

The Psychoanalysis Of Dissociative States, The Sense Of Safety And Self Blame In Victims Of Childhood Sexual Abuse*

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The integration of dissociated states, the lack of a sense of safety and the tendency of the victim to blame herself are three issues frequently met with in the analysis of people suffering from childhood sexual abuse. I use her throughout this paper only because many of the victims are women. The paper addresses these three fundamental issues.

Integration of Dissociated States

The first issue I want to address is the integration of dissociated states. DSM III-R (APA, 1987) defines dissociation as a disturbance in the normally integrative functions of identity, memory, or consciousness. If this occurs primarily in identity, the person's customary identity is forgotten and a new identity may be assumed or imposed. Dissociation augments repression and splitting (Brenner, 1994) . It is an elaboration of splitting leading to the constellation of ego alien ego states. It develops as a primitive, adaptive response of the ego to the overstimulation and pain of external trauma and may result in disturbances in awareness, memory and identity. This defense results in a vertical split stimulating corresponding ego states alternately enacted but not integrated (Shengold, 1989) . Dissociation exists on a continuum with multiple personality disorders representing the most extreme form of this kind of process (Brenner, 1994; Burland & Raskin, 1990; Davies & Frawley, 1994) .

Many victims of sexual molestation have suffered a trauma of monumental proportions in terms of the effect it has on later personality development (Bernstein, 1990; Margolis, 1991; Steele, 1990) . The molestation's causal relationship to many of the person's later difficulties qualifies it as a traumatic neurosis for some people. It also qualifies as a traumatic neurosis in that like other traumas sufficient experience of the event failed to occur to allow symbolization and then forgetting and repression in childhood (Huizenga, 1990; Levine, 1990) .

Forgotten experience is generally relegated to the preconscious where retrieval can occur by introspection, or to the unconscious where retrieval requires the analysis of defense. There is a horizontal split in the ego. In both cases, full articulation of the events in consciousness occurs before forgetting takes place (Freud, 1933) . The situation is different with trauma. Traumatic events present the ego with too many stimuli to experience and think about. The ego splits off or dissociates unsymbolized experience to avoid ego dissolution before it has been able to symbolize it (Bernstein, 1990; Burland & Raskin, 1990; Davies & Frawley, 1994) .

For example, when Father yells at Baby, Baby initially experiences her body being assaulted. An image of Father develops, if the yelling is not traumatic. This image can then evolve into a thought of Father yelling and Baby can compare that thought with other more benign images of Father. She can thus soothe herself. Adequately symbolized experience relegates Father's yelling to the preconscious and forgetfulness or to the unconscious and repression. However, traumatic yelling confronts the ego with too much stimulation, foreclosing experience and articulation. This results in a splitting off a dissociated ego state as a somatic memory; a sensory experience devoid of images or words. This forms the basis of a dissociated state. Representational functioning fails in trauma.

The dissociated state returns with particular force when it is first recovered. Some

accidental occurrence will often trigger this recovery. In the case presented below, associations to a dream in the fourth year of her analysis led to recovery of memories of being raped.

Recovery of dissociated states often engenders the experience of flashbacks and somatic memories (Kramer, 1990) where the patient relives the childhood sensory experience. This reliving often has a terrifying reality and past can become confused with present. Lack of prior symbolization has deprived the memories of a structure and context in time. An example of such a state would be extreme pain in the vagina that causes the patient to double up. She relives the experience of being penetrated as a child, but lacks words or images to attach to the experience. The patient needs help in bearing the distress and owning the memory if thought about the experience is to evolve. Bearing the distress facilitates a sensory experience being brought to a level of cognition and formulated thought.

Recovery of the trauma stimulates a pattern of alternating ego states where the person alternately experiences themselves as being molested or unprotected and then denies the events (Diamond, 1994). During states of denial, the person may function quite adequately, albeit without the knowledge of previously conscious ego states. Treatment then becomes a matter of either helping the patient to put words to and make sense of the trauma, or analyzing their resistance to facing the trauma.

Davies and Frawley (1992; 1994) lucidly illustrate the centrality of dissociated experience in the understanding and treatment of victims of childhood sexual abuse. However, they think of dissociated states as almost akin to separate personalities that have an independent existence within the patient. They advocate "Speaking directly to the child persona in the adult survivor as the most effective way of recovering all traumatic memories." Furthermore, they maintain that, "The establishment of an alliance between the child persona and the analyst has the effect of symbolically changing the original traumatic experience of isolation and despair by bringing about the internalization of a new therapeutic object relationship that produces permanent internal change."

Shengold (1991) takes issue with this and asserts that Davies and Frawley "don't appreciate that the dissociated state is a product of resistance." Grotstein (1979) observes that some people who have particular difficulty integrating the trauma will experience the return of the dissociated state as an alien force akin to the experience of demonic possession. Schwartz (1994) asserts the importance of treating the whole person when dealing with dissociated states rather than looking at the personality as composed of separate parts.

My thesis is that integrating the dissociated state requires addressing the motive for resistance. The patient often wants to defensively reify the existence of a separate personality because they are too ashamed or guilty to own the ego state as part of themselves. Analysts supporting this tendency risk fostering further fragmentation and regression.

It is also useful when working with people who have regressed to primitive mental states to frame their difficulties in terms of the transference. Genetic interpretations and reconstruction's are reserved for later in treatment (Kernberg, 1975). The following material illustrates this technical approach.

Case of Mary

Studying cases at the severe end of the diagnostic spectrum of psychopathology provide information on patients less damaged but who demonstrate similar patterns in more

truncated forms. Mary's premorbid personality structure made her particularly vulnerable to trauma. However, she was also severely damaged by being raped at age 7 and molested at age 8. The effect of the trauma is detailed in this presentation, although other aspects of her personality were dealt with in her analysis. A man picked Mary up on the way home from school when she was 7 and offered her a ride home in his car. He took her to a remote area, forced her to have intercourse with him and then to orally copulate him. A lifeguard at a local pool digitally penetrated her when she was 8. She resorted to desperate and extreme defenses to protect herself from the impact of the traumas.

The following is a synopsis of Mary's history that emerged over her 10 year analysis. I reported the early stages of this patient's analysis previously (Paul, 1987) . What follows concerns the middle and end stages of her treatment. Mary appeared acutely depressed when I first saw her at 25. The termination of her previous therapy stimulated despair in Mary about the possibilities of her being helped by treatment. Her former therapist, a psychiatric resident, referred Mary to me because of concern about her frequent suicide attempts. The resident also felt that she could not be as available for Mary as she needed her to be.

Mary revealed a chronic picture of social isolation since childhood and a chronic depression that began to result in frequent suicide attempts once she reached adolescence. For the first three years of treatment she was amnesiac to the molestation and the rape. Mary described her mother as remote emotionally. She saw father as a stern disciplinarian who always frightened her. She had 3 older brothers. Her relationships with her brothers formed the basis of her social life. The only exceptions to this were two girlfriends, Helen and Vicki, who lived in the Midwest. She frequently spoke to them on the phone.

Mary gave the appearance of someone very ashamed of herself. She kept her eyes always focused on the ground; she rarely spoke and when she did speak, she spoke in a barely audible whisper. She gave the appearance of a person experiencing shame. She talked about finding her life meaningless; getting little enjoyment from her work as a medical assistant; and of having no friends. She had no interest in developing friends because she did not find human relationships very gratifying. She felt frightened and awkward around people. Her silent stance with her peers resulted in them taunting her since childhood as being stupid or strange. She often voiced the belief that her destiny was to die. Her arm's displayed a lattice work of scars that were a product of years of self mutilation. She would only wear long shirts early in treatment because she was ashamed of her arm's appearance.

Mary suffered from diffuse feelings of dread and pervasive expectations of being attacked and punished. It emerged later in treatment that an omnipresent fear of sexual assault compelled her social isolation. Walking down the street in the presence of strange men frightened her. However, she was afraid of both men and women hurting her. She routinely locked herself in her apartment on Friday afternoons because she experienced diffuse feelings of "nameless dread" (Bion, 1984; Grotstein, 1991) at these times. Later, we determined the rape occurred at this time.

Mary had been a relatively outgoing child who loved nature and athletic activities prior to being raped. After the rape she withdrew. She recalled not saying anything to either parent after the event since the rapist threatened to harm her if she did. She went to sleep and awakened from a dream in which she felt she was dying. She recalled going into the kitchen and crying uncontrollably after the dream and getting little attention from either parent. After this experience, her personality changed and she became house bound, afraid to let her mother out of her sight and pursued a socially isolated,

anhedonic life style.

She was the most frightening patient I have ever treated. Her silent stance and severe depression made me frightened that she would kill herself in the first three years of treatment. She put her fear of death into me so she could experience death as a blissful release.

She was seen 5 times a week for 10 years sitting up. Mary took various anti-psychotic and anti-depressant medication periodically throughout her treatment. For a while she took Mellaril, 30 mg. and Ascendin, 50 mg. daily. Her defect in containing depression, anxiety, and her vulnerability to disorganization of mental functioning made medication necessary. A psychiatrist colleague prescribed the medication.

Integration Of Experience

When I first saw Mary she was struggling to consciously suppress and unconsciously disavow aspects of her personality that upset her to think about. She spoke of her mind becoming progressively empty as she sought to empty it of conflict. She experienced this concretely as losing chunks of her body and would speak of her body as having less and less substance. She also found it increasingly difficult to talk because she felt there was less in her mind to talk about. She reported that her body was becoming progressively transparent. Mary was negatively hallucinating her body.

Mary had the magical belief that she could eliminate unpleasant experience and memory by an act of will. This is, of course, an impossible thing to do and what one suppresses has to return in one form or another. One day a hallucinated "double" appeared that tormented Mary. The "double" would sit on the bookshelf during the session and mock Mary. It would often sneak up behind Mary, when she was at home, and punch or choke her. She was a silent patient and this occurred early in my work with her. She was amnesiac to any sexual abuse at this time. The function of the "double" mystified me. The immediate stress in her life was her disillusionment with her former psychiatrist and she was reluctant to talk about this. Moreover, she maintained that she could not say very much about all this since the "double" had all the thoughts.

This experience had a compelling reality to it. Mary had returned to a state where feelings were demons. This evoked something in me that once believed this long ago. I recall having rescue fantasies at the time and tentatively considered calling in a priest to exorcise this Catholic patient. I was at a loss as to how to reach Mary and I remember recalling a movie in session, "The Three Faces Of Eve," that dealt with the treatment of a multiple personality. Stimulated by the movie, I asked to speak to the double. This was a mistake. The "double" came into Mary's body and informed me that she hated Mary for her cowardice in not facing life, for being frightened by everyone and everything, and for being too "chicken" to talk to me about things that she needed to talk to me about. However, when I asked the "double" to leave at the end of the hour, it refused. It became clear over time that the "double" represented the return of a dissociated, depressed, angry molested child who wanted my help. Now, however, the adult Mary that organized experience and functioned in the world was gone. Her condition worsened. She became increasingly depressed and would stand on the roof of my building, contemplate jumping off and believed that her destiny was to die. I recall during this period being very anxious and preoccupied in the hour preceding her appointment with me. I would frequently glance at the window almost expecting to see Mary fly by. I hospitalized her.

The technical error consisted in not addressing from the beginning the motive for the defense of dissociation. A comment such as "you are ashamed for some reason to own

the thoughts coming into your mind and so you need to disown them," might have been more helpful and averted the fragmentation. This was easier to see in retrospect than at the time, since she was such a silent patient.

The hallucination was a concrete expression of the dissociated "molested child" ego state wanting to have a voice and get help from me. Integration of the experience involved interpreting the motive for the defense. I subsequently interpreted that Mary had to disavow this experience long ago because it was overwhelming for her to deal with and that there was no one there to help her. It was useful to point out that now the memory was returning because a new sense of self needed acceptance. One can state explicitly or leave implicit the fact that now there is someone (the analyst) to help her bear the unbearable. Addressing the motive for dissociation promoted integration enabling Mary's discharge from the hospital in a month.

The return of the "molested child" threatened the "adult Mary." It correctly viewed awareness of this ego state as undermining her ability to function and was ashamed of memories of vulnerability. Mary's personality was at war with itself and each part sought to have control over consciousness. However, it's essential to address the motive for dissociation, which is just one form of externalization. Freud (1933) comments that persecutory experience or paranoid ideas of reference often reflect unbearable feelings of guilt or shame. The person cannot face the intensity of their shame and projects their superego. Integration of this experience requires the person be helped to bear how ashamed they are of being frightened to face life in this case.

It is useful technically to frame this in terms of the transference. One might interpret, "You're ashamed of how afraid you are of life, but you're even more concerned that I will be ashamed of you if you let me know this." Mary could more easily get some distance from the nature and content of her shame, when I located it in me. She could also appreciate a more forgiving alternative to her way of thinking about her experience when articulated in terms of my thoughts about her.

The patient sometimes splits off and projects the "adult ego state" into another part of their personality. Tausk (1919) describes a process whereby the patient externalizes aspects of their personality that are too shameful or too frightened to own and then projectively identifies with the dissociated ego state. The end stage of this is an influencing machine or "double" that persecutes them. Intermediate stages of this process involve unwanted aspects of the personality split off and projected into another part of the person's personality. A variation of this in cases of childhood sexual abuse occurs when the "adult ego state" fears that owning the "molested child ego state" would risk ego dissolution. The patient resists integration. The patient may report an experience of an alien voice that will say that, "It never happened." The voice may also say, "You are bad for needing the therapist." The "adult ego state" employs the defenses of denial and omnipotence and defends against the return of the "molested child ego state" who needs the analyst. Addressing the motive for dissociation of the ego state is important. The "voice" alternately reflects attempts at denial or pathological self sufficiency. It is an attempt to avoid facing the trauma and avoid the analyst who reminds them of it. A useful interpretation might be that they prefer to believe it never happened because it is unbearable to think that such a terrible thing could have happened. Commenting on the patient's reluctance to turn to the analyst to help them bear the unbearable is useful. Supporting the patient's wish to deal with this as a separate personality promotes fragmentation.

Davies and Frawley (1994) speak to the "molested child ego state" and do not report this kind of fragmentation. Perhaps when they address it they do it in such a way as to analyze the motive for resistance or perhaps they have not worked with such regressed

patients. However, Mary functioned on such a concrete level that she was unable to dialogue with the hallucinated "double." She asserted she did not know anything about it and could not say very much about anything because the "double" had all the thoughts. Her concreteness precluded the necessary play space for a dialogue (Giovacchini, 1979) . Merely inquiring into the double's existence produced a fragmentation and undermined the "adult ego state" that organized experience and functioned in the world.

Memory Of The Rape

The return of the memories of the rape was extremely disorganizing. Omnipresent fears of assault coupled with shame over how frightened and defenseless she was came to the fore. The following is typical of the fourth year.

Patient. I feel as if I'm having a nervous breakdown. I was going to call you last night, but I was afraid it was too late and that wouldn't be fair to you. I'm afraid of being a burden. Even now you seem in a bad mood. I don't feel comfortable talking about my agitation.

Someone is going to get me. There are bugs crawling all over me. (She is hallucinating.)

Analyst. You're frightened of something, bugged about something specific. P. I'm frightened by being around people because I'm afraid of being raped and beaten. I'm frightened of walking down the street, especially if I see men. I'm afraid of taking a shower at Cynthia's house; frightened I'll be assaulted in the shower. My boss was talking about female parts the other day and I became very frightened. I'm ashamed of how frightened I am and it's difficult to tell you these things. An. You're ashamed of how frightened you are but you're even more concerned that I will think less of you if you reveal your fear to me.

This intervention and similar ones led to uncovering how much Mary damned herself for being so frightened and not fighting harder during the molestation and rape. She saw her fear as the reason for the rape. She believed that if she had fought harder and not been so frightened the rape might not have happened.

Patients who resort to extensive use of dissociation often make a pseudo adjustment and relate to their environment in an 'as if' way (Deutsch, 1942; Winnicott, 1960a) .

Consequently, they do not feel the locus of control for their lives resides within themselves. The focus of their lives becomes placating or avoiding others because they are not in touch with what they need to please themselves. Dissociating the molested child may result in their body being dissociated as well. The body is the locus for the needy self. Disowning the body, results in disowning affectional, sexual and dependency needs as well. They enact a constricted mental existence primarily. They may feel out of control when they begin to reclaim the trauma, their emotions, and their body. This occurs because they've never articulated emotions sufficiently to themselves so that they could think about them and master the emotions associated with the experience.

Because the emotional self is so foreign to the 'as if' personality, recovery of dissociated emotions is experienced as occurring with a will of it's own: as thoughts without a thinker; as words without a speaker (Bion, 1984) . It is important the analyst recognizes the danger that the person feels themselves to be in at these times and that they need help in regaining control if they are to feel safe. The following session was typical for Mary during the fifth year.

P. I'm tired of this struggle. I don't know if I want to change. I feel I've changed here and didn't choose to change. I just started to talk to you. (i.e., Mary is not in touch with the molested child ego state that wants to talk to me at this moment.) I wrote you about the rape on Friday and then over the weekend I said the very same thing to Cynthia. It just happened. If it happened there it could happen anywhere on the outside. An. You need me to respect your need not to talk, so that you can have control over what you tell me. P. What do I do, parcel out what I tell you? I should just make up my mind whether I want to change or not. An. You're sharing with me how frightening it is to have this need to tell

me things and be afraid of flowing out of yourself. It's hard to imagine that as you put words to your feelings, you'll have increasing control over them. P. I hate this. It was important to recognize the need not to talk (Winnicott, 1963) . Mary was in danger because she was unable to choose to "not think" or "not talk." She couldn't turn her thoughts off or repress them as neurotics can do. The primary anxiety in this session was her fear of being out of control of her thoughts and her behavior. Patients like Mary want an immediate solution that would help them get in control. Unfortunately, this is an impossible wish. However, one can allude to a more long term solution with the promise that words for their emotions will ultimately give them control of their behavior that they long for. Moreover, it is often enough to calm the patient down at times like this, if one recognizes the state of danger that they're in. This locates the danger internally rather than externally and offers hope that it will eventually be under their control.

Some patients experience the need to talk as arising from being in the presence of the analyst, since they dissociate the need to talk to the analyst. Furthermore, they project the needy molested child ego state into the analyst and the patient experiences the analyst as making thoughts happen. They may also deny the dissociated molested child and then the patient may believe that the molestation didn't happen at all and that it was all the analyst's idea.

The Sense Of Safety

The second issue I want to address is the lack of a sense of safety in victims of childhood sexual abuse. A mother who ministers to and contains the infant child's needs imbues her with a feeling of safety. Grotstein calls this a Background Presence Of Primary Identification (1990a; 1990b; 1991) because the mother gratifies not so much a particular need but a more general need for safety. Bion (1962) and Winnicott (1960b) make related contributions. The externally experienced Background Presence provides a feeling of protection. Sufficient connection with her imbues the child with a life long belief in her significance and an illusion of being omnipotently protected. The internally experienced Background Presence contains the child's emotions, transforms them into something manageable and returns an improved product to the child. Adequate containment as an infant imbues her with confidence about coping with her emotions.

Childhood sexual abuse often shatters the sense of safety, flooding her with uncontrollable, unspeakable emotions (Huizenga, 1990; Levine, 1990) . Recovery of the memory of the trauma in treatment revives early experiences of being unprotected. Recovery of the trauma for some patients may also bring with it increased dependence on the analyst. This arises because: 1. The person feels unprotected on the outside as they recall and relive in the transference how unprotected they were by their parents. The patient frequently feels that the molestation happened to begin with because the parent didn't sufficiently protect them or prepare them for the dangers of the world. They also feel unprotected on the inside because they feel unable to repress the memories that come up with increasing force. They feel molested by their feelings and demonstrate a fundamental lack of confidence in their ability to regulate affect. There is a lack of an adequate external and internal Background Presence or object. The patient frequently deals with this lack of safety by clinging to the analyst.

The patient clings to external background object because the internalized representation is insufficient. The patient derives an illusion of safety from the physical proximity of the analyst. The failure to adequately internalize a Background Presence often results in an inability to repress. Such a patient may cling to the analyst because the analyst can provide words for the wordless experience that the patient senses will ultimately help them master the trauma.

The following session illustrates Mary's lack of safety. Mary reports a somatic memory of being skewered in this hour. She concretely experiences somatic memories, such as being skewered, because the experiences were never symbolized. I knew from previous material that skewered referred to a state of extreme fear. The following is representative of a session during the sixth year.

P. My family calls this an addiction. That makes me feel it's wrong to need you so much. I should move out from my mother's house and get away from them. If I did that, I couldn't see you as much because I couldn't afford it. I need you because I don't feel safe to remember memories by myself. Last night the memories were coming up and my brain felt like skewers were going through it. I felt as if I was dying. An. You felt as if you were being transformed by the fear, because you didn't have words to think about it. P. What if I really was never molested and I just attached that fear and distress to this imaginary event and it really belongs elsewhere. An. You are sharing with me that you have not remembered enough to give you a conviction of truth and to be sure that this happened. I attempt to translate this into what the sense memory means to help the patient symbolize the trauma. It is essential to recognize the fear of ego dissolution and loss of the self. It is useful to frame this annihilation anxiety in terms of the transference and relate her panic to her despair that I won't be able to help her to keep a sense of herself in the face of her intense feelings.

It is characteristic of Mary to try to deal with terror by denial. People frequently employ this primitive defense to deal with childhood sexual abuse. Mary was uncertain about what happened to her at this point in the treatment. She often wanted to deny it ever happened. At times, she vacillated between believing that nothing happened to suspecting that her father molested her. It took repeatedly returning to the events for her to get a sense of conviction that it was the son-in-law of the next door neighbor who raped her. It is also helpful if the analyst can point to other memories that confirm her belief that something really did happen. It helped Mary to remind her of the marked drop in her grades during this time and the evidence of tissue damage around her traumatically stretched hips. Framing the dilemma of not knowing the truth of the event because they haven't remembered enough, and maintaining neutrality about the reality of it is advisable. If the analyst takes a position that it happened, he or she risks stimulating the patient's tendency to split and view the analyst as a bad object who manufactured the idea of sexual abuse.

The following session also illustrates the vulnerability of a person in the process of recovering dissociated memories of the trauma. They feel less frightened if the analyst acknowledges their fear. This session occurs in the sixth year.

P. I'm going crazy. I belong in a hospital. I don't know what to do about it. My feelings about you are overwhelming me, I'm overwhelmed by what we talk about, and I'm overwhelmed by all the things in my life. Helen is coming into town and I'm frightened that I'll tell her stuff that I don't want to and that I haven't yet talked to you about. An. You need contact with me to feel protected. I provide you with a skin that keeps in and keeps out what you need to keep out. You don't feel you have enough of me to feel contained and thus you feel vulnerable to everything flowing out of you. P. It might. Helen is my only friend and she has come a long way to talk to me. She has strong opinions. Unlike you, she will ask me questions whether or not I want to talk about things. She had me in tears in 5 minutes the last time. An. Feelings of obligation make you feel that you can't be honest about your feelings of not wanting to talk. You also don't know which feelings you want to keep on a light level and which you want to talk more deeply about. You haven't talked to me enough to be sure what you feel. Consequently you feel too vulnerable to influence. P. I don't want to go.

Withdrawal And Detachment As Methods Of Defense

Failure to adequately address the motive for resistance is a frequent cause for these patients precipitously leaving treatment. It is necessary to go slowly when uncovering the dissociated trauma and take one's cues from the patient in assessing their readiness to go deeper. Adequate analysis of the motives for flight and withdrawal often results in the patient spontaneously returning to recollections of the trauma themselves. Mary would also resort to withdrawal, detachment and flight during periods when she felt terrified. What was essential was to analyze was the motive for resistance at these times rather than address readily available id material and encourage her to talk about the dissociated molested child ego state.

The following illustrates Mary's tendency to detach from herself and from me when I'm not immediately available to her in times of need. She feels if I cared about her, I would be there when she needed me. She sees my failure to do so, as signaling my indifference. This is in the seventh year.

P. I don't know where I am because I retreated from writing this story about being molested and now I feel unreal. An. When you write about being molested memories return and you feel it is happening to you again. Therefore you leave your body and feel unreal. P. Just writing about it was enough to do that. I don't want this to happen. I don't want these memories to come back. I want to forget it. All I ever do is think about it. I want to die. I can't see the point of having to live always having to remember the horrible and shameful thing that happened to me. An. These memories are coming back and wanting to be owned. They want help in being owned and made sense out of so that they could eventually be unremembered. This is difficult to do because you feel so unprotected. P. I get angry at you for implying that you could do anything about this. I'm reliving the most difficult thing in my life, and you're not there! You don't care! If you cared about me, you'd be there for me. You are the only one who understands. I hate how dependent I am on you! I can't see just living to be with you. An. You feel that if I cared about you I'd be there just when you need me and it's hard to imagine that I could send you away with some feeling of regret that I can't be there for you as much as I know you need me to be.

The absence on an internal Background Presence or protective shield results in the person not being able to consciously forget or unconsciously repress memories of the trauma. Omnipresent memories torment them and stimulate nameless dread, terror, chaos and randomness. They feel soiled and degraded and succumb to despair because a different life is unimaginable. They don't appreciate that putting words to what has previously been wordless, dissociated ego states, affects this and facilitates repression. The analyst functioning as a Background Presence and protective shield facilitates this.

The Dilemma Of No Longer Being Numb

Patients often experience themselves as unprotected and in danger as they move toward mastery of the dissociated trauma. They sometimes feel that they have had their defenses taken away by the analyst and given nothing in its place. This contributes to seeing the analyst as a dangerous object. This fear of the analyst and of acknowledging the dissociated state needs interpretation, to mitigate subsequent impulses toward self destructive acting out. This is in the seventh year.

P. I don't want to talk to you because your words make things worse. You don't understand the effect words have on me. I beg you to calm me down and I feel like a burden infringing on your weekend. You never calm me down. That's why I don't want to talk to you. I want to go back to the way I was. At least then I was numb. There weren't these things happening without my consent. An. You try to push things out and to cut off parts of your personality. Yet, what is pushed away inevitably comes back. In your case it came back as a double. P. At least then there was someone to talk to (She is, in part, being sarcastic.) You leave me all alone, stirred up and I can't calm myself down. An. You assume that because this happens in the short run, we won't be able to eventually find

the words for your emotions so that in the long run you are calmed down. P. I hate your long run!

Learning To Forgive Oneself

The third issue I want to address is the analysis of self blame. Victims of childhood sexual abuse often blame themselves for what happened (Bigras, 1990; Katan, 1973; Margolis, 1991; Steele, 1990) . They do not realize that they were trapped, without options and had no choice but to act as they did. This inability to forgive themselves is at the core of their chronic depression, self hatred, low self esteem, rejection of their bodies and penchant for suicide.

Before a person can forgive themselves, it is often first necessary to uncover that they do blame themselves for the event. The self reproach is often unconscious. One may offer a more benign explanation of events only after one uncovers that they do indeed blame themselves.

Small children feel sexual acts primarily as aggressive acts (Katan, 1973) . There is often a lack of a coherent self and a sense that whatever fragments of self do exist, feel degraded, unacceptable and worthless (Bigras, 1990) . There are multiple determinants for the tendency to turn the aggression for the molester onto the self and blame oneself for the event. 1. There is a tendency to identify with the aggressor. 2. They turn aggression on themselves rather than risk threatening a vitally needed relationship. 3. They need to ascribe meaning to a meaningless act of violence.

Why does the child victim come to blame herself for the sexual assault and not rage at the molester? Ferenczi (1933) addresses this question in his article "Confusion of Tongues." He asserts that the child looks to the adult for tenderness and the adult molester looks to the child with passion and/or sadism. This creates confusion in the child that she deals with by splitting her personality. To paraphrase Ferenczi, one would expect the first impulse and the emotions of children after such violence to be that of reaction, hatred, disgust and energetic refusal. 'No, I do not want it. It is much too violent for me. It hurts. Leave me alone!' The child would have reacted like this or something similar if enormous anxiety hadn't paralyzed her. These children feel physically and morally helpless. There isn't sufficient consolidation of their personalities in order to be able to protest, even if only in thought. The overwhelming authority of the adult makes them dumb and can rob them of their senses. "The same anxiety, however, if it reaches a certain maximum, compels them to subordinate themselves like automata to the will of the aggressor, to divine each one of his desires and to gratify these; completely oblivious of themselves, they identify with the aggressor" (Ferenczi, 1933) . Through identification, he disappears as a part of external reality and becomes intra instead of extra psychic. The child succeeds in maintaining the previous situation of tenderness to the molester but hates herself. She now treats herself with the same sadism previously expressed by the molester. When she attacks herself for not having fought harder she is demonstrating a lack of connection with her own helpless rage and is enacting a sadistic attack on herself. They behave as if they are largely id and superego and there is little ego. Modern psychoanalytic work with trauma supports Ferenczi and finds there is "little ego" during traumatic overstimulation (Davies & Frawley, 1994) . Diamond (1994) elaborates on this adaptive response to trauma.

Fairbairn (1943) discusses another potential basis for the self hatred of the victim. The child is dependent on the parent for their survival. Acknowledging disappointment with the parent (or significant caretaker) who is also a molester would threaten the child with the loss of a vitally needed relationship.

Grotstein (1990a; 1990b; 1991) asserts that random, meaningless violence is unbearable. It is essential to find meaning in experience to avoid the experience of chaos and terror. Affecting a pseudo omnipotence (Caruth, 1994) and feeling responsible for the act preserves a sense of meaning and purpose and evades the experience of nameless terror.

Identification with the aggressor and the need for meaning help to explain why children, like Mary, raped by strangers, blame themselves. Mary was not dependent upon her assailant for emotional supplies, but identified and effected pseudo omnipotence as a regressive maneuver to provide an ego in an id dominated existence.

These children have lost touch with the evidence of their own senses so they blame themselves. First what the patient hates herself for needs uncovering, then she needs help to remember why she went along with the adult (i.e., fear of punishment, belief that this was the only way they could get the longed for affection). She will only then reconnect with the evidence of her own senses and forgive herself.

Forgive Herself For Her Fear

Mary blamed herself for her cowardice. She believed that if she had fought harder, she could have prevented the rape. Once the basis for her self hatred was uncovered, a more benign explanation of events could be offered.

[Mary remembers the rape when she was 7 years old.] P. I damm myself for being afraid. An. You were not protected and imbued with a feeling of safety so that you wouldn't be afraid in the world. P. I hate myself for having detached and given him my body. An. There must have been a reason that you left your body. P. There is this terrible pain. I feel it in my vagina. (She has a somatic memory and experiences the past as if it were happening in the present.) He's spreading my legs, he's talking to me and putting his hand in my panties. I'm fighting him, but he lies on top of me and I'm immobilized. It hurts me so much, my body is going numb all over. There is just pain. I scream and start to cry and he puts his hand over my mouth and threatens to hurt me even more if I make noise. I'm on the ceiling somewhere looking at him doing this to me. An. So, you left your body to protect your spirit. It was the only way you had to save something of yourself and not be totally destroyed. You had no choice but to do what you did. You blame yourself for being a coward, because you don't remember how hard you fought and how you were helpless to do other than you did.

The next door neighbor's son-in law raped Mary when she was 7 and a lifeguard at the local pool molested her when she was 8. She also baby sat for the man who owned the tennis shop that she worked at when she was 10. He attempted on one occasion to French kiss her while she was at his house. She would often loudly reproach herself for not being more vigilant that she had allowed herself to get into these compromising positions. She would repeatedly shout "I should have known!" She meant by this that she should have been more vigilant. She took the fact that she wasn't more vigilant as indicating that she must have wanted the sexual assault. It was necessary to help her to remember why she didn't know; why she wasn't more wary. Only then did she come to appreciate that it was because she had adopted a stance of naiveté and denial as a way of dealing with how frightened she was of men. It was only when she could appreciate this defensive naiveté made her vulnerable to exploitation, that she could begin to forgive herself.

Forgive Herself For Reflexive Sexual Response

Mary blamed herself for the way her body responded when she relived the sexual assault. She would occasionally lubricate. Her body's response mortified her and felt like a betrayal. She assumed that this was the way it was when she was a child and she hated

herself for making it easier for him to penetrate her. Her greatest fear was that the lubrication indicated that she somehow wanted the rape and debasement. She feared she was a "7 year old slut." Mary needed help clarifying why she believed herself a slut, (i.e., I'm a slut because I lubricated), since she was cut off from the testimony of her own senses. This clarification enabled exploration of the true state of affairs in her childhood. Extensive exploration of her mental state, as she remembered it, revealed that there was no pleasure involved in the molestation and rape, but only terror and pain. Once the basis of her self hatred was uncovered a more benign explanation was offered; namely that lubrication was a reflexive response. The baby lubricates when mother changes its diapers. Mary could then appreciate that lubrication, per se, is hardly a basis for self hatred nor an indication that she "wanted to be raped."

For children like Mary, who took no pleasure in the sexual assault, suggestion that she took pleasure in the rape would run the risk of increasing her self hatred. She would hear this as asserting that she sought violation and debasement.

Generally, children wish for sexual contact, but need a boundary reinforced by the parent. Desire for the parent is only safe when met with boundary reinforcing (Spivak, 1994). What is confusing in early childhood is that the child's repressed sexual fantasies at the time of the molestation traumatically revive these oedipal and preoedipal fantasies. These fantasies cause the child to confuse early oedipal and preoedipal wishes with experience of sexual abuse. The child cannot distinguish the difference and becomes afraid of fantasy. (Huizenga, 1990; Levine, 1990). They cannot permit the practice love characteristic of the oedipal romance.

Mary longed for her father's attention and would pretend to be asleep at night so he would pick her up and carry her to bed. This was her only physical contact with him. She believed that her longing for male attention made her responsive to the offer of the rapist to give her a ride home. She subsequently became guilty about any longings for male attention because she equated that with inviting degradation. Interpretation of this dynamic helped her to be less afraid of needing men.

For some people, their guilt about their pleasurable response to the molestation forms the basis of their self hatred. However, because they identify with aggressor, they become cut off from their senses. A confusion occurs between what they wanted and what they needed (Ferenczi, 1933). They may have wanted some erotic contact with the parent, but what they needed was the parent to maintain a respectful boundary. They may also feel guilty because they confuse the need for pleasure with the need for affection. They need help with their confusion, before they can forgive themselves.

Recovery Of The Rage

The patient gets in touch with the rage at the molester for having damaged them and the rage at the parents for having failed to protect them following working through of the rage against the self and the identification with the aggressor. She feels the rage as overwhelming and this is the most frequent stimulus for experiences of fragmentation, fears of ego dissolution and impulsive suicide attempts.

These patients often inadequately articulate or symbolize the rage when they first discover it. Consequently, there is a tendency on the part of the patient to want to act on their feelings. This tendency needs restraining.

The following vignette illustrates the push toward action. I indicated that Mary was generally a silent patient or at best a person of few words. She repeatedly asserted that she could not access her rage at the rapist without acting on it. She complained that simply sitting in the office and talking about her feelings was ineffective and pointless.

She needs to hit, throw or break something. She became increasingly despairing of anything meaningful being accomplished in her treatment.

The following vignette is illustrative of this phase. Transference interpretations deal with the analyst as the unprotecting mother and as the molester. This occurs in the eighth year.

P. I want to go to the hospital, but there is not any insurance. An. You're disappointed that you can't find a safe place. P. There will never be a safe place. I'm all alone out there. Even when I'm with people I'm alone. An. A stray who is separated from the herd is vulnerable and afraid of being attacked. You're afraid that I won't be there to help you find a way of connecting. P. What if I don't want to connect with people. An. When I talk about connecting, you think I'm going to force you to be a social butterfly rather than help you develop a capacity to connect so that you could choose whether or not you wanted to be social. P. Sometimes I think you will force me to do things against my will. I'm afraid that you will cause feelings to happen in me or you'll trick me. An. You're afraid that I'm a molester who will force things on you without respect for whether you want it or not because I'm just interested in my own selfish needs. P. I wish you wouldn't say that. It starts things happening in me. An. You're experiencing me as the molester making things happen in you against your will. P. Why would a grown man do something like this to a little girl! What possible pleasure could he have gotten from hurting me! [She screams angrily as she remembers the rape.] (Mary gets up from her chair and picks up an Eskimo carving that she had given me. The carving depicts a man pointing a harpoon with one hand, while protecting his genitals with a harpoon holder with the other hand. She paces the room while looking at the window. I know from prior sessions that she wants to throw the statue out the glass window at times like this.) An. You don't have words for what you're feeling right now. The impulse is to do something like break the window because of that, rather than talk about what you're feeling.

Mary repeatedly voiced her despair that maybe I'd taken her as far as she could go and what she needed was an "anger therapist" who specialized in dealing with anger. Words were not enough! She was expressing a need to enact her rage, since action stimulates words for previously wordless disassociated ego states. She needed to act before she could think. I eventually decided to hospitalize her for a weekend during this period. I reserved the patio area for a couple of hours where she could throw things around while I interpreted the meaning of her rage. The patient found this very useful. The closed unit of the hospital afforded additional protection because afterwards she couldn't "turn the rage off." The patient was grateful for the fact that when she returned to her room and tried to pull the drawers out of her bureau in an attempt to throw them around the room, the lock on the drawers prevented it. When the rage is first uncovered there is also a wish to prematurely confront the molester, if possible, or the parent, rather than come to know and experience the full meaning of the rage. It is important that the analyst not support this wish because it may expose the patient to more additional stimulation than they can handle at the moment.

Reclaiming The Body

Mary needed to disown her body because she blamed herself for the rape and molestation. She did not realize that she was trapped, without options and had no choice but to act as she did. Mary could begin to own that she had a body and sexual needs as her hatred for and shame about the rape and her body began to diminish.

She initially experienced sexual sensations without corresponding fantasies. Mary's initial impulse was to reject the sensations and mutilate her body. She needed help in tolerating the sensations sufficiently so that she could discover what it was that she wanted. This is in the eighth year.

P. (This is a Friday session.) I feel overwhelmed by sexual sensations and feelings. I feel all alone and that there is no one who cares about me. My relationship with you doesn't

do any good, because I only feel that you're here when I'm talking to you. I feel so overwhelmed that I feel in danger of cutting myself. An. When I'm not there for you when you need me, you feel uncared for and alone. It's difficult to bear these sensations when you feel alone. P. Yes. I want to cut out my vagina. I can't stand the pressure. I want to talk to you over the weekend. Don't make me leave. An. You feel rejected and uncared for when I leave you. You lose touch with the caring me that always comes back to you at these times because you are so angry at me for leaving you.

This session illustrates an important technical principle in dealing with people just beginning to acknowledge that they have a sexual feelings. When the person who has dissociated her body first begins to reclaim it, it is a frightening experience. People living a pseudo mental existence are divorced from their sexual existence. They first need help to tolerate being aware of bodily sensation so that they can discover what they want. It would have been an error to interpret that Mary wanted intercourse in the session. I first needed to deal with her resistance to acknowledging that she had a body and sexual sensations before addressing readily available id material or the aim and object of those sensations.

Learning To Love Again

Once one forgives oneself for participating in the molestation, one has less a need to dissociate the body. Acceptance of the body ushers in acceptance of the need to love and be loved again. Fears of loving and trusting people often occur during this period.

Mary suffered from profound feelings of alienation from her needy self and from other people. This was directly traceable to the rape. Her personality before the rape was much more alive and outgoing. Following the rape she became a silent, withdrawn and detached girl who was afraid of letting her mother out of her sight. The following vignette is typical of the ninth year.

P. I want to be dead. I don't want to change. No one can take care of me. I can't take care of myself. There is no safe place. I almost succeeded in killing myself before. It wasn't so painful. I want to do it again. My life is pointless. I live in terror. I don't fit in. People see the terror and treat me differently. An. You assume that you will always feel so terrified and there won't come a time when you'll feel significant enough to me to feel safe. P. All I do is work so that I can make money to see you. I then sit in my room. People say it will get better, but it doesn't. An. You're afraid to invest your life with meaning so that you could feel less terrified. P. What would you have me care about. An. You're afraid to let yourself feel so that you could discover what you care about. P. I have these things in my life. My life still feels unimportant. An. You're afraid to care again, because in the past when you cared you were terribly hurt and you're afraid that will happen again. P. It also happens in the present.

This session marked a turning point. Mary increasingly began to acknowledge her fears of being hurt again if she allowed her self to get involved. A need for love and to love emerged as her fears diminished. Her depression lifted, her life began to feel meaningful and she fell in love with a woman. This was the first time in her life that she ever wanted anyone sexually. It was also the first time she ever acknowledged enjoying sex. She moved to live with this woman in a midwestern city shortly after she met her. She reported no longer feeling depressed or afraid of involvement.

Mary was resistant to transference interpretations of me as the molester. She maintained that they frightened her too much. The limited opportunity to explore those fears in the transference may have contributed to her aversion to men. However, Mary had gone as far as she wanted to in the analysis and I respected that.

Mary was a deeply divided woman. Intensive study of this one case demonstrated rather

dramatically the importance of analyzing the motive for resistance to owning dissociated states in order to further integration. However, I've also confirmed the usefulness of the technical interventions illustrated in her case in a number of other cases that I've treated and supervised.

Follow-up

Mary visited me 3 years following termination. She appeared to be a different person from the one I remembered. I remembered her as a shadow person, who was never fully present. I remembered her as someone that one would barely notice and who gave the appearance of trying to blend into the woodwork. She would always have her eyes downcast, speak in a whisper and give the appearance of timidity and shame. The woman who appeared in my office was robust in manner, jovial in spirit and looked me straight in the eye. She informed me that she was still with her girlfriend and the relationship was going well. She was attending college, majoring in Political Science, and hoped to be a lawyer someday. She commented on how weird it was to be back in my office and remember what a lunatic she was. She then added, somewhat wistfully, that she first learned how to talk about her feelings with me. However, she went on to say that after learning to do that she had to go off and learn for herself. She said she was happy.

Summary

Adequate understanding of dissociation requires appreciating its function as a resistance. Victims of childhood sexual abuse alternately acknowledge the trauma and then flee from it in treatment. Interpreting the motive for resistance promotes integration. If one reifies the existence of a separate personality when addressing dissociated ego states, one promotes fragmentation. Common motives for resistance include, fear of over stimulation and ego dissolution and shame and self hatred. The victim blames herself for having participated in the act and doesn't realize that she was trapped and without other alternatives. Interpreting these motivations diminish the need to dissociate.

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