CHILDHOOD AND ADULT SEXUAL VICTIMIZATION:

Living in the Aftermath of Transgression and Quest for Restoration of the Self

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IMPACT, RECOGNITION, UNDERSTANDING, AND MANAGEMENT

Sexually traumatized children and adults feel stripped of their dignity and sense of control, and often reenact in feeling, thinking, and behavior the dissociated imprints of horrific, and loathsome memories. These and other untoward effects tend to encroach upon all spheres of victims' existence—upon their bodies, minds, emotions, faith-based values, relationships, and cultural values. The persons being discussed in this article are child sexual abuse (CSA) victims, and sexual assault (SA) victims.[1],[2] While in SA the trauma wears away and fractures the structure of the personality already fashioned, in CSA *repetitive, trauma-on-trauma* deforms the personality.[3],[4] In CSA the very foundation of the self structure is affected due the experienced battering to the spirit and injury to the soul.

Essentially, the effects of trauma activate and imbed within the survivor a legacy of chronic, unrelenting, inescapable traumatic anxiety. Both show a number of shared abuse-based responses; for example, both forms of trauma leave indelible trauma imprints on the mind and body, associated with both classical and operant conditioning and biochemical encoding of fear structures on the substratum of the self. These trauma effects pervasively influences the way victims (a) process feelings, (b) think about their distress, (c) find a personally purposive theory of healing, (d) shape the quality of communicative interpersonal transactions, and the way they (e) experience personal identity. This article sets out to highlight the impact, and increase recognition, deepen understanding of sexual trauma, and provide a guide for helping victims. Studies have shown that women who have endured sexual assault are more likely to be diagnosed with a mental condition, such as anxiety, somatic, depressive, and substance abuse disorders, than women who have not experienced this type of psychological trauma. These survivors, moreover, are more likely to suffer suicidal attempts, experience sexual dysfunction and general health problems, and a significant minority experience revictimization; that is, being subjected to another assault. Scientific findings reveal that sexually assaulted women who were also abused as children have a higher degree of psychopathology than not only nonvictims, but also CSA and SA victims.[5] Trauma experts also hold that revictimization is associated with having been sensitized by the original trauma, and losing the sense of self-protecting acuity essential to accurate appraising of environmental threats and risks.[6],[7]

IMPACT—PREVALENCE OF CHILD SEXUAL ABUSE AND ADULT SEXUAL ASSAULT

Generally, scientists found that there is a 25% estimate of CSA for girls and 10% for boys. Traumatizing abusers are often not relatives, but know the child victims they molest (60%). Fewer perpetrators are relatives of the children they abuse (30%).7 The National Crime Victimization Survey (NCVS) estimated that 500,000 persons were sexually assaulted in the United States during the period between 1992 and

1993. Of this figure, 28% were attempted rapes, while over 33% were completed sexually traumatizing assaults.[8] More recent statistics indicate that in 2001 there were 249,000 victims of rape, attempted rape, or assault. While one in every six American women have been victims of attempted or completed rapes in their lifetime, on American college campuses one in every five women reported being a rape victim at some time during their lives.[9] Studies and clinical experience reveal that CSA victims are more likely to suffer severe mental illness, along with acting-out, violence, suspiciousness, and hostility.[10] Depending on the age at the time of the trauma, adult patterns of sexual trauma symptoms differ significantly (e.g., trauma in early childhood vs. at the adolescent years, etc.).[11] Child sexual abuse and assault victims of both genders often respond with numbing of emotions, and avoidance of feelings, people, places, and circumstances that may trigger horrific remembrance. They experience, moreover, memory problems, anxiety, and reexperience aspects of the abuse in waking and sleeping states, and go through the sense of being dazed or "spaced out," and feel as if perceptions of self and world are unreal.

In contrast to CSA victims, who strongly desire the abuse to end, and have had to adapt to violence and abuse over time, the SA survivors aspire to return as speedily as possible to pre-trauma levels of normalcy, and eschew mental and behavioral rehearsing of the trauma, preferring rather to put the trauma ordeal out of their minds, *now.*

For many SA victims the urgent, post-event motive is to go on with their lives, to include continuing intimate and sexual relating, even though this activity may exacerbate their distress. In spite of fear associated with affectionate touching and being touched in intimacy contacts, SA victims' struggle to make sense of what has happened serves distracting ends to allow them to minimize the anxiety they would experience were they to become fully aware of the meaning of the sexual terrorism they had endured. They also set out to "prove" that the event had no untoward effects on their lives, as they engage in denial, avoidance, and numbing. This excessive suppression of strong affect contribute to the expression of dissociative vulnerabilities. Denial is particularly strong in victims who knew their assailants.

As a consequence of trauma, victims become hypersensitized to "sexual signals" from the opposite sex. They may perceive more "evidence" of sexual interest than non-traumatized women,[12] as they scan the environment with high levels of hypervigilant anxiety. They are on edge as they anticipate and evade further assault, take flight away from relationships and from life itself, and into the arms of isolation and stasis which strip them of vitality and of a future of possibilities and personal growth. These victims can benefit from the intervention of well-trained traumatherapists.

RECOGNITION—GENERAL RESPONSE TO SEXUAL TRAUMA

The Subjective Experience of Transgression

People have a natural subjective belief that one's self is an inviolate and highly prized, stubbornly personal possession. As a consequence of tragically overwhelming events, the belief is smashed to smithereens. This is especially true for victims of sexual trauma—an experience that sets body and mind into a tailspin of disorganization. In child sexual abuse and adult sexual victimization the person experiences the traumatic onslaught as a *transgression of the self.* Here, the word "transgression" has to do with an infringement or violation of one's most precious and guarded possession held up to self and world as something of awe or reverence, irreducible and irrefutable in the uniqueness of its cohesive structure and functions. People often speak of "spirit" as being a part of the total self, as in the well-known components affirming expression, "mind, body, and spirit." Perhaps the truth is that spirit is not "part" at all, but pervades the whole of the self. Recently, one of the authors saw a training card at a

national trauma/substance abuse conference that read: "There is no part of life that does not contain spirit; therefore, spirit is not a "part". Saying that one's spirit is a "part" is like believing that some of the ocean is not wet." What is transgressed in CSA and SA is not solely the victim's body and mind, which are experienced as narcissistic wounds, but rather the spirit that holds the fabric of the self together,[13] promoting "the power to know, to love, and to will."[14], p. 28-29

What's Missing in Contemporary Explanations for What Makes Sexual Victimization "Traumatic"

When sexual abuse or assault victims explain why their responses are so persistently distressing and disruptive to most spheres of their daily lives, they typically respond by saying, "I was violated!" We keep in mind that the victim is 100% accurate in this assertion. But we go beyond and ponder the question, "What is the true significance of "being violated"? What is its role in the "traumatic state"? It is clear that being violated derives from a subjective appraisal of the inner state of the self.

The trauma literature is replete with assertions and explanatory models of trauma induction, employing variously such terms as overwhelming, negative conditioning, breach in the stimulus barrier, or meaning/appraisal of life-threat or injury to self or others. Additionally, science-based vulnerability factors as the role of prior trauma, age, gender, lower SES, ethnicity, and the subjective response of fear, helplessness or horror. Most trauma experts who explain why an event is traumatic or nontraumatic admit the area still remains unclear, and in need of more scientific investigation.

Though study and practice in the area of psychological trauma have demonstrated beyond question the inextricability of mind and body, forcing us to rethink our Western tendency to separate one from the other, available knowledge still lags behind and is incomplete. It's incomplete because inquiry into the *third force* has been overlooked, abandoned, and relegated to fanciful, religious speculations. Many believe that such musings are too far-flung from the highly esteemed standard of hard science. As science-based knowledge grows, however, trauma experts are recognizing that hard science does not have all the answers, and that a *science of persons* that incorporate both relevant scientific findings and an appreciation for art, wisdom, and spirit.

The chemical elements that comprise the human body are said to have a monetary value of 98 cents. But from cultural, philosophical, and theological systems of belief human being are esteemed to possessing *inestimable* value. If this view is correct, then the total value of a human being would go beyond the physical body and its biochemistry. But, what factor would confer such inestimable value on human beings so undervalued as determined by the pittance of 98 cents? It is *spirit*, referred to here as the *third force* in the organization and meaning of life, neglected far too long in the discourse on trauma initiation and course of associated symptoms and comorbid disorders. Spirit infuses the mind and body with healthy narcissism, and sense of self, and the uniqueness of personality and identity, all of which are seriously compromised in sexual traumatization.

Does *spirit* being discussed here refer to a mental disposition, to a lively quality of action, to an attitude, or to a tendency? Or, to something else? The specific meanings of "spirit" being referred to in the context of traumatic disruption and annhilatory anxiety come from the Latin *spiritus*, meaning breath, and from *spirare*, to blow, breathe. It is the animating, vital force integral to the living. This is what is squelched, shattered, battered, or hammered in child and adult sexual victimization, battered women syndrome, and torture. Thus, in the aftermath of traumatic distress, Zen (Buddhism) therapy holds the spirit is *dis*-eased and in need of *liberation*.[15] But because the physical body and spirit are inseparable; that is, the living body never exists without spirit, infringement upon the victim's body, as in incest or rape, violates

intrinsic spirit as well. These untoward events are experienced as a *traumatic transgression* of mind, body, *and* spirit. Dealing with the transgression against the *life of the self*, the traumatherapist's role may be translated from Greek roots as one who serves or attends to the soul.[16] Spirit is the common denominator that permeates and unifies all aspects of the self, contributing to its coherence and cohesiveness, and to its contemporary and future efficacy and *aliveness*.

Though in trauma it is undeniably true that it is the body that "keeps the score" (B. van der Kolk), "tells the embryonic trauma narrative" (E. R. Parson), or "bears the burden" (P. Levine), it is the spirit-violation, along with overwhelmed mind and body functions, processes, and structures, as in CSA and SA, that cause the event to be *traumatic*.

From Awesome Self to Awful Existential Yoke: The Demise of the Awe-Inspiring Self

In the repetitive sexual molestation of a child, there is a virtual traumatic mugging in the dark alleys of adult wanton abuse of the child's natural and developmentally-expected *awe of self*. Perhaps a child's *biotendency to be with others*, a "wish for company," as Anna Freud put it,[17] result in a state of consistent vulnerability and innocent availability for adult abuse. A truly negative change occurs after this transgressive manipulation, the misuse of a child's body for adult sexual gratification. Caught between the proverbial rock and hard place, the child experiences this change deep within the self as a down-spiraling, from being spirit-infused and alive to being essence-defused and vacuous—from *awesome to awful*. For some victims exposed to CSA cumulative abuse stress, the dehumanized self[18] may be so altered as to appear stripped of most of the vestiges of feeling human.

The altered view of self with *awe* lay at the heart of post-victimization stress experience. After trauma awe of self (or the awesome self) is replaced in the abused child by the awful omnipresent yoke (or burden) and dread that accompany relational transactions and the physical environment. As Sandor Ferenczi once noted, the child is blamed for the incest, as the adult denies responsibility. The victim senses the trauma-altered self as *unconformable*, that is, as a force going in opposition to the former self's "traditional pattern" of perceiving, learning, knowing, believing, trusting, and acting. Thus, the trauma-tainted self experiences the constellation of PTSD symptomatology as rebel against the organization of the pretrauma self. This transgression creates a myriad of symptoms whose masquerading language of secrets are too terrible to be uttered,[19] at times resulting in mental and somatic distress illustrated in the words of a 9/11 victim, "every part of my mind and body aches!"[20]

Self and Relational Dynamics: Being "Sane" in Insane Totalitarian Places

The child's trauma-generating interpersonal network can be described in terms of a set of bizarre relational dynamics. These transgressive dynamics continually threaten children's sense of "going on being,"[21] debasing and forcing them to surrender self to the heavy burden of growing up fast, and learning how to survive. Survival depends on skill acquisition: among these is preemptive appraisal of cues emitting from adults' behavior in a pathological environment of totalitarian child-control. These burdens of unspeakable stress involves, as well, the maintenance of preemptive/defensive readiness through a hypervigilant orientation that sees the obvious, but goes beyond the "facade" to possible *subterranean* emotional and behavioral landmines in unstable, uncharitable adults.

Thus, abused children often find themselves forced into detective work in order to psychologically traverse a potentially treacherous interpersonal terrain. They learn to assess the "abusing lethality" of

adult's mood and behavior, and then mobilize adaptive maneuvers to detour around, over, and under—to execute any necessary evasive action to survive this troublesome family environmental terrain. The child attempts to *de*-activate the mines before they explode. To this end, she or he uses both good adaptive common and *un*common sense by "being good" and adopting a "pacifying demeanor" to avert adult wrath. The cumulative trauma-on-trauma pattern of abuse re-exposure over time results in a *system of relational abusive violence*. Here, the abuse is, essentially, in ominous opposition to the soul of one who is least able to defend and protect self from the abusive ravages of adult power, vice, and depravity.

What contributes immeasurably to the child's distress and helplessness is the awareness that the transgressive violence against the spirit and inner life of the young self is deemed "legitimate," and so the light of the young self dims and laughter is no longer heard. Moreover, from the child's perspective, the traumatizing environment is a place where no joy, no light, no hope, and no love is allowed to take hold and flourish, only a quandary of emotional and spiritual darkness, helplessness, and buried rage to be resurrected at a later time, and unleashed suddenly on unsuspecting targets, to include the self. The child suffers day by day existential malaise, and faces contradictions in mood and behavior—of appearing to be alive (or animate) yet emotionally lifeless. Extinctive anxiety was originally experienced during the abuse, but is now relived when the delicate filament of the self is strained during subsequent abuse or memory revivifications of the trauma. This form of anxious arousal is akin to annihilation anxiety in that both have to do with fear of non-existence, a notion that is rather threatening to most human beings.

Caught up in the throes of the trauma, the victimized child is also robbed of his or her individuality and sense of self—of free will, of spontaneous aliveness, and autonomous behavior. Many of these children suffer severe deficits in the development of awareness of self and body image, and show a mental fixity on sexual themes and distortions of the body.[22]

This form of anxiety also involves the subjective experience of non-being, of "being erased," and is characterized by "a chronic suspenseful, 'up-in-the-air' feeling … [with] a despair-inducing diffuseness."[23] Due to the dreadfulness of continuing abuse, the child is rapt, seized, and stress-worn by tormenting emotions that ultimately lead to suffering "prison-like confinement"[24] as a way of life. The child's very existence is unendingly threatened to decompensate into stillness. It is the child's own resilient strengths—from pre-trauma, constitutional, and post-trauma islands of health—that are deployed to maintain the organization of experience even in these dire circumstances. Without such inexplicable adaptive clout on the part of abused children, they may go downwards into a sense of abysmal nothingness,[25] the demise of consciousness.

The traumatized child, additionally, is exposed, in this the bizarre relational dynamics to secrecy, threats of exposure (to vilification, humiliation, and moral condemnation), threats of abandonment, fear of repeated sex-based and physical injuries, and further degradation. These children are constantly wary when adults come near, and when they are away from home may fear returning home (and may become runaways).

What's profoundly remarkable is the abused child's trauma-derived capacity to keenly intuit and be perceptually and emotionally in sync with the "admired"/despised adults. Adept at reading adult inner states of evil, selfish indulgence, idiosyncrasies, instability, potential violence, irritability, and episodes of sexual arousal, these children find a way to survive. In the context of high acuity to adult behavior, these they learn to distract themselves—away from dwelling on adult predatory appetites. They learn not show how they feel internally—to survive a child-hostile, lascivious, and destructive milieu. Indeed, the children hide their true self, subterraneously, and are in a persistent state of near-adrenergic burnout. Associated with this state are paranoid expectations of attacks. This state of being chronically revved-up with terror-driven paranoid expectations, is akin to living in a internal police state.

Abuser relational dynamics lay at the center of the child's dissociative/annihilative fears. Abusive adult relationships deprive the child of genuine, unconditional regard, affection, and psychological protection from being overwhelmed by environmental impingements.[26] In the absence of such interpersonal protection, the child's own intrapsychic defense operations fail and to mature to provide optimal protection against traumatic anxiety. With the absence of first and second lines of defense, the child's efforts to establish and maintain his or her own internal homeostasis, produces the emergence of an "autonomous, split-off organization" of the personality.[27] Generally, this *functional* survival system may be characterized as *relational adaptive dissociativity*. This consists of a psychic split between being emotionally close/dependent on the abuser for love/sustenance, on the one hand, and being separate/detached enough to anticipate and take physical/emotional cover when threats of sporadic episodes of abuse or violence are given free rein in attacks. Cues-reading is a critical survival skill in the armamentarium abused children are forced to develop—to be able to make strategic decisions "on cue," to either stand with and join the "the enemy," or engage in silent but active evasive action. The child's empathic channels may lead to inside knowledge on how to mobilize hypervigilant detouring to forestall/circumvent the abuser's erratic narcissistic practices and idiosyncratic abusive corruption.

Children's search for psychological mastery over their trauma-influenced lives also involves repetitive play of trauma themes, accompanied by intense levels of paranoid fear. They may feel "entitled" to punishment associated with a "bad-self introject," and low self-esteem. With a poor self-concept, the child exhibits a "frozen stare," one that communicates the struggle between being too insignificant for adult protective love, and, at the same time, aware of being too significant for adult defilement. Many feel they have seen, felt, and understood too much about human cruelty and wanton carnal indulgencies.

Disorders of Extreme Stress (DES): Recurring Relational Violence Abuse

Early childhood trauma is powerfully determinative of severe disruptions, distortions, and splintering of the identity system implicated in the post-traumatic outcome, Disorders of Extreme Stress (DES, or "Complex PTSD").[28],[29] DES represents an extreme traumatic disturbance of the self caused by "extreme, repetitive trauma." The younger the survivor and the more intense the abuse, the greater the damage to the identity system, and the greater the risk for long-term distressing symptomatology for the victims entire lifeline. DES is comprised of such *self disorder symptoms*[30] as *distortions in self perception* (as in a negative view of self as damaged, with little or no redeemable qualities), *deficits in affect regulation* (e.g., anger, guilt, shame), *impulse regulation* (suicidal thoughts and actions, self abuse as in wrist-cutting, and risk-taking, "living-on-the-edge, behavior), *somatic disturbance, self-esteem, human relationships* (e.g., catastrophic expectancies leading to social isolation and aloneness, intimacy problems, distrust, victimizing others, etc.), *severe dissociation* (e.g., "spacing out," amnesia, feeling "unreal"),[31] *internalization of perpetrator mannerisms* (becoming [like] the abuser in temperament, mood, expressions, in behavior, and in aggressive thoughts and feelings against self and others), and a *problematic meaning system* (e.g., absence of hope, lack of capacity for forgiveness, vanquished religious faith, distorted beliefs about self and others, etc.).[32]

Dissociative Identity Disorder (DID)

Here, the serious nature of the abuse at an early age makes the child vulnerable to fragmentation of the identity system, leading to a the major post-traumatic outcome, dissociative identity disorder (DID). In this disorder, the self fragments are isolated into distinct identities with little, if any, awareness between or among the various "personalities." Reconceptualizing the previously used diagnostic entity, "multiple personality disorder," the DSM-IV introduced "dissociative identity disorder" (DID), "the presence of two

or more distinct identities or personality states … that recurrently take control of behavior."[33] p. 484 This disorder springs from repeated sexual assaults and concomitant narcissistic wounding of the spirit in a yet immature self organization. Thus, DID is etiologically rooted in "chronic abuse [which] stimulates repeated dissociations which, when chained together by a shared affective state, develop into a personality with a unique identity and behavioral repertoire"[34], p. 46.

Ostensibly helpful to therapists and victims is the notion that, intermingled with dissociative pathology, are highly valued adaptive functions of dissociation: It (1) conserves energy by facilitating automatic action to responses, (2) offers efficiency of effort, (3) handles irreconcilable conflicts, (4) helps escape the pain of traumatic reality, (5) isolates catastrophic experiences, (6) directs discharge of emotions, and (7) submerges individual identity for the group identity.[35] Studies have shown that 97 to 98% of DID-affected persons have had a history of child abuse.

In DID the structure of the immature self is strained and overtaxed by repetitive influx of powerful life-threatening and soul destroying stimuli from the abusing milieu. These unrelenting trauma episodes result in a vulnerable structure that eventuates into "splitting self into auxiliary selves" in the context of heightened adrenergic activation—to permit survival and consciousness to go on.

Post-Traumatic Stress Disorder (PTSD)

The victim may suffer post-traumatic stress disorder (PTSD), a condition that comes as a response to overwhelming events, according to the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (DSM-IV).[36], p. 484 The disorder is comprised of the stressor event, and a clustering of three symptoms—intrusion, avoidance, and arousal. Intrusive symptoms consist of vivid twilight recurring traumatic memories that make survivors feel "as if" the trauma is happening in the present. Each sensory modality may serve as a triggering pathway to a network of terrifying memories and chilling emotional reactions within the survivor. Thus, sounds, tastes, odors, and bodily sensations may activate their own reliving of latent traumatic memories into active reexperiencing of the trauma in the immediate present.

When intrusive, vivid symptoms strike they may be accompanied by an altered state of consciousness known as "dissociation," causing such diverse reactions as numbing, detachment, feeling unreal like a fictional character, with gaps in memory. Intrusive symptoms in the person with PTSD resonate echoes of haunting experiences of the past that drive out things that are important to self and others transpiring in the here-and-now. This trauma fixity on warding off intrusion induces the feeling of being trapped in traumatic history of abject misery, and emotional confinement. This sense of being trapped goes together with no real sense of being safe in a world perceived as abandoning in its failure to ameliorate and offer meaningful solutions to traumatic distress and threats to psychological breakdown.[37]

One of the most negative consequences of victims' having endured transgressive trauma is the persistently unpleasant, anhedonic mood, and peculiar absence of pleasure and positive feelings. They are often unable to express positive feelings, or participate joyously in social or communal settings. Traumatized people often give others the impression of being totally focused on self, a narcissistic stance that many family members and friends find overly self-indulgent and very perplexing. Further confusing to others is victims' persistent reticence to taking on ordinary daily activities because they are fearful of being overwhelmed by strong feelings reminiscent of the trauma.

Normal, unconstricted and freely expressed range of human emotions is available to most people. Emotions give color to life and experience. But when trauma strikes, the victims typically develop intolerance for strong emotions, while their emotional lives become constricted, suppressed, repressed, or

dissociated. The relative wide range of existing emotions is shrunken down and narrowed so the victims appear to be restricted to experiencing only negative, dysphoric emotions like terror, rage, irritability, and depression.

The victims' internal emotional life of turmoil and confusion may be imperceptible to others, and they may have difficulty averting intense emotional eruptions. Numbing/avoidance symptoms of PTSD are the "silent killers" of victims' will, motivation, psyche, and spirit. Though these symptoms are far less dramatic than intrusive symptoms, they make the victim feel like "a walking corpse," empty, with a deep hollow inside with death-like, immobilizing coldness, and inert sensation of nothingness. Interpersonally, the individual comes across to others at home, on the job, and in the community as aloof, vulnerable, listless, lacking in energy, and as disinterested in them or in the immediate environment. They come across unequivocally as people with something on their minds, but closed to interpersonal transactions.

While on a symbolic level intrusive symptoms represent the victim's need to master the trauma (through telling about it via sensory, affective, verbal, cognitive, and actional revivifications), numbing and avoidance represent its opposite—succumbing passively to a death-like grip of dullness, depletion, emptiness, diminished capacity for self-caring, and diminished responsiveness. Reenactments in some ways are about the need for connection for the purpose of forcing an indifferent and unresponsive environment into at least tacit affirmations that the trauma did occur and did awful damage to the self. Numbing and voidance tell another part of the story: "I am disconnected, an island unto myself; I don't need anyone!"

Avoidance and numbing are probably the most harmful of all trauma symptoms in that they devastate and damage human growth and development. These symptoms, moreover, deprive the victim of the rich, life-expanding influence of diverse stimuli. Developmental unfolding that ordinarily leads to a progressive increase in personal power and maturation, with actualizing potential, is possible only when the individual is exposed to an increasingly diverse quantity and quality of stimuli, emanating, radiating, and irradiating, from the interpersonal, physical, and spiritual worlds. Trauma often prove to be a developmental "crisis," that is, a critical period that, depending on how well it is managed, can promote or obstruct the healthy evolution of the individual's identity.[38]

UNDERSTANDING—THE EFFECTS OF TRAUMA TRANSGRESSION ON IDENTITY AND THE LIFELINE

One consequence of the tendency in SA and CSA victims to employ denial and mental suppression of memories, dissociation, and occurrence of general CNS dysregulation is the inducing of such psychosomatic symptoms, as pelvic pain, discomfort during intercourse, inability to reach orgasm, vaginismus, and other symptoms, like gastrointestinal ulcers, migraine, and eating disorders. Some survivors may numb the pain by abusing food (bulimia and anorexia nervosa), using alcohol and drugs,[39] or may overwork, or may experience a combination of these. Despite the findings of studies using structural magnetic resonance imaging (MRI) that PTSD is associated with smaller hippocampal volume among various traumatized populations, the most unequivocal conclusion from current studies is that "anatomical abnormalities may be more likely to result from childhood than from adult trauma."[40], p. 41

The Sexually Abused Male Child

When the male child or adult is the target of CSA or SA, the emerging gender and even established self identities of these victims become shattered, diffused, and a persistent psychological burden. They are inclined to talk less about the traumatic episodes, first, because this is characteristic of most traumatized

individuals, irrespective of gender. Second, society sanctions male nonresponsiveness to trials and tribulations. However, terror-driven stoicism militates against the essential processing of the trauma in victims' minds and bodies. Thus, sexually traumatized boys tend to feel particularly stigmatized and ashamed, are more reluctant to share thoughts and feelings about the abuse, and tend not to seek mental health services of any kind. Gender socialization in American society tells a victimized boy that he is shamefully inadequate for being so passive, weak, and impotent, so unlucky to "fall" or "succumb" to the abuse. Society sees the sexually traumatized male child, adolescent, or adult as undeserving of respect and of the good things of life. While adolescents and adults of both sexes abused in the early years by their mothers feel the abuse meant they were homosexuals, boys abused by their fathers experience profound humiliation, shame and anger, fearing they are homosexuals, and wondering whether their fathers also homosexual.[41] Our social collectivity hides the reality of boys' and men's victimization from itself. And society's collective psyche takes a dive down into mental oblivion—not to think or acknowledge the trauma-tattered lives of male victims.

As boys grow and interact with siblings, peers, and others at school and community, their developmental need to identify with male peers takes on particular urgency. Sexual trauma blocks the fulfillment of this normal, societally-sanctioned tendency. Studies have found the probability of alcohol problems to be 80% for men who were sexually abused as children, compared to 11% for men who had not been sexually abused.[42]

Sexually abused males have been observed to also suffer encopresis, and other medical conditions, engage in risk-taking and acting-out behaviors, and feel stigmatized and filled with rage and feelings of revenge. Because of the diffuseness of his own gender identity, the abused boy or youth flounders around, unsure of himself, as self-doubt, anxiety, and the need to identify with other males, and, at the same time, counter-identify with them, become a painful and distressing reality. Young molested male children feel degraded, and may thus take on hyperaggressive behaviors, an exaggerated display of pseudo-male prowess, offering protection to his fragile self-esteem, and wounded male narcissism. Mental illnesses among hostile and suspicious boys (and girls as well) may be rooted in childhood sexual abuse.[43]

The Assumptive World—From Basic Assumptions To Shattered Assumptions

Dr. Jerome Frank, formerly of Johns Hopkins in Baltimore advanced the highly valued concept of the *assumptive world*, in his book *Persuasion and Healing*.[44] He defined the assumptive world as the totality of a person's theory about self and world formed during the course of life's experiences. Moreover, the assumptive world imposes order on the intensely impinging stimuli from within and without, facilitates relationships and prediction of others' behavior, and the impact, evaluation, and meaning of one's own actions. So shocking is the assault on the victim's assumptive world that even when it is founded on a healthy, adaptive basic sense of trust in early caretakers and the environment, the effects of trauma can severely damage the basic architectural design of the victim's identity.

People who are fortunate enough to avert having to suffer severe traumatization tend to naturally see the world as meaningful and consistent, as reliable, and trustworthy, while having a positive view of self.[45] The traumatic shattering of the survivor's assumptive world, additionally, produces heightened subjective awareness that something has gone tragically wrong, but in this sense exists in the absence of insight into what happened, why it happened, and control over responses. The search for meaning, then, becomes another important feature of the competently managed treatment enterprise with sexual trauma victims.

In the presence of these profound changes in the assumptive world of the survivor, anxiety flares up, efficient mental regulation dwindles, as withdrawal and cynical distrust of others intensify. The environment and its cultural institutions are now experienced as depriving, inconsistent, threatening, and as potentially traumatizing. Life for the untreated sexually traumatized victim over time may be characterized as going down a road and seeing nothing but the ubiquitous signs, "Retreat, no safe place—here or elsewhere!"

Victim-Into-Victimizer Phenomenon: Dissociated Behavioral Reenactments

Often taken into the self at the traumatic moment is the personification of the abuser/assailant through a psychological process of internalization. This issue has far-reaching implications for the victim's recovery and integration with the assistance of therapy. Clinical observation shows that, during the traumatic episode, the victim *learns* a behavioral repertoire of aggression, mood instability, impulsivity, distrust, and a "going against people" tendency. The *victim-into-victimizer* phenomenon is difficult to conceive of and talk about—to patients or among clinicians and certain political groups. This is because to many this concept is too much like "blaming the victim," which victims and therapists are careful to avoid, even disdain. Often, rather than addressing these issues in therapy, both therapist and client at conscious, preconscious, and subconscious levels of awareness collude *to keep this scorching, unpalatable issue off the table of therapeutic explorations*. Since blame and blaming is so central in trauma, not bringing this issue up might limited the long-term value of the overall treatment enterprise.[46]

Many victims talk about how they have changed since the traumatic episode, and how they get angry like their perpetrators, how they feel like hurting others, to force them to realize just how painful their ordeals are. For some victims, their pretrauma view of self as continuous from one moment to the next was lost, and replaced with behavioral and attitudinal reenactment learned from the abuser. Internalization of the violence and transgressive behavior of the abuser interferes with the victim's lifeline development. This internalization is experienced as poisonous and corrosive to the evolution of victims' personal growth during the life cycle.[47],[48] The victim has lost a life-affirming sanctuary of consistency and stability, and now expects to live in a harm-oriented world, anticipating threats, and, because of *perpetrator internalizations,* in many instances, victims become threatening to others. Victims are often unaware of these traumadynamics.

When victims come for assistance, they bring their internal reality with them characterized by profound trauma-based narcissistic injury, mortification, and sense of failure. Janet saw the sexually traumatized individual as dwelling in a perpetual state where they "remain confronted by a difficult situation, one in which [he or she] has not been able to play a satisfactory part, one to which … adaptation has been imperfect, so that [the person] continues to make efforts at adaptation."[49], p. 603 Thus, when traumatherapy works it (1) accomplishes a turn around of the sense of helplessness and perpetual failure in self-regulation, (2) increases mastery over difficult situations (emotions), (3) empowers to satisfactorily solve the trauma-based puzzles of life, (4) enhances sense of completion (consummation of action), (5) supports post-trauma adaptation, as well as (5) facilitates a triumph over the power of what Freud called "blindness of the seeing eye," where "one knows and does not know a thing at the same time," translated to mean denial or disavowal.[50]

MANAGEMENT—HELPING SURVIVORS DEAL WITH POST-TRAUMA SYMPTOMS, NEGATIVE INTERNALIZATIONS, AND TRANSGRESSION OF THE SELF

An Issue Overlooked in the Trauma Literature: The Victim's Internalization of the Transgressive Abuser

For the victim, traumatherapy needs to be challenging, engaging, illuminating, and transforming, while the therapist, balancing security *and* growth, is compelling, and is reliably the "real thing."[51] Therapists are thus required to be psychologically stable. This stability offer a form of *adaptational resilience;* that is, a capacity to *participate* in the survivor's endopsychic world, while maintaining sufficient control and objectivity to not be overwhelmed nor drown in the survivor's traumatic helplessness. Additionally, the therapist exudes confidence, is wise, warm, and caring deeply for the welfare of the patient.

Trauma therapists are to be competent, a mentor with a healing vision, filled with practical tips that are immediately useful, and able to provide a five-star experience for the victim/survivor. The therapist works conscientiously to engage and help transform the skeptical, distressed, and cynical victim to a true believer in self and process (the trauma treatment), convinced that it is possible to gain power to live a life of abundant contentment, joy, and happiness.

The therapist understands that therapy is chiefly a path or journey, not a destination, and that therapy teaches the importance of putting the past in some personally meaningful perspective through "*now* trauma processing." Getting on with it (life) is seen here as superior to getting deeper into it (trauma effects) with little or no exist strategy. Therapists also require that the survivor learn that while on the therapeutic highway it is important to focus on the car's windshield--looking *ahead,* while using the rear view mirror (i.e., the traumatic past *and* positive lessons learned) to *check* forward movement, periodically. The best, most valuable kind of learning in therapy comes from the survivor's focus on the here-and-now, where the survivor actually contemplates and plans the building of a future for personal integration, and coherence.

In general, conceptually, traumatherapeutic strategies and goals include: (1) balancing overstimulation (that comes both from the therapeutic relationship and from induced reliving of traumatic memories), with recuperative self-soothing, and (2) dealing with the *internalized victimizer presence.*[52] Traumatherapy can work effectively only in the present, incorporating the early focus on memory processing. The past is gone, the future is not yet, and therapy itself is *not* life. Therapy explores and seeks the integration of the victim's pretrauma faith in the humanity of others, of a belief in their capacity and willingness to treat others humanely, and to do what is right. Additionally, victims lost the belief that other people typically strive for honesty, fairplay, and goodness. This is especially true for victims of interpersonal traumatic violence (as in physical and sexual abuse, assault, torture, and combat). For these victims the biochemical imprinting of person-engineered violence, sadistic madness, and cruelty are important issues for therapists and their clients to apprehend in traumacare. The therapeutic relationship is a key factor in working internalized violence, sadism, and seduction impulses to resolution.

Case Studies [a]

Case Example 1: Child Sexual Abuse (CSA), Female: Dissociative Identity Disorder (DID)

Sally is a 40-year-old single, unemployed Caucasian female who has a long history of physical, sexual, and emotional abuse that began in early childhood when she was about four to five years old. Her first recollection of sexual abuse is from her father whose physical abuse at times bordered on torture. Sally was the only child born to her parents. Her mother suffered from depression and would often be

emotionally and physically unavailable to family members, while her father was an alcoholic with an inconsistent work history.

Sally's father would sneak into her bedroom at night to have sexual relations with her, and threatened familial separation if she told anyone about his abuse practices. He would also tell Sally that the sexual contacts were because she was "special." She has a long history of self-injurious behavior such as cutting her arms and inserting sharp objects into her vagina. She describes her life as being very confusing, with events and experiences that do not logically connect together. She reported that she frequently "loses time" or does not know what has occurred for long periods of time, especially at nighttime and when in the company of males.

Sally is unable to give a coherent history of her life: she experiences enormous gaps in her memory as she attempts to recollect her history. She reported having dramatically experienced a "fugue" state, and when she "came to," realized she had traveled to another state. She did not know the date, location, or how she came to be there. This had happened many times in her life.

She told her therapist she would notice writings throughout her apartment that looked different than her own handwriting about which she has no previous knowledge. Moreover, she conceded she has many objects of clothing that she did not even like, and did not know why they were in her closet. People were heard to call her by the wrong name. This was very confusing for her. And, to her chagrin, found her confusion made even worse when people became angry with her, saying that she lies, and could not be trusted to tell the truth. The victim also stated hearing voices inside her head, but stated the voices did not sound like her own, and also would experience annihilation anxiety. The high levels of anxiety made her feel she could "die at any moment."

As is so well known in the post-trauma lives of sexually abused women, Sally also reported a history of abusive relationships with men for many years. When she begins to remember painful memories associated with her father and other abusive men, she become anxious, then loses time. She reports not having any friends with whom she could talk, and get support and perspective. She lives a life devoid of pleasure, and refuses to use mood-altering substances. She fears substance-induced vulnerability and increase in the sense of fragmentation.

Sally's dissociative pathology is characteristic of victims with severe post-traumatic dissociation originating in early sexual abuse with serious identity fragmentation. This results in the formation of distinct coherent identities in the context of altered states of consciousness.[53],[54] These autonomous identities may at times coexist, at other times operate in sequence, while still at other times alternate, but in the absence of the normal integrative functions of thinking, feeling, behavior, memory, and identity. This means that conscious functions go on without the benefit of integrative coordination and connection so critical to healthy personal daily functioning.

While dissociation may have proven an effective defense during the initial moment of the trauma to ensure survival, Sally's serous identity fragmentation reduced effective problem-solving in her every day life, while increasing the sense of inner tumult and confusion.

For sexually traumatized victims with PTSD or DID like Sally, securing treatment with a trauma specialist is extremely important. For they are trained to identify and evaluate trauma problems, and then skillfully intervene in illuminating past traumatic events and offering hope, resilience, and control.[55]

Case Example 2: Child Sexual and Physical Abuse, Male:
Post-Traumatic Stress Disorder and Substance Abuse

Wayne is a 35-year-old divorced Caucasian male. He and his wife were married for four years and have one child. Their relationship ended in divorce due to Wayne's substance abuse, withdrawal from family involvement, and a lack of intimacy within the relationship. He presents with a history of depression, addiction to heroin, cocaine, and marijuana. He states that he has been using substances since early adolescence. He enrolled in a substance abuse program with the objective of transitioning into a trauma/PTSD Program. While in the substance abuse program Wayne's traumatic remembrances and nightmares began to surface. He complained of nightmares, intrusive thoughts, sleep disturbance, and feelings of anger, and paranoia.

Wayne was born into an intact family in 1968; he is the youngest of four children. His father, who was physically abusive to all members of the family, had several addictions that included substance abuse and compulsive gambling. When Wayne was six, his parents divorced and he lived with his mother and siblings. Three years later, his mother remarried a man who also had a history of substance abuse and physical aggression. It was at this time that the stepfather began to sexually abuse 9-year-old Wayne, his older brother, and his sister. He stated that his mother treated him kindly, but was emotionally detached and unavailable due to the abuse and threats that she received from her husband. The sexual abuse continued until Wayne was in his early teens, and the physical and emotional abuse continued until he moved out of the house.

Wayne's stepfather would force the children to engage in sexual activities with each other for his entertainment, as well as his drinking companions whom he would bring home. When Wayne was approximately 14 years old, his older brother sexually abused him. One day their mother caught them engaged in felatio. She proceeded to utter Biblical fire and brimstone rhetoric, indicating their behavior was sinful and wrong. Many years later when Wayne confronted his older brother about the abuse, the brother pulled out a Bible and started to preach to Wayne. At that point, Wayne remembered his mother's non-supportive Biblical "intervention" years before in which he felt let down and angry with her. He attacked his brother to harm him mortally, but their sister intervened and prevented Wayne from harming his brother any further. He left the house and broke all contact with his siblings until the mid-phase of his therapy.

The assessment revealed that Wayne's behavior throughout his High School years was volatile and hostile. Wayne was suspended from school several times for fighting because he was teased, ridiculed, and made fun of. Wayne describes his time in High School as being isolated, depressed, and as not fitting in with the other students. Wayne was singled out as "strange," and would respond violently against those who bullied and ridiculed him.

Wayne graduated from High School at age 17. He reported that throughout his adult life, including the military that he would get in violent conflicts with people around him. As a result of the physical and sexual abuse and degradation he endured while growing up, and made worse by peer teasing throughout his High School years, Wayne decided to join the United States Marine Corps as a way to escape and gain self-respect and bolster his self-esteem. He also thought that by joining the Marines he would prove to himself and others that he was a real man and not some passive queer.

During his first eight weeks of Basic Training in the United States Marine Corps, Wayne excelled at the physical demands. At the beginning of the next six weeks of training he was sexually assaulted early one morning by three members of his training unit. The three people who assaulted him threatened him with

death if he told anyone about this event. They also told him that they would turn any story he told around and tell others that he solicited them.

Throughout the three years he spent in the Marine Corps he never mentioned the sexual victimization episode. It was after the assault that Wayne was frequently reprimanded for fighting and not acting as a member of the team. He was often reprimand for his physical appearance and the sloppy way he kept the living quarters designated for him. Wayne was also brought up on disciplinary charges before the Captain for drinking, fighting with other soldiers, and for his general military attitude and outlook.

During the evaluation process, Wayne further revealed that since leaving the military memories have surfaced from the past, and he found himself falling into a self-destructive mode observed in persistent use of drugs and alcohol. However, when he was sober for any period of time, his paranoia, nightmares, and flashbacks would increase and devastate his conscious experience. As his anxiety level would rise, his paranoid aggression would become indiscriminatively focused on anyone around him at the time. He would be highly suspicious of people he saw as "intruding into my space." As a protective/defensive interpersonal maneuver, Wayne would immediately explode into rage. When asked what he would like to do about his circumstances and the sexual victimization, he stated that he would like to better understand why he is the way he's been in the past.

Case Example 3: Sexual Assault (SA) by Group of Male and Female Assailants, Female: Post-Traumatic Stress Disorder (PTSD) Traumatic Conversion Reaction, and Ethnocultural Issues

Tanya is a 38-year-old, single woman of African American heritage who was referred by a neurologist after finding no organic basis for her lack of sensation from her waist down. This symptom began when she became engaged to be married in five months. The conversion symptom occurred after the plans had been made and the date for the wedding set. Tanya began to remember the brutal rape she had endured when she was 20 years of age. "I was a very young, innocent girl," she explained, "It was too much for me to deal with." During traumatherapy the details emerged over time: one male friend had raped her while she was held down by another male and two females. She exclaimed, "Four of them and only me!" Each rapist took turn in the collective abuse. The details were vague, and had remained shrouded in amnesia and other dissociation-based processes. But rage, disgust, humiliation, and shame were ever-present in her life since the episode.

Tanya was an executive secretary at a large advertisement firm at the time of the rape. This was the first time the victim had experienced a conversion reaction, the first time in therapy, with no history of previous traumatization. The course of Tanya's post-traumatic illness over the ensuing 18 years had been manifest in incapacity to neither establish nor maintain healthy intimate and sustaining nonintimate relationships. Getting and holding onto good jobs were elusive. Since the rape, Tanya had been involved in self-destructive behaviors, multiple sexual partners, to include group sex, and sadistic sex acts. For years she wished to seduce men, to let them "pay for" what "they" had done to her. But she also wanted to "get back" at the "incest girls," women assailants whom she believed to be "like family" until they raped her. For her, women were also "at fault, they had helped me get raped." In therapy, these issues surfaced and were addressed, particularly in Phase 3 of the treatment.

Tanya stated that sexual relation with her fiancé was very stormy, chaotic, difficult and inconsistent: at times "My sexual appetite was so great, I felt like a slut," she explained," at other times, "I was a nun."

Deeply, "I did not feel I deserved such a good man in my life. I guess I don't think I deserve to be happy. He's just terrific."

Tanya was born into an intact family with two brothers and two sisters, a fact that was not lost to her unconscious mind. Its dynamic significance had linked "family" to rapists, and thus became an important issue for Phase 3 explorations in therapy. Growing up she felt loved and appreciated by both parents during her entire childhood and adolescent years. As an African American victim in therapy, the clinician was mindful of the need to be aware of the potential for racial bias in assessment and treatment, and the importance of a transcultural perspective with victim/survivors of ethnocultural minority backgrounds. [56] [57] '

Notwithstanding Tanya's positive upbringing, she reports growing up in the South feeling like and outsider, and was very suspicious during her encounters with the White people in society. She believed her view of self, family, and community had been shaped by her experiences with racism. In examining Tanya's life she believed that her family was unable to protect her from the negative effects of the community where she grew up. It was clear that early sociocultural conditionings and internalizations where she grew up also shaped the victim's sense of self.

The way Tanya described her self-view was reminiscent of many Black Americans mentioned in Comer's *Beyond Black and White.* These Americans grew up believing what they had been taught, "that white is good, that black is bad; that white is strong, that black is weak, that white is intelligent, that black is stupid; that white is moral, that black is immoral; that white is beautiful, that black is ugly."[58] Her almost exclusive focus on survival during her early years is of interest here. Like Johnson and Lubin's account of the Vietnamese people's tendency "to frame and contain potential distress … [and] move on and focus on survival,"[59] Tanya was also doggedly determined to *contain within self* the memories and affects associated with the collective rape experience.

After the rape, Tanya was severely depressed for months, suffering from intrusive ideation—flashbacks and other reexperiencing phenomena in which she revisited in memory and emotions the brutality of the forced rapes, seeing her abusing assailants. Low self-esteem and self-loathing, and shame and guilt were early issues brought into the therapy. Helping the patient to develop self-compassion and self-soothing to trust her own instincts and body, and the exploring of the meaning of gender, race, and "family" were important considerations in therapy.

It is important to note that, despite the clinical and scientific advances in trauma treatment, clinicians still rely on clinical wisdom and available knowledge about trauma dynamics to do their best traumawork.

Phase-Oriented Therapy for Sexual Trauma Victims

Phases of Post-Sexual Trauma Therapy: Principles, Procedures and Techniques

For over a century the treatment enterprise with trauma victims had been conceptualized in terms of a series of phases, originating in the ground-breaking work of Jean Pierre.[60] Daniel Brown of Harvard Medical School and Associates highlight this way of organizing trauma treatment as the most widely used today, mentioning Mardi Horowitz and Erwin Parson as two trauma experts who have rediscovered and applied the phase-oriented treatment model to contemporary treatment ventures. Specifically, they view Horowitz's contributions as a modern rediscovery of phase-oriented treatment, and Erwin Parson's work, also employing a phase-oriented design, as essentially laying "an integrated foundation for contemporary

treatment."[61] The phase-oriented model has in very recent years been applied to such varied trauma populations as adult female and male CSA victims,[62-64] rape victims,[65] dissociative identity disorder,[66] inner city children exposed to community violence,[67] child victims,[68] families, [69] and war veterans.[70-72]

Multitheoretical Orientation and Applications.

Despite what most trauma authors claim about the efficacy of single techniques in treating PTSD (for example, "a behavioral approach to the treatment of PTSD," or "treating trauma using cognitive-behavioral techniques," or "a psychodynamics approach to treating victims of incest," etc.), there is no evidence that single techniques go all the way to deal with the wide assortment of disruptions in post-trauma relational transactions. Thus, a rational, prescriptive approach is preferable; that is, one that organizes a variety of psychotherapy orientations geared to work together, integratively to resolve specific clinical/developmental problems. This prescriptive approach[73] employs techniques that range from behavioral, cognitive, cognitive-behavioral, existential, and psychodynamic schools of therapy.

Even though intrusion and arousal symptoms appear to be the most behaviorally and emotionally dramatic and distressing to survivors due to the high levels of disintegrative anxiety, clinical experience has shown that another class of symptoms of PTSD may be even more insidious, and more damaging to the self.[74] These symptoms form the dissociative core of *numbing-avoidance-arousal defense* reinforced by the persistent, unrelenting "biological engine of hyperarousal"[75],[76] The multiplicity of trauma symptomatology requires a broad range of treatment techniques to reduce the frequency of clinical failures in traumatherapy. When numbing/avoidance and related dissociative elements are not adequately addressed in treatment the processing of the patient's trauma psychopathology is undermined.

These defenses retard development by anesthetizing emotional engaging, and by robbing the self of the surprise that comes from the *courage to be,*[77] the daring to take growth-enhancing risks. These defenses, moreover, are about strict, dissociation-based control over developmentally critical *spontaneous engagements* with the world of persons, and natural and non-natural, animate and inanimate features of the environment.

The present proposed multiphase, developmental model was designed to manage the multiplicity of problems victims and survivors endure in wake of overwhelming events.

Phase 1: From Denial and Excessive Emotional Reactivity Toward Internal Security, and Realization

The basic function of Phase 1 is *stabilization:* helping the survivor to learn how to reduce traumatic stress responses, particularly arousal and emotional reactivity set in motion by instigating environmental devices. This phase promotes in the survivor a sense of internal security in and outside the treatment relationship as well as developing trust. Additionally, the victim learns how to effectively contain unbidden, spontaneous memories and induced emotional reactivity.

A systematic life-history review and data collection were conducted for each survivor mentioned in the case studies above by the trauma professional. This consisted of information from pretraumatic, traumatic, peritraumatic, and posttraumatic aspects of the survivor's experience.

In this phase, survivors are introduced to such techniques and procedures as trauma education (imparting knowledge about trauma and PTSD, and the normalizing of the stress response for victims and families), grounding, centering, visualization, and relaxation skills training (to control fear and anxiety), breathing

retraining (slow abdominal breathing), and positive self-talk (exchanges with negative thinking). Homework is essential for survivors at each of the three phases of the treatment. In this phase homework assignment included writing autobiographical narratives from childhood to the present time; and letters to perpetrators (for Sally, Wayne, and Tanya). Family Kinetic Drawings (figures are drawn "doing something," and are later highlighted by color pencils or crayons), letters to non-abusing parents, and application of the WILFY™ Method ("What I Learned From You")[78] are clinical procedures found to be useful with patients like Sally and Wayne whose healing and integration required communications with traumatizing figures in early childhood. In this phase survivors also learned about their diagnoses and meanings, the meaning of their symptoms and responses, therapy "tough spots" or challenges, and the implications for success or failure of the treatment experience.

These behavioral and cognitive techniques provide anti-reactivity control to help survivors cope with the trigger-induced subjective sense of being overwhelmed by emotions driven by traumatic thoughts, images, sounds, physical sensations, taste, and smell. The treatment of victimized women needs to include reality-based self-defense training to prevent future revictimization.[79]

Since the first phase is conceived as critical to attaining subsequent phasic developmental resolutions,[80] the therapist ensures that survivors have grasped the basics and are progressing to advanced levels of stress management skills *before* they move to the next phase where the emotionally evocative power of direct exposure requires preparation. These and other techniques were found to be immeasurably beneficial in stabilizing the survivors' inner world to ensure a sense of inner security that lay the foundation for identity consolidation. This acquired sense of security reinforces confidence early in the efficacy of the process, and offers courage to continue this most difficult and essential work.

As an aspect of Phase 1 treatment, psychopharmacologic agents such as SSRIs, Nefazodone, Venlafaxine, tricyclic antidepressants, or mood stabilizers have proven to be useful with survivors in therapy.[81] These and other medications either used singly or in combination often offered significant benefits to trauma survivors.

Sally, Wayne, and Tanya were also encouraged to keep a log for recording contemporary reality and distorted dimensions of everyday life. This includes identifying and writing down specific cues that instigate dissociative reliving, and feelings, fantasies, thoughts, aspirations, triumphs, and actions. Writing (journaling) facilitates cognitive and emotional processing of trauma now widely accepted as having healing properties for mind and body.[82] For the three survivors, this procedure facilitated self-understanding, and self-appreciation for who they were, who they are, and whom they are to become through a newly acquired sense of future (no longer of a foreshortened future, but of expanded, forward striving view—a future of possibilities).

For many survivors, the first phase begins a transformation in which good feelings are no longer evanescent, but stay around a while and endure. Levels of threat posed by suicidal and homicidal ideation and self-injurious behaviors are continually monitored, and a contract for safety is formulated for these survivors, particularly for Sally.

In Sally's case, Phase 1 began the essential overall task of integration, the transforming of alternating, sporadic inner experience into continuity of consciousness. The therapist helped Sally develop a lifespan continuum from birth to the present, constructing a cognitive-affective-experiential bridge of the identity system that spans pretraumatic-to-post-traumatic histories. For DID survivors therapy requires the capacity of both patient and therapist *to go into the unknown,* facing the portents and threats posed by disintegrative anxiety. For Sally, the alters created an internal "regime of terror," requiring active, trauma-

informed expert management to forestall regression, while enhancing the chances for integration and sense of coherence.

Management of DID illness in patients can be very daunting to both survivor and therapist, especially in the context of severe fragmented personality identities. Moreover, during this phase Sally began learning about "internal communication," and conceptually grasping the importance of acknowledging and listening to the dissociated voices within her mind and body, and then make appropriate and safe "team decisions" about the most adaptive way to meet collective needs. Thus, Sally's treatment also consisted of identifying and clarifying communications and establishing safety contracts with each alter.

This phase also attends to the special needs or concerns of each alter, and develop meaningful strategies to meet these divergent needs and perspectives. Sally's extreme passivity and apparent underlying "silent brewing" rage called for assertiveness training in order to help her express her opinions, needs, desires, and feelings adaptively to be able to secure the things she needs from others. This focus would continue in Phase 3 where strong, split-off emotions connected to *trauma-based internalization* of violence (that may undergird her passivity, forcing her into, what Karen Horney referred to as the *self-effacing solution*) could be identified, elaborated, understood, and integrated.

Wayne's treatment plan consisted of combination therapy (individual and group). As member of a trauma therapeutic education group for adult male survivors of incest and child abuse, he was encouraged to examine his life in a constructive way to help him better cope in the aftermath of multiple traumatic events. As an aspect of the treatment enterprise, the group fostered a means of gaining insight through collective experiencing and mutual support.

Assessment with Tanya, the third case reported above, revealed she suffered from a trauma-origin conversion reaction, in which she had lost sensation in the lower parts of trauma-related thoughts, feelings, and actions flooded her conscious experience after setting a date for her marriage. She was able to make connections between her current problems and their traumatic antecedents. As Tanya established emotional bonding with her therapist she achieved courage to trust and to believe that it was possible to recover her body—"from the waist down." She spoke about her aversion for sex with her fiancé, this occurring just after setting a marriage date five months away. The apparent conversion episode became a problem for her two months prior to trauma treatment.

Conversion reactions have been viewed as loss of memory for the trauma, even though awareness of the trauma is "evident" through the body parts that were affected.[83] Tanya's lower extremity gave "voice and expression" to unspeakable horror of gang rape. Conversion represents a loss of language, and her lower body represented what was being symbolized.

After a detailed exploration of underlying dynamics for Tanya's conversion symptoms, the therapist introduced her to Phase 1 treatment procedures, which included learning about trauma and PTSD, trauma and the psychodynamics of conversion symptoms and their possible meanings, sexual trauma and implications for intimacy and general relational behavior, and responses to daily stressful events. Due to the close culture-based values held by the family, family therapy[84],[85] consultations were helpful to Tanya in dealing with shame, secrets, alienation, anger and distrust that had consumed the family. It was very important to Tanya that, as she began to understand the dynamics of trauma upon her life, her family would also attain this knowledge as well. She felt in need of respite from her the family's negative comments and attitudinal "attacks."

Family values and perceptions dictated that Tanya should be reliably resilient rather than passively succumbing to what had happened to her. The trauma symptoms she experienced were seen by family members as evidence of mere weakness and lack of will. But, since she had always been "the strong one" of the family before the rape, family members were miffed by her changed attitude and behavior. Tanya, like her family, preferred to see problems as "disease" with a cure through medical treatment. They were not prepared to view her problems in psychological terms, and so resisted and ridiculed this possibility. Thus, by necessity, racial/ethnocultural issues were interwoven into the fabric of the sexual abuse treatment itself with Tanya.

Like many African American children, Tanya grew up using a self-inoculating coping[86],[87] strategy to deal with an environment perceived to be difficult and inhospitable.

Tanya believed that suffering was the legacy of being Black in America, and that the rape and associated violence and injustice were just another burden to be borne without complaining.

From a family-cultural values perspective, Tanya was expected to go on as though nothing had happened, and she was not allowed to "complain" to family members or friends. Prior to the rape, the patient had always been close to her family and visited them frequently. A brief assessment and comparison of her social network before and after the rape revealed that her visits with family members and friends decreased, and she experienced emotional indifference and disconnection from them. This degree of alienation reflected Tanya's *social network disturbances*.[88] She had the strong conviction that she could not (due to cultural prohibitions) share her ordeal with anyone, that "her trauma' was hers to bear alone. In fact, she felt there was "virtue in legitimate human suffering" like hers. This led her to maintain a *purposive* attitude of silent stoic suffering, and, as she put it, "I refused to dwell on this thing!" However, her behavior and body told another story she could not forever ignore or escape.

A variety of culture-based phenomena appeared to be operative in Tanya's clinical presentation and ongoing behavior and attitude in therapy. The many reality-based problems this survivor faced during the first phase of therapy required therapeutic adaptations to everyday life.[89],[90] to help Tanya to access concrete social, medical, and financial services.

With this survivor and others of ethnoculturally diverse backgrounds with histories of rape, and child sexual abuse and maltreatment[91], it is useful for practitioner to become cross-culturally sensitive. That is, "to develop skills and practices that are attuned to the unique worldview and cultural backgrounds of clients striving to incorporate understanding of client's ethnic, linguistic, racial, religious, and cultural backgrounds into therapy."[92],[93]

In transcultural trauma treatment some interventions may prove to be modifications of contemporary practices with Western-oriented survivors. Were it not for the conversion reaction, which brought her focus on physical/medical concerns and restraints to her ability to move around physically, it is doubtful that Tanya would have *come* for therapy. And if a multicultural perspective were not used with her in therapy it is doubtful whether she would have *remained* in treatment until termination.

Race and ethnocultural factors are usually omitted from the clinical trauma literature, giving the impression that they have no relevance. Tanya's case illustrates the need to integrate cross-cultural factors in sexual trauma treatment. We know that the field of ethnopharmacology is growing because clinicians are recognizing the reality of cross-ethnic variations and ethnospecific factors in how the body absorbs, distributes, metabolizes, and excretes drugs (pharmacokinetic), and the reactions between drugs and living systems (pharmacodynamics).[94]

According to McCann and Pearlman, treatment decision-making that advances the survivor from one phase to a developmentally more advanced one, depends on a few factors: Among these are "the willingness and readiness of the client, the phase of therapy, and the availability of considerable resources and capacities."[95], p. 225 This phase ends with a solid foundation for Phase 2, and acquisition of *realization.*

Realization is a mental state that is an outcome of early resolution, relief, and confidence in the treatment. It shapes a level of motivation that ensures traumawork will continue, that the patient will persist and not give up. Realization regulates treatment- and social-destroying emotional reactivity, and bolsters stability without which progressive awareness and integration may not occur.[96] Realization is when the lights go on in the mind and displaces the darkness, and transforms despair and hopelessness. This state of mind energizes subsequent treatment phases, and offers the necessary acceptance and, commitment from which flow motivation to complete the therapeutic work. It is an outgrowth of hard, successful trauma work during the first phase of therapy. It refers to a specific point victims reach when they conceive vividly as real the traumatic past, the present trauma realities, and the prospect of a future *beyond* trauma.

Realization is about *being real after discovering what's real.* The survivor, no longer victim, brings into concrete existence new, healing affirmations that have been so elusive prior to therapy. This is the time when fear of breakdown is transformed into anticipation, courage, and optimism that Phase 2 will be an adventure not a portent of awful things to come.

Phase 2: From Quasi-Stabilization and Reactivity Toward Increased Internal Security, Control, and Consolidation

In Phase 2 Sally's treatment was devised to break up dissociative amnestic barriers which are associated with alters containing fragments that compartmentalize the memory for the trauma. Basically, the objective of this phase is less about recovering memories and more about processing memories to release intrinsic meaning, and to build control, and mastery. Sally's repetitive and cumulative exposure to child sexual is reflected in Freud's early writings on the evolution of traumatic neurosis in victims of traumatic abuse. He stated, "What left the symptom behind was not always a single experience. On the contrary, the result was usually brought about by the convergence of several traumas, and often by the repetition of a great number of similar ones."[97], p. 37 Thus [in treatment] it was necessary to *reproduce the whole chain of pathogenic memories* in chronologic order, or rather in reversed order, the latest ones first and the earliest ones last."[98], p. 37

This memory work emphasizes a cognitively-engaged mastery viewed as superior to mere emotionally-based abreaction, because mastery brings about integration of narrative memory. Integration is transformational in that it fosters a structural turn-around in capacity for modulation of arousal and impulsivity, evidence of developmental maturation trends in the survivor's self.

This phase attempts to accomplish one fundamental task, the *processing of trauma memory.* In this process, memory is the actual focus of the treatment. The techniques used in this phase are referred to collectively as *direct therapeutic exposure* (DTE). This process is defined as "repeated or extended exposure, either in reality or in fantasy, to objectively harmless, but feared, stimuli for the purpose of reducing negative affect."[99], p. 3

Memory processing made it possible for Sally, Wayne, and Tanya to transform narrative trauma memory into consensually-validated information that could now be part of their autobiographical memory and history. To enhance integration and achieve a stable sense of self it is necessary for conflicts between and

among alters be identified and processed toward integration. The post-trauma striving to achieve a cohesive self is accompanied by life-affirming ideals and high, realistic ambition, accompanied by a progressive dissolution of disjunctive walls within the self.

Phase 3: From Shame, Guilt, and Transgressive Narcissistic Injury to Connection, Spirit, Integration and Acceptance

While Phase 2 focused on trauma memory processing, this phase centers attention on *processing relational representations* (or relational processing).[100] As noted before, as a consequence of the sexual trauma, survivors experience shame, guilt, self-doubting, and narcissistic injury in wake of sexual transgression trauma. This form of trauma is caused by *people*—human agents; that is, in interpersonal transactions with the victim. Trauma always involves people—individual or group: *it's the internalization of people that dynamic therapeutic techniques of this phase aim to address.* What happens to victims after exposure to brutal rape and CSA is a negative transmutation that derives from having *internalized* the overwhelming violence, sadism, and cruelty of the perpetrator. This is why many victims are mystified by discovering their behavior and attitude "reminding" them of their perpetrators/violators. This internalization is not a neutral event: there are significant consequences for the victim, the therapist, and for the course of treatment and recovery.

In this phase what's called for are technical approaches aimed to reverse this adverse trauma effect. Cognitive-behavioral procedures are used in the early part of the phase, and are geared to deal with trauma-based relational schemas. Psychodynamic techniques are employed in later parts of the phase to deal with internalized violence and transgression. Emphasis on relational dynamics of sexual trauma in this phase is referred to here as *direct relational exposure* (DRE). In part, DRE involved the use of the survivor's free trauma recall, combined with exploration of transference (reactions to pretrauma experiences with people), trauma-origin transference (TOT; experiences with people associated with the event), and countertransference (therapist responses based on early experiences in therapist's life), trauma-origin countertransference (TOC; experiences with people associated with a traumatic event in the therapist's past), vicarious identification (with the survivor's suffering), and assisting the survivor to establish and maintain personal boundaries.

Through DRE procedures survivors learn about the enduring effects the victimizer's traumatizing actions had on their bodies, minds, spirit, and life in general. Accessing and processing trauma relational information may contribute to the progressive mobilizing of trauma-arrested development.[101] And because of the survivor's newly acquired experience of intrapsychic and social security accrued over time *in* and *outside* of therapy, new levels of courage are available to engage in transference work, free-association, and imagery techniques to gain even greater freedom from the imprisonment of trauma dynamics. Reliving intense emotions in a security-generating therapeutic environment can lead to corrective/restorative effects on those neuroendocrine, biochemical, and neuronal pathways of vulnerabilities associated with PTSD and complex PTSD.

These relational dynamic that are sufficiently powerful to alter neuronal pathways may not be amenable to resolution through cognitive-behavioral techniques alone. This is in part because the persistent negative affects in survivors involve *interpersonally-born* hostility, and violent, sadistic fantasies now unconsciously owned but consciously disavowed by the victim/survivor. It was thus very difficult for Tanya to conceptually grasp the notion that she had been changed in such radical ways as to "resemble" her perpetrators in a number of ways as she reflected on her feelings of revenge and *rage at the source*[102] of her trauma.

Memory processing (as in direct therapeutic exposure, DTE[103]) is obviously an important consideration in the overall structure and organization of trauma treatment planning and implementation. However, it should not be the only focus in trauma treatment of severe dissociative and chronic PTSD cases. Thus, *who* the victim has internally *become* after the trauma[104] is not an issue of deconditioning of negative affect, but is one of *identity* and its restoration, and should *not* be ignored in traumatherapy. Identity (or a cohesive sense of self in the aftermath of severe dissociation) requires other forms of integrative procedures—from the therapeutic relational domain that involve the *person* of the therapist.

There are two kinds of internalized tendencies after sexual trauma: (1) experiencing the dissociated aspects of perpetrator mannerisms, rhythms, style, voice tone, and behavior, and (2) the narcissistic scarring and spirit-wounding producing narcissistic rage, and a deep pervasive sense of violation. Notwithstanding Tanya's knowledge that her perpetrators were given severe sentences for their crime against her, she felt no relief. This is quite instructive in light of the scenario we often see on television among victims and surviving family members and friends who believe that justice can only be served when the criminal is caught and punished to the fullest extent of the law.

But even after the harshest punishment is meted out, very little relief is experienced by victims and their families. Why might this be so? What victims are often not aware of perpetrator aggression, hate, and power-divesting behaviors have made an indelible imprint on the survivor's mind and body. This imprint needs to be resolved, for it is probably the only way victims/survivors will be free of tendencies to self-hatred, antipathy, and paranoidal fears and distrust of others (all based on internalized attitudes and projective internal devices). The intensity of ever-present angry feelings (actually it *is* aggression) experienced by many victims is a way to repair open trauma wounds or narcissistic injuries. These feelings also represent an unconscious longing for reconnection, and for integrative wholeness. Additionally, negative affects are motivated to deal with the perpetual numbing experience of nothingness, sense of transgression, and vacuousness that never seem to go away.

Working on her "dissociated perpetrator self" was very difficult for Tanya as it is for most survivors of horrific sexual violence and sadism. One of the major unacknowledged problems in sexual trauma treatment yet to be meaningfully articulated in the literature is the consequence of failure to resolve internalized perpetrator aggression-based elements. When unresolved these elements go beyond distrust and antipathy for the criminal violators themselves. These extend to all or most people, since the traumagenic transgressive violation resulted in a severing of the victim's connection from the very corpus of society. Essentially, this severing produces a breakdown of a sense of communality and connection,[105] making all or most persons seen as "alien" suspects with possible re-victimizing intensions on their minds. For some victims these "suspects" may be mostly males (for Sally and Wayne), for others both males and females (as in Tanya's case).

Tanya complained of feeling "just like" her assailants, of "feeling evil," and of not being able to free herself from the intense hatred, and wish to do to harm to her assailants and to even nonassailants. But it doesn't end here: her feelings of anger were not only aimed at the "generalized other" of society, but also directed against the self—as in self-hatred, self-mutilation, suicide ideation and behavior, and even traumatic conversion. This appears to be the case because the internalized aggression is structuralized into the mind and body, and, therefore, an intrinsic part of Tanya's overall biopsychobehavioral functioning.

"At times," Tanya explained, "I feel as if I could do the same thing to them or to someone else. I can't get the hate out of me: and it's killing me!" During another session, she queried, "Is it possible for me to be that cruel, hateful, like them [assailants]?" As the treatment progressed she was able to feel intense emotions as her former emotional constrictedness gave way to greater range of feelings and comfort with her self and with an increasingly intense treatment relationship. As she remembered more aspects of her

ordeal, and progressively and succeeded in integrating dissociative affects and cognitions, her trauma-based conversion moved to complete remission. This major success increased Tanya's self-esteem, commitment, and motivation to work even harder in therapy to take even greater risks, which lead to even greater gains in self management, realization, and in relational development.

D. W. Winnicott On Developmental Arrests and Its Reversal.

After the sexual traumatic event, the victim experiences life as a day to day post-traumatic retreat in personal maturation. Like developmentally immature younger persons, trauma victims experience annihilation anxiety, intrapsychic disorganization, distrust, impulsivity, and ineffectual social functioning. This state is reminiscent of the passivity, dependency, and vulnerability of earlier developmental periods. The survivor's developmental arrests is additionally observed in the incapacity to remember, to use symbols and language, and to experience both the cognitive and affective aspects of the trauma simultaneously.[106]

The concept of developmental arrest is a useful one in helping the therapist and survivor to conceptualize the work that has to be done. If one aspect of post-traumatic sexual victimization can be understood as producing arrested development, then trauma treatment may be understood as a system of care that facilitates growth and maturation of the victim's self. This is in line with Kohut's assertion that when therapy works it may be regarded as having "reactivated the developmental potential"[107] of the traumatically distressed, vulnerable self.

After reviewing the empirical basis for outcome-relevant treatment with chronic PTSD sufferers, Ford and Kidd concluded that the self-psychological works of Kohut and Wolf, and Parson may be of value with DESNOS-based disturbances of the self.[108] This is in part because the survivor who suffers DESNOS pathology also experiences severe deficits in general self-regulation, self-soothing, in self-esteem, and in modulation of arousal and aggression.

This level of trauma-born immaturity requires a particular kind of clinical environment, comprised of the therapist's technical and personal qualities and attitude. Essentially, this environment is one with an overarching design that accommodates a broad spectrum of *holding* techniques to deal with wide-ranging types of trauma symptomatology. Traumatherapy helped Tanya resolve her traumatic conversion through making deep, buried memories of the traumatic event conscious. This gave *language* to her *mute, unsymbolized, dissociated experience*.[109]

Growth beyond trauma is thus an important ideal: it implies a reversing of trauma-origin developmental arrest. Personal growth here implies the maturation of control structures that facilitate healthier, more adaptive behavior. Such enhanced capabilities are associated with maturational events associated with *new psychic structure*.[110] New structures facilitate internal power that is resistive of threats to regressive/dissociative and other primitive trauma processes. This developmental *deepening* begins on the surface. Kluft is correct when he asserts that therapists need to work with "trauma 'from the top down,' working with consciously available material first, because the best approach to uncovering unavailable material [is] resolution of presenting concerns."[111], p. 106 The model proffered in this article actually begins with easily accessible memory/affect configurations that may be readily tolerated in the treatment. "From the top" treatment includes: rapport-building relational strategies, cognitive and behavioral approaches, while "down" practice include existential/phenomenological, and psychodynamic techniques.

D. W. Winnicott wrote extensively on the role the patient-therapist relationship in mobilizing arrested development. He noted a striking similarity in dynamic patterns of bonding to the infant-caretaker

relationship. He was a British pediatrician turned psychoanalyst. As a specialist in pediatrics, he saw infants and young children and their mothers for treatments and consultations. He later studied the adaptive value of the rhythms, pulse, mutual cueing, and affectional bonding between child and caretaker. This essential biological/emotional mutuality led him to later theorize that the nature of this relationship was *prototypical.* It was requisite for promoting a sense of safety and nurturance, and for separateness and independence in anxiety-prone, developmentally immature persons. The survivor also benefits through the acquired ability to come to emotional terms with the good and bad in people and the world.[112]

The indispensability of the therapeutic alliance in traumatherapy emerges from the positive influence this relationship has on fostering integrative health and meaning for the survivor. This influence does not only manifest itself in surface behavioral change, but in structural endopsychic/somatic change that prove to be salutogenic—toward adaptive, integrative functioning.

Someone might ask, "What therapist variables would ensure the ability to move the survivor's arrested development forward? Are such variables as age, gender, experience, level of personal maturity, shared ethnicity, or theoretical orientation the essential elements for this treatment task?" Obviously, all the factors—singly or in combination—can enhance the value of sexual trauma treatment for survivors. Beyond these specific factors, however, is the indispensable treatment variable, the *clinical therapeutic attitude* characterized by resolute empathic attunement that is most important. This attitude involve intersubjective phenomena[113] that pass back and forth from survivor to therapist, infusing both with *inside trauma data* that facilitate relational processing, and the achieving of transformational insight and control.

The therapist also presents self as a model of containment and control, and of contentment, aspiration, and hopefulness. S/he, additionally, shows the way when it comes to learning how to trust, and demonstrations of competence in managing life and here-and-now reality. The therapist ensures a treatment atmosphere where not only intratherapy security is maintained, but where there is generative empathy and passion[114] for the patient's welfare. By this is meant a kind of parental preoccupation[115] that genuinely responds to the patient's trauma-associated maturational needs.[116] [114] Here, in practice, the therapeutic relationship takes preeminence over technique, and technique over theory. Here, when there is clinical conflict between survivor-driven therapeutic actions, and pure theoretical abstraction, the survivor's needs are given primacy. This challenge also involves the therapist's willingness and capacity to "hang in" with the survivor, and be capable of living in a *shared,* turbulent emotional climate and terrain without reverting to "sidelining" diversions, away from the patient's traumatic distress when things get hot and heavy in the treatment. This personal and technical connectivity of therapist and survivor ensures attainment of corrective emotional experience through an altruistic, unselfish adult "concern in *establishing* and *guiding* the next generation" [italics add].[117] [114] We, like Winnicott are aware that adults in traumatic distress in psychotherapy are not infants or young children. But in trauma the degree of neurobiological enfeeblement and dissociogenic-proneness make the victim resemble one who has lost the developmentally early capacity for self-soothing and modulation of arousal and dysphoric emotions. And these are developmentally early achievements during the course of the individual's lifeline. Clinical practice shows that trauma-caused deficits in basic self regulation are best overcome when the survivor experiences an environmental anchoring in therapy.

In mobilizing arrested development out of stagnation caused by denial, apathetic numbing, and avoidance dynamics, the therapist does not only provide a safe, professionally pleasant environment for the work to occur, but she or he is empathically attuned to the survivor's memories and traumadynamics, making them comprehensible and congruent with a positive future viewpoint for growth.

The therapist is *the* anchoring agent whose empathic availability functions to regulate internal disorganization, while forestalling biological slippage down into adrenergic turmoil, chaos, and

helplessness. Moreover, here the therapist is experienced by the victim as an *extension of self,* providing regulatory and soothing/reassuring functions until s/he reclaims lost developmental ground and is then sufficiently equipped to perform these functions for self.

According to Kohut, these internally-based changes reflect positive structural shifts that were made possible due to "micro-internalizations."[118] These come from the therapeutic environment and positive influences and experiences outside of therapy. The patient now learns to transform *self as survivor* (that is, one who still restlessly thrashes about, with little or no inner peace) into *self as boomer* (that is, one who blossoms with hope, insight, resilience and control—intrapsychically, spiritually, socially, and neurobiologically).

The Meaning of Safety—From Whom, From What?

Despite trauma therapists' view of safety as the sine qua non in achieving effectiveness in trauma treatment, no unequivocal explanations have been articulated to date about what is meant by "safety." The concept of safety is so ubiquitously used and intuitively "understood" that no one ever seems to ask, "Safety from whom, from what?" For many clinicians and survivors, alike, the need for safety after trauma is self-explanatory.

Clinicians, like family members, friends, and pertinent officials after traumatizing disasters, often give good safety advice to help keep victims safe from remembering and reexperiencing the trauma, and from being exposed to potentially dangerous environmental situations. And these reality-based instructions are often very clear, prudent, helpful, and consensually understood. The general impression conveyed is that what victims are to be kept safe from is some unseen, amorphous but powerful physical presence. The presence is ill-defined, but dreadful, lurking out there somewhere in the socioenvironmental sphere. But, more often than not, the *true* object of fear is the internalized multifarious demonic presences of the abuser.

This pernicious presence comes from inside *not* from outside the survivor. And only a treatment environment that is capacious in holding and containing primordial fears and anxieties will suffice. In essence, it is the person of the therapist that truly provides safety for the *internally* endangered victim. Thus, what therapists keep survivors safe from are the *internalized presences* of the abuser (or perpetrator), or *whom* they have become as a consequence of exposure to seduction, cruelty, and the demonic madness of sexual victimizing.[119] Because the danger of which we speak here is *within* (not related to any particular external threat), Winnicott's formulation on the therapeutic *holding* attitude, is essential here.

What's taken into the self and shaped by the experience of sexual traumatization is a toxic self-representation. This representation is a mental structure; that is, an enduring influence over time) organized around a dynamic amalgamation of sexuality and aggression into one. This sexuality-aggression complex is internally experienced in a most confused and mystifying presence, which leads to experienced passivity. In Tanya's and Sally's clinical presentations, from the perspective of psychological defense, both showed considerable *passivity.* Trauma-originating passivity is a common dynamic/behavioral symptom that undergirds intense, internally experienced menacing rage. Here, the survivor may, at any given moment, not be certain whether s/he is experiencing sexual feelings and tenderness for an intimate, or feeling revenge toward the internalized perpetrator or seducer. Obviously, this creates havoc to intimacy and on one's general sense of well-being. Intense dynamic psychotherapy elements of the third phase are geared to assist the survivor with this difficulty as well.

The therapist, being aware of the passivity tendency monitors its vicissitudes in the treatment. Brown, Scheflin, and Hammond, speaking of the often heard saying that *"There is nothing more dangerous than a good victim,"* conclude that "Until the survivor of chronic, cumulative relational abuse *can face his or her own internalization of the abuser, s/he will remain fearful of him/herself and of him/herself in relationships with others* (italics added)."[120], p. 489

It is thus possible for psychological trauma to force a developmentally secure individual into a confluence of neurobiological and behavioral alterations reflective of fixation, passivity, and other developmental deficits. Interpersonal bonding between survivor and therapist is essential for severe cases of arrested development. The survivor, essentially, is in need of another person who serves as a *validating and maturational agent* that operates to *push active development forward.* The validating agent plays a key role in "buttressing a damaged or fragile self."[121] *The therapist's capacity for empathy is thus experienced here by the survivor as corrective;* that is, transforming the seductive/violent experience of sexual trauma through *an experiential bridging* to the world of healthy human relating replete with compassion, altruism regard, and benevolent behavior.

The power of this relationship is the therapist's capacity and willingness to use introspection and empathy, a powerful communicational channel of support and of intersubjectivity. This intersubjectivity is reflected in the back-and-forth flow of precognitive, cognitive, and affective experience between survivor and therapist. This spontaneous emotional interchange may potentially yield a breakthrough for the survivor beleaguered by destructive internalized presences, and associated absence of spontaneity of response.

Through intersubjectivity the therapist gains psychosomatic insights into the survivor's internal experiencing, which contribute to three developmental post-trauma achievements: (1) feeling of *internal security,* (2) feeling of *competent to live* (in restoration of self-soothing, modulation of arousal, and managing intrusion, dysphoric mood, relationships, and general efficacy in life),[122] and (3) perception of *being worthy* of life, especially the good things of life (longevity, and in terms of regulation of shame, self-pity, self-destructiveness, and post-traumatic moral stress[123]).

This relationship helps to ground survivors in both *understanding* traumatic alterations in the self *and* taking *action* in the areas of "rock-pushing" and "rock attitude," as existential concerns. These concerns are always present in trauma treatment whether they are discussed and explored or avoided and ignored.

This existential awareness in therapy helps survivors to examine, understand, and take action to integrate the responses and knowledge of how the very foundation of life had been shaken and shockingly altered.

Existential Crisis In Trauma: Achieving the "Rock Attitude"

What might the role of existential considerations be in the aftermath of sexual trauma? To bring survivors from relational (traumatic) reenactment to relational connection, or to "shared communal adaptations"[124], p. 32 they must *choose.* For they are confronted by the harsh reality of experiencing one's life trajectory to be inexplicably and dramatically altered. Facing this harshness is necessary: it's the best antidote for avoidance, non-responsibility for one's self, isolation, absence of meaning in life, as well as absence of sense of communality. Sisyphus, in the Homeric myth, later elaborated by Camus, was faced with a bewildering challenge in which he had to *choose* in order for resolution to occur.

Often, therapists and patients approach sexual trauma treatment with what appears to be a preference for magic, fantasy, illusion, and unreality. This is observed in the unrealistic expectation of rapid symptoms

relief, "express flight" resolution of intrapsychic intrapsychic, intra-somatic, and interpersonal stress-based responses. Symptom-relief is often viewed as the beginning *and* end of restorative integration after trauma, which may potentially set up the survivor to "who fail to make the *tough choices and commitments* necessary for existential adaptation." We know that at the trauma-shattering event threatened the very foundation of life and existence. This is an *existential crisis,* "a critical moment in which one confronts death, meaninglessness, isolation, and/or issues of freedom and responsibility [italics added]."[125], p. 11

Taking one's life back after sexual trauma is not easy: it takes hard work, directed to "re-weave a new fabric of meaning" [126], p. 32 after trauma-inducted ontological insecurity. Life proceeds when trauma-lost capacities for spontaneous experiencing, what Winnicott called "illusion" (the mid-ground between traumatic reality and non-reality).[127] In reversing ontological insecurity, this phase of the treatment helps the survivor *transform existential crisis into meaning.* How is this possible? The French philosopher Maurice Blondel responds, "When something has meaning it has a solution, an explanation, a goal" [italics].[128] For Frankl, meaning comes from *honoring* the trauma, by which he means "becoming consciously aware of opportunities for self-transcendent *giving to the world* that are embedded in the trauma situation and trauma memory" [italics added].[129] These issues speak of salutogenicity or the strengthening aspects traumatic exposure therapists need to acknowledge and help survivors to appreciate if true healing and integration is to occur.

Along with therapists' functions, the sexual trauma survivor has to take "major responsibility for the shaping and direction of the enterprise."[130] And, like those survivors of unremitting, repetitive *relational abuse,* enlightened by their unspeakable suffering, survivors tended to show stoicism as they "turned to face the worse *straight-on,* without sentiment or special hope, simply to keep watch over life."[131], p. 87

This is what Sisyphus discovered to be critical to his transformation. He had been confronted by a truly life-altering challenge that thrust him into an existential dilemma.

He had angered the gods; now he had to pay. He was condemned and banished to the underworld where his punishment was hard labor consisting pushing an enormous boulder up to the top of a mountain. Despite his Herculean efforts, as he approached the top of the mountain the huge rock would roll back down of its own weight. Again and again he pushed up and climbed up, but the rock rolled down, over and over again. Then it dawned on Sisyphus that his situation was desperate. Initially, he lost hope: the repetitive, stereotypic up-down failure was devoid of all meaning and of any possibility for future success. Experiencing his circumstances intolerable, he felt trapped like many trauma victims. And, like many victims whose persistent traumatic disabilities make them feel condemned to suffer in the underworld of dissociated terror and helplessness, Sisyphus' unbearable suffering dreadfully threatened his very existence.

Sisyphus realized that the exhilarating experience that comes from success would continually elude him, that, in fact, he would never have the joy of seeing the boulder go over the top of the mountain and roll down the other side. His dilemma: to be (find a way to resolve his plight and go on with life) or not to be (take his life). He *chose* to *reconcile* himself to the oppressive terms of his existence. And, in a transcendent moment, he made a *psychic turning:* he *accepted* and *chose* the fate he inherited from the gods. When he did this, essentially saying "Yes" to his wretched existence, he *became master of the rock, master of himself, master of a silent happiness,"* [132] We understand from Sisyphus' experience that in trauma-based existential crises there may be no room for magic, fantasy, illusion, and unreality—only choosing, accepting, and *making commitments to life*, facilitated by the disciplined "rock-pushing" that precedes the attainment of "rock attitude." [131]

"Will—The Most Serious Trouble".

Is *will* important in traumatherapy? Many survivors come to treatment for relief, but perhaps most are not motivated to change; that is, to identify and appreciate the deep underlying shattering of the self structure that will require more than getting by with relief alone. Janet believed that even more devastating to the trauma survivor than the well-known disturbance of memory and action was *will—"the most serious trouble."*[133] Acquiring integration requires the active employing of the survivor's will, which is addressed more directly and affirmed in third phase.

Will, the *act* of making a choice or decision or the power of choosing or determining, is an ongoing problem in trauma treatment. This is because its damage diminishes the ability to work through the difficult challenges traumatic memories generate, and achieve integration. Will also has to do with expressing desire for *future action,* determination, insistence, or persistence. Motivation is also in a state of deficiency after trauma, which is the stimulus for action; it implies a need or desire that operates on the will to create action. It's will that impels action. The two previous phases thus laid the foundation for subsequent "reclamation of the human spirit"[134] due to prior successes in symptom management and positive reinforcements, and relational achievements with the therapist.

Repairer of the Breach: Traumatherapist As Bridging Agent:

Metaphorically, the therapist is here conceptualized as a *safety-maturation practitioner* who provides a vital relational bridge—over the troubled waters of the self induced by trauma, and over and between the pre-trauma and post-trauma selves, between public and private, between person and community, between past and present, between "life" (new access to a full range of "freedom-engendering" emotions) and "death" (benighted numbing/avoidance and fragmentation-proneness), and between trauma-based terror and the integrative sense of safety. The traumatherapist understands that, in order to survive psychologically, the trauma patient had to transmute the organization of the self through "adaptation to danger [and] becoming 'danger' itself."[135], p. 161 Becoming danger itself is a post-trauma defense against the mind's tendency to compulsively repeat the painfully distressing memories and feelings associated with assault/transgression. Mastery of internalized sadism (originating from experiences in the abuse/assault situation) and cruelty appears to be a central biopsychological motivation in sexual trauma treatment.

Since therapists know, as cited before, that "there is nothing more dangerous than a good victim," they are cognizant of the patient's normal unconscious projective tendency to perceive them not only as people who caringly supports and rescues, but also as victim, co-victim, or as violent attacker/seducer."[136], p. 160 These trauma-born identifications (or "trauma perspectives") of the therapists require recognition and clinical management, to include relational processing that employ the transference/countertransference sphere of the treatment relationship.

Throughout this article an emphasis has been made on the role of the therapist in establishing and maintaining a treatment alliance in which goals are articulated and agreed upon (the therapist had informed the victim/survivor of the three phases of the therapy, the goals of each, and what he or she is to expect as the enterprise progresses over time), task assignment are made and monitored, and where emotional/relational bonding is an important goal. The contributions of the therapist discussed so far fall broadly within technical and relational dimensions.

Winnicott's widely mentioned concept in clinical theory and practice is "good-enough" caretaker. This concept is most comforting to therapists who work conscientiously with greatly distressed trauma

patients. Rather than placing the pressure upon themselves for perfection, being "good-enough" is sufficiently first-rate. Therapists need only do their job: doing the best they can, using the best available knowledge in the trauma field, adequate preparation and experience for the work, feeling competent, being benevolent, while monitoring countertransference feelings and vicarious identification with survivor.

We're aware that therapists' functions are not a usual focus of most clinical and scientific reports in the trauma treatment literature. We, however, believe this dimension of treatment has implications for not only therapeutic efficacy, but for general patient welfare. Highlighted here are the therapist's positive, therapy-enhancing qualities. The therapist: (1) makes investments in the survivor, (2) understands the inner trauma-caused damage, (3) demonstrates acceptance, (4) inspires confidence and trust in the survivor, (5) achieves cognitive-affective congruence and empathic connectedness, (6) maintains the integrity of the (boundaries of the) treatment frame, (7) recognizes salutogenic response of the survivor, (8) demonstrates confidence and confidence in his or her ability to help, and (9) displays and sustains an image of the benevolent authority. "Benevolent authority" deserves some comment here, because clinical experience has shown how central authority dynamics are the survivor's ability to go on and fully engage the world.

It seems that traumatherapists almost organically eschew the notion of being *authority.* This is because many see the connotations of authority as negative, as unkind, controlling, manipulative, callous, self-serving (at the expense of others), or even as cruel. The word authority is too closely associated in the mind of some therapists and victim/survivors with the perpetrator of the original trauma, and those who may have induced secondary trauma, like officials within the law enforcement and the criminal justice systems. But, whether the treatment duo wants to admit it or not, both know the truth: it's the victim who comes to the therapist, because the therapist is deemed credible, trained, has understanding of problems presented, is trustworthy, and can be effective in the alleviating traumatic distress and distress.

The psychological and sociocultural influences that shape this role disavowal may be very harmful to survivors in traumatherapy. This is in full recognition of the high-profile sentiment that the personal is political. Obviously, politics has it place, particularly in creating public policy for funding prevention and treatment.[137] The contention here is that the power stripped away from the victim through sexual victimization was personal. After the trauma, the victim experienced the stark absence of self-authority (that is, control in preventing the event in the first place), and the ongoing helplessness that accompanies efforts to control the symptoms of PTSD, dissociation, and complex PTSD. These experiences and symptoms are reminders of "dysfunctional authority" processes—both intrapsychic and external.

Clinical experience and observation show authority perceptions and problems experienced by survivors are central problems that often go unresolved. But it's costly to the survivor when this problem is ignored or not recognized for its pernicious effects on their lives. If the survivor is to go on and successfully assume parental, supervisory, managerial, and other leadership roles in life, then it is necessary to work through relationally processing unresolved trauma-based authority issues. Pervasive leadership role-avoidance remains as evidence of nonresolution in some survivors' functioning. Unresolved authority issues, essentially, carry a high economic cost—in lost wages and missed opportunities for career acceleration in survivors.

The Role of the Group in Resolving Sexual Trauma-Based Secrecy, Shame, and Stigma.

Although no control studies exist, group treatment is regarded as the treatment of choice for PTSD or in combination with individual psychotherapy. Why group therapy with sexual trauma survivors? In part

because the group may be superior in resolving such difficult post-trauma issues as secrecy, stigma, shame, and humiliation than individual therapy. Working through powerful emotions and increasing comfort in interpersonal relationships may result in a "script-rewrite" which allows the survivor of traumatic abuse to alter the self-concept and emerge finally as winning conqueror of incessant traumatic distress, while diminishing the negative power of internalized abuser/assailant influences.

Generally, the therapy group is uniquely capable, like no other modality, to offer members the opportunity to explore and work through fear-based distortions of human relationships. This inimitable qualification of the group with trauma survivors establishes a peer-oriented environment where the deepening of trust, the growing to emotional maturity and the development of higher levels of interpersonal relationship are possible. Members learn, additionally, that they are similar to others in the group in significant ways, and each experiences self through others. Thus, members relive common experiences and become aware of mutual impact. When the group fosters a climate where secrets, shame, and stigma are dealt with successfully, women survivors are motivated to deal with such critical quality of life issues as avoided healthcare services, to include physical checkups and gynecological examinations.[138]

The group also has an exceptional power to transform personal trauma narrative into a positive biographical narrative. This comes about when each member shares his or her trauma personal history in the context of the group's social-reflective structure, or what Garland refers to as a "gallery of mirrors."[139] The group's mirrors permit meaningful revelations and shared reliving of trauma memories and feelings. Each member's image is *reflected back* by other members, clarifying perplexity and illuminating obscurity caused by the original trauma and subsequent negative behavioral and attitudinal adaptations.

In terms of the group developmental sequencing, Herman and Shatzow, in concurrence with Parson's observation some 19 years ago, hold that treatment should evolve through a series of group types. The early group begins with a time-limited homogenously-organized group (that is, "all females," "all males," "all incest survivors," "all rape victims," etc.) progressing to collective settings with mixed diagnoses at advanced levels.[140],[141] Regarding to first phase group treatment, van der Kolk notes that "Parson has explained the need for therapist activity such as modeling, assertiveness training, and reading assignments in such groups." Moreover, "He cautioned against the active exploration of aggression-dominated symptoms during the initial phases of group development."[142], p. 164

Speaking on the importance of safety-maintenance in group therapy, as a precondition for establishing goals, boundaries, reassurance, bonding, individual empowerment, and communal sharing, she writes, "The psychologist Erwin Parson … invokes the metaphor of the platoon to convey the tight organization of the group: 'The leader must be able to establish meaningful structure, laying out the group's goal (mission), and the particular terrain (emotional) to be traversed."[143]

Though it is clinically prudent to form the early-phase group with either all female or all male victim/survivors, in the advanced groups or group stages, women and men may be expected to get down to the difficult work of gender-based identifications, with an opportunity to work through harmful, irrational generalizations (for example, experiencing "all men as rapists, or sexual abusers") and fears.

As a victim of both CSA and SA, Wayne also participated in group therapy (in addition to individual treatment), which facilitated memory processing of shame, guilt, humiliation, hatred, sense of betrayal, and interpersonal aggression. His group experience, shared with eight other male survivors, focused on military and pre-military sexual assaults. The group helped him achieve constructive social insight, and improved coping and control.[143]

Since among the personal capacities trauma shatters is the capability for attachment, adversely impacting affect dysregulation, and self-esteem, the group therapist's willingness to self-disclose enhances affective connection, particularly in the early phases of the encounter. Sensitively sharing relevant information on the part of therapists, essentially, reduces the imbalance or asymmetry in the treatment situation, creating a more egalitarian process, while humanizing the harsher connotations of therapist's authority. In the group the therapist discusses their own experience and reactions. As they engage in this vital activity, they are not only *disclosing* but *presencing* (that is, being fully present in the moment with the survivor when it truly counts the most).

Ethnocultural Factors, Trauma, and Therapists' Self-Disclosure.

In Phase 3, the therapist explores cultural factors associated with Tanya's self-identity. Generally, in order for therapists working with survivors like Tanya to be effective, they find it necessary to become transculturally competent,[144],[145] and understand the meaning of "wearing the mask"[146] for African American survivors. Because some minority trauma patient experience an irreconcilable interpersonal distance from White and higher SES status minority group therapists, reducing distance is critical for engaging the patient in post-trauma integrative work, particularly in the context of ethnocultural differences in therapy. These patients feel the therapist is "above" them, looking down to further put them down. However, minority trauma victims may see self-disclosing activity by the therapist as security-enhancing and trust-building initiatives on the part of the therapist.

Studies reveal that therapists who disclose about themselves are better liked, and the treatment is more effective in reducing symptoms in distressed patients. This is good news for traumatherapist: they often find it extraordinarily difficult to assess, treat, and prevent premature termination with traumatized minority patients. Thus "self-disclosure by the therapist may improve both the quality of the therapeutic relationships and the outcome of treatment."[147],[148] [148]

We make a distinction between two forms of disclosure: (1) sharing factual information about self, and (2) imparting highly personal information that modifies the asymmetry in the relationship—geared to share power. Both forms of disclosure are important and are used at various times during the course of the treatment, depending on potential benefit or harm. We hold that sharing of the second kind of disclosure is most useful in trauma treatment. For it may assist the therapist "to effectively monitor and manage race-based countertransference reactions."[149], p. 7 Like Johnson and Lubin's account of traumatized Vietnamese people's tendency "to frame and contain potential distress…[and] move on and focus on survival,[150] Tanya had been fixated on survival, a desperate, counter-growth state of mind with intrinsic denial, avoidance, and dissociative elements.

Generally, the better the treatment relationship is, the more leverage the therapist has in instilling courage in going down trauma's memory lane, moving developmentally into here-and-now living, and then offer freedom to trauma patients who are now able to build a future. The more the survivor believes the therapist is sensitive to his or her culture, the easier the formation and maintenance of the treatment relationship.

Survivors often find it difficult to freely disclose the details of their trauma to others. But Tanya's reticence, in addition, resonated her culture and family values from which there was also no easy escape for her. These values had shaped her life and now influenced her post trauma symptoms and experience. Learning about her culture empowered the therapist to more accurately "read" her reticence and absence of eye-to-eye with insight to establish and solidify the treatment relationship.

SUMMARY AND CONCLUSIONS

In sum, the therapist designed an atmosphere that was gentle and lovingly sensitive, creating an enveloping of safety for the victim. The clinical problems presented by sexual trauma survivors in therapy are conceptualized as *developmental deficits.* Therapy, then, provides a process and a "place for the repair of a deficit, an unmet developmental need."[151], p. 343 This therapeutic objective and attitude smoothed the progress of therapy, employing a multiphase, multitheoretical model based on the observation that survivors' developmental needs change progressively over time. The model applied sought to overcome "the limitations of uni-dimensional treatment approaches to date [and that] combination treatment strategies involving biological, psychological, and psychosocial modalities will prove more effective,"[152] the present model addressed the complex symptomatology of PTSD, complex PTSD, and dissociation.

Each phase takes the survivor closer to integration and post-integration levels of personal growth *beyond* mere psychological recovery—to human growth and maturation. The first two phases were instrumentally designed to addressed the major symptoms of PTSD (intrusion, avoidance, and hyperarousal), and memory processing, chiefly employing trauma education (to develop conceptual labeling to gain control), anxiety management training (included relaxation training, breathing retraining, and thought stopping), cognitive therapy (positive thinking/self-talk), and behavior therapy (exposure in imagination[153]). Psychopharmacologic agents are used in specific sequencing and combinations to deal with the symptoms of PTSD, among these are: SSRI antidepressants, newer antidepressants, tricyclic antidepressants, mood stabilizers, and anti-anxiety medications.[154]

The third phase ushered in psychodynamic approaches (to deal with internalized abuser presences, sadness, grief, guilt, and basic antipathy against the non-suffering world). The therapeutic efficacy of exposure therapy is well-documented in fostering positive change in the overwhelmed, emotionally reactive, constricted victim. However its use in the present multiphase model incorporated an understanding of the various limitations of this approach when it comes to addressing a broad spectrum of post-trauma symptoms and important functional deficits, to include relational dysfunctions, grief, sadness, guilt, shame, and the borderline phenomena of impulsivity, self-abuse, and characteristic poor social functioning.[155] Orsillo and Batten review the inherent limitations of the exposure approach in a recent contribution in which they propose a comprehensive, alternative model of care in meeting more realistically the complex treatment needs of trauma survivors.[156]

This phase also emphasized the treatment relationship, which was viewed here as *key* to treatment efficacy, unlike other approaches that tend to relegate the treatment relationship to some secondary, "just happens to be there" role. While acquisition of knowledge about PTSD and the survivor's pretrauma life history and technical activity were important, it was truly *the creation of a new kind of relationship* that made it possible for the traumatized self to mature from arrest and vulnerability to release and growth. This involved the therapist's capacity to present an *essential likeness,* a mirroring, to the survivor, which provided the survivor with a secure psychological base.

This sense of security made it possible to explore alternatives to numbing, stasis, disorganization, rage, and futurelessness, while helping the fragile self "to approach imminent change with a mastery orientation."[157], p. 245 Additionally, this relationship made it possible for victim/survivors to *de*-generalize the ubiquitous perception of trauma figures. This referred to a reduction in trauma-based generalizations where the survivor perceived potential abusers almost everywhere, of seeing every man or woman as a potential sexual predator/terrorist. This *degeneralizing* occurred through the therapist's enabling availability that helped the survivor in reassessing both past and present relationships, and

facilitated the *transferring* of the survivor's feelings for the abuser *onto the person of the therapist* for resolution.

This transferring, essentially, made it possible to alter the survivor's trauma-based worldview that blurred the boundary of reality, so that "innocent" individuals, even spouses and lovers, were unconsciously seen as potential abusers/rapists. This tendency toward men was seen in Sally, Wayne, and Tanya, while Tanya viewed both men and women as potential rapists/predators. All viewed women as neglectors, ineffectual people who had shown closed eyes and deaf ears to abuse. This ubiquitous trauma-based perception increases the gulf of separation and isolation between self and others, reducing the chances for enhancing the survivor's own healing through connection and sense of communality.

Moreover, this phase continued addressing the clinical emergence of unresolved interpersonal problems, adopting Winnicott's concept of "adaptation to need."[158] In effecting an adaptation to need, this phase continued to address the symptoms of PTSD and DESNOS-based self disturbances, but with a focus on the co-constructed meaning of these symptoms in the treatment relationship. Transference and countertransference responses were explored to foster integration of relational and identity elements, as well as coming to terms with the sense of betrayal and abandonment, humiliation, abuse degradation, and interpersonal cruelty.

Using principles of dynamic trauma treatment, the therapist acknowledged the patient's need for safety, but progressed beyond to help the survivor balance, as noted before, safety-seeking with maturation-advancing. The therapist used the close affectional bonds developed during the two first two phases to reconnect survivors to their adaptive pretraumatic history, essential for identity reconstruction and consolidation. Identity, like the brain, is a significant target that was shattered by traumatic exposure.

Since trauma had brought about a collapse of pretraumatic knowledge about the self and world, the therapist's presence, personality, and commitment to the survivor ensures a new informed internal model for the patient, one of successful function, control, affection, and hope. Here, the survivor's subjective experience of the therapist is not only as a *guarantor* of safety, but as an *health and growth promoter* of psychological and physical well-being. This comes about as a result of the therapist's "persistent engagement"[159], p. 14

The acquisition of a sense of safety and predictability is a fundamental precondition for the positive changes we've been describing. Since relational experiences are often fraught with "acquired reminiscences of danger in relationships" emblazoned upon the mind and body of survivors, safety continues to be a critical issue even in the third phase. However, in this phase safety means something very *different:* it refers to security from what's within *not* what's external. What was once external (the traumatic occurrence) had become *interiorized* during the event. A stable relationship experienced as safe and competent guards against this source of terror: the internalized abuser/seducer presences. This is why therapists need to monitor, control, and use, as appropriate, their own psychological responses for the ultimate benefit of the patient.

Relational processing is thus an integral aspect of this phase: it addresses the negative affects associated with the internalization of transgressive seduction and violence. To reach this overarching goal required an integrative model that, having in earlier phases used cognitive and behavioral techniques and procedures, now draw on psychodynamic techniques, primarily in addressing transference and countertransference issues which make it possible for survivors to "enact, identify, and work through *central internalized relational configurations"*[160], p. 440 These relational configurations reflect "deformations of relations and identity."[161]

Emotional processing theory is found within cognitive-behavior therapy. It holds that "a pathological fear structure concerning the traumatic event"[162], p. 61 requires direct activation (of information associated with the trauma) in order for the trauma to be successfully resolved.[163] Like the pathological fear structure proposed in the processing of trauma in cognitive-behavioral therapy,[164] psychodynamic theory proposes an *internalized* representational fear/transgressive structure associated with the abuser/attacker. This representational fear structure can be corrected through new information derived from emotional, physiological, pre-cognitive, and cognitive elements transpiring between therapist and survivor.[164]

These new data are, in effect, incompatible with the former terror-based relationship, a specter that has haunted and perturbed the survivor's mind since the event. These incompatible pieces of data are believed to usher in new, corrected information essential for resolution to occur. Here, transference manifestations serve as representational activating experiences, replacing the original trauma structure with acquisition of new psychological structure Kohut called "transmuting internalizations,"[164] deriving from the positive relational inputs of the therapist. This achievement functions to provide true *corrective* emotional and growth experiences.[165]

There are so many details to keep track of when the patient in therapy suffers the effects of transgressive violence that many therapists feel besieged by the deluge of powerful affects, painful memories, and disorganized thinking. Managing these responses often places tremendous pressure on therapists' minds and bodies. Some worry that during some unguarded moment in therapy, something will be said, sensed, thought about, felt, remembered, or done that may go unnoticed or mismanaged leading to some intratherapy catastrophe. They may tend to incorrectly view difficult, challenging moments in therapy as errors in technical and personal judgment, potentially leading to iatrogenic "second wound" or "sanctuarial traumatic stress"[166] But, according to Batten and Orsillo's insightful observation, these reactions are "normal human responses to danger and loss," and cautions "that it is the suppression and avoidance of these reactions, not simply the experience of the reactions, that can impede the therapeutic process."[167]

As a gift, therapy's complexities present both hazards and promise.[168] Winnicott proposed a position geared to ameliorate therapists' doubts, worries, and duress in therapy. One of his widely mentioned concepts in clinical theory and practice is "good-enough" caretaker. Far from indicating mediocrity, this concept is most comforting to therapists in that they need not place inordinate pressure on themselves for perfection.

Monitoring countertransference feelings and vicarious identification with the patient/survivor[169] is important because the therapist is to always be able to differentiate his or her own psychological issues from the survivor's needs. This is particularly necessary since the perplexing nature of the patient's traumapathology, and intrinsic problems in learning from experience, wield a powerful impact on the therapist's functioning. The therapist, as a influential container for strong affects, facilitates the capacity to tolerate ambiguity, doubting, confusion, and to bear depression, and modulate anxiety, anger, and arousal. The relationship enhances integration of the survivor's trauma-induced feelings of mistrust, guilt, shame, self-doubt, lack of initiative, low ambition, low motivation, identity confusion, as well as unresolved concerns related to mortality.[170],[171],[172] [166] Naturally, the more severe the patient's disturbance the greater demands the treatment makes on the therapist's self organization; for example, disorganized patients suffering from severe dissociative, complex PTSD, and DID. In these cases the therapist is confronted with severe boundary strains and challenges originating in the shattering impact of trauma on identity. Survivors, like Sally, who experienced dissociation-dysregulated boundaries struggled with "selves that starve and possible suffocate."[173] As Zerbe notes, such patients, internally resembling Pablo Picaso's *Les Demoiselles d'Avignon,* reveal severe "disconnection and dissonance."[174] Accompanying these deficits are also problems in access and use of language (the trauma had caused mute,

unsymbolized, experience), and, like other severely traumatized individuals that Pierre Janet had observed, Tanya, Sally, and Wayne "had trouble learning from experience, and … had reduced capacity to grieve, to work through more routine conflicts, and to accumulate positive, healing experiences."[175], p. 444 The diminished capacity to learn from experience is implied in the "all-too-common occurrence" of revictimization among victims of childhood sexual abuse.[176], p. 459

Survivors' insight acquired through the explorations of this phase can potentially increase adaptive discriminatory capacities to detect and preempt re-victimization experiences. For Rothstein notes that "reconstruction of trauma is an integrative act which connects past and present, cause and effect, on new levels of developmental organization, restoring personality continuity."[177], p. 22 This reconstruction involves engaging the trauma memories, verbalizing the trauma narrative, and balancing of core beliefs about self and world.[178],[179] Thus these procedures are geared to restore the survivor's self-awareness, self-caring, and natural self-love, which are private possessions stripped away by the trauma.

Sexual trauma survivors in dynamic therapy learn to integrate "the memory traces of the trauma [that] linger as *subconscious fixed ideas* that cannot be 'liquidated' as long as they have not been translated into a personal narrative and instead continue to intrude as terrifying perceptions, obsessional preoccupations, and somatic reexperience. "[180], p. 1533 Additionally, dynamic procedures enhanced the capacity to transform subconscious fixed ideas into autobiographical memories,[181] ensuring acquisition of a new healing language, self-soothing, and "containing [of] inappropriately destructive behavior toward others."[182], p. 140

The menacing internalized images of abuse and violence will activate reenactments of frightening past relationships in the treatment situation via transference manifestations. Since in CSA the child is blamed for the abuse, while the abuser denies any responsibility, as Sandor Ferenczi once observed in his classic paper on the "confusion of tongues between the adult and child,"[183] the dynamic therapy aspects contribute to coming to emotional terms with abuser-based fright, and the displaced internalized blaming by the abuser.

In addition, severely sexually traumatized people in therapy bring with them a *vulnerability-based idealization.* This relates to the tendency to adulate the therapist to the pinnacle of being all-powerful and all-perfect. Experienced as invincible rescuer, the therapist is a figure of utter perfection and strength, and, in contrast, is the survivor's vulnerability and neediness that create intolerance that leaves "no room for human error.[184] This idealization is often a very necessary transitional point—from the menacing power of internalized abuser/attacker dynamics to the promise of integrated freedom and capacity to live freely with others. This clinical dynamic tendency challenges the therapist's own sense of emotional security and identity, as the therapeutic integrative effects transform idealization to a reality-oriented, "down-from-up, down-to-earth," perception of the therapist.

Naturally, related to these therapist's functions is the question of therapist's own trauma history. Have the therapist's problematic trauma dynamics been sufficiently resolved to make growth veridically possible for the survivor? Will these problems result in inadvertent boundary crossings and boundary violations[185],[186] that could contribute to iatrogenic dissociative responses in the patient?. There are many contemporary therapists who are themselves survivors—of rape, incest, early neglect and abandonment, domestic violence, war, and of natural or human-engineered disasters. Unsurprisingly, there are advantages to being a survivor/therapist, but, not usually discussed in the trauma literature, there are probably as many drawbacks as well.

The potential obstacles, if acknowledged, understood, and regulated in the therapist, may prove assets to the treatment, while failure to recognize them may unintentionally impede the patient's growth and

maturation. Trauma-origin countertransference and related boundary struggles in the therapist[187],[188] may account for some instances of increased anxiety and renewed sense of endangerment in survivors while in therapy. Often, what occurs are symptoms increase, premature termination, or the triggering of abuse/assault memories and fragmentizing affects. This iatrogenic potential is another difficult area of clinical trauma practice ignored in the trauma literature.

These boundary problems may be observed in two basic countertransferentially-based patterns: (1) Therapists' unrelenting, blind impulsive actions to rescue the victim/survivor (but without a functional *observing-self capacity,* an objective facility necessary for insight, and control over boundary-subverting behavior, and (2) the passionate creation of a *cocoon shelter* which, rather than offering "cover" for the survivor's pain and distress, creates new problems—a constricted way of life, and helplessly consigned to self-defeating patterns of a developmental arrest.

The therapist who create a "feel too cozy" environment in the therapy may do the survivor a disservice, failing to ensure the therapy is truly a corrective emotional experience for the patient. In so doing, therapists may unconsciously repeat the autonomy-depleting experience of the traumatic past. Here, they err in not focusing enough on building the patient's autonomy, freedom, and self-government. Freud was aware of boundary problems in treatment, and wrote that some therapist may inadvertently make "everything as pleasant as possible for the patient, so that he may feel well there and gladly take flight … there … from the trials of life. In so doing [the therapist] entirely forgo making [the patient] stronger for life and more capable of carrying out the actual tasks of his life."[189] Freud felt this scenario must be prevented by therapists.

In this phase, the therapist further engaged in "systematic and sensitive inquiry" to explore the nature of Tanya's previous exposure "to race-related stressors."[190] This specialized assessment may be warranted with some minority group survivors. Addressing race-related factors made it possible for the therapist to learn about Tanya's previous efforts to manage her trauma through abusing food, alcohol, drugs, and hyperwork. For as Adebimpe notes, "Blacks are so proficient in wearing a "mask" that psychiatric impairment can be very difficult to ascertain."[191] The transculturally-informed therapist acknowledges the presence of this trained *interior-exterior incongruity* in Black trauma survivors, and understands that it may prove to be a source of significant diagnostic error when the African/European identity is expressed in PTSD symptoms and dissociative disorders.[192],[193], [194]

In treating chronic PTSD and dissociative disorders as identified in the three survivors presented in this article, the therapist and patient have a powerful ally, despite the well-known brain-damaging impact of trauma. Conceived as a form of "social construction," good traumatherapy enhances intrinsic neurobiological and maturational properties, attributable to neural plasticity. Edelman's hypothesis is useful. He holds that "it is the unique expansion of the cerebral cortex in humans that allows one not only such specific flexibility in learning and memory[195] but also enables abstract and conceptual thought, planning for the future, and even the concept of free will"[196], p. 181,

Phase 3 ends with a series of constructions in which the patient sees self *prospectively* into the proximal and distal future as positive, happy, and productive, and as no longer throttled by traumatic anxiety and paranoid distress. This procedure is referred to as *foretelling;* it fixes the person's gaze not on past trauma fixations, but on the prospective experience[197] characterized by an effervescent sense of future replete with positive challenges toward a successful life.

SELECTED ONLINE RESOURCES

National Center For Post-Traumatic Stress Disorder (NCPTSD)
www.ncptsd.org

The Sidran Institute
www.sidran.org

National Organization For Victims Assistance (NOVA)
www.trynova.org

Children's Crisis Treatment Center
www.cckids.com

Center For Traumatic Stress Research
www.uku.edu/education

Footnotes:

[1] The terms "victim" and "survivor" are often used interchangeably; however, in this article, the former refers to persons who have *endured* through the event, but remain absorbed and constricted by the trauma, the latter, those who have *learned through* active post-event coping and associated growth..

back

[2]Ochberg, F. (1985, December). It's the Victims of Violent Crime Who Need Help. *Johns Hopkins Magazine*
back

[3]Herman, J. (1992). *Trauma and Recovery.* New York: Basic Books.
back

[4]Parson, E. R. (1996, March). *"Sexual Trauma: Cognitive Miscalculation, Affective Misalignment, Memory, Dissociation, and Attachment,"* A Masters Class Conducted at the Second Annual Conference on Trauma, Loss, & Dissociation: Foundations of 21st Century Traumatology, Georgetown University Medical Center & Kairos Ventures II, Ltd.
back

[5] Murphy, S., Kilpatrick, D., et al. (1988). Current Psychological Functioning of Child Sexual Assault Survivors: A Community Study. *Journal of Interpersonal Violence, 3,* 55-79.
back

[6]Nithish, P., Mechanic, M. & Resnick, P. (2000). Prior Interpersonal Trauma: The Contribution of Current PTSD Symptoms in Female Rape Victims, *Journal of Abnormal Psychology 109,* 20-29.
back

[7]Parson, E. R. (1996, March). *"Sexual Trauma: On Cognitive Miscalculation, Affective Misalignment, Memory, Dissociation, and Attachment."* A Masters Class Conducted at the Second Annual Conference on Trauma, Loss, & Dissociation: Foundations of 21st Century Traumatology, Georgetown University Medical Center & Kairos Ventures II, Ltd.
back

[8]Ackerman, P. Newton, J. McPherson, W, Jones, J. & Dykman, R. (1998). Prevalence of Post-Traumatic Stress Disorder and Other Psychiatric diagnoses in three groups of Abused Children (Sexual, Physical, and Both). *Child Abuse & Neglect, 22,* 759-774.
back

[9]National Crime Victims Survey. *Bureau of Justice Statistics,* U.S. Department of Justice, 1999.
back

[10]National Crime Victims Survey. *Bureau of Justice Statistics,* U.S. Department of Justice, 2000.
back

[11]Shahar, G., Chinman, M., Sells, D., & Davidson, L. (2003). An Action Model of Socially Disruptive Behaviors Committed by Persons with Severe Mental Illness: The Role of Self-Reported Childhood Abuse and Suspiciousness-Hostility. *Psychiatry, 66,* 42-52.
back

[12]Donat, P. (2003). The Role of Sexual Victimization in Women's Perceptions of Others' Sexual Interest. *Journal of Interpersonal Violence, 18,* 50-64.
back

[13]Brazier, D. *Zen Therapy: Transcending the Sorrows of the Human Mind.* New York: Wiley.
back

[14]Penn, M. & Wilson, L. (2003). Mind, Medicine, and Metaphysics; Reflections on the Reclamation of the Human Spirit. *American Journal of Psychotherapy, 57,* 19-31.
back

[15],[16]Brazier, D. *Zen Therapy: Transcending the Sorrows of the Human Mind.* New York: Wiley.
back

[17]Freud, A. (1965). *Normality and Pathology in Childhood.* New York: International Universities Press.
back

[18]Parson, E. R. (1995, April). Panelist. *The Dehumanized Self: Response to Traumatically Impinging Environments.* First Annual Conference on Trauma, Loss & Dissociation: Foundations of 21st Century Traumatology, Radisson, Mark Plaza, Alexandria.
back

[19]Parson, E. R. (1992). The Language of Anxiety: The Subjective Experience of Vulnerability. *Journal of Contemporary Psychotherapy, 22,* 1-9.
back

[20]Parson, E. R. (2001). *Helping Children Cope with Post-September 11th Trauma in Home and School Settings.* September11Trauma.Com Institute.
back

[21]Winnicott, D. W. (1975). *Through Paedriatrics to Psychoanalysis.* New York: Norton.
back

[22]Critchley, E. (1995). *The Neurological Boundaries of Reality.* Northvale, NJ: Aronson.
back

[23],[24]Parson, E. R. (1992). The Language of Anxiety: The Subjective Experience of Vulnerability. *Journal of Contemporary Psychotherapy, 22,* 1-9.
back

[25]Novak, M. (1970). *The Experience of Nothingness.* New York: Harper and Row.
back

[26]Winnicott, D.W. (1975). *Through Paediatrics to Psychoanalysis.* New York: Basic Books.
back

[27] E. Parson in D. Brown et al. (1998). Memory, Trauma Treatment, and the Law. New York; and R. Ulman and D. Brothers (1989). *The Shattered Self: A Psychoanalytic Study of Trauma.* Northvale, NJ: Analytic Press.

[back](#)

[28]Roth, S., Newman, E., Pelcovitz, D., van der Kolk, B., & Mandel, F. (1997). Complex PTSD in Victims Exposed to Sexual and Physical Abuse. *Journal of Traumatic Stress, 10,* 539-555.

[back](#)

[29]Herman, J. (1992). *Trauma and Recovery.* New York: Basic Books.

[back](#)

[30]Parson, E, R. (1988). Post-Traumatic Self Disorders (PTsfD). In J. Wilson, Z. Harel, & B Kahana (Eds.). *Human Adaptation to Extreme Stress* (pp. 245-283). New York: Plenum.

[back](#)

[31]Van der Kolk, B., Pelcovitz, D., Roth, S. Mandel, F. McFarlane, A., & Herman, J. (1996). Dissociation, Somatization, and Affect Dysregulation. *American Journal of psychiatry, 153* (7 Festschrift Supplement), 83-90.

[back](#)

[32]Parson, E. R. (1998). Traumatic Stress Personality Disorders (TrSPD), Part III: Mental/Physical Trauma Representations—From Focus on PTSD Symptoms to Inquiry into Who the Victim Has Now Become. *Journal of Contemporary Psychotherapy, 28,* 141-171.

[back](#)

[33]American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 4th ed.,* Washington, DC: American Psychiatric Association.

[back](#)

[34]Braun, B. & Sachs, R. (1985). The Development of Multiple Personality Disorders: Predisposing, Precipitating, and Perpetuating factors. In R. Kluft (ed), *Childhood Antecedents of Multiple Personality* (pp. 38-64). Washington, DC: American Psychiatric Press.

[back](#)

[35]Ludwig, A. (1983). The psychobiological functions of dissociation. *Journal of Clinical Hypnosis, 26,* 93-99.

[back](#)

[36]American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 4th ed.,* Washington, DC: American Psychiatric Association.

[back](#)

[37]Winnicott, D. W. (19). Fear of Breakdown.

[back](#)

[38]Wilson, J. P. (1980). Conflict, Stress and Growth: The Effects of War on Psychosocial Development Among Vietnam Veterans. In C. R. Figley & s. Leventman (eds.), *Strangers at Home: Vietnam Veterans Since the War.* New York: Praeger Publishers.

[back](#)

[39]Batten, S. V. & Hayes, S. C. (In Press). Acceptance and Commitment Therapy in the Treatment of Comorbid Substance Abuse and Posttraumatic Stress Disorder: A Case Study. *Clinical Case Studies.*

[back](#)

[40]Friedman, M. (2002). Hippocampal Volume in PTSD. *NC-PTSD Quarterly, 11,* 40-41.

[back](#)

[41]Kramer, S. (1991). Psychopathological Effects of Incest. In S. Kramer and S. Akhtar (Eds.), *The Trauma of Transgression: Psychotherapy of Incest Victims.* Northvale, NJ: Aronson.

[back](#)

[42,43]Shahar, G., Chinman, M., Sells, D., & Davidson, L. (2003). An Action Model of Socially Disruptive Behaviors Committed by Persons with Severe Mental Illness: The Role of Self-Reported Childhood Abuse and Suspiciousness-Hostility. *Psychiatry, 66,* 42-52.

back

[44]Frank, J. (1973) *Persuasion and Healing: A Comparative Study of Psychotherapy.* Baltimore: Johns Hopkins University Press.

back

[45]Janoff-Bulmann, R. (1992). *Shattered assumptions: Towards a new psychology of trauma.* New York: Free Press.

back

[46]Parson, E. R. (In press). *Post-Traumatic Group Psychotherapy.*

back

[47]Erikson, E. H. (1968). *Identity, Youth and Crisis.* New York: W. W. Norton.

back

[48]Parson, E. R. (1988). Post-Traumatic Self Disorders (PTsfD). In J. Wilson, Z. Harel, & B. Kahana (Eds), *Human Adaptation to Extreme Stress* (pp. 245-283). New York: Plenum.

back

[49]Janet, P. (1919). *Psychological Healing. Vol. 1.* trans. E. Paul & C. Paul. New York: Macmillan, 1925,

back

[50]Hindle, D. (2002). "I'm Not Smiling, I'm Frowning Upside Down": Exploring the Concept of the Claustrum and Its Significance in Work with an Adolescent Girl. *Journal of Infant, Child, and Adolescent Psychotherapy, 2,* 131-156.

back

[51]Being "real" to the victim in therapy is reminiscent of British psychoanalyst Margaret Little's observation that the lost, distressed person needs to experience the therapist as someone with whom it is possible to have a relationship.

back

[52]Parson, E. R. (1998). Traumatic Stress Personality Disorders (TrSPD), Part III: Mental/Physical Trauma Representations— From Focus on PTSD Symptoms to Inquiry into Who the Victim Has Now Become. *Journal of Contemporary Psychotherapy, 28,* 141-171.

back

[53]Ross, C., Miller, S., Reagor, P., Bjournson, L., Fraser, G., & Anderson, G. (1990). Structured interview Data on 102 Cases of multiple personality Disorder from Four Center. *American Journal of Psychiatry, 147,* 596-601.

back

[54]Putnam, F., Guroff, J. Silberman, E., Barban, L., & Anderson, G. (1990). The Clinical Phenomenology of Multiple Personality Disorder: Review of 100 Recent Cases. *Journal of Clinical Psychiatry, 47,* 285-293.

back

[55]Parson, E. R. (1995, April). Conference Director-A 2-day Conference, "PTSD in Victims of Rape, Urban Violence, Self-Abuse & War: Diagnostic, Therapeutic, & Ethnocultural Factors. The Dean Foundation & the VVA Wisconsin State Council, Madison, WI.

back

[56]E. R. Parson in S. Booker. (December 20, 1999). Ticker Tape. *Jet Magazine,* p. 10.

back

[57]Parson, E. R. (August 1996). *Ethnicity and Post-Traumatic Stress Disorder: Reaching Out to African American, American Native, Hispanic American, and Asian American Veterans With Readjustment Problems From War.* Address Invited by VA Secretary Presented at the Inaugural Administrative/Organizing Meeting of the Congressionally-Appointed Committee on Minority Veterans Affairs (The Center For Minority Veterans), VA Central Office, Washington, DC.

back

[58]Comer, J. (1972). *Beyond Black and White.* New York: Quadrangle/*The New York Times Book Company.*

back

[59]Johnson, D. R. & Lubin, H. (1995). Uncovering PTSD in the Republic of Vietnam. *NCP Clinical Quarterly, 5,* 7-10.
back

[60]Pierre, J. (1889). *L' Automatisme Psychologigue.* [psychological automatism]. Paris: Felix Alcan; van der Hart, O., Brown, P., & van der Kolk, B.A. (1989), Pierre Janet's Treatment of Post-Traumatic Stress, *Journal of Traumatic Stress, 2,* 379-395.
back

[61] Brown, D., Scheflin, A, & Hammond, D. (1998). *Memory, Trauma Treatment and the Law: An Essential Reference on Memory for Clinicians, Researchers, Attorneys, and Judges.* New York: W.W. Norton.
back

[62]Courtois, C. (1988). *Healing the Incest Wound: Adult Survivors in Therapy.* New York: Norton.
[63]Crowder, (1995). *Opening the Door: A Treatment Model of Therapy with Male Survivors of Sexual Abuse.* New York: Brunner/Mazel.
[64]Briere, J. (1989). *Therapy for Adults Molested as Children.* New York: Springer.
back

[65]Hartman, C. & Burgess, A. (1988). Rape Trauma and Treatment of the Victim. In F. M. Ochberg (Ed.), *Post-Traumatic Therapy and Victims of Violence* (pp. 152-174). New York: Brunner/Mazel.
back

[66]Kluft, R. (1984). Aspects of the Treatment of Multiple Personality Disorder. *Psychiatric Annals, 14,* 5-55;
-Braun, B. (1986). Issues in the Psychotherapy of Multiple Personality Disorder. In B. Braun (Ed). *Treatment of Multiple Personality Disorder* (pp. 3-28). Washington, DC: American Psychiatric Press;
-Braum, B. (1988). The BASK Model of Dissociation: Part I. *Dissociation, 1,* 4-23; Putnam, F. (1989).
-Ross, C. (1989). *Multiple Personality Disorder: Diagnosis, Clinical Features, and Treatment.* New York: Wiley.
back

[67]Parson, E.R. (1997). Post-Traumatic Child Therapy (P-TCT): Assessment and Treatment Factors in Clinical work with Inner-City Children Exposed to Catastrophic Community Violence. *Journal of Interpersonal Violence, 12,* 172-194.
back

[68]James, B. (1989). *Treating Traumatized Children: New Insights and Creative Interventions.* Lexington, MA: Lexington Books.
back

[69]Brende, J. & Goldsmith, R. (1991). Post-traumatic Stress Disorder in Families. *Journal of Contemporary Psychotherapy, 21,* 115-123.
back

[70] Scurfield, R. (1985). Post-Trauma Assessment and Treatment: Overview and Formulations. In C. Figley (Ed.), *Trauma and Its Wake: The Study and Treatment of Post-Traumatic Stress Disorder* (pp. 219-256). New York: Brunner/Mazel.
[71]Keane, T., Fisher, l., Krinsley, K., & Niles, B. (1994). Post-Traumatic Stress Disorder. In M. Hersen & Ammerman (Eds.), *Handbook of Prescriptive Treatments for Adults* (pp. 237-260). New York: Plenum.
[72]Dohrenwend, B. (In press). Positive Tertiary Appraisals and Post-Traumatic Stress Disorder in Vietnam Veterans: The Roles of Positive Affirmation, Positive Reformulation, and Defensive Denial. (E. R. Parson, Consultant to this Research Project), Columbia University Presbyterian Medical School, New York City. Article to be published in the *Journal of Clinical and Consulting Psychology*).
back

[73]Wolf, A. (2003). Pragmatism, Pluralism, and Psychotherapy Relationships: An Overview with John C. Norcross. *Journal of Contemporary Psychotherapy, 33,* 129-143.
back

[74]Parson, E. R. (1981). The Reparation of the Self. *Journal of Contemporary Psychotherapy, 14,* 4-51.
back

[75]Parson, E.R.. Batten. S.V., & Jones, S.O. (2003, August , 14). Discussion of Numbing/Avoidance and Arousal Traumadynamics at the Contemporary Clinical and Research Issues in Traumatic Stress. VAMHCS, Baltimore Division.

back

[76] Marshall, R., Turner, B., Lewis-Fernandez, R., Koenen, K., Neria, Y., & Dohrenwend, B.P.(In press). Predicting Chronicity in Vietnam Veterans with Combat-Related PTSD: New Findings from the National Vietnam Veterans Readjustment Study.

back

[77]Tillich, P. (1952). *The Courage To Be.* New Haven: Yale.

back

[78]Elliott, K. (1995). The WILFY Method: Unlearning Lessons from the Past. *Journal of Cognitive Psychotherapy: An International Quarterly, 9,* 259-266.

back

[79]Prins, A. (2002). Women and Trauma Forum—The Role of Self-Defense Training in Sexual Revictimization. *NCP-Clinical Quarterly, 11,*

back

[80]E. R. Parson in Brown, D.., Scheflin, A, & Hammond, D. (1998). *Memory, Trauma Treatment and the Law: An Essential Reference on Memory for Clinicians, Researchers, Attorneys, and Judges.* New York: W.W. Norton.

back

[81]Foa, E., Davidson, J. & Frances, A. (1999). The Expert Consensus Guideline Series: Treatment of Post-Traumatic Stress Disorder (1999). *Journal of Clinical Psychiatry, 60,* (Supplement 16).

back

[82] Pennebaker, J. (1987). Confession, Inhibition, and Disease. *Advances in Experimental Social Psychology, 22,* 211-244.

back

[83]Breuer, J. & Freud, S. (1895/1957). *Studies in Hysteria.* (James Strachey, tr.). New York: Basic Books.

back

[84]Brende, J. & Goldsmith, R. (1991). Post-traumatic Stress Disorder in Families. *Journal of Contemporary Psychotherapy, 21,* 115-123.

back

[85]Brende, J.O. & Parson, E. R. (1985). *Vietnam Veterans: The Road to Recovery:* New York: Plenum.

back

[86]Powell-Johnson, G. (1983). *The Psychosocial Development of Minority Group Children.* New York: Brunner/Mazel.

back

[87]Parson, E. R. (1991). Integrating the Multicultural Self: Relevance of Psychohistorical and Intercultural Factors in PTSD Treatment with Black American Veterans. *NC-PTSD Clinical Newsletter, 2 (1),* 14-15.

back

[88]Bland, S., O'Leary, E., Farinaro, E., Jossa, F., Krogh, V., Violanti, J., & Trevisan, (1997). Social Network Disturbances and Psychological Distress Following Earthquake Evacuation. *Journal of Nervous and Mental Disease, 185,* 188-194.

back

[89]Brende, J.O. & Parson, E. R. (1985). *Vietnam Veterans: The Road to Recovery:* New York: Plenum.

back

[90]Parson, E. R. (1985). Ethnicity and Traumatic Stress: The Intersecting Point in Psychotherapy. In C. R. Figley (Ed.), *Trauma and Its Wake: The Study and Treatment of Post-Traumatic Stress Disorder.* New York:Brunner/Mazel.

back

[91]Castillo, A. & Bailey, J. (2002). Holding and Treating the Traumatized Child: A Preschooler's Resilience In Mastering His Fears and Making Sense of His Life. *Journal of Infant, Child, and Adolescent Psychotherapy, 2,* 67-93.

back

[92]American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders (4th ed.),* Text Revision (DSM-IV TR). Author.

back

[93]American Psychological Association (1990). *Guidelines for Providers of Psychological Services Ethnic, Linguistic, and Culturally Diverse Populations.* Author; Falicov, C. (1998). *Latino Families in Therapy. A Guide to Multicultural Practice.* New York: Guilford; Fukuyama, M. & Sevig, T. (1999). *Integrating Spirituality in Multicultural Counseling.* Thousand Oaks, CA: Sage.

back

[94]Lin, K-M & Poland, R. (1995). Ethnicity and Psychopharmacology. *Review of Psychiatry.* In Bloom, F., & Kupfer, D (eds.), *Psychopharmacology: The Fourth Generation of Progress* (1907-1917). New York: Raven..

back

[95]McCann, L. & Pearlman, L. (1990). *Psychological Trauma and the Adult Survivor: Theory, Therapy, and Transformation.* New York: Brunner/Mazel.

back

[96]E. R. Parson in McCann, L. & Pearlman, L. (1990). *Psychological Trauma and the Adult Survivor: Theory, Therapy, and Transformation.* New York: Brunner/Mazel.

back

[97]Freud, S. (1984). Two short accounts of psychoanalysis. In J. Strachey (Tr.), *Five Lectures on Psychoanalysis.* Singapore: Penguin Books.

back

[98]Freud, S. (1984). Two short accounts of psychoanalysis. In J. Strachey (Tr.), *Five Lectures on Psychoanalysis.* Singapore: Penguin Books.

back

[99]Boudewyns, P. & Shipley, R. (1983). *Flooding and Implosive Therapy.* New York: Plenum.

back

[100]Parson, E. R. (1998). Traumatic Stress Personality Disorders (TrSPD), Part III: Mental/Physical Trauma Representations— From Focus on PTSD Symptoms to Inquiry into Who the Victim Has Now Become. *Journal of Contemporary Psychotherapy, 28,* 141-171.

back

[101]E. Parson in D. Brown et al. (1998). *Memory, Trauma Treatment, and the Law.* New York; and R. Ulman and D. Brothers (1989). The Shattered Self: A Psychoanalytic Study of Trauma. Northvale, NJ: Analytic Press.

back

[102]Horowitz, M. (1986). *Stress Response Syndromes.* New York: Aronson.

back

[103]Boudewyns, P. & Shipley, R. (1983). *Flooding and Implosive Therapy.* New York: Plenum.

back

[104]Parson, E. R. (1998). Traumatic Stress Personality Disorders (TrSPD), Part III: Mental/Physical Trauma Representations— From Focus on PTSD Symptoms to Inquiry into Who the Victim Has Now Become. *Journal of Contemporary Psychotherapy, 28,* 141-171.

back

[105]Herman, J. (1992). *Trauma and Recovery.* New York: Basic Books.

back

[106]van der Kolk, B. (1994). The History of Trauma in Psychiatry. *Psychiatric Clinics of North America, 17,* 583-600.

back

[107]Kohut, H. (1984). *How Does Analysis Cure?* Chicago: University of Chicago Press.
back

[108]Ford, J., & Kidd, P. (1998). *Early Childhood Trauma and Disorders of Extreme Stress as Predictors of Treatment Outcome with Chronic Post-Traumatic Stress Disorder.* Trauma Information Pages. www.trauma-pages.com/ford98.htm.
back

[109]Parson, E. R. (1999). The Voice in Dissociation: A Group Model for Helping Victims Integrate Trauma Representational Memory. *Journal of Contemporary Psychotherapy, 29,* 19-38.
back

[110]Kohut, H. (1972). *The Restoration of the Self.* New York: International Universities Press.
back

[111]Kluft, R. (1996). Treating the Traumatic Memories of Patients with Dissociative Identity Disorder. *American Journal of Psychiatry, 153,* 103-110.
back

[112]Kudler, H. (1991). What is Psychological Trauma? *NCPTSD Clinical Newsletter, 2,* 8.
back

[113]Editorial (2001). *British Journal of British Psychotherapy, 13,* 161-162.
back

[114]Schafer, R. (1959). Generative Empathy in the Treatment Situation. *Psychoanalytic Quarterly, 28,* 342-373.
back

[115]Winnicott, D.W. (1992). *Through Pediatrics to Psychoanalysis: Collected Papers of D.W. Winnicott.* New York: Brunner/Mazel.
back

[116]Parson, E. R. (1981). The Reparation of the Self. *Journal of Contemporary Psychotherapy, 14,* 4-51.
back

[117]Erikson, E. (1980). Themes of Adulthood in the Freud-Jung Correspondence. In N.J. Smelser & E. H. Erikson (Eds.), *Themes of Work and Love in Adulthood* (pp. 43-47), p. 45).
back

[118]Kohut, H. (1972). *The Restoration of the Self.* New York: International Universities Press.
back

[119]Parson, E. R. (1998). Traumatic Stress Personality Disorders (TrSPD), Part III: Mental/Physical Trauma Representations—From Focus on PTSD Symptoms to Inquiry into Who the Victim Has Now Become. *Journal of Contemporary Psychotherapy, 28,* 141-171.
back

[120] Brown, D., Scheflin, A, & Hammond, D. (1998). *Memory, Trauma Treatment and the Law: An Essential Reference on Memory for Clinicians, Researchers, Attorneys, and Judges.* New York: W.W. Norton.
back

[121]Henderson, J. (1984). Play in the Psychotherapy of Selfobject Relating. *Canadian Journal of Psychiatry, 29,* 417-424.
back

[122]Broucek, F. (1979). Efficacy in Infancy: A Review of Some Experimental Studies and their Possible Implications for Clinical Theory. *International Journal of Psychoanalysis, 60,* 311-316.
back

[123]Parson, E.R. (1994). History, Art, Psychiatry, and Science: The War Veteran in Perspective, Finally! (Book Review: *Achilles*

in Vietnam: Combat Trauma and the Undoing of Character, by Jonathan Shay, M.D., Ph.D.). *Journal of Contemporary Psychotherapy, 24,* 65-69.

back

[124]Lifton, R.J. (1978). Advocacy and Corruption in the Healing Profession. In C. Figley (Ed.), *Stress Disorders Among Vietnam Veterans.* New York: Brunner/Mazel.

back

[125]Steel, K. & Colrain, J. (1990). Abreactive work with sexual abuse survivors: Concepts and Techniques. In M. A. Hunter (Ed.), *The Sexually Abused Male: Applications of Treatment Strategies.* (Vol 2., pp. 1-55). Lexington, MA: Lexington Books.

back

[126]Parson, E.R. (1990) Parson). Post-Traumatic Demoralization Syndrome. *Journal of Contemporary Psychotherapy, 20,* 20-33.

back

[127]Winnicott, D.W. (1975). *Through Paediatrics to Psychoanalysis.* New York: Basic Books.

back

[128]M. Blondel in Ellerman, C. (1997). The Absurd Sensibility of Existential Psychotherapy: Clinical Application of Survivors' Experience of Treblinka and Other Death Camps. *Journal of Contemporary Psychotherapy, 27,* 119-130.

back

[129]Lantz, J. & Gregorie, T. (2003). Existential Trauma Therapy with Men After Heart Attack. *Journal of Contemporary Psychotherapy, 33,* 19-48.

back

[130]Robert Jay Lifton in Parson, E.R. (1990) Parson). Post-Traumatic Demoralization Syndrome. *Journal of Contemporary Psychotherapy, 20,* 20-33.

back

[131]Des Pres, T. (1980). *The Survivor: Anatomy of Life in the Death Camps.* Oxford: Oxford University.

back

[132]Ellerman, C. (1997). The Absurd Sensibility of Existential Psychotherapy: Clinical Application of Survivors' Experience of Treblinka and Other Death Camps. *Journal of Contemporary Psychotherapy, 27,* 119-130.

back

[133] P. Janet in van der Kolk, B. & van der Hart, O. (1989). Pierre Janet and the Breakdown of Adaptation in Psychological Trauma. *American Journal of Psychiatry, 146,* 1532.

back

[134]Penn, M. & Wilson, L. (2003). Mind, Medicine, and Metaphysics; Reflections on the Reclamation of the Human Spirit. *American Journal of Psychotherapy, 57,* 19-31.

back

[135],[136]Parson, E. R. (1994). Inner City Children of Trauma: Urban Violence Traumatic Stress Response Syndrome (U-VTS). In J. Wilson & J. Lindy (Eds.), *Countertransference in the Treatment of PTSD.* New York: The Guilford Press.

back

[137]Parson, E. R. (1987, April). "Freud, Veterans, and Public Policy." Paper presented at the Spring Meeting of the APA Division of Psychoanalysis, Vista International Hotel, New York City.

back

[138]Nathan, S. (1988). Applying Self Psychology to the Special Problems of Women Patient: Incest Trauma and Eating Disorders. (Panel at Division 39 [Psychoanalysis] of the American Psychological Association.). *Psychologist-Psychoanalyst, 8(5).* 17.

back

[139]Garland in Parson, E. R. (In press). *Post-Traumatic Group Psychotherapy.*

back

[140]E. R. Parson in van der Kolk, B. (1987). *Psychological Trauma.* Washington, DC: American Psychiatric Press, Inc.

back

[141]Herman, J. & Shatzow, E. (1984). Time Limited Group Psychotherapy for Women with a History of Incest. *International Journal of Group Psychotherapy, 34,* 605-610.

back

[142] E. R. Parson in van der Kolk, B. (1987). *Psychological Trauma.* Washington, DC: American Psychiatric Press, Inc.

back

[143]Herman, J. (1992). *Trauma and Recovery.* New York: Basic Books.

back

[144]Parson, E.R. (1993). Ethnotherapeutic Empathy (EthE)—Part II: Techniques in Interpersonal Cognition and Vicarious Experiencing Across Cultures. *Journal of Contemporary Psychotherapy, 23,* 171-182.

back

[145]Wilkinson, C. (1985). *Ethnic Psychiatry.* New York: Plenum Medical Books Company.

back

[146]Dunbar, P. (1897). We Wear the Mask. In *Lyrics of a Lonely Life.* New York: Dodd, Mead.

back

[147]Broucek, F. & Ricci, W. (1998). Self-Disclosure or Self Presence? *Bulletin of the Menninger Clinic, 62,* 427-428.

back

[148]Constantine, M. & Kwan, K. (2003). Cross-Cultural Considerations of Therapist-Disclosure. *JCLP/In Session. 59,* 581-588.

back

[149]Parson, E.R. (1990). Post-Traumatic Psychocultural Therapy (PTpsyCT): Integration of Trauma and the Shattering Labels of the Self. *Journal of Contemporary Psychotherapy, 20,* 237-258. Assessment, and Treatment Implications. *NCP--Clinical Quarterly, 10,* 1-10.

back

[150]Johnson, D. R. & Lubin, H. (1995). Uncovering PTSD in the Republic of Vietnam. *NCP Clinical Quarterly, 5,* 7-10.

back

[151]Ormont, L. (2001). Meeting Maturational Needs in the Group Setting. *International Journal of Group Psychotherapy, 51,* 343-359.

back

[152]Shalev, A. (2001). What is Post-Traumatic Stress Disorder? *Journal of Clinical Psychiatry, 62,* 4-10.

back

[153] Keane, T. (1995). The Role of Exposure Therapy in the Psychological Treatment of PTSD. *NCP—Clinical Quarterly, 5,* 1-6.

back

[154]Foa, E., Davidson, J. & Frances, A. (1999). The Expert Consensus Guideline Series: Treatment of Post-Traumatic Stress Disorder (1999). *Journal of Clinical Psychiatry, 60,* (Supplement 16).

back

[155],[156]Orsillo, S. M. & Batten, S. V. (In press). Acceptance and Commitment Therapy in the Treatment of Posttraumatic Stress Disorder. Behavior Modification.

back

[157]Trad, P. (1991). Applying a Prospective Approach to the Working Through Phase of Psychotherapy. *Journal of Contemporary Psychotherapy, 21,* 231-246.

[158]Winnicott, D.W. (1975). *Through Paediatrics to Psychoanalysis.* New York: Basic Books.

back

[159]Kohut, H. (1984). *How Does Analysis Cure?* Chicago: University of Chicago Press.

back

[160]Frawley-O'Dea, M. (1997). Transference Paradigms at Play in Psychoanalytically Oriented Group Therapy with Female Adult Survivors of Childhood Sexual Abuse. *International Journal of Group Psychotherapy, 47,* 427.

back

[161]Herman, J. (1992). *Trauma and Recovery.* New York: Basic Books.

back

[162]Rothbaum, B., Meadows, El., Resick, P., & Foy, D. (2001). Cognitive-Behavior Therapy. In Foa, E. et al., *Effective Treatments for PTSD.*

back

[163]Foa, E., Riggs, Massie, & Yarczower (1995). The Impact of Fear Activation and Anger on the Efficacy of exposure Treatment for PTSD. *Behavior Therapy, 26,* 487-499.

back

[164]Foa, E., Steketee, Rothbaum, (1989). Behavioral/Cognitive Conceptualization of Post-Traumatic Stress Disorder. *Behavior Therapy, 20,* 155-176.

back

[165]Parson, E. R. (1998). Traumatic Stress Personality Disorders (TrSPD), Part III: Mental/Physical Trauma Representations— From Focus on PTSD Symptoms to Inquiry into Who the Victim Has Now Become. *Journal of Contemporary Psychotherapy, 28,* 141-171.

back

[166]Parson, E, R. Post-Traumatic Self Disorders (PTsfD). In J. Wilson, Z. Harel, & B Kahana (Eds.). *Human Adaptation to Extreme Stress* (pp. 245-283). New York: Plenum.

back

[167]Batten, S. V, & Orsillo, S. M. (2002, February). Therapist's Reactions in the Context of Collective Trauma. Special Series: AABT Responds to September 11. *The Behavior Therapist,* pp. 36-39.

back

[168]Yalom, I. (2002). *The Gift of Therapy: An Open letter to a New Generation of Therapists and Their Patients.* New York: HarperCollins Publishers, Inc.

back

[169] McCann, L. & Pearlman, L. (1990), Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims. *Journal of Traumatic Stress, 3,* 131-149; Sabin-Farrell, R. & Turpin, G. (2003). Vicarious Traumatization: Implications for the Mental Health of Health Workers. *Clinical Psychology Review, 23,* 449-480.

back

[170]Tomb, D. (1994). The Phenomenology of Post-Traumatic Stress Disorder. *Psychiatric Clinics of North America, 17,* 237-250.

back

[171]S. Freud in Weisaeth, L. (2002). The European History of Psychotraumatology. *Journal of Traumatic Stress, 15,* 443-452.

back

[172]Kohut, H. (1972) *The Restoration of the Self.* New York: International Universities Press.

back

[173],[174]Zerbe, K. (1995). Selves That Starve and Suffocate: The Continuum of Eating Disorders and Dissociative Phenomena. *Diagnosis and Treatment of Dissociative Disorders.* Northvale, NJ: Aronson.
back

[175]Pierre Janet in Weisaeth, L. (2002). The European History of Psychotraumatology. *Journal of Traumatic Stress, 15,* 444.
back

[176]Chu, J. (1992). The Victimization of Adult Women with Histories of Childhood Abuse. *Journal of Psychotherapy Practice and Research, 1,* 259-269.
back

[177]Rothstein, A. (1986). *The Reconstruction of Trauma: Its Significance in Clinical Work.* New York: The American Psychoanalytic Association.
back

[178]Foa, E. & Street, G. (2001). Women and Traumatic Events. *Journal of Clinical Psychiatry, 62,* 29-34.
back

[179]Drummond, L. Behavioural Approaches to Anxiety Disorders. *Postgraduate Medical Journal, 69,* 222-226.
back

[180]van der Kolk, B. Trauma and Memory. In B. van der Kolk, A. McFarlane, & L. Weisaeth (Eds.), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society* (pp.279-302). New York: Guilford.
back

[181]Parson, E. R. (1998). Traumatic Stress Personality Disorders (TrSPD), Part III: Mental/Physical Trauma Representations—From Focus on PTSD Symptoms to Inquiry into Who the Victim Has Now Become. *Journal of Contemporary Psychotherapy, 28,* 141-171.
back

[182]Frawley-O'Dea, M. (1997). Transference Paradigms at Play in Psychoanalytically Oriented Group therapy with Female Adult Survivors of Childhood Sexual Abuse. *International Journal of Group Psychotherapy, 47,* 440.
back

[183]Ferenczi, S. (1933). Confusion of Tongues Between the Adult and the Child. In *Final Contributions to the Problems and Methods of Psychoanalysis* (pp. 156-167). London: Hogarth.
back

[184]Herman, J. (1992). *Trauma and Recovery.* New York: Basic Books.
back

[185]Gibbard, C. & Lester, E. (1995). *Boundaries and Boundary Violations in Psychoanalysis.* New York: Basic Books.
back

[186]Harper, K. & Steadman, J. (2003). Therapeutic Boundary Issues in Working with Childhood Sexual-Abuse Survivors. *American Journal of Psychotherapy, 57,* 64-79.
back

[187]Harper, K. & Steadman, J. (2003). Therapeutic Boundary Issues in Working with Childhood Sexual-Abuse Survivors. *American Journal of Psychotherapy, 57,* 64-79
back

[188]Davies, J. & Frawley, M. (1994). *Treating the Adult Survivor of Childhood Sexual Abuse.* New York: Basic Books.
back

[189]Edelman, G. (1992). *Bright Air, Brilliant Fire: On the Matter of the Mind.* New York: Basic Books.
back

[190]Scurfield, R. (1985). Post-Trauma Assessment and Treatment: Overview and Formulations. In C. Figley (Ed.), *Trauma and Its Wake: The Study and Treatment of Post-Traumatic Stress Disorder* (pp. 219-256). New York: Brunner/Mazel.

back

[191]Adebimpe, V. (1981). Overview: White Norms and Psychiatric Diagnosis of Black Patients. *American Journal of Psychiatry, 138,* 279-285.

back

[192]DuBois, W.E.B. (1903). *The Souls of Black Folks.* Chicago: McClure.

back

[193] McNair, L. (1992). African American Women in Therapy: An Afrocentric and Feminist Synthesis. *Women in Therapy, 12,* 5-19.

back

[194]E. R. Parson in Marsella, A., Friedman, M. Gerrity, E., & Scurfield, R. (1996). *Ethnocultural Factors in Post-Traumatic Stress Disorder; Issues, Research, and Clinical Applications.* Washington, DC: American Psychological Association.

back

[195]Post, R., Weiss, S., Smith, H., Zhang, L., Xing, G., Osuch, E., & McCann, U. (1998). Neural Plasticity and Emotional Memory. *Development and Psychopathology, 10,* 829-855.

back

[196]Edelman, G. (1992). *Bright Air, Brilliant Fire: On the Matter of the Mind.* New York: Basic Books.

back

[197]Trad, V. (1991). Applying a prospective Approach to the Working-through Phase of Psychotherapy. *Journal of Contemporary Psychotherapy, 21,* 321-256.

back

[a] *These three cases represent the treatment experience of the authors of this article over the years. Specific details of the victim/survivors have been changed to protect the identity of those presented.*

back

Erwin R. Parson, (1943-2006) Ph.D., A.B.P.P. was a Diplomate in Psychology, a Master Clinician and Trauma Treatment Technology Developer for over 20 years. Having worked in the area of administration of trauma programs, Dr. Parson also worked in the direct treatment of trauma adult and child victims. He was the author of dozens of articles and book chapters in the area of trauma, ethnicity, and healing.

Dr. Erwin Parson was a member of Gift From Within's Board of Directors.