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The Instability of Emotional Bonds in Childhood and Its Relationship to Sexual Abuse

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Abstract

Inconsistencies and instability in primary emotional bonds during childhood often create contexts of neglect that heighten subjective vulnerability to child sexual abuse. This study aimed to explore pre-existing deficiencies in emotional bonding and caregiver neglect prior to the occurrence of sexual abuse through a qualitative, descriptive, and hermeneutic approach. Analyzing the life histories of two clinical case studies (a 14-year-old girl and a 10-year-old boy), hermeneutic interpretation suggested exploratory hypotheses regarding how early attachment instability and caregiver neglect may compromise self-protection mechanisms, distort identity formation, and foster feelings of worthlessness. These proposed mechanisms are presented as non-causal clinical hypotheses, maintaining explicitly that sole liability and fault for sexual abuse rest entirely with the perpetrators. Findings underscore the value of integrating primary bond stabilization and parental reflective capacity into child protection frameworks.

Keywords

Emotional Bonds, Neglect, Child Sexual Abuse

1. Introduction

Child sexual abuse (CSA) constitutes a severe rupture of bodily and intrapsychic boundaries, executed through relational power asymmetries, authority, manipulation, or coercion. Although these traumatic events manifest across various socio-environmental contexts such as educational institutions and public spaces, they occur predominantly within the domestic sphere. In Mexico, data from the Senate of the Republic (Senado de la República LXV Legislatura, 2023) indicates

that approximately 5.4 million children and adolescents have experienced sexual violence, with 60% of cases perpetrated by family members and 40% by non-familial individuals. Despite the implementation of prevention frameworks, this population remains uniquely vulnerable due to developmental dependency.

According to UNICEF (2017), CSA encompasses a continuum of invasive behaviors ranging from non-consensual physical contact to penetrative acts. When perpetrated by an intra-familial figure, the traumatic impact is severely amplified, inflicting profound damage on the child's integrity, dignity, and psychological organization. Furthermore, feelings of fear, unconscious shame, and guilt contribute to pervasive underreporting. As Hameed (2021) notes, the convergence of abuse and structural neglect yields severe developmental adversity; thus, the efficacy of primary and secondary intervention initiatives relies on targeting underlying risk factors and enhancing parental reflective capacity regarding protective child-rearing practices.

From a psychoanalytic framework, Janin (2009) argues that intra-familial sexual abuse frequently operates through a compulsion to repeat, inflicting structural damage on ego consolidation and identity formation. This traumatic intrusion impairs the child's capacity to process and communicate affective states, thereby destabilizing psychological maturation and the structural organization of the self. When primary object relations are characterized by inconsistency and emotional neglect, the child's protective shield is eroded, leaving the ego vulnerable to states of psychic helplessness. Consequently, sadomasochistic relational patterns may become internalized, leading to ego splitting and self representations dominated by feelings of worthlessness. Intra-familial abuse thus establishes hostile and incestuous object ties that impede self-other differentiation and obstruct the development of a bounded intrapsychic space.

The weakening of primary emotional ties leaves the child vulnerable to persistent psychic helplessness and emotional distress. Under these conditions, sadomasochistic object relations may become internalized, leading to ego splitting, a pervasive sense of defectiveness, and an unconscious perception of being inherently bad, dynamics that drive the child to systematically avoid genuine affective closeness. When sexual abuse occurs within the domestic domain, hostile and incestuous object ties prevail, severely obstructing identity consolidation, self-other differentiation, and the elaboration of integrated intrapsychic representations. Conversely, when the abuse originates from extra-familial sources, the trajectory toward post-traumatic integration is more favorable, provided the family apparatus functions as a protective containment system.

Winnicott (2016) argues that healthy ego development requires the presence of a "good-enough mother" who provides adequate holding and adapts to the infant's physiological and emotional needs. This capacity involves setting aside parental narcissistic demands to accommodate the child's emerging subjectivity. Such maternal attunement facilitates the gradual differentiation of the child's self from the primary object and allows the construction of a distinct intrapsychic

space within a safe, protective environment. However, traumatic intrusions of this nature inflict profound scars on the psychic apparatus. These sequelae are exacerbated when primary caregivers deny the abuse or disavow pre-existing patterns of emotional neglect and parental indifference. This systemic failure of protection constitutes a form of relational violence that exposes the child to chronic abandonment and environmental risk factors (Prieto et al., 2019). Indeed, incidents of sexual abuse frequently occur in contexts marked by deficient parental supervision, which creates structural vulnerabilities that perpetrators exploit (Niassy et al., 2025).

As Gutiérrez and Lefèvre (2019) emphasize, parental responsiveness and protective attachment ties are fundamental pillars for post-traumatic recovery; thus, comprehensive rehabilitation requires specialized interdisciplinary intervention targeting both individual trauma and dysfunctional family dynamics. Regrettably, parental awareness is frequently compromised; the occurrence of abuse, whether intra- or extra-familial, often confirms pre-existing dynamics of developmental neglect. When confronted with the reality of abuse, parents frequently resort to denial or minimization as defensive mechanisms to disavow their own protective failure. For the victimized child, this environmental failure creates a profound subjective crisis. Disclosures met with invalidation, victim-blaming, or humiliation compel the child to adopt silence as a defensive posture against further rejection or intimidation. Ultimately, the mistrust, invalidation, and hopelessness experienced by the child represent a continuum of early attachment vulnerabilities that have been established since the earliest stages of development.

The deleterious consequences of child sexual abuse cannot be evaluated in isolation, as traumatic experiences are structurally intertwined with pre-existing or co-occurring patterns of emotional neglect and maltreatment. As Uribe (2010) posits, clinical manifestations such as post-traumatic stress, dissociative disorders, academic impairment, language deficits, and suicidal ideation are pervasive across diverse forms of child abuse rather than pathognomonic to sexual trauma alone. However, the traumatic event induces a severe rupture among affect, speech, and representation; during the intrusion, adaptive responses fail, giving rise to defensive operations that manifest through heterogeneous psychological symptoms. Furthermore, because sexual trauma intersects with moral consciousness, pervasive feelings of guilt and shame predominate, intensified by the moral condemnation embedded within family and educational structures.

According to Losada and Jursza (2019), specific dysfunctional family dynamics frequently characterize environments where sexual abuse occurs, including domestic violence, intimate partner conflict, and an intergenerational transmission of childhood trauma. These family systems are typically marked by socio-emotional isolation, deficient support networks, diffuse generational boundaries, and role-blurring vulnerabilities that stem directly from early inconsistencies in emotional bonding.

Emotional bonds originate prior to birth through parental cathexis and unconscious fantasies surrounding the anticipated child. Dolto (2000) highlighted that while initial bonding is mediated by fantasy, the infant's birth necessitates a realignment of parental expectations, ideally giving way to real relationships grounded in protective holding, security, and affective attunement.

Consequently, clinical assessment must transcend a reductionist focus on the isolated abusive incident to encompass the child's complete relational and developmental history. Mental health professionals are tasked with constructing a comprehensive psychodynamic understanding to establish a protective containment space (holding) that enables the traumatized child to initiate psychic reorganization. Accordingly, the primary objective of this study was to identify structural deficiencies in primary emotional bonds and patterns of neglect preceding the occurrence of child sexual abuse.

2. Method

2.1. Participants and Ethical Considerations

This study employed a qualitative, hermeneutic methodology grounded in a psychoanalytic theoretical framework, focusing on the interpretive analysis of subjective experiences, relational dynamics, and intrapsychic structures associated with early attachment and trauma. Participants were selected through purposive sampling from a university-affiliated psychological clinic at the Autonomous University of Zacatecas, Mexico. Inclusion criteria required: a) a documented history of extrafamilial sexual abuse during childhood or adolescence, b) active engagement in psychological therapy, and c) availability and willingness of primary caregivers to participate in developmental history evaluations. The sample comprised two clinical case studies: "Susy," a 14-year-old adolescent female (evaluated alongside her biological father and stepmother), and "Joe," a 10-year-old male child (evaluated alongside his biological mother and stepfather).

Informed consent was formally obtained from the participants' legal guardians (parents), alongside written assent from both minor participants following age-appropriate explanations of study procedures, confidentiality limits, and voluntary participation. Formal review and approval by an institutional ethics committee was not required under local institutional regulations for this qualitative clinical case study, as it was based on non-invasive retrospective clinical process notes from standard psychological care. The study strictly adhered to the principles of the Declaration of Helsinki (World Medical Association, 2024) and the Ethical Code of the Mexican Psychological Society (Sociedad Mexicana de Psicología, 2015). Pseudonyms and altered non-essential biographical details were used to guarantee anonymity. Specific authorization to publish anonymized clinical case summaries was granted by the legal guardians. In scenarios where family environments presented potential ongoing risks, independent clinical safety protocols were established, mandating immediate reporting to child protection authorities (DIF) in accordance with national safeguarding laws.

2.2. Procedure

Data collection occurred across two sequential phases within a specialized psychoanalytic clinical setting. Phase 1 involved two semi-structured clinical history interviews (60 minutes each) with primary caregivers to reconstruct the participants' developmental trajectories, family history, and early attachment dynamics from conception onwards. Phase 2 comprised eight individual psychotherapeutic sessions (50 minutes each) per child participant, conducted by a licensed clinician-researcher. Primary analytical data were gathered through detailed process notes compiled immediately following each clinical session, capturing verbal accounts, non-verbal indicators, affective play, and relational dynamics.

To verify that identified relational difficulties and caregiver neglect preceded the onset of sexual abuse, a rigorous chronological cross-referencing procedure was executed. Timelines derived from intake developmental records, medical/school records, and caregiver histories were systematically mapped against the children's retrospective clinical narratives. This chronological triangulation confirmed that primary bond instability and environmental neglect were established prior to the abusive events.

2.3. Procedure Data Analysis

Clinical process notes and interview transcripts were evaluated using qualitative content analysis and hermeneutic interpretation (Souza, 2008). Operational narrative indicators were established a priori to classify key theoretical constructs: "bond instability" was identified through narrative accounts of unresolved maternal loss, chronic parental conflict, contradictory caregiving expectations, and caregiver emotional distance; "neglect" was categorized through documented unmonitored environmental hazards, physical trauma resulting from lack of supervision, and systematic invalidation of the child's emotional state.

Themes were developed iteratively and compared cross-case to isolate commonalities and divergent relational configurations. To maintain analytical rigor and address potential researcher bias, the clinician-researcher systematically examined countertransference dynamics, therapeutic relationship influences, and alternative diagnostic hypotheses (e.g., primary organic anxiety disorders, neurodevelopmental variations, or acute stress responses independent of attachment history) through weekly peer clinical supervision.

3. Results

3.1. Case 1 Susy

Susy is a 14-year-old girl in her third year of middle school. She was referred by her school due to high levels of anxiety and for telling her classmates that she was sexually abused by a man in a vacant lot after her sports activities ended; she says she took a shortcut to get home because it seemed easier. To date, she has not told her parents about this incident because she is afraid they will punish her for going to that place and coming home so late. Since that incident, she says she has felt

very desperate and guilty; during the day, she binges on food and then vomits. Susy lives with her father and her stepmother; she says she loves her dad very much, but she misses her mother terribly. Her mother left when Susy was 4 years old. She remembers that her parents constantly had very heated arguments. One night before her mother left, she asked Susy if she wanted to go with her or stay with her father; Susy replied that she would stay. The next day, her mother left, and Susy never heard from her again.

Her father hasn't given her a credible explanation; her aunts, her mother's sisters, reported her as missing, since no one has heard from her. They've even told Susy that her father might have done something to her. Her aunts told her that on one occasion they went to investigate the house and were digging in the yard when they found her mother's cell phone; because of that, they told her that her father might have killed her. When her father found out what her aunts had told her, he forbade Susy from having any contact with any of her mother's relatives. Susy doesn't have the courage to ask her father what really happened; she feels that they're growing further and further apart. For the past few months, they haven't agreed on anything; if Susy wants one thing, her father tells her the opposite.

She says she feels very lonely because she has no one to confide in. On one occasion, she posted a video on social media in which she claimed she had been sexually abused; a cousin saw the video and told Susy's father, who angrily asked her if it was true and why she was doing such things. Susy just told him she was joking, that it wasn't true, because if he found out, he would punish her. She says she gets along very well with her stepmother, but she doesn't trust her enough to tell her what happened. She doesn't have any friends either; she has a hard time getting close to them.

Clinical Presentation and Referral: Susy was referred by school authorities due to severe, debilitating anxiety and peer disclosures regarding a child sexual abuse (CSA) incident perpetrated by an unknown male in a vacant lot. The victim had taken an unfamiliar shortcut home following school activities. Initial disclosure to primary caregivers was inhibited by intense fears of parental retribution and punishment for arriving late. Symptomatology and Intrapsychic Conflict: The post-traumatic clinical presentation is marked by acute affective distress, pervasive guilt, and bulimic patterns involving binge-eating episodes followed by compensatory purging.

Early Attachment and Maternal Abandonment: Susy resides with her biological father and stepmother. Her early relational history is defined by catastrophic maternal abandonment at age four following chronic marital conflict. Prior to vanishing, the mother forced the four-year-old child to choose between parents. Susy elected to stay with her father, and the mother subsequently severed all communication.

Systemic Secrecy and Relational Isolation: Severe inter-familial conflict persists; maternal relatives filed missing person reports and raised suspicions of severe foul play against the father. In response, the father imposed a strict relational cutoff,

prohibiting Susy from contacting her maternal family. Communication between Susy and her father is characterized by growing emotional distance and persistent conflict. Lacking a secure containment space, Susy sought indirect trauma disclosure via a social media video; however, upon paternal confrontation, she defensively retracted the claim as a "joke" to evade punishment. She exhibits profound social isolation, an inability to form peer attachments, and a lack of emotional trust toward her stepmother.

3.2. Case 2 Joe

Joe, 10 years old, is in the 4th grade and lives with his mom and stepdad. When he was 5 years old, his father died of alcohol poisoning. Afterward, his mother moved in with her current partner. Joe says he gets along very well with him because on weekends they go to the park to play, unlike his father, who was always drunk and had very heated arguments with his mother. At school, a boy two years older than him sexually abused Joe. His mother sued the perpetrator, and one of the penalties was that he had to pay for Joe's psychological therapy. Since the sexual abuse occurred, Joe stopped speaking; he wouldn't communicate with anyone, and his gaze was expressionless. Even his mother was at her wits' end because she didn't know how to get him to say anything. As the therapy sessions progressed, Joe was able to begin communicating again through speech. He recounts, as a humorous anecdote, that when he was 4 years old, his mother was busy with household chores and a compressor was running; Joe walked over, stuck his hand in, and lost the phalanx of his middle finger.

Later, when he was 6 years old, his mother asked him to bring his stepfather some food since he was working at a construction site. Just before he arrived, there was an open manhole, and Joe fell in. He was unconscious for several minutes, and then a worker called for help to take him to the hospital. Joe says he doesn't have any friends because they don't want to hang out with him; he's almost always alone, playing on his cell phone.

Clinical Presentation and Family History: Joe is a fourth-grade student who resides with his mother and stepfather. His early childhood was marked by exposure to severe domestic violence and paternal chronic alcoholism, culminating in his biological father's death from acute alcohol poisoning when Joe was five years old.

Traumatic Event and Post-Traumatic Symptomatology: Joe experienced sexual abuse within the school setting, perpetrated by a male peer two years his senior. Following the assault, Joe exhibited acute post-traumatic regression characterized by profound, trauma-induced communicative withdrawal, complete verbal silence, and an expressionless gaze. Legal proceedings initiated by the mother resulted in court-mandated psychotherapeutic intervention for the victim.

Psychic Defenses and Pre-Existing Neglect: Within the psychoanalytic therapeutic frame, Joe gradually restored verbal communication. Notably, he recounted severe early physical traumas using inappropriate affect and manic defense mechanisms, narrating life-threatening injuries as humorous anecdotes.

These included a traumatic finger phalanx amputation at age four due to unsupervised contact with operating machinery, and a severe fall into an uncovered manhole at age six while running an errand alone, which caused loss of consciousness and emergency hospitalization.

Socio-Emotional Profile: Joe displays persistent social withdrawal, absence of peer relationships, and an over-reliance on digital media as a defense against interpersonal engagement.

Despite these early neglect patterns, Joe's mother demonstrated active protective responses following the sexual assault: she filed a legal suit against the perpetrator's family and secured court-mandated psychotherapeutic treatment for Joe. Additionally, his stepfather engaged constructively by taking Joe to the park on weekends, offering a contrast to the biological father's violent behavior. Joe continues to exhibit social withdrawal and reliance on digital media, but therapy has facilitated the restoration of speech and initial trauma elaboration.

4. Analysis and Discussion

The clinical analysis of Case 1, Susy, illustrates a profound failure of primary containment (holding) and an absence of protective object relations. Although the stepmother maintains superficial oversight, there is a distinct lack of affective attunement and genuine trust, leaving the adolescent devoid of a safe space to process complex trauma. In the absence of external containment, the patient internalizes the trauma through a rigid and punitive superego, which manifests through severe unconscious guilt, self-devaluation, and bodily harm. The bulimic symptomatology characterized by binge-purging cycles operates as a somatic enactment of drive disorganization and self-punishment, reinforcing the unconscious fantasy that she is inherently "bad" and deserving of suffering.

Furthermore, the unresolved ambiguity surrounding her mother's sudden disappearance is experienced intrapsychically as a catastrophic abandonment, fostering an omnipotent belief that she herself is responsible for the maternal rupture. This primary loss is compounded by secondary guilt regarding her decision to alter her route on the day of the assault. The paternal figure presents an unintegrated, split object representation oscillating in the patient's fantasy between a terrifying, destructive threat and a benign figure, which further destabilizes the patient's ego structure and prevents the consolidation of an organized, cohesive identity.

In Case 2, Joe, the narrative reveals a trajectory of cumulative developmental trauma and chronic environmental neglect preceding the sexual abuse. The recurrent physical accidents characterized by severe bodily injuries reflect a continuous failure of maternal protection and an absence of parental attunement, leaving the child without a secure psychic place within the primary objects' domain. Unable to symbolize or integrate these somatic intrusions, the child experiences a progressive erosion of the protective shield. The incident of sexual abuse acts as a traumatic intrusion that structurally confirms the baseline environmental neglect

characterizing his entire developmental history. In response to this compounding trauma, the child deploys massive defensive withdrawal, resulting in profound emotional detachment, mutism, and an inability to execute libidinal object cathexis. The pervasive failure of parental protection across his early childhood deprives the ego of the necessary conditions for relational investment, consigning the child to a state of chronic psychic helplessness and emotional isolation. However, while earlier literature suggested that extrafamilial abuse universally carries a more favorable prognosis than intrafamilial abuse, contemporary systematic reviews, as noted by Gutiérrez & Lefèvre, establish that recovery is heavily moderated by caregiver support, abuse characteristics, and parental protective responses. Because both cases in this study involved extrafamilial perpetrators, direct empirical comparisons with intrafamilial abuse cannot be established.

Furthermore, Joe's case highlights the protective role of caregiver intervention: his mother's immediate legal action, enforcement of court-mandated therapy, and the stepfather's positive relational engagement served as crucial external containers that facilitated Joe's communicative recovery. These supportive actions underscore that pre-existing neglect does not preclude subsequent protective capacity, and caregiver mobilization remains a primary catalyst for child trauma recovery.

5. Conclusion

Clinical practice must extend beyond a singular, reductive focus on the traumatic sexual incident to systematically evaluate pre-existing disruptions in primary object relations and developmental neglect. Therapeutic intervention requires the psychodynamic reframing of early environmental failures, enabling the clinician to provide an adequate holding environment that facilitates the integration of fragmented life histories and ego identity. Rather than over-focusing exclusively on the abusive event, the clinical process demands an empathic listening frame attuned to the patient's relational matrix and subjective reality, allowing for the gradual elaboration of both past trauma and present relational patterns.

Furthermore, discerning the locus of abuse, whether intra-familial or extra-familial, is crucial for prognostic evaluation; extra-familial trauma carries a more favorable trajectory when the primary family can function as a protective containment system. Conversely, in cases of intra-familial abuse where the primary environment is compromised, the analyst must temporarily serve as a secure auxiliary ego and protective container.

Concurrently, intervention must target parental reflective capacity, fostering awareness of the protective and nurturing responsibilities inherent to caregiving. In line with Winnicottian theory, establishing secure bonds of trust and a holding environment underpins the child's continuity of being (going-on-being). This developmental foundation equips the ego with essential protective resources, enabling the child to perceive environmental hazards, establish self-preservative boundaries, and seek protection.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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