Countertransference in the face of growth: reenactment of the trauma

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Abstract

Treatment of survivors of childhood sexual abuse (CSA) poses difficult challenges for therapists. This is, namely, because of the wide array of powerful countertransference (CT) reactions. A vast amount of literature exists which describes these patterns. However, discussion until now has predominantly focused on the reaction of therapists to the negative effects of the trauma.

The present chapter addresses an aspect of CT that, to the best of the authors' knowledge, has yet to receive any attention in the literature on trauma: countertransference in response to reports of gains or positive changes after trauma. This has been defined in the literature as posttraumatic growth (PTG). Exploring countertransferencial reactions to PTG and the mutual effects that occur between the two, will provide further insight into the phenomenon of PTG. It will also assist therapists in assuming responsibility for their part in the appearance of PTG and the ways it unfolds in therapy. Five distinct positions of countertransference will be presented: dissociated therapist; therapist as perpetrator; therapist as neglectful parent; therapist as rescuer; and mourning therapist. The authors argue that these positions should be considered as reenactments of dissociated self-states and relational dynamics, rooted in the original trauma, that must be worked through in psychotherapy in order to foster integration and healing.

Introduction

Treatment of survivors of childhood sexual abuse (CSA) poses difficult challenges for therapists, due to of the wide array of powerful countertransference reactions. There is vast literature which exists, describing these patterns. However, discussion until now has predominantly focused on the reaction of therapists to the negative effects of trauma, while overlooking the reactions to patients' reports on the positive effects of trauma.

The present chapter, therefore, addresses countertransference that develops in response to patients' reports of gains or positive changes after the trauma, defined in the literature as posttraumatic growth (PTG). Exploring countertransferencial reactions to PTG and the mutual effects that occur between the two will provide further insight into the phenomenon of PTG. It will also assist therapists in assuming responsibility for their part in the very appearance of PTG and the ways it unfolds in therapy.

The present chapter will first discuss the psychological process and long term ramifications of CSA. Second, the concept of PTG will be presented together with a clinical vignette. Following this, the controversy regarding the nature of PTG will be discussed. Third, the role of transference (T) and countertransference (CT) dynamics within the treatment of CSA will be presented, with a particular focus on the reenactments of dissociated self-states and relational dynamics through T-CT. Fourth, in regards to the patients' reports of PTG, five CT positions will be offered. Lastly, the significance of the therapist's reflective stance will be discussed.

The trauma of childhood sexual abuse

Childhood sexual abuse refers to:

> …the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. (World Health Organization, 1999, p.75)

Child sexual abuse is considered incest when the sexual act is performed by a parent, family member, as well as relatives or people who function in family roles.

CSA is one of the most malevolent traumas occurring within the interpersonal realm. The abused child is subjected to exploitation, use of force, betrayal and fiduciary breaches at the hands of the perpetrator, who uses the child for sexual gratification while invalidating the child's needs. Denial and abandonment by other adult figures who overlook the abuse are also part of the abused child's experience, as they minimize or justify the abuse and thus enable its continuation.

Moreover, unlike other forms of interpersonal violence, sexual abuse of children, particularly when committed by someone emotionally close to the child, who they know and trust, constitutes an intolerable combination of exploitation, injury and intrusion. Although such an act invalidates the child's needs, he or she may interpret this as an expression of love and affection by the perpetrator who uses the child's need for tenderness as a way to satisfy his or her needs. Thus, the child experiences unbearable conflict, since any kind of recognition regarding the abuse may impede the child's perceived ability to preserve close emotional connections, which are essential for normal development (Seligman, 2004). Different

psychological mechanisms, dissociation in particular, help the child avoid the unbearable knowledge concerning the abuse and preserve the bonds with the abusive perpetrator (Ferenczi, 1932).

A wide variety of long-term effects have been associated with childhood sexual abuse (e.g., Briere & Elliott, 2003). A meta-analysis, including thirty-seven studies published between 1981 and 1995, indicated that adults who were sexually victimized during their childhood appeared to be at an increased risk for developing a variety of symptoms, such as posttraumatic stress disorder (PTSD)**,** depression, suicidality, sexual promiscuity and sexual perpetration (Paolucci, Genuis, & Violato, 2001).

Furthermore, according to various researchers and clinicians (e.g., Herman, 1992; Herman & van der Kolk, 1987), exposure to a protracted pernicious interpersonal trauma, such as CSA, could result in a complex form of PTSD (or disorders of extreme stress not otherwise specified [DESNOS]; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). This disorder includes deep and long-lasting difficulties in a variety of domains in one's life and reflects damage to the basic elements of the survivor's personality. Alterations in the regulation of affective impulses, attention and consciousness, self-perception and relationships with others, as well as somatization and changes in systems of meaning, are suggested to be a part of this syndrome (Herman, 1992; Herman & van der Kolk, 1987). Although generally the focus of clinical and empirical studies have been on the long term negative effects of CSA, often the posttraumatic experience is more complex, as the present vignette demonstrates:

Tal, a woman in her thirties, seeks help for emotional distress resulting from incest trauma. During the intake she reports that she was eight years old when her father sexually assaulted her for the first time. These

sexual assaults lasted for five years. She describes feelings of contamination and shame and constant vigilance towards others. At present, she finds it hard to trust her partner, and when he touches her without warning she feels as though she might burst, or alternatively, she experiences dissociation and detachment. However, before ending our session she smiles, and comments that she feels that the abuse was not in vain and that it made her stronger. As a result of the incest she now knows that she "can handle anything" and she "believes in herself and in her abilities." She reports that her relationships with those close to her are stronger, as she has learned to appreciate others and to be honest with the people in her life.

CSA survivors' perceptions regarding their traumatic past may be multifaceted. Notwithstanding the reports of the trauma's negative ramifications, survivors may also attribute positive effects to their traumatic past, as was demonstrated in the vignette, a phenomenon which is most commonly known as *posttraumatic growth* (PTG).

How can one understand reports of PTG among survivors of severe and harsh trauma, such as CSA? What challenges might it raise during psychotherapy and how do therapists react to such reports of PTG and what are their common countertrasferential reactions? While the former question has gained much attention within the trauma literature, the latter remains largely uninvestigated. Hence, the present chapter explores therapists' countertransference reactions in response to their patients' reports of PTG.

Posttraumatic growth – Definition and prevalence

Posttraumatic growth (e.g., Calhoun & Tedeschi, 2006; Calhoun, Tedeschi, & Tedeschi, 1999) – also known as *perceived benefits, positive aspects*, and *transformation of trauma* (Bloom, 1998; Calhoun & Tedeschi, 1990; Tedeschi & Calhoun, 1988) – is defined as positive psychological changes resulting from a struggle with a past traumatic experience (Calhoun & Tedeschi, 2006). PTG refers to

the individual's report of personal development that, at least in some areas, has surpassed what was perceived by the person as being present before the traumatic event. Hence, trauma survivors who report PTG have not only survived or recovered from the trauma, returning back to their level of pre-trauma functioning, but they have also undergone positive changes that surpass their previous status quo. Posttraumatic growth, then, has been conceptualized as a phenomenon that has the quality of transformation, or a qualitative change in functioning, unlike the seemingly similar concepts of resilience, sense of coherence, optimism and hardiness (Tedeschi & Calhoun, 1995).

It is important to underline that, according to Tedeschi and Calhoun (2004), PTG and traditional measures of psychological adjustment are thought to be independent because domains of growth are conceptually distinct from general emotional adjustment. PTG is not the same as an increase in well-being or a decrease in distress (Tedeschi & Calhoun, 2004). Therefore, as was demonstrated in the vignette, PTG and emotional distress may very well coexist.

Many stressful or traumatic events have produced reports of posttraumatic growth, at least in some form, including bereavement (e.g., Calhoun & Tedeschi, 1989-1990), disease (e.g., Tennen, Affleck, Urrows, Higgins, & Mendola, 1992), combat (e.g., Sledge, Boydstun, & Rabe, 1980), terror (e.g., Levine, Laufer, Hamama-Raz, Stein, & Solomon, 2008) and war captivity (e.g., Feder et al., 2008; Lahav, Bellin, & Solomon, In Press). PTG has also been documented among sexual assault survivors (Burt & Katz, 1987; Frazier, Conlon, & Glaser, 2001; Veronen & Kilpatrick, 1983), as well as among CSA survivors (Draucker, 1992; McMillen, Zuravin, & Rideout, 1995; Silver, Boon, & Stones, 1983).

According to Tedeschi and Calhoun (2004) PTG is exhibited in three domains: elevated positive self-perception, improved interpersonal relationships, and a more optimistic world view. An increased appreciation for life is a major element of trauma survivors' reports of PTG, with a possible report of a major revision of how they approach and experience their daily lives. They might also report a change in life priorities with an increase in the importance of aspects that might have previously been considered insignificant, and a recognition of the importance of not taking things for granted. Growth in this domain might also manifest in an engagement with or strengthened belief regarding spiritual and existential matters.

A general sense or recognition of increased personal strength is another domain of posttraumatic growth. According to Tedeschi and Calhoun (2004), while coming to grips with surviving the trauma, individuals may gain insight into the sense of possessing more strengths and powers than they ever imagined. This experience of enhanced competency could enable more active, assertive and effective coping with difficulties in the future. Moreover, the need to develop new interests during the trauma as a way to improve coping may expose individuals to new possibilities for one's life. This may lead to taking a new and more fulfilling path in life.

Lastly, PTG might be indicated in the interpersonal domain (Calhoun et al., 1999). Closer, more intimate, and more meaningful relationships are also reported as part of the individual's experience of posttraumatic growth. A greater connection to others can also be manifested by experiencing an increased sense of compassion, particularly for others who may share the same difficult fate.

The nature of PTG - Genuine transformation or illusory defenses

Although PTG has been repeatedly reported in numerous psychosocial studies, there remains a controversy regarding its nature and long-term implications. On the

one hand, PTG is viewed as a genuine transformation in basic beliefs about the self and the world, resulting from struggles with the effects of trauma (e.g., Calhoun & Tedeschi, 2006; Schaefer & Moos, 1998). On the other hand, PTG is contested as a phenomenon which reflects, at least in part, illusory defenses that may be maladaptive and hinder coping in the long-term (e.g., Davis & McKearney, 2003; Hobfoll et al., 2007; Maercker & Zoellner, 2004; McFarland & Alvaro, 2000). This view suggests that individuals facing threatening events may respond with positive illusory perceptions of themselves, of personal control, as well as unrealistic optimism (e.g., Taylor, 1989). These positive illusory perceptions might serve as a cognitive avoidance strategy in the face of trauma, strengthening efforts to avoid acknowledging the traumatic event and the multiple losses it entails. However, such perceptions may have deleterious effects on adjustment in the long run (e.g., Maercker & Zoellner, 2004).

Maercker and Zoellner's (2004) Janus Face Model of PTG suggests that PTG includes both a constructive aspect and an illusory aspect. While the constructive component of PTG is purportedly associated with functional cognitive restructuring and adjustment, the implications of the self-deceptive illusory component is inconclusive, depending on its function as well as the time when it is applied.

According to Maercker and Zoellner (2004), in the short run, the illusory component of PTG does not necessarily represent denial or efforts to avoid thinking about the traumatic material. On the contrary, this aspect of PTG might coexist with deliberate thinking about the trauma and reflect an acute coping mechanism that fosters self-enhancement cognitions while under threat, in order to reduce stress. Hence, use of this mechanism might lead to short-term palliative results, with neither positive nor negative effects. However, if this illusory element is linked to avoidance

efforts, fostering the evasion of thinking about the trauma in the long run, then it could act as a way to deny and repress traumatic memories, having long-term negative effects on adjustment (Maercker & Zoellner, 2004).

The contested discourse regarding the nature of posttraumatic growth and its implications is further accentuated by findings that imply the potential illusory function of PTG. For instance, McFarland and Alvaro (2000) investigated the impact of self-enhancement motivation on the temporal comparisons of survivors of stressful life events. Their results, based on experimental approaches, revealed that survivors were more likely than their acquaintances to describe greater improvement in their personal qualities after traumatic life events than after mild negative life events. Moreover, the findings revealed that while there were no differences between the two groups (i.e., severe-event survivors and mild-event survivors) regarding their current assessment of personal capabilities, the recalled pre-event ratings by those who endured severe events were significantly more negative in comparison. Thus, it seems that survivors of severe events appeared to have perceived improvement by devaluing their previous attributes rather than by elevating their current traits. In addition, findings showed that threats to feelings of self-worth played a causal role in prompting self-enhancing temporal comparisons, so that participants who experienced negative feelings, had a tendency of negative pre-event ratings compared to participants who, during the experiment, were induced to experience more pleasant feelings. Altogether, the findings of these studies support the view that perceptions of personal improvements reflect, at least on some level, motivated illusions (McFarland & Alvaro, 2000).

Mixed empirical findings regarding the relationship between PTG and well-being among survivors of various traumatic events also deepens the debate

concerning the nature of PTG. For instance, considering the relation between PTG and psychological distress, studies varied, as did the findings, which indicated positive, negative, and no relation between the two (for review see Helgeson, Reynolds, & Tomich, 2006; Linley & Joseph, 2004; Zoellner & Maercker, 2006). The meta-analytic review by Helgeson et al. (2006), found PTG to be related to lower depression but greater avoidance and intrusive thoughts. Notwithstanding, the studies in the review that used well-established measures indicated that PTG was related to more global distress and intrusive-avoidant thoughts.

A similar trend of mixed findings has been found regarding the association between PTG and PTSD symptoms (e.g., Helgeson et al., 2006; Linley & Joseph, 2004). While some studies have revealed a negative association between the two (e.g., Frazier et al., 2001), with lower levels of distress associated with greater growth, others have found the opposite (e.g., Dekel, Ein-Dor, & Solomon, 2012; Greene, Lahav, Kanat-Maymon, & Solomon, 2015), with higher posttraumatic symptoms associated with greater growth. Others still have uncovered a curvilinear relationship between trauma and PTG (Levine et al., 2008).

Thus, the discourse concerning the essence of PTG implies that PTG may be a complex multifaceted phenomenon that holds various meanings for CSA survivors. This may have important implications which are not limited to the theoretical realm but which are also concerned with the clinical realm.

The following sections look at the therapist's responses, as reflected in countertransference reactions, when facing their patient’s reports of PTG. First, the definition of countertransference and its particular role in the treatment of trauma survivors is presented. We will then discuss our understanding of the countertransference relations as a reflection of the patient's unsymbolized and

dissociated representations of the self as well as internalized relational systems. From this perspective, and based on Ferenczi's trauma theory, we will then suggest five variations of countertransference reactions in regards to the patient's reports of PTG.

Countertransference reaction in the face of PTG

The concept of countertransference has gone through major transformations over the years. The view of the analyst as a blank screen upon which the patient projects feelings and wishes has shifted to that of two co-participants involved in a process of discovery and co-construction centered upon the evolving patient's sense of self (Aron, 1996). The intersubjective perspective, which is adopted by the authors, views CT as "the analyst's experience of and contribution to the transference-countertransference... [which] refers to an unconscious intersubjective construction generated by the analytic pair" (Ogden, 1998, p.25).

In psychoanalytic treatment, transference (T) and countertransference (CT) relationships are considered to be central to understanding the patient's self-transformative process. This emphasis is especially critical when it comes to treating trauma survivors (Herman, 1992). This is because, profound trauma, such as CSA, cannot be registered symbolically or verbally (Ferenczi, 1932). Often, the traumatic experience remains unorganized and unsymbolized, and therefore cannot be contained, apprehended, articulated, represented, or narrated, nor be recalled (Laub, 1992). Survivors are often entrapped in their trauma, "not truly in touch either with the core of his traumatic reality or with the fatedness of its reenactments and thereby remains entrapped in both" (Laub, 1992, p. 69). In treatment these unsymbolized memories begin to emerge as formless affects and body sensations, frequently taking the form of unexpected reactions to external stimuli, particularly in relation to the

therapist. In these moments, there is an activation of the past, or a collapsing of the past and present via transference-countertransference enactments.

Countertransferential reactions are often an expression of dissociated aspects of the traumatic past. The therapist's CT may unfold the patients' dissociated self-states which are unavailable to consciousness and highly disintegrated (Bromberg, 2011). Furthermore, the patient's split-off representations of irreconcilable aspects of the traumatic relations may be reenacted through the transference-countertransference relationship (Davies & Frawley, 1992, 1994). It is thus particularly important that the therapist be ready to attend to his or her countertransferential responses since they are the map that should guide the therapist through the hidden banks of the transference and the patient's dissociation. Working through the T-CT dynamics is clearly the foundation which enables the healing process to take place, as the therapist helps the patient name, form, and symbolize these dissociated, unformulated aspects of trauma and integrate them.

The trauma literature has indeed paid extensive attention to CT and documented various reactions experienced by the therapist treating CSA survivors (Davies & Frawley, 1994; Neumann & Gamble, 1995). However, these accounts describe the countertransference patterns only in relation to the negative ramifications of the trauma. The therapist's CT, in the face of the patient's positive reports of PTG, has yet to be explored, and will be investigated within the present chapter for the first time.

Based on Ferenczi's (1932, 1949) theory concerning psychological adaptation to child abuse, and the authors' clinical experience in therapy and during clinical supervision, the authors have identified five different types of countertransference reactions to reports of PTG during the treatment of CSA survivors. As will be

demonstrated, these CT patterns may reflect reenactments of the patient's dissociated self-states and dissociated relational dynamics. These types of CT include the dissociated therapist, the therapist as perpetrator, the therapist as neglectful parent, the therapist as rescuer, and the mourning therapist.

The fragmentation of the patient's self-object world as resulting from the original trauma, is reflected in the CT reactions of the therapist. Two general polarities can be identified within the presented CT positions: on the one hand, the therapist's embrace of the patient's reports of PTG, as reflected in the first three positions; and, on the other hand, the therapist's complete negation of the patient's reports of PTG, as indicated in the last two positions.

Position I - The dissociated therapist

The CT position of the dissociated therapist develops as a form of identification with the dissociated child. The sexually abused child reacts to the overwhelming, unbearable, and dangerous attacks at the hands of the perpetrator by dissociating the self from these experiences. Dissociation, which constitutes splitting off from the immediate perception of the experience, enables the abused child to temporarily escape from the pain and suffering, an ability that is crucial for their survival (e.g., Davies & Frawley, 1994; Putnam, 1993). According to Ferenczi, in stressful situations the "partial negation and distortion of reality is its replacement by a dream" (1932, p. 180). In more extreme circumstances, dissociation is manifested by the "total negation of reality" (Ferenczi, 1932, p. 180). As a result, the child feels invulnerable to pain or to being hurt, as if the traumatic event is happening to someone else. Moreover, the dissociated child may even show "a manic feeling of pleasure, as if [he or she] had succeeded in withdrawing completely from the painful situation" (1932, p. 6), while in fact trying to survive the abuse.

The extreme gap between the split-off suffering and the trauma survivor's appearance of intactness and even pleasure from the abuse, which commonly appears as part of dissociation, may be the key for understanding the reports of PTG by CSA survivors. Reports of gains and benefits as a result of the trauma, as indicated in PTG, could reflect the negation of the traumatic reality and its replacement by an alternate dissociative narrative (Lahav et al., In Press). This narrative is detached from the intolerable pain of the abuse and constitutes a substitute reality where the abuse was not in vain, and where the self not only survived the trauma but was also strengthened by it.

While the dissociated beliefs of PTG may be essential for the child's survival during the trauma, it might pose impediments when experienced after the trauma is over. Similar to other dissociated experiences, PTG may entail significant mental maneuvering (Braude, 2000), including disavowal and even temporal or complete amnesia of the traumatic and painful experiences. These are often re-experienced in the form of dreams, flashbacks, and flooding of the original feelings and sensations (Chu & Dill, 1990). Moreover, this fragmentation prevents working through the trauma and inhibits the healing process (Davies & Frawley, 1994).

In psychotherapy with CSA survivors, the self-state of the dissociated child that holds on to the PTG narrative might be reenacted by and with the therapist. The therapist who experiences this form of CT tends to embrace, in excessive fashion, the patient's reports of posttraumatic growth, over emphasizing it and even viewing it as a reflection of the patient's strengths and capabilities. This trend goes hand-in-hand with emotional detachment and avoidance of traumatic content by the therapist, who feels compelled to keep the patient's hope and faith in the benevolence of the world and to protect the patient from emotional pain.

The therapist who identifies and reenacts the dissociated child through this form of CT cannot bear the pain and sense of helplessness associated with CSA. As a result, the therapist splits these feelings off from his or her consciousness. Instead of experiencing the intolerable agony, horror, and helplessness, of learning about such acts of sadism, cruelty, deception and betrayal, alternate narratives about the "positive" aspects of the trauma, as manifested in PTG reports, become dominant.

While at the beginning of the therapeutic process this position might serve as a source of comfort for both the patient and the therapist, encouraging hope, in the long run it might hinder the healing. As the therapy progresses, this CT position will possibly impede the reflection and processing of those parts of the patient's experience which deviate from the narrative of growth. The patient's painful traumatic experiences, as well as other dissociated self-states which relive the traumatic past and suffer desperation and pain, do not have the opportunity to be expressed in therapy and thus remain unspoken and overlooked. These self-states would likely be expressed outside therapy in untreated dissociated symptoms, such as self-injury or re-victimization. In this way, the original dissociation is repeated in the present, as the fragmentation of the self only deepens.

Position II - The therapist as perpetrator

The CT position of the therapist as perpetrator develops when the therapist comes to embody the patient's representation of the abuser, a representation that was previously internalized to protect himself/herself during the abuse. This belongs to the

process known as identification with the aggressor, as described by Ferenczi (1932, 1933).[1]

According to Ferenczi, the sexually abused child who experiences both repeated invalidation of his or her basic needs as well as protracted sadistic attacks has to identify with the perpetrator in order to protect the self. Subordinating themselves to the perpetrator, abused children replace their own experience and agency with that of the perpetrator (Ferenczi, 1932, 1949; Frankel, 2002). The child's self has been demolished by terror, leaving him or her with "no emotions of [his or her] own – living somebody else's life . . . instead of one's own life" (1932, p. 171; see also 1933, p. 163).

The child who identifies with the perpetrator subordinates himself/herself to the perpetrator as a way to cope with the abuse. Consequently, the child then seeks to enter into the perpetrator's mind in order to know what the perpetrator wants. In this way, the child can anticipate the abuse and minimize the hazards. Lastly, in order to ensure survival, the child submits and complies (Ferenczi, 1932, 1949; Frankel, 2002).

The abused child who identifies with the perpetrator is no longer resistant or hateful, but feels for and understands the perpetrator. The child in this position feels the way the perpetrator expects him or her to feel. This also includes experiencing what the perpetrator feels. This form of identification may also include denial of the abuse. This then creates confusion, leading the child to doubt his or her own

[1] Ferenczi's concept was originally named "identification with the aggressor". The authors will refer to "identification with the perpetrator" based on Ferenczi's concept. Ferenczi's concept of identification with the aggressor is very different from Anna Freud's (1936) later use of the term, by which she describes that by impersonating the aggressor, assuming his attributes or imitating his aggression, the child transforms himself from the threatened person into the person who makes the threat. While Ferenczi denotes a pervasive change in the abused child's perceptual world, Anna Freud describes a more limited event of behaving like the perpetrator and taking on his attributes (Frenkel, 2002).

perception of reality (Ferenczi, 1932). The child might even experience the pleasure the perpetrator derives from the abuse and “become so sensitive to the emotional impulses of the person he fears that he feels the passion of the aggressor as his own." (Ferenczi, 1932, p. 91)

According to Ferenczi (1932) the split part of the personality that identifies with the perpetrator is able to escape from the cruel reality. This occurs through premature progression, which includes rapid sexual, emotional and intellectual maturity manifested in precocious abilities, hypersensitivities, superintelligences and even clairvoyance (Frankel, 1998). This precocious development enhances survival by enabling the child to assess the environment and to satisfy the perpetrator's needs (Ferenczi, 1932).

The defensive process of early maturity may lead to excessive achievement and the compulsive tendency to take on "superhuman tasks" (Ferenczi, 1932, p. 80). However, this part of the child's self is lacking feelings of its own, since this might hinder efficient performance. In addition, this dissociated self-state remains vulnerable due to a continuing wish to regress (Ferenczi, 1932), and not to take on any responsibilities or to perform (Ferenczi, 1949). As an adult, this self-state allows the survivor to preserve relationships with the abuser and to keep the experiences of the abuse at bay.

We would like to suggest that the survivor’s perceptions regarding the salutogenic effects of the trauma, manifested in the reporting of PTG, might be rooted in this process of identification with the perpetrator. Adopting the perpetrator's denial regarding the prolonged pernicious ramifications of the abuse and embracing the perpetrator's distorted beliefs concerning the gains and advantages of the abuse for the victim, may lead to reports of positive changes and growth. Moreover, CSA survivors'

reports of PTG may reflect their inappropriate, over-matured presentation, which were defensive reactions in the face of the abuse.

In psychotherapy, the traumatic relational matrix between the perpetrator and the abused child who identifies with the perpetrator, is often relived and reenacted (Davies & Frawley, 1994). The therapist in this CT position takes on the role of the perpetrator who ignores the child's needs and exploits the child's trust for his own sake. Similar to the former CT position, the therapist in this position over-emphasizes and validates the patient's reporting of PTG and takes it at face value. However, as opposed to the retreated and detached approach that characterizes the preceding CT position, the current position of the therapist reflects aggression and sadism towards the patient. The therapist who reenacts the role of the perpetrator unconsciously uses the patient's reporting of PTG as a legitimate excuse to doubt the harshness of the patient's trauma, to invalidate the distress and to expose the patient to excessive pain in an unregulated manner during therapy.

Furthermore, the therapist in this position could use the patient's reports of PTG as a way to overlook the social responsibility regarding the abuse. Similar to other voices often heard within the social discourse, the therapist also perceives the patient as responsible for the abuse, as though the patient initiated the abuse and even benefited from it.

The patient, on the other hand, may reenact the self-state of the abused child who identifies with the perpetrator and relive the traumatic dyadic relational system. As in the original abusive dynamics, the patient subordinates to the therapist and adopts the therapist's stances, feelings and perceptions. Hence, the patient gives special emphasis to the "good parts" of the traumatic past – the advantages and the positive changes accompanying the abuse. Moreover, the over-matured self-state of

the patient may become dominant in therapy, demonstrating impressive abilities and achievements, thus strengthening the therapist's stance regarding the patient's growth.

However, in instances when the patient's split-off part of the injured child arises and expresses distress, the therapist may express his/her disappointment and accuse the patient of being spoilt. The therapist may even misuse prior reports of PTG in order to dismiss the patient's protests. Lastly, if the patient abandons the narrative of PTG, the therapist might experience it as a personal attack against him/her or the therapy and use clinical concepts, such as resistance or negative therapeutic reaction, as a means to justify emotional abandonment of the patient.

Position III – The therapist as neglectful parent

The CT position of the therapist as neglectful parent develops when the therapist identifies with the patient's internal representation of the neglectful parent. The trauma of CSA often exposes the child not only to the betrayal of the abuser, who is often someone emotionally tied to them, but also to the neglect and betrayal of the non-abusive parent(s). This neglect is manifested by the denial of the abuse and disavowal of the child signaling that something wrong is going on. The neglectful parent minimizes the severity of the abuse and degrades the child's perceptions of and reactions to it (Davies & Frawley, 1994; Ferenczi, 1932). Hence, the child cannot find help or support within the relationship with the parent and is left profoundly and unbearably alone (Ferenczi, 1949).

Although emotions, such as disappointment and rage, toward the neglectful parent do exist, the parent was often also loved and needed by the child. Therefore, the relational constellation of the neglected child with the neglectful parent is split off

from consciousness and, instead, the patient preserves a conscious image of a loving and available parent or of a weak and helpless parent (Davies & Frawley, 1994).

The CSA survivor's report of PTG might reflect the abused child's attempts to please the neglectful parent. By minimizing the harsh ramifications of the abuse and pointing to the positive benefits of the trauma, the CSA survivor can preserve their attachment to the neglectful parent and keep other parts of the self at bay which cry out for help and experience rage against the parent's neglect.

In psychotherapy, the abused child–neglectful parent relational matrix is reenacted in the T-CT relationship regarding the patient's reporting of PTG. As such, the therapist who reenacts the role of the neglectful parent may over-embrace the patient's reports of PTG, while ignoring its potential defensive qualities as well as overlook the patient's needs and distress. Invalidating the severity of the abuse and over-relying on the reports of PTG, the therapist may experience an exaggerated confidence concerning the patient's mental condition, as if the patient can cope with the traumatic memories without any help. Moreover, the therapist in this position may be occupied with his/her own narcissistic needs and use the patient's positive reports as a way to enhance their professional image. Like in the original traumatic interaction, the therapist's attitude towards the patient may be characterized by hypocrisy (Ferenczi, 1931). Namely, while on the surface the therapist expresses caring concern, the therapist actually stays uninvolved and even denies the patient's adversity.

On the other hand, the patient who reenacts the role of the neglected child in therapy may try to live up to the therapist's expectations. The patient, thus, may excessively report PTG or emphasize positive aspects of the trauma, while underestimating the negative effects. The patient may present optimistic points of

view and portray himself/herself as a well-functioning adult who enjoys life. It is as if the patient is saying to the therapist, "I am fine. You should not worry about me. The thing that happened to me was not so bad and even has a positive side, so you do not have to care for me."

Although the patient tries to please the therapist by emphasizing alleged growth, he/she may often use alternative paths to communicate the things which are left unspoken, such as distress, unbearable pain, suffering, as well as anger toward the neglectful therapist. Similar to the abused child, who disperses clues in a desperate effort to get the parent's attention and save the self, the patient uses the symptomatic language or somatization as a way to express adversity. As long as the T-CT dynamics stay unelaborated, the patient's distress could be manifested outside the therapy by various symptoms such as self-injury or re-victimization. Yet, as time passes, the patient might express rage toward the therapist overlooking his/her needs, directly as well as indirectly through the exacerbating symptoms.

Position IV – The therapist as rescuer

This CT position of the therapist as rescuer develops when the therapist enacts the role of an omnipotent, all-giving rescuer in reaction to the patient's helplessness and suffering. Even though the abused child often develops compensatory self-states in order to survive the abuse, there are other dissociated states that perpetuate the experience of the defenseless and helpless child, who remain defenseless and helpless, constantly reliving the trauma. Desperately dependent, this part of the self-state cries out for help and rescue (Ferenczi, 1932).

In psychotherapy, this patient's self-state of the helpless victim, which yearns to be rescued, may elicit strong rescuing responses from the therapist (Herman, 1992;

Saakvitne, 1990). This dynamic leads to the development of the omnipotent rescuer-helplessness victim dyad which then creates a position of CT expressed by negative attitudes toward the patient's reports of PTG.

The therapist who enacts the omnipotent rescuer perceives the patient as a helpless child who must be saved. This comes at the expense of other aspects of the patient's condition that deviate from the victim role, effectively obscuring the patient's strengths. In this state, moreover, the therapist is unable to tolerate reports of positive feelings on the part of the patient regarding either the abuse or the perpetrator, considering them to be distorted.

Thus, when the patient reports PTG, the therapist who enacts the role of the rescuer responds to the patient with negation and dismissal. The therapist ignores the patient's reports of positive transformations resulting from the abuse or, at other times, minimizes these reports and emphasizes the negative effects of the trauma. The therapist may even adopt a didactic approach that could be manifested by pointing out the "distortions" or biases accompanying PTG beliefs and encouraging the patient to acknowledge the "true" effects of the trauma.

Meanwhile, the patient might try to gratify the therapist's needs by intensifying the victim role. The patient may appear to be a defenseless and powerless victim who cannot take responsibility for their own healing process or help themselves in any way. Feeling lost and weak, the patient becomes extremely dependent on the therapist and expects the therapist to rescue him/her and even to undo the abuse. It is as if the patient says to the therapist, "rescue me, save me! I know nothing, you have the knowledge and the power to help me, and without your help I will be lost."

At the same time, however, the patient conceals conflicting feelings and perceptions. As such, experiences of being potent and powerful, dissociative states of the self that negate the abuse and/or identify with the perpetrator, are all eradicated from the therapy discourse. This dynamic leaves the PTG beliefs silenced and censored. Moreover, the patient may feel great guilt and shame for holding PTG beliefs, as if they indicate that as a child he/she in fact enjoyed or wanted the abuse or that he/she is in a state of denial. Thus, these split-off parts of the self are left untouchable and unelaborated, and instead reenacted outside of therapy, perpetuating fragmentation of the self.

Position V – The mourning therapist

The CT position of the mourning therapist develops when the therapist identifies with the patient's experience of profound loss. Childhood was robbed from the survivor of CSA. The abused child loses (and sometimes never had) his/her sense of safety, innocence and playfulness of childhood, which are replaced by experiences of danger, terror, pain, isolation and confinement. These negative experiences are not integrated into the self and are registered separately in split-off self-states that reflect painful loss as well as a sense of deadness. Ferenczi (1932) described this self-state, which performs like a "body divested of its soul", as reflecting "the ashes of earlier mental sufferings" (pp. 9, 10).

In psychotherapy, the therapist's identification with the patient's experience of loss and despair leads to the development of the CT position of the mourning therapist (Herman, 1992; Saakvitne, 1990). The therapist in this CT position feels deep agony and grief, mourning over the abused child. Sinking into despair and losing hope, the therapist may view the abuse as a malignant wound which cannot be overcome and

perceive himself/herself as helpless and incapable to help. The therapist's faith in the therapeutic process is, thus, impeded dramatically.

Flooded with anguish, the therapist in this position cannot discern other self-states of the patient that may hold the experience of enduring the abuse, competence, and even growth. Hence, the therapist might ignore the patient's reports of PTG or even negate it offhand without reflecting or investigating its meaning. At other times, the therapist may refer to the patient's reports of PTG as an echo from the past – as the child's desperate clinging onto comfort or hope that no longer exists.

On the other hand, the patient may try to resonate with the therapist's CT by only bringing to therapy the self-state of the lost, emotionally dead child. Frozen, numb and detached from emotions, the patient may appear in therapy as lifeless. This "emotionally dead" self-state has already given up on the possibility of salvation and thus does not express resistance, distress or pain.

In this way, other split-off self-states of the patient, which remain alive and even experience growth and self-enhancement, are excluded from therapy. From time to time the patient may attempt to bring up these types of experiences and discuss them with the therapist. Nevertheless, as long as the therapist is immersed in grief, these efforts are doomed to fail and the healing process is in jeopardy.

Discussion

For the first time in the trauma literature, this chapter presents five possible CT positions that develop in relation to reports of PTG by patients who are survivors of CSA. We suggested that these CT positions should not be studied in isolation but in the context of the patient's reports, and that they should be understood as reenactments of dissociated self-states or traumatic relational dynamics that are split off from the patient's consciousness. As such, the CT reaction of dissociation may be

viewed as an expression of the therapist's identification with the dissociated abused child. The CT position of the perpetrator may be understood as an embodiment of the patient's internal representation of the abuser. Likewise, the other positions are also reflections of the traumatic representations.

The reenactments of the dissociated traumatic representations are inevitable and essential to the therapeutic process in the treatment of CSA survivors. Such therapeutic stances constitute the main avenue for expressing the unthinkable traumatic experiences and uncovering dissociated elements (Davies & Frawley, 1992, 1994). This eventually allows the patient to identify, mentalize, and integrate the dissociated elements of his/her inner world. However, at the same time, these reenactments, when manifested in CT reactions, may pose a threat to the healing process and run a risk of re-traumatization, as they constitute repetition of the original trauma.

Hence, it is crucial for the therapist to attend to his or her emotional responses toward the patient and to use them as a way to learn more about the patient's own experience. Moreover, the therapist should take responsibility for his or her reactions and consequent behavior, and avoid "blaming" the patient's past. Although originating from the patient's internal world, the therapist reacts, and by doing so he/she has a responsibly in the resulting consequences. Furthermore, the therapist's CT does not only stem from the survivor's internal world, but also from the therapist's internal world and dissociated material, as well as from the interplay between the two.

The current analysis of the CT reactions in relation to the patient's reports of PTG further illuminates the phenomenon of PTG. PTG seems to be a multidimensional phenomenon constituting multiple meanings for CSA survivors, reflecting repetition of the traumatic past, rather than its resolution. Reports of PTG

often represent enactments of dissociated self-states or dissociated relational dynamics that originated in the trauma. Hence, even when the patient reports PTG, he or she can, at the same time, hold other perceptions, which are equally valid, regarding the trauma and its implications. The dissociative structure of the survivor's personality can elucidate the, often documented, co-existence of reports of PTG and emotional distress. These contradicting reports may reflect dissociated and disintegrated aspects regarding the past trauma.

As the current chapter has illustrated, patient's initial reports of PTG can elicit a variety of CT reactions from the therapist during treatment, which in turn effects the patient's future reports of PTG. While some CT reactions enhance the patient's reports of PTG, others contribute to minimizing and obscuring PTG within therapy. Thus, similar to the polarized dissociated states, split-off extremities regarding PTG might be reenacted during treatment, leading to over-embracement versus complete negation of reports of PTG. This could constitute a repetition of the original trauma, as parts of the survivor's experience are, again, invalidated and split-off from consciousness. Thus, working through these reenactments is essential and could enable the extrapolation of the dichotomous polarities, while taking into account other aspects of the traumatic experience. This will allow a gradual integration and healing.

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