

# The Use of Touch and the Synthetic, Anatomically Correct Penis in the Diagnosis and Treatment of Sexual Abuse

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*This article discusses three clinical cases involving severe child sexual abuse. Each of the cases is analyzed from three perspectives – cognitive development, object relations and traumatic intrusion into the body of the children. In each case small and large synthetic penises the size of flaccid and erect penises were used as objects of play by the children because of clear and convincing evidence that these children were victimized by an erect penis. The penises were effective vehicles by which the children could reenact and discharge the fright from their traumatic injury when they did not otherwise have the verbal skills to relate their victimization because of developmental arrest and/or significant dissociative process. Therapeutic alliance and the necessity for negative and sometimes hostile transference neurosis in a safe therapeutic setting is emphasized as critical to successful therapy outcome.*

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**KEY WORDS:** sexual trauma, dissociation, reenactment, declarative memory, procedural memory, discharge, state dependent learning, state dependent recall, abreaction, touch, holding, anatomically correct penis, somatosensory learning, attachment, cognitive development, therapeutic alliance, transference neurosis

## Introduction

Clinicians who work with severely sexually abused children understand the difficulty these children have in expressing, understanding and working through their victimization in therapy. In my experience, there is perhaps no group of children that brings to the therapeutic setting a more resistant, disorganized, sometimes aggressive and angry, sometimes passive and shame-filled transference neurosis than children who have been sexually abused by an exploitative male with an erect penis. There is ample literature on the assessment of these children through the use of pictures, anatomically correct dolls and drawings (Steward, 1996). Books and articles are devoted to discussion of trauma with short shrift being given to effective therapeutic technique on young children (Perry, 1999; van der Kolk, 1996); Prior, 1996; Scharff, 1998; Herman, 1992). The presenting problem for clinicians is how to work with these seriously troubled, highly resistant, anxious children.

At its inception psychotherapy with these children is usually challenging because of the difficulty they have in recalling, conceptualizing and verbalizing outrageous and overwhelming intrusion (van der Kolk, 1996; Prior, 1996; Herman, 1992). In my own experience, drawings of male and female anatomy are sometimes helpful in allowing children to begin to talk about what has happened to them, but frequently do not allow the discharge of the traumatic fright (Herman,

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1992 ; Scaer, 2002). I have witnessed the use of crayons and magic markers to simulate the penis with only marginal therapeutic success.

Additionally, the public and institutions need to be educated on the severity of the sexual abuse problem and the difficulty in obtaining effective therapy. The very nature of this work, which, if successful, necessarily requires the reenactment of graphic sexual acts by children, is abhorrent to our institutions and to the political religious climate of our culture. "It is one of the more painful ironies of contemporary therapeutic practice that at the very time we are learning so much about the healing power of relationships, our institutions and ideologies so often prevent these relationships from occurring. Much of the time, our public mental health system pursues policies and encourages fragmented, incomplete, and ultimately cruel treatment in which the basic anxieties and needs of the traumatized child are not addressed." (Prior , 1996). Because of the nature of this work, therapeutic approaches that graphically expose the prior sexualization of children are met with resistance. In my opinion, however, they are necessary to advance the field.

It is the purpose of this article to explore a treatment approach that we have found to be successful. It explores the use of touch and anatomically correct synthetic penises in the treatment of these seriously victimized children. Its intent is to give practitioners the tools to effectively unburden these children from their horrors.

## **History**

Approximately 20 years ago, the anatomically correct doll was introduced as a medium by which mental health professionals could detect sexual abuse in young children (Steward,1996 ; Glaser,1989). Somewhat like cabbage patch dolls but with breasts, vaginas, anuses, pubic hair and penises, the dolls had a rather dramatic effect on the field (Steward, 1996; Leventhal et.al.,1989). Their use constituted the first recognition by professionals that sexually abused children do not have the verbal or conceptual skills or the conscious recollection of the event(s) to express what happened. These children whose intrusion occurred while functioning at sensorimotor or preoperational stages of cognitive development (Kegan, 1982, Piaget, 1954) or who have stored in their body but not cognitively the memory (van der Kolk, 1996) could use the doll to see, touch and act out the sexual touch that had occurred.

At that time, this brilliant and courageous exploit into unknown territory had some pitfalls. The users of the dolls were accused of ethical violations and sexualizing children (Steward, 1996). Although original psychoanalytic theory posited that we are sexual beings (Freud, 1920) driven by libidinal and aggressive impulse, critics implied the use of such dolls constituted a traumatic sexual intrusion (Glaser, 1989). Subsequent research has shown that the use of the dolls is not a sexual intrusion (Glaser, 1989; Steward, 1996). Rather cues are necessary for complete and accurate recall of the event (Fivush, 1993) and the younger the child and/or the more distant the event to be recalled, the more the child must rely on cues and often very specific cues (Baker-Ward et al., 1993; Ornstein et. al. 1992).

## **Method**

I will discuss using three illustrative cases the use of synthetic phalluses as the medium by which sexually abused children can further identify and express their victimization during therapy. One was small and flaccid. The other was a seven and one half inch erect penis. In all three cases the following criteria were used before the children were shown the phalluses:

- 1.) There was clear and convincing evidence in the form of verbal, written or pictorial expression by the child that he had been exposed to sexual abuse by an erect adult penis. Other forms of evidence could be the tearing of tissues or observation of sexual activity. Finally, it could be circumstantial evidence involving the sexual acting out of a repetition compulsion by the child and reenactment of prior trauma (van der Kolk, 1996).
- 2.) The establishment of a therapeutic alliance between the child and the therapist. This requires several treatment sessions and evidence that the child formed an attachment with the therapist. Evidence of therapeutic alliance may be the child telling the therapist he loves him, wanting to jump into his arms, provoking touch by the therapist, touching the therapist, refusing to leave when the session has expired or reports by the parents that the child enjoys the sessions and is improving at home and at school. The most powerful evidence of a therapeutic alliance is the traumatized child entering into aggressive or violent play with the therapist (Prior, 1996). This is the ultimate sign of trust by the child, for he is saying to the therapist that he feels safe in his relationship with the therapist to reenact the violence that was perpetrated on him. If the child is not attempting violent play with the therapist, it is likely that the child's "bad feelings" are being contained by the therapist. In this case, real internal and behavioral change are not likely to occur.
- 3.) There was consent to use the phallus by the child's non-offending parent or the guardian of the child, and the parent or guardian attended all psychotherapy sessions with the child.
- 4.) The child was unable to clearly articulate his abuse or express affect related to the abuse thereby evidencing a dissociative process (van der Kolk, 1996).

All three children were quite disorganized and suffering from a complex post-traumatic disorder. As such they presented chaotically, and, thus, these vignettes may reflect this chaos.

### **Case Studies: Darren**

Darren is a five-year-old boy whose parents are separated and divorcing. The last year and one half Darren's behavior has become increasingly aggressive to the point he has been thrown out of two daycare centers because of his "manhandling" other children. In one situation he fondled another boy's penis. Darren's mother was forced to quit work because she could find no other centers for him. One day during bathing, Darren remarked to his mother that his father and he fondle each other's penis, or "winkie" as he called it. He made such a comment on numerous occasions necessitating his mother calling Social Services. Social Services did three diagnostic sessions and declared sexual abuse by the father to be unfounded. They diagnosed him as Bi-polar and Attention Deficit Hyperactivity Disorder (ADHD) and referred him to another therapist who was unable to make any therapeutic gain because of Darren's hyperactivity. Darren was referred to a psychiatrist who prescribed Ritalin. His behavior deteriorated rapidly. He was then referred to me.

At the first session, it was apparent this was a boy who, though attached to his mother, was highly anxious and burdened with great internal pressure. He was unable to sit still and wandered about the room. Attempts to communicate were fruitless because of his inability to focus on any conversation for more than seconds at a time. Half way through the first session, in the presence of his mother and an intake assistant, Darren walked over to me as I was attempting to talk with him and touched the clothing over my penis. When asked what he was doing, he recoiled, startled by my question and by my not being receptive to his relating to me in this manner. Undaunted, he approached me two other times and touched my penis, the last time, attempting to stroke it. I stated to him, "I wonder if you and your father touch each other that way". He exploded with that comment, which had resonated with a place of shame, anxiety, vulnerability and pain within him. This was a boy who was accustomed to relating to adult males through their penis but was very ashamed of it.

In therapy Darren continued to verbalize his sexual abuse with considerable difficulty. However, he drew pictures of himself and his father in bed with both of their penises exposed. He drew pictures of his penis and his father's penis and their relative sizes. He was unable to express verbally what had happened to him. His mother recalled Darren having a red anus after visits to his father. She believed it was related to improper cleaning after defecating.

As Darren's therapy progressed, he began saying "fuck", "fuck you" and "fucking bitch" in guttural tones. He also spoke of Christmas day when his father came to visit and gave him a red bike. He explained how he and his father went into his bedroom while his mother showered and took off their clothes. He said his father had put "slippery stuff" on Darren's "butt". But he was unable to express what happened after that, although the affect within him was obvious. With each inquiry about what had then happened, Darren would dissociate and then begin hyperactive movement.

Session eight was remarkable. He went behind my couch. There was considerable rustling of clothes. He reappeared naked. He then proceeded to act out his victimization and aggression. He got down on the floor on all fours, spread the cheeks of his buttocks and showed us where his father put his "winkie". He then proceeded to insert his fingers into his anus. After this explicit acting out, care was taken to soothe him and calm him. Finally, he was helped to put his clothes back on.

The next three sessions were equally remarkable, but not as remarkable as the changes occurring outside the therapeutic setting. He began to relate to other children and his mother without aggression. He began to sing. His grandmother described his decrease in hyperactivity as "miraculous". Plans were made to enroll Darren in kindergarten.

Within the therapeutic setting, Darren continued to work very hard. He repeatedly entered the room, went behind the couch and took off his clothes. In the ninth and tenth sessions, he allowed himself to be held and related to both his mother and me with appropriate eye contact and conversation. What was once a frantic, apparently unrelated heathen was becoming a related boy. Although finding a non-sexually exploitive way for his body to be related to, Darren continued to have difficulty articulating what had happened to him sexually.

At this point, the anatomically correct penises were introduced into the therapeutic setting. Clear and convincing evidence existed for the sexual abuse of Darren, and clearly a therapeutic alliance existed. Darren was refusing to leave the therapy sessions, would run into my arms in the hall and waiting room outside my office and was beginning to show signs of much more organization and relatedness in his family and socially. Most importantly, he had begun to engage with me in violent play consisting of kicking and hitting me and reenacting his

sexual trauma. His mother took part in every session. He still was unable to conceptualize and articulate what had happened to him because he had not the cognitive ability to do so. Both the small and large phalluses were shown to Darren at the beginning of the session. Upon seeing them, Darren stated with glee, "Oh, winkies!" Putting the big one up to his mouth and proclaimed, "This smells just like my dad's". He then paraded around the room with the erect one at his pelvis stating that it looked just like his dad's. He stood up, grabbed the erect phallus and began throwing it to the ceiling, hitting his mother and me with it, and pounded it on the furniture acting out his rage. He put the penis in his mouth and fellated it. These spontaneous acts showed that Darren was familiar with an erect penis and it was no stranger to his mouth. Care was taken to soothe Darren at the end of the session. He did not want to leave and asked to take the "winkies with him".

In the next session, Darren came into the room and asked for his "winkies". I told him which drawer to look in and he immediately opened the drawer and grabbed them with glee. He paraded around the room with them, fellated the larger one and began biting the head with such ferocity that his mother and I at one point had to hold it so he did not bite off the head and swallow it. He went behind the couch and emerged with only his underpants on. He then lay on the couch. When asked if that was how he was lying on Christmas when he and his dad were in bed together, he became highly agitated. When asked what happened then between him and his father, he simulated his father's act of anal intercourse with him by making a humping motion. When the session came to an end Darren did not want to leave or get dressed. The relief he was feeling was obvious.

With this treatment his behavior at home and with peers continued to improve. Unfortunately, Social Services terminated Darren's therapy because they felt his nudity and his use of the erect phallus constituted sexual abuse. They were unable to see that these were reenactments of the abuse that had already occurred and were crucial to Darren's treatment. They referred Darren to a day care facility for traditional play therapy with no human touch. Darren soon fondled another child. He regressed to the point of defecating in his pants when Social Services allowed visitation with his father. His mother says he has never again revisited therapeutically the horror of the abuse by his father, but instead has begun frantically acting out again.

## **CASE #2: Ike**

Ike is a ten-year-old boy whose mother found him having anal intercourse with his stepfather, Matt. His stepfather had carried on a sexual relationship with him for four years consisting of fondling, mutual oral sex and anal sex. The case was reported to Social Service authorities who referred it to the police for prosecution. Therapy was initiated with Ike. It consisted of traditional play therapy and drawing. Ike was reluctant to discuss his victimization with his therapist and his mother despite his cognitive level being concrete operational with some ability to objectify feelings and sensations (Kegan, 1982); Piaget, 1954). He grew depressed and began failing in school. His mother feared that Ike would victimize his younger sister. The trial against Matt was imminent and Ike was not ready to testify. When asked what happened to him, he, because of overwhelming conflict and confusion, was unable to articulate anything meaningful. He was referred to me for treatment.

His first session showed to me that he was wholly untreated concerning his sexual victimization. Having felt erotic pleasure as well as rage and ashamed about what really amounted to a four year exploitation perpetrated on him by Matt, Ike would not articulate anything about it. As I tried to support him with a touch of my hand, he had a startle response. This was a boy who did not trust the touch of a man. His body told me so but his voice could not.

By the third session a therapeutic alliance was shown by Ike's willingness to act out his rage and fright with me. He presented very agitated, running around the room and smashing things in my office. His mother and I held him. He began crying and sobbing, calling me a "bitch" and "queer". When I pointed out to him that perhaps that is what he thought about himself, he began crying hysterically. He disclosed that he had to perform oral sex on Matt and had repeatedly had anal intercourse with him. He then got up and ran into the men's room where he hid in the stall and cried. Eventually he was talked out of the stall and back to my office where he was assured that he was doing the work of therapy and he was not a "bitch" or "queer".

The next few sessions with Ike constituted a regression in terms of therapeutic gain. Again, Ike had difficulty describing his feelings around the trauma. He was also horrified by the notion that he gained pleasure from this four-year incestuous relationship with a stepfather whose love he desperately wanted because his biological father had abandoned him.

Encouraged by the therapeutic success shown by Darren and Jennifer (next vignette) I introduced the two phalluses into the next session. Ike grabbed the smaller one and said that it looked like "the little man" and started to pretend that the little man was walking around. Ike then grabbed the erect penis and said that it looked like a rocket. He then pretended that the rocket was lifting off and flying away. Playing pensively with the penises for perhaps ten minutes, Ike was afraid to talk about what they really were. When confronted, he admitted he knew what they were and stated flatly that the erect one was unlike Matt's, which was shorter and crooked. Ike then calmly and clearly talked about what happened to him. He held the penis tightly and the words and feelings flowed out of him. He added detail to his description of his sexual relationship with Matt and was not frightened so long as he could hold the penis in his hand.

In subsequent treatment sessions, Ike refused to participate in the session until he could grip the larger erect phallus in his hand. He has continued to work on his victimization. He has advanced to the next grade in school, when before he was failing. He is currently prosecuting Matt in criminal court. It was Matt's penis that Ike had handled so many times and it was not until Ike could again handle it in a therapeutic setting and gain control over it that he could begin working through his shame and rage over his abuse and move to the next developmental level.

### **Case #3: Jennifer**

Jennifer is a ten-year-old girl who is in the foster care of exceptionally concerned, intelligent parents. Her biological father has never been part of her life. She spent the first six years with her biological mother, Nancy, and mom's boyfriend, Tom. She is the youngest of four siblings and her mother has lost custody of and/or parental rights to all of them.

Eye contact was difficult for her, as well as touch. Her cognitive development was severely arrested and she was diagnosed as mentally retarded, although she clearly wasn't.

In our first session it became apparent that this was a child who was not normally attached and one who had been the victim of abusive treatment. Her attachment style could be classified as anxiously disorganized (Holmes, 1996; Parkes, 1991). Although not to the level of dissociative identity disorder, she had a powerful dissociative process in place involving unintegrated ego states that were expressed and acted out without conscious cognitive control or awareness. Her presentation involved movement from a sweet, compliant sexually seductive Shirley Temple, to a withdrawn waif, to a rageful controlling demon scratching and clawing at me and spitting in my face. Once she kicked me in the head with great force. If she was not acting seductively, she was acting with contempt.

For the first year of therapy, a good deal of touch and holding was used in establishing a therapeutic alliance. She became more and more organized, began to be able to function in school and relate in a way at home that gave the foster parents hope that she could become a part of their family.

After one year of therapy she began talking of taking baths with Nancy and Tom. She drew pictures of their baths with all three of them in the tub and then in bed. She reenacted on the floor acts of sexual intercourse. She had not the vocabulary or the conceptualizations to describe verbally what had happened to her or in her presence. Clearly she had formed a therapeutic alliance with me, for, in addition to expressing affection, she was willing to act out her rageful, spiteful, violent side with me as a transference object (Fairbairn, 1952). Ample evidence existed for the existence of sexual abuse: pictures, seductive behavior and reenactment in therapy of sexual acts. Yet she was unable to articulate what had happened to her. Her foster parents were advised of the success I had with the use of the phalluses and they consented to their use with Jennifer.

Their introduction resulted in the opening of a floodgate. Jennifer showed no interest in the small flaccid penis but was enamored with the larger erect one. She immediately stated that it looked like Tom's. She then put it in her mouth and began fellating it in a way that made it apparent that such behavior was familiar to her. She licked and sucked on it as a sexually experienced woman would who attained great excitement and pleasure from the act. She explained how she did that with Tom repeatedly and in the presence of her mother, who also did it. She described acts of a ménage a trois between them. She used the phallus to show how Tom had inserted his phallus into Nancy. She then went on used to tell her that it would not hurt her if he "peed" (ejaculated) in her mouth. She described the noises he made when ejaculating and the white liquid in her mouth, which she swallowed. She described how Tom had made her his wife and how she got him beer from the refrigerator and fellated him while he watched television.

She repeatedly held the penis while she talked of her adventures with it. She wanted to take it home with her after the sessions. Consciously, she felt no shame or guilt as she talked of her sexual activities with Tom. She asked if she could touch my penis or fellate me and seemed somewhat surprised when I denied her request.

Clearly such activity was the norm in her household and she was not aware of its impropriety. It was not until much later in her therapy that feelings of great shame and guilt over her sexual relationship with Tom began to emerge. So painful was the affect around her victimization that she wanted to leave the room or refuse to talk about it. Nearly two years into her therapy she is coming to grips with what happened to her and the fact that she was victimized and humiliated. Occasionally she will still go into the drawer of my desk and hold the phallus as she talks about it. As with Ike, when she can hold the penis and have control over it, she can metabolize her fright, shame and rage.

## **Discussion**

### COGNITIVE DEVELOPMENTAL CONSIDERATIONS

In treating children such as Darren, Ike and Jennifer it is crucial for the therapist to locate the stage of cognitive development at which the child was operating at the time when he was abused and the stage of cognitive development at which the child should be at the time of treatment. The clinician needs to know the former stage because that will provide a guide as to the child's ability to conceptualize at the time he was intruded upon. The child is likely to be developmentally arrested at that stage and still functioning there (Kegan, 1992; Masterson, 1981). The clinician needs to know the child's expected cognitive level because he can compare the child's present functioning with the expected level. By doing so, the clinician understands how much work needs to be done to get the child from the level of developmental arrest to the appropriate level of functioning.

If abused between the ages of birth and three, the child will only have recorded the invasion to his body sensorially and motorically. Thus his treatment will only be effective if he is able to feel kinesthetically and act out motorically his abuse. If he were between 3-6 years at the time of victimization, he should be able to understand feelings and sensations, but his perceptions of them may be inaccurate or subject to distortions (Kegan, 1992). Therapy again may involve both sensorimotor acting out, as it did in the case of Darren, Jennifer and Ike, as well as a cognitive processing of perceptions of the abuse. If abused during concrete operations (6-13 years), he will have the capability to understand feelings and sensations and his perceptions of them can be accurate (Kegan, 1992). All forms of therapy should be made available to concrete operational children including play therapy, talk therapy and kinesthetic work involving touch.

The validity of the children's perceptions, regardless of their stage of cognitive development, must be tempered by the reality of trauma and what it does to the body and psyche, for in the face of severe intrusion, a dissociative process occurs which allows the victim to not feel his pain, rage, vulnerability or fright. Associations are cut off (van der Kolk, 1996). The recognition of pain is cut off but disorganization results. In such cases the body is always keeping the score (van der Kolk, 1996), for the child will act out his abuse with his body. Thus, successful therapy with severe trauma victims of any age may involve an explosive, abreactive recapitulation of the traumatic event and take months and perhaps years for the event to be understood and worked through therapeutically.

Jennifer and Darren were abused while they were in the sensorimotor and preoperational stages of cognitive development (3-6 years of age) (Kegan, 1982; Piaget, 1954), while Ike's abuse started when he was transitioning from preoperational to concrete operational (6-13 years of age) developmental. Preoperational children are magical thinkers and illogical. They will tell you that a pound of feathers is heavier than a pound of lead because the volume of the feathers is greater. They confuse apparent and imagined events with real events. They are a slave to their perceptions and have no way to objectify the truth of them. They may conceptualize fellating a penis the same as sucking on a popsicle, and, when they act out their abuse with the phallus in therapy, it is as if they are sucking on a popsicle. They, however, do have some capacity to objectify sensations and feelings, unlike sensorimotor children (0-3 years), who are the subject of their sensations (Kegan, 1982). Concrete operational children like Ike are able to think about their sensations and make sense of their perceptions. They should be able to objectify what has happened to them. The problem that all three of these children have, in addition to their arrested cognitive development, is that they likely do not have their feelings available to them because the trauma they endured caused a dissociative process which prevents them from feeling their rage and shame associated with betrayal and abuse.

#### ATTACHMENT AND OBJECT RELATIONS ASPECTS

The driven need for human beings to attach, be connected and be loved when they are living in a situation that is abusive and betraying to them is the conflict that brings about the severe psychopathology and dissociative condition in sexually abused children. Fairbairn (1952), Bowlby (1969) and Ainsworth (1982) have described this drive vividly in their work. The child needs to maintain the feeling that he is attached to and loved by the abusive parent. This requires considerable mental gymnastics and psychic energy, which splits the child in two (Prior, 1996). In order to maintain the delusion of being loved in the face of severe intrusion and abuse, the child believes himself to be the cause of his mistreatment and takes on feelings of shame and self hatred (Firestone, 1985). Accompanying this internalization of self-hatred and shame is a dissociative process, which allows the child to split off his fear and hatred of the abusive parent and sometimes the memory of the abusive events. Thus he experiences the world as an unsafe, hostile place caused by his badness. He many times projects his rage and then experiences it in the form of paranoia, or in the anger of others toward him (projective identification) when he acts it out (Fisch and Arnold, 1991).

The sexually abused child becomes numb and lives in a state wherein he cannot experience himself, his body or his surroundings as being real. To deal with this psychic deadness and split off rage he will typically be in constant movement or acting out in other ways that allow him to feel real but which appear to be highly disorganized and aggressive to others. He will typically be misdiagnosed as having Attention Deficit Hyperactivity Disorder (ADHD) or a Bipolar Disorder. His conflict is unbearable and insoluble without effective, competent treatment. "The child cannot live thinking that he is completely vulnerable, but he cannot live thinking that he is utterly bad and the cause of his own violation. These dilemmas, and the anxiety they entail, literally tear the psyche apart and expose the child to the threat of psychic annihilation" (Prior, 1996). It is this condition that creates the torment and disorder we see in traumatized children such as Darren, Ike and Jennifer.

As is obvious from the description of these children's treatment, each of them suffered from severe shame and guilt, was enraged by their intrusion, was not safe to express it directly but needed to act it out with aggression in the transference they brought into the therapy setting. It is safety in the therapeutic setting, which is accepting of the expression of aggression and rage that is the key to the child's integrating and metabolizing his feelings over his mistreatment, seeing himself as good, attaining a coherent sense of self and proceeding to adulthood (Prior, 1996). Touch and the use of the phallus are helpful agents in the accomplishment of this therapeutic purpose.

### SEXUAL ABUSE AS AN INVASION OF THE SKIN AND INTRUSION OF THE BODY

Sexual abuse constitutes an invasion and intrusion upon the body of the child. It is a penetration of the skin, which protects the child and keeps badness out and goodness in. Freud developed the notion of the ego but defined it in terms of the body by emphasizing, "the ego is first and foremost a body ego" (Freud, 1923). Anzieu (1989) described several functions of the skin:

- 1.) Maintaining the psyche as an extension of maternal holding
- 2.) Containing it as an extension of passive and active aspects of maternal holding
- 3.) Protecting the psyche
- 4.) Individuating the self by color, texture, value and race
- 5.) Associating sensory input
- 6.) Supporting sexual excitation
- 7.) Recharging the libido
- 8.) Registering information about the world
- 9.) Attacking the psyche by burning itching and disintegrating

Protection of the skin of the child and the attendant sensations by the parents results in an inchoate sense of self and a sense of safety (Scharff, 1998). Failure to protect the skin results in great anxiety and fright and fears of "leaking, dissolving, disappearing or falling into boundless space." (Ogden, 1989). People who have been abused generally experience the mother as a "void, a boundless and unprotective space, like the terrifying mother of infancy who cannot protect from disintegration anxiety" (Scharff, 1998). Children who have been seriously sexually abused such as Darren, Ike and Jennifer have a primitive fright about them. They are terrified of disintegration and annihilation and it is this fear against which they must stay defended.

Certainly the skin includes mucosal areas such as the vagina, mouth, anus and sensitive areas such as the penis. "The child whose skin is touched or penetrated erotically and aggressively by a parent or family member experiences a violation of the skin and mucosal surfaces. The rupture cannot be repaired by the dream function or by thought because dreaming and symbolic thinking have been invaded too (emphasis mine). Even if maternal care in infancy has been good, its derivatives in the skin function of maintaining and containing the psyche are now ruined, and there is a retrospective emptying out of the good maternal experience" (Scharff, 1998). The goal of therapy must then be to restore the integrity of the skin and the wholeness of the body as a receptacle of good as opposed to evil and shame. It must be to help the child recreate a healthy

ego and be able to use representative and symbolic thinking, which are necessary for mental health and any sort of freedom from anxiety and creativity.

Healthy touch by therapist and caretakers is not only recommended to accomplish this, it is demanded. Frequently, children who have been sexually abused either approach touch in a sexualized manner, as did Darren when he touched my penis, or in a very avoidant manner, as did Ike and Jennifer. In either case their relatedness to other people is damaged by the intrusion upon them and needs to be repaired. Clearly, Darren was attempting some sort of healing as he lay naked in my lap and the lap of his mother after acting out his victimization. In so doing he was trying to discover a different way of relating--one that was kind, not invasive and respected the integrity of his naked body without seeking to violate it. In the case of these children, it was clear by the actions of their body and the transference they brought into their relationship with me that they sought healthy touch. They either sought it actively by initiating it or passively by provoking it.

Typically the sexualized invasion of the skin and mucosa is recorded sensorially in the primitive parts of the brain and the psyche in the form of procedural memory (van der Kolk, 1995 ; Scaer, 2002 ;Herman, 1992). Very young children lack the cognitive function to process the recording, and, therefore, do not have the benefit of sufficient declarative memory for the event (Scaer,2001 ; Perry, 1999) Thus thought and frontal lobe activities of the brain are of little use in helping the young child deal with the assault on his body. The recording of this information is done according to the sensory state of the child at the time of the abuse (Perry, 1999, van der Kolk, 1995), and, generally the memory of that state can be recalled when he reexperiences it. It is then that the trauma associated with that state can be recalled (state dependent recall). Thus a reenactment by the child of the original assault is a typical occurrence. It allows him to reexperience an event which was psychically overwhelming for him and over which he had no mastery or control. For example, it was predictable that Darren, when faced with relating to an adult man, chose the only way he knew how, by attempting to massage my penis. It was also no accident that he would hurl guttural “fucks” and take off his clothes in the session before recapitulating his sexual relationship with his father, for those were the states he was in at the time he was being victimized. It was no accident that Jennifer, when given a phallus similar to that of an erect adult male’s, fellated it in a manner typical of a mature woman who, for the penis brought her back to the state wherein she was victimized. It was no accident that Ike needed to hold the phallus in order to discuss his victimization, for when he did so, it reenacted the state he was in when victimized. It is the joining of the child with the therapist and caretaker of the child in this reenactment that is crucial for the child to believe he is being heard, for when victimized at such early stages of cognitive development he does not have the words to communicate that would allow him to be heard. He has only actions and sensations. The phallus allows him to reexperience his sensations, his actions and the actions of his father and their attendant sensations when he was being abused. This is the stuff out of which a therapeutic alliance is formed and strengthened and successful treatment can take place.

Without the reenactment at a sensory, kinesthetic level, sexual abuse therapy with these young children is, in my opinion, a failure. The affect, feelings and sensation which still overwhelm the child must be accessed or processed otherwise they are destined to be acted out later, perhaps in the form of these children victimizing other children or, when they become

adults, victimizing other children or adults. The unaccessed, unintegrated, unmetabolized affect lies waiting like a ticking time bomb (Prior, 1996). Only therapy that allows for the recognition of the affect and it to be integrated through touch of skin and re-enactment of abuse will be effective.

### FURTHER SUGGESTIONS FOR TREATMENT

As mentioned earlier, there is now quite a bit of material available on sexual trauma inflicted on children (van der Kolk, 1996; Prior, 1996; Perry, 1999; Scharff, 1998; Herman, 1992). There is, however, very little material available on the effective treatment of these children. There are books available on traditional play therapy and the traditional treatment of children who present with neurosis (Coppolillo, 1987). Those books generally do not contemplate the sort of sexualized intrusion presented in these three cases. There is a woefully inadequate government treatment guide by Health and Human Services (2001) that suggests therapy for all sexually abused children from infancy to age 18 should be essentially the same without real cognizance of Piagetan concepts of cognitive development, the dissociative effects of trauma, concepts of state dependent learning and recall, and the individuality of each victimized child. It suggests that children younger than six should have total freedom to express themselves in therapy but then are forbidden to remove their clothes even if they need to do so to express their victimization. It does not conceptualize the traumatized body of the child as perhaps the most important medium for the child to express his/her abuse.

The report suggests that children should be able to verbalize their abuse in a safe setting but then naively goes on to suggest that a four year old's attempt to touch the genitals of the therapist should be immediately stopped and corrected without the therapist using such an attempt as an extremely important therapeutic repetition of his abuse requiring meaningful interpretation and intervention by the therapist with the child. Of course such touching should ultimately be stopped, but not without it being used to show the child that the way he has been related to and now relates to the world is wrong. To shame the child over his attempts to touch the therapist will not foster a safe therapeutic environment and discourage the child from relating his trauma and discharging it.

What I am suggesting in this paper is that severe intrusion and sexual abuse to children must be diagnosed and treated in ways that heal the skin and the soul of the child. Methods must be employed that allow for a discharge of the frozenness of traumatic fright (Scaer, 2001) Traditional psychotherapy employing only talk is frequently meaningless with these children because they have been victimized at stages in their development when they are slaves to their sensations and perceptions and have not the cognitive capability to conceptualize or explain what has happened to them. Traditional talk therapy with these children is also ineffective because it does not address the dissociative process that makes so many of their traumatic memories unavailable to them. Traditional play therapy is also ineffective because it does not involve touch of the skin that has been intruded upon and does not present toys or instruments similar to those that caused these children's victimization. If a child had been victimized by an armed robber, certainly the therapist would not withhold a play gun from the child who is working his victimization through in play therapy. There would be no fear of retraumatizing the child as the child joins with the therapist by acting out his victimization with the gun. The gun would be

seen as a necessary instrument for such authentic reenactment and working through of the event. Similarly, when there is strong evidence of sexual intrusion, the therapist should not hesitate to present a synthetic phallus to a child to allow her to act out her victimization.

If you as a therapist are going to do this work, you must feel secure in your own sexuality in order for the child to become secure in his/hers. The child is already gripped with shame. The withholding of the penis actually reinforces the notion that what happened to her was something to be ashamed of since it is not allowed to be seen or touched. The withholding of the phallus is similar to a denial that there is a 20,000-pound elephant on your elevator, for the instrument of their abuse, the penis, is like a 20,000-pound elephant in their hearts. It is by the touching of the phallus that they can have a relearning experience that this is not an instrument of shame but was an instrument that was misused by their abuser. They can recall and relate what had happened to them in a safe setting and get their therapist and caretaker to join them in this reconstructive experience. They then have the possibility of recognizing as adults that a penis as well as touch can be sources of great pleasure and reward and not necessarily instruments of betrayal, hatred and abuse. To withhold a phallus and touch from the therapeutic setting only prevents or delays these reconstructive experiences.

When a child comes into psychotherapy for treatment of gross sexual intrusion, she feels that all people including the therapist are wolves in sheep's clothing (Prior, 1996). It is for that reason these children are so resistant to the process. They are reluctant to be touched or held in a loving way or to be complimented in a loving way. They do not trust it, for they were abused in the guise of love by someone much bigger and stronger than they. Through their relationships they have been harmed. It is the job of the therapist to provide a setting that accepts the rage and aggression of the child as well as his shame. It is only then that the child can form a therapeutic alliance and begin a reconstructive process. "Only through relationship is trauma through relationship cured" (Prior, 1996).

The process of psychotherapy should result in the realization by the victimized child that the therapist is really a sheep in wolf's clothing who is allowing the child to relive the predatory and nightmarish events of his intrusion and traumatization. It should become clear through therapy that the therapist is only a medium and messenger of the traumatic intrusions and not the perpetrator of them merely because he is facilitating their reenactment by the child. It is important that the child conceptualize this as well as social service agencies and state licensing boards for mental health practitioners.

In that regard, it is incumbent upon our institutions to recognize that talk therapy or simple cognitive behavioral interventions are not enough in treating children whose developmental arrest precedes talk or the ability to conceptualize sexual intrusion or whose dissociative process is so significant that meaningful recall and reenactment is defended against. If our institutions insist that the treatment of these children remains a sterile, superficial exercise as opposed to an active, sometimes aggressive and violent reenactment of aggression and sexual violence, then there will be little movement forward in the relief of the emotional burden these children bear. It is up to these institutions to concern themselves with the welfare of the patients and not with what they perceive to be the political correctness of their positions. Failure to

acknowledge what is really required in treating these damaged children will result in ruined lives for these children as well as for many others.

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