# My first encounter with Sexual Abuse

## *My Early Experience*

I want to begin by outlining my credentials for writing about sexual abuse of children.

In 1976 I joined the staff at St. Charles Youth Treatment Centre, was a secure resource run directly by the (then) Department of Health and Social Services for the most dangerous and disturbed adolescents in the country. It was a brave idea created by the Social Service Inspectorate following the case of Mary Bell. The point is that there was nowhere appropriate to put this clearly disturbed child. The social service inspectorate believed that she was potentially treatable, also that there were likely to be a significant number of potentially very dangerous adolescents who might also be treatable. Following their advice a premises was discovered in Brentwood, Essex, initially designed to be a 'borstal' or youth detention centre. At that point they said they thought that an approach combining Therapeutic Community and psychoanalytic ideas would probably be worth trying and then they left the Director and his staff to see if they could find out what worked. They felt that a key to its success was to appoint senior practitioners from teaching, nursing and residential child care.

In 1978 I was appointed leader of one of the two 'treatment' units. At this stage we were beginning to get a handle on some essentials; apparently I got the job because of my argument that the task was to provide these young people with an experience of being 'contained' in a relationship rather than the physical building. To this end I suggested that a careful and regular enquiry into the emotional impact the kids were having on the staff would enable us both to understand something about them but also to organise ourselves around the concept that this emotional experience was the real connection with the underlying problems these kids were suffering from.

By 1979 violent incidents had pretty much disappeared. A particular young woman started to feature more and more in the clinical discussions I held with my team on Thursdays. There was an interesting division of views about her but, more interestingly from my point of view, about the different approaches made by individual staff to working with her. In brief, a number of male staff found themselves have deep and meaningful conversations with her during the shift. Often isolated from the rest of the team. Others of the male team were anxious about being left alone with this patient. Half the women perceived the girl as highly sexual and manipulative and they didn't like her. These women expressed anxiety about the 'counselling' men getting caught up with her in an inappropriate way. Although the Sexual Offences Act decriminalized private homosexual acts between two men over 21 in 1967, a large number of gay men either denied to themselves their true nature, or went to enormous trouble to hide it from others. One such man was part of the staff team and his reaction to this girl was to become incomprehensibly angry with her. And then there were another group of women who didn't know why people were making such a fuss.

## *Impact of child on staff group*

My attempt to understand the meaning of this dynamic led to a shocking conclusion. My thoughts developed like this: first there was the way that some of the male staff seemed drawn into close relationship with the young woman, so much so that some of the female staff were very concerned about their 'safety', these women also saw the girl as highly sexual. Interestingly there were others of the female group who seemed not to notice anything. Those men who were anxious about being alone with her couldn't express what raised their anxiety, only that they felt it. [These days, partly as a result of this early

experience, I take the view that 'anxiety' is merely the name we give to a feeling that has not yet been named.]

On the face of it, one might form the conclusion that this was an adolescent young woman thrilled by the potential of being a sexual adult and engaging in provocative seductive behaviour. However, I had, by now, learned to look for what was 'hidden' and to be highly suspicious of the 'apparently obvious' interpretation; experience was teaching me that the surface 'behaviour' was more often a coded message not a confession. I tried to open my mind to what else had that 'shape' about it. Which is when I realised that it was what we then called 'incest'. It wasn't that sexual abuse of children was unknown, it occupied the caseload of many professionals, particularly social workers and those working in child guidance clinics. It's just that nobody had really captured the full extent of this, which is why it wasn't a 'go to' hypothesis for the understanding of those young people I was dealing with.

In what follows I shall try to describe the more detailed discoveries we began to make once we'd understood what we were dealing with. Or, rather, what the young woman was presenting to us.

More shocking was that, once we were familiar with the patterns set up int he staff group in the context of sexual abuse, we discovered that more and more of our adolescents had been abused. Our attempts to speak of the extent of this abuse, certainly within our population of kids, revealed massive resistance in a very large number of professionals.

## *Impact on the child*

These early experiences provided me a baseline for understanding both the damage that sexual abuse of children does to the victims, as well as the recognition of the complex processes involved in the provision of treatment. It also revealed an unexpected difficulty in achieving social and professional recognition of society's complicity in a continuing epidemic of such activity. The Paedophile Information Exchange represented what might seem to you an extraordinary voice; they were campaigning for the reduction to the age of consent to sexual relationships and had managed to insinuate themselves inside the National Council for Civil Liberties (NCCL), now known as Liberty, and the British Association of Social Workers arguing that to challenge the right for children to have sex was a transgression of their civil liberties. Fortunately my institution was not the only place that was discovering the huge amount of sexual abuse going on in our society and this dreadful organisation was ejected from both these bodies and the members of it were investigated by the police.

To return to the description of what I learned from this early experience of the encounter with people who had been sexually abused, the more we came to terms with the shocking discovery of the extent of this abuse, the more we noticed how the abusive activity was represented in the emotional experience of staff in the context of their relationships with the young people. For example, night staff, from time to time, would be accused by children of inappropriately going into their rooms at night. Day staff would be subject to direct accusations of breaking boundaries with children. The boundary breaking was rarely manifestly sexual; more often it was about breaking the rules of the treatment unit. For instance, offering a young person cigarette (please bear in mind that almost everybody smoked in those days and kids were allowed to smoke from the age of 16).

We realised that we were witnessing a phenomenon previously associated with shellshock (post-traumatic stress disorder had not been named at this point); specifically, the inability to symbolise the traumatic experience which meant that it was only ever relived. Thus, we could see that the children who were accusing us of boundary breaking and experiencing us as untrustworthy were providing important information about their experiences and their need for those experiences to be understood. Therein lay a hope this raw experience, by which I mean unsymbolised could be transformed gradually into symbols that could be thought about. Realising that sexual abuse traumatises the victim, we found ourselves in a position to think about the importance of the provision of a mechanism to transform 're-enactment' into 'information that can be thought about'. In other words, 'acting out' around the boundary could be seen as a crucially important means of communication with the staff group, enabling the staff group, who had the ability to symbolise the emotional 'battering' from these kids could turn that raw experience into something that could be thought about. But we also learned, entirely by trial and error, that handing back our 'understanding' of the emotional experience each had had of being abused, merely made them feel abused by us. Just because we could symbolise the emotional experience of being with them, didn't mean they could. We had to contain this and only comment on how anxious they were that we were going to hurt them; we 'contained' their emotional experience, trusting that there would come a time when they had restored a capacity to symbolise and would be able to explore those feelings for themselves. Not only had the staff team, through offering emotional relationships with the young people changed the provision of safety from walls to relationships, it became a container in the true sense of container/contained as Bion described it.

I must add that it was serendipitous that my earliest experiences of child sexual abuse should occur in the context of working with adolescents. This provides me with the perfect segue into talking about treatment. However, I must first describe something of my understanding of the adolescent process to give a proper context to the challenge of treatment.

# Theory

## *Development*

In my view, it is the interference with the process of adolescent development that shows most clearly the damage that sexual abuse does. For this reason, I need to describe my own approach to understanding the adolescent process and I shall start by applying a principle that I hold to be essential to the psychoanalytic task, to begin at the beginning rather than at the point of encounter.

Affects, or feelings, are the means by which we are aware of ourselves and things around us. If we did not feel, nothing would happen; feelings are the psychic experience of ourselves and the world around us. Some feelings are linked to physiological states, but others are clearly more abstract, more mental.

This was the first discovery for Freud, who observed that feelings, and the management of them, are what life is all about. His next deduction had to do with the link between feelings and behaviour. He realised that animals are aroused to action by feelings. He called this process "drive theory". He took the view that human behaviour, like that of animals, was based upon drives and their fulfilment. He argued that the organism experiences a feeling as intensely uncomfortable, he called this unpleasure, to such an extent that the only release is to act to find the 'object' that would satiate the feeling. Which means to remove

it. This allowed him to suggest that all organisms sought a state of stasis, meaning the absence of stimulation. This was later the basis for his concept of the death instinct. At this point he described this behaviour as the pleasure principle meaning that emotional stimulation was experienced as unpleasure and it was this that forced the animal act to remove it.

We know that it is the intensity of the emotion that drives the animal to act. What does the infant do that makes it possible for them to think instead and, in doing so, face reality. I hope you forgive me for making this story into a brief paragraph. First, as suggested by Bion, human beings have a built in Curiosity drives that operates (and he called this mechanism alpha function) constantly to explain to themselves what is happening to them. The first 'explanations' had already been discovered before this crucial insight and were called the primitive defences. A quick perusal of these shows that all of them create a space between the source of the feeling and the self. I suggest that this has the impact of reducing the intensity of the emotional experience.

Once the intensity is reduced, there is space for the infant to develop the capacity to symbolise. Alpha function (what is going on here?) transforms the raw material (beta elements) into alpha elements. All that the infant requires now is an experience that will provide a 'template' for the space for thinking. This is provided by the process of 'container/contained'. These are the necessary steps that enable the infant to explore 'reality'.

The unremitting activity of alpha function enables us to 'learn from experience'; yesterday's explanation will never quite provide the answer to today's question, 'what's going on here?'. However, we can continue to cling to the same 'explanation'. Which is very damaging to development. I shall return to this.

## *Adolescence*

We must now make a big leap from early infant development to the adolescent stage.

Freud claimed that there is a significant difference between the 'phallic' and the 'genital' stages of development. His theory is supported by neuro-science using MRI scanning to show the changes in brain function. This is confirmed by the known fantasies of children and adolescents; it is only with adolescence that fantasies develop a particular sado-masochistic element that clearly leads to the urge to penetrate or be penetrated. Before puberty, these urges do not appear in fantasies. These facts help us to understand why child sexual abuse is so damaging.

Prior to puberty, the images of sex are encapsulated within a masturbatory context. This does not mean that a child doesn't imagine sex with other people, it only means that the concept of sex is masturbatory. In the adult world we encounter patients for whom sex is only either masturbating inside the other or using a man's penis as a dildo.

A child is not capable of understanding sex between two adults simply because the hormone and brain changes that provide that 'concept' have not happened yet. Sexual abuse is abusive because it deprives the child of the discovery of these changes by prematurely imposing an experience for which the child's 'explanation' does not change in the light of experience.

Mo and Eglé Laufer defined the task of the adolescent stage of development as 'to take possession of the adult, sexual body'. The successful journey through adolescence leads to the discovery of the adult, sexual identity.

The experience of the impact of the biological changes that I referred to earlier, as with all conscious arousal, are experienced as feelings. By now the child has developed a complex collection of symbols or images that can be evoked by feelings. The curiosity drive requires the child to explain current experience deriving from what is already known. Thus, the explanations for sexual urges begin in most adolescents as disturbing images of wanting to do something to somebody else. These images of "doing" accompany very powerful feelings and the combination of those images with the intensity of feeling can be very disturbing.

The normal adolescent process involves joining with groups of other adolescents to explore together the urges, the wishes and how to manage them. This process takes time and involves a great deal of adaptation towards those feelings and of their sense of identity. It is clear, however, that the unsettling powerful feelings will push adolescents towards a yearning for some kind of certainty that will rescue them.

The child who has been sexually abused can manage the question about adult sexuality in a very simple way; "I already know this I have been part of an adult sexual relationship, there is nothing for me to achieve here, I have already achieved it". This 'explanation' acts as a full stop to further exploration, it offers the yearned for state of certainty that I referred to earlier. Certainty does not allow learning from experience, only 'not knowing' can do that. So, what happens when an 'explanation' does not change in the light of further experience? [I told you I'd come back to this]

The answer was first described by Britton (1998) who said that it becomes an unconscious belief. Such a belief is treated as a fact'. I would add that this is often hardly noticed, the factual nature of it means that it simply fits in with the view of the world. It is only when the belief is made conscious that there is a need to do something about, which is to test it against reality. We might say that this is the task of therapy, to uncover the patient's unconscious beliefs in such a way that he can feel able to explore them.

Thus, the sexually abused child at the point of the beginning of the adolescent journey believes that he has already achieved an adult sexual identity through the experience of having sex with an adult. This is not experienced as a belief but a fact. It also creates an over-valuing of the concept of experience; which will re-emerge in the discussion about expertise.

# Therapy

## *Resistance*

It is my view that the boundary is where the real work happens. This is not the place, nor do I have time, to describe more about this idea and what falls out from it in terms of both practice and ethics. Instead I can say something about the importance of setting the boundaries and the two activities conducted by the therapist, within the 'therapeutic container': in the centre is the encounter with the patient in which a benign enquiry takes place, at the boundary those events that have been described so often by psychoanalysts; transference, projection, projective identification and so on occur. It is the work at the boundary that is emblematic of psychoanalytic therapy.

This container is both a source of security and the site of massive anxiety, particularly for patients who have been abused. Although many people, including most patients at one time or another, form the belief that the therapist has an aim, a plan for the therapy, nothing could be further from the truth. The psychoanalytic process works properly only in the absence of such a state of mind within the therapist, whose approach has been variously described as 'free-floating attention' (Freud), 'negative capability' (Keats) and 'without memory or desire' (Bion). It has become customary to include Keats' definition but I'm not sure whether anyone has explained why. If you go back to the source, a letter written on 21st December 1817, you will find a simple but brilliant definition but, more than that, he gives a context for his idea; this state of mind is the source of real art, and the example, William Shakespeare. For me this is deeply reassuring because, although there is a serious scientific version of psychoanalysis, to which this paper is a minor contribution; the other version of psychoanalysis, the process of therapy, linked though it must be to the science, only works if we accept it is an art. I find the knowledge that we are practicing an art deeply reassuring when I allow myself to slip into a state of mind in which I give up any expectation of certainty or, indeed, understanding. At least in a conscious, cognitive way.

And now for the unique process of working with the victim of sexual abuse. This is someone who has been traumatised in the proper sense of that word.
Shell-shocked soldiers of the First World War were traumatised because they had no expectation of the actual experience, which was a tsunami-type shock. And the tsunami wiped away or totally closed down alpha function; there could be no mechanism to provide symbolic representation of what occurred, the event belonged to the state that Freud had called the pleasure principle. Only action would be possible and that action was to get the hell out of here.

A problem for therapists is that victims of trauma are aware that they were victims of trauma. They have a memory that such an event took place. So it can seem possible for them to speak about the event as if they are speaking about the actual experience but 'speaking about' is not the same as genuinely "remembering it". Real remembering is being able to articulate the feelings of the moment of trauma and that requires the capacity to symbolise.

Thus we may perceive that there are two levels from which the 'trauma' can be described, the memory that it happened and the emotional experience itself. To do the latter requires the re-creation of symbolic function which would fall into the task of the therapist.

And then there's an extra problem, which I shall come back to at the end of the paper. Creating a narrative from that position, detached from the actual experience can and very often does serve to protect the victim from the danger of encountering the actual feelings. Such a narrative will serve to cover up the real experience along with the consequences of that experience for one's identity. What I mean by this is that the traumatic experience has to be 'explained' while it is happening because of the built in alpha function: what's going on here. Whilst there are a range of possible explanations reflecting the differences between individuals, all these explanations have to help the victim to manage the experience of the sexual abuse. Whatever explanation the victim settles upon will act as closing the door on further investigation; this creates the ubiquitous characteristic, 'no damage was done'. The way this happens is explained by Ron Britton's idea of unconscious belief. The explanation is protected by a combination of repression and the accompanying implementation of the belief. I have found over the years that there is a way in which being a victim of trauma is

such a powerful shock that it is essential for an instant unconscious belief to develop to the effect; 'I can manage this'.

Many people come for treatment for trauma a considerable time after the traumatic event. Often because of a psychological collapse. I am saying that this is because the apparent ability to describe the events of the trauma actually served to maintain the unconscious belief that no damage has been done, in the case of S/A specifically, that I was enabled to become adult earlier than my friends.

So the therapist encounters a patient who is able to acknowledge that it happened, (I am aware that some victims come without any idea that they have been abused, I consider this to be in the realm of dissociation, and I don't have the time to address this type of presentation). In the course of the therapeutic encounter the therapist will be faced with communications that appear to be the expected types of unconscious to unconscious events. Her job is to recognise that the exchange between herself and her patient will be out of sync. The therapist who opens herself to not knowing, will have an experience that she is able to transform into a symbol to be thought about. The problem is that unlike any other therapeutic engagement (except with borderline personality disorder patients), any attempt to share her understanding of what has been going on between patient and therapist will be experienced by the patient as abusive.

The reason that this is so relates to what I have introduced as the concept of unconscious beliefs. In the case of the victim, the unconscious belief which protects them from the agony of continual re-experiencing the abuse, is that they became prematurely adult. There are various associations held unconsciously within this belief that must be worked through before it becomes possible to think with the patient. This might take a very long time because the therapist has to find the gentlest path to opening up the discussion, not of the patient's past but of this current therapeutic relationship. The therapist will need to notice the patient's unconscious communications, that are always expressed as some form of action towards the therapist, so that she can comment about the patient's experience of her rather than the analyst's interpretation of what's going on in the patient. John Steiner, in the context of working with borderline patients introduce the idea of the analyst-centred interpretation for identical reasons that I am referring to it here. If you tell a patient that they are feeling this or that feeling or that they have some idea consequent upon some kind of feeling, the patient will experience you as abusively pushing into their mind. The exchange between therapist and patient is always on the boundary, even when it appears to be a benign enquiry because of two things;

1. the absence of symbolisation for the patient and
2. the terror of having the unconscious belief that protects them from discovering the reality of how it felt to be sexually abused ripped away from them

A simpler way of putting that is that the preconception of a loving, kind or benign attitude in the other has been replaced with the certainty of something invasive/abusive.

For example, a patient who has a sibling who was also a victim of sexual abuse, will often bring to the therapy a commentary on this sibling. Usually in the form of a criticism about his apparent disregard of the abuse. He gives the impression that it didn't happen and the patient gets angry about the way that the sibling has chosen a career that is on the border of sexual abuse, for instance he is a social worker and encourages his clients to take legal action against the abuser.

The therapist notices a pressure to engage in a discussion about the sibling, perhaps feeling that here is an opportunity to talk about something equally controlling in the patient. This temptation will miss the point that the apparently intelligent, even compelling analysis of the sibling's displacement outside himself of his own, denied, experience of abuse is not a form of thinking, it is a form of action. The words are used to batter the therapist into an engagement that appears to be adult. Thus, confirming the unconscious belief that the patient simply achieved an early move from child to adult.

Perhaps it is possible to see that, in this encounter, once one realises that words can be used as 'things' to penetrate the therapist's mind or the therapist's capacity to manage 'not knowing', there is a clear re-living of the abuse. You could say that a premature claim of adult capacity - in this case thinking - is being brought into the therapeutic container in an attempt to get the therapist to agree that real, adult functioning has been achieved.

Another example might help to understand this point. When I was the leader of the treatment unit at St Charles Youth Treatment Centre, I came over to visit the house (as we called those units) and was greeted in the living room by one of the young women, a very sexual person. She came up to me and asked if she could ask me about something that had been disturbing her. She began to talk about developing fantasies of being beaten and dominated by a sexy older man. I tried to talk to her about how she felt about these fantasies. The conversation went on in that vein until I noticed with shock that I was no longer standing up but lying beside her on one of floor cushions.

This was one of those early experiences that taught me about the complexities we are studying today; here was an apparently normal, therapy-type encounter in which I appeared to be treated as a respected adult. But the apparent conversation, at least from the unconscious part of the young woman, was actually an action designed to create a re-enactment of sexual abuse.

I am very lucky to get to 'supervise' some talented therapists, lucky because I get to learn from them. This is a vignette from a recent meeting in which the supervisee was describing a session with a patient who had lost a very loving father at the age of 4. She is not a victim of sexual abuse but her trauma about the loss of this wonderful dad was not attended to in a family in which everyone's attention at the time was on the mother, who had collapsed in the face of the loss of her husband.

Today the patient is staying at her mum's; her brother and his family, who live there, are away, so she's alone with mum. This is the place she grew up. The session is online.
She says that she had wanted to start to think about her wish for a relationship. She stops speaking.
Therapist says, "perhaps it's difficult to speak there", meaning in mum's house
Patient replies, "no, it's ok, but I have no thoughts.
The therapist recognises this statement, the patient will often say, there are no thoughts.
Sometimes in the silence, her eyes move from side to side.
Therapist, "what are you thinking?"
Patient, "about my niece… who lives here, 5 next week… a telephone call with the child who told an excited story about watching a screen on the back of the chair in the car on a long journey. She was excited because it was a freedom that she wouldn't have at home."

The therapist had the thought that, in telling this story, the niece's lived experience allows the patient to experience something more held inside her.

My understanding of that was that this process was possible because the niece story also symbolised the patient's emotional experience of being with her own father. The patient is offering this image as the alternative to 'no thoughts'. She has found the beginning of symbolic representation of what she lost when she lost her father.
The therapist did not express her own thinking but said, "something happened to you at this age but you weren't able to share it".
The patient's reaction was to become stone-faced.
The therapist asks, "does it make sense?"
The patient replies, "yes, but I can't change it. I have no thoughts"
After a pause, the patient tells another story, this time of what a delightful father her brother is; she describes a video of him playing with his daughter (her niece).
The therapist says, "You are showing me what it might be like if you could do what your niece has done; the alternative to 'no thoughts'."
The patient starts to cry.

Now let me be clear here; these enactments are not an expression of anything destructive from the patient, in the absence of the capacity to symbolise, they are actions that re-create something. In that sense they are the unconscious attempt to be understood. All that I am saying is that the therapist has to recognise that the real message is in the enactment, not the words, so she has to be aware that a 'symbolic' response will also be experienced as an 'action' and address that by describing how the patient fears that the therapist will be unable simply to note that something is happening that is very difficult to put into words. Monitoring this form of communication will help the therapist to sense when 'action' is beginning to change into the beginning of symbolisation.

In this regard, it is important for the therapist to be aware of a different sort of communication. This arises when the patient appears to be speaking about the abuse. This time the job of the therapist is to distinguish between a stumbling attempt to describe feelings and an 'intellectual' commentary on the memory that the patient was abused. The key to recognising the difference is the way feelings are expressed. When the victim is genuinely in touch with the event itself, there will be feelings to do with wanting what happened and the expression of shame or guilt or confusion. There is never confusion in the commentary about the memory that it happened, because a description of the event from the outside, 'that this happened to me' acts as a means of defending against having to re-experience the feelings involved in the actual abuse  The memory that it happened leads to distortions which I want to describe next.

## *Expertise*

I have in mind the victim who remembers 'that it happened' but has not yet been in touch with the feelings aroused during the abuse, and yet chooses not to get therapeutic help. Juxtaposed with this type of memory will be socially based ideas that abusers have so often themselves abused. This is a terrifying idea and, without therapy, has to be addressed in some way. In my experience there is only one way to deal with this fear and that is to provide oneself with an internal container that acts like a shell or carapace to lock away the danger. This shell is always constructed from rules about behaviour. As well as these rules applying to the victim, they are, by default, applied to everyone. Especially others whose behaviours might appear suspect or even dangerous.

One of the worst sort of event that can happen in a reflective practice group is when a new member of staff, having been introduced to the facilitator, says, "I think I should tell you

that I have been sexually abused as a child." As facilitator, you know, as they utter the first 6 words, what they are going to say but there is no way to stop them.

What happens to the group? The group experiences this as an action, the placement of an embargo on ever being able to talk about sexual abuse. To slow down the process for the sake of clarity; the new member of staff, sounding like someone sharing in an adult way, is actually 'acting'. The action is to pull the team into the same, carapace-like arrangement. Locked away is the teams' ability to talk about the experience of sexual abuse that they are receiving from their patients; it is all the emotional material… emotional material that the team has, hitherto, been able to process through their intact symbolic function. This has now been locked away in a direct reflection of what this new member of staff has already done to themself. In doing this, they have imposed on the group (action, not a genuine communication), their identity as an expert on the subject and also the unconscious communication, 'I am very vulnerable'.

Of course, this is the point in the paper that I regret not using a PowerPoint. This is because it is easier to show in pictures the significance of this internal container which is protected from the view of the victim by an unconscious belief. And how this identical arrangement is created in someone by a 'survivor' identifying themselves either as a victim of historic abuse or as an expert by experience. The locked away container contains the emotional material. For the victim, this is the material that remains unsymbolised; for the unsuspecting other, it is their emotional response to people who have been abused, particularly therapists who are treating such people. In the absence of a drawing, the best I can come up with is that the clinician is suddenly non-platformed; as if their understanding of abuse based on a large data-base is felt to be 'traumatising' by the expert by experience.

It follows that any expression of the capacity to experience and think about the emotional experience of abuse is a threat to this arrangement. The simple resolution to this threat is to put a carapace over it, just as the victim has already done to their own emotional experience. The unconscious belief, 'I have achieved adult sexual identity', must mean, 'I have managed my own history of abuse'; it follows, therefore, that I have expertise in understanding sexual abuse.

I am adding this section at the end of this paper to address the reasonable question, what gives me the right to speak of these things? It is this question that has informed the way I have structured this presentation because I too am claiming expertise. Essentially that I have authority to describe the challenges of working with victims of sexual abuse.

The absence of the symbolic function leaves the trauma victim to describe to themselves an external view of the experience but without access to the emotional memory, which, without help, remains unsymbolised. This results in a commentary created entirely within the conscious/cognitive mind which, rather similar to AI, provides a compelling description but with the over-arching atmosphere of certainty; there is no space for not knowing, for that state of mind described as negative capability. It allows for a label of 'expert'. I have witnessed the impact of this on panels of inquiry into such things as historic child abuse. These panels include people who are identified as 'experts by experience'. I am not challenging the inclusion of such people, only the simple error that their expertise is in the same category as someone who has worked with many victims. The latter really are 'experts' because their data-base is large; the 'expert by experience' is expert in only one experience, their own and that, if they have not had the help necessary to activate symbolic

function precisely in the actual, personal experience of abuse, is more an intellectual commentary.

This problem in such inquiries is the reason why they take so much longer to reach any satisfactory conclusion because, in an identical group dynamic to the one I described in the reflective practice group, the panel has been set up to fear that their emotionally-based understanding of the issue is actually abusive to these colleagues. The claim of expertise is an action that recreates the scenario of the abuse. Exactly like it was for my staff group at St Charles all those years ago.

My own position right now is that I am eager to hear your thoughts and views, so that I can learn from them.

Thank you for your kind attention.