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Dissociative Processes and Transference–Countertransference Paradigms in the Psychoanalytically Oriented Treatment of Adult Survivors of Childhood Sexual Abuse

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Clearly recognized by researchers in the field as one of the major long-term sequelae of childhood trauma, discussion of the process of dissociation remains embedded in the classical psychoanalytic literature and is not often referred to in contemporary psychoanalytic writing. This article attempts to update the definition of dissociation in accordance with contemporary research on traumatic stress and posttraumatic stress disorders and to demonstrate the manifestations and impact of dissociative phenomena in the psychoanalytic treatment of adult survivors of childhood sexual abuse. Several points are emphasized: (1) treatment of the adult survivor of childhood sexual abuse involves recognition of the simultaneous coexistence and alternation of multiple (at least two) levels of ego organization; (2) at least one level represents, in split-off form, the entire system of self- and object representation, including unavailable, affectively loaded memories and fantasied elaborations and distortions originating in the traumatogenic abusive situation; and (3) there is present a kaleidoscopic transference–countertransference

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picture that shifts illusively but can often be understood as based on the projective–introjective volleying of a fantasized victim, abuser, and idealized, omnipotent savior.

ONLY RECENTLY, and still amid great controversy, have mental health professionals returned to the issue of treating, from a psychoanalytic perspective, the adult survivor of childhood sexual trauma. The growing awareness of the actualities of childhood abuse, in concert with the burgeoning numbers of men and women seeking professional help in dealing with long-term residual effects of their abusive experiences, has created a desperate need for psychoanalytically trained clinicians educated in this area and alerted to the specific needs of this patient population.

It is our contention that we can afford to sacrifice, in this context, neither clinical experience and sophistication, nor a thorough, working understanding of the maladaptive intrapsychic organizations typical of the psychological adjustments of adult survivors of childhood sexual abuse. Analysts must be alerted both to the specific constellations of reality preserving/distorting defenses used by adult survivors and to the particular transference-countertransference paradigms that represent the introduction of these defenses into the intersubjective field of the analytic work. The analyst's attention to his or her own pattern of reaction, be it primary or counter to the patient's reaction, is of paramount importance and must assume an organizing function in any attempt to interpret a central therapeutic configuration. We firmly believe that it is within the context of an informed analytic treatment that adult survivors can best move beyond the pervasive guilt and shame that are their unique legacy, to deal with the underlying defensive compromises that make continued experiences of victimization and abuse a lifelong pattern.

The tension and mistrust that exist between psychoanalysis and the field of childhood sexual abuse are, of course, historic. To date, many classical analysts persist in their denial of the realities of childhood sexual abuse, a denial we believe to be unconscionable, given the incontrovertible results of current, quality research on the subject. Though it is not our intention in the present paper to review fully the incidence and demographics of childhood sexual abuse in this country, we do believe that inclusion of certain key statistical findings serves to substantiate our

conviction that a reconciliation between psychoanalysts and researchers in the field has become an emergent clinical and social necessity.

All available, current research points to the same conclusions. Actual sexual molestation of children is, and for a long while has been, a reality of life in our society. It will not be dismissed, and it will not be isolated by race, religion, or socioeconomic classification. Our best current estimate is that between 20 and 35% of all women have had unwanted sexual encounters with adult males sometime before their 18th birthday, and 8.5 to 15% report that such contact was with a close family member (Russell, 1986). Between 1 and 4.5% of all women report having been sexually abused by a biological father, adoptive father, or stepfather (Finkelhor, 1979; Herman, 1981; Herman and Hirschman, 1981; Russell, 1983, 1984, 1986). These studies were intentionally conducted on nonclinical, primarily middle-class populations; in many cases the populations consisted entirely of randomly selected college students. Findings across studies were remarkably consistent, and all researchers agreed that if there was error, it was to underestimate the actual incidence of abuse. Unfortunately, the findings on the incidence of sexual abuse of male children are much less consistent and therefore less conclusive. Finkelhor (1979) places the figures at 8.6% for general abuse and 1.5% for abuse by a close family member. More research on the abuse of male children is a necessity.

Clearly, the time has come to reopen a serious psychoanalytic dialogue about the specific psychological sequelae of early childhood sexual trauma. Our intention in the present paper is to focus on the clinical manifestations and therapeutic implications of dissociation as it is used defensively by adult survivors. Our belief is that dissociation, more than any other clinical phenomenon, is intrinsic to the intrapsychic structure and organization of this patient group and, to a large extent, is pathognomic of it. Though contemporary psychoanalytic discussion of dissociation in victims of abuse is minimal and will be reviewed below, our belief in the primacy of this clinical phenomenon emerges out of a confluence of three other bodies of empirical data. These are the areas of childhood sexual abuse (Briere, 1989; Courtois, 1989); trauma and posttraumatic stress disorders (Van der Kolk, 1987; Krystal, 1988; Ulman and Brothers, 1988); and specific dissociative disorders, including multiple personality disorders (Putnam, 1989; Ross, 1989). From these disparate areas of investigation comes confirmation of the recurring connection between childhood trauma, particularly physical and sexual

trauma, and the process of dissociation. Indeed, a recent empirical study of 278 university women found that a measure of dissociation could successfully discriminate between abused and nonabused subjects when no other measures were employed (Briere and Runtz, 1988).

In the present paper we use the concept of dissociation to refer to an organization of mind, not unlike splitting, wherein traumatic memories are split off from associative accessibility to the remainder of conscious thought, but rather than being repressed and forgotten, as would be the case in a topographical/structural model, they alternate in a mutually exclusive pattern with other conscious ego states. As with splitting, the clinical question is not what is conscious and what is unconscious but, rather, what is available and conscious to the patient at a particular point in time, and what clinical interventions best serve the purposes of integration. Unlike splitting, in which the goal is to protect the good object from the murderous impulses of an angry, frustrated self, dissociation aims to protect the person from the overwhelming memory of traumatic events and the regressive fantasies that these memories trigger.

It will become clear, however, that our position differs significantly from the classical position, which regards dissociation as a regressive defense against the overwhelming aggressive and libidinal drive derivatives stimulated by early sexual and aggressive assault. Though our view preserves the importance of powerful sadomasochistic struggles, we view dissociation not merely as a defense against drive but, rather, as a process that preserves and protects, in split-off form, the entire internal object world of the abused child. We believe that in making contact with the split-off, dissociated, child persona within the abused adult, we free these archaic objects to work their way into the transference-countertransference paradigms through projective-introjective mechanisms and, in so doing, enable patients to work through each possible configuration within the therapeutic relationship.

The following discussion is divided into three sections: (1) a brief, historical review of the concept of dissociation, (2) a review of the more contemporary psychoanalytic writing on the concept of dissociation, (3) a clinical description of dissociation as it appears in the treatment of adult survivors of childhood sexual abuse, including a specific discussion of the transference-countertransference dilemmas that emerge when treating patients whose intrapsychic structure depends heavily on dissociative mechanisms.

Dissociation in Historical Context

The legacy of mistrust and misunderstanding between psychoanalysts and those in the field of childhood sexual abuse had its inception in the very earliest period of psychoanalytic thought and writing. The much debated process of Freud's (1896) wholehearted commitment to, and subsequent rejection of, the "seduction hypothesis" is, by now, well known to those familiar with the history of psychoanalytic thought. Although it is not within the scope of this paper to analyze the reasons behind Freud's rejection of a hypothesis he had believed in so intensely, we do wish to examine the impact that this change of heart ultimately came to exert on the direction of psychoanalytic thought and practice.

Though Freud came to doubt that early sexual trauma could account for all neurotic manifestations and turned the attention of the psychoanalytic community, therefore, from the realities of childhood trauma to the complexities of infantile fantasy and intrapsychic structuralization, he did dramatically underestimate the incidence of actual sexual abuse and inadvertently cast aside an enormously rich body of literature on the nature of intrapsychic processes specific to adult survivors of childhood sexual abuse. Only today is this literature beginning to resurface, as Freud's conclusions about the psychical integration of infantile traumatogenic events are subject to empirical study. Indeed, Freud's (Breuer and Freud, 1893–1895) earliest psychoanalytic writings on the predisposition to altered states of consciousness and ego dissociation and splitting in the victims of childhood sexual trauma are almost entirely supported by the results of contemporary research (Van der Kolk, 1987; Krystal, 1988; Ross, 1989; Putnam, 1989; Ulman and Brothers, 1988).

Clearly, Freud believed that his early hysterical patients had been sexually abused. In "The Aetiology of Hysteria" Freud (1896) concluded:

> If you submit my assertion that the aetiology of hysteria lies in sexual life to the strictest examination, you will find that it is supported by the fact that in some eighteen cases of hysteria I have been able to discover this connection in every single symptom, and, where the circumstances allowed, to confirm it by therapeutic success [p. 199].

Later in the same paper he wrote:

> I therefore put forth the thesis that at the bottom of every case of hysteria there are one or more occurrences of premature sexual experience, occurrences which belong to the earliest years of childhood but which can be reproduced through the work of psychoanalysis in spite of the intervening decades [p. 203].

In this context we turn back to Breuer and Freud's earlier clinical papers in and attempt to review their prescient description of the clinical manifestations of early sexual overstimulation in their adult hysterical patients. The theme of dissociation and the dual nature of consciousness, with which we are particularly concerned in this paper, assume a central role throughout their early writing. In their "Preliminary Communication, The Mechanism of Hysterical Phenomena" (Breuer and Freud, 1893 to 1895), the authors state unequivocally:

> The longer we have been occupied with these phenomena the more we have become convinced that the splitting of consciousness which is so striking in the well-known classical cases under the form of "double-conscience" is present to a rudimentary degree in every hysteria, and that a tendency to such a dissociation, and with it the emergence of abnormal states of consciousness (which we shall bring together under the term "hypnoid") is the basic phenomenon of this neurosis. . . . Ideas which emerge in them are very intense but are cut off from associative communication with the rest of the content of consciousness [p. 12].

Though Freud later moves in a direction that stresses the repression of traumatic events within a topographical model of the mind, wherein there is a layering of levels of consciousness depending on the acceptability of the memories (later impulses) contained therein, he and Breuer are, at this time, still describing in their hysterical patients not a layering but an alternation of differing experiences of consciousness. It is not that one group of associations is conscious and one group unconscious; rather, they are independent, mutually exclusive ego states, associatively unavailable to each other, which alternate depending on the patient's emotional state, the stimulation of traumatic memories, and the particular configuration of transference-countertransference material operative at a particular time.

In the first of his published case studies, that of Frau Emmy Von N., Freud describes the phenomenon unmistakably:

> What she told me was perfectly coherent and revealed an unusual degree of education and intelligence. This made it seem all the more strange when every two or three minutes she suddenly broke off, contorted her face into an expression of horror and disgust, stretched out her hand towards me, spreading and crooking her fingers, and exclaimed, in a changed voice, charged with anxiety: "Keep still! Don't say anything! Don't touch me!" She was probably under the influence of some recurrent hallucination of a horrifying kind and was keeping the intruding material at bay with this formula. These interpolations came to an end with equal suddenness and the patient took up what she had been saying, without pursuing her momentary excitement any further, and without explaining or apologizing for her behavior—probably therefore without herself having noticed the interpolation [Breuer and Freud, 1893–1895, p. 49].

The case studies in this volume contain many such evocative examples of recurrent dissociative episodes. Unfortunately, Freud's abandonment of the seduction theory in September 1897 relegated these early clinical and theoretical conceptualizations to the ancillary position of scientific history. For the most part, clinicians today read "Studies on Hysteria" to learn about the early stages in the development of psychoanalysis and Freud's struggles to develop a working model of the mind and to elucidate a technique that would overcome the powerful forces of repression, unconscious conflict, and symptom formation. The brilliant clinical descriptions so richly depicted in the text and so pertinent to work with adult survivors of childhood sexual abuse were to be lost for many years to come.

Not until the work of Sandor Ferenczi did the actualities of early childhood trauma and their psychologically devastating sequelae again become the focus of serious psychoanalytic inquiry. Ferenczi (Freud's pupil, analysand, and, after Fliess, his closest personal friend) would eventually jeopardize his relationship with Freud and his respect and esteem within the psychoanalytic community to promulgate his belief in the primacy of these events. In a letter to Freud dated December 25, 1929, Ferenczi writes:

> In all cases where I penetrated deeply enough I found uncovered the traumatic-hysterical bases of the illness. . . . The critical view that I gradually formed during this period was that psychoanalysis deals far too one-sidedly with obsessive neurosis and character analysis—that is, ego psychology—while neglecting the organic-hysterical basis of the analysis. This results from overestimating the role of fantasy, and underestimating that of traumatic reality, in pathogenesis . . . [Dupont, 1988, p. xii].

Unfortunately, the presentation of these views (Ferenczi, 1932) and their ultimate publication (Ferenczi, 1949) led to an irreconcilable break with Freud, and ultimately, during the last years of his life, Ferenczi was branded by Jones (1961) and other members of the international psychoanalytic community, as the victim of an emotional and mental breakdown.

Psychoanalytic politics notwithstanding, the publication of Ferenczi's clinical diaries (Dupont, 1988) clearly put to an end speculation about his mental deterioration and provided the most profoundly insightful observations, to date, on the psychological adaptation and resultant psychopathology of childhood sexual traumata. In treatment observations on four different patients, Ferenczi touched upon the major theoretical and technical issues facing those analysts working with this population. Of course, dissociation and ego splitting assume a position of some primacy, but also included in the diaries are comments about identification with the aggressor, somatization of early abusive memories, inclinations toward certain countertransferential pitfalls, and some of the masochistic elements inherent in the psychoanalytic situation that exacerbate the resistance of those with a history of abuse.

In a diary entry dated January 12, 1932, Ferenczi revealed his own particular view of the dissociated ego states he observed in his patients. Ferenczi's metaphors were a far cry from the "hysterical," "delirious," "hallucinating" images referred to by Freud and Breuer. To Ferenczi the dissociated state included more than a set of associatively isolated traumatic memories; he described the dissociated state as a whole person, a child, and the delirious quality of that child as the reactivation in the treatment setting of the traumatically overstimulating, abusive situation.

The patient Ferenczi (Dupont, 1988) refers to here had been sadistically abused over a long period of time by several family members. Ferenczi writes:

> A being suffering purely psychically in his unconscious, the actual child, of whom the awakened ego knows absolutely nothing. This fragment is accessible only in deep sleep, or in a deep trance, following extreme exertion or exhaustion, that is, in a neurotic (hysterical) crisis situation. Only with great difficulty and by close observance of specific rules of conduct can the analyst make contact with this part: the pure repressed affect. This part behaves like a child who has fainted, completely unaware of itself, who can perhaps only groan, who must be shaken awake mentally and sometimes also physically. If this is not done with total belief in the reality of the process, the "shaking up" will lack persuasiveness as well as effectiveness. But if the analyst does have that conviction, and the related sympathy for the suffering being, he may by judicious questioning (which compels the sufferer to think) succeed in directing this being's reflective powers and orientation to the point where it can say and remember something about the circumstances of the shock [p. 9].

So complete and ill-spirited was Ferenczi's ostracism from his dearest friends and oldest colleagues, that it would be many years before any other analyst would again raise the specter of real trauma and sexual abuse, and then only in ways that revealed obvious conciliatory overtures toward the classical psychoanalytic theory.

Contemporary Psychoanalytic Literature

This injunction against serious consideration of childhood sexual abuse was powerfully effective within the psychoanalytic community for many years. Written discussions of this very important clinical phenomenon are dramatically sparse in the subsequent psychoanalytic literature, and papers pertaining to the long-term sequelae of such abuse are even more unusual. Those articles that do exist, for the most part, follow a traditional psychoanalytic line, one that downplays the effects of actual trauma and stresses, instead, regression to more dangerously primitive fantasies and to earlier forms of psychosexual excitation and discharge (Greenacre, 1950, 1967; Shengold, 1967, 1989; Dewald, 1989). In the clinical work with adult survivors of abuse, specific discussion of dissociation can be found in the literature, but here again the concept is

embedded in a drive theory model of psychopathology, and its interrelationship to early childhood trauma, though mentioned, is oddly understated.

Fliess (1953) was the first writer to call attention to what he regarded as the intrinsically hypnotic factors within the analytic situation. He attempted to demonstrate how certain patients could exploit these factors and, in so doing, bring about what he termed "the hypnotic evasion." This term referred to a self-induced alteration in consciousness, marked by a mild sleepiness or emotional withdrawal, which could be used as a defense against unacceptable transference fantasies, usually of a sexual nature. To Fliess, the alteration in consciousness was a resistance, employed to defend against unacceptable impulses. Clearly, the analyst's task was to interpret the defensive use of this hypnotic evasion and, in so doing, render the unconscious fantasy accessible to interpretation.

In a series of moving clinical vignettes, Dickes (1965) attempts to communicate the pervasiveness of this type of alteration in consciousness as seen in clinical practice. For the first time, he ties this type of defense directly to childhood experiences of sexual or physical abuse. Dickes says: "Childhood events as described in my patients offer some clues to the development of a pathological hypnoid state in the adult. This adult state is often a repetition of a childhood hypnoid state which occurred as a means of warding off intolerable feelings due to overstimulation and abuse" (p. 397). Dickes, however, maintains the classical position that hypnotic evasion is a resistance to treatment and a defense against unconscious aggressive and libidinal fantasy. He, too, stresses the primacy of interpretation of unconscious drive derivatives as the single most important factor in the treatment.

Of all contemporary psychoanalytic writers, no one has studied the effects of early childhood abuse as thoroughly as Shengold (1963, 1967, 1971, 1975, 1979, 1989). Proceeding from the work of Fliess and Dickes, Shengold stresses the centrality of what he calls "autohypnotic states" in the mental lives of adult survivors. He believes that the autohypnotic state essentially relieves the patient from the burden of being responsible for what is said and felt during the analytic hour. Though he also maintains a classical drive model and views autohypnosis as "the ego's need to defend against drive tensions" (1989, p. 141), Shengold adds two very significant perspectives to what has heretofore been described. He stresses the possibility that autohypnosis can also be used to facilitate

drive discharge, a phenomenon that transcends the defensive functions described above. Here the alteration in consciousness is used to facilitate a traumatic reenactment, either within or outside of the transference, and to deny the experience of significant gratification of libidinal and aggressive impulses. In addition, Shengold describes how the hypnotic state can bring about a "concentrated hypercathexis of perceptory signals" that enhances one's awareness of peripheral stimuli and evokes a state of what he terms "hypnotic vigilance" (p. 143). Though it stems from the simultaneous need to defend against the derivatives of instinctual drive or their discharge, the process, as described in clinical vignettes, appears inadvertently to heighten the patient's sensitivity to a range of other experiences within the therapeutic relationship.

In moving from a position that regards autohypnosis as merely an ego defense against instinctual impulses to one that recognizes that the dissociative state involves the possibility of an expansion of awareness, Shengold moves somewhat closer to our own position, though by no means close enough. Our belief is that the expansion of awareness goes far deeper than Shengold describes. Rather than viewing the dissociative experience as a resistance to the analytic work, we view it much as Freud viewed the dreams of his early analytic patients—as "the royal road" to otherwise unavailable, split-off experience and memory. We believe that only within the dissociative state can the analyst come to understand the internal object world of the abused child and that only within this state can the split-off self and object representations play themselves out in the transference-countertransference configurations. Contrary to Shengold's position that the analyst must be hypervigilant himself to such instances of autohypnosis because they represent the patient's evasion of responsibility for what is thought, felt, and said in the analytic space, we believe such a traditional "resistance interpretation" to be counterproductive.

Our hope in this paper is to show that only by allowing ourselves to enter, rather than interpret, the dissociative experience; to encourage temporarily the evasion of responsibility; and to expect that unwitting reenactiments, gratifications, and frustrations will be the hallmark, and not the downfall, of the analytic work will the patient and therapist come to occupy the same relational matrix. By our clinical description we hope to demonstrate that only from within this shared field can the analyst hope to experience, contain, comprehend, and ultimately interpret the

fragmented, ever-shifting projective, introjective, counterprojective processes that come, ultimately, to define our most profound levels of participation in the analytic endeavor.

We turn now to a clinical description of this phenomenon and to an analysis of the transference-countertransference paradigms that emerge in a system where dissociative mechanisms play such a central role.

The Child Imago and Dissociative Processes

Most survivors of childhood abuse are faced with the dilemma of having to negotiate the external, interpersonal worlds of friendship, school, authority, career, and so on, in spite of the fact that, relatively early on, they have been betrayed by a person with whom they share one of the most intimate relationships of their lives. It is remarkable to observe the degree to which most survivors can painstakingly erect the semblance of a functioning, adaptive, interpersonally related self around the screaming core of a wounded and abandoned child. This adult self has a dual function; it allows the individual to move through the world of others with relative success and at the same time protect and preserve the abused child who lives on, searching still for acknowledgment, validation, and compensation. The impact of this essential splitting and dissociation at the core of the personality and its effects on all later personality development form the body of this paper.

In the preceding review of early classical literature, we have attempted to demonstrate a critically important point. The patient who was sexually abused as a child is not an adult patient with particularly vivid memories of painful childhood experiences existing in the context of other, happier, more loving times. We stress here that this child is a fully developed, dissociated, rather primitively organized alternative self. In this regard, we speak concretely, not metaphorically. It is imperative that the therapist who begins working with an adult who has survived significant childhood sexual abuse understand that he or she is, in fact, undertaking the treatment of two people: an adult who struggles to succeed, relate, gain acceptance, and ultimately to forget and a child who, as treatment progresses, strives to remember and to find a voice with which to scream out his or her outrage at the world.

The dissociated child-self has a different ego structure, a more primitive and brittle system of defenses, a fuller and more affect-laden set of memories and has clearly become the repository for the patient's intense, often overwhelming rage, shame, and guilt. We often find the child with a different wardrobe, facial expressions, body postures, voice quality, and set of linguistic expressions. "She" takes on the persona of a timid little girl; "he," of an awkward preadolescent whose emergent sexuality has lagged behind that of his chums.

It should be noted that dissociation exists along a broad continuum, with coexistent, alternative ego states moving in ever-shifting patterns of mutual self-recognition and alienation. It is not uncommon for the child-self to contain several different personas, often with different access to historical information and memory. Common among these personas are the good, perfect child, the naughty, omnipotent child, and, ultimately, the terrified, abused child. Given the frequent coexistence of these alternative states, we do not believe that they represent true multiple personality organizations. In most instances the adult and the child are at least partially aware of each other's existence; it is the child's incestuous secret and overwhelming rage about which the adult is often completely ignorant. We would be remiss, however, in not reporting that although not all adult survivors of childhood sexual abuse show multiple personality structures, the best current estimate is that between 88 and 97% of all multiple personalities have experienced significant sexual abuse, physical abuse, or both in childhood (Putnam, 1989; Ross, 1989).

Although the adult and the child are, in most situations, aware of each other, they are not friends. They have entirely different emotional agendas and live in a constant state of warfare over whose needs will take priority at any given time. Each feels entirely abandoned by the other. The child believes that the adult has "sold out" by progressing with her life as a grown-up. After all, grown-ups are bad and do bad things. To become one of them is the ultimate betrayal. The child takes every opportunity, therefore, to subvert the adult's attempts to separate from her past and her identity as a victim, to become a part of the outside world. She uses the techniques she was taught by her abusive parent (other) to undermine the confidence of her other self: seduction, cajoling, manipulation, and threat of abuse (in this case self-inflicted). As she herself felt invaded, she often invades the unexpecting, conscious sensorium of the adult in inappropriate and disruptive ways, causing

great confusion and disorientation, at times bringing to a halt whatever activity the adult was engaged in at that moment. She stands in relation to her adult-self—a provocateur, with a terrorist's commitment to a program of unrelenting insurgence.

On her end the adult persona "hates" the sadistic and disruptive child with bitter intensity. On the most conscious level, the adult views the child as a demanding, entitled, rebellious, and petulant pain in the neck. If she remembers being sexually abused in childhood, she blames her child-self for the abuse and thereby refortifies her insistence on the child's thorough and complete badness. She was "the seductress," and, as one patient announced with burning rancor in her first session, "She got what she deserved. . . . It was coming to her."

It is almost incomprehensible to us that here the patient is talking about herself, the part of herself that was rather sadistically abused as a child and abused by her own father. We see, though, the effectiveness of the dissociation that spares both the adult persona and the father from the full impact of the child's rage. The hate is turned back upon the child, who has, after all, been well trained in the art of self-victimization.

In situations where the patient has not yet recovered actual memories of childhood sexual abuse, she stands in relation to her demanding and disruptive child-self as a passive and mystified player who gives voice to the child's tantrums, mood swings, and demands without exactly understanding why. "It's as if a voice rises up in me," reported one patient. "I know it's my voice. . . . I recognize the sound of it . . . but it's so odd, I have no idea what the voice is going to say. All I know is that usually it says something to get me into trouble." If the disparity between the intensity of the child's rage and shame and the content of her thoughts becomes severe enough, the patient may experience full dissociative episodes where the child is given full reign to express, remember, and reenact, without any conscious recollection of the experience. As is the case with true multiple personalities, patients, for example, report losing time and suddenly finding themselves in the middle of a situation but not remembering how they got there. One patient would report, with some regularity, sitting down to write business reports only to find that they had already been done and done to perfection! "It's like the shoemaker and the elves," she would say. "I go to sleep and when I wake up, there it is!" This particular patient entered treatment because of persistent problems on her job. Though it was immediately clear that her personal life was also extremely restricted, she kept these issues out of the early phase

of her treatment by insisting that a social life was completely unimportant to her. On her job, the patient was considered a truly brilliant and incisive thinker whose written analyses supported and gave direction to much of her firm's ongoing work. She however, was, completely incapable of presenting her written work either within her office or to clients. She was terrified of being looked at, exposed, and penetrated by the stares of others. A severe inhibition, based in large measure upon dissociated exhibitionistic urges, would give rise to the most paralyzing experiences of humiliation and shame in these situations. The inhibition was so complete that others would often be called upon to present the patient's work to clients. To make matters worse, the patient was considered moody and demanding, with a reputation among colleagues for being "entitled and difficult to get along with."

With no conscious recollection, then, of the ongoing sexual abuse by her father between the ages of 7 and 12, the patient had perfectly re-created the emotional climate of these confusing early years in her present work life. She was gifted, special, and favored in some way that remained quite a mystery to her. Since she had no memory of writing her "brilliant" reports, she could hardly value herself for writing them, as others valued her. Despite her vague sense of specialness, she also felt despised and abused by her colleagues. She felt deserving of this abuse since she agreed that her behavior was often demanding and unpredictable. The patient herself experienced these abrupt mood swings and outbursts of demanding, entitled behavior as ego-alien intrusions, and on occasion when the affect was most intense, she had no recollection of them at all. Without the memories that would spur compassion for this "other self," the patient was filled with fear and self-loathing.

Patient: It's like there's this baby part of me. . . . She's scared and pitiful sometimes, and I hate her for that . . . but then she turns hateful and demanding. . . . She won't be satisfied. . . . I try, but I can't. She wants more and more, but I don't know of what. She won't leave me alone, and she won't grow up. Sometimes I think she takes over completely, and part of me gets scared of what she'll do. I go away, I think. . . . I just can't bear to listen.

Therapist: It seems to me she's likely to stay around until someone hears what she's trying to say.

Patient: The less attention she gets, the better. The only thing I can do is ignore her . . . starve her out . . . otherwise, she'll never leave. If

> I give her nothing at all, maybe she'll go away and leave me alone. [quietly] Maybe she'll die. . . . I really want her to die.

Here again are the hatred and death wish for the child-self, not, this time, the omnipotent seductress who is blamed by the adult for her own abuse, but the raging and entitled child who makes her pain clear but keeps its source a mystery to all, including herself. Not yet on the analytic scene, but struggling to emerge, is the terrified child, living in a dissociated world of perpetual abuse and terrorized not only by the actions of another but by the prospect of speaking her own words and knowing her own mind.

It is almost always the adult-self who presents herself for treatment. Either she is struggling with overt, nightmarish memories of childhood, or, in her amnesia, she is plagued with one or many of a list of vague, debilitating complaints: sexual dysfunction, depression, intense guilt, poor self-esteem, self-destructive impulses, drug and alcohol abuse, and so on (Gelinas, 1983). Only slowly and after much careful testing does the child persona begin to make her presence known. She may step forth boldly and dramatically, as in the development of sudden panic attacks or in the eruption of painful and frightening somatic complaints. The child may also enter quietly, almost imperceptibly. The therapist may first become aware of her presence by an oddly childish mannerism—a way of wiping away tears or twisting a lock of hair. At other times, the child may signal her arrival with a subtle change in vocabulary, grammar, body postures and movements, different styles of clothing, a particular voice or facial expression. Many times the therapist's first awareness of change has to do with a perceived shift in the nature of the transference or in his or her own experience of the countertransference. Regardless, however, of the specific manner of entrance, it is most often the case that the child enters the analytic scene sometime before the recovery or disclosure of specific memories of past abuse begins.

The reasons here are clear. From the child's perspective the analyst is, as yet, an unknown quantity, a stranger. True, she has been listening, but what she has heard has been limited by the nature of the adult-analyst interaction. From the child's point of view, the analyst and the adult interviewed and chose each other. It is they who have evolved a relationship and have begun to define the limits of their trust and to deal with painful and intimate issues. As a dissociated self system with a separate object world and ego structure, the child has been kept very far

away from the analytic field. The child has had little or no impact on the analytic relationship, and this relationship has affected her only insofar as she has perceived enough trust between the analyst and the adult to encourage her participation. To be sure, the emergence of the child in the treatment signifies that the early work has proceeded well and that the heart of the treatment is about to begin.

There are now two different patients on the analytic scene: an adult-self whom the analyst has already begun to know and an elusive child-self who appears and disappears at will; introducing endless confusion into the analytic process. It behooves us to pause here and take a closer look at this child-self system and at the ways in which he or she attempts to engage the analyst in playing out unconscious wishes, dreams, and fears.

Without question, the most singularly important thing to understand about the child is that he or she exists only in the context of a perpetually abusive, internalized object relationship. This aspect of the self and this aspect of the object have been literally ejected from the patient's more integrated personality functioning and allowed to set up an independent existence for the sake of pursuing its separate needs. Let us propose, as others have done (see, for example, Kernberg, 1976; Volkan, 1976; Ogden, 1986), that mature personality organization is an amalgam and integration of a multitude of widely varying self experiences and object experiences, each with its own unique affective-ideational-instinctual charge. This integration leads ideally to internal representations of the self and object that are wide ranging, at times contradictory, but not mutually exclusive. Love and hate coexist, are modulated by each other and give rise to the potential for ambivalence and mourning, as well as intense passion and ambition.

In the patient who has been sexually abused, the child aspect of the self representation, along with that of the abusing other and their complex system of emotional connection and exchange, is cordoned off and isolated from the rest of the personality. It remains virtually frozen in time, the images unmodulated by any others of a different, perhaps gentler nature. These images become the embodiment of the murderous rage and pernicious self-loathing that drive the child in his or her relationships with others. In their intensity they fuel the psychotic-level terrors of annihilation and world destruction that so infuse the patient's internal experience. The child cannot grow. Her anger and self-hatred go untempered, therefore unintegrated. Her world is a world of betrayal,

terror, and continued emotional flooding. Her reality has been penetrated by a hostile, invasive force and her perceptions tragically distorted by her abusive experiences. What is bad she is told is good; what hurts is something she has been told she secretly wants and asks for. Her body aches. Her mind is in a constant state of upheaval and confusion. When, as a child, she turned to those around her for a way out, she was confronted either with threats and further abuse or with neglect and formidable denial. The child is incapable of expecting anything different from the analyst. She experiences herself as terrified, completely alone, and helpless. Only the adult persona can ask for and receive help. The child cannot ask, and it is, indeed, a long while before the analyst's "help" begins to penetrate the formidable dissociative barriers.

The extreme dissociation of the abused child into a separate self and object system is, essentially, an attempt by the patient at damage control. As physicians attempt to isolate and remove a potentially invasive malignancy before it can affect healthy tissue, the adult survivor of childhood sexual abuse attempts to isolate and eject the toxic introject and accompanying self representation before the capacity to trust oneself and others is entirely destroyed. The child-self may be condemned to a world of unrelenting paranoia, but the adult persona, having ejected these toxic experiences, attempts a rudimentary integration where self and object representations coalesce at a higher level of development. Indeed, the adult persona of many of our patients is marked by a rather hypomanic defensive style, where aggression is routinely projected and then denied. The adult in these instances takes on an air of uncanny innocence. He or she is often eager, if not compulsively driven, to help others. The consummate self-denier, the patient is unaware of the ways in which others take advantage of her well-intentioned need to help and equally unaware of her own resentment at often being taken advantage of. She struggles but fails to make sense of her complete inability to say no. Others seem to be capable of possessing her completely.

Clearly, the balance attained here between adult and child is tenuous at its best, with a codetermined impairment of ego functioning that makes successful adaptation virtually impossible. Secondary process thinking is subject to the constant intrusion of more primitive ideational strains. Reality testing is impaired by the pathological defensive patterns and the dissociative trends that give rise to a confusing duality in functioning. Somatic complaints are rampant, and the struggle against self-abusive urges is constant and unrelenting. Unlike diseased tissue that

can be rendered harmless, once removed, the child-self is fully aware of her extradition and can wage an insidious campaign against the adult and thus make any successful adaptation even more unlikely.

Often at this precise moment of crisis, as adult and child are beginning to come together and memory of childhood abuse threatens to emerge and overwhelm the adult sensorium, a third persona can appear. This is an adolescent protector-self aspect of the personality who conveys a tough, streetwise, intensely cynical view of the world. She comes equipped with a truly dazzling array of impulsive, acting-out, self-abusive symptomatology designed to preoccupy the adult, befuddle and distract the therapist, and, above and beyond all else, obfuscate the threatening emergence of the child-self and her traumatogenic memories. The compendium of delinquent and self-abusive behavior includes stealing, truancy, pathological lying, burning, cutting, and the entire spectrum of anorexic-bulimic symptomatology.

The adolescent persona has no memories of specific childhood abuse and, rather than understanding her delinquent, self-abusive behavior as symptomatic of an earlier trauma, she often uses her own abusiveness to excuse a general attitude of parental neglect, indifference, or hurtfulness. The adolescent must at all cost contain the child, but the only methods of containment and control available to her are the cruel and sadistic methods she experienced as a child. The adolescent persona is, in essence, the clinical manifestation of the sadistic introject in its dissociated adult form. Certainly this extreme resolution cannot work indefinitely, and the adult, at great unconscious risk, enters psychoanalytic treatment.

Once the participation of all the psychic players has been assured, the goal and direction of the analytic treatment are relatively straightforward. Of tantamount importance is the integration of the adult and child personas' experiences. This involves, above all else, the recovery and disclosure of as many memories of early sexual abuse as possible, including, of course, the actual memories as they emerge for the patient; the fantasies and secondary elaborations that arise in the patient's associations, dreams, or memories; and a full, affectively integrated reliving and working through of the traumatic overstimulation, terror, and dissociation. Only when the patient witnesses the dissociation during the course of treatment does she become truly convinced of its existence. Only then can she begin to anticipate and circumvent the experience and thus obviate it at times of heightened emotionality and excitement. As the

adult listens to the child's words and slowly begins to understand their significance, new meaning is given to previously inexplicable symptoms. The acceptance and integration proceed slowly, but ideally the interpenetration of these two personas provides each with some compensation for this intensely painful process.

The adult, no longer terrified of the child's experiences, comes to appreciate the reasons for her rage and to acknowledge its justification. There is a new compassion for this former enemy and a wish to heal her wounds. Because the adult slowly comes to allow the child back into a shared consciousness, she can also provide the child with some sorely needed parenting. In providing understanding and acceptance for her child-self, the adult can go a long way toward gratifying a painfully frustrated developmental need. The child, on the other hand, is no longer driven to undermine the adult's successes. Her program of insurgence can, at last, come to an end. The adult's thought processes are no longer subject to constant invasion and disruption. In addition, the adult is revivified by once again integrating the child into her inner world. 'In excising the dangerous child persona, many other important childlike capacities have been lost to her. The child, now freed from her painful and all-consuming burden, is released to discover, perhaps for the first time, these other capacities and to bring them back to the adult, who also experiences them anew. Vitality and the shameless passion known only to children can reinfuse the adult's interpersonal world. Play and fantasy, for so long dangerous, regressive forces, will enrich her internal life and breathe creativity into her practical, survival-oriented mind. Ambition, always too close to aggression and exhibitionism, either dissociated or inappropriately acted out, can assume a more readily modulated position and spur the adult to a greater enjoyment of her successes. One patient, for example, presented her dysphoric, anhedonic, rigid adult-self for treatment. Some time later, when she had made considerable progress in integrating the dissociated child-self, she reported to her analyst a day spent at an amusement park. She had ridden the fastest rides, eaten cotton candy, flown a balloon, and reveled with delight in all these pleasures. In her next session she began to muse about returning to school for a master's degree in her field.

This is the force and these are the consequences of integration. But during this intensely painful phase of treatment, the forces of integration exist in a constant battle with the ever-ready tendencies toward dissociation and disorganization. For during this phase adult and child together

must come to terms with the two most deadening realities: the first, the realities of the abuse that occurred and the second and perhaps more difficult fact, a childhood that was destroyed and will never be reclaimed.

It would appear, in this regard, to be a universal fantasy among all adult survivors of childhood sexual abuse that once the horrible facts of the abuse become known, the world will be moved to provide a new and idealized, compensatory childhood. This fantasy had always been the antidote, the daily painkilling drug that became an addiction for the tortured child. She fed herself, in one patient's words, "daily doses, prn for pain," in order to go on living. Often the renunciation of this wish proves to be even more unimaginable for the child than accepting the realities of her abuse. Acknowledging the impossibility of bringing this fantasy to realization represents a betrayal of her most sacred inner self. Often this issue gives rise to the most serious suicidal ideation, a threat that must, particularly in this context, be taken seriously. Even when suicide is not an issue, however, renunciation of this idealized, compensatory childhood almost always results in a refortification of dissociative defenses and hatred for the child-self. Through a purely childlike piece of logic, the dissociated self believes some form of these words uttered by one patient:

> If what happened to me was unfair . . . if I did not deserve it, then I would get what I did deserve . . . what all the other children had. If people only knew, they would make sure that I got it. If I am not going to get it, even now when they know the truth . . . then I must have deserved what happened to me after all. I must be bad.

Another patient:

> This is too much. I can deal with the abuse . . . I think . . . maybe I can. But the idea that this is all there will ever be, that when I think of being little, all I will feel is pain and terror . . . that's too much. . . . I can't live with that. I want to feel what I see in the eyes of little children. You [therapist] say I deserve this . . . so why can't I? The sense of safety, I want a place that's safe. I want to get into trouble and be mischievous . . . safe trouble . . . usual trouble. I want someone else to do the worrying and the punishing. I'm tired. You say I can feel some of these things as a grown-up. . . . You tell me about them. But how can I feel

them when I'm not sure what they are . . . words. It's like trying to describe a color to someone who was born blind.

This underlying theme, which runs throughout the treatment, does call forth periods of the most profound and intractable mourning. It tests a patient's determination to survive the threat of overwhelming disorganization, and it challenges the analyst's capacities to withstand his patient's despair and the limitations of his own abilities to alleviate suffering. Above all else, the analyst must allow the patient to experience and express his grief in full measure. This expression must be unencumbered by a need to appear better for the analyst's sake. The patient must recognize and come to terms with the finality and irreversibility of the traumatic loss. This is a long and arduous process of working through intense rage and profound pain. Every resistance possible will be called up by the patient to avoid this mourning process, and the analyst will inevitably be swept up into a maddening conundrum of elusively shifting transference-countertransference enactments. The child will hold on, first, to her denial, then, to her expectation of compensation, with a ferocity that the analyst may not have experienced previously. In addition, the analyst may experience some trepidation about allowing such primitive transference paradigms to play themselves out and about tolerating such extreme regressive disorganization in a previously functional patient. Our contention, however, is that this regressive process is unavoidable and that only by allowing the child-self to emerge, speak, and mourn will the emotional trauma be healed and the structural insufficiencies mended.

In attempting to analyze this kaleidoscopic pattern of rapidly changing transference-countertransference resistances to the mourning process, the therapist must keep in mind what has been learned about the internal object world of the dissociated child-self. Specifically, the internal object world of this child-patient is organized around the representations of only three major players: a victim, an abuser, and an idealized, omnipotent rescuer. Any resistances that emerge during the analytic process will represent some fantasied relationship among these three. Unless all combinations and permutations are reexperienced and worked through in the transference-countertransference analysis, the treatment will not be complete.

Indeed, many attempts at analyzing adult survivors of childhood sexual abuse fail because both the therapist and the patient become

locked into acting out one particular paradigm to the exclusion of, and as a resistance to, any others. The most common deadlock would appear to occur when the therapist assumes the role of omnipotent rescuer and the patient that of the helpless victim. The patient fails to experience her own potential for growth and change and instead credits the analyst with supreme power over her. In many ways this occurrence is a natural, perhaps a necessary precursor to analyzing more complex object relationships, and it can inadvertently contribute to the establishment of a powerful working alliance. The therapist, quietly listening to the patient's memories of overwhelming childhood terror and helplessness, is deeply moved. He relates to his own experiences of terror and helplessness; he perhaps places his own children or fantasied children in such a hideous predicament. Empathic concern for the abused, helpless child is surely the countertransference response most readily and nonconflictually available to the analyst. His grandiose fantasies of rescuing a frightened child represent perhaps the best part of himself or herself. The child, for her part, has found an ally at long last, someone who will listen, care, and respect her particular needs for support, while she recovers and works through memories of her abuse. The analyst will tolerate the patient's regression during this time and provide the necessary ego support to make the working through, mourning process possible. Indeed, some therapeutic modifications may become necessary, for example, double sessions, additional sessions, phone contact between sessions. A safe holding environment must be created to contain the intense affective discharge and ego disorganization that will accompany the traumatic levels of stress reawakened during periods of the treatment.

The therapist's very willingness to accede to the patient's often necessary demands for extra-analytic contacts, however, gives rise to a major therapeutic dilemma. As the analyst struggles to rescue the tortured child from her endless nightmare, he or she may inadvertently interfere with the mourning process—which must go on—by refortifying the child's expectation that complete compensation will be made to her. It is eventually from the analyst, who seems so eager to help, that this compensation will come to be expected. The child, who at first needs certain modifications in analytic technique to begin the recovery and mourning process and to tolerate the regressive disorganization that ensues, eventually comes to expect and demand these interventions as evidence of the analyst's real concern for her and devotion to her. The treatment parameters thus lose their original ego-supportive function

and become symbolic expressions of the analyst's love. They become "the stuff that compensation is made of." An entirely different transference paradigm now exists. The demands that were at first reasonable and uttered with quiet urgency become more strident and entitled. They slowly call for greater sacrifices on the part of the analyst and become increasingly difficult to keep up with. The relationship has, in essence, become an addiction for the patient, who must receive larger and larger infusions of compensation to be satisfied. As with any addiction, each dose stimulates an inevitable demand for more, and ultimately the demands can simply not be met. One must remember that though the child demands ever-increasing expressions of love as compensation, she has in her dissociated state never experienced anything but abuse, neglect, and betrayal. The analyst must, therefore, fail her. This experience is all she has known.

What has happened? It appears that in attempting to prove himself trustworthy to his ever-doubting patient, by acceding to necessary and sometimes unnecessary demands, the analyst has acted out a masochistic surrender and in so doing has reawakened and called forth the sadistic introject within the patient, that is, that part of the patient who is closely identified with her own abuser. This sadomasochistic reenactment is even further intensified by the fact that in presenting himself as an omnipotent rescuer, the therapist becomes, in Fairbairn's (1944) terms, an "exciting bad object," one who stimulates and awakens deep-seated desires that cannot at the same time be gratified.

The patient who was sexually abused as a child is vigilantly defended against those who make promises and attempt to resuscitate hope. Promises are broken, and hope leads inevitably to disappointment. Only self-sufficiency and a renunciation of all dependency needs create a margin of safety. To refortify her counterdependent defenses against the "exciting" analyst, the patient calls upon the sadistic introject to launch a full-scale attack upon the therapist's integrity and competence. It becomes the mission of the abuser, within the abused-child persona, to trap the therapist into revealing the emptiness of his promises, thereby rescuing the frightened child from giving hope, in the form of a trusting relationship to the analyst, another chance. Paradoxically, the mechanism of failure begins with the analyst's most ardent wish to help and rescue. It is by dint of his need to be seen as the good and nurturing rescuer, that the analyst assures his position as the exciting, therefore

dangerous deceiver who must be destroyed. Hear the desperation in one patient's protest, occurring at a moment when the analyst had done something that truly moved her:

> Oh, no, you don't, get away from me. . . . Please . . . don't you understand? I hate you! I must hate you. You're too dangerous. You're the biggest threat of all. It would kill me to have it happen again . . . to be deceived. There isn't any hope left . . . none. . . . Well, maybe some. But I'm begging you, please . . . there's very little. If you're not sure . . . if you can't go all the way, then please go away and leave me alone.

On one level we hear the cries of the terrified, abused child recoiling from the presence of her seducer. They are in the latent meaning, of the language and not the manifest content, of the passage "Please, I beg you, please don't; go away, don't touch me again, or I will die." Here the patient clearly perceives the analyst, who has dared come too close, as a dangerous seducer.

The analyst, however, is at a most delicate choice point. To the extent that he backs off, he re-creates the neglect and denial of all the adults who originally failed to rescue the abused child. To the extent that he reassures the patient of his ability to "go all the way," he sets in motion the sadistic introject who will set about the task of proving that the analyst just does not have what it takes and that he in no way means what he says. The analyst's best intentions, experienced as dangerously seductive, must be spoiled. Whether by dint of ineptitude or deceit, the patient views the analyst as unhelpful.

The patient, on the other hand, has gone from the role of helpless victim to that of a demanding, insatiable, and constantly critical abuser. She seduces the analyst into rescue attempts, doomed to fail. The analyst has moved from his cherished role as savior to the increasingly masochistic role of victim who will do, say, give anything to appease the encroaching other. Via projective identification and counteridentification, the patient experiences herself as a victim but is experienced by the analyst as a seductive abuser; the therapist experiences himself as concerned and available, determined to rescue, while to the patient he is cruelly withholding or dangerously seductive.

Our contention is that all of these paradigms will be played out in the

transference-countertransference; that they are intrinsic to the work with adult survivors of childhood sexual abuse. The patient must experience herself as all: victim, abuser, and savior; and the analyst must do the same. Therapist will seduce patient, and patient will seduce therapist as a part of the natural process of intimate bonding. Both will think long and hard, during the course of this work together, about the nature of abuse and the differences between benign and malignant seduction.

Here we take strong exception to the classical psychoanalytic position of the analyst as dispassionate commentator on the vicissitudes of the patient's instinctual life. Even when this position is expanded to include issues of ego, defense, and adaptation, our belief is that an approach based exclusively on verbal interpretation of impulse, prohibition, and gratification will inhibit the emergence of dissociated states and, with them, the recovery and disclosure of specific traumatogenic memories. We contend that adherence to such standard analytic fare fosters compliance by the adult persona and, inadvertently, collusion with the essential pathological duality at issue. Only by entering, rather than interpreting, the dissociated world of the abused child, can the analyst "know," through his own countertransferences, the overwhelming episodes of betrayal and distortion that first led to the fragmentation of experience.

As with all analytic work, it is ultimately the analyst's ability to both participate in and interpret the unfolding historical drama and to relate this history to current interpersonal difficulties, that encourages the progression of insight, integration, and change. Parts assigned in the dramatic productions of patients for whom powerful dissociative trends predominate, are, however, fluid and ever-changing. They are assigned, reassigned, and assigned again. Both therapist and patient must be willing to read all parts and reinterpret the action from each different perspective. Only in this way can the full range of interpersonal possibilities, as motivated by dissociated matrices of internalized self and object relationships, become realizable.

Our belief is that the interpretive process within the analytic experience is the only way to end the constant cycle of dissociation, projection, projective identification, and reintrojection that makes the history of abuse not only a painful memory, but an ongoing reality. We stress, here, the word "process." Included in our conceptualization of the transformational aspects of the treatment are the patient's experience of the analyst's availability and constancy, the analyst's willingness to participate in the shifting transference-countertransference reenactments, and, finally, his

or her capacity to maintain appropriate boundaries and set necessary limits. Though verbal interpretation provides the patient with a highly significant, cognitive conceptualization of the analytic experience, we believe the experience itself to be equally mutative.

It is particularly the analyst's ability to work within the transference to familiarize the patient with the sadistic introject that will lead to the greatest analytic change. The analyst's true talent will be tested in trying to accomplish this work without making the patient enormously guilty or refueling the cycle of child-hate for another go-around. The abuser within the child persona is, after all, the part of the patient who was determined to survive and who borrowed from her abusive parent ways of protecting the more vulnerable parts of herself. She turned a passive trauma into an active one, gave the world good reason to be angry with her, and thus reconfirmed with her current interpersonal problems the belief that she must always have been hateful and therefore responsible for her own abuse.

Though we believe that this interpretive analytic work with adult survivors of childhood sexual abuse must occur within a safe and relatively nurturing environment where the therapeutic alliance is strong enough to survive the relentless battering of projective mechanisms we have described, we wish to stress in the most unequivocal terms our belief that it is ultimately the interpretation of primitive pathological structures, in the context of this nurturing containment, that makes reintegration, growth, and healing possible. The positive working alliance between analyst and patient is necessary but not sufficient to accomplish such profound change. The notion that treatment is curative because it provides the patient with the attention and devotion that were missing originally is, to our way of thinking, a significant failure in empathy, for it fails to take into account the patient's lifelong struggle with the sadistic forces, now internalized and self-abusive, that so pervaded her early years. It also sets in motion the process described above whereby the analyst becomes the target of constant assault and can find himself in a position of masochistic surrender vis-à-vis the patient.

Certainly, the patient needs to know that the analyst cares and is moved by her difficult struggle. She needs to feel the analyst's presence and support as terrifying memories flood her consciousness. She needs to know that the analyst is flexible enough to make certain therapeutic modifications and accommodations when regression and disorganization

threaten to become too overwhelming. But in doing battle with sadistic forces, in working through experiences of murderous rage and dreams of retaliation, and in contending with the deadening hopelessness and fear of attachment, the patient, in addition to all else, needs to sense the analyst's strength. The patient needs to know that the analyst can protect herself at the same time that she cares for others and that she can say no to unreasonable demands and set appropriate boundaries. At the height of the most intense struggles to control and dominate the therapist and extract additional concessions as proof of concern, the patient is often, in disguised form, testing the therapist's capacity to set limits and establish boundaries. Only in this way, by sensing that the analytic structure is sound, can the patient give way to the most intense inner struggles. The patient can rest assured that the analyst will be neither gobbled up by insatiable demands nor moved to a form of retaliation against the patient that could destroy the treatment entirely.

Finally, a word about the tendency toward dissociation in adult survivors of childhood sexual abuse and classical psychoanalytic conceptualizations. Unfortunately, it is not difficult to see how early psychoanalysts became convinced of the accuracy of Freud's rejection of the seduction theory and why so many patients were for so long willing to be convinced of an interpretation that so defied their most terrifying experience. Surely, the classical theory, which regarded sexual abuse memories as fantasized oedipal victories, a theory in which the child was the perpetrator and not the victim of abuse, served only to revivify the patient's pathological, defensive splitting and dissociation, rather than helping to mend the internal breach. Both patient and therapist colluded in accepting a system of beliefs that set back the recovery and disclosure of memories by denying their reality and labeling them oedipal fantasies, wish-fulfillment fantasies of the child's own creation.

Adults who have been sexually abused as children are only too willing to believe that the nightmarish memories that begin to flood their waking thoughts are not real. It is a most heartfelt wish to be convinced that what they begin to perceive as a traumatically overwhelming past is merely a fantasy of their own creation. Certainly, when the dissociative and projective tendencies described above engender such intense hatred for the child-self and when the fantasies are viewed as the child's creation, the patient is relieved to turn the entire issue around and make, first, the fantasies and then, ultimately, the abuse itself the child's own fault. These haunting, as yet dimly illuminated perceptions, which cause

such panic and terror for the patient during recovery and disclosure, can once again be denied. They are bad thoughts, belonging to an evil child-self, and as such are intellectualized, discredited, and dismissed via classical interpretation.

The clinical danger of such an approach is twofold. Certainly, it represents a secondary betrayal of the child whose original abuse was ignored, denied, and unattended to by the significant adults in his life. In addition, the therapist's denial of facts that are struggling so mightily to emerge deals a serious blow to a system of reality testing already damaged by an intricately interwoven set of pathological defenses needed to keep the truth from awareness.

The analyst, too, must initially favor a system of interpretation that allows him to avoid confronting the reality of widespread sexual abuse among children. In particular, there is a need to deny the traumatic childhood terror of patients with whom the analyst has developed a close and intimate bond.

For all of these reasons it is easy for the adult and analyst to agree on a theory that appears to silence the child and at the same time make sense out of her nightmares. This approach has the added advantage of not causing regressive ego disorganization, but rather, of strengthening preexisting defenses and allowing the adult to resume control of her life. As long as the patient remains in treatment, the child knows she will be safe. She may choose not to speak directly in this treatment, for fear that her words will be ignored or misunderstood; however, she does experience a holding effect wherein she knows she is safe, both from the dangers outside and from the sadistic introjects within.

In the most traditional sense we have here a transference cure, whose limited effectiveness does not become clear until after the treatment has been terminated. Every analyst who works with adult survivors of sexual abuse is confronted regularly with patients who have "completed" other treatments but have yet to open up for analytic scrutiny the raw, primitive, internal world of the abused child-self.

Vastly different is the treatment that ensues when the analyst accepts the reality of early childhood sexual abuse, when he is familiar with current research and understands how to distinguish such a reality from wishful oedipal fantasy. We, by no means, wish to imply here that the latter does not exist as an important clinical entity, accounting for a wide-ranging spectrum of neurotic symptomatology, but the presentation of these two clinical phenomena is so vastly different that they can

be recognized as such and treated each in the appropriate way. Here we will touch upon just a few of the key distinctions.

The most telling distinction is that the patient struggling with problems related to unresolved oedipal conflict is unlikely to present with the severe symptomatology and ego fragmentation described earlier. The phenomenological presentation of oedipal material is also markedly different from that of sex abuse memories. Oedipal fantasies, while frequently disturbing to the patient, do not carry the imagistic or affective intensity of sexual trauma memories. Further, the anxiety surrounding oedipal material is usually a response to the murderous rage felt toward the same-sex parent. It does not evoke the explicitly and precociously sexual material graphically reported by sex abuse survivors. Oedipally derived anxiety, in fact, is usually warded off from direct subjective experience. It is, instead, manifested in classical, neurotic, compromise formations. When the patient discusses her oedipal conflict in treatment, her ego functioning will most often remain intact.

Anxiety connected to sex abuse memories, on the other hand, is linked directly to the sexual aspects of the survivor's relationship with the perpetrator. Most often this anxiety is not successfully warded off through symptom formation but, rather, is subjectively experienced by the patient, who frequently feels flooded by the memories and their associated affects. Severe impairment of ego functioning, flashbacks, and intrusive thoughts about the abuse often result. Finally, oedipal fantasies are most likely to be reported in symbolic form; the analyst hears derivatives of the conflict rather than fully formed memories. In contrast, the sex abuse survivor quite often relates vivid, highly affectively charged, direct memories of her abuse. Even the survivor who remains amnesic about her abuse will proffer derivatives that are more violent, less romantic, and more threatening to ego functioning than will the oedipal patient.

If, with all this in mind, the analyst communicates to her patient that she accepts the reality of childhood sexual abuse, and that she is willing, with her patient, to think and speak the forbidden, the child, who has never spoken, will listen. She hears the possibilities, and though it may be some time before she makes her appearance, the construction of the groundwork necessary for such an emergence has begun. The analyst has earned the child's attention. Now she must remember that though she addresses the adult patient some of the time, the listening child, with her

very separate agenda, takes in every word and filters it through the matrix of her own internal system of object-related needs, wishes, and fears.

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