in theories of human development (Bowby 1988; Hartmann 1958; Winnicott 1965). The environment remains of central importance to researchers in neuropsychology and in the study of attachment and empathy (Applegate and Shapiro 2005). Because the brain develops in a use-dependent fashion (Perry 1997), environmental experiences directly shape brain formation. For example an adaptive function of the ego is affect regulation (Applegate and Shapiro 2005). Whether one should seek connections with others or pull away from others and be ready to resist or flee are examples of neurobiological and ego responses to the environment.
Language is an ego function which is initially conflict free. Yet, many abused children suffer language delays as well as problems with other autonomous ego functions (Martin 1980). Traumatized children frequently have impairments in expressive language, comprehension, and social communication skills (Henry et al. 2007). From a psychodynamic perspective, language delay or impairments stem from the stress of abuse which hinders this skill from unfolding by involving it in intrapsychic conflict and stress. Addressing this from the position of neurodevelopment, language impairments in traumatized children are related to changes in the body's stress response system as a result of exposure to abuse. In addition, the environment in which an abused child lives frequently does not support experimentation with language development or offer language stimulation for the child.

Certain ego functions may progress in a rehabilitative environment. Recent findings from neurobiology (Applegate and Shapiro 2005, p. 76) suggest that the developmental tasks which can more easily be rehabilitated in a proper environment are those that are not relational in nature. However, according to Montgomery (2002) relational skills are amenable to change through ongoing psychodynamic psychotherapy. This is because psychotherapy is essentially a right brain to right brain interaction. And, it is the right brain which is particularly plastic. This is indicated through research which demonstrates the brain physically changes through exposure to repeated experiences. It is the plasticity of the brain which leaves it both vulnerable to abusive environments and which also allows it to respond to rehabilitative opportunities (Perry 1997).

Anna Freud (1965) suggested under stress there is ego regression in which the most recent achievement will be lost first and will without intervention, regress backward in a step-by-step continuum. Sexually abused children are often described by the non-offending caregiver as regressed. In fact, this is often a clue that something is wrong. Parents may report such symptoms as renewed bed wetting, whining, or clinging behaviors, which are manifestations of ego regression.

Increased aggressiveness in very young sexually abused children often takes the form of biting or kicking others. In the sexually abused preschooler, aggressive behavior may be a function of id domination or of what Anna Freud termed identifying with the aggressor (1966, p. 113): a child introjects some characteristic of an anxiety object and so assimilates an anxiety experience he has just undergone. The child transfers himself from the person being threatened into the person who is making the threat. This defensive process may be a contributing factor in the repetition of victims of abuse wherein one becomes the aggressor (offender). Moreover, aggression and sexuality may be indicative of an abused child's difficulty regulating affect and emotion because of elevated stress responses.

Psychological defenses can become hard wired in the brain and remain largely unconscious (Applegate and Shapiro 2005). Applegate and Shapiro (2005, p. 151) refer to work by Cozolino who viewed defenses in a manner in which neural networks become organized to diminish the anxiety and depression associated with attachment difficulties in early development. Applegate and Shapiro (2005, p. 90), discuss research by Perry in which he describes how an over-reliance on the fight or flight coping strategy may become engrained and trait-like via its effect on the child's neurobiology.
Differentiation and Individuation

According to Winnicott (1986 p. 233) in the earliest stages of infancy there is only the mother–infant unit. They belong to each other and cannot be disunited. Over time the infant develops a sense of self as separate from the mother. A good enough mother, according to Winnicott, has a strong empathic relationship with her child, and is defined by her ability to meet the child’s needs through identification with the child, and not by any specific intelligence level. Healthy ego development occurs in what Winnicott refers to as the three-dimensional holding environment. The three-dimensional holding is made up of physical holding, mother and infant together (where the father provides holding for the mother), and father and mother and infant all living together (Winnicott 1965, p. 43). The psychological holding of the mother by the father to which Winnicott referred, may be thought of today as a role for a partner or other significant adult in the mother’s life. The good-enough mother provides holding for the infant who proceeds in development from total dependence to appropriate independence.

Winer (1989, p. 365) points out the paradox of individuation for the young victim of incest. On one hand the child is forced into premature autonomy by being forced into a relationship which has qualities of lust, jealousy and revenge. However, the child is also deprived of autonomy by being used as an extension of the parent’s will. These are the conditions for the formation of Winnicott’s concept of a false self. The self is false because it is derivative not of individuation, but of an aspect of the child–caregiver relationship. Herman (1982) states that the abused child sacrifices her own sense of self in order to attempt safety within the relationship and refers to this as a trauma bond.

Miller (1981) describes abused children as “prisoners of introjects” and proposes that abuse leads to the development of an “as if” personality. Children deny their own feelings in order to protect the self-object (parent). Applegate and Shapiro (2005, p. 53) refer to research by Fonagy and associates in which the dynamics that give rise to a false self as described by Winnicott stem from the caregiver’s dysregulated affect which impairs her/his ability to read the infant’s affective cues. In this situation the caregiver mirrors back to the infant her/his own emotional state, thus invalidating the infant’s experience. The infant conforms to the caregiver’s agenda and thus sacrifices his/her own reality. The compliant self may appear to be the true self; however it lacks vitality and originality.

In a research study by Stovall and Craig (1990) sexually abused children were found to have statistically significant differences in their mental representations of self and others as compared to non-abused children from otherwise distressed environments. This refutes a contrary position of some researchers who have claimed that it is the overall home environment, not the actual abuse, which causes psychological difficulty. A significant aspect of Stovall and Craig’s research is that conscious perceptions of others were positive, while unconscious perceptions of self and others were found to be negative. Similarly, Waldinger et al. (2001) discovered distorted mental representations of self and others in their study of sexually abused preschoolers. Kilgore (1988) describes abuse as a psychological dilemma for a child in which the child simultaneously perceives and confuses the “good” object.
(parent) and "bad" behavior (abuse). The ego attempts to cope by splitting affect and experience, and mind from body often leaving the child to internalize the bad aspects and assigning the good to the abusing parent. Bradley (2000) (in Applegate and Shapiro 2005, p. 151) reports that intrapsychic mental representations exist at the neurobiological level. These schemas or internal working models are organized in the neural networks of the social brain.

Attachment

Research in neuroscience demonstrates that early experiences with caregivers and the quality of attachment influence the limbic system of the brain which is responsible for affect regulation (Applegate and Shapiro 2005). This research further supports the already extensive psychodynamic theoretical literature which stresses the importance of stable, empathic caregiving experiences in the early years of life. According to James (1994, p. 2), "an attachment is a reciprocal, enduring, emotional, and physical affiliation between a child and a caregiver. A healthy attachment relationship therefore promotes physical and psychological growth for the child whose needs take priority over those of the caregiver(s)."

Attachment problems are understood as varying in subtypes and stemming from a range of experiences (Bowlby 1988; Solomen and George 1999; Zeanaah et al. 2004). Included in these early experiences are hostile-abusive environments, psychologically traumatic experiences, loss, inconsistent and unstable environments, and trauma bonds. Applegate and Shapiro (2005) refer to such families as "vulnerable dyads" indicating the concern that infants in at-risk families will not develop a secure internal working model for attachment experiences.

Neurological responses to abusive experiences frequently leave children with an inability to read others' emotional states, challenges with attachment, and memory problems (Applegate and Shapiro 2005); all of which result in relational inadequacies. In addition, recent research has suggested that affect regulation is passed down from one generation to another. "Children who grow up in these families are seen as at risk for such problems as inability to self soothe, the inability to modulate intense emotional arousal, and an inability to regulate sexual and aggressive impulses" (Bradley 2000 in Applegate and Shapiro 2005, p. xvi).

Perry (1997) reports that the biological changes that coexist in such an environment include the over-use of the fight or flight response, a hypervigilance to the environment, and a constant scanning for cues of danger. These neurobiological consequences of hypervigilance and elevated heart rate with other physiological changes designed for the fight or flight response interfere with the child's ability to form attachments. Applegate and Shapiro (2005, p. 187) relate these neurobiological alterations to Freud's idea of signal anxiety in the ego. When a person senses stimuli in the environment reminiscent of previously experienced danger, the amygdala activates the body to respond to this fear. When healthy development of signal anxiety is impacted by a stressful environment, the anxiety can override other ego functions and leave the person in a state of fearfulness. Consequently, the molding

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of the neurological system in this manner predisposes a child to be in a state of hypervigilance and to aggressive behavior.

The child welfare and mental health systems, even with all good intentions, can promote attachment disturbances. The iatrogenic effects of inconsistent foster care-givers, lengthy delays in court proceedings, and short-term or multiple mental health care providers further harm attachments, and pose additional barriers for treatment.

Case Example

The following is a case example of a young child sexually abused and brought up in an environment which failed to meet her developmental needs. Her behavior reflects concerns in many areas of development including: attachment, empathy, social skills, and underdeveloped or distorted mental representations of self and others. She demonstrates delays in various aspects of ego development such as language, judgment, self-control, and affect regulation.

M. was a 5-year-old female referred to an outpatient mental health clinic due to a history of sexual abuse, physical abuse, and neglect. At the time of referral she was in foster care with two of her three siblings. This was her third foster home and she had been living there for 4 months. M. had also lived intermittently in family shelters with her mother and siblings. M. had no contact with her birth father. Psychological testing indicated that she had delays in visual motor integration and in vocabulary knowledge and other aspects of language development. In her most recent school placement she was described by school officials as passive, compliant, and unlikely to initiate interaction with adults. M. wanted to please adults. She was aggressive with other children but responded to limits. She had few friends. M. was observed to urinate on toys and other objects.

Traditional play therapy was implemented. This involved holding weekly sessions in the same room at the same time and establishing a predictable routine which included choosing a snack at the beginning of each session, announcing the end of the session was approaching (5 min), and cleaning up together. Expressive, non-mechanical toys were available to her each session.

M. often selected dolls and doll house for her play. She referred to her foster mother as Mom. In her play she routinely fashioned stories that involved two mother figures. This seemed to indicate caregiver uncertainty, confusion, and in some situations, loyalty conflict. In her play she created themes of reunification with her birth mother and father. Her play, in light of her unstable caregivers and living arrangements over the years, suggests the concern that the multiple mother dolls reflect her anxiety about caregivers rather than authentic multiple attachments.

Regression was also noted in her identification with the infant doll which she named after herself. She would often have the mother dolls feeding and holding it. In addition M. wanted the therapist to take over tasks that she was capable of doing herself and to provide her with a great deal of reassurance. This indicated the need for mirroring as she attended to the developmental task of constructing an internal working model of self and others.
A salient aspect of her play was the frequency with which she demonstrated sleep as the way the child doll coped with anxiety. M. would initiate through play, either an aggressive or sexualized act, and/or that of a separation of mother and child. Subsequent to this action, M. would have the doll fall asleep. Moreover, she herself would go into a small place such as under a desk and pretend to sleep during the play scenes of anxiety and separation. It appeared that sleep, a method of dissociating from the experience that she created (experiences that were very prominent in her life), was her method of coping with overwhelming stress and anxiety. The repetitive nature further indicates the traumatic nature of these events in her life.

M. often initiated sexualized play and aggressive play with dolls. In fact, whenever she developed sexualized play among the dolls and toys, she also developed aggressive play. The aggression was observed to be both physical and oral (hitting, kicking, and biting). This may represent the child's experience of sexual abuse as an aggressive act and also demonstrates her difficulty with affect regulation. M. 's brain has actually organized around an abusive environment and the fear and stress responses seem to activate her system to respond in this outwardly aggressive fashion.

Another relevant theme in her play was that of objects being taken away involuntarily. For example she would take things away from the dolls such as play food, crayons, toys, and clothes. This seemed to represent the many losses in her life over which she has had no control.

M. was offered a snack at the beginning of each session. She frequently took more than she could/did eat. Interestingly, she took some home with her each time. Perhaps this served a transitional object for her.

Her behavior and style of relating are understood as a consequence of life trauma. Her presentation is indicative of a style of internal mental representations wherein she has developed a manner of compliance with adults, strangers and familiar persons, while at the same time relating to peers in a more victimizing manner. This raises concerns about her ability to develop empathy. M. is at risk to develop a false self as she attempts to have her needs met by being what she believes adults want her to be. She is likely to fail to discriminate among adults who attend to her in any way, raising concerns that she would be a victim to other offenders.

Implications for Practice

Early, stable clinical intervention using multiple modalities has the potential to make significant changes in a young, sexually abused child's life. Play therapy offers a child the forum to express, and ultimately integrate, the range of feelings she may have for the offender, the self, others, and the abuse. Through stable, supportive, play therapy the therapist will be able to offer the child the opportunity to develop new, healthier internal mental representations of self and others. Also, repeated opportunities for engaging in socially acceptable ways of expressing feelings and needs may help neurologically to reconstruct methods for coping with stress and anxiety.
The non-offending parent or caregiver should also be included in the treatment in order to provide a holding environment for the child that will be most conducive to improved mental health. Given that many sexually abused children present with symptoms of attachment concerns, involving the primary, non-offending caregivers in the treatment will be of most importance. A study by Lovett (1995) demonstrated that abused children may view their non-offending mothers as warm and accepting, not as rejecting and distant as sometimes assumed by child welfare workers. Also Elbow and Mayfield (1991) state that mothers often believe their child’s disclosure of abuse and do in fact take the necessary steps to protect them. A form of dyad treatment will build on, or develop, a sense of security and acceptance; qualities which are essential for the healing of split affect, and perceptions of self and others. And, interventions with the non-offending caregiver can focus on stabilizing the environment to lessen the need for the child to be in state of hyperarousal.

Case management remains central to high quality child mental health care. Given the importance of the environment to young children, it may be necessary for a preschool teacher or other child care providers to be connected in some way to the treatment. The therapist will also need to work closely with children’s protective services, and if necessary legal system representatives. All of this requires that the therapist have good professional supports, and seek appropriate supervision.

Conclusion

Sexually abused children are treated as objects for another’s use. The child is either manipulated or forced to provide gratification for the adult caretaker, thereby robbing the child of an empathic experience. Compliance or obedience dominates as opposed to mastery, exploration, or other attempts at supporting the sense of self. The child is introduced to an aggressive and/or sexualized style of relating to individuals and to the world and this has tremendous significance for how she/he organizes subsequent life experiences. A young child does not have the ability to modify her environment, thus she is left to internal means of survival.

An abusive home is neither an “average expectable environment” nor a “good enough environment.” A caregiver who sexually abuses and misuses a child lacks any ability to empathize and identify with the child, qualities that Winnicott has emphasized. The child attempts to cope in a variety of ways, all of which negatively bear upon ego development, optimal neurobiological development, and object relations. The foundation exists for borderline personality organization, repetition of mistreatment in future relationships, body image problems, and dissociative disorders.

Clinical interventions are warranted for sexually abused children and their families. Professional and sensitive case management can minimize further system-induced trauma. Moreover, the developing brain remains open to new experiences to some degree over the lifespan, particularly at younger ages (Applegate and Shapiro 2005). And, as importantly, treatment of young children provides hope for the prevention of future victims of childhood sexual abuse by interrupting the pattern.
References


