

## Chapter 2

# Sexual trauma during adolescence

## 2.1 Introduction

Trauma of a sexual nature is a complex, multidimensional phenomenon. ‘Trauma’ is derived from the Greek word *traumatōs* which means ‘wound’ and has reference to a psychological injury from a threatening or horrific experience (Webb, 2007a: 7). Sexual trauma is not a singular phenomenon: it may be committed by a stranger, an acquaintance or intrafamiliarily; it may be violent or consist of non-contact sexual overtures; it may be chronic CSA or a single incident (Webb, 2007a: 8-13). CSA is traumagenic (Finkelhor & Browne, 1985: 538).

In this chapter a literature review will be undertaken on the effect of CSA on adolescents. Attention will be awarded to the neurobiological findings pertaining to non-specific trauma, as well as the psychopathological consequences and emotional, cognitive and behavioural ramifications of CSA. How trauma affects the developmental process of the adolescent will be investigated. In the last section the Gestalt conceptualisation of the signs and patterns presented by survivors of CSA will be discussed.

## 2.2 Traumatic experiences and neurobiology<sup>7</sup>

“Our brain is designed to sense, process, store, perceive and act on information from the external and internal world to keep us alive.” (Perry, 2000: 1)

We so often hear that one’s problems are “all in your head” (Amen, 2009: 3); in fact, they are, as neurophysiological processes. In this section the researcher will explore how the body responds to stress and trauma, how emotions are processed, the formation of memories and hemispheric lateralisation. In doing so, the researcher hopes to ascertain whether neurobiological findings have treatment implications for the sexually abused adolescent.

### 2.2.1 The stress response

When working with people who were subjected to a traumatic experience, it is important to understand what is happening to them physiologically, and to know when these normal adaptive reactions become maladaptive.

When a stressful event occurs, a total-body alarm is set off which has neurophysiological, cognitive, emotional and behavioural implications. As the threat increases, the release of stress hormones and

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<sup>7</sup> The information and conclusions made in this section must be considered as highly simplified and as preliminary – neuroscientific and neuropsychological research with ever more sophisticated instruments generates new discoveries daily.

activity of the sympathetic nervous system will intensify resulting in, amongst other reactions, an increase of heart rate, blood pressure and muscle tone and the conversion of glycogen to glucose (Kensinger, 2009: 100; Perry, 2000: 2; Williams & Gordon, 2007: 359). This amplification mobilises the body to run away from, or fight the threat. Fight or flight is often not an option for children, who may in some cases freeze. Freezing is a means of dissociation (Perry: 2000: 3; Valent, 2007: 6).

If the threat is intense and/or prolonged and is outside the normal range of experiences, we refer to a traumatic experience. Trauma is associated with extreme activation of the neurophysiological processes. As soon as the trauma ends the acute posttraumatic period begins. It is during this time that the survivor will attempt to process and make sense of her experience. Sometimes the stress response system does not return to the pre-trauma homeostasis and neural systems change in a “use-dependant” way (Lee & Hoaken, 2007: 289; Perry, 2000: 6). This is when a response that was adaptive during the trauma event, becomes maladaptive, and when symptoms of Posttraumatic Stress Disorder appear.

The stress response has therapeutic implications for the survivor of CSA: The symptoms of posttraumatic stress are highly unsettling for the trauma-survivor and her family, friends and acquaintances. Normalising the stress response – albeit in a simple form – might be a relief for the survivor and her support system (Perry, 2000: 10).

### **2.2.2 Processing emotions**

Experiencing trauma is highly emotive; it is valuable to know how emotions are processed in the “emotional brain” and the “thinking brain”<sup>8</sup> (Malchiodi: 2008a: 7). Various regions of the brain are responsible for processing emotion (Banich, 2004: 397-407); nonetheless, Kensinger (2009: 105) asserts that the “‘core’ emotional memory network” involves engagement between the amygdala, hippocampus and orbitofrontal cortex.

It is suggested that emotional processing in the subcortical regions unfolds outside conscious awareness; however, activity in these regions closely involves the cortical regions. The amygdala – with neural connections to various subcortical and cortical regions (Hamann, 2009: 114) – is believed to be mainly involved in orchestrating attention and other automatic, adaptive responses to threatening emotions. Williams and Gordon (2007: 355) refer to the amygdala as an “alarm center”. Amygdala-fusiform gyrus interaction boosts the encoding of visual details, possibly related to flashbacks. The role of the hippocampus is to consolidate memory by linking contextual and historical information to the initial incoming stimuli (to determine whether the situation is really dangerous or not) (Williams & Gordon, 2007: 356; also Dalenberg, 2006: 276; Lee & Hoaken, 2007:

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<sup>8</sup> Williams and Gordon (2007: 349) caution that the subcortical systems (“for rapid, non-conscious appraisal of emotion”) and the cortical systems (“for conscious elaboration”) should not be considered in terms of a dichotomy, but rather as a parallel assimilation of emotions.

290). Prolonged and extreme stress appears to damage the hippocampus (Tramontana, Hooper, Watts-English, Ellison & Bethea, 2009: 134). Studies suggest that hippocampal atrophy in child abuse survivors and war veterans with PTSD may contribute to emotional dysregulation and the fragmentation of memories (Banich, 2004: 402; Klorer, 2008: 50; Tramontana *et al.*, 2009: 134). The hypothalamus mediates autonomic and endocrine reactions to activate the flight-flight response. Lee and Hoaken (2007: 290) posit that the over-activation of the limbic system may hamper information processing, needed to determine intent, personal accountability and faith in others. These cognitive schemata are often negatively affected in survivors of CSA.

A person becomes consciously aware of the outcome of emotional processing through activity in the cortical regions, the so-called thinking brain. It is hypothesised that the dorsolateral prefrontal cortex (PFC) – important in working memory – regulates conscious action linked to feelings. Banich (2004: 406) asserts that lateralisation occurs here: unpleasant emotions (associated with withdrawal from the situation) seem to activate the right hemispheric PFC; activation of the left PFC is associated with pleasant feelings and approach behaviour.

The parietal and parietotemporal regions seem to be involved in the comprehension and recall of emotional information so that appropriate action can be taken (Banich, 2004: 408, 427). The right hemisphere is involved in comprehending tone of voice, facial expressions and gestures, as well as categorising scenes based on their emotional content (Banich, 2004: 427). The right hemisphere also seems to be mainly responsible for processing threatening material. Labelling emotions and cognitively working out relationships between an emotion and a situation appear to be mainly processed in the left hemisphere (Banich, 2004: 412).

Impairment of the functioning of the orbitofrontal cortex and cingulate gyrus during high stress seems to be associated with the diminished social connectedness of an individual (Amen, 2009: 41; Banich, 2004: 411; Valent, 2007: 10). The sexually traumatised child may invariably turn away from her support system; those people that might have helped her to overcome the trauma.

Thus, when it comes to emotional processing, it seems as though there are two pathways, the one conscious and the other unconscious: “the high road in rich detail to the cortex” where an image is combined with knowledge, earlier memories and one’s ability to verbalise; at the same time the “low road to the amygdala in a degraded and nonverbal image” (Dalenberg, 2006: 294). From the above, it seems as though emotions are not always processed in a sequenced, verbal and meaningful way, particularly in situations of very high stress and negative emotions such as during CSA. Under such circumstances a fragmented, non-sequenced and non-verbal process ensues; this process and resultant outcome should be considered during therapy and other interventions with traumatised children and adults.

### 2.2.3 Memory

A long-term memory, Hamann (2009: 115) asserts, is the end result of numerous processing phases (which include the attentional, perceptual, encoding, semantic, consolidation, storage and retrieval phases). Furthermore, a single event has many episodic details and features (Kensinger, 2009: 102). Although it is widely acknowledged that emotions have a powerful influence on memory for events, Hamann (2009: 114, 115) cautions that findings conflict: any or all of these stages or features might be modulated by emotion.

Kensinger (2009: 101) asserts that memories are typified by “focal enhancements” of the central arousing event, particularly if the concurrent emotion is negative; peripheral features of the event are often forgotten. Moreover, it appears as though memory for perceptual details and spatial location is enhanced, whereas memory of temporal order and decision-making (which includes conceptual and semantic details) about the event may not be improved or even encoded during high stress (Kensinger, 2009: 102).

Kensinger (2009: 101) suggests that verbal, semantic and autobiographic elaboration and rehearsal consolidate memories. It could therefore be deduced that conscious avoidance (deliberately not talking about the sexual incident) or unconscious avoidance (dissociation) could contribute to the fragmentation of memory (Dalenberg, 2006: 290).

Steele and Malchiodi (2008: 269) distinguish between explicit and implicit memory. Explicit (or declarative) memory refers to facts and events that a person is aware of cognitively. Explicit memory enables us to process information in order to make sense of our experiences. Conversely, “[i]n implicit memory there is no language”, only images and bodily sensations (Malchiodi, 2008a: 10). Malchiodi’s proposal concurs with that of Kensinger (2009: 108), who distinguishes between perceptual and semantic-conceptual encoding; the former is predominantly engaged during the processing of negative events and the latter if the experience is positive.

It is speculated that trauma (including CSA) may be stored as an implicit memory (Steele & Malchiodi, 2008: 269). This information is stored nearly exclusively, according to Baggerly (2007: 347), in the right limbic system. Flashbacks – invasive pictures, smells and sounds of the traumatic experience – are thought to be ‘produced’ here. Sensory memories are believed to be divorced from a narrative (Dalenberg, 2006: 295). From the above it appears that it is important to address the implicit, piecemeal and unconnected trauma memories of the CSA during memory work, and in doing so enhance meaning-making of the event.

### 2.2.4 Right and left hemispheric lateralisation

Hemispherical lateralisation refers to how certain neurological functions predominantly reside in the left or the right hemisphere. Split-brain studies suggest that the left hemisphere is dominant for

language, whereas the right hemisphere excels in spatial, non-verbal tasks (Banich, 2004: 118). The left hemisphere also seems to predominantly focus on detail and work in an analytic way, whereas the right hemisphere appears to process information in a gestalt (holistic) fashion (Banich, 2004: 126). Furthermore, it seems as though there is a right hemispheric bias to threat (Banich, 2004: 422).

Lateralisation may have implications for the way a trauma narrative could be communicated: verbally, involving mainly the left hemisphere, or non-verbally, involving predominantly the right hemisphere. Drawing, clay and sandtray work are tactile and visuospatial and appear to involve primarily the right hemisphere (Malchiodi, 2008a: 17). A subsequent verbal exploration of a projection during therapy will largely involve the left hemisphere and allow integration and productive processing of the experience.

### **2.2.5 Re-membering a traumatic event**

In conclusion, it might be therapeutically valuable to first focus on the “troubled side” of the brain of trauma-survivors (Klorer, 2008: 51). Action and perceptual-orientated activities during therapy should help to bridge the divide between implicit and explicit memories (Klorer, 2008: 51). Talk therapy, which predominantly recruits the frontal regions (Kensinger, 2009: 108; Sweeney & Homeyer, 2009: 308) and/or the left hemisphere (Klorer, 2008: 52) may, at least initially, be less productive than play therapy. Semantic and conceptual processing of a traumatic experience – which includes meaning-making – appears to best follow on the perceptual processing during therapy.

In this dissertation the researcher will show how the application of play therapy, expressly the *9FPS*, is in agreement with the neurobiological theories of trauma processing and resolution. In the next section the consequences of CSA will be attended to.

## **2.3 Consequences of child sexual abuse**

Sexual abuse is only one of the many traumas that children and adolescents may be exposed to. In this section attention will be awarded to the sequel of traumagenic CSA specifically.

### **2.3.1 The role of the environment field**

In traditional societies such as exist in parts of Namibia, many children grow up in environment fields in which authoritarian, inflexible parenting styles are practised (Fox, 2002: 323; Shino, 2000: 99). Such children are often more vulnerable to sexual exploitation because they are less able to assert themselves against sexual perpetrators and are less free to disclose any undue attention. Children, including adolescents, are expected to revere, respect and obey their parents, family members and older persons (Jewkes, Rose-Junius & Penn-Kekana, 2007: 171). It is only approaches by “strangers, ‘weirdos’, kidnappers and other monsters” (Summit, 1983: 182) that can be fought off. Similarly, it was found that Namibian parents have great difficulties to communicate with their children about sex, sexuality and self-protection (Dippenaar, 2004: 266-268; Fox, 2002: 328; Shino,

2000: 98; Yamakawa, 2001: 2); they may also not use contemporary “talk-technology” to incite or scaffold discussions (Wilbraham, 2009: 67). Children subsequently do not have the vocabulary or candiness to verbalise what happened to them.

Disclosure is a multifaceted phenomenon consisting of the child-communicator and a *confidante*-interpreter, a subject (the sexual abuse that happened somewhere else with someone else) and a means of communication (the sign). This process, according to Jensen (2005: 470), is socio-culturally situated and dependent on the interpretive *repertoire* of the *confidante*. She forwards that the CSA message is frequently misinterpreted because the sign may have contradictory meanings. As a case in point, the parent may forward that the survivor’s behavioural difficulties relate to the hormonal surges of adolescents (the so-called age *repertoire*). Clearly, intrapersonal and interpersonal meaning-making of the CSA is inextricably embedded in the organism-environment field.

### **2.3.2 Pathological effect of CSA**

Not all sexually abused children are diagnosable with a pathological disorder. In fact, Hunter (2006: 351) asserts that about 40% of survivors present with few or no symptoms on standardised assessment instruments. In contrast, Hetzel-Riggin (2009: 47) asserts that, because traumatic experiences impinge on developmental processes, the effect thereof on children and adolescents is far-reaching and prolonged. Research supports the lifelong prevalence of pathological disorders (Bolton *et al.*, 2004: 1011; Chaffin *et al.*, 2005: 215; Johnson *et al.*, 2001: 190; Sadock & Sadock, 2003: 886) and the impairment of psychosocial functioning (Bolton *et al.*, 2004: 1011; Hunter, 2006: 350). Not being diagnosable and not displaying measurable symptoms does not mean that the survivor of CSA is unaffected.

Sadock and Sadock (2003: 886) assert that, “No specific psychiatric symptom results universally from sexual abuse”. Child and adolescent survivors of CSA are frequently diagnosed with an Anxiety Disorder (most often ASD or PTSD), a Mood Disorder (mainly Major Depressive Disorder) and a Dissociative Disorder, amongst other disorders (Biyong & Theron, 2000: 4-5; Chaffin *et al.*, 2005: 210; Johnson *et al.*, 2001: 179; Nader, 2007: 30-36; Perry, 2000: 7-8; Sadock & Sadock, 2003: 886, 889).

People exposed to traumatic events are commonly evaluated against the diagnostic criteria of initially the ASD, and after a period of four weeks, the PTSD (APA, 2000: 471). The first criterion – a trauma event which involves actual or threatened death, injury or which threatens the physical integrity of the self or others (APA, 2000: 467) – could be considered an “existential reminder of one’s mortality” (Cohen, 2002: 2). The other symptom categories are re-experiencing, avoidance and arousal.

With regard to child survivors of generic trauma, Ryan and Needham (2001: 438) assert that the diagnostic criteria for PTSD “have not yet been fully resolved” and Cohen *et al.* (2000: 31) claim that the criteria are not sensitive enough for developmental variations. Children often present with “impulsivity, distractibility and attention problems (due to hypervigilance), dysphoria, emotional numbing, social avoidance, dissociation, sleep problems, aggressive (often re-enactment) play, school failure and regressed or delayed development” (Perry, 2000: 7); a cluster of symptoms not denoted in the DSM. Perry (2000: 7-8) consequently cautions against the under-diagnosis and misdiagnosis of child survivors. Firstly, according to Perry (2000: 7; also Hunter, 2006: 351) about twice as many children as those diagnosed with PTSD, present with significant posttraumatic signs and symptoms, but lack all the criteria needed to be diagnosed. Secondly, many signs and symptoms of PTSD look similar to those of other psychiatric disorders in children (Perry, 2000: 7-8; Nader, 2007: 30-36). Most importantly, PTSD is associated with non-specific trauma, such as a motor vehicle accident; it does not make provision for the unique features of a sexual trauma (Finkelhor & Browne, 1985: 530).

### **2.3.3 Emotional, cognitive and behavioural effects of CSA**

Bolton *et al.* (2004: 1008) caution that longitudinal studies have found that children and adolescents present with serious subthreshold signs and impaired psychosocial functioning, even when no diagnosis can be made. Similarly, Nader (2007: 21) warns that the diagnostic criteria capture “only limited aspects of posttraumatic psychopathology”. A number of subthreshold signs and symptoms related to trauma and sexual abuse have been described in the literature: weepiness, nervousness, ambivalence, anger outbursts, rebelliousness, revengefulness, promiscuity, self-abusive behaviour, substance abuse, phobias, developmental regression and withdrawal from friends and family (Blom, 2006b: 179; Biyong & Theron, 2000: 4-5; Dippenaar, 1998: 94-99, 134-149; Dippenaar, 2004: 221-235; Ferreira & Read, 2006: 184-185; Perry, 2000: 7). According to Noll, Trickett, Susman and Putnam (2006: 469) sleep disturbances – resulting in “sleep debt” – impact on the brain maturation of children and adolescents and may contribute to school and academic problems.

Worry and rumination – repetitive, self-focused thoughts which involve “going over past events, wondering why they happened, and thinking about the meanings of those events” (Nolen-Hoeksema, Wisco & Lyubomirsky, 2008: 406) – often relate to aversive self-awareness and a depressed mood. Celano *et al.* (2002: 64-66) also emphasise the potentially adverse effect of such cognitive distortions, particularly blame misattribution. They list some of the attributions that lead to self-blame in CSA survivors: “for failing to recognise the abuse, for participating in the abuse, for failing to seek help, for failing to avoid or control the abuse, for pleasure gained, for failing to protect siblings, for failure to protect oneself, and for the family reaction to disclosure” (p. 66); the researcher would like to concur with Leclerc, Wortley and Smallbone (2010: 30): self-blame for

accepting gifts and privileges. According to Nolen-Hoeksema *et al.* (2008: 407) these linguistic endeavours constrain conscious access to traumatic images.

In the *Four Traumagenic Dynamics Model of CSA*, Finkelhor and Browne (1985: 531-533) conceptualised the traumagenic sequel of specifically CSA. They describe how traumatic sexualisation, stigmatisation, betrayal and powerlessness alter the cognitive schema and the affect of children and adolescents. To illustrate betrayal and stigmatisation: The adolescent realises that she has been betrayed by the trusted adult-perpetrator, by those who should have protected her, by her own impaired judgement and by her body which responded to the sexual stimulation. The emotional sequel to betrayal is sadness and anger, which manifest in grief reactions and hostility. Stigmatisation has reference to, amongst others, risk-taking actions, delayed disclosure and accepting gifts (Niederberger, 2002: 63); it could be other-imposed, self-imposed or both. Stigmatisation may lead to a distorted sense of self, even self-loathing (Biyong & Theron, 2000: 4-5; Celano *et al.*, 2002: 65).

### **2.3.4 Coping with CSA**

From a strength-based Gestalt perspective the ways in which children and adolescents cope during and after the sexual abuse are relevant. Leclerc *et al.* (2010: 28) identify some of the ways in which survivors resisted the CSA: they “yelled or screamed, fought back, said no, told they didn’t want to, cried, told someone else what was happening, told they were scared, demanded to be left alone, said they would tell someone... tried to get away...” These were categorised into forceful and non-forceful, physical and verbal resistance.

Using neurobiological evidence, Valent (2007: 4) extrapolates survival strategies applied during generic trauma: Flight and fight are linked to the activation of the sympathetic nervous system, relate to the two basic emotions fear and anger and are reflected in the PTSD criteria (Valent, 2007: 6-7). Adaptation is a “rolling with the punches” tactic when escape is perceived as impossible; surrendering often results in grief and constant rumination (Valent, 2007: 5, 9). When a child or adolescent seeks the protection of a caregiver, the strategy attachment is used. If a survivor successfully rescues another during the traumatic event, positive meaning-making is enhanced. Freezing, according to Valent (2007: 6), is evoked when the danger is perceived as unavoidable.

Chaffin, Wherry and Dykman (1997: 233), Tremblay, Hébert and Piché (1999: 938) and Dippenaar (2004: 228-235) extrapolated coping strategies applied by survivors following sexual abuse. In Chaffin *et al.* (1997: 233) *Avoidant strategies* include “I just tried to forget it”; *Internalised strategies* consist of “I stayed by myself” and “I blamed myself for causing the problem”; *Social coping* involves “I tried to fix the problem by doing something or talking to someone” and survivors employing *Angry strategies* yelled and were furious. The survivors who applied self-blame, withdrawal and resignation (*Internalised strategies*) reported more guilt and were most adversely affected, whereas *Social strategies* were thought to be the most effective way of coping.



Disclosure or non-disclosure could also be perceived as coping mechanisms (Dippenaar, 2004: 228-230; Hunter, 2006: 352). To reveal or to conceal the sexual secret constitutes another crisis in the traumagenic dynamics of the sexual abuse. Often children opt for silence. Of the survivors of child rape that participated in a study by Smith *et al.* (2000: 279), 82.2% did not divulge the CSA within 24 hours; in fact, less than one-fifth disclosed within a day, one-fourth within a month and almost half only disclosed after five years. Research findings on adolescent disclosure are inconsistent. In Smith *et al.* (2000: 283) and Collings, Griffiths and Kumalo (2005: 280) adolescents disclosed more promptly, arguably because they had an extended field with more *confidantes*, or because they were adequately assertive to face the consequences of disclosure. Conversely, the adolescents in Goodman-Brown, Edelstein, Goodman, Jones and Gordon (2003: 533) delayed disclosure. The authors forward that older children know that they might be stigmatised and may attribute some responsibility to themselves. From a Gestalt perspective non-disclosure could result in an *impasse*. “They may want to change, but they don’t: they keep the *status quo* because they are too frightened of going through the *impasse*” (Perls, 1972: 29). The *impasse* is characterised by constant computing: thinking about telling someone (Goodman-Brown *et al.*, 2003: 537). The survivor will vacillate between fearfulness and hopefulness about the outcome of a disclosure.

Despite Gestalt’s anti-diagnostic stance and position of singularity, Kepner (2003: 149) asserts that survivors of CSA do present with commonalities: signs and patterns (as opposed to a PTSD). He additionally proposes that each survivor “brings his or her own resources to managing them”. The Gestalt practitioner thus recognises the possible manifestation of posttraumatic signs and patterns (PTSP) as well as the resources of clients. In the next section the development of the adolescent, how CSA might infringe on ‘becoming’ and treatment implications will be discussed.

## 2.4 The adolescent

“Adolescence is not only a time of vulnerability, it is also an age of opportunity”  
(Anthony Lake, Executive Director, UNICEF, 2011: iii).

In this section the adolescent developmental phase and the traumagenic effect of CSA on teenagers will be attended to. Considerations relating to the special needs of adolescents during therapy will also be explored.

Sadock and Sadock (2003: 35) assert that the onset and (in particular) the duration of the adolescence phase vary. Divergent biological, social and political determinants of the phase are used in Namibia (MGECW, 2009: 22). Adolescence is usually divided into early (age 11 to 14), middle (age 14 to 17) and late (17 to 20) adolescence (Sadock & Sadock, 2003: 35). As stated in Chapter 1, in this study adolescence is considered to range between the ages of eleven and seventeen years.

Adolescence is characterised by many biopsychosocial changes. The process – with rapid physical changes, separating from parents, contemplating a vocational direction, becoming self-supportive and

acquiring an intimate partner – differs between individuals, but is often not intrapersonally synchronised. This disparity, according to Sadock and Sadock (2003: 35), adds to the stress of adolescence. Adolescence was previously perceived as a period of inner turbulence and risk-taking conduct (Steinberg & Lerner, 2004: 46; Wilbraham, 2009: 65). Since the turn of the millennium, however, positive youth development is gaining attention: “being resilient in the face of challenges” (Lerner, Almerigi, Theokas & Lerner, 2005: 11; also Sercombe, 2010: 32).

The so-called “grand theories” of development – those of Freud, Piaget, Erikson and Kohlberg – are critiqued for trying to explain everything related to adolescence (Steinberg & Lerner, 2004: 46) from their respective foci. Gestaltists and other theorists (Steinberg & Lerner, 2004: 47; Weiten, 2000: 320, 321, 324) assert that these models do not adequately acknowledge individual uniqueness and cultural differences and that they are “stage” theories. Seeing that the theories do have value, and because a universal and comprehensive Gestalt developmental model has not been recognised (Toman & Bauer, 2005: 180), these theories will be discussed next.

Freud’s (1856–1939) developmental model revolved around psychosexual development. During adolescence, the *Genital phase*, interest in sex and sexuality is revitalised, which could lead to “meaningful participation in the areas of work and love” (Sadock & Sadock, 2003: 203). Sexual abuse is bound to affect sex, sexuality and intimacy. Rumstein-McKean and Hunsley (2001: 482) propose that traumatic sexualisation could be expressed on a continuum from under-sexualisation to over-sexualisation – which may affect intimacy.

In 1929 Piaget first published his theory of cognitive development in which he described how a person’s thinking, reasoning and memorising develop in a succession of stages. Adolescents could be expected to function on the *Formal operational level*. During this stage, the thought processes become more abstract, rational and oriented towards the future. Adolescents could be expected to attack problems systematically, envision possible courses of action and are generally more introspective (Sadock & Sadock, 2003: 138; Weiten, 2000: 323). Gestaltists do not look favourably upon this “computing”, which is believed to underlie neurosis (Fagan & Shepherd, 1972: 4) and depression (Nolen-Hoeksema *et al.*, 2008: 401).

Erikson published his theory of psychosocial development in 1963. He envisaged eight psychosocial crises which have polar outcomes. In adolescence, he hypothesises, the crisis relating to *Who am I and where am I going?* can result in either identity or confusion. Identity, according to Weiten (2000: 329), involves the acceptance of the self as uniquely individual and acquiring a sense of direction. De Decker, Hermans, Raes and Eelen (2003: 22) emphasise the importance of an intact autobiographical memory in relation to the development of the ‘self’. Sadock and Sadock (2003: 37) define confusion as “a failure to develop a cohesive self or self-awareness”. Confusion thus relates to the Gestalt concept of disowning unfinished business and creating a false self (Mackewn, 2004: 25). Moreover,

avoidance of traumatic autobiographical memories – such as the CSA – could also impair “imagining the future” (De Decker *et al.*, 2003: 23).

Kohlberg’s model of moral development was also originally published in 1963. Related to the cognitive abilities described by Piaget, Kohlberg distinguishes three levels of moral development. During the *Conventional period* (some persons may advance towards *Postconventional morality* during late adolescence) the adolescent holds a good girl / bad girl orientation or later an authority orientation (Weiten, 2000: 325). The moral rules and codes are externally determined, internalised and rigidly complied to. Evidently, the introjection of “*shoulds* and *should nots*” (Perls, 1972: 17, original emphasis) has reference. When one ‘has broken the rule’ and has become “spoiled merchandise” (Finkelhor & Browne, 1985: 535) by surviving CSA, the self may inculcate a bad girl self-perception.

Gestalt theory perceives development as creative adjustments by the organism, a “process of self-in-relation to the world” (Toman & Bauer, 2005: 181). As such, “selfing” (Parlett, 2005: 56) continues throughout life. With adolescence it could be theorised that the external and internal fields assert “a compelling invitation to ‘risk doing something differently’” (Parlett, 2005: 57). Toman and Bauer (2005: 183-190) applies Levin’s field theory and Anna Freud’s developmental lines to conceptualise the invitations adolescents are likely to encounter: (a) dependency to self-reliance, (b) development toward body independence, (c) egocentricity to companionship, and (d) play to work. It is forwarded that these lines co-exist and that at a given time some might become figural, whereas others retreat to ground (Toman & Bauer, 2005: 184).

Considering the Gestalt conceptualisation of development, CSA is bound to affect the child in her totality (Ferreira & Read, 2006: 193) and would be ever present (either as figure or ground) (Toman & Bauer, 2005: 185). Evidently such an experience could have a profound influence on the “evolution of the self” (Mackewn, 2004: 79). Applying Toman and Bauer’s (2005: 184) development lines, this dynamic process could be interrupted in the following ways:

**Developmental line 1:** Toman and Bauer (2005: 182) remark that adolescents’ “disembedding” from parents leads to the establishment of self-reliance. After a traumatic experience such as CSA and depending on organism-environment forces, an adolescent may either reverse to increased dependency on her “family field (a place of belonging)” (Toman & Bauer, 2005: 182), or may bolster contact boundaries against a dangerous world in an attempt to be less dependant. Adolescent negativism (Sadock & Sadock, 2003: 37), “wanting to be heard” (Toman & Bauer, 2005: 191) and teenage uprising are rooted in the development line self-reliance, and (as will be shown) have treatment implications.

**Development line 2:** Body-related difficulties can be expected when a child’s physical body was invaded. Some ramifications of CSA which relate to this development line are somatisation, body

image difficulties, sleep and eating disturbances, a decline in self-care, promiscuity or the inhibition of sexuality, self-mutilation and suicide ideation or attempts (Calam, Horne, Glasgow & Cox, 1998: 905; Collings, 1997: 40; Finkelhor & Browne, 1985: 534-535). Conversely, the adolescent may conceal her bodily distress, “She feels one way inside and presents herself another way outside” (Oaklander, 2006: 111).

**Development line 3:** It is the companionship line – a human need that is “most salient” during adolescence (Toman & Bauer, 2005: 189) – that is probably most affected by trauma of a sexual nature. Social withdrawal has been mentioned as having a neurobiological basis (Amen, 2009: 41; Banich, 2004: 411; Valent, 2007: 10). Because of their growing environment field, adolescents “often view themselves through the eyes of their peers” (Sadock & Sadock, 2003: 38). Divergence from the ‘norm’ – such as having been sexually abused – could lead to feelings of isolation and a loss of self-esteem. Whereas it was not possible for the survivor to prevent the sexual abuse, she can still control her thoughts and responses to others by means of egotism and behavioural fixations. Ferreira and Read (2006: 194) postulate that companionship is disrupted by self-protective contact modifications, which in turn lead to constrained spontaneity, feelings of being evermore different (from the peer group) and isolation.

**Development line 4:** One would expect an adolescent to become more focused on academic achievement and/or the exploration of possible careers (Toman & Bauer, 2005: 190). Conversely, it is not unusual for a survivor to lose hope for the future and to doubt whether her life has any meaning after a traumatic experience (De Decker *et al.*, 2003: 23; Ferreira & Read, 2006: 189). Moreover, some trauma reactions affect academic work and performance: intrusive thoughts, flashbacks, depression, tiredness from sleep-deprivation and concentration difficulties. The play-to-work developmental line may be negatively affected by CSA.

**Therapeutic considerations:** Oaklander (2006: 94) asserts that an adolescent “brings a lot of baggage” to the tasks of individuation and therapy. Becoming response-able for defining and re-organising a “self-gestalt” (Toman & Bauer, 2005: 188) is therefore an important task for the sexually assaulted teenager in therapy.

A number of issues should be borne in mind during therapy with adolescents: With their becoming self-reliant, compelled into therapy by ‘others’ and possibly often subjected to adults lecturing them, a therapist must be “a very different type of adult” (Toman & Bauer, 2005: 191). The non-judgemental, invitational therapist who facilitates authentic contact should be able to establish a working alliance with an adolescent. Initial meetings are an important platform to defy perceptions that the therapist is aligned to parents (Oaklander, 1988: 185; Toman & Bauer, 2005: 192). Words are never enough; the therapist could expect to be tested (Toman & Bauer, 2005: 192). Moreover, after long periods of silence survivors of CSA might present with impenetrable contact barriers.

Milgrom (2005: 5) cautions that adolescents may perceive play therapy indignantly; they are becoming adults and playing is not “cool”. The therapist of this research explains the value of play therapy to clients by referring to neurobiological research on hemispheric specialisation, although conceding that the research findings are inconclusive. It is important to mention that the Gestalt therapist – being holistic oriented – will not be problem-focused, but will enhance awareness of “developmental assets” (Steinberg & Lerner, 2004: 51).

CSA, which intrudes upon the self in so many ways, will probably have developmental implications. Adolescence, the phase of becoming an adult, is *per se* wrought with changes and challenges, which include the “synaptic pruning” and myelination of those areas in the brain important for survival and conscious thought (Sercombe, 2010: 38-39). Tramontana *et al.* (2009: 135) posit that PTSD leads to structural brain differences of the developing brains of children and adolescents. In the next section attention will be awarded to the way Gestalt theorists and therapists conceive the PTSP of survivors of CSA.

## **2.5 Gestalt conceptualisation of posttraumatic signs and patterns**

“[T]hese symptoms are the ‘normal’ reactions to ‘abnormal’ situations”  
(Ferreira & Read, 2006: 185; also Scott & Stradling, 2001: 56).

In the following section the aetiology of PTSP will be discussed from a Gestalt perspective. It is important also to elucidate the Gestalt conceptualisation of natural human functioning.

Gestalt questions the psychopathological paradigm: “doing labeling” (Reynolds, 2005: 169). Claveaux (*sine anno*: 5) maintains that diagnosis is merely a model through which realities can be described and, in doing so, they become manageable. “De werkelijkheid blijft altijd complexer dan het model”. The Gestalt therapist perceives the client’s expressions as creative adaptations to the field; a view of “dis-ease” opposed to disease (Ingersoll, 2005: 140).

In Gestalt the individual-environment entity is called the field (Mackewn, 2004: 49). A person needs the environment for survival and self-actualisation; the environment is therefore part of the fundamental structure of the self (Toman & Bauer, 2005: 185). The self could be conceived as the nucleus of a person (Claveaux, *sine anno*: 8) from where awareness of and contact with the environment transpires. Through contact-making the self is in process, forever making creative adjustments, developing and changing.

According to Joyce and Sills (2006: 30-33) the self has three zones of awareness: the inner zone, outer zone and middle zone<sup>9</sup>. Being out of touch with any of these zones or allowing one zone to be overly dominant, would impair the overall functioning of the organism. To illustrate: a flashback originates from the inner zone, but is perceived as though it is from the outer zone. Confluence of the inside and the outside of the client (Lobb, 2005: 29; Scott & Stradling, 2001: 62) makes psychological distancing from the trauma event impossible (Ferreira & Read, 2006: 184). If the contact functions of the inner zone are desensitised because of CSA, figure-ground differentiation will be affected. It is, however, the middle zone that relegates such significance to experiences that they become unfinished business. Perls, Hefferline and Goodman (quoted in Ingersoll, 2005: 134-135) define (cognitive) introspection: it “is a deliberate turning of attention to these activities in an evaluating, correcting, controlling, interfering way...” The middle zone also manages the relational field (Joyce & Sills, 2006: 32). It could be expected that a trauma survivor may have field-focused filters which may contaminate her relational interaction with the field: with the self, others, the world and the therapist.

When the organism becomes aware of an urge, interest, need or wish, this need moves to the centre of awareness (the figure), whereas other business fades (it becomes ground). This background is the whole context of the salient figure (Yontef, 2005: 88). The organism turns to the field to satisfy the pressing figure, and now the organism engages in a very specific way with the field, the Gestalt cycle of experience: Sensation → Awareness → Mobilisation → Encounter and action → Contact → Integration and assimilation → Differentiation, closure and withdrawal (Joyce & Sills, 2006: 34; Mackewn, 2004: 19). Experience is cyclic, which means that once a wish is satisfied it withdraws as a figure, and another urge, interest, need or wish will become figure and press for closure. Serok (2000: 40) concludes, “There is primal order in God’s creation of the universe”.

The continuum of contact may be disrupted at any phase of the Gestalt cycle of experience and may be helpful or less useful under the field circumstances. In Mackewn (2004: 106-108) these modifications are presented as polarities on a continuum<sup>10</sup>; in Reynolds (2005: 160-164) contact modifications are linked with the phases in the Gestalt cycle of experience. In Table 2.1 below the researcher presents the continuum of contact modifications. The polar opposites represent the contact modifications that might be applied by sexually abused adolescents. In the middle column the more flexible contact option is given.

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<sup>9</sup> As a caveat, the reader is reminded that awareness can only be holistic – the distinction between internal and external experiences is made purely to clarify concepts.

<sup>10</sup> Joyce and Sills (2006: 113) proposed different polarities, for example retroflexion is opposed to impulsiveness.

| Gestalt cycle of experience                                                            | Continuum of modifications <sup>11</sup> of contact                                                                                                                                                                                                        |                               |                                                                                                                                                                  |
|----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Sensation</b>                                                                       | Desensitisation – the survivor blocks both internal and external stimuli from affecting her sensations (e.g. the survivor will seem numb and deadened, often to cope with trauma)                                                                          | Sensitivity                   | Supersensitivity – the survivor's contact boundary is permeable; she is unable to protect the self (e.g. hypervigilance to potential dangers or hypochondria)    |
| <b>Awareness</b>                                                                       | Introjection – the adolescent blindly accepts beliefs, attitudes or expectations imposed on her (e.g. <i>Good children should forgive others...</i> )                                                                                                      | Chewing, destructuring        | Spitting out, rejecting – the survivor seems to reject anything given, sometimes also love and attention (e.g. mistrust and rebellion)                           |
| <b>Mobilisation</b>                                                                    | Projection – some aspect of the self is disowned and ascribed to another (e.g. blaming others)                                                                                                                                                             | Imagination, assumption       | Owning, literalness – the survivor accepts all responsibility, even for what is not hers (e.g. guilt following sexual abuse (Joyce & Sills, 2006: 125))          |
| <b>Encounter and action</b>                                                            | Retroflection – the survivor holds back impulses – expression of feelings or action – or turns her actions onto the self (e.g. being overly reserved, not mourning losses, somatisation or self-mutilation)                                                | Expression                    | Violence, aggression – the survivor's emotions boil over (e.g. low frustration tolerance)                                                                        |
| <b>Contact</b>                                                                         | Deflection – the survivor turns away from contact with important business and focuses on superficial issues (e.g. during therapy the adolescent may use humour, excessive or impersonal talking or may push interventions away (Joyce & Sills, 2006: 116)) | Focussing, contact            | Bluntness – the adolescent is confrontational, which might lead to a loss of support                                                                             |
| <b>Integration and assimilation</b>                                                    | Egotism – the survivor is so preoccupied with her thoughts, feelings, actions, history or boundaries that assimilation of other business is thwarted (e.g. she considers words and actions so carefully that spontaneity is lost, blaming the self)        | Spontaneity                   | Impulsivity – the survivor has difficulty to reflect or monitor herself (e.g. "It is as if he escapes from his feelings into action" (Joyce & Sills, 2006: 123)) |
| <b>Differentiation, closure and withdrawal</b><br>(also referred to as Demobilisation) | Confluence – the survivor merges unboundedly with another (which avoids withdrawal from the figure). Individuation and 'letting go' is hampered.                                                                                                           | Differentiation, separateness | Isolation – the survivor withdraws and is not able to establish a relationship or mobilise support (e.g. dissociation, depersonalisation)                        |

Table 2.1: Continuum of styles of contact (Adapted from Mackewn, 2004: 107 and Reynolds, 2005: 160-164)

<sup>11</sup> Mackewn (2004: 105, 106) refers to styles of "interrupting" or "moderating" contact, whereas Lobb (2005: 32) refers to "disturbances". Generally such interruptions are held to be creative adjustments by the organism during difficult situations (Lobb, 2005: 33).

To illustrate, the CSA survivor may be desensitised (resulting in habitual inappropriate sexualised behaviour) or supersensitive (resulting in a fixed pattern of withdrawal from males who are all perceived as potential perpetrators). During therapy awareness of the adolescent's ways of being, as well as the adaptive option, sensitivity will be enhanced. The adolescent will then be able to choicefully engage with the options.

The Gestalt model explains the rumination and assortment of cognitive distortions commonly seen in CSA survivors as the contact boundary modification egotism (Ferreira & Read, 2006: 194; Marvasti, 1994: 338). Egotism is a cognitive preoccupation within the middle zone of the self – thwarting contact with the inner and outer zones. Cognitive distortions are characteristically associated with causation of and accountability for the event (Cohen *et al.*, 2000: 33; Cohen & Mannarino, 2004: 826; Nolen-Hoeksema *et al.*, 2008: 402). Moreover, definition of self, others, the world and God change (Urman, Funk & Elliott, 2001: 409): the self is hopelessness, helplessness and powerlessness, others are not virtuous and helpful and the world is unjust and dangerous. God does not seem as protective, omnipotent, omnipresent and omniscient as previously believed (Urman *et al.*, 2001: 409). Contact with the environment is continually determined by one's definition of self (Lobb, 2005: 29). To protect herself, the CSA survivor has to be vigilant, there is no time for spontaneity and sometimes she withdraws from the dangerous environment field.

Everybody uses modifications. Should the organism maintain such modifications despite changing field conditions, it becomes a habitual style of contact – a fixed pattern of behaviour (Joyce & Sills, 2006: 112; Mackewn, 2004: 105).

Gestalt underwrites the innate ability of organisms to recover (Ferreira & Read, 2006: 181). Nonetheless, under certain circumstances – for example a client who has too few resources, understanding or support, sadly often children – the organism cannot deal with a situation in a growth-enhancing way. She may then prematurely interrupt the Gestalt cycle of experience and close the trauma-gestalt and its underlying sensations, emotions and thoughts. This leads to unfinished business (Hardie, 2004: 3; Joyce & Sills, 2006: 130-131), fittingly metaphored as “organismic indigestion” (Latner, quoted in Schoeman, 1996b: 68). To keep such unfinished business out of awareness demands energy; furthermore, the unfinished business – ever pressing for closure – expresses itself in various signs and patterns (Joyce & Sills, 2006: 130-131; Mackewn, 2004: 24). The organism is plagued by preoccupied thoughts and compulsive behaviour (Hardie, 2004: 3). Furthermore, although the unfinished business may be in the background, all new experiences are “verstoord en gekleurd door de grond van de onafgeronde gestalt” (Claveaux, *sine anno*: 10). Life becomes restricted, interpersonal difficulties arise, tension intensifies, an explosive response is continually inhibited and ultimately feelings are blocked out (Serok, 2000: 41-42). Gestaltists perceive the methods of burying memories as creative adjustments to cope with the CSA and the



concomitant pressure of the unfinished business. Claveaux (*sine anno*: 4) justifies, “Het vermijden van datgene dat je leven bedreigde getuigt van gezond verstand”.

Both Cohen (2002: 3) and Claveaux (*sine anno*: 11) consider PTSP as a disturbance of the Gestalt cycle of experience, specifically the demobilisation phase (analogous to differentiation, closure and withdrawal). The organism is unable to assimilate and integrate the trauma experience and therefore cannot disengage from it. PTSP is perceived as emanating from unfinished business and, unless full contact with the event and concomitant thoughts and emotions is established, the energy tied to the trauma cannot be demobilised.

As indicated, although the self is fluid, it needs to experience itself as whole, an entity. One set of PTSD diagnostic criteria is the “persistent avoidance of stimuli associated with the trauma” (APA, 2000: 468). “People often believe that change involves trying to get rid of various qualities within themselves” (Mackewn, 2004: 69). A traumatised adolescent wants, most of all, to erase the trauma memory, obliterate all the associated thoughts and feelings, wipe out the sensory-bodily sensitivities and escape from the symptomatic expressions of sexual trauma. In order to relieve and disown these, she might avoid, project, retrofect, dissociate, desensitise and suppress CSA reminders; those sensations, emotions, thoughts, activities, people, places and discussions associated with the trauma (Cohen & Mannarino, 2004: 820; Schaefer, 1994: 309). In Gestalt terminology, the self (which *is* the field) tries to become what it is not. “We don’t want to be ourselves” (Perls, 1972: 24). These creative adaptations to deal with overwhelming circumstances deny integration and ownership of the experience. Continuity disappears, “het verdeelt de wereld en jezelf in ervoor en erna” (Claveaux, *sine anno*: 4). Concomitant anxiety about fragmentation, falling apart, is a well-documented sequel to CSA (Claveaux, *sine anno*: 10).

“[P]ushing worries away does not cause them to disappear” (Webb, 2007b: 51). The DSM-IV-TR requires that the traumatic experience is “persistently reexperienced” in a number of ways (APA, 2000: 468). In fact, according to Serok (2000: 41), the unfinished business is remembered better than that completed, because of lingering tension. Flashbacks, reoccurring dreams and intrusive recollections after unresolved trauma could be considered an organism’s unconscious struggle to deal with the original incident. Gestalt practitioners believe that unfinished business is forever “calling out for attention” (Mackewn, 2004: 24). Only when the gestalt is formed can it recede to the ground and can energy be availed for adaptive endeavours (Claveaux, *sine anno*: 9; Ferreira & Read, 2006: 201).

One PTSD symptom cluster is the “persistent symptoms of increased arousal” (APA, 2000: 468). Hypervigilance, sleep difficulties and physiologic reactivity are related to the organism’s need to, in the face of danger, keep vigil and be prepared for flight or fight. This could explain the irritability, poor impulse control and sleeplessness of survivors of sexual abuse (Claveaux, *sine anno*: 9). Concentration difficulties, memory impairment and a drop in scholastic achievement could relate to

restlessness and fatigue, as well as the energy demands of keeping unfinished business submerged (Joyce & Sills, 2006: 130).

## **2.6 Conclusion**

To summarise: Oaklander (2006: 5) asks, “What brings children to therapy?” Trauma, she explains, can result in the child to protectively cut herself off in some way – a contact-making difficulty (Oaklander, 2006: 7). Moreover, contact functions, according to Oaklander (2006: 6), are “the very same modalities that make up one’s self”. Following Oaklander, the researcher supports the notion that, when a client dissociates a traumagenic sexual experience, she loses part of herself.

In this chapter the researcher attempted to elucidate the impact of CSA: posttraumatic signs and patterns, fragmentation of self and other-awareness and interrupted selfing. Neurobiologically, trauma appears to bring about autobiographical memories that are non-sequential, non-verbal, sensorimotor and therefore devoid of meaning. The researcher is of the opinion that such memories, particularly during the adolescent phase, are hard to ‘stomach’. The cognitive and introspective teenager wants to pattern and make meaning of her experiences. No wonder that many survivors bury the CSA as unfinished business. The researcher concurs with the premise that the original senselessness of CSA combined with its traumagenic ramifications, have significant therapeutic implications.

In the next chapter Gestalt therapy for survivors of CSA will be explored. Attention will be awarded to the specific therapeutic modalities that will be used during the research.