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Elizabeth Lind Crane
Is It Ever Appropriate to
Encourage a Survivor of
Sexual Trauma to Forgive: A
Theoretical Analysis

ABSTRACT

The topic of forgiveness is pervasive in popular culture and is being written about in psychological literature. This theoretical study was undertaken to examine the theoretical basis of forgiveness interventions and how these theories intersect with trauma-informed treatment. This study specifically explores the theoretical basis of the therapeutic value of a survivor of sexual trauma choosing to forgive her perpetrator in an attempt to determine the potential risks and benefits of forgiveness interventions. Literature was reviewed on the treatment of sexual trauma, including current practices. Then, a review of the literature on the treatment of sexual trauma and how forgiveness is understood from a cognitive behavioral perspective and a psychodynamic, specifically object relations, perspective was completed. The literature shows that sexual trauma significantly disrupts a survivor's core beliefs and internal object worlds and that forgiveness may be one way to repair this disruption. However, in order to do no harm, the therapist must determine for each individual survivor whether forgiving the perpetrator would be beneficial or is contraindicated. A careful assessment must be done of the survivor's ego defenses and object relations, the trauma circumstances, and the existence and nature of any preexisting relationship between the survivor and the perpetrator before a therapist considers discussing the topic of forgiveness in therapy.

IS IT EVER APPROPRIATE TO ENCOURAGE A SURVIVOR OF SEXUAL
TRAUMA TO FORGIVE: A THEORETICAL ANALYSIS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2010

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CHAPTER I

INTRODUCTION

The topic of forgiveness is pervasive in popular culture, self-help sections of bookstores, and even among some mental health professionals. In a recent brochure I came across from the American Psychological Association, one of the books advertised, as a part of the APA Lifetools series, is titled *Forgiveness Is a Choice: A Step-By-Step Process for Resolving Anger and Restoring Hope*, by Robert Enright, PhD., of the International Forgiveness Institute. A PBS Series, *This Emotional Life*, featured a segment on a forgiveness workshop with Frederic Luskin, PhD., of the Stanford Forgiveness Project. The message seems to be, if you have been wronged and are still harboring anger toward the transgressor, by choosing forgiveness, your life will improve.

Much is also being written about forgiveness in psychological literature. In the *Handbook of Contemporary Psychotherapy: Toward an Improved Understanding of Effective Psychotherapy* (2009), there is a chapter on the science of forgiveness. In his book, *The Forgiving Self*, Karen (2001) writes:

Forgiveness is as fundamental and important as any topic in psychology...it embraces the meaning of love and hate, the nature of dependency, the torments of envy, the problems of narcissism and paranoia, as well as the tension between self-hatred and self-acceptance, between striving for maturity and refusing to grow up (p. 9).

Over the last two years, I have been working with adolescents who have experienced sexual assault and wondering what it might mean to discuss the topic of forgiveness with them. Would it be harmful or beneficial? The intersection of these issues was brought home to me when I met with a 17 year old female, Kara, for the first time. She had been at a large party, had been drinking, and unwillingly had sex with a guy she met for the first time that night. In our initial interview, without any prompting from me, she told me that she was very religious and that she had already forgiven him.

Another adolescent's story brought this issue up for me again and raised more questions. Anna Maria is a 17 year old female, the daughter of immigrants. Although she was from a different part of the state, I met her in a small city in Western New England where she was living in a foster home and I was working in a child advocacy center. Anna Maria's family of origin was large, and there was a significant age range from the oldest to youngest sibling. As she approached adolescence, Anna Maria began getting into trouble and fighting with her mother. Her older sister and her husband offered to have Anna Maria live with them. Within a year of moving in with her sister, Anna Maria's brother-in-law began having sexual intercourse with Anna Maria. This abuse continued for several years. Eventually, Anna Maria disclosed details of the situation to an adult at school and was removed from her sister's home and placed in foster care. She gave a statement to the police department about the abuse, but soon after was pressured by her family members, including her mother, to recant this statement. She was told that her accusation threatened the stability of the family. Her mother had a trauma history of her own and strong Christian beliefs which influenced the way she believed Anna Maria should behave.

What if I were to work with Anna Maria at age 25 or 30? What should I take into account when considering whether to explore the topic of forgiveness? Would it ever be appropriate for me to encourage Anna Maria to forgive her brother-in-law? To forgive her mother? Her sister?

Research is being done on what psychotherapists think about the use of forgiveness interventions in therapy. Konstam, Marx, Schurer, Emerson Lombardo, and Harrington (2002) conducted a study which explored whether the topic of forgiveness comes up in therapy and how likely therapists are to raise the subject. Among the therapists they surveyed, many reported that forgiveness issues are relevant to clinical practice (Konstam et al, 2002). For a small number of respondents, the presenting problems being addressed when forgiveness was discussed included sexual abuse, rape, and trauma. Several questions arose: how to define forgiveness, what forgiveness models might be useful, and how these models might be applied to different populations (Konstam et al, 2002).

Moffet (2005) writes about the clinical disagreement between psychotherapists who advocate forgiveness and psychotherapists who advocate a spiritually neutral stance with their clients. She suggests that that clinical exploration of the issue of forgiveness is shaped by pro-forgiveness advocates when others decline to study this topic (Moffet, 2005).

As psychotherapists, many of us will work with clients, both male and female, who have experienced sexual trauma. However, gender does play a significant role in any discussion of this issue. Sexual abuse victims are predominantly female and transgressors are predominantly male. Studies show that 20-25% of women will be

subject to sexual abuse or rape over the course of their lifetime and one third of women will deal with a form of battering by a husband or partner. 90-95% of perpetrators are male (Lamb, 2006). Forgiveness advocates have both noted rape and incest as possibly unforgiveable offenses and used these offenses as case examples of when forgiveness might benefit a client (Lamb, 2006).

I began to wonder how I might support a client who asks about forgiving the perpetrator of her sexual abuse. Because sexual trauma survivors are a particularly vulnerable population, I questioned whether it would ever be appropriate to encourage forgiveness for these clients. If there are appropriate circumstances, what are they? It seems especially problematic to consider forgiving within the context of intentional interpersonal trauma. Is it ever appropriate to forgive a perpetrator who harmed another by an act of sexual assault or abuse? Should I only discuss forgiveness with a client who brings up the topic herself?

As a social worker being trained at an institution with a psychodynamic focus, I began to consider what the theoretical basis of forgiveness interventions might be and how these theories might intersect with trauma-informed treatment. I did not want to ignore the possibility of discussing forgiveness with a survivor of sexual trauma if there was a possible mental health benefit, nor did I want to advocate forgiveness with a survivor if that would be potentially harmful. In order to decide whether to consider encouraging forgiveness as a therapeutic intervention when working with those who had experienced sexual abuse, I wanted to know how to assess the risks and benefits within a theoretical framework. Thus, this thesis attempts to answer the question: What is the

theoretical basis for understanding the possible therapeutic value of encouraging a sexual assault survivor to forgive her transgressor?

The next chapter, Chapter II, provides further introduction to the conceptualization and methodology of this study. I also define key terms including sexual trauma, forgiveness, and cognitive behavioral and object relations perspectives. Chapter III provides the history of the treatment of sexual trauma, a brief overview of the diagnoses associated with trauma, and current trauma treatment practices today. Chapters IV and V provide an in-depth review of the literature on how sexual trauma is conceptualized and treated from cognitive behavioral and object relations perspectives and how forgiveness is understood and being implemented within both of these frameworks. Chapter VI summarizes the study, discussing and analyzing the findings, seeking areas of synthesis and possible integration, providing suggestions for clinicians, and exploring directions for further research on this topic.

CHAPTER II

METHODOLOGY

Within this chapter I provide a conceptual framework for the theoretical study to follow. I then provide a definition of terms I will use in this study. I conclude by identifying potential methodological biases and considering both the strengths and limitations of this study.

Conceptualization

The purpose of this theoretical study, as discussed in the introduction, is to answer the question: what is the theoretical basis for understanding the possible therapeutic value of encouraging a sexual assault survivor to forgive her transgressor? In an effort to answer this question, I will review the relevant literature on the treatment of sexual trauma from both cognitive behavioral perspectives and object relations perspectives, focusing on understanding the psychological function of forgiveness within these frameworks. I am considering cognitive behavior theory because several proponents of forgiveness interventions are cognitive-behaviorally based. Since interpersonal trauma damages relationships and forgiveness may offer an avenue for the repair of relationships, I also consider object relations theory.

This study is conceptualized as an exploration, geared toward psychodynamically trained therapists and graduate students. The purpose of the study is to examine the use of forgiveness interventions in treating sexual assault survivors in an effort to determine when and how to address this topic in ways that best meet the needs of the client.

Trauma survivors are a particularly vulnerable population and forgiveness is often an emotionally loaded concept, so it is critical for therapists to have a clear understanding of both the potential benefits and risks of discussing the topic of forgiveness.

Definition of Terms

Sexual Trauma

Kathryn Basham (2008) offers a definition of trauma which she believes is useful to clinicians: “an emotional state of discomfort and stress resulting from memories of an extraordinary, catastrophic experience that shatters the survivor’s sense of invulnerability to harm, rendering him acutely vulnerable to stressors” (Figley 1988/1995 in Basham 2001, p.415).

In the DSM-IV-TR (American Psychological Association, 2000), trauma is defined within the context of post traumatic stress disorder. One criteria of traumatic stress is exposure to a traumatic stressor. A traumatic stressor is one in which an individual directly experiences an event involving actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnesses an event that involves death, injury, or the threat of the physical integrity of another person, or learns about the unexpected or violent death, serious harm, or threat of death or injury suffered by a family member or intimate associate. A second criteria determining whether an individual experienced trauma is that her response to this event involved helplessness, intense fear, or horror. Sexual assault is listed as a traumatic event. For a child, a developmentally inappropriate sexual experience, even without the threat of violence or injury, is classified as sexually traumatic (pp. 463-464).

Allen (2001) notes that interpersonal trauma is an intentional threat or injury that occurs within the context of an interpersonal contact. For this reason, the character of the relationship is a critical aspect of the trauma. Sexual trauma is a subset of interpersonal trauma. For the purpose of this study, sexual trauma will include rape, some instances of sexual harassment when a survivor has experienced a threat to her physical or psychological integrity, and childhood experience of developmentally inappropriate sexual experiences (pp. 13-15). The intentionality of interpersonal trauma adds a moral dimension to the experience which may complicate the consideration of forgiving a transgressor.

As with many mental health issues, the language used to describe those who seek treatment can be damaging. This study focuses on the treatment of those who have experienced sexual trauma. Although this phrase is cumbersome, it is important to note that these individuals should not be defined by one or more traumatic events they have endured. For the purpose of this study I will refer to individuals who have experienced sexual trauma as clients or survivors. My intention in choosing survivor instead of victim is to emphasize the aspect of hope inherent in the treatment process.

Cognitive Behavioral Therapy

Cognitive behavioral therapy is a frequently used and commonly accepted modality for the treatment of trauma (Rothbaum and Foa, 1996; van der Kolk, McFarlane & van der Hart, 1996; Foa & Rothbaum, 1998). Relevant to this study, Lamb (2002a) writes that many forgiveness models are based on cognitive behavioral therapy. According to Wright, Basco, and Thase (2006), cognitive behavioral therapy is an approach which is based on two underlying principles. The first principle is that an

individual's thoughts control his emotions and his behavior. The second principle is that an individual's behavior has a significant impact on his thought patterns (p. 1). Cognitive behavioral therapy focuses on current thought patterns and behavioral reactions to daily circumstances. Typical interventions include cognitive restructuring and behavioral modification.

Object Relations Psychotherapy

In contrast, psychodynamic therapy, of which object relations psychotherapy is a subset, focuses on the client's intrapsychic experience. Psychodynamic theory focuses on "inner energies that motivate, dominate, and control...behavior" and examines the source of these energies in both developmental history and present experience (Berzoff, Flanagan, and Hertz, 2001, p. 4.) Flanagan (2001) writes that object relations theory refers to the work of a group of psychodynamic scholars in Britain and the United States. Object relations theory focuses on the complex relationship of self to other and examines the process through which individuals develop the capacity to see themselves as separate and independent from others while still needing to be strongly attached to others (Flanagan, 2001). According to object relations theory, each person has an internal, often unconscious, experience of relationships which differs from her external interactions with others and is more compelling and powerful (Flanagan, 2001). Object relations psychotherapists use this theory as a basis of their work with their clients. I have chosen an object relations lens to examine the treatment of trauma and the understanding of forgiveness because of the centrality of relationships in both experiences: trauma as rupture, forgiveness as one potential avenue for repair.

Forgiveness

Affinito (2002) writes that forgiveness is “the decision to forgo the personal pursuit of punishment for the perpetrator(s) of a perceived injustice, taking action on that decision, and experiencing the emotional relief that follows” (p.93). This is the operational definition that I have chosen to use in this study. It is important to recognize that, using this definition, the therapist must have a clear understanding of the ways in which the survivor makes meaning of the traumatic event, the perceived injustice. It is equally important to recognize that no matter what definition of forgiveness the clinician chooses, the survivor will come into therapy with a pre-existing understanding of this concept of her own, based on her lived experience. With this in mind, I will use the above definition in discussions of encouraging the forgiving of a transgressor of sexual trauma. However, I will continually call attention to the necessity of the therapist and the survivor developing a mutual understanding of the concept of forgiveness within a survivor-specific context.

Methodology

This theoretical thesis contains six chapters. In the first chapter, the introduction, I have described the purpose of the study and my motivation in choosing to do this research. In this, the second chapter, I describe how the study is conceptualized, define significant terms used in the study, and outline the methodology employed.

The third chapter explains the phenomenon to be studied, sexual trauma and its treatment, focusing on seminal works on the topic by Herman (1997), van der Kolk (1996), and Allen (2001). I go on to include research on current practices. I also consider moral issues related to interpersonal trauma because these moral issues may impact a

client's understanding of forgiveness and must be taken into account when considering the encouragement of a client to forgive a transgressor. Finally, in examining this literature on treatment of sexual trauma, I attempt to identify the use, if any, of forgiveness interventions.

In the fourth chapter I review literature on cognitive behavioral perspectives on the treatment of sexual trauma in an attempt to understand and describe the possible therapeutic value of encouraging a sexual assault survivor to her transgressor through this lens. According to Lamb (2002), the basis of many forgiveness models has its roots in cognitive behavioral methods. In addition, there is much being currently written about the use of cognitive behavioral therapy to treat trauma (van der Kolk, McFarlane & van der Hart, 1996; Foa & Rothbaum, 1998; Kubany & Watson, 2002; Cohen & Mannarino, 2008a; Ehlers, Clark, Hackmann, McManus & Fennell 2005). I examine research on the current cognitive behavioral models of treatment of sexual trauma and specifically explore the use of forgiveness interventions from this perspective.

In the fifth chapter I review literature on healing sexual trauma using object relations psychotherapy in an effort to develop a theoretical understanding of the possible therapeutic value of encouraging a survivor of sexual trauma to forgive from this perspective. I will consider the theories of Klein, Fairbairn, Winnicott, and Mahler. I will examine these theorists' understanding of the concepts of empathy, compassion, and interpersonal transgression in an attempt to understand forgiveness within this framework. I will also examine the underlying concepts of object relations theory and how they are used in clinical practice and how and whether the encouragement of

forgiveness coincides with these principles. I will accomplish this through the examination of current treatment models and their interventions.

To narrow the field of literature and keep this study relevant to the social work audience for which it is intended, the review in these three chapters will be conducted through reading literature written primarily by members of the professional social work and psychoanalytical communities. I will not consider literature on philosophical or religious views of forgiveness except as reflected in psychological journals and books. In addition, because the focus of this study is the therapeutic value of forgiveness interventions, I do not plan to review literature on restorative justice and victim offender mediation.

Finally, the sixth chapter of this study provides a discussion and summary of these cognitive behavioral and object relations theoretical approaches to the treatment of sexual trauma and their conceptualizations of encouraging a client to forgive the perpetrator of sexual trauma in the course of therapy. Through each lens, I will examine the role of the therapist with particular attention to understandings of the value of being directive versus non-directive, and recommendations on when in the therapeutic process to adopt each approach. I will consider the possible risks and benefits of encouraging forgiveness, from each perspective, during particular phases of the trauma treatment. Keeping in mind that clients with trauma histories may have developed different symptoms, I will explore the specific vulnerabilities associated with various diagnoses. In an attempt to offer guidance to new social workers on the use of forgiveness interventions, I conclude with recommendations.

Study Biases and Limitations

Due to time constraints, this study will be limited to the consideration of cognitive behavioral and object relations theories and will not consider self psychology or relational theories. Although contrasting the theoretical frameworks of cognitive behavioral therapy and objects relations psychotherapy, I will not consider research on the efficacy of these approaches. Although group therapy has been shown to be an effective mode of treatment for traumatized persons, particularly in the area of increasing interpersonal efficacy (Herman, 1997; Foa & Rothbaum, 1998; van der Kolk, McFarlane, & van der Hart, 1996), I have chosen to explore only individual psychotherapy.

I will not be examining literature on pastoral counseling or philosophical views of forgiveness. In the treatment of sexual trauma, I will mention the perspective of feminist theories when they arise in the literature, but will not give them thorough consideration.

As a practicing Christian, I believe in the power and value of forgiveness in my personal life. Being trained at an institution with a strong psychodynamic focus, I am concerned about using a directive approach, particularly when there is a danger that my values and beliefs may influence the decisions of my client. I have informed my advisor of my biases and have checked in with her, additional mentors, and peers while conducting this study.

Conclusion

Within this chapter, I have outlined my approach to this theoretical study. This has included describing how the study is conceptualized, a definition of terms, and a discussion of biases and study limitations. In the following chapter, Chapter III, I address the phenomenon of the treatment of sexual trauma.

CHAPTER III

THE TREATMENT OF SEXUAL TRAUMA

Within this chapter I explain the phenomenon of the treatment of sexual trauma, beginning with the history of the treatment of trauma and continuing on to examine issues of oppression and vulnerability, diagnosing post-trauma symptoms, the concept of personality disorder and relationship concerns for trauma survivors, and recommendations for treatment.

History of the Treatment of Trauma Survivors

Humans have been aware of the connection between overwhelming fear and the resulting intrusive memories, arousal, and avoidance since the time of Homer (van der Kolk, Weisaeth, & van der Hart 1996). Mental health professions, however, have struggled with the concept that individuals' biology and psychology can be permanently impacted by life events (van der Kolk, Weisaeth, & van der Hart 1996). In a history that reflects trauma survivors' experiences of intrusive symptoms, disorientation, and disbelief, mental health professionals have alternated between periods of intense focus and deep skepticism of the anecdotes of trauma survivors (van der Kolk, Weisaeth, & van der Hart, 1996). The question throughout history has been whether posttraumatic symptoms are the result of moral weakness or the result of the human body being incapacitated by an overwhelming experience (van der Kolk, Weisaeth, & van der Hart, 1996).

The history of trauma treatment began 150 years ago when French physician Briquet first attributed “hysterical” symptoms to childhood trauma histories (van der Kolk, Weisaeth, & van der Hart, 1996). Charcot also worked with “hysterics”. By 1880, he had determined that hysterical symptoms were psychological in origin and could be both induced and relieved through hypnosis (van der Kolk, Weisaeth, & van der Hart, 1996; Herman, 1997). When Babinski later took over as chief of Salpêtrière, he rejected Charcot’s ideas about the etiology of hysteria. Instead, he proposed that “simulation” and suggestibility were determining characteristics of the disease (van der Kolk, Weisaeth, & van der Hart, 1996). In an historical foreshadowing of what would happen time and again over the next century, trauma survivors’ experiences were invalidated for the first time (van der Kolk, Weisaeth, & van der Hart, 1996).

Freud, Breuer, and Janet were all followers of Charcot’s. Freud with Breuer, and Janet independently, determined that hysterical somatic symptoms were a manifestation of intensely upsetting events that were not stored in conscious memory. They developed their own theories of the etiology of hysteria and found that uncovering difficult memories, and the intense associated feelings with them, led to a relief of symptoms. Uncovering these memories led Freud and Janet to explore the sexual lives of women (Herman, 1997).

In his work “The Aetiology of Hysteria” (Freud, 1896 in Herman, 1997), Freud attributed hysterical symptoms to the experience of a premature childhood sexual encounter with an adult. This hypothesis is echoed in the DSM-IV criteria for Posttraumatic Stress Disorder (PTSD; American Psychological Association, 1994). After Freud’s work was published, however, he became increasingly concerned about the

social implications of his premise. His reaction was shaped by the social and political climate of Victorian Western Europe (Herman, 1997). Due to Freud's misgivings, he recanted his view and proposed that symptoms could be explained as repressed fantasy (van der Kolk, Weisaeth, & van der Hart, 1996; Herman, 1997). As a result, the predominant psychological theory for almost a century was based on the denial of the experience of women (Herman, 1997).

In the early twentieth century, after World War I, psychiatrists began treating hysteria in war veterans. During World War I, and the decades that followed, given Babinski's hypothesis that "simulation" was the cause of veterans' symptoms, war neurosis was reformulated as a disease of the will, a failure of willpower (van der Kolk, Weisaeth, & van der Hart, 1996). Those who developed symptoms were considered to have inferior constitutions, to lack motivation, and to be cowards. Some physicians believed that the soldiers' symptoms were the result of a psychiatric condition (Herman, 1997). Bonhoeffer, a German physician, corroborated this premise. He concluded that nearly all of his patients suffering from posttraumatic stress were genetically predisposed and inherently weak. "War neurosis" became linked with attempts to receive undeserved insurance compensation, and this compensation was eventually denied to sufferers (van der Kolk, Weisaeth, & van der Hart, 1996). Psychodynamic therapists have often failed to distinguish reason and reality, contending that all irrationality exists in the client's internal world (Boulanger, 2007).

Around WWII, psychiatrists began to use the term "battle fatigue" (Herman, 1997; Basham, 2008). Kardiner published "The Traumatic Neuroses of War" in 1941, in which he presented a formulation of trauma similar to Janet's (van der Kolk, Weisaeth, &

van der Hart, 1996; Herman, 1997). Kardiner also kept meticulous notes on diagnoses war veterans had received before the trauma diagnosis. These included hysteria, malingering, and epileptiform disorders (van der Kolk, Weisaeth, & van der Hart, 1996). Traumatic symptoms were also being reported in Holocaust survivors (Basham, 2008). The therapeutic value of social connection was the basis of informal rap groups veterans participated in during the Viet Nam War (Herman, 1997). After working with Holocaust survivors and male and female Viet Nam War veterans, mental health practitioners began to acknowledge the existence of a distinctive psychological syndrome, PTSD (Basham, 2008).

The sociopolitical climate created by the feminist movement in the 1970's created a new impetus for examining the experiences of women. Psychotherapists recognized that post-traumatic symptoms were more prevalent among civilian women than male veterans (Herman, 1997). The feminist revolution also led to increased advocacy and protection for survivors of domestic violence, rape, and child abuse (Herman, 1997; Basham, 2008). A center for research on rape was established at the National Institute for Mental health in 1973. Rape began to be viewed as the subordination of women through the use of terror, a crime of violence instead of a sexual act. Society began to recognize that rape is often used as a means of political control (Herman, 1997).

“Rape trauma syndrome” was first identified by mental health professionals in Boston in 1972 (van der Kolk, Weisaeth, & van der Hart, 1996; Herman, 1997). They bore witness to the fact that women experience rape as life threatening event, one in which mutilation or death are feared. Psychotherapists also began to recognize the commonalities between hysteria in women and combat neurosis in men (Herman, 1997).

PTSD was included in the DSM-III in 1980 (American Psychological Association, 1980 in Basham, 2008). Historically, as sexual assault survivors began to be diagnosed with PTSD, their feelings of shame, humiliation, and anger began to be viewed as less significant than the PTSD symptoms of helplessness, fear, and numbness (Lamb, 2006).

Issues of Oppression and Vulnerability

Over the past 150 years, treatment of trauma has often involved invalidation of the experiences of survivors. Often, victims are blamed for having become victims (Basham, 2008). It is to the perpetrator's advantage to promote a survivor's forgetting. The level of power a perpetrator has corresponds directly to his ability to control survivor's perception of reality (Herman, 1997). A recent example of this is the false memory movement that came about in the early 1990's started by individuals accused of sexually abusing their now adult children decades earlier. The claim was made that therapists were helping their clients create falsely recovered "pseudo-memories" (Gedney, 1995).

Sexual assault is now recognized as a crime of power. The key component of rape is the violation of an individual physically, psychologically, and morally (Herman, 1997). The purpose of rape is to dominate, terrorize, and humiliate the victim which intentionally generates psychological trauma (Herman, 1997). The reactions of those close to the survivor may compound her violation. "Many acts that women view as terrorizing violations may not be regarded as such, even by those closest to them" (Herman, 1997, p. 67). In this way, women are not only violated, but also stripped of their reputation (Herman, 1997).

I am concerned that encouraging the survivor of sexual assault to forgive her perpetrator without fully considering the meaning the survivor associates with the event and its aftermath, as well as the meaning she associates with forgiveness, may be yet another way in which the survivor's experience is invalidated. This study is an attempt to prevent that from occurring.

The Posttraumatic Experience

The Experience of Trauma

Typically, when the body responds to danger, adrenalin creates a higher state of alert which includes the ability to acutely focus on the current situation, the ability to ignore physical sensations of hunger, fatigue, and pain, and intense feelings of fear and anger are produced. This set of adaptive reactions, known as the fight or flight response, stimulates changes in arousal, attention, perception, and emotion. A traumatic reaction occurs when neither escape nor resistance is possible and the body's self-defenses are overwhelmed and her systems become disorganized (Herman, 1997). During a traumatic event, cognition, memory, sensory perception, and emotion are fragmented. These functions which are normally integrated to form a cohesive narrative of an incident are unable to work together (Herman, 1997). An individual's sense of continuity is affected by trauma on two levels. Initially, while experiencing overwhelming anxiety, her body rhythms are disrupted by a surge of cortisol and time seems to stand still. Later, after the event, because the memory has not been integrated, time continues to stand still (Boulanger, 2007).

After the Traumatic Event

Herman writes that the central dialectic of the experience of psychological trauma is the conflict between the determination to deny the horrible event that occurred and the determination to make known that the event did occur (Herman, 1997). The lack of the sense of a future is common post-trauma. The fundamental experience of being traumatized is one of resignation and the acceptance of the inevitability of death and destruction (Krystal, 1968/1978/1988 in van der Kolk, Weisaeth, & van der Hart, 1996). This hopelessness is echoed in Kardiner's description of the posttraumatic experience as "the Sisyphus dream", the sense that every attempted or anticipated activity is futile (van der Kolk, Weisaeth, & van der Hart., 1996). As a trauma survivor begins to make meaning of the event, feelings of profound loss and anger often emerge (van der Kolk & McFarlane, 1996).

Posttraumatic Symptoms

According to van der Kolk and McFarlane (1996), posttraumatic symptoms can be broken into six categories: intrusions, repetitive re-exposure, constriction, dysregulation, attention issues, and changes in defenses and self-concept (van der Kolk & McFarlane, 1996). Charcot characterized memories of traumatic events as "parasites of the mind" (Charcot, 1887 in van der Kolk & McFarlane, 1996, p. 9). These memories, or intrusions, consist of intense feelings and bodily sensations and can occur during aroused states or when exposed to triggers (van der Kolk & McFarlane, 1996). The traumatic event is experienced as if it is occurring in the present. Intrusions can manifest as nightmares, flashbacks, panic or rage, somatic impressions, or reactions to others. Longer

term, intrusions may become evident in personality types or persistent life themes (van der Kolk & McFarlane, 1996).

An intrusive memory typically consists of sensory elements but lacks concrete details which would create a chronological, contextually oriented account. If another traumatic event occurs, it may evoke a cascade of earlier recollections (van der Kolk & McFarlane, 1996). Over time, specific triggers become generalized and attention to these triggers crowds out the ability to pay attention to unrelated stimuli. This compounds the sense that the traumatic event is of utmost importance (van der Kolk & McFarlane, 1996). Survivors experience their world as a dangerous place, full of thoughts and feelings related to trauma. As a result, they spend energy avoiding thinking about their present reality and planning for the future, and their connection to the past increases further (van der Kolk & McFarlane, 1996).

A survivor's compulsion to reenact the trauma leads to additional suffering for her and those with whom she interacts regularly. This repetitive re-exposure can take several forms: aggression toward others, self-harm, or further victimization (van der Kolk & McFarlane, 1996).

Survivors begin to organize their lives in ways that allow them to avoid reliving traumatic events and the accompanying emotions. This avoidance may become apparent in a variety of ways which may include literal avoidance of situations (van der Kolk & McFarlane, 1996). Emotional numbing exacerbates avoidance. Substance abuse, eating disorders, and self-harm are short-term, desperate efforts to seek emotional numbing and reduce distress. While these adaptive actions may stop intolerable feelings temporarily,

eventually these behaviors trigger the exact emotions the survivor was intending to numb (Allen, 2001).

Although numbing and avoidance are often grouped together as symptoms, they are distinct responses (van der Kolk & McFarlane, 1996). Feeling nothing is preferable to continually feeling irritable and angry. As a result, survivors gradually withdraw from activities and become detached from others. Withdrawal and detachment involve both physical and psychological changes (van der Kolk & McFarlane, 1996). Increased sensitivity to trauma-related stimuli may lead to central nervous system changes as well as adaptations of behavior (van der Kolk & McFarlane, 1996).

Dysregulation occurs when a human body reacts to environmental stimuli as if there is a present threat of death. This may become evident as hypervigilance, inappropriate startle response, or agitation. This state also involves a major physiological response (van der Kolk & McFarlane, 1996). Survivors go immediately from stimulus to response without recognizing what is happening. They may have an intense emotional reaction to a minor stimulus. They may either react aggressively or become immobilized. Again, it is important to note that this reaction involves both biological and psychological responses (van der Kolk & McFarlane, 1996).

As a consequence of dysregulation, a survivor becomes unable to articulate feelings and unable to make reasoned, independent decisions (van der Kolk & McFarlane, 1996). Due to the generalization of a sense of threat, the world begins to feel like an unsafe place. However, due to the breakdown of the mind-body system, a survivor does not heed physical warning signals and is exposed to further danger. At the same

time, normal physical reactions take on greater significance and the survivor loses trust in her body's reactions (van der Kolk & McFarlane, 1996).

Trauma survivors characteristically suffer from attention issues. Because their lives become organized around not feeling and they do not plan possible responses to future triggers, they struggle to determine which incoming stimuli are relevant to their current experience and warrant a response. This makes it difficult to take in new experiences and acquire new information (van der Kolk & McFarlane, 1996).

A survivor is also forced to deal with changes in her defense mechanisms and self-concept. Her identity and worldview must be rebuilt in light of the experience of trauma. One adaptive defense mechanism is a survivor's propensity to blame herself for what happened. The assumption of personal responsibility is preferable to feelings of vulnerability and helplessness (van der Kolk & McFarlane, 1996). In assessing her conduct, someone who has experienced trauma struggles to find a balance between unrealistic guilt and denial of all moral responsibility (Herman, 1997). The issue of shame is crucial to understanding dysregulation. Shame arises from a sense of having let herself down. Yet, denial of shame makes a survivor more vulnerable to future abuse (van der Kolk & McFarlane, 1996).

Trauma Diagnoses

Post-trauma Disorders

Developing PTSD is only one of several possible outcomes after experiencing trauma. The current organization of the DSM by discrete diagnoses discourages curiosity about how symptoms are interrelated and how biological and physical processes interact (van der Kolk & McFarlane, 1996). A combination of internal and external factors may

impact whether a trauma survivor presents with classic PTSD symptoms. She may have adapted to her post-traumatic state in such a way that she does not experience PTSD symptoms. In addition, both unresolved grief and influences of a non-Western culture may have changed the symptom picture (Lindy & Wilson, 2001).

There are a range of psychiatric disorders which frequently co-occur with PTSD, including mood disorders, dissociative disorders, panic disorder, substance abuse and personality disorders (van der Kolk & McFarlane, 1996). In addition to PTSD, these psychiatric disorders may arise as a result of exposure to traumatic events (McFarlane, 2001). When the disorders are not comorbid with PTSD, they may be interwoven with PTSD (McFarlane, 2001).

No matter what presenting problem causes a client to seek treatment, it is important to discern whether she has any trauma history, particularly when considering encouraging a client to forgive.

Personality Disorderedness

Allen (2001) proposes that individuals who have suffered interpersonal trauma, particularly in attachment relationships, often develop chronic difficulties in interpersonal relationships. All of the symptoms of personality disorders that develop can be related to the trauma and early attachment can be discussed as “personality disorderedness” instead of trying to diagnose specific personality disorders (Allen, 2001, p. 263). Many of the characteristics of different personality disorders overlap and it is most helpful to look at common characteristics with respect to interpersonal relationships (Allen, 2001). In treating “personality disorderedness”, a therapist must use a theoretically coherent approach, be consistent over time, and focus on interpersonal relationships (Allen, 2001).

Traumatic events have a major effect on relational life due to the impact on the psychological structures of the self, as well as meaning systems associated with attachment to others (Herman, 1997). A survivor's capacity for intimacy is compromised by her intense and contradictory feelings of need for intimacy and fear of intimacy. Survivors both desperately seek relationships and withdraw from them due to lack of trust and feelings of guilt, shame, and inferiority (Herman, 1997). Clients with borderline personality disorder and somatization disorder often have trauma histories. They also have characteristic difficulties with intimacy because they fear both abandonment and domination (Herman, 1997).

Current Treatment Practices

For the purpose of this study, I will not consider the acute phase of treatment which occurs immediately following a traumatic event.

Trauma Assessment

van der Kolk, McFarlane, and van der Hart, (1996) write that an individual's response to a traumatic event is what characterizes PTSD, not the event itself. As discussed above, the survivor begins organizing her daily life in an attempt to avoid intrusive memories, feelings of helplessness, and physiological hyperarousal. This impacts her ability to deal with stress, her concept of herself, and her sense of her ability to manage her external circumstances (van der Kolk, McFarlane, & van der Hart, 1996). In assessing a client's symptoms, it is vital to assess her experiencing of intrusive memories, her level of physiological hyperarousal, including her ability to trust her physical reactions, and her ability to experience satisfaction or pleasure. It is also important to gauge her ability to imagine a future, her attention and concentration, which

may mimic Attention Deficit Disorder, as well as memory issues and any experience of dissociation. Finally, it is essential to assess the existence or level of self-harm, aggression toward others, and somatization (van der Kolk, McFarlane, & van der Hart, 1996).

A thorough biopsychosocial assessment of a trauma survivor will involve a detailed history of the traumatic event, including the nature of the event, the client's role in and response to the event, her thoughts and feelings about her role and response, and any previous traumatic experiences. The therapist must assess the client's typical coping strategies, her cognitive functioning, and her cultural and religious belief systems (van der Kolk, McFarlane, & van der Hart, 1996).

Overall Treatment Goals

In working with trauma survivors, clinicians must attempt to shift a client's focus from reminders of the past to engagement with the present, which may include addressing the capacity to respond to daily circumstances. The therapist should strive to help the client regain control of her emotional responses and put the traumatic event in the greater context of her life. It is critical that the event and the survivor's response to it be integrated into her self-concept (van der Kolk, McFarlane, & van der Hart, 1996).

There are two fundamental aspects of a survivor's post-trauma condition which must be addressed in therapy: undoing her conditioned anxiety response and changing her self-concept and worldview. The self-concept and worldview can be transformed through rebuilding a sense of control and integrity and working to establish meaningful, mutually satisfying relationships (van der Kolk, McFarlane, & van der Hart, 1996).

van der Kolk, McFarlane, & van der Hart (1996) write about the survivor's need to "overcome fear of life itself" and note that therapy must address the cognitive schemes which have been shaped by the trauma (van der Kolk, McFarlane, & van der Hart, 1996, p. 431). This overarching theme of fear may include a fear of confronting her shame and vulnerability, her fear of the memories of the traumatic events, and her fear of re-engaging fully in life (van der Kolk & McFarlane, 1996). Human beings organize their understanding of the world based on an individual model of reality, which has been constructed through the unconscious integration of lived experience. Traumatic experiences are processed through this internal framework which includes latent self-concepts and views of relationships (van der Kolk, McFarlane, & van der Hart, 1996). As a result, effective treatment must take on a client's sense of control and mastery, her ability to trust and allow intimacy, her capacity for self-care, and her capacity for empathy for others (van der Kolk, McFarlane, & van der Hart, 1996).

If a therapist focuses solely on the phenomena of intrusion, numbing and arousal, she may pay less attention to the adaptive changes in the survivor's behavior that have occurred as a result of the trauma. Appropriate treatment must take both into consideration (van der Kolk & McFarlane, 1996). The client may be experiencing problems in the areas of hyperarousal, attention, and relationships. Effective treatment in one area will likely positively impact functioning in all areas (van der Kolk & McFarlane, 1996).

A successful clinician will assist her client in the process of making the intolerable tolerable. Work toward increasing her capacity for managing her feelings must occur within a stable treatment structure, which acts as a container for the client.

This container provides an environment in which she can practice self-regulation and secure attachment. Creating a coherent trauma narrative both requires and further promotes containment (Allen, 2001; van der Kolk & McFarlane, 1996). It is vital that the treatment process focus on the meaning of the traumatic event to the survivor (van der Kolk & McFarlane, 1996). Most importantly, empowerment is the key to recovery. Therapy must be based on validating the survivor's experience and supporting her efforts to control her behavior, not controlling the client herself (Herman, 1997).

Phases of Treatment

According to Herman (1997) trauma recovery in three-stages, during which progress is unpredictable, and often involves working through contradictions. The first stage of recovery is focused on establishing safety and moving from a pervasive sense of unpredictable danger to one of consistent safety. The second stage concentrates on the process of remembrance and mourning and helps the client progress from an understanding of the traumatic event as a dissociated impression to an integrated memory. The third stage centers on reconnection to oneself and others and involves moving from isolation and stigmatization to connection with a reconstructed social network (Herman, 1997).

van der Kolk, McFarlane, & van der Hart (1996) echo and expand on these stages. The first stage, stabilization, involves psycho-education about the experience of trauma and accessing and identifying emotions. They break remembrance and mourning into two phases: undoing conditioning to traumatic memories and responses and restructuring of trauma-based cognitive frameworks. Reconnecting to oneself and others follows. Finally, the authors recommend seeking opportunities for reparative emotional

experiences (van der Kolk, McFarlane, & van der Hart, 1996). Activities in this final phase might include a self-defense course, or a wilderness experience or finding a personal mission (Herman 1997).

Establishing Safety

The first step in establishing safety involves naming the client's set of problems through assessment and diagnosis. The therapist must then help the survivor attempt to restore some sense of control. A key component of this process is creating a safe treatment environment and evaluating the survivor's living situation (Herman, 1997). The most common therapeutic error in treating trauma survivors is avoiding the traumatic material. The second most common error is neglecting to establish safety through a secure therapeutic alliance before approaching this material (Herman, 1997). Creating safety for the client outside the office can be particularly complicated when she is still in a relationship with someone who has abused her in the past (Herman, 1997).

Establishing safety may also involve assessing for the existence of self-harming behaviors including substance abuse, eating disorders, self-mutilation, and chronic suicidality. The therapist must help the survivor develop self-soothing skills, particularly survivors of chronic childhood abuse (Herman, 1997). For survivors of sexual trauma, although filing criminal charges is a way of pursuing compensation, the legal process may cause the return of post-traumatic symptoms. Clients need to make an informed choice based on awareness of all risks and benefits (Herman, 1997).

Intentionally not doing harm is critical throughout treatment and also an important factor in determining when to terminate treatment (Lindy & Wilson, 2001). The clinician needs to balance the maintenance of a safe, consistent environment, which might be

sacrificed by early termination, with the sense that treatment should continue indefinitely. Reluctance to terminate may be based on positive attachment countertransference (Lindy & Wilson, 2001).

Throughout treatment, the therapist must always be wary of piercing the survivor's newly formed, gradually thickening protective trauma membrane. She must seek to understand how and why this barrier was created (Lindy & Wilson, 2001). This entails understanding how a survivor's current defenses are enabling her to manage the memory of the trauma. The therapist must develop empathy for the client's current struggle (Lindy & Wilson, 2001). It is crucial to establish trust and respect the survivor's tolerance for affect. The therapist must be careful to follow the survivor's lead in disclosing traumatic content (Lindy & Wilson, 2001). Determination of the pacing of treatment and the timing of disclosures needs to be reached collaboratively, through frequent, open discussions (Herman, 1997).

Reconstructing the Trauma Narrative

Reconstructing the trauma narrative involves both creating a contextual memory of the event and mourning the losses associated with the traumatic experience. The construction process involves integrating the traumatic experience into the survivor's story by moving from a pre-narrative, devoid of feelings and interpretations of the event, to a complete account with physical details, emotions, and evaluation (Herman, 1997). Throughout, the therapist acts as both witness and ally. Reconstructing this story should begin with the survivor's hopes, dreams and relationships (Herman, 1997) as well as her coping skills (van der Kolk, McFarlane, & van der Hart, 1996) before the traumatic event.

Together, the therapist and the survivor create an organized, detailed account that is oriented in both time and the historical context of the survivor's life (Herman 1997, van der Kolk, McFarlane, & van der Hart, 1996). This new story includes both an account of the event and the responses of the survivor and those close to her (Herman, 1997; van der Kolk, McFarlane, & van der Hart, 1996). In addition, the constructed narrative must contain sensory input - what the survivor was seeing, hearing, and smelling at the time (Herman, 1997; van der Kolk, McFarlane, & van der Hart, 1996). Finally, the created story must include an account of what the survivor was thinking and feeling and the physical responses of her body (Herman, 1997; van der Kolk, McFarlane, & van der Hart, 1996). At times, the survivor may spontaneously choose to paint or draw as a means of nonverbal communication (Herman, 1997). The ultimate goal of this process is to integrate all components of the experience into a verbal narrative (Herman 1997; van der Kolk, McFarlane, & van der Hart, 1996).

Memory and dissociation are central issues in the process of constructing the trauma story. The residual memory fragments which have been stored somatically must be discovered and translated into words (van der Kolk, McFarlane, & van der Hart, 1996). When experiencing extreme emotions, such as terror, memories are encoded implicitly, and may be acted out subsequently without being understood (Allen, 2001).

Traumatic memories must be reconstructed integrating both context and meaning (van der Kolk & McFarlane, 1996; Herman, 1997). It is crucial to explore beliefs, assumptions, and values that were destroyed by this experience and acknowledge the inadequacy of belief systems in explaining it (Herman; 1997). The therapist acts as an objective, caring witness while the client comes to terms with the dialectic that denial of

the story makes her feels crazy, but accepting it seems too much too bear (Herman, 1997). The therapist must not make any assumptions about the factual circumstances of the trauma or the meaning of the trauma to the survivor and must be able to tolerate uncertainty both in herself and her client (Herman, 1997). In the end, the survivor must transform her story from one of shame and humiliation to one about virtue and dignity and, at the same time, construct a new belief system which allows her to understand and make sense of her undeserved suffering (Herman, 1997).

Trauma inevitably involves loss. Psychological structures that support secure attachment to others are damaged, and in the case of sexual trauma, bodily integrity is also damaged (Herman, 1997). While creating the trauma narrative, the survivor often becomes immersed in grief and typical mourning rituals do not help. Although mourning is necessary for recovery, many clients dread it because they are afraid that once they start grieving they will not be able to stop (Herman, 1997). Grieving may also be viewed as conceding the victory to the transgressor, and be a blow to the survivor's pride. It is important to reframe the grieving as an act of courage and educate the client that the mourning process will likely last longer than she wishes, but it will not last forever (Herman, 1997). In telling the story, the trauma will begin to evoke less intense feelings and the event will become only one part, and not the most interesting or important part, of her life story. In this way, the connection to the past will begin to weaken and time will begin to move forward again (Herman, 1997; van der Kolk, McFarlane, & van der Hart, 1996).

The survivor may have several possible losses to mourn: the loss of her childhood, the loss of basic trust, loss of the belief that a parent is good, and loss of the

capacity for love (Herman, 1997). Acknowledgment of any of these losses may lead to deep despair (Herman, 1997). In attempting to understand the therapeutic value of a sexual trauma survivor forgiving her perpetrator, it is important to note that the loss of trust and the loss of the belief in the goodness of another may be important components of the meaning associated with both the traumatic event and forgiveness.

According to Herman (1997), resistance to mourning can lead to an impasse in the recovery process and this resistance may be “disguised” as a “fantasy of forgiveness” (Herman 1997, pp. 189-190). She views the forgiveness fantasy as an attempt to bypass anger and achieve empowerment. Herman writes that the survivor imagines that she can overcome her rage and undo the impact of the trauma by choosing a bold act of love instead. Because this forgiveness is often unattainable, when it is not attained, the survivor suffers further (Herman, 1997). Herman (1997) notes that in most religions, a perpetrator must seek forgiveness and earn it through repentance and confession and that remorse is rare in a transgressor. She states that after mourning, the survivor can seek a reparative experience in other relationships and does not need to extend this love to the perpetrator. The survivor may feel sorrow, compassion and disengagement but clarifies that this is not the same as forgiveness (Herman, 1997).

Reconnecting with Self and Others

The phase of treatment devoted to reconnecting with self and others focuses on reestablishing connections with social supports and rebuilding interpersonal skills (van der Kolk, McFarlane, & van der Hart, 1996). Now that the survivor has come to terms with her traumatic past, her next task is to develop new beliefs about herself and the

world she lives in and develop new relationships. This will allow her to create a future (Herman, 1997).

In reconnecting with herself, the client should be encouraged to practice self-forgiveness and respect for the victimized self while celebrating the survivor self (Herman, 1997). In devoting energy to self-care, she may rediscover her hopes and ambitions. She may choose to transform fantasy into action (Herman, 1997). The survivor will need to adjust to a calmer, more ordinary life (Herman, 1997; van der Kolk, McFarlane, & van der Hart, 1996).

In reconnecting with others, the survivor needs to develop a capacity for appropriate trust, a greater capacity for self-reflection and a tolerance for ambivalence. This will involve forgiving both the therapist's and her own limitations. She may experience a second adolescence and begin to explore new intimate relationships (Herman, 1997).

Opportunities for Reparative Experiences

During the final phase of reconnection, survivors may choose to engage their fears. By taking a self defense class or participating in a wilderness program, the survivor has an opportunity to rebuild her "action system" and experience normal physiological responses to danger. Through the experience and management of the fight or flight response, she can learn to tolerate fear (Herman, 1997; van der Kolk, McFarlane, & van der Hart, 1996).

In addition to creating a trauma narrative, recovery will be enhanced if the survivor is able embrace a personal mission (Herman, 1997), to find actions which demonstrate control of her emotions and behavior (van der Kolk, McFarlane, & van der

Hart, 1996). This may involve pursuing a “survivor mission” through social justice or a public action (Herman, 1997, p.207). Ideally, this mission will involve an action that symbolizes triumph over helplessness and despair (van der Kolk, McFarlane, & van der Hart, 1996). In the final chapter of this study, I will explore the possibility that forgiveness is related to this phase of recovery.

Termination

When terminating with a trauma survivor, it is important to discuss the reality that trauma is never fully resolved. Future life events may bring up traumatic memories and feelings and symptoms may recur under stress (Herman, 1997). At this time, it is important to review the survivor’s strategies for empowerment and reconnection and to leave the door open for further treatment (Herman, 1997). Termination is appropriate when the survivor has rebuilt a capacity for pleasure and is able to engage in mutual relationships with others (Herman, 1997).

The Treatment Relationship

“Healing the self requires the most ambitious of interpersonal therapies” (Allen, 2001, p.79). When working with a trauma survivor, a therapist is called upon to use her understanding of trauma, as inexplicable as it is, go on to find empathy for the survivor’s experience of depletion, helplessness, and powerlessness, and help her out of that state (Allen, 2001). The foundation of trauma treatment is safety within the therapeutic relationship (van der Kolk, McFarlane, & van der Hart, 1996). In the life of a survivor, the treatment relationship is unique because its only purpose is to promote her recovery (Herman, 1997). However, the implicit power imbalance may bring up childhood

feelings of dependence, accompanied by the inability to trust. Both client and therapist will struggle to form a working alliance (Herman, 1997).

The collaborative nature of the therapeutic alliance is particularly important in trauma treatment. It is vital that the relationship is based on persuasion, not coercion, and mutuality, not authoritative control (Herman, 1997). This relationship is complicated because of the interpersonal aspects of sexual trauma which may emerge in the transference and countertransference. Issues of mistrust, betrayal, dependency, love, and hate must all be addressed as they arise (van der Kolk, McFarlane, & van der Hart, 1996). The survivor is unable to make reasoned, independent decisions (van der Kolk & McFarlane, 1996). In addition, affect regulation, attention, perception, and the ability to accept positive emotions have all been compromised (van der Kolk, McFarlane, & van der Hart, 1996). A survivor's greater feelings of helplessness and abandonment, along with the desperate need to be rescued by the therapist, often lead to idealized expectations (Herman, 1997). Rage can also be displaced from the perpetrator to the caregiver (Herman, 1997). It is critical that the trauma membrane originally created by family and friends and subsequently internalized by the survivor be maintained within the therapeutic relationship (Allen, 2001).

Therapists encounter the most profound effects of trauma in the realm of the self. A traumatic event impacts both the "I", the subjective self, the self with agency, and the "me", the objective self, the self-concept (Allen, 2001). Often, traumatized individuals either have not developed or can no longer trust their gut feelings because they have become associated with punishments and rewards through attachment relationships (Allen, 2001). The numbing of emotions, combined with a diminished subjective self,

effects the capacity for mentalization, which then impacts the ability to reflect (Allen, 2001). After trauma, a survivor is painfully aware of her objective self as worthless, helpless, shameful, unlovable, and hopeless but has no awareness of her subjective self and therefore no sense of agency (Allen, 2001). The therapist may need to “embark upon a journey” with the client to understand “how she lost her self” (Boulanger, 2007, p. 62). It is easier to address problems with the “me” than the “I”. Healing the “I” involves a long complicated process of consistent, empathic attunement (Allen, 2001), with an “exquisite attunement” to nonverbal, latent communication (Herman, 1997). The clinician must introduce the idea of self-dependence as a bridge between autonomy and relatedness. While self-dependence is developing, transitional objects may be helpful (Allen 2001).

When creating a therapeutic alliance with a trauma survivor, creating a therapeutic contract (Herman 1997, van der Kolk, McFarlane, & van der Hart 1996) can be helpful and keeping appointments faithfully is critical (Herman 1997). The expectations of both participants in the relationship should be laid out (van der Kolk, McFarlane, & van der Hart 1996): knowledge and skill/ paying a fee, listening and bearing witness/telling the truth, and finally, maintaining confidentiality/full self-disclosure (Herman, 1997). Emphasizing the cooperative nature of the work is crucial (Herman, 1997). The therapist must be consistent, unbiased, caring, and interested. She must have enough stability and integrity to recognize and work through any disappointments or failures that occur within the relationship (Spitz, 2006).

A survivor’s transference reaction typically involves rage against the caregiver and a desire to have the therapist experience the shame, terror, and helplessness she

experiences. At other times, this helplessness creates a need for the therapist to become the all-powerful rescuer, constructing a triadic relationship between victimizer, client and therapist (Herman, 1997). The clinician's countertransference may cause her to experience helplessness, rage, and grief. In her role as witness, she may find herself caught between identification with the guilt of the bystander and the skeptical judgment of the perpetrator (Herman, 1997). The therapist runs a great risk that traumatic countertransference may cause her to assume the role of rescuer and disempower the client (Herman, 1997).

Pacing

Lindy and Wilson (2001) urge clinicians to take their time in evaluating and treating a trauma survivor and to fully consider the individual survivor and the nature and context of the traumatic event. They caution therapists to "do no harm" (Lindy & Wilson, 2001, p.432).

In determining the pacing of treatment, the therapist should take on the role of consultant and constantly monitor the survivor's level of tolerance of the traumatic material (van der Kolk, McFarlane, & van der Hart, 1996). It may be helpful to frame the process of recovery as akin to running a marathon (Herman, 1997). Because re-experiencing trauma is so distressing, the survivor may wish to tell the story all at once in the hope that the catharsis will end her symptoms (Allen, 2001). However, Kluft (1993) writes "the slower you go the faster you get there" (Kluft, 1993, in Allen, 2001, p. 42).

In pacing trauma treatment, three crucial elements must be considered. First, it is important to remember the details of the trauma material that have already been communicated. Next, it is vital to pay attention to current interpersonal dynamics being

described or coming up in the treatment relationship. Finally, the therapist must observe the survivor's defenses that protect against trauma, particularly when these defenses may prevent the uncovering of further details or more profound feelings (Lindy & Wilson, 2001). Supervision and consultations are critical in balancing the third element (Lindy & Wilson, 2001).

Psycho-education

Psycho-education is significant in working with trauma survivors. It is crucial in helping to explain and promote understanding of traumatic reactions. Topics should include the exploration of intrusions and the nature of traumatic memory and its impact on a survivor's ability to access and experience emotions (McFarlane, 2001). Psycho-education should promote self-understanding and self-acceptance as replacements for self-blame and self-denigration (Allen, 2001). Educating clients about attachment and reenactment and helping them understand that attachment is the basis of distress regulation is also important (Allen, 2001).

It can be helpful to educate survivors about trauma as a chronic physical illness. This may validate a survivor's current experience and promote hope by focusing on the possibility of recovery. In addition, the survivor may recognize that her failure to move on is not a character flaw (Allen, 2001).

Finally, educating survivors about what to expect during the recovery process is a key component of treatment (van der Kolk, McFarlane, & van der Hart, 1996). A survivor should be taught the function of emotions and how that function has been negatively impacted by the trauma. Explaining the functional value of emotions in

recovery may increase the client's willingness to work to access and identify feelings (van der Kolk, McFarlane, & van der Hart, 1996).

Multi-modal Treatment

Therapists must continually reevaluate the effectiveness of treatment and assess what is being accomplished (van der Kolk, McFarlane, & van der Hart, 1996). It is important to prioritize treatment goals (van der Kolk & McFarlane, 1996). Different symptoms suggest different approaches, as do different stages of recovery (van der Kolk, McFarlane, & van der Hart, 1996). Treatment decisions should be based on both clinical judgment and a thorough understanding of post-trauma disorders (van der Kolk, McFarlane, & van der Hart, 1996). Intrusions are effectively treated with cognitive behavioral interventions such as exposure and desensitization. When a survivor is experiencing avoidance and interpersonal problems, treatment needs to focus on relationships and social supports (van der Kolk, McFarlane, & van der Hart, 1996).

Hyperarousal and physiological reactivity can be reduced with medication (Herman, 1997). Stress levels can be decreased with relaxation and vigorous exercise (Herman, 1997). A survivor's confusion can be addressed using cognitive behavioral strategies including psycho- education, charting symptoms and reactions, and creating concrete safety plans (Herman, 1997). Attachment issues are best tackled within a trusting psychotherapy relationship and social alienation calls for social strategies (Herman, 1997).

Reconstruction of the trauma narrative does not address the social or relational damage done by the traumatic event. A relational aspect of treatment is required to

address numbing and social withdrawal (Herman, 1997). Fully effective treatment will probably involve a multimodal approach (van der Kolk & McFarlane, 1996).

Moral Questions

Examining a client's psychological trauma, especially when considering interpersonal violence, forces a therapist to consider human beings' capacity for evil and leads to essential questions of principle, which make it impossible to remain morally neutral (Herman, 1997). A trauma survivor may feel that acknowledging that she has suffered psychological harm grants the perpetrator a moral victory in a way that acknowledging physical harm does not (Herman, 1997). This may be important in establishing both the meaning of the traumatic event and assessing the survivor's understanding of forgiveness.

Lindy and Wilson (2001) caution therapists on the need for awareness of the interventions they are using and to take ethical precautions. Herman writes that "working with victimized people requires a committed moral stance" and an "understanding of the fundamental injustice of the traumatic experience" (Herman, 1997, p.135). The role of the therapist is to ally oneself with the survivor, not to provide pre-packaged answers (Herman, 1997). This concept is particularly relevant to the use of a forgiveness intervention with a trauma survivor.

I discovered one study on the use of a forgiveness intervention with incest survivors (Freedman & Enright, 1996). Because this study is based on a cognitive behavioral model, I will discuss this study in Chapter IV.

In this chapter, I have examined the phenomenon of the treatment of sexual trauma. In the next chapter, I will explore the treatment of sexual trauma and how forgiveness is understood from a cognitive behavioral perspective.

CHAPTER IV

HOW TRAUMA AND FORGIVENESS ARE UNDERSTOOD FROM A COGNITIVE BEHAVIORAL PERSPECTIVE

In this chapter, through a review of the literature, I examine the treatment of sexual trauma using cognitive behavioral therapy (CBT). I first explain the conceptual framework of CBT. I then explore current CBT practice models used in treating sexual trauma. Finally, I examine existing forgiveness interventions, which have their roots in CBT. While there is a lot of literature available on the topic of forgiveness, and there are several forgiveness models with roots in CBT, I only discovered one forgiveness intervention that addresses the treatment of sexual trauma directly.

Theoretical Basis of CBT

In the early 1960's, Aaron Beck pioneered the field of CBT. He first developed theories which combined cognitive and behavioral approaches in working with clients with emotional disorders. (Wright, Basco, & Thase, 2006). Beck was influenced by several post-Freudian psychoanalysts, including Adler, Horney, and Sullivan who proposed connections between psychiatric disorders and personality structure. He was also influenced by the work of Kelly on personal constructs, termed core beliefs or self-schemas in CBT. In addition, Beck drew from Ellis's development of rational-emotive therapy (Wright et al., 2006). Behavioral components of CBT have their roots in the work of Pavlov, Skinner, Wolpe, and Eysenck in the 1950's and 60's. In the 1970's,

Meichenbaum and Lewisohn began to incorporate both cognitive and behavioral approaches in their therapy (Wright et al., 2006).

The theoretical foundations for cognitive behavioral therapeutic approaches can be found in learning theory, which form the basis for exposure therapies, and cognitive theories, which focus on core beliefs and assumptions and an individual's process of evaluation (Foa & Rothbaum, 1998). Cognitive theory is based on the assumption that the way life is interpreted, rather than the events themselves, determines emotional responses (Foa & Rothbaum, 1998). In addition, specific emotions are related to a set of thoughts. Anxiety is connected to the perception of danger and anger is linked to the perception of having been treated wrongly or unfairly. Guilt is related to the perception that the self has behaved wrongly or unfairly and sadness is related to the perception of loss (Foa & Rothbaum, 1998). According to cognitive theory, emotional responses which are more extreme and/or last longer than expected have their roots in distorted or maladaptive interpretations (Foa & Rothbaum, 1998).

The goal of CBT is to develop an awareness of dysfunctional interpretations and correct them (Foa & Rothbaum, 1998). This can be applied to treatment of trauma survivors because their worldview is dominated by their perception of danger. They are unable to distinguish between benign and dangerous environmental stimuli (Foa & Rothbaum, 1998). It is possible that pro-forgiveness practitioners might frame not being willing or able to forgive as a cognitive error or dysfunctional interpretation.

The Role of Schemas

The cognitive behavioral construct of a schema originates in personality and social psychology theories. A schema is defined as a thought structure comprised of the

attributes of an idea or type of stimulus and the ways those attributes are inter-related (Janoff-Bulman, 2006) or a core framework of assumptions and beliefs that shape the way an experience is perceived (Foa & Rothbaum, 1998).

Traumatic events are significant disruptions to a survivor's inner world. One way of conceptualizing one's inner world is through the set of fundamental assumptions the individual uses to form her perceptions of the external world (Janoff-Bulman, 2006). These assumptions are acquired and reinforced through years of experience and allow each individual to make sense of the world. A client's underlying, most abstract schema is based on her set of fundamental assumptions (Janoff-Bulman, 2006). These assumptions represent her most profound and extensive understanding of the world and provide her with basic expectations of the way the world operates (Janoff-Bulman, 2006).

An individual's schemas frame the world as benign or malevolent, life as full or devoid of meaning, and self and others as worthy of trust and having inherent value. Other schemas involve safety and power (Foa & Rothbaum, 1998; Janoff-Bulman, 2006). Survivors must try to understand a traumatic event through an existing schema or modify this schema (Foa & Rothbaum, 1998). Schema changes usually occur gradually when concrete, specific assumptions are challenged by an experience. During a traumatic event, the experience is so overwhelming that a survivor's fundamental assumptions are called into question. (Janoff-Bulman, 2006). Survivors are stunned by how naive their fundamental assumptions were before the trauma. Both their internal and external worlds are viewed as unreliable post-trauma (Janoff-Bulman, 2006).

Social-cognitive models are centered on the process trauma survivors use to integrate traumatic events into personal schemas, either by changing existing schemas or

by incorporating new information into existing schemas (Shipard, Street, and Resick, 2006). A model proposed by McCann, Sackheim, and Abrahamson suggests five dimensions that may be impacted by a traumatic event: safety, trust, power, esteem, and intimacy, all of which may be influenced with respect to self or others (McCann, Sackheim, & Abrahamson in Shipard et al., 2006). Survivors may struggle to adapt if positive schemas are challenged or negative schemas are confirmed (Shipard et al., 2006). Dual representation theory discusses two types of memories and two types of emotions. Verbally accessible memories are differentiated from situationally accessible memories, which cannot be voluntarily accessed or easily modified. Successful integration of the traumatic event requires accessing both types of memories (Shipard et al., 2006). The primary emotions experienced during the trauma, such as fear, are contrasted with the secondary emotions related to the meaning of the event to the survivor, for example, shame. Schema conflicts can be resolved through deliberate quest for meaning (Shipard et al., 2006). A forgiveness intervention is one possible way to address secondary post-trauma emotions.

Cognitive Behavioral Roots of Forgiveness Models

The goals of forgiveness interventions are based on the cognitive-behavioral methods of Ellis, Bandura, Beck, and Seligman (Lamb, 2002a) and much of the literature on forgiveness comes from a cognitive perspective (Haaken, 2002). This cognitive-behavioral approach can be contrasted with the humanistic psychology advocated by Rogers and Maslow. CBT is a more directive methodology and involves identifying cognitive errors (Lamb, 2002a). Proponents of forgiveness therapy believe that if a client can change the way she thinks about her psychic distress, the transgressor, and the

harmful act she will be able to forgive the perpetrator. By forgiving, which involves altering her attitude and adapting a new way of framing the event, a client can achieve happiness and well-being (Lamb, 2002a). This change process is similar to what occurs in Beck's therapy for depression or Ellis's treatment of life problems. By confronting existing thought patterns and responses, an individual can find release from her continued response to the past (Lamb, 2002a). These models often use an approach which involves the survivor setting up the terms under which she will release the transgressor from an emotional debt (Haaken, 2002).

The forgiveness intervention developed by the Stanford Forgiveness Project, one example of integrating positive psychology into psychotherapy, is a cognitive-behavioral intervention. A number of forgiveness approaches utilize the CBT strategy of reframing (Harris, Thoresen, & Lopez, 2007). There are four cognitive processes related to forgiveness that can be addressed in therapy: developing empathy for the perpetrator, developing an awareness of personal faults and limitations, assessment and understanding of the perpetrator's behavior, and cycles of rumination, which may be the greatest obstacle to forgiveness (Bono & McCullough, 2006). The field of post-traumatic growth reflects an increasing interest in potential life changes, including self-perception, relationships with others, worldview, and philosophy of life, all of which may occur as the result of a traumatic experience (Calhoun & Tedeschi, 2006).

Cognitive Restructuring

According to CBT theory, cognitive restructuring initiates change through the following process. The client identifies the thoughts and beliefs her fear is based on and examines these thoughts and beliefs to determine how accurately they reflect reality.

Then, in collaboration with the therapist, she adjusts these thoughts and beliefs to make them more reality-based (Foa & Rothbaum, 1998). In addition to the primary emotion of fear, the therapist can address secondary emotions of anger, shame, guilt, (Foa & Rothbaum, 1998) and helplessness (Shipard, Street, & Resick, 2006). Maladaptive thoughts are identified and challenged within a given context (Shipard et al., 2006). Cognitive restructuring is present-focused. The ways in which these thoughts affect current feelings and behaviors are examined (Shipard et al., 2006).

The primary goal of cognitive restructuring is to alter an overly negative assessment of the traumatic event and its consequences. This is accomplished through examination of parts of the trauma narrative which cause the most distress and identification of alternative ways to understand these components and incorporate a new perspective into the story (Ehlers, Clark, Hackmann, McManus, & Fennell, 2005). This comprehensive narrative of the trauma experience incorporates her understanding of what occurred following the event, including the responses of those close to her, which may also need to be evaluated and potentially understood differently (Ehlers et al., 2005). A secondary goal of cognitive restructuring is to diminish the re-experiencing of the trauma through the creation of a trauma narrative which places traumatic events within a timeframe and lived context (Ehlers et al., 2005). A tertiary goal is to bring an end to maladaptive behaviors and thinking patterns (Ehlers et al., 2005). The final aspect of cognitive restructuring relates to creating safety. In this process, the survivor learns to identify environmental stimuli which trigger re-experiencing and practices grounding herself in present time and space (Ehlers et al., 2005). It is crucial to keep in mind not doing harm (Lindy, 2001) and always maintaining safety (Herman, 1997) when treating

trauma survivors. The evaluation of an assessment of the traumatic event as overly negative, as in the first goal, seems quite subjective. In applying this model, discussing forgiveness might be appropriate in working toward the third goal.

Current CBT Trauma Treatment Models

Cognitive behavioral therapy (CBT) for trauma represents a broad group of treatment models which share an emphasis on common treatment goals including observable outcomes, symptom relief, time-limited, goal-oriented interventions, and active client involvement fostered through a collaborative approach (Monson & Friedman, 2006). Treatment plans are based on case conceptualizations formed with a clear understanding of post-trauma disorders, recognizing that post-trauma outcomes vary widely and have multiple dimensions and causes (Monson & Friedman, 2006).

CBT is often incorrectly characterized as a mechanical, technical therapeutic approach. Yet, like all other modes of therapy, a strong therapeutic alliance is essential (Monson & Friedman, 2006). The success of CBT can be attributed to three factors: identifying and addressing thought structures and patterns, the repeatability of the treatments, and the fact that clients are actively searching for rational approaches to improving their lives (Bono & McCullough, 2006).

Among commonly used CBT protocols for the treatment of trauma are cognitive processing therapy, prolonged exposure, and stress inoculation training, although the mechanisms of change for these models are not well understood (Shipard et al., 2006). The most effective CBT treatments for trauma are those based on exposure therapy using narrative writing or imaginal exposure, on cognitive restructuring which addresses the meaning of the trauma, or these two methods combined (Ehlers, Clark, Hackmann,

McManus, & Fennell 2005; Rothbaum & Foa, 1996). Cognitive therapy models are based on the premise that addressing maladaptive beliefs, flawed attributions, and skewed perceptions may be more successful than exposure interventions alone. CBT for PTSD typically supplements exposure with a form of cognitive intervention, most often cognitive restructuring (Shipard, et al., 2006).

Trauma memory is distinctive because the world is seen as inherently dangerous and the self is seen as unable to cope. It is more difficult to change disorganized memory. Treatment should focus on organizing memory and rectifying maladaptive beliefs (Rothbaum & Foa, 1996). Treatment based on reliving trauma allows a survivor to process memory emotionally, after which she is able to see the event as a unique occurrence and regain the ability to distinguish between dangerous and safe situations. A reduction in symptoms may shift a survivor's self-perception in terms of her ability to cope (Rothbaum & Foa, 1996).

Other CBT models for the treatment of trauma have been developed. These include trauma focused CBT for children (Cohen & Manniarino, 2008a, Cohen & Manniarino, 2008b) and CBT for battered women and formerly battered women (Kubany, Hill, Owens, Iannce-Spencer, McCraig, Tremayne, & Williams, 2004; Kubany & Watson, 2002). Anxiety management training was found to positively impact levels of fear and depression in female rape victims (Rothbaum & Foa, 1996).

Cognitive Processing Therapy

Cognitive processing therapy (CPT) was originally developed for the treatment of survivors of rape and other crimes and has three main goals. The first goal is to address non-fear emotions such as shame and guilt. The second goal is to explore the meanings of

different aspects of the traumatic memory. The final goal is to consider ways in which the survivor's self-concept and worldview have been affected by the traumatic event (Shipard et al., 2006). In the process of examining the client's self-concept and worldview, the therapist and client look for distortions of perception related to safety and trust and ways in which the survivor's self-concept may be overly negative, leading to self criticism. The therapeutic dyad should pay attention to instances of overgeneralization (Shipard et al., 2006).

The foundation of CPT is the role of the therapist as coach in reviewing homework the client has done between sessions. The first session of CPT is begun with psychoeducation about trauma and the survivor is asked to write a statement of the meaning of the event to her and her understanding of why the event occurred (Shipard et al., 2006). In the next session, the client and therapist examine this impact statement searching for cognitive errors. They are also looking for overgeneralizations as a response to the traumatic event which has impacted the client's view of herself and the world. The basis of the therapeutic process during the first phase of treatment is challenging and working to modify any cognitive errors and incorrect perceptions of the self (Shipard et al., 2006).

The next phase of CPT treatment focuses on exposure to the memory of the event, with particular attention on accompanying thoughts, emotions, and sensory input. Using Socratic questioning, the therapist challenges the principles underlying the client's self-concept and worldview and offers potential alternative perspectives on her actions. In so doing, the therapist is examining and assessing the client's level of self blame for the event (Shipard et al., 2006).

The final phase of CPT is centered on aspects of the survivor's worldview that may have been negatively impacted by her traumatic experience. These include concepts of safety, trust, control, self-esteem, and intimacy. Again, any overgeneralization of the trauma to daily living and views of herself and the world are assessed and challenged (Shipard et al., 2006). During this phase, the therapist should acknowledge the ways in which the client may be engaging in avoidance strategies and discuss the role that substance use plays in increasing the client's vulnerability for further victimization (Shipard et al., 2006).

During CPT, in addition to challenging individual cognitive errors in automatic thoughts, the therapist and the survivor search for underlying patterns of counterproductive thinking, or schemas. Worksheets are used to facilitate the examination of maladaptive beliefs and thought patterns (Shipard et al., 2006). Shipard, Street, and Resick (2006) present a case of secondary forgiveness in which a survivor of sexual assault considers forgiving his father for physically abusing him and contributing to the situation which led to a traumatic event. The therapist and client discuss his anger toward his father, as well as his feeling that he was not entitled to anger due to self-blame. The survivor needed to allow himself to experience anger toward his father and the abuser before he could consider forgiving them (Shipard et al., 2006). In this phase of examination of cognitive errors and schemas, forgiveness of the perpetrator might also be considered.

Forgiveness Models

The topic of forgiveness might be included in the models discussed above, but it is not the primary focus. The following models utilize a CBT approach centered on forgiveness.

Enright's theory of how reasoning develops with respect to forgiveness is based on a model by Kohlberg and relates stages of justice to stages of forgiveness (Mullet & Girard, 2000). Girard and Mullet (2000) propose a forgiveness schema and base their work on information integration theory (Girard & Mullet, 2000). Other theoretical models are based on rational-empirical theory, which utilizes a task-analytic approach (Malcolm & Greenberg, 2000).

In a review of published forgiveness models, Wade and Worthington (2005) consider fourteen examples. Most of this research on forgiveness has focused on group interventions. The models were examined for common elements and the mechanisms of change of these elements (Wade & Worthington, 2005). The core elements include defining forgiveness, helping survivors remember the pain associated with the traumatic event, working with survivors to develop empathy for the perpetrator, examining times when the survivor has hurt others, and promoting forgiveness of the wrongdoer. These models consider how to best accomplish these tasks in a careful, client-centered manner (Wade & Worthington, 2005).

Common Elements of Forgiveness Models

Some common elements of forgiveness models are: clearly defining forgiveness, remembering and addressing the pain of the traumatic event, developing empathy for the

offender, encouraging the forgiveness of the offender, and addressing obstacles to forgiveness (Wade & Worthington, 2005).

A misunderstanding of the definition of forgiveness can pose significant difficulties for survivors of severe abuse. By clarifying the definition, the therapist increases the likelihood of healing through forgiveness (Wade & Worthington, 2005). In remembering the pain associated with the traumatic event, forgiveness is more profound and long-lasting when connected to a specific offense. Sharing the experience of the offense may promote a therapeutic alliance and diminish the impact of the event through catharsis. The goal of this therapeutic element is to diminish the negative feelings associated with the traumatic event (Wade & Worthington, 2005). However, special consideration should be given to the timing of sharing the story. Due to the distress of re-experiencing trauma, a survivor may wish to tell her story all at once in the hope that the catharsis will relieve her symptoms immediately (Allen 2001).

The purpose of working to develop empathy is to attempt to change the survivor's view of the offender and establish context for the behavior, to strive to see the offender as a fellow human being impacted by life circumstances (Wade & Worthington, 2005). When offenses are pre-meditated and/or particularly reprehensible, caution and sensitivity are required and developing empathy for the perpetrator may be contraindicated (Wade & Worthington, 2005). In examining the times a client has hurt others, the therapist works with the client to acknowledge the difference between judgment of the offense and judgment of the individual who perpetrated the offense, thus addressing an attribution error (Wade & Worthington, 2005). It is important to avoid causing further injury to the survivor or alienating them and the therapist must be careful

not to imply any connection between occasions when the client has hurt others and her own experience of trauma. Discussing past offenses must be handled non-judgmentally (Wade & Worthington, 2005). It appears that a practitioner using this model would be directive and explicitly encourage empathy for the transgressor.

Encouraging forgiveness of the offender has two components, committing to the process of forgiveness and dealing with the inability or unwillingness to forgive. In committing to forgiveness, the survivor sets a goal of forgiving and strives to achieve this goal while developing an awareness of possible future obstacles to this goal (Wade & Worthington, 2005). Dealing with the inability or unwillingness to forgive may involve addressing anger, revenge, avoidance, cycles of rumination, and re-acknowledging the pain associated with the trauma. Through cognitive restructuring the survivor develops new perspectives, perhaps finding new meaning in the event (Wade & Worthington, 2005).

Malcolm and Greenberg (2000) state that there are five components to the process of forgiveness. The first component involves accepting powerful emotions such as anger and sadness. The second element entails letting go of needs which have not been met in a relationship. The third component involves the client shifting her perspective of the transgressor. The fourth step entails working to develop empathy for the offender and the final step involves creating a new concept of both herself and the perpetrator (Malcolm & Greenberg, 2000).

Enright's Forgiveness Model

According to Enright and Fitzgibbons (2000), "forgiveness therapy may not be congruent with forms of therapy that claim to be value free" (Enright & Fitzgibbons,

2000, p. 15). To implement this practice model, therapists must be comfortable discussing the moral value associated with some behaviors, e.g. offering mercy (Enright & Fitzgibbons, 2000). It is not clear to me whether the clinician would be explicit and ask the client whether they were interested in forgiveness-based treatment before using this intervention. I am also unsure as to whether the therapist would disclose her moral stance.

A key component of forgiveness therapy is recognizing, confronting, reducing, and possibly eliminating anger. Revealing anger can be difficult when a survivor has developed strong defenses against it. Forgiveness is one approach to resolving conscious and unconscious anger (Enright & Fitzgibbons, 2000). Most therapies rely on the expression of anger to resolve it, particularly in mood disorders. The potential benefits of using a forgiveness intervention include a decrease in depressive symptoms, reduced anxiety, a higher level of hope, greater self-esteem, and less preoccupation with the wrongdoer (Enright & Fitzgibbons, 2000).

The forgiveness model developed by Enright contains four phases: the uncovering phase, the decision phase, the work phase, and the deepening phase. This developmental model is not rigid and there is no set timeframe as to when forgiveness will occur (Enright & Fitzgibbons, 2000). Forgiveness is based on two central concepts, morality and transformation. Morality, the pursuit of good, has an interpersonal aspect, with the focus on behaving with good intentions toward others. Justice and mercy are also related to forgiveness (Enright & Fitzgibbons, 2000). I am concerned that this model does not describe the process by which the moral basis of forgiveness, and whether it is congruent with the client's beliefs, is explored with the client. With respect to transformation, forgiveness implies changes in the survivor's response to the transgressor, her emotional

state, and her relationships. A therapist must be ready to help a client understand the concept of forgiveness, correct any misperceptions, and promote further understanding (Enright & Fitzgibbons, 2000). The authors use the following operational definition of forgiving:

People, upon rationally determining that they have been unfairly treated, forgive when they willfully abandon resentment and related responses (to which they have a right), and endeavor to respond to the wrongdoer based on the moral principle of beneficence, which may include compassion, unconditional worth, generosity, and moral love (to which the wrongdoer, by the nature of the hurtful act or acts, has no right). (p.24)

Clarifying a client's understanding of forgiveness will help determine whether she wishes to engage in forgiveness therapy. Common misunderstandings of the meaning of forgiveness involve the concepts of reconciliation, forgetting, condoning, and excusing. The client may also fail to differentiate moral weakness and forgiveness (Enright & Fitzgibbons, 2000). It is evident that Enright and Fitzgibbons (2000) do not associate moral weakness and forgiveness. It is not apparent how they would explore forgiveness within a client's meaning system without imposing their own values.

There are potential concerns that the therapist must watch for. The choice to forgive belongs to the client and she should never experience even subtle pressure to make this choice. The choice may be rejected initially or after the process has begun

(Enright & Fitzgibbons, 2000). The family may have pre-existing expectations about forgiveness, either pro or con. The survivor may not be able to separate the ideas of reconciliation and forgiveness (Enright & Fitzgibbons, 2000).

This phase model serves as a cognitive map for the therapeutic process of forgiveness. The uncovering phase focuses on gaining insight into the impact of the traumatic event on daily living. The work in this phase involves examining the psychological defenses the survivor is using to avoid unwanted feelings and addressing these feelings which may include anger, shame, and guilt (Enright & Fitzgibbons, 2000). The level of preoccupation with the traumatic event and the transgressor are also assessed. The therapist collaborates with the survivor in exploring her fundamental schemas and how they have been altered by the trauma (Enright & Fitzgibbons, 2000).

In the decision phase, the survivor works toward gaining a clear understanding of the concept of forgiveness and making a decision to forgive based on this understanding. The survivor develops an awareness that her current adaptive strategies are not working and develops a willingness to consider forgiveness. She then makes an intellectual commitment to forgive the wrongdoer with the understanding that her feelings about forgiving will change over time (Enright & Fitzgibbons, 2000).

During the work phase, the client strives to gain an intellectual understanding of the wrongdoer. This new perspective then leads to changes in her feelings about the transgressor, herself, and their relationship. The broader perspective of the offender is reached through the process of exploring his life circumstances and the circumstances which may have led to the abuse and possibly considering him as a fellow human being (Enright & Fitzgibbons, 2000). The client also reframes her sense of responsibility. For a

survivor of sexual trauma, it is vital that she never assumes any responsibility for the event. Next, the therapist allows for the development of empathy, being careful to assess for the survivor's safety by considering possible enabling of or enmeshment with the transgressor (Enright & Fitzgibbons, 2000). The survivor is encouraged to develop compassion, while accepting the traumatic event and the pain associated with it. "Giving the moral gift" of forgiveness is the final step in this phase, but may not be appropriate for survivors of sexual trauma (Enright & Fitzgibbons, 2000, p. 84). Being encouraged to offer a "moral gift" is value laden and involves judgment of a client's decision.

The deepening phase is centered on finding meaning in suffering, greater connection with others, reducing negative feelings, and discovering a new sense of purpose in life, which may involve adjustments to existing schemas (Enright & Fitzgibbons, 2000). In this phase, the survivor nurtures an awareness that she has benefitted from the forgiveness of others. She may also wish to connect with other survivors. Some clients choose to take action as a way to find new purpose and further resolve the traumatic event. At the end of this phase, the client reflects on the changes that have occurred in her feelings, her self-concept, and her relationships (Enright & Fitzgibbons, 2000). Accepting and absorbing the pain that is causing sadness and anger can be a long, difficult process. Some clients have been betrayed so profoundly that dealing with their pain completely may be impossible. Survivors of parental abuse, rape, or incest will have the most difficulty resolving the pain of the transgression (Enright & Fitzgibbons, 2000). The expectation of finding meaning in suffering is potentially morally loaded and, for many, directly related to their religious or spiritual beliefs.

In related research, Freedman and Enright (1996) conducted a study with incest survivors in which forgiveness was the stated goal. There were twelve participants in the study, all adult women between the ages of 24 and 54. All had been abused as a child by a male relative. The survivors participated in weekly, hour-long individual sessions for an average of approximately fourteen months (Freedman & Enright, 1996). (The intervention was based on the process model described above). The length of the therapeutic process is variable and is dependent upon both individual responses and the severity of the abuse suffered. Individual reactions must be respected and taken into account when determining the pacing of the therapy. The intervention continues until the client reports that she has forgiven (Freedman & Enright, 1996). After the intervention, the authors reported increased self-esteem and hope and decreased depression and anxiety among the participants as compared to a control group. No negative effects of the intervention were demonstrated (Enright & Fitzgibbons, 2000). It seems difficult to interpret the results of a study that continued until its stated goal was met. In addition, it is not clear how it was determined that no negative effects were demonstrated.

Other Forgiveness Models

Another set of interventions was developed by Worthington, McCullough, and others. These were distilled into the Model to REACH Forgiveness (Wade & Worthington, 2005). In this five-step approach, the client begins by remembering (R) the offense. In a supportive environment, the survivor recalls the event, any associated feelings and thoughts, as well as any adaptive behaviors. Next, the survivor develops empathy (E) for the offender. She examines the context of the event, and tries to imagine what the offender was thinking and feeling leading up to and during the event (Wade &

Worthington, 2005). The third step involves offering the offender an altruistic (A) gift of forgiveness. The client remembers when she has received forgiveness in the past. This process is meant to elicit humility and gratitude for received forgiveness. Next, the survivor publicly commits to forgiving the transgressor, even if only by speaking the words aloud to herself (Wade & Worthington, 2005). In the final step, the client agrees to maintain, or hold (H) onto, both her commitment to forgiveness and all of the changes that have occurred during the treatment process (Wade & Worthington, 2005). It is worth noting that Worthington explicitly espouses a Christian perspective in some of his writing (Worthington, 2003). Altruism, humility, and gratitude are all moral constructs that are often associated with Judaism, Christianity and Buddhism.

Luskin's group forgiveness intervention is centered on working with clients to understand the intellectual, affective, and behavioral aspects of experiencing hurt, ascribing blame for the offense, and creating a narrative of the offense (Wade & Worthington, 2005). This process includes psycho-education about physiological responses to events and the way they influence thoughts and feelings. The intervention was implemented using small, same-sex groups which met weekly for ninety minutes over a period of six weeks (Wade & Worthington, 2005). In his self-help book, Luskin (2002) mentions rape twice in passing but never addresses trauma specifically (Luskin, 2002).

In this chapter, I have examined the treatment of sexual trauma using a cognitive behavioral therapeutic approach and considered the use of forgiveness models within this framework. In the next chapter, I will explore sexual trauma treatment and forgiveness from an object relations perspective.

CHAPTER V

HOW TRAUMA AND FORGIVENESS ARE UNDERSTOOD FROM AN OBJECT RELATIONS PERSPECTIVE

In this chapter, I will examine sexual trauma from a psychodynamic perspective, and, more specifically, from an object relations perspective. I will consider theorists who influenced this school of thought and salient concepts they developed which are relevant to treating trauma survivors. Finally, I will examine the concept of forgiveness within an object relations framework and explore an existing psychodynamic forgiveness model.

Psychodynamic Psychotherapy and Sexual Trauma

Psychodynamic psychotherapy focuses on internal energy and motivations, the way these internal phenomena determine behavior, and what the sources of these forces are in developmental history and present experience (Berzoff, Flanagan, and Hertz, 2008). Psychodynamic theory examines all of the internal and external forces which influence an individual's psychological development, including mental and emotional aspects (Berzoff, Flanagan, and Hertz, 2008). Psychodynamic psychotherapy centers on the continual process of 'remembering, repeating, and working through' clients' presenting problems. Events and fantasies that occurred in the past, as well as the associated feelings, are explored within the transference of the therapeutic alliance (Spitz, 2006).

Freud was initially interested in the impact of external events, which he termed practical reality but later shifted his focus toward internal experiences, or psychic reality

(Garland, 1998c). Freud also distinguished between automatic anxiety, which indicates present danger, and signal anxiety, which indicates the threat of danger. After trauma, the survivor's ego can no longer afford to trust signal anxiety and she no longer distinguishes between the two states (Garland, 1998c).

Agency is a critical component of psychodynamic therapy. Historically, the psychodynamic therapists have ignored the significance of the traumatic event and the need to explore it. Instead, focus was placed on the individual's response to the event (Boulanger, 2007). If drives or internal objects affect the way a client understands reality, this implies that the drives and internal objects are more powerful than reality. The death instinct was proposed as an explanation for the inability to account for the experience of trauma (Boulanger, 2007).

Psychodynamic therapists "have the tools but not the theory" to work effectively with trauma survivors (Boulanger, 2007, p. 3). Several major obstacles confront clinicians using psychodynamic theories in treating trauma survivors, especially survivors of adult onset trauma. What role do external events play in a client's intrapsychic world and how significant are they? In addition, since many theories understand internal structures to be fixed after successfully navigating childhood development, how are current external experiences and their relationship to intrapsychic structures dealt with (Boulanger, 2007)? How does a mode of therapy which focuses on the agency of the client, her ability to articulate her experience, and her capacity to reason deal with traumatic events which have impacted all three of these aspects of her life (Boulanger, 2007)?

This intrapsychic approach may be inadequate for treating sexual assault. The individual has been violated, as have societal norms (Spitz, 2006). The survivor has been psychologically overwhelmed, her trust has been shattered, and she has become alienated from others. The survivor needs validation of her experience of the events. Otherwise, the shame she is already feeling may be exacerbated (Spitz, 2006). It is vital to both recognize the horror that the survivor experienced as a result of her encounter with external reality while acknowledging the potential for reconnection and support in that world (Spitz, 2006).

A trauma survivor's experience is psychotic, as if she has a thought disorder and is not based in reality, but is based on real, external events (Boulanger, 2007).

Psychodynamic treatment is fundamentally concerned with how individuals interact with reality (Eagle & Watts, 2002). A survivor's post-trauma experience presents a dichotomy because the source of the distress is found both within the individual and in the traumatic event (Boulanger, 2007). "When trauma occurs in adult life, it disrupts the predictable in a way that makes it impossible for some to recover or reestablish the familiar" (Boulanger, 2007, p. 53). An individual experiences a traumatic event within the context of her personality traits, developmental history, and life story. All of this will influence her ability to manage the feelings the trauma invokes, her ability to trust, and her level of self-awareness (Spitz, 2006).

Lacan describes three realms of psychic experience. The Imaginary consists of images, both perceived and imagined, which exist in the conscious as well as the unconscious. The Symbolic realm is where words and the objects and ideas they represent exist, where meaning is created. Psychotherapy happens in this realm

(Boulanger, 2007). In the third realm, the Real, things cannot be represented by symbols and therefore cannot be articulated. The Real is timeless and cannot be explored (Boulanger, 2007). Trauma takes place in the realm of the Real (Boulanger, 2007; Kirshner, 1994) and as a result, the experience cannot be assimilated (Kirshner, 1994). Trauma involves a loss of symbols (Garland, 1998c). The Real is also characterized by “objectlessness” (Grotstein, 1992 in Boulanger, 2007, p. 55). Trauma occupies the gap between psychodynamic theory and practice because it cannot be symbolized or imagined. Thus, working with trauma survivors presents a significant challenge to psychodynamic clinicians (Boulanger, 2007).

“Indifferent reality” is unequivocal evidence that cannot be changed by principles of desires, “facts that are indifferent to life or death” (Green, 1997 in Boulanger, 2007, p. 57). When “indifferent reality” cannot be taken in or articulated, it becomes traumatic reality (Boulanger, 2007). The survivor is continually faced with the fear of repeating a breakdown which has already occurred (Winnicott, 1974). Independent of character traits and developmental history, specific symptoms occur as a result of exposure to trauma. The probability of psychological consequences increases as the severity and length of the event increase, post-trauma reactions can last indefinitely. These reactions include intrusive trauma memories, and behavior to avoid these memories (Boulanger, 2007).

Survivors often blame themselves for not being able to move on. Symptoms of psychological trauma are not immediately noticeable and the survivor rarely discusses them, increasing her sense of isolation (Boulanger, 2007). It is essential to explore both views the survivor has of herself, as perfectly normal and irreparably damaged, and

address her feelings of alienation and shame (Spitz, 2006). The longer adaptive, or maladaptive, behaviors persist, the more difficult they are to recognize and change. The survivor does not recognize herself as her psychic self has collapsed (Boulanger, 2007). Through the process of being “wounded by reality” (Boulanger, 2007, p. 62), the psychological foundation of the self is encountered in ways that do not occur in an average expectable lifetime. It is important to examine the process through which the self was dismantled (Boulanger, 2007).

Self-regulation and one’s fundamental sense of self, self as separate from other, self with agency, feeling self, and fully integrated self anchored in time are all developed within a relational holding environment. The deep sense of isolation that trauma survivors experience comes from three interrelated sources: the loss of the internal structure connecting internal object representations, the loss of external social connections, and the perceived loss of connection to humanity (Boulanger, 2007).

All sexual trauma survivors do not share the same blueprint of their experience, nor do they all exhibit the same symptoms. The clinician cannot make assumptions about the survivor’s psychological state at the time of the trauma, whether other trauma has occurred, what the client is feeling, and whether the client is open to insight-oriented or reconstructive, interpretive work (Lindy, 1996). The therapist must always explore and address the survivor’s intrapsychic world, the psychological effects of the traumatic event, the psychological impact of the meaning of the event, any current symptoms and the way all of these aspects are interrelated (Boulanger, 2007).

The therapist must recognize that mechanism of the survivor’s traumatic memory has both an adaptive function and a neurological basis, which means that she has no

control over when or how it is accessed. It is important for the clinician to preserve the tension between the survivor's experience of the trauma and the way she organizes the experience (Boulanger, 2007). Balancing the tension between the survivor's objective and subjective self when evaluating the impact of the trauma is also vital (Eagle & Watts, 2002). By emphasizing the survivor's ongoing experience and ability to change her current responses and behavior, both she and the therapist can approach the consequences of trauma with an open mind (Boulanger, 2007).

The Therapeutic Relationship

The therapist can help the sexual assault survivor reconnect with and rebuild her self concept by becoming an extension of her observing ego. By forming a therapeutic alliance, the survivor can experience reconnection with another (Spitz, 2006). Although relational theory incorporates social context into the process of therapy, trauma challenges the core of an individual's experience of herself and deeply alters internal representations of relationships with others. This impacts the treatment relationship (Boulanger, 2007). Typically, in psychodynamic therapy, the focus is on the intrapsychic functioning of the client and external events play a secondary role in formulating a treatment plan. In dealing with trauma, this is not possible (Boulanger, 2007). The therapist acts as a representative of the larger social world, so it is crucial that she be validating and empathic and allow the survivor to hope that others will do the same (Spitz, 2006). However, assigning priority to empathic understanding pits the therapeutic relationship against the power of the client's experience, which cannot be articulated (Boulanger, 2007).

Repetitions of the traumatic experience are a central feature of psychodynamic therapy. The repetitions are expected, vital components of the therapeutic process in which the survivor unknowingly locates the therapist and her behavior within the reliving of the trauma memory (Lindy, 1996). Aspects of the therapist's office may trigger intrusive traumatic memories, symptoms of anxiety, somatic sensations, and the emotions of shame or terror. The therapist must exercise careful judgment about when and how to reflect her observations of the client's reaction (Lindy, 1996). Her responsibility is to tolerate the lack of connection without interpreting it (Boulanger, 2007). Only as therapy progresses, the therapeutic alliance is established, and the treatment begins to supply a secure holding environment can the trauma be expressed and worked through within the relationship (Lindy, 1996).

In working with the therapist, the survivor is able to transform her unformed sensations and depressed mood, along with her adaptive defenses such as splitting, dissociation, or disavowal, into integral parts of her trauma narrative (Lindy, 1996). In reenacting her trauma experience, the survivor demonstrates the impact of the event on her sense of self. She places herself and her therapist in the traumatic situation, with all of the accompanying feelings, psychological defenses, and adaptive behavior (Lindy, 1996). Through the transference, the therapist can help the survivor find words to express the subtleties of her experience and the meaning of the event. An essential element of the recovery process is managing the traumatic reenactment within the transference and countertransference (Lindy, 1996). It is important for the therapist to pay attention to the nuances involved when trying to determine how and when to help the survivor discover more as opposed to how and when to help her compartmentalize the

trauma so it doesn't spill into other areas of her life. It is also important to recognize the complexity and depth of the reenactment. Along with the possible roles of victim and perpetrator are feeling states, object relations, and points in the story where a critical self-concept is buried (Lindy, 1996).

Object Relations and Sexual Trauma

Object relations practitioners explore and attempt to alter the survivor's internal object relations and intrapsychic world, as opposed to post-trauma symptoms and diagnoses (Garland, 1998a). Trauma can be defined as an event that occurs in external reality that upsets existing self and other object representations and relationships (Eagle & Watts, 2002). This significantly psychologically disruptive event involves the continual threat of the destruction or loss of 'the good object' (Kirshner, 1994; Eagle & Watts, 2002). The good object as a symbol of internalized goodness, is vital to the ability to participate emotionally in a world of others and may be necessary for psychic survival (Kirshner, 1994). Objects relations theories are based on the significance of maintaining the good object as a prerequisite for a stable, secure internal object relations world (Eagle & Watts, 2002). Effective psychodynamic treatment is closely tied to preserving or recovering this symbolic object (Kirshner, 1994).

Object relations trauma theory has generally been centered on a survivor's developmental history, the significance of her intrapsychic world, and the subjective process of introjection and projection through which she engages with the world (Eagle & Watts, 2002). However, insisting on understanding a traumatic event within the context of a survivor's developmental history can be profoundly alienating (Eagle & Watts, 2002). Historically, object relations theories, all of which focus on social context

and interpersonal relationships, understood the adult intrapsychic structure is relatively unchangeable. More recent theorists see personality as constantly changing in response to life events (Boulanger, 2007). Trauma is beyond understanding within an object relations framework which is based on a fixed psychic structure, favoring the value of agency, the power of reason, and the ability to symbolize (Boulanger, 2007).

A traumatic experience can bring up memories of past experiences, all filtered through the existing lens of internal object relations (Garland, 1998b). Whether the traumatic event is a natural disaster, an accident caused by human error, or an intentional act of aggression, the survivor interprets the meaning of this event in relation to the most difficult aspects of her internal object relations (Garland, 1998c). The impact of trauma reaches beyond visible symptoms and affects the survivor's identity, including the nature of her internal objects, her understanding of them, and the way they relate to each other (Garland, 1998c). The impact of the trauma is influenced by the reactions of a survivor's significant other objects (Srinath, 1998). The survivor will make sense of the traumatic event using the internal object relationships that are most like those in the event, both in similarity of the physical situation and of the participants. In this process, the traumatic event is unconsciously connected to past events and associated struggles (Garland, 1998c; Spitz, 2006).

After the initial response to a traumatic event, the longer term response consists of a loss of agency and a loss of connection to others. Her internal object world has been damaged. The event confirmed her anxiety that the world and her internal objects cannot be trusted and may also confirm existing aspects of her internal self object (Garland, 1998b). An individual's expectations of her own responses and those of the people

around her are termed object expectations (Flanagan, 2008). After a traumatic event the safety of the good object has been attacked. This causes the survivor to regress to a more primitive mode of functioning and involves the use of more primitive ego defenses (Eagle & Watts, 2003). In Kleinian terms, the survivor moves from a depressive position to a paranoid-schizoid position. In Winnicottian terms, she develops a 'False self' (Eagle & Watts, 2003). Intimate relationships appear to be the most susceptible when an individual returns to the paranoid-schizoid position (Haaken, 2002).

Within this framework, it might make sense to explore forgiveness within an internal object relations framework, specifically addressing object expectations. It would be worthwhile to consider with the survivor what her hopes are for the ways forgiveness might change her self-concept, her concept of others, specifically the transgressor, her relationships with others, and her perception of external reality.

Moment of Attack

When trauma occurs, the internal object world is partially or completely destroyed. This loss of objects prevents the integration of the experience and causes the memory to be stored as a series of unformed, disorganized impressions (Boulanger, 2007). During a traumatic event, the ego works to distort internal and external reality in an effort to restore stability. The interpersonal engagement that occurs impacts the established internal object relations and perceptions of the world. In order to adapt, new object relation configurations are developed (Eagle & Watts, 2003).

During the moment of intimacy of the attack, the psychic boundaries of the attacker and the victim are ruptured, by either violent projection and projective identification or coerced introjection. In this transitional realm of experience, (see

explanation of transitional experience below) these boundaries are meshed and identities are mutually exchanged (Eagle & Watts, 2003). In order to overcome the lack of meaning of a world without objects, the survivor may introject the transgressor. Alternatively, she may also attribute the occurrence of the trauma to her own lack of worth or believe that she deserved the occurrence of the event (Boulanger, 2007). Before considering the forgiveness of the transgressor, it is necessary to sort out the complicated object relations between the survivor and the offender and the interplay of their defenses during and after the traumatic event.

Containment and Symbolization

When early childhood development progresses smoothly, containment is the basis of the relationship between an infant and her parent. The caregiver can recognize and understand the baby's most primitive fears and anxieties while remaining stable and capable. The baby eventually internalizes the ability to think about her anxieties without being enmeshed in them (Garland, 1998b). The caregiver as the good object acts as a gateway into the symbolic world of human interaction (Kirshner, 1994). When a client is able to symbolize, the symbol is recognized as a representation of an object or experience, but distinct from it. The symbol has its own properties, and consequently, events can be thought about, imagined, and discussed without being relived (Garland, 1998b).

A traumatic event is a failure of containment, and this failure of containment is psychologically traumatic. A sexual assault signifies a disastrous breakdown of "the maternal container" (Garland, 1998b, p. 108). In trauma, both internal and external containers have been compromised. The external world is now unpredictable and unsafe

and her good internal objects could not prevent this event from occurring (Garland, 1998b). The ability to symbolize and to connect aspects of external world with internal objects and relationships are functions of an internalized container. When this container is no longer functioning, the goal of treatment is to restore these abilities (Garland, 1998b).

The Value of Illusions

Fairbairn and Winnicott both proposed that all human beings require some illusions, or a sense of omnipotence in some areas of life, to shield them from unmanageable anxiety. Winnicott asserted that, in order for individuals to exist without debilitating anxiety, they must maintain illusions (Winnicott, 1958 in Boulanger, 2007). Fairbairn believed that maintaining the illusion that she lives in an orderly, benign world is what allows an individual to live fully (Fairbairn, 1952 in Boulanger, 2007). Trauma survivors, by the act of living through their experience, lose the protective shield of these illusions and are directly confronted with terror (Boulanger, 2007). One distinction between survivors of childhood and adult onset trauma is that in adulthood, survivors are not able to deny their loss of agency. They can no longer believe the illusions they had previously maintained about reality (Boulanger, 2007).

Object Relations Theory

Klein

The paranoid-schizoid position is a way of organizing experience, which is common to all individuals as infants, in which the self and others are seen and known as either a good object, deserving of and providing love, or a bad object, deserving of and providing hate. The ego alternates between these two mutually exclusive loving and

hateful states (Mitchell & Black, 1995). The paranoid-schizoid position is characterized by the constant, overriding fear, or paranoia, that the self or the ideal other will be annihilated by a persecutory bad object (Segal, 1964; Mitchell & Black, 1995).

Throughout life, an individual will struggle to manage this paranoid anxiety. This fear of annihilation is related to an individual's own aggression. As a result, some of her aggression is projected onto external objects. Because a world filled with malice is not tolerable, the individual also projects some of her loving impulses onto external objects (Mitchell & Black, 1995).

As an infant matures, a natural tendency toward integration impacts the way experience is organized. Consequently, the perception of a whole object, which is sometimes good and sometimes bad, develops. The infant now relates to the world from the depressive position (Mitchell & Black, 1995). Now that objects are viewed as whole, the individual has ambivalent feelings toward objects. When she experiences frustration and fantasizes about destroying the ideal object, she is destroying the entire object, not only the split off bad object. By destroying the ideal object, she destroys her guardian and the anchor of her internal world, which provides her sense of safety (Mitchell & Black, 1995). Depressive anxiety is now dominant, characterized by extreme guilt and terror created by her destructive capacity (Mitchell & Black, 1995; Segal, 1964).

In the depressive position, repression takes the place of splitting. The ability to form symbols develops, which allows for sublimation, and the ability to connect ideas and think abstractly emerges (Segal, 1964). Relationships with others include both love and hate. After a destructive fantasy, the individual experiences profound remorse, along with love and concern for the object. Thus, reparative fantasies are created to undo the

destruction and heal the object (Mitchell & Black, 1995). Ideally, through repetitive cycles of loving, frustration, destruction, and reparation the child is able to preserve her relationships with whole others and internalize her reparative capacity which balances and makes up for her destructive capacity (Mitchell & Black, 1995, Segal 1964).

Forgiveness may be viewed as a reparation fantasy (Herman, 1997).

Relationships are more complex and more resilient when an individual is in the depressive position. In the paranoid-schizoid position, love is untainted but fragile. In the depressive position, love has been hardened by cycles of frustration and reparation. Love is more robust and more profound, but is contingent on a belief in an internal reparative ability. (Mitchell & Black, 1995). In the depressive position, an individual begins to distinguish between psychic reality and external reality. She recognizes impulses and fantasies as belonging to psychic reality (Segal, 1964). When psychic pain is experienced, as in trauma, a vicious cycle is set up. The experience of the pain caused by reality causes unhealthy projective identification which causes reality to become more persecutory and painful (Segal, 1964; Kirshner, 1994).

Throughout life, an individual will revert from the depressive position to the paranoid-schizoid position. Severe stress will induce this shift (Mitchell & Black, 1995). During an assault, ego boundaries are permeable and the ego is more vulnerable to fusion, merger, or fragmentation. The victim is forced to contain the projective identification of the attacker (Eagle & Watts, 2003). After trauma, the survivor regresses and begins to employ primitive ego defenses. These include projection, introjection, projective identification, splitting, and denial (Eagle & Watts, 2003). A trauma survivor's world can be overcome with paranoid-schizoid experience. In this world,

persecutory part objects are projected out onto others, where they increase their attack. The survivor then re-introjects the part objects in an attempt to regain control (Boulanger, 2007).

Annihilation anxiety provides an accurate description of the terror experienced during severe psychic trauma. In the midst of the terror experienced during trauma, internal psychic reality and external reality become one (Boulanger, 2007). For an adult who has become accustomed to the depressive position, characterized by ambivalence, experiencing trauma and returning to an internal object world dominated by persecutory objects is extremely disorienting. Now, she is without subjective self, without agency, without history, and is incapable of using her internal objects (Boulanger, 2007). Many survivors will be paralyzed by annihilation anxiety at some point during therapy (Boulanger, 2007).

Fairbairn

The moral defense. Fairbairn observed that neglected children were reluctant to label their parents as bad even if the parents had been physically abusive or were alcoholic (Mitchell & Black, 1995). Instead, the children viewed themselves as bad which allowed them to internalize their parents as good objects, see the world as a safe place, and maintain a sense of hope. This was a more tolerable understanding of the world (Sutherland, 1989; Boulanger, 2007). Fairbairn proposed that the child tries to control her parents by internalizing them, but because they are so powerful, they act like evil spirits within the child. The child cannot survive without her parents, so she internalizes them at the superego level (Sutherland, 1989). At the subconscious level, the child's guilt acts as a defense. If she lets go of her guilt, she must also let go of her

parents, which is terrifying (Sutherland, 1989). This defense evolved from the belief that “it is better to be a sinner in a world ruled by God than to live in a world ruled by the devil” (Fairbairn, 1952 in Boulanger, 2007, p. 59). Unless considered carefully, forgiving a transgressor may perpetuate a survivor’s internalization of other bad objects. Guilt must also be addressed before forgiveness is contemplated.

Hysteria and war neuroses. Fairbairn viewed ‘hysterical conversion’ as a defense which is used when repression can no longer be sustained and the client feels compelled to enact the repressed situation. A reaction to external stimuli which reactivates repressed memory and can be expressed through somatization (Sutherland, 1989). Fairbairn proposed that a ‘hysteric’ attempts to identify external, accepted others while remaining ignorant of the part of the self which has been rejected (Sutherland, 1989). Fairbairn considered a survivor’s experience of talking about childhood sexual abuse as renewing her relationship with a bad object. He saw shame as a reaction connected to identification with early objects (Sutherland, 1989).

Fairbairn coined the term war neuroses, acknowledging that veterans’ symptoms were psychological rather than neurological (Boulanger, 2007). Fairbairn’s experience with war neurosis involved assessing the mental status of veterans and discussing their treatment (Sutherland, 1989; Boulanger, 2007). He noted that soldiers with war neuroses were demonstrating that traumatic events in an individual’s external world can disrupt the balance established between person and environment (Sutherland, 1989). Fairbairn identified veterans’ separation from their families as one component of the trauma they experienced and also took group morale into consideration (Sutherland, 1989). Fairbairn divided the veterans into two groups, those who were only dealing with separation from

their family systems and those who had encountered extremely dangerous situations. He viewed trauma as being attacked by bad objects (Sutherland, 1989).

In working with veterans with ‘war neurosis’, Fairbairn was particularly interested in their use of splitting as a defense and their varying levels of attachment with family members (Sutherland, 1989). He wrote that the most significant factor that contributed to a soldier’s breakdown is his “infantile dependence upon his objects” (Fairbairn, 1952 in Boulanger, 2007, p. 51). Fairbairn viewed the intrapsychic structure as a closed, fixed system. Therefore, personality cannot be changed in adulthood (Boulanger, 2007). Fairbairn’s theory does not have a mechanism to explain a client’s encounter with the external world that is overwhelming and incongruent with her internal world. Traumatic memories are connected to bad internal objects, but the client has a passive role in her experience (Boulanger, 2007).

Treatment. According to Fairbairn, the role of the therapist is to become a safe, good object who can remove the survivor’s devils by accepting their projection (Sutherland, 1989). The release of bad objects through transference is preferable to the unplanned release of these objects due to fear of being attacked. Fairbairn described this fear, and the resulting adaptive behavior, as a major symptom of war neurosis. Repetition compulsion is the alternative to treatment (Sutherland, 1989).

Winnicott

Both infants as they develop and individuals throughout life need to experience an adequate holding environment: time spent with another when they feel completely connected, secure, loved, and provided for (Flanagan, 2008). A therapist’s role is to create a holding environment in which a client is able to interact naturally within the

therapeutic alliance and allow feelings to unfold (Flanagan, 2008). The ‘good enough’ mother has the capacity to contain the infant’s emotions. The infant develops her processes of introjection, reparation, and concern for the other in order to preserve and protect her mother (Kirshner, 1994). An individual’s sense of continuity develops during infancy. In the caregiver’s presence, as she rocks and soothes the infant, matches the infant’s feeling states, and adopts a feeding schedule to meet the baby’s needs, the infant experiences the absence of time. In this absence of time, the baby is able to go on being, while strengthening her ‘true self’ (Boulanger, 2007). Winnicott emphasized the importance of continuity in developing a healthy psyche. This continuity is disrupted by trauma (Boulanger, 2007).

Winnicott pictured the realm of transitional experience as the transition between two ways of viewing the self in relation to others. It exists between the experience of subjective omnipotence, characterized by self-absorption, and objective reality, characterized by artificial adjustment to the outside world (Mitchell & Black, 1995). The importance of transitional space is mediating the impact of reality’s impingement (Eagle & Watts, 2002). Trauma is an impingement which changes the internal object relations of the survivor. It occurs in the realm of transitional experience, where it is possible to encounter new dimensions of experience. Trauma can induce toxic object relations configurations (Eagle & Watts, 2003).

A breakdown is the “failure of a defense organization”, a breakdown of the self as a result of a significant environmental stressor (Winnicott, 1974, p. 103). Fear of breakdown is connected to the individual’s life experience and environmental inconsistencies. Clients often fear a breakdown which has already occurred (Winnicott,

1974). Trauma survivors continually fear a breakdown which has already happened (Boulanger, 2007). There are a number of “primitive agonies” which can cause a breakdown (Winnicott, 1974, p.103). These include “feelings of falling forever, of falling to pieces, losing the relationship between body and mind, the loss of continuity and...having no means of communicating with another” (Boulanger, 2007, p.23). An experience of the threat of annihilation can produce these “primitive agonies” (Boulanger, 2007). Severe trauma induces the fear of annihilation which causes catastrophic dissociation. This near encounter with death makes it impossible to ‘go on being’. This dissociation is “the death that happened but was not experienced” (Boulanger, 2007).

Winnicott envisioned the therapeutic environment as a place where a client can continue her developmental process. He saw the therapist’s role as one in which she tries to understand the client’s individual experience at the deepest level (Mitchell & Black, 1995). This is accomplished by allowing the client to “go on being” (Flanagan, 2008) to connect with her present experience and articulate this experience (Mitchell and Black 1995). Optimal development involves an environment in which the client is held, lovingly and protectively, without being too tightly constrained. It is necessary to balance attachment and the client’s capacity to be separate (Flanagan, 2008).

Mahler

Mahler proposed four phases in the process of separation and individuation. The fourth stage of this process is termed “on the way to object constancy”, where object constancy is the ability to maintain the belief in an object’s goodness even when the object is currently being hurtful or disappointing (Flanagan, 2008).

Important Defenses in Object Relations

Introjection plays a significant role in object relations theory. Introjection is the process of internalizing entire relationships with others or just one aspect of an object (Flanagan, 2008). Through introjection, an individual is able to master an experience in which others are hurtful or disappointing. When this occurs, the "badness" of the hurtful object is taken in (Flanagan, 2008).

A more complex identity is created through the process of projective identification, during which intolerable feelings are split off and projected onto others. This serves as a form of communication (Srinath, 1998). While projection is an intrapsychic process, projective identification occurs within a dyad (Flanagan, 2008). In infancy, a child's intolerable feelings are communicated through projective identification. The parent receives these feelings through introjective identification. She then gives meaning to the child's experience and transforms them cognitively into a more manageable form. The infant eventually internalizes this process and her identity is constructed through these progressive identifications (Srinath, 1998).

Through projective identification, trauma survivors enact the role of part objects in the externalization of the transgressor's intrapsychic world. The survivor is imprisoned in the perpetrator's internal object world without access to her own less toxic and familiar objects (Boulanger, 2007). Projective identification can be used defensively after trauma in two distinct ways. The intolerable fear or hopelessness felt during the trauma can be directed toward others who are seen as holding those feelings or the survivor may take in good or bad traits of the other (Srinath, 1998). In therapy, the clinician has the opportunity to provide corrective experiences (Flanagan, 2008).

The Therapeutic Relationship

A vital task for the clinician is to be ready, when others are unable, to recognize the magnitude of the survivor's loss and to work with her to create a meaningful perception of her collapsed self. The therapist must be able to grasp the depth of the damage inflicted by the survivor's encounter with reality with the aspiration of being a good enough object who the survivor can introject without harm (Boulanger, 2007). In developing a shared understanding of the survivor's experience, the therapist can begin to address the survivor's overwhelming sense of isolation. The survivor can begin the process of reestablishing trust (Boulanger, 2007).

Reenacting a traumatic event within the treatment relationship may be the only option the survivor has for communicating her level of suffering, which she is unable to articulate. In her extreme distress, she makes use of projective identification (Garland, 1998c). The client's "wish to annihilate" is aimed at both the therapist, as the one who perceives her, and herself, as the one being perceived. The survivor struggles to differentiate the two (Garland, 1998c). A client acquires her identity through the unconscious process of identification with various aspects of her objects. She develops the ability to alternate between her own perspective and how she is viewed by others (Srinath, 1998). When an individual perceives that she is viewed as an object to be destroyed, her sense of self is deeply altered and destabilized. The presence, physically or through internal representation, of others who view her as benign can partially ameliorate the effect of the harmful other (Boulanger, 2007).

Object relations treatment of a trauma survivor involves working with the individual and her object world, not the traumatic event, in a way that enables integration

of the event into her view of herself and the world. This mode of treatment makes it possible to let go and mourn any losses associated with the event, including changes in her perception of herself and the world (Garland, 1998b). Ferenczi appeared to endeavor to become the good object for his traumatized clients or minimally, to provide a reparative experience by offering unlimited patience, compassion, understanding, and kindness (Kirshner, 1994).

It is vital for the therapist to balance being open to the survivor's experience and willing to take it in while being secure enough to avoid being destabilized by it. This process of containment is critical to the treatment but presents a significant challenge. The client may both fear and hate the clinician before trust is established (Garland, 1998c). The therapist follows the client's lead and the majority of the work occurs in the transference as the therapeutic relationship develops. The role of the therapist is to create a secure environment in which the survivor's experience is contained and simultaneously create an opportunity to repair the damage done to the internal object world by the trauma (Garland, 1998c).

Above all, the therapist must provide a holding environment that the client actively experiences as the basis of effective treatment. The therapist needs to be available as a container capable of reverie. In working with a trauma survivor, she must engage her more actively to reestablish the ability to think about the event and to avoid allowing dysfunctional relational patterns to become ingrained (Eagle & Watts, 2002). The goal of an object relations therapist is to help change an intolerable experience into a form in which it can be articulated and considered cognitively instead of continually being overwhelmed by it. A flashback is a failure of the internalized container, the place

where “thinking about something” can occur (Garland, 1998b, p. 110). The loss of the internal container is related to the subjective loss of self (Garland, 1998b).

The therapist should strive to achieve optimal pacing to avoid flooding or overwhelming the ego. She should endeavor to reestablish and maintain ego boundaries and functions (Eagle & Watts, 2002). The clinician should work to restore the good object by engaging in transference as well as optimizing already established connections to earlier introjects. The level of intervention must correspond to the survivor’s level of need (Eagle & Watts, 2002). Significant components of effective treatment for trauma survivors include a willingness to discuss details of the traumatic event while paying attention to the empathic connection, establishing and maintaining safety in order to work in the transference, and most importantly, the provision of a new object experience (Kirshner, 1994). Even when the therapist approaches her work with the best of intentions, there is a possibility that she may re-traumatize the survivor (Kirshner, 1994).

An Object Relations Perspective on Trauma and Forgiveness

Forgiveness must be understood and discussed within a frame of reference, like any moral quandary. Using a psychodynamic approach, this includes the exploration of developmental and psychological factors (Haaken, 2002). Psychodynamic psychotherapy is focused on the internal process of forgiveness. Treatment centers on developmental history and internal object relations. Reaching the state of forgiveness is less important than understanding self and other objects, unconscious motivations, and psychological defenses and the way all of these relate to the trauma narrative (Haaken, 2002). A psychodynamic perspective of forgiveness includes an assessment of internal object relations: who are the dominant objects in the survivor’s internal world? How would

forgiving the perpetrator reorganize or change this internal world? How significant would these changes be? (Haaken, 2002). In stating the mental health benefits of forgiveness, it is critical to differentiate between the transgressor as the survivor's internal object and the transgressor as an individual in her external world of relationships. When discussing the repair of the external relationship, it is important to recognize that the perpetrator may also play a vital role in the survivor's internal object world (Haaken, 2002). Both the external role and internal representation must be addressed in therapy (Haaken, 2002). One of the goals of treatment is to develop a "richer, more complex, and flexible" internal object world (Haaken, 2002, p. 175). Considering forgiveness is more challenging for a client with rigid or predominantly negative object expectations (Haaken, 2002).

In working to forgive, the survivor must first develop empathy for the perpetrator. To do this, it is necessary that she move from the paranoid-schizoid position to the depressive position and have the ability to tolerate ambivalence (Verhagen, 2006). The ability to tolerate ambivalent feelings about the self can also occur. In the depressive position, the client is capable of participating in reciprocal relationships (Verhagen, 2002). However, the survivor may need to build on her capacity to retaliate, beginning in the paranoid-schizoid position, before she can begin to integrate her good and bad self objects and move toward the depressive position (Haaken, 2002).

Because of the moral value often associated with forgiveness, the superego may be an important consideration. A survivor's conscience and sense of the greater good may cause her to minimize her anger and outrage. A primitive, harsh superego, particularly one influenced by authoritarian religious or cultural dogma, may be quite difficult to

override (Haaken, 2002). Encouraging forgiveness may foreclose on personal development (Lamb, 2002b). Insisting on differentiating between good and bad forgiveness may not allow for ambivalence and may foreclose on the survivor's internal process of resolving conflict. This artificial boundary also minimizes the complexity of human interactions that may benefit from repair (Haaken, 2002).

The development of the ability to forgive may be evidence of progress toward the depressive position, toward the ability to tolerate ambivalence and integrate object aspects. It is also possible that the decision to forgive is a reaction formation, a defense against paranoid anxiety (Haaken, 2002). Forgiveness may also be viewed as a form of undoing, as a survivor attempts to undo her identity as a victim or simply undo the traumatic event (Haaken, 2002 in Lamb, 2006).

A client may need to protect herself from awareness of her anger for a number of reasons. The anger may trigger anxiety about further violence and her own destructive ability. Denial and projection may serve as ego defenses in this situation (Young & Gibb, 1998). All individuals struggle with childhood memories of being treated unfairly and having wanted revenge. Only when this desire is confronted can the client grieve and consider forgiveness (Steiner, 1987 in Young & Gibb, 1998). A traumatic event is often experienced as profoundly unjust. Some survivors become fixated on the injustice of the event. Holding onto the emotion of grievance may not allow a survivor to let go of her identity as a victim (Young & Gibb, 1998).

Focusing on injustice may serve to shield a survivor from a profound sense of loss and suffering as well as feelings of guilt and shame. Forgiveness and reparation are only possible in a relationship after a survivor has expressed her wish for revenge both in

fantasy and in tolerable ways in her relationships (Young & Gibb, 1998). Expressing resentment may be seen as too damaging to her pride. Anger and destructiveness may be seen as too dangerous or violence provoking. In these cases, grievance has to be maintained (Young & Gibb, 1998). Thus, if grievance is serving as an adaptive defense, this must be explored and addressed before the topic of forgiveness can be introduced.

A Forgiveness Model

In her book, *Helping With Forgiveness Decisions* (1998, currently out of print) Affinito (2002) proposes a psychodynamic model for addressing forgiveness in counseling. She intentionally distinguishes between “forgiveness in counseling”, which acknowledges that clients may raise the issue of forgiveness in therapy, and “counseling forgiveness”, in which forgiveness is a stated goal (Affinito, 2002, p. 88). She outlines several phases in this process: allowing the client to share her experience of the injustice, collecting information, choosing an action, and finally, deciding whether or not to seek punishment (Affinito, 2002).

The first step in this model involves the exploration of the client’s experience of the event, including all associated feelings (Affinito, 2002). The therapist validates the client’s experience and emotions and allows her to express any rage or vengeful fantasies. The goal of this phase of treatment is to lessen anger, resentment, and preoccupation with the transgressor (Affinito, 2002). A reasoned decision must be based on all of the information available. Thus, the next step entails examining the impact of the event on the client, what intrinsic rules were broken, and the effect the event had on the community (Affinito, 2002). The transgressor’s motives and the client’s sense of responsibility and guilt are considered with the goal of empowering the client. Being able

to view the offender as a human being with faults makes him seem less powerful (Affinito, 2002). The final goal of addressing forgiveness in counseling involves deciding whether to seek punishment for the perpetrator. Affinito (2002) notes that forgiving someone may involve accusing him. It is crucial for the client to think through all aspects of her decision and carefully consider the risks, benefits and possible outcomes (Affinito, 2002).

When considering punishment, it is essential to think about how much control the client has over whether the outcome she desires will occur. She must recognize that punishment will not necessarily affect her emotional connection to the transgressor (Affinito, 2002). It is important to discuss her expectations of how this punishment will impact the future. It is also significant to distinguish punishment and vengeance (Affinito, 2002). Deciding not to punish does not mean not taking action (Affinito, 2002). Affinito (2002) explicitly states that she is an advocate of her definition of forgiveness: “the decision to forgo the personal pursuit of punishment for the perpetrator(s) of a perceived injustice, taking action on that decision, and experiencing the emotional relief that follows” (p.93). She writes that the only circumstance in which forgiveness should be rejected is when punishment is chosen instead (Affinito, 2002). Choosing to forgive is “worthy of consideration” as it can lead to improved mental health and the client’s ability to lead a more productive life as a member of society (Affinito, 2002, p. 109). Affinito does not appear to address the complexity of coming to terms with not seeking punishment. Nor does she address the fact that the decision to forgive may need to occur multiple times as the client remembers the event and re-experiences all of the associated emotions.

In this chapter, I have examined the treatment of sexual trauma using a psychodynamic approach based on object relations theory and considered the topic of forgiveness within this framework. Forgiveness, which is often viewed as a religious concept, was only mentioned directly in one resource which may reflect a long historical divide between psychoanalysis and religion.

In the next chapter, Chapter VI, I will discuss and analyze my findings, synthesize the elements of the two perspectives examined, and consider the limitations of the study. I will conclude with synthesis and analysis of the literature reviewed as well as recommendations for practice and suggested areas for further research.

CHAPTER VI

DISCUSSION

The purpose of this study has been to explore the question: What is the theoretical basis for understanding the possible therapeutic value of encouraging a sexual assault survivor to forgive her transgressor? In this final chapter I provide an analysis of my findings, seek elements of synthesis between the perspectives reviewed, and explore the limitations of the study. I conclude with recommendations for practice and areas for continued research.

Summary

The previous five chapters have addressed the research question on the theoretical basis of forgiveness interventions for sexual trauma survivors through introducing the topic, outlining methodology and terminology, summarizing the treatment of sexual trauma, describing the current treatment practices, and reviewing the literature from both cognitive behavioral and object relations perspectives on the treatment of sexual trauma and the understanding of forgiveness.

In Chapter III, I introduced the phenomenon of the treatment of sexual trauma. A review of the history of the treatment of this population highlights the invalidation of the experiences of survivors. The mental health community has alternated between attributing the psychological symptoms which occur as a result of trauma to the character weakness of the survivor and the incapacitation of the psyche after being overwhelmed.

The experiences of sexual trauma survivors began to be viewed differently when rape was recognized as an act of violence. It is important to recognize the role of women in society and the issues of oppression and vulnerability that have influenced the history of the treatment of sexual trauma. Part of the rationale for doing this study was to prevent the use of forgiveness interventions from being yet another avenue for the invalidation of a survivor's experience or a further misuse of power in asking a female survivor to forgive a male perpetrator.

Also in Chapter III, I explored the experience of trauma and post-trauma. During trauma, because the individual's emotional system is overwhelmed, she is not able to form a cohesive memory or a coherent narrative of the experience. Instead, this memory is stored in fragments which cannot always be voluntarily retrieved. After the trauma, there is a loss of agency, as well as a pervasive sense of hopelessness and futility accompanied by emotions of profound loss and anger. A survivor's life may become organized around avoiding traumatic memories, leading to adaptive behavior. In addition, she experiences changes in her psychological defenses and self-concept and strong feelings of guilt and shame. These alterations may precipitate the development of a set of personality traits which cause difficulties in interpersonal relationships. These difficulties often play out in the therapeutic relationship. A therapeutic contract can be helpful in outlining the expectations of both the therapist and the client.

The therapeutic relationship with a sexual trauma survivor is complicated by her diminished ability to make decisions and the complex, potent transference and countertransference within the alliance. Difficulties in the therapeutic relationship allow an opportunity for the therapist to model asking for forgiveness and offering forgiveness

as a way to repair the relationship when the therapeutic contract has been broken. Because the first consideration must always be not doing harm, it is vital to pay attention to the client's guilt and shame in this process. It is vital that the treatment relationship is based on persuasion, not coercion, and mutuality, not authoritative control (Herman, 1997). In deciding on the pacing of the treatment, the therapist should act as a consultant (van der Kolk, McFarlane, & van der Hart 1996; Allen, 2001).

Also in Chapter III, I discussed the impact of trauma on a survivor's self-concept and worldview and the importance of assessing this impact. Included in her worldview is her view of relationships with others and related to that, an important aspect of her self-concept is her capacity for empathy (van der Kolk, McFarlane, & van der Hart, 1996). Empathy is frequently noted as a prerequisite for forgiveness.

Lastly, in Chapter III, I examined the phases of recovery for a sexual trauma survivor. Herman (1997) describes these as establishing safety, remembrance and mourning, and reconnection to self and others. Allen (2001) discusses the process of containment and its role in creating safety. The construction of the trauma narrative, which most experts see as vital to recovery, occurs during the process of mourning and remembrance. Herman (1997) proposes that the "fantasy of forgiveness" often arises during this phase of treatment and cautions that when a survivor seeks forgiveness for her perpetrator and does not achieve it, this causes further suffering (Herman, 1997, pp. 189-190). During the reconnection phase of recovery, the survivor looks for opportunities for reparative emotional experiences. Herman (1997) recommends that these experiences occur in relationships other than that with the perpetrator. Later in this chapter, I will discuss forgiveness within the context of ego defenses.

In Chapter IV, I reviewed the literature on the treatment and sexual trauma from a cognitive behavioral perspective, beginning with an outline of the conceptual framework, and then examining current treatment practices and existing forgiveness models. The theoretical basis of CBT stems from learning theory, cognitive theory, and behavioral theory. A major tenet of CBT is the assumption that it is the interpretation of experiences, not the experiences themselves, that determines emotional responses. These interpretations are formed using an individual's fundamental assumptions, also termed schemas and core beliefs. These fundamental assumptions are acquired in childhood and reinforced throughout a person's life. These assumptions allow an individual to make sense of the world. According to CBT, if an emotional response to an event is more severe or prolonged than expected, this is the result of dysfunctional interpretations, which stem from cognitive errors and invalid fundamental assumptions. Traumatic events cause a significant disruption of an individual's fundamental assumptions. A survivor's internal and external worlds are now seen as unreliable. There are five critical aspects of her schema which may have been impacted: perceptions of safety, trust, power, esteem, and intimacy (McCann, Sackheim, & Abrahamson in Shipard et al., 2006).

An examination of forgiveness models which have their roots in CBT also occurs in Chapter IV. Four thought processes related to forgiveness can be addressed through cognitive restructuring. These include: developing empathy for the transgressor, developing awareness of personal faults, assessment and understanding of the perpetrator's behavior, and cycles of rumination. Directly related to the core elements of these existing forgiveness models are: remembering the pain of the traumatic event, developing empathy for the perpetrator, examining times when the survivor has injured

others, and encouraging forgiveness of the perpetrator. Dealing with anger is a focus of these models, too.

Finally, in Chapter IV, I explored the work of forgiveness proponent Robert Enright, who developed and researched a four phase model. Enright states that forgiveness may not be appropriate for survivors of sexual abuse (Enright & Fitzgibbons, 2000). However, he conducts research involving incest survivors (Freedman & Enright, 1996) and does not describe how he determined whether this course of action was appropriate for these individuals. Enright also states that his intervention is client-centered and that the choice to forgive always belongs to the client: she should never experience even subtle pressure to make this choice (Enright & Fitzgibbons, 2000). Yet this study continues until a survivor chooses to forgive. This appears to be another contradiction. Did some participants in his study choose not to forgive and get dropped from the study? Did they not perceive any pressure to forgive while participating in a study where forgiveness was the stated goal?

In Chapter V, I examined the treatment of sexual trauma through a psychodynamic, object relations lens. I included theorists who influenced this school of thought and their conceptualization of trauma, and examined the concept of forgiveness from this perspective, and explored an existing psychodynamic forgiveness model. The literature revealed that working with trauma survivors poses a significant challenge for psychodynamic psychotherapists because trauma is an interaction of what Freud called practical reality, or external events, and psychic reality, or internal experiences. In addition, psychodynamic psychotherapy focuses on a client's agency which is lost after trauma. This mode of treatment is based on examining how drives and internal object

representations shape an individual's response to a traumatic event. There has been debate around whether an adult's intrapsychic world is fixed or mutable.

The literature I reviewed in Chapter V highlights a relationship between containment and symbolism, agency, emotional regulation, object representations, and external connections. Trauma disrupts an individual's internalized container and leads to a survivor's loss of the ability to symbolize. She may also lose her internal objects and the illusions which have allowed her to live without constant anxiety have been shattered. When a therapist focuses on empathic understanding, she can place the therapeutic relationship in opposition to the power of the survivor's experience, which she is unable to articulate (Boulanger, 2007). It is vital to explore the meaning of the traumatic event with the survivor.

Also in Chapter V, I reviewed object relations literature on the treatment of sexual trauma. Experts discuss the importance of the threat of the loss or destruction of the good object, which is the foundation of a stable, secure object relations world. More recent theorists hold the view that personality continues to be shaped by events throughout a lifetime. A traumatic experience is filtered through the existing lens of an internal object world while, at the same time, this internal object world is damaged by the attack on the safety of the good object. A trauma survivor reverts to a more primitive mode of functioning. This may be described as the paranoid-schizoid position, acting as one's 'False self', or a loss of object constancy.

I examined the ideas proposed by several object relations theorists. I examined Klein's premise of the paranoid-schizoid and depressive positions and the importance of projection, introjection, splitting, and reparation within her model. I also explored

Fairbairn's concept of the moral defense, his understanding of trauma, and his belief that the intrapsychic structure of an adult is fixed. Next, I considered Winnicott's conception of the holding environment, transitional experience, fear of breakdown, and his contrasting belief that the developmental process continues throughout a lifetime. Finally, I briefly introduced Mahler's model of development and the idea of object constancy.

According to the literature, when working with trauma survivors, the therapist should attempt to be a good enough object for the survivor to introject so she can begin the process of reestablishing trust and addressing her isolation. The therapist needs to provide introjects which are alternatives to the ones presented by the traumatic event, and possibly some which already existed in her internal object world. Without symbolization, the survivor will use projective identification to communicate her distress to the therapist. The paramount task of the therapist is to establish and maintain ego boundaries which create a holding environment wherein the survivor can change her intolerable experience into a form in which it can be articulated.

Finally, in Chapter V, I examined the literature on forgiveness from an object relations perspective. Within this framework, the perpetrator must be seen as both an internal representation in the survivor's internal object world and a real individual in her external world. Both aspects of the transgressor must be explored. Empathy and forgiveness are only possible when a survivor is in the depressive position, but even in the depressive position, forgiving may be a reaction formation. Becoming fixated on the injustice of the traumatic event may also serve as a defense. In addition, forgiving may be a form of undoing. A psychodynamic model of forgiveness is explored.

Analysis

In this section, I include a discussion of topics which were not directly related to the two theoretical perspectives examined, but which provide further context for consideration of forgiveness in counseling.

History of the Study of Forgiveness in Psychology

Forgiveness was not studied in early decades of psychology research. Piaget and Behn linked the capacity for forgive with the emergence of moral development in the 1930's. In 1945, Litwinski proposed an emotional framework which supports interpersonal forgiveness (McCullough, Pargament & Thoresen, 2000). Pastoral counselors in the 1950's and 60's examined the potential mental health benefits of forgiveness. In the late 1950's Heider defined forgiveness as not choosing vengeance (McCullough et al., 2000). There has been an increased interest in the study of forgiveness since the 1980's in the context of examining moral development (McCullough et al., 2000). The John Templeton Foundation issued a request for proposals on forgiveness research in the late 1990's (McCullough et al, 2000). The Templeton Foundation asked social science researchers to design studies that would demonstrate the benefits of forgiveness (Lamb, 2002a). Lamb (2002a) likens this to drug companies funding research on the usefulness of their new products.

Cautions

In discussing survivors of childhood sexual abuse, Bass and Davis (1994) write that the only requirement for recovery is self-forgiveness. They state that healing does not require developing compassion and forgiveness toward family members who didn't protect the survivor or toward the perpetrator (Bass & Davis, 1994). The authors note that

a survivor is “not more moral or courageous” if they choose to forgive the perpetrator and that it can be “insulting” to encourage a survivor to forgive a perpetrator (Bass & Davis, 1994, p. 161). They also write that if feelings of forgiveness and compassion occur organically and spontaneously, this can contribute powerfully to healing. Forgiveness can reduce the intensity of emotions toward the transgressor and allow separation from him (Bass & Davis, 1994). However, they also state that trying to forgive can foreclose on the recovery process and, depending on the details of the abuse, may not be appropriate (Bass & Davis, 1994).

Mental health professionals do not agree on whether a client should, by choice, endorse a benevolent stance toward the offender (Denton & Martin, 1998 in Konstam et al, 2002). Some forgiveness writers acknowledge that discussing forgiveness with survivors of sexual abuse (Freedman & Enright, 1996) or in cases of domestic violence (Affinito, 2002) is potentially harmful, ill-advised, and inappropriate. Yet, they may believe this concern is based on the misunderstanding that forgiveness involves reconciliation (Freedman & Enright, 1996).

Cautions related to gender and oppression. Issues related to power dynamics must be addressed when discussing forgiveness (Verhagen, 2006). Granting forgiveness implies the use of power for a survivor, who is feeling powerless. This may make the decision to forgive a transgressor more appealing (Haaken, 2002). Females are conditioned to privilege relationships with others whereas males develop with individuality as a priority (Gilligan, 1982 in Lamb, 2002b). It is worthwhile to consider the concept of “role-expected forgiveness” (Trainer, 1981/1984 in Lamb, 2002b).

Lamb (2006), who self-identifies as a feminist psychologist, writes that in case examples used in forgiveness literature, the clients are most often women. She notes that male victims of Catholic clergy abuse are not being encouraged to forgive (Lamb, 2006). Gender and role expectation issues may arise in transference and countertransference. It is important for the therapist to pay attention to how cultural expectations of women and anger may be playing out (Haaken, 2002). The therapist must help the survivor explore options for communicating anger. If sexual abuse survivors are encouraged to forgive this may foreclose on the process of dealing with her anger and reinforce the social dictate that women should not express anger (Burstow, 1992 in Lamb, 2002b).

Without intending to do harm, when a therapist advocates forgiveness with a sexual abuse survivor, particularly early in the treatment, she places an additional responsibility on the survivor (Lamb, 2006). Battered women are at particular risk for remaining in dangerous situations when they forgive abusive partners (Lamb, 2002b). Even forgiveness advocates write that promoting empathy for an abuser requires particular care and caution. The therapist must beware of condoning the abuser's behavior or identifying with the perpetrator (Wade & Worthington, 2005). A forgiveness intervention is contraindicated when the perpetrator has not shown remorse, the violation is too severe, or the traumatic events are too recent, but forgiveness may be effective for some sexual abuse victims (Noll, 2005).

Karen (2001) notes that the desire to repair a damaged relationship is an innate human impulse and forgiveness is one possible form of this reparation. It can serve to reconnect individuals who are kept apart by alienation and hatred and allow a survivor an avenue for release from bitterness and primary identification as a victim (Karen, 2001).

He goes on to say that he will not focus on trauma in his exploration of forgiveness (Karen, 2001). This is yet another reminder that while there may be therapeutic value in forgiveness, it may not be appropriate in working with trauma survivors. Thus, the therapist must exercise extra caution.

Restorative Justice

Affinito (2002) believes that therapists must understand forgiveness within the context of injustice. This involves being aware of the alternatives of retributive justice, restorative justice, which includes victims' rights organizations, and pervasive justice, which involves seeking justice for an entire community (Affinito, 2002). The topic of retributive justice was raised in Affinito's (2002) forgiveness model. I have not examined literature on restorative justice or pervasive justice.

Authors have mixed opinions on the subject of unilateral forgiveness, that is, forgiveness which is offered without an apology or expression of remorse from the perpetrator. Lamb (2006) is concerned that forgiveness therapy focuses on the decision of the survivor to forgive the perpetrator independent of perpetrator remorse. She writes "an injustice can be committed through unilateral forgiveness" (Andrews, 2000 in Lamb, 2002a, p. 8). Others note the "in spite of" character of forgiveness (Tillich, 1940 in Affinito 2002, p. 99). They state that not allowing a survivor to consider forgiveness unless the perpetrator asks for it requires her to remain angry with and connected to the perpetrator. The process of forgiving returns energy to the client, which she can put into living with a healthier, more compassionate outlook (Affinito, 2002).

Although forgiveness is discussed in the context of both recovery and eating disorders, I have not explored these topics in this study.

Synthesis

View of the Treatment of Sexual Trauma from Both Perspectives

From both CBT and object relations perspectives, trauma damages a survivor's internal and external worlds. An internal object relations world, using object relations terminology, is called a schema in CBT terminology. In both frameworks this internal world is populated by internal representations of the self and important others, internal representations of the relationships, and the attributes of these symbolized individuals and relationships. In addition, the survivor's ability to participate in external relationships has also been damaged. The two theories diverge on how to address internal representations of self, other, and relationships in treatment. In CBT, cognitive restructuring would be used to identify cognitive errors or faulty attributions. In object relations based therapy, the therapist would explore these internal objects while simultaneously attempting to provide a corrective alternative introject.

Both CBT and object relations based therapy examine psychological defenses and behavior which has developed as an adaptation to the trauma. In CBT, maladaptive behavior might be addressed using some type of exposure intervention. The two theories acknowledge a survivor's inability to articulate her experience. In object relations theory, this is placed within the context of containment and the therapeutic relationship is identified as an environment in which containment can be re-established. While both theories note that psychological defenses must be considered, CBT would not address these defenses directly as it does not focus on a client's intrapsychic experience. Later in this chapter I will outline specific ego defenses to be assessed when working with a trauma survivor and considering forgiveness of the perpetrator.

Understanding of Forgiveness from Both Perspectives

Through an object relations lens, forgiveness can be seen as one possible means of reparation after a relationship with a good object has been damaged. In order to be capable of this act of repair, the individual must have reestablished her sense of agency and be able to recognize that she has this reparative capacity. This application of Kleinian theory is most applicable when the survivor had an already existing relationship with the perpetrator at the time of the traumatic event and the perpetrator was previously viewed as a good object. A relationship which did not previously exist, or which was not benevolent might not benefit from reparation.

Although forgiveness models were specific about the process of forgiveness, I did not find any explanations of the CBT theoretical basis of forgiveness in the literature.

Complexity

A comprehensive discussion of the therapeutic values of forgiveness must address the complexity of the issue. As with most concerns that arise in treatment, what is appropriate should be decided on a case by case basis. Haaken (2002) asks, “Is there a productive middle ground between an overidealization and a devaluing of forgiveness (Haaken, 2002, p. 184)?” I believe our task as clinical social workers is exactly that, to find a middle ground, to meet the survivor before us where she is, assess the details of her particular situation, and support her exploration of forgiveness of the perpetrator if she is interested doing so.

Ambivalence

As a psychodynamic psychotherapist, it is crucial to be attentive to signs of ambivalence when a client has consciously made the decision to forgive. Helping the

client tolerate and accept this ambivalence and acknowledge her unforgiving self allows active engagement with feelings of aggression which still exist (Haaken, 2002). Karen (2001) writes that while anger can be a precursor to forgiveness, an individual can feel anger and forgiveness at the same time (Karen, 2001). Lamb (2006) raises a concern that if therapy is focused on forgiveness, diverse truths and experiences may not be encouraged and valued, especially those which may be difficult for the survivor and the therapist (Lamb, 2006). I echo her concern. I did not find a discussion of ambivalence in the CBT literature on forgiveness. The phase models presented recognize that a client will not always progress through the phases in linear order, but discussions of anger and forgiveness are kept separate. It is not clear whether ambivalence would be valued if it arises and how it would be addressed.

Survivor/Perpetrator Relationship

Although they possess both intrapsychic and interpersonal dimensions, trust, empathy and forgiveness must all be discussed within a specific relational context (Verhagen, 2006). For this reason, it is vital to explore the survivor's relationship with perpetrator. Did they have a relationship before the traumatic event? Was the perpetrator ever a good object in the survivor's life? Reparation of the relationship between the survivor and the perpetrator will have a different character and level of importance depending on the answers to these questions. If the survivor had never met the perpetrator before the incident, he may not have been represented in her internal object world. If the sexual assault involved a father or grandfather, there may have been an existing internal representation of both the perpetrator and the relationship beforehand. If the survivor was

attacked by a good object, this significantly damages her intrapsychic world. Not only was her internal container destroyed, it was destroyed by a previously benevolent object.

Therapeutic Stance

In considering the topic of forgiveness of the perpetrator of sexual trauma, a therapist must be clear in her therapeutic stance. If she is using a psychodynamic approach, she will be non-directive and allow the client to decide whether forgiveness is a topic she wishes to explore. If it is, it will be only one aspect of the treatment, and the exploration should include a thorough examination of the client's object relations.

If the therapist is using a CBT approach, she will be more directive. She may encourage the survivor to forgive the perpetrator, but she should be very clear and explicit about her motivation for doing so and her role in the process. After making her point of view known, she must allow the client to choose not to forgive. If a client chooses not to forgive, the therapist and client can decide how to proceed from there. As an alternative, a therapist using a CBT approach might consider using the cognitive restructuring techniques of examining the evidence (Wright, Basco, & Thase, 2006) to weigh the pros and cons of forgiving the perpetrator and be less directive about this decision.

A therapist must be aware of her own rationale when discussing forgiveness. If she is inclined to advocate for forgiveness, she may be reacting to her own anxiety provoked by the client's rage (Haaken, 2002). On the other hand, she should not dismiss the topic because of her own personal bias. Working with both sexual trauma (Herman, 1997) and forgiveness (Enright & Fitzgibbons, 2000) requires taking a moral stance. The therapist must be aware of the position she holds. She must also be intentional about if,

and if so, how, she discloses her stance to her client. This will depend on the theoretical perspective she is working from.

The Therapist's Role

I support several of Affinito's (2002) views. First, that it is essential that the therapist explore the meaning of forgiveness within the client's religious, cultural, and moral beliefs (Affinito, 2002). I also agree with her suggestion that the decision whether to forgive a transgressor must be treated like any other decision a client makes in therapy. This process includes exploring the client's view of forgiveness within her moral values (Affinito, 2002). Finally, I concur that no one can be convinced to forgive. The decision to forgive a perpetrator, and then acting on that decision, can only be arrived at after a careful examination of the survivor's intrapsychic experience (Affinito, 2002).

The role of the therapist is to help the client decide whether forgiveness, as one of several possibilities, is the most appropriate decision given her specific circumstances (Affinito, 2002). There are many reasons why, depending on an individual's circumstances, the decision to forgive may be challenging, unattainable, or contraindicated. If this decision has not been carefully considered, or is made without agency, it may serve as an act of self-betrayal (Karen, 2001).

The Superego

The role of the superego needs to be considered in discussing forgiveness. An examination of justice and injustice may include the topics of judgment, guilt, and blame. An assessment of guilt needs to occur early in the process of discussing forgiveness (Affinito, 2002). In addition, forgiveness may be associated with moral or characterological strength or weakness (Verhagen, 2006). Haaken (2002) notes that

stating forgiveness as a goal of therapy may make it more difficult to accomplish. It is also hard to examine psychological defenses and adaptive behavior from a moral perspective. Instead, a psychodynamic approach encourages the exploration of the full range of internal voices which may be silenced by the superego's pressure to forgive (Haaken, 2002).

Forgiveness in the Therapeutic Relationship

From an object relations perspective, one of the tasks of the therapist is to provide a corrective emotional experience. In this case she may be viewed and experienced by the client as a forgiving object and/or a forgiveness seeking object. Working through difficulties in the therapeutic relationship provides opportunities for this corrective experience. This process may be complicated by personality disorder and may require a long period of time. Herman (1997) writes about trauma survivors forgiving themselves and their therapists. Akhtar (2002 in Verhagen, 2006) writes about the importance of the depressive position with respect to forgiveness within the transference relationship (Akhtar, 2002 in Verhagen, 2006). Verhagen (2006) feels that the development of the capacity to forgive the therapist is not sufficient for forgiveness of a perpetrator and that the client's agency in the decision to forgive the perpetrator must constantly be reaffirmed (Verhagen, 2006).

Containment

As I stated earlier, object relations based therapy intentionally creates a holding environment for the trauma survivor. Within this therapeutic container, the survivor may reestablish her capacity to use symbols and both articulate her current experience and construct a trauma narrative. One aspect of the therapeutic process with a sexual trauma

survivor is that of progressive identification. During this process, the survivor may be able to reconstruct her identity (Srinath, 1998). Thus, it is within this external, therapeutic holding environment that she can work to repair her identity and internalize a container. I am concerned if a survivor is engaged in therapy with forgiveness as a stated goal, she may not be willing to sacrifice this container by choosing not to forgive. Similarly, I worry that after a trauma survivor has established a relationship with the therapist, and this therapist has become a good object, she would not want to risk losing this good object by asserting herself and not choosing the agreed upon goal. In therapy, it is always challenging to allow a client to ‘go on being’ and not feel pressured to create a false self in your presence in order to please you. Is it possible for a client to ‘go on being’ when there is an agenda in therapy?

Client’s Religious Beliefs

Garland (1998b) writes that a sexual assault is a demonstration of a catastrophic breakdown of “the maternal container” (Garland, 1998b, p. 108). For a person of faith, God may be seen as an omnipotent, maternal good object, the ultimate container. In this case, it would be important to explore how the survivor understands God’s failure to prevent the traumatic event. Within the context of her faith, how does the client understand suffering? How does her faith impact her understanding of forgiveness? A survivor’s faith may add an additional layer of complication to the discussion of forgiving the perpetrator which must be explored thoroughly.

Implications for Practice

Education

Affinito writes “to advocate forgiveness without sufficient definition and training may be to practice outside one’s level of competence and, therefore, to verge on the unethical” (Affinito, 2002, p.88). I propose that a therapist who is considering discussing forgiveness with a sexual trauma survivor must invest time in learning about forgiveness in counseling, be willing to explore and understand her own perspective on the topic, and be willing to thoroughly explore this issue with the survivor. This will include acknowledging and dealing with the ambivalence that will arise.

Assessment

In their analysis of interventions that promote forgiveness, Wade and Worthington (2005) ask how to identify clients for whom a forgiveness intervention is appropriate. This question is particularly pertinent in working with trauma survivors. In considering the topic of forgiveness of the perpetrator of sexual trauma, the first step is a careful evaluation of the client’s situation with regard to safety. If a client came into therapy seeking to forgive her perpetrator of incest, I would be honest about the complexity of the task, my reservations about setting this as a goal of the therapy, as well as my willingness to explore this process with her thoroughly and carefully.

I feel it is important to assess whether a client is psychologically capable of forgiving a perpetrator. Because Kleinian object relations theory offers one possible way of considering forgiveness, I will discuss assessment of a client’s object relations in terms of the Kleinian position she is in. As was discussed in Chapter V, after trauma, even if an individual had previously reached the depressive position in her interpersonal relations,

after a traumatic event she would likely revert to the paranoid-schizoid position. The depressive position is characterized by the ability to tolerate ambivalence and participate in multifaceted, flexible relationships. In contrast, the paranoid-schizoid position is typified by the ego defense of splitting, which may manifest as the cognitive error of black and white thinking in CBT. An individual who is located in the paranoid-schizoid position is unable to see the perpetrator as a whole object with both good and bad qualities. She is incapable of feeling both anger and compassion toward the perpetrator. Thus, it is not reasonable, and would not be beneficial, to encourage a survivor to forgive the perpetrator of sexual trauma unless she is currently in the depressive position.

Herman (1997) discusses how borderline personality disorder, which may be the result of sexual trauma, is equated with the failure to achieve object constancy, the failure to form self-soothing introjects, and difficulty in forming an integrated self concept (Herman, 1997), all of which would locate a survivor with these symptoms in the paranoid-schizoid position. An assessment of a client's Kleinian position would involve paying careful attention to how she describes her relationships and how she relates to you in treatment to determine whether she was engaging in splitting or projection. If she is using these immature defenses, she is most likely in the paranoid-schizoid position. Haaken (2002) warns that although some view forgiveness as an indication of movement toward the depressive position, it may instead be a reaction formation. This is further motivation for assessing a client's object relations before discussing, much less advocating, forgiveness.

Further Research

I recommend psychotherapists conduct additional research on the mental health benefits of advocating forgiveness with trauma survivors. Ideally these clinicians will not have designed forgiveness interventions and will not be funded by pro-forgiveness foundations. Further qualitative research on the experiences of therapists, particularly those practicing from a psychodynamic perspective, who are engaged in discussing forgiveness with trauma survivors would also be helpful in shaping protocols on how to approach this topic. Finally, there is a scarcity of research on the experiences of trauma survivors who have participated in discussions of forgiveness in therapy. The narratives collected in this research would be invaluable in determining the therapeutic value of a trauma survivor forgiving a perpetrator.

Conclusion

The therapist's primary and overriding task in working with survivors of sexual trauma is to do no harm, which has direct implications for the consideration of the forgiveness of the perpetrator of the trauma. The therapist must explore and strive to understand the unique circumstances of each survivor's story, including her developmental history, the details of the traumatic event, and whether or not she and the perpetrator had a pre-existing relationship. The survivor's psychological state must be carefully assessed with respect to the defenses of splitting and projection to determine whether she has the necessary ego strength and sense of reality to make a measured, informed decision. Next, the therapist must seek to find a middle ground between encouraging forgiveness of the perpetrator when the circumstances indicate that this may be harmful to the survivor and automatically dismissing the forgiveness of the perpetrator

as a therapeutic intervention. Whether or not the survivor decides to consider forgiving the transgressor, it is critical that the therapist continually acknowledges the complexity of the survivor's decision process and encourages ambivalence throughout this process.

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