

The (Ab)use of Reliving Childhood Traumata

Ruth Miltenburg

BUNNIK, THE NETHERLANDS

Elly Singer

UNIVERSITY OF UTRECHT,
THE NETHERLANDS

ABSTRACT. Most treatments of adult survivors of child abuse are based on the assumption that without memory, without an understanding or felt experience that the abuse is at the heart of the client's difficulties, the survivor is lost. This paper questions this assumption. The alleged therapeutic value of reliving is based on the denial of unbearable suffering, and on an abstract idea of mental health which has its roots in psychoanalytic theories for the treatment of non-abused clients. Reliving abusive experiences can lead to a repetition of the abuse and an exacerbation of the client's problems. Unbearable experiences demand 'abnormal' defence or coping strategies, which are not necessarily undesirable or pathological.

KEY WORDS: child abuse, coping, healing, reliving, therapy

But how are you going to make me suffer the pain that I have managed to avoid in the trauma without a renewed split, that is, without any repetition of mental disorder . . . ? Does it not seem an impossible undertaking?

Ferenczi noted in his clinical diary on 30 June 1932 (Ferenczi, 1988, p. 181) these despairing questions, put to him by a woman who had been seriously abused as a child. Why must the horrific be relived? It feels like being abused all over again. Doesn't this lead to more psychological damage? It is also evident from Ferenczi's diary that he was unable to give the woman any satisfactory answer. Ferenczi disagreed with Freud about the role of actual child trauma in psychopathology, but he subscribed to Freud's theory that psychological suffering is primarily caused by the repression of childhood memories. He also felt that the psychoanalytic cure should be aimed at uncovering the repressed memories and defence mechanisms, and working through the experience that the patient was unable to cope with as a child. However, during the last 10 months before his death, the period of his diary, Ferenczi increasingly came to doubt the therapeutic value of uncovering traumatic memories. It appeared that reliving the abuse sometimes gave temporary relief, but that subsequently the horrors from childhood would return in their full violence.

THEORY & PSYCHOLOGY Copyright © 1997 SAGE Publications. VOL. 7(5): 605-628
[0959-3543(199710)7:5]

After his death in 1933, Ferenczi's work with victims of child abuse was ignored within the world of psychoanalysis. Psychoanalysts may even be accused of playing an active role in the general public denial of (sexual) child abuse. It was not until the end of the sixties that the difficult process of recognition began, first with the recognition by physicians such as Kempe of physical abuse, and subsequently the exposure by feminists of sexual abuse. Only at the end of the seventies were the first therapists and psychoanalysts ready to accept the full truth about abused children, leading them to a reappraisal of the relation between reality and fantasy. This did not, however, imply a re-evaluation of Freud's belief that recovering and reliving the painful events of childhood is an important part of therapy (Krimendahl Wolf & Alpert, 1991). In fact, reliving and recovering memories are common in therapies for clients abused as a child. In a recent study undertaken by qualified American and British therapists it was found that 71 percent made use of the therapeutic techniques to help clients to recover their memories of child sexual abuse (e.g. hypnosis, interpretation of dreams); while 25 percent believed that healing mainly depended on recovering such memories (Poole, Lindsay, Memon, & Bull, 1995).

Memory recovery therapies, however, are controversial. In psychological circles, there has probably been no greater stir in the nineties than the debate over this form of therapy, with many journals devoting special issues to the matter (see, e.g., *American Journal of Psychotherapy*, 1996; *Applied Cognitive Psychology*, 1994; *Consciousness and Cognition*, 1995; *Counseling Psychologist*, 1995; *Feminism & Psychology*, 1996; *Journal of Psychohistory*, 1995; *Psychoanalytic Dialogues*, 1996). But these discussions are primarily about *the reality or validity of the client's memories* recovered while in therapy and the risk of leading non-abused clients to create *false memories*. The nature of memory is in question: whether memories can be repressed and then recovered; whether memory enhancement therapeutic techniques actually 'help' clients 'remember' rather than merely impose explanations for clients' interpersonal problems; whether qualified therapists can tell the difference between fantasies or implanted memories and 'authentic' recovered memories of child abuse. There is also a strong political dimension to these discussions (Schuman & Galvez, 1996). Are survivors of child (sexual) abuse to be silenced again? Has a general backlash against feminism also influenced the debate about false memories of female incest survivors? We will not try to summarize or evaluate the delayed memory debate. In this article we want to raise another issue: Ferenczi's doubts about *the healing power and (ab)use of memory work for clients who have been abused during childhood*.

Nowadays, the danger of renewed traumatization through this reliving is generally recognized (Briere, 1992, 1996; Putnam, 1989; Salter, 1995; Van der Kolk, 1987), but it is treated as more of a *technical and ethical problem*.

New therapeutic techniques are developed to avoid overwhelming the client during the necessary process of reliving. Therapists are warned for ethical reasons not to push too hard and advised to ask for informed consent to make sure that the client knows about the pain and risks of reliving. But therapists seldom raise Ferenczi's *theoretical questions*: Why do we believe that human beings can bear the reliving of their most devastating experiences? Why are we so sure that reliving has a healing power? These are the questions we wish to address in this article.

The Theoretical Arguments

Since the seventies, there have been numerous publications about therapies for people abused during their childhood written from various theoretical perspectives: feminist theories (Bass & Thornton, 1983; Butler, 1978; Driver & Droisen, 1989), psychoanalytic theories (J.M. Davies & Frawley, 1994; Kramer & Akhtar, 1991; Rothstein, 1986; Shengold, 1989), cognitive-behavioural theories (Janoff-Bulman, 1992; Jehu, 1988), trauma theories (Van der Kolk, 1987), hypnoanalytic theories (Kluft, 1986; Putnam, 1989; Van der Hart, 1991), system theories (Trepper & Barrett, 1989) and eclectic theories (Briere, 1992, 1996; Courtois, 1988; Herman, 1992; Meiselman, 1990; Salter, 1995). The therapeutic techniques they recommend are also diverse, but what most have in common is that uncovering and reliving past traumatic experience are seen as necessary preconditions for real healing.

Breaking the Silence

The first argument for uncovering and reliving is related to protest against society's denial of child abuse. The child is too often forced into silence both by the abuser and by the social environment. Socialist feminist theoreticians in particular have drawn attention to the collective refusal of knowledge of sexual abuse of girls by male perpetrators; not only at a theoretical level but also within the helping professions (Bass & Thornton, 1983; Butler, 1978; Driver & Droisen, 1989; Rush, 1977/1996). Psychoanalysis, with its emphasis on children's oedipal fantasies and sexual desires, is blamed for implicitly accusing the child rather than the sexually abusive parents (Rush, 1977/1996). Dissenting from this approach, feminist therapists emphasize the importance of disclosure and validation of the victim's story. Within the feminist helping circuit, uncovering the experience has a political as well as a personal-therapeutic significance. In group therapy, survivors of child abuse can find recognition in each other's stories and feel that they are not alone in having suffered in such a way. Abuse of children, especially girls, is seen as a structural given in our patriarchal society that victims can—together with their therapists—resist by bearing witness and demanding

redress. Many women have been motivated to write autobiographically about their incestuous past; Armstrong (1978) and Fraser (1992) are well-known examples. Socialist feminists locate the 'personal' within the grounds of the 'political', that is, within the context of cultural practices and power relationships.

Today, the damaging effects of 'not wanting to know' and 'blaming the victim' are generally recognized, even by psychoanalysts (Blum, 1986; Shengold, 1989; Steele, 1986). Indeed, most therapeutic theories begin with the premise that not only is the abuse itself traumatic, but also the fact of its denial by those immediately around them and the generally negative reactions to the abnormal behaviour of children who are or have been abused. One should mention here the so-called 'secondary accommodation syndrome' (Summit, 1983).

The argument for breaking the silence is primarily an argument for the *victim's right to speak* and the duty of others to listen and to take action against injustice. There is first a personal and political need for awareness of injustice, suffering and damage caused to the victims (Armstrong, 1996). Only in the context of the so-called 'healing discourse' (M. Davies, 1995) does this speaking and knowing become a therapeutic necessity: if the victim wants to be healed, he or she *must look at the past and relive his or her personal history of abuse*.

Survival Strategies Later Form the Core of Pathology

Rieker and Carmen (1986) articulate rather neatly the therapeutic argument: 'The original defenses employed by both child and adult victims are viewed as adaptive survival strategies that later form the core of survivors' pathology' (p. 360). This argument emphasizes the way in which a child has to adapt psychologically to the abusive environment in order to survive. This adaptation is healthy at the time; the child has no other alternative. For instance, the child learns to deny the abuse, to distrust everybody and to cope with his or her violent emotional reactions. Such strategies will also assimilate the manipulative messages from his or her abusive parent(s), such as 'don't feel', 'be in control at all times', 'nobody will believe you', 'you are a bad boy/girl' (Briere, 1992, 1996; Courtois, 1988; Herman, 1992; Jehu, 1988; Salter, 1995; Steele, 1986; Summit, 1983), and can foreclose the possibility of the traumatic experiences being worked through in a healthy way. The result is then psychopathology.

During therapy, survival strategies have to be dismantled so that the wound can heal and the arrested process of development can be completed. For this reason, according to Courtois (1988), for instance, the survivor is 'urged to remember the trauma of the incest and to feel the emotions which were split off in order to survive the abuse ordeal' (p. 126). The core

objective of the treatment is once again admirably summarized by Rieker and Carmen (1986):

... to help the victim, in a safe and controlled way, to recall the abuse and its original affects and to restore the accurate meanings attached to the abuse: that is, to recontextualize the trauma. ... With this kind of understanding, the abused patient will be able to grieve and to let go of both the trauma and the distortions in memory and affects that once were necessary. (p. 369)

Both socialist feminists and trauma therapists share this belief in the value of speaking out, but beyond that they agree on almost nothing (M. Davies, 1995). At the core of the socialist feminist argument for breaking the silence and uncovering child abuse is a severe criticism of psychoanalysis, which, it is claimed, has pathologized victims of child abuse and legitimized the refusal to believe them. The therapeutic arguments, on the contrary, build on a psychoanalytic foundation. Trauma therapists plead for healing rather than political action. The individual survivor has to face her or his sufferings; he or she has to integrate the abusive experiences in his or her personal biography. To clarify the theoretical background of this therapeutic position, we should return briefly to Freud's work and that of his followers.

Psychoanalysis and the Healing Effects of Uncovering Memories

Freud (1917/1969) saw the repression of painful experiences during childhood as one of the main causes of psychopathology, a fundamental tenet of his psychoanalysis which is still held by present-day psychoanalysts. Unintegrated mental content is held to lead to weakening of the personality, and to result in undesirable behaviour, hysterical symptoms, chronic mourning, post-traumatic stress syndrome and multiple personalities (Eagle, 1991; Greenberg & Safran, 1989). Over the course of development of his theory and associated therapeutic principles, Freud gave several explanations for the pathogenic working of repressed childhood memories. Both his explanations and his therapeutic principles together provide the theoretical framework for the modern 'memory recovery therapies' with survivors of child abuse.

The Catharsis

In the early period of Freud's seduction theory, according to which traumata are the result of sexual abuse, he believed that repression would lead to a damming up of 'psychic energy' that would then be unable to find natural expression (Freud, 1895/1982a, 1904/1982b). Blocked psychic energy was supposed to be injurious, because the organism is: (1) threatened by an

excessive accumulation of excitation; (2) exhausted by the energy that it takes to maintain the repression. If the patient could remember the repressed experience under hypnosis, the psychic energy could then be discharged by expressing the emotions associated with the repressed event, such as anger, fear, desperation or disgust, and following this abreaction or catharsis the symptoms would disappear spontaneously.

In later development of his thought, Freud no longer saw the damming of psychic energy as the core of the pathology, yet he and his followers continued to emphasize the therapeutic value of expressing emotions. Modern hypnotherapists working with abused people, for instance, attach great therapeutic value to the expression of emotions (Putnam, 1989; Van der Hart, 1991), while other therapists working with survivors of child abuse (e.g. Briere, 1992) merely mention catharsis as one of the healing processes invoked by the recovery of the experience.

Recovering and Giving Meaning to Repressed Desires and Conflicts

According to Freud's later theories, repression leads to pathology because (1) the repressed instincts and desires still attempt to achieve satisfaction; and (2) the ego is weakened by repression and the accompanying defence mechanisms (Freud, 1917/1969, 1937/1982c). According to Freud, all repressions have their origins in early childhood; they are the primitive defence mechanisms of an immature and weak ego. Freud (1937/1982c) felt, like many modern therapists, that defence mechanisms were probably essential to the early development of the ego, but that later the same defence mechanisms become a threat to healthy development (a view remarkably similar to the argument of Rieker & Carmen, 1986). The repression causes a person unconsciously to continue searching for satisfaction at an infantile level. The repressed returns in an unrecognizable form, for instance, in the unconscious inclination to reconstruct old conflicts, the unconscious compulsion to repeat, or to delude, weakening the ego through its distorted image of reality. Besides this, defence takes a great deal of energy, which is also weakening. According to Freud, repressed conflicts from childhood should be acted out in a clinical setting during psychoanalysis, in the transference between patient and analyst, and interpreted on the basis of a reconstruction of the childhood experiences that lie at the base of the repression (Freud, 1937/1982c).

Modern psychoanalytic therapists often repeat these ideas of Freud. Salter (1995) writes, for instance: 'By moving from present to past, he [the client] learns what is charged, what counts, what still surfaces today after all these years, what fragments of the past cling like stuck debris to bits of the present' (p. 298). They also maintain Freud's thesis that the ego of the patient has to find the courage to reject the old defence mechanisms (Freud,

1937/1982c). Briere (1992) calls the working through of one abuse memory after another 'an act of extraordinary bravery' (p. 88), during which the survivor should learn the ability to 'experience painful affect for longer periods of time without significant dissociation or tension-reduction' (p. 138).

Empathy and Motherly Care

In developments of psychoanalytic theory since Freud, such as object-relations theory (Mahler, Bergman, & Pine, 1975; Winnicott, 1960/1965) and self psychology (Kohut, 1971), a much greater role is given to the quality of maternal care in the development of psychopathology. Freud's thesis that young children can be overwhelmed by violent emotional conflicts because of their weakly developed ego-organization is generally accepted. The mother figure should support the child's weak ego by fulfilling the role of an 'external auxiliary ego'. A 'good enough mother' reacts empathically to the child's violent emotions, helps to contain, understand and regulate the emotions. She comforts: the reality is not as bad as the child thinks. If the mother cannot fulfil this function, however, the child has to employ defence mechanisms (splitting off or creating a 'false self'), which form the core of later psychopathology. The Freudian idea that early defence mechanisms form the core of the pathology is thus maintained.

Psychoanalysis based on object-relations theory is concerned not only with the recovery of experience in the way Freud saw it, but also by the analyst offering corrective experiences as a good and caring mother-figure. In the presence of the empathic analyst, the painful emotions and old conflicts of the survivor of child abuse can be explored, spontaneously expressed and integrated in the 'self-organization' (Briere, 1992; M.G. Fromm & Smith, 1989; Salter, 1995; Steele, 1986).

Child Abuse and the Psychoanalytic Heritage

In his early work, Freud believed he had discovered that childhood traumata were caused by actual sexual abuse. Later, however, in his seminal *Three Essays on the Theory of Sexuality*, Freud (1905) abandoned this seduction theory of psychopathology in favour of an alternative view of childhood 'trauma', which sees the origin of the neuroses in fantasy and instincts: for instance, the little boy's forbidden oedipal desires towards the mother, or the little girl's deep shame and envy because she has no penis. Freud lost his interest in the psychological effects of real traumata.

Modern psychoanalysts, however, often employ Freud's later theories to deal with a group of clients whom Freud was no longer interested in: adults traumatized as a child by real experiences. We can find Freud's therapeutic

ideas from both early and late stages in their theories: recovering repressed contents; reconstructing the past; acquiring insight into their own defence mechanisms; abreaction, correcting incorrect ideas about self and others; making contact with and acceptance of emotions and desires that were threatening during childhood; the rejection of old pathological and primitive defence mechanisms and the development of healthy and mature ways of expressing emotions and satisfying desires. These Freudian ideas can be clearly found in congress papers such as 'The Reconstruction of Trauma' (Rothstein, 1986) and 'The Trauma of Transgression' (Kramer & Akhtar, 1991), in which psychoanalysts discuss treatment of people abused during childhood. Gillman (1986), for instance, like Freud, emphasizes the influence of 'universal childhood fantasies': incest can encourage the child's oedipal desires, resulting in strong guilt feelings which have to be repressed. For this reason Gillman emphasizes 'reconstruction of the child's experience, including the fantasy formations directly related to the perception of the traumatic event' (p. 74). Working from object-relations theory, Steele (1986) emphasizes the analyst's validation of the emotions and reactions of the patient to the abuse. According to him, the analyst is 'the external auxilliary ego which helps the patient's observing ego understand what happened and how to find new ways to cope with it' (p. 69).

Most *non-psychoanalytic treatments* of survivors of child abuse—whether cognitive, feminist or eclectic in orientation—*also* start from the assumption that 'without memory, without an understanding or felt experience that the abuse is at heart of the client's difficulties, the survivor is lost' (Salter, 1995, p. 228), and most include at least one or more elements of the psychoanalytic cure. Cognitive-behavioural theories underline Freud's thesis that incorrect ideas and fantasies which the patient has developed in childhood have to be corrected: the client must know and feel what really happened (Janoff-Bulman, 1992; Jehu, 1988). The essential aim, according to Rieker and Carmen (1986), is 'to recontextualize the trauma' and to find the real meanings unclouded by the defence mechanisms. Horowitz's conceptualization of 'stress response syndromes' is a reformulation and revision of Freudian psychoanalysis that incorporates cognitive processing theory. Horowitz (1986) suggests that post-traumatic avoidance and intrusion of traumatic memories (flashbacks, nightmares, ruminations) represent the mind's constant effort to integrate traumatic material into pre-existing cognitive schemata that did not include the trauma. He hypothesizes that these intrusions represent the mind's automatic attempt to desensitize and integrate affectively laden material. Therefore stepwise exposure and reliving is advised in therapy; to strengthen the inborn form of systematic desensitization of affect (Briere, 1996).

When it comes to treatment, the difference between psychoanalytic and non-psychoanalytic theories lies especially in the non-psychoanalytic use of

more active and directive techniques to achieve the uncovering and reliving: hypnosis, directive questioning, requesting the writing of an autobiography, role playing, stimulating dialogues with the inner child, and so on. Since most therapists—both analysts and non-analysts—are aware that uncovering excessively painful memories too fast can harm the survivor, new ‘supportive’ techniques are developed to balance the ‘uncovering’ techniques (Briere, 1996; Salter, 1995). In addition to breaking down the survival strategies, the therapist has to help and advise the client to develop new, healthy coping strategies, to learn new ways of dealing with violent emotions. For instance, clients learn techniques such as self-hypnosis, relaxation exercises, consciously avoiding triggers. Assertiveness training, victim groups and various forms of creative therapy are also recommended.

Rethinking Psychoanalytic Assumptions

Psychoanalytic theories on treatment, therefore, also predominate in non-psychoanalysts’ views of the treatment of people abused during childhood. Memory recovery techniques are as common for psychodynamic therapists as for cognitive therapists working with survivors of child abuse (Poole et al., 1995). But how justified are these ideas about the healing power of uncovered and relived memories? Freud developed his mature psychoanalytic theory on the assumption that traumata arise from infantile fantasy. According to Anna Freud, ‘Keeping up the seduction theory would mean to abandon the Oedipus complex, and with it the whole importance of fantasy life, conscious or unconscious fantasy. In fact, I think there would have been no psychoanalysis afterwards’ (letter quoted in Masson, 1984: p. 113). The psycho-analytical cure is concerned with working through repressed sexual desires, narcissistic hurts, old guilt feelings caused by infantile fantasies and griefs from the mother’s failure to match the child’s expectations. Without wishing to minimize these inner conflicts, we do not believe that their recovery will psychologically overtax most adults. But more to the point of the issue we are dealing with, how does this analytic therapy apply to people who really were abused as children? Can adults cope with remembering their real experiences of abuse without the defence mechanism that therapists term ‘pathological’? Can the adult always bear what was unbearable for the child?

Unbearable Suffering

Ferenczi’s patient, with whom this article began, was afraid that as an adult she did not have the psychological strength to cope with re-experiencing the horrors of her childhood. The recall of sadistic cruelty and admission of the accompanying emotions—cruelty, betrayal, (life-threatening) danger and

loss of trust and physical integrity—was, according to her, more than she could bear without resort to some form of anaesthesia or means that Ferenczi labelled pathological.

Nowadays, almost all therapists who encourage the uncovering and reliving of past trauma acknowledge the almost unbearable suffering of clients during this process (Briere, 1992, 1996; J.M. Davies & Frawley, 1994; Herman, 1992; Kramer & Akhtar, 1991; Meiselman, 1990; Putnam, 1989; Rothstein, 1986; Salter, 1995; Shengold, 1989; Van der Kolk, 1987). According to Putnam (1989), some clients even feel that 'remembering is worse than actually being there' (p. 230). This is probably the reason for the strength of 'resistance' during therapy and the negative attitude of many adult survivors towards treatment (McFarlane, 1989). The emphasis in treatment is on confronting and addressing the very subject survivors try most to avoid, namely the traumatic event itself.

Many victims of serious and lengthy child abuse have gaps in their memories, either remembering nothing of their childhood, or having periods during which everything to do with the abuse disappears from memory (Albach, 1993; Herman & Schatzow, 1987). Robins (1966) found that of 71 adults diagnosed as having been cruelly abused by their fathers, only 22 could report this 30 years later. However, a similar study by Femina, Yeager and Otnow-Lewis (1990) showed that this failure to report does not necessarily indicate amnesia. A number of adults said that they knew about the abuse but, during the follow-up, purposely declined to mention it because they did not want to. It would recall too many emotions. These people felt that as children they had been forced to do more than they could or wanted to endure as adults, a contrary view, of course, to that of the therapists. Many survivors don't have repressed memories, but they do work hard to forget (Ceci & Loftus, 1994).

Trauma memory recovery therapists *overestimate the psychological abilities of adults*. Even for adults who were not abused as children, the direct or indirect confrontation with seriously traumatized children can be extremely painful. For example, research on emergency staff has shown that work with seriously ill and injured children breaks down the natural defences and leads to strong identification with the victims (Dyregrow & Mitchell, 1992). Post-exposure response to child trauma includes feelings of helplessness, fear and anxiety, existential insecurity, rage, sorrow and grief, intrusive images, self-reproach, and so on. The same theoreticians who advocate reliving note that working with survivors of trauma can 'challenge the therapist's basic faith' (Herman, 1992, p. 141), and can lead to secondary post-traumatic stress disorder (Briere, 1989) or traumatization (Courtois, 1988). If professionals in the field of childhood trauma are unable to cope with seeing or listening to the stories of violence against children without symptoms, can we then expect this from the adult who was once that child?

As long ago as 1963, referring to victims of the Holocaust, the American psychoanalyst Eissler posed the question: how many murdered children should a person be able to bear without symptoms, in order to demonstrate a 'normal constitution' in the eyes of psychoanalysts? It is quite probable that abnormal psychological actions or mechanisms are necessary in order to be able to live with unbearable suffering.

Memory and Memories from Childhood

One of the most debated assumptions in psychotherapy in the nineties is that people are able to remember experiences as they occurred during childhood. As we said earlier, we shall not try to summarize this heated debate beyond stating our position: that we agree with cognitive psychologists like Loftus (1993a, 1993b) and Lindsay and Read (1994) who seriously criticize the concept of recovering repressed memories. For instance, most people have no verbal memory of events that took place before the age of 4 (Hewitt, 1994; Loftus, 1993b; Terr, 1988). Terr, for example, concludes that trauma at a very young age results in subsequent behavioural expressions that strongly resemble what has previously occurred. This conclusion was based on a comparison of inexplicable behaviour with objective information about what had taken place previously (using, for instance, the evidence of pornographic photos of the person as a baby), but of course this kind of material is only exceptionally available. More often one has to conclude on the basis of behaviour that some disaster must have occurred, without there being any conscious memory of it. If therapists succeed in retrieving memories by the use of suggestive questioning, there is, according to Loftus (1993a), the danger that clients can develop a 'false memory' without realizing it themselves.

Memories of traumata at a later age vary greatly in character. At one end of the scale is the knowledge that something terrible happened, combined with compulsive behaviour which could be explained by 'some disaster', without the person concerned being able to remember anything. At the other extreme is a realistic and extremely detailed memory. However, memories are constructions of the past that can change with time. What people actually remember is often very different from what happened during the period of their life they are remembering. Loftus (1993b) points out that it is unclear whether this is the result of an unconscious repression, as therapists often presume, of infantile amnesia or of motivated forgetting. Literally reliving or finding 'the truth' about what happened is therefore impossible.

Research into the Effects of Treatment

We can be brief about research on the effectiveness of various forms of treatment for people abused during childhood, since there has been hardly

any systematic evaluative research in this field (Beutler & Hill, 1992; Briere, 1996; Cahill, Llewelyn, & Pearson, 1991). One exception is Jehu (1988), who evaluated therapy for incest victims on the basis of cognitive restructuring, and showed clear positive effects. The specific aspect of treatment which this article is concerned with—uncovering and reliving—remains unclear, however.

Because of the lack of systematic evaluative studies of individual therapies, we have looked at case-studies to see whether they provide any clear information about the effectiveness of treatment. The result is disappointing: there is a significant lack of systematic case-studies that report complaints at the start of the treatment, progress, length of time, results at the end of the psychoanalysis or therapy and follow-up information. We have to take the therapists' word for it if they say that the therapy was successful. However, they seldom say this. Most authors make much use of cases to illustrate symptoms, defence mechanisms, transference and countertransference phenomena, but few authors—Salter (1995) for instance—use cases to illustrate how they work, and only very occasionally do they state that a treatment has been successfully concluded. Briere (1992, 1996) cites no successfully concluded therapy; J.M. Davies and Frawley (1994) name 1; Meiselman (1990) 2; Salter (1995) 1; Shengold (1989) 2; Putnam (1989) 0; in Kramer and Akhtar (1991) 1; and in Rothstein (1986) 1. In Van der Kolk (1987) 2 unfinished cases are described, both with a seemingly positive prognosis. Apart from the successes, there are untold numbers of therapies with only minimal results, therapies broken off and therapies in which the client's situation has deteriorated. Shengold (1989, p. 67) compares two clients, who have terminated their psychoanalyses, with Oedipus, who has solved the mystery but has to live on crippled and blind. One recalls the despairing pleas of Ferenczi and his patient, and all those case-studies in which endless talking and reliving are described without noting any perceptible progress (Haaken & Schlaps, 1991). Many people are unable to give any meaning to what they have experienced as senseless violence and brutal injustice (Silver, Boon, & Jones, 1983). Unburdening the emotions (catharsis) does not help if thinking back to the horrors only continues to recall the same violent emotions (Foa & Kozak, 1986).

All the authors cited above write about the deep despair, the depressions, suicidal behaviour and aggressive outbursts of the clients during their treatment. But this is supposed to be only a phase that the client has to work through. All authors state that an unspecified number of clients are unable to cope with the exacerbation of their problems, abandon hope of improvement and stop the therapy. The authors also note that sometimes during therapy, though they rarely specify how often, psychiatric hospitalization may be necessary. Shengold (1989) states that clients 'must again bear the unbearable, and their "constitution" may not be up to it' (p. 300). Nevertheless Shengold and many other therapists continue to be convinced of the

therapeutic power of reliving past suffering. In medical care, the introduction of a new drug would never be permitted under such conditions of non-existent evaluative research, no proven efficacy and numerous harmful side-effects.

(Un)ethical Rules

The acknowledgement that reliving often undermines 'the load-bearing walls' (Salter, 1995, p. 264) of their clients' way of living does not, however, lead to questioning the assumptions on which their therapy is based. Instead, trauma recovery therapists have tried to minimize the destructive effects of reliving by developing *ethical rules for good practice*: to do it 'slowly' and 'with respect' for the client in a 'safe and controlled manner' (Briere, 1992, 1996; Courtois, 1988; Enns, McNeilly, Corkery, & Gilbert, 1995). Therapists are warned against proceeding too fast; they are advised to balance supportive techniques with uncovering techniques and to develop a gentle and respectful approach toward the resistant client.

We seriously doubt whether these kinds of ethical rules could counteract any abusive effects of memory recovery therapy. What these ethical rules in fact demonstrate is an unshaken belief in the healing power and the necessity of reliving and uncovering (Lindsay, 1995; Loftus, Milo, & Paddock, 1995). Courtois (1988) writes, for instance: 'It is critical that the therapist respects the survivor's defenses and not move too quickly to dismantle them' (p. 192). In spite of this 'respect', however, the defences remain still to be dismantled. The possibility that certain experiences might still be causing intolerable suffering in a client is denied. Furthermore, a therapist can never know what is the limit of tolerance for a particular client; there are no objective criteria for intolerability. The ethical rule of preparing the survivor beforehand for difficulties that may increase as treatment progresses—giving 'the client the opportunity to render informed consent to treatment' (Briere, 1992, p. 145)—is also highly dubious. The therapist is simply asking the client, under the cover of this 'legitimation', for his or her consent to the severe suffering entailed in the therapy, which is supposed to be 'for his or her own good'. To many of the survivors of child abuse this must sound like the past. And what is one to think of the ethical rule 'to do it slowly'? By 'slowly', Briere (1996) means a step-by-step recollection, not only of the factual aspects of the abuse (e.g. who, what, where and when), but also of the physical sensations associated with the abuse (e.g. smells, touchings, gasps, physical and psychic pain). How are we supposed to construe this 'step-by-step' approach in the case of clients who have suffered repeated abuse since early childhood?

For example, in the case of Rosi R. (Adler, 1995), when Rosi R. was 3 years old, her parents tried to kill their five children with poison and by

slashing their wrists and then committed suicide; only Rosi and two brothers survived. After this massacre she was maltreated by her fostermother and as a young girl raped by a relative. In her psychoanalysis, Rosi was encouraged to relive all this in her own time. It was a year before she remembered how her mother had tried to kill her. She remembers that she was lying in the bed of her sister, mother's favourite. Was 'the wrong bed'—she wondered—the reason why she was cut less than the other children? And was it her fault that her sister died? Rosi was deeply shocked by these new 'facts' and her analyst lost practically all power to help. The latter writes: 'As an object of this transference I was unable in my innermost being to cope with this dreadful thing with which Frau R. reproached herself' (Adler, 1995, p. 933). After this session Rosi broke off her treatment for six months and felt extremely suicidal. In the end, the analysis lasted five years: five years during which Rosi was engulfed by more and more terrible discoveries to the extent that serious problems began to threaten her marriage. None of this led to the desired therapeutic result. As readers of this case-study we are unable to know whether Rosi's memories of the details of the abusive experiences are true or false, but regardless of that we do know that they are traumatizing for Rosi in the here and now. We also know that her analyst can offer her no security, and that the idea of a stepwise reliving under the therapist's control is an illusion. Nobody can know, neither therapist nor client, what may come to the surface either as 'true memory' or 'fantasy' during the reliving process, nor how shocking it will be. During the course of her analysis, Rosi R. became increasingly aggressive toward her therapist; but then who would not become aggressive toward a therapist who provides no help but allows you to suffer the entire reliving process? Adler, however, points to this as unconscious transference of Rosi's 'extreme sadism' caused by her identification with her aggressors. Nowhere in this article is there any sign of the least ethical doubt about this therapist's approach; nor from the editors of the *International Journal of Psychoanalysis*. One must assume that it is seen as an example of 'ethical good practice'.

Recovered memory therapists assume that human beings can and should be desensitized toward any abusive experience, but there is no empirical foundation for this assumption and no ethical justification for it. Nobody should arrogate the right to prescribe in the name of 'healing' or 'mental health' the desensitizing of another toward severe suffering that they have endured or toward crimes inflicted on children.

Child Abuse and the Concept of Mental Health

In the introduction we asserted that the occurrence of child abuse has long been denied. Only since the seventies has the connection been admitted between child abuse and psychological problems among these children, also

later in their adult life. On the one hand, the result of this denial has been, up to the seventies, a complete lack of culturally accepted ideas and procedures for helping victims of child abuse. The experiences of abused children were simply ignored. On the other hand, it meant that abused children and the adults they later became were forced into secrecy while they developed unaided their own ways of coping with these experiences. Their coping strategies were by definition aberrations from the 'normal' and were mostly viewed as pathological, without taking into account the background of the behaviour concerned. Current thinking about helping survivors, however, is still rooted in a dominant culture of turning a blind eye and not wanting to know, and nowhere is this more apparent than in those psycho-therapeutic topics that are most fiercely disputed: 'breaking the silence' and 'the fight for recognition of social injustice' in the eighties, and 'the truth' of memories of child abuse in the nineties. And quite probably, this article would not be necessary had there been among psychologists a more profound realization of what some children have to endure; a suffering that can be literally intolerable for them, even in later life. Unbearable suffering can only be lived with the help of 'abnormal' psychological methods. In other words, adequate recognition of child abuse requires a reconsideration of the concept of 'mental health'. How can we design a therapy whose starting-point is the psychological reality of people who have been abused during childhood? The first necessary step is to liberate ourselves from psychological concepts which merely block any positive evaluation of 'abnormal' psychological methods employed to make life bearable.

Abnormal is Not Necessarily Undesirable

We reject the hypothesis that survival strategies which were valuable at the time of the trauma later form the core of pathology. Freud and all his followers claim that nobody exists without defence mechanisms, yet no one has clearly defined the border between defence mechanisms that are healthy and those that are pathological. It is not at all clear what actually constitutes a pathological survival strategy, but pathology is in practice defined by social-cultural values and norms of healthy functioning (Ingleby, 1980; Levenson, 1992). In the field of 'bereavement', Stroebe, Gergen, Gergen and Stroebe (1992) have shown that allegedly pathological grief work can be deliberately acted out because it fits the life-style, values and goals of the mourning person. We would also plead for recognition of people's different life-styles, values and goals, for different 'strategies of survival'. Instead of 'pathological' and 'healthy', we think it preferable to distinguish between desirable and undesirable forms of behaviour, emotions or survival strategies according to the individual client; in other words, to base this distinction on

the client's own *values, standards and goals*, as far as these comply with the law and with generally accepted social behaviour.

If the therapist wants to support a client, the question that needs to be answered is whether a particular survival strategy helps or hinders the client from attaining his or her goals. Once this question is posed, it will become apparent that some survival strategies have served the client's goals extremely well throughout his or her life. Many examples of such strategies are to be found in research on survivors of early traumata and in autobiographies: focusing on externals in order to hold undesirable memories at a distance; self-hypnosis; unshakeable belief in and continuous practice of hard work for a better future (Chase, 1987; Fraser, 1992; Martin & Elmer, 1992; Zimrin, 1986). This also means admitting such so-called pathological strategies as dissociation, motivated forgetting or repression of memories, which can all help people to make their lives tolerable (Weinbach & Curtiss, 1986).

Suffering and the Inability to Forget

Freud claimed that the main cause of psychopathology is the repression of childhood memories. This thesis must be discarded for victims of child abuse, for many of whom the opposite will be true: they suffer from the inability to forget. They have problems with flashbacks, nightmares, triggers which cause panic reactions, loneliness because they can trust no one, and so on (Kendall-Tackett, Williams, & Finkelhor, 1993; Malinosky-Rummel & Hansen, 1993). They frequently suffer in addition from the fact that they do not succeed in building up a kind of life that they want (Martin & Elmer, 1992). They discover that they have patterns of behaviour that get in the way of their realizing important goals. Such undesirable forms of behaviour are often associated with the way in which they have learned to survive. But this fact does not mean that they wish to repudiate all their coping strategies. They cannot do that, for survivors are seldom aware of all the measures that they have in fact taken to survive. No person—abused or not abused—is consciously aware of the entire panoply of resources and manoeuvres on which their behaviour rests in any case, not even after years under psychoanalysis (Wallerstein, 1986). What survivors are primarily aware of is undesirable behaviour and their frustrated goals. When survivors seek help it is because their coping strategies are failing then *in specific respects*. They seldom want—the goals that recovered memory therapists insist on—that their entire system of survival should be therapeutically raised as a matter of conscious awareness and intervention; otherwise these same therapists would not have reported so regularly an extreme resistance to their therapeutic interventions. In our experience, survivors want support in repairing

their defences or in learning new ways of coping *without* condemnation and the destruction of their way of life (Miltenburg & Singer, in press).

These demands are possible without making conscious and reliving all the experience that lies at the root of their system of survival. In keeping with an awareness of undesirable behaviour on the part of the client, it is possible to assist the client to find out in the *here and now* how that behaviour is brought about; and how partial adjustments to the old survival strategy can change this behaviour. The following is an illustrative example: A woman has the uncontrollable urge to hit out if someone suddenly comes up behind her. She thinks it has something to do with her past. Together with the therapist she analyses exactly what she does with her body and what she feels in the present. 'My body completely stiffens, I go cold, and I make myself small inside, I hold my breath, etc.' She discovers which (physiological) signals she gets before actually hitting out. The next time she notices these signals outside the therapy room, she takes a deep breath and uses a number of other techniques that already belonged to her 'defence repertory'. After several practices and attempts, she learns how the impulse to hit out can be stopped.

In the therapeutic approach we propose, we are *not concerned to cure* pathological survival strategies, but rather *to learn to base new coping strategies on the survival system* that the client has already developed. Any theoretical underpinning for such a therapeutic approach will essentially involve *learning theories* that can reflect the role of human activity in the construction of mental processes and skills. At present, there are several theoretical developments worth remarking in this area, particularly attempts to apply Vygotsky's cultural-historical theory of development or activity theory to learning processes in therapy (see, e.g., Leiman, 1992, 1994; Ryle, 1991, 1994; and Wilson & Weinstein, 1990). We report a similar attempt of our own elsewhere (Miltenburg & Singer, in press). This theoretical renewal on therapeutic territory connects with the much broader current of theory which places social-emotional development in a historical and cultural context (Fernyhough, 1996; Valsiner, 1987; Wertsch, 1985, 1991). Vygotsky's theory that thought and emotional behaviour at the intrapersonal level are rooted in interpersonal experience is important not only for an understanding of learning processes that lies at the root of the survival system; it is also a theoretical insight that is essential to the way in which the therapist supports the learning processes in adult survivors who are trying to adjust parts of that survival system.

Returning to the Past with Concrete Goals in View

Finally then: is remembering and reliving childhood abuse always harmful? Our answer is 'no', as long as clear conditions are met. It is part of the heritage of psychoanalysis that uncovering childhood traumata at a cognitive

and emotional level has become an aim in itself, and this is the view we find inadequate and even pernicious. It is an idea that leads to abstract aims, such as 'reintegration' (Meiselman, 1990), 'recontextualizing traumata' (Rieker & Carmen, 1986), a 'feeling of wholeness' (Shengold, 1989) and 'healing the incest wound' (Courtois, 1988; Herman, 1992), the result of which is that the therapist asks the client to suffer for an abstract, undefined aim which the client cannot possibly understand. Besides which, there are no criteria to establish whether this aim has been achieved (Pedder, 1988). Clients often have to work on their past for years at the cost of damage to their concrete objectives, which can become completely unattainable as a result of this uncontrolled growth of their problems during therapy. These concrete aims are very often essential basics of living in the present, whose importance should not be denied, such as holding a job, saving a marriage, maintaining the care of the children, and so on.

Under what conditions can the retrieval of past experiences contribute to the welfare of survivors? The most important conditions are: (1) that there should be a clear relation to the goals of the survivor in the here and now; and (2) that the survivor him- or herself should determine what is alleged about whom. For instance, many survivors, but certainly not all, want to bear witness against a great personal and social injustice. In the socialist-feminist literature, this urge for survivors to break down the walls of silence is amply documented (Armstrong, 1978, 1996; Bass & Thornton, 1983; Browne, 1991; Rush, 1977/1996). These survivors want recognition for what has been done to them. They also want to be believed and they want that some action should be taken at the social level against child abuse. Evaluative research on victim groups shows that, for many survivors, being able to share experiences enhances confidence and support and leads to improvements in their own capacity to function adequately (Folette, Folette, & Alexander, 1991).

In cases of individual therapy it can also be meaningful to recover bits of what happened earlier, but equally here, too, under the above-mentioned conditions. A client may want to talk to the therapist about what happened in the past because nobody else wants to listen (Bass & Thornton, 1983). An understanding of their own undesirable behaviour and coming to master it can be another important motif; but for this purpose the general outlines of what happened are usually sufficient. Reliving is absolutely unnecessary (Milteneburg & Singer, *in press*; Ryle, 1991). A client may also be struggling in the present with questions whose resolution requires clarifying particular episodes of the past; as, for example, with questions of guilt, such as: 'If only I had been able to protect my sister against my father . . . or was I really a wicked child?'; 'Was it only my parents who were bad?' (Miller & Porter, 1983). The following is a good example of a positive goal of recovery of the past: a concentration camp victim wanted to recover that past in order to

have memories of her last shared experiences with her children (E. Fromm & Brown, 1991). All these goals are very personal; and certainly not everyone has the same goals. A client will seldom actually want to wade through the past all over again (even if this were possible), but what they usually want is to discover or feel a specific aspect of the past which they feel bears on the realization of a concrete personal goal.

Our criticism therefore is directed against the assumption that it is necessary to uncover and relive the entirety of a past abusive childhood trauma in order to heal. The doctrine that this is a necessity imposes an enormous moral pressure on clients: they are judged to be too ill, too weak or even too cowardly if they cannot or do not want to work on their recovery in the prescribed fashion. The victim is then wrong. It is a doctrine founded on a *therapeutic theory which was originally developed in a context of clients who had not suffered abuse*. Such a theory, due to its basis of dubious assumptions, can be extremely harmful for people who have suffered from childhood abuse.

References

- Adler, H. (1995). Recall and repetition of a severe childhood trauma. *International Journal of Psychoanalysis*, 76, 927–943.
- Albach, F. (1993). *Freud's verleidingstheorie* [Freud's seduction theory] (Doctoral dissertation, University of Amsterdam). Middelburg: Stichting Petra.
- American Journal of Psychotherapy* (1996). vol. 50, no. 2. Special issue on the Recovered Memory/False Memory Debate.
- Applied Cognitive Psychology* (1994). vol. 8, 281–364. Special issue on the Recovered Memory/False Memory Debate.
- Armstrong, L. (1978). *Kiss daddy good-night: A speak-out on incest*. New York: Hawthorne Books.
- Armstrong, L. (1996). *What happened when women said incest*. London: Women's Press.
- Bass, E., & Thornton, L. (Eds.). (1983). *I never told anyone: Writing by women survivors of child sexual abuse*. New York: Harper & Row.
- Beutler, L.E., & Hill, C.E. (1992). Process and outcome research in the treatment of adult victims of childhood sexual abuse: Methodological issues. *Journal of Consulting and Clinical Psychology*, 60, 204–212.
- Blum, H.P. (1986). The concept of the reconstruction of trauma. In A. Rothstein (Ed.), *The reconstruction of trauma: Its significance in clinical work* (pp. 7–27). Madison, WI: International Universities Press.
- Briere, J.N. (1989). *Therapy for adults molested as children*. New York: Springer.
- Briere, J.N. (1992). *Child abuse trauma: Theory and treatment of the lasting effects*. New York: Sage.
- Briere, J.N. (1996). A self-trauma model for treating adult survivors of severe child abuse. In J.N. Briere, L. Berliner, J.A. Bulkley, C. Jenny, & T. Reid (Eds.), *The APSAC handbook on child maltreatment* (pp. 140–157). London: Sage.
- Browne, A. (1991). The victim's experience: Pathways to disclosure. *Psychotherapy*, 28, 150–156.

- Butler, S. (1978). *Conspiracy of silence: The trauma of incest*. New York: Bantam.
- Cahill, C., Llewelyn, S.P., & Pearson, C. (1991). Treatment of sexual abuse which occurred in childhood: A review. *British Journal of Clinical Psychology*, 30, 1–12.
- Ceci, S.J., & Loftus, E.F. (1994). 'Memory work': A royal road to false memories? *Applied Cognitive Psychology*, 8, 351–364.
- Chase, T. (1987). *When the rabbit howls*. New York: Dutton.
- Consciousness and Cognition* (1994). vol. 3, no. 3. Special issue on the Recovered Memory/False Memory Debate.
- Counseling Psychologist* (1995). vol. 23, no. 2. Special issue on the Recovered Memory/False Memory Debate.
- Courtois, C.A. (1988). *Healing the incest wound: Adult survivors in therapy*. New York: Norton.
- Davies, J.M., & Frawley, M.G. (1994). *Treating the adult survivor of childhood sexual abuse: A psychoanalytic perspective*. New York: Basic Books.
- Davies, M. (1995). *Childhood sexual abuse and the construction of identity: Healing Sylvia*. London: Taylor & Francis.
- Driver, E., & Droisen A. (Eds.). (1989). *Child sexual abuse: Feminist perspectives*. London: Macmillan.
- Dyregrow, A., & Mitchell, J.T. (1992). Work with traumatized children. Psychological effects and coping strategies. *Journal of Traumatic Stress*, 5, 5–17.
- Eagle, M.N. (1991). Psychoanalytic conceptions of the self. In J. Strauss & G.R. Goethals (Eds.), *The self: Interdisciplinary approaches* (pp. 49–65). New York: Springer.
- Eissler, K.R. (1963). Die Ermordung von wievielen von seiner Kinder muss ein Mensch symptomfrei ertragen können, um eine normale Konstitution zu haben? [How many murdered children should a person be able to bear without symptoms?] *Psyche*, 5, 241–291.
- Enns, C.Z., McNeilly, C.L., Corkery, J.M., & Gilbert, M.S. (1995). The debate about delayed memories of child sexual abuse: A feminist perspective. *The Counseling Psychologist*, 23, 181–279.
- Femina, D.D., Yeager, C.A., & Otnow-Lewis, D. (1990). Child abuse: Adolescent records vs. adult recall. *Child Abuse & Neglect*, 14, 227–231.
- Feminism & Psychology* (1997). vol. 16: Special issue on the Recovered Memory/False Memory Debate.
- Ferenczi, S. (1988). *The clinical diary of Sándor Ferenczi* (J. Dupont, Ed.). Cambridge, MA: Harvard University Press.
- Fernyhough, C. (1996). The dialogic mind: A dialogic approach to the higher mental functions. *New Ideas in Psychology*, 14, 47–62.
- Foa, E.B., & Kozak, M.J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin*, 99, 20–35.
- Folette, V.M., Follette, W.C., & Alexander, P.C. (1991). Individual predictors of outcome in group treatment for incest survivors. *Journal of Consulting and Clinical Psychology*, 59, 150–155.
- Fraser, S. (1992). *My father's house: A memoir of incest and of healing*. London: Virago.
- Freud, S. (1969). Allgemeine Neurosenlehre. In *Vorlesungen zur Einführung in die*

- Psychoanalyse und Neue Folge*. Studienausgabe Bd 1 (pp. 245–445). Frankfurt am Main: Fischer. (Original work published 1917.)
- Freud, S. (1972). Drei abhandlungen zur sexualtheorie. In *Sexualleben*. Studienausgabe Bd V (pp. 37–145). Frankfurt am Main: Fischer. (Original work published 1905.)
- Freud, S. (1982a). Zur Psychotherapie der Hysterie. In *Schriften zur Behandlungstechnik*. Studienausgabe Ergänzungsband (pp. 37–97). Frankfurt am Main: Fischer. (Original work published 1895.)
- Freud, S. (1982b). Die Freudsche psychoanalytische Methode. In *Schriften zur Behandlungstechnik*. Studienausgabe Ergänzungsband (pp. 99–106). Frankfurt am Main: Fischer. (Original work published 1904.)
- Freud, S. (1982c). Die endliche und unendliche Analyse. In *Schriften zur Behandlungstechnik*. Studienausgabe Ergänzungsband (pp. 351–392). Frankfurt am Main: Fischer. (Original work published 1937.)
- Fromm, E., & Brown, D. (1991). Hypnoanalyse voor traumatische herinneringen en ontwikkelingstekorten ten gevolge van incest. In O. van der Hart (Ed.), *Trauma, dissociatie en hypnose* (pp. 221–248). Amsterdam: Swets & Zeitlinger.
- Fromm, M.G., & Smith, B.L. (1989). *The facilitating environment. Clinical applications of Winnicott's theory*. Madison, WI: International Universities Press.
- Gillman, R.D. (1986). Physical trauma and actual seduction. In A. Rothstein (Ed.), *The reconstruction of trauma: Its significance in clinical work* (pp. 73–94). Madison, WI: International Universities Press.
- Greenberg, L.S., & Safran, J.D. (1989). Emotion in psychotherapy. *American Psychologist*, 44, 19–29.
- Haaken, J., & Schlaps, A. (1991). Incest resolution therapy and the objectification of sexual abuse. *Psychotherapy*, 28, 39–47.
- Herman, J.L. (1992). *Trauma and recovery*. New York: Basic Books.
- Herman, J.L., & Schatzow, E. (1987). Recovery and verification of memories of childhood sexual trauma. *Psychoanalytic Psychology*, 4, 1–14.
- Hewitt, S.K. (1994). Preverbal sexual abuse: What two children report in later years. *Child Abuse & Neglect*, 18, 821–826.
- Horowitz, M.J. (1986). *Stress response syndromes* (2nd ed.). Northvale, NJ: Jason Aronson.
- Ingleby, D. (Ed.). (1980). *Critical psychiatry: The politics of mental health*. New York: Pantheon.
- Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: Free Press.
- Jehu, D. (1988). *Beyond sexual abuse: Therapy with women who were childhood victims*. Chichester: Wiley.
- Journal of Psychohistory* (1995). vol. 23, no. 2. Special issue on the Recovered Memory/False Memory Debate.
- Kendall-Tackett, K.A., Williams, L.M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin*, 113, 164–180.
- Kluft, R.P. (1986). Treating children who have multiple personality disorder. In B.G. Braun (Ed.), *Treatment of multiple personality disorder* (pp. 79–105). Washington, DC: American Psychiatric Press.

- Kohut, H. (1971). *The analysis of the self*. Madison, WI: International Universities Press.
- Kramer, S., & Akhtar, S. (Eds.). (1991). *The trauma of transgression: Psychotherapy of incest victims*. Northvale, NJ: Jason Aronson.
- Krimendahl Wolf, E., & Alpert, J.L. (1991). Psychoanalysis and child sexual abuse: A review of the post-Freudian literature. *Psychoanalytic Psychology*, 8, 305–327.
- Lamb, S., & Edgar-Smith, S. (1994). Aspects of disclosure. Mediators of outcome of childhood sexual abuse. *Journal of Interpersonal Violence*, 9, 307–326.
- Leiman, M. (1992). The concept of sign in the work of Vygotsky, Winnicott and Bakhtin: Further integration of object relations theory and activity theory. *British Journal of Medical Psychology*, 65, 209–221.
- Leiman, M. (1994). The development of cognitive-analytic therapy. *International Journal of Short Term Psychotherapy*, 9, 67–81.
- Levenson, M.R. (1992). Rethinking psychopathy. *Theory & Psychology*, 2, 51–71.
- Lindsay, D.S. (1995). Beyond backlash: comments on Enns, McNeilly, Corkery, and Gilbert. *The Counseling Psychologist*, 23, 280–289.
- Lindsay, D.S., & Read, J.D. (1994). Psychotherapy and memories of childhood sexual abuse: A cognitive perspective. *Applied Cognitive Psychology*, 8, 281–338.
- Loftus, E. (1993a). The reality of repressed memories. *American Psychologist*, 48, 518–537.
- Loftus, E. (1993b). Desperately seeking memories of the first few years of childhood: The reality of early memories. *Journal of Experimental Psychology: General*, 122, 274–277.
- Loftus, E., Milo, E.M., & Paddock, J.R. (1995). The accidental executioner: Why psychotherapy must be informed by science. *The Counseling Psychologist*, 23, 300–309.
- Mahler, M., Bergman, A., & Pine, F. (1975). *The psychological birth of the human infant*. New York: Basic Books.
- Malinosky-Rummell, R., & Hansen, D.J. (1993). Long-term consequences of childhood physical abuse. *Psychological Bulletin*, 114, 68–79.
- Martin, J.A., & Elmer, E. (1992). Battered children grow up: A follow-up study of individuals severely maltreated as children. *Child Abuse & Neglect*, 16, 75–82.
- Masson, J.M. (1984). *The assault on truth: Freud's suppression of the seduction theory*. London: Faber & Faber.
- McFarlane, A.C. (1989). The treatment of post-traumatic stress disorder. *British Journal of Medical Psychology*, 62, 81–90.
- Meiselman, K.C. (1990). *Resolving the trauma of incest: Reintegration therapy with survivors*. San Francisco, CA: Jossey-Bass.
- Miller, D.T., & Porter, C.A. (1983). Self-blame in victims of violence. *Journal of Social Issues*, 39, 139–152.
- Miltenburg, R., & Singer, E. (in press). A theory and method for living in an abusive world. *Journal of Child Sexual Abuse*.
- Pedder, J.R. (1988). Termination reconsidered. *International Journal of Psycho-Analysis*, 69, 495–505.
- Poole, D.A., Lindsay, D.S., Menon, A., & Bull, R. (1995). Psychotherapy and the recovery of memories of childhood sexual abuse: U.S. and British practitioners'

- opinions, practices, and experiences. *Journal of Consulting and Clinical Psychology*, 63, 426–437.
- Psychoanalytic Dialogues* (1996). vol. 6, no. 2. Special issue on the Recovered Memory/False Memory Debate.
- Putnam, F.W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York: Guilford.
- Rieker, P.P., & Carmen, E. (1986). The victim-to-patient process: The disconfirmation and transformation of abuse. *American Journal of Ortho-psychiatry*, 56, 360–370.
- Robins, L.N. (1966). *Deviant children grown up*. Baltimore, MD: Wilkins.
- Rothstein, A. (Ed.). (1986). *The reconstruction of trauma: Its significance in clinical work*. Madison, WI: International Universities Press.
- Rush, F. (1996). The Freudian cover-up. *Feminism & Psychology*, 6, 261–276. (Original work published 1977.)
- Ryle, A. (1991). Object relations theory and activity theory: A proposed link by way of the procedural sequence model. *British Journal of Medical Psychology*, 64, 307–316.
- Ryle, A. (1994). Projective identification: A particular form of reciprocal role procedures. *British Journal of Medical Psychology*, 67, 107–114.
- Salter, A.C. (1995). *Transforming trauma: A guide to understanding and treating adult survivors of child sexual abuse*. Thousand Oaks, CA: Sage.
- Schuman, J., & Galvez, M. (1996). A meta/multi-discursive reading of 'false memory syndrome'. *Feminism & Psychology*, 6, 7–29.
- Shengold, L. (1989). *Soul murder: The effects of childhood abuse and deprivation*. New Haven, CT: Yale University Press.
- Silver, R.L., Boon, C., & Stones, M.H. (1983). Searching for meaning in misfortune: Making sense of incest. *Journal of Social Issues*, 39, 81–102.
- Steele, B.F. (1986). Child abuse. In A. Rothstein (Ed.), *The reconstruction of trauma: Its significance in clinical work* (pp. 59–72). Madison, WI: International Universities Press.
- Stroebe, M., Gergen, M.M., Gergen, K.J., & Stroebe, W. (1992). Broken hearts or broken bonds. *American Psychologist*, 47, 1205–1212.
- Summit, R.C. (1983). The child sexual abuse accommodation syndrome. *Child Abuse & Neglect*, 7, 177–193.
- Terr, L. (1988). What happens to early memories of trauma? A study of twenty children under age five at the time of documented traumatic events. *Journal of the American Academy of Child and Adolescent Psychiatry*, 27, 96–104.
- Trepper, T.S., & Barrett, M.J. (1989). *Systematic treatment of incest: A therapeutic handbook*. New York: Brunner/Mazel.
- Valsiner, J. (1987). *Culture and the development of children's action*. Chichester: Wiley.
- Van der Hart, O. (Ed.). (1991). *Trauma, dissociatie en hypnose*. Amsterdam: Swets & Zeitlinger.
- Van der Kolk, B.A. (Ed.). (1987). *Psychological trauma*. Washington, DC: American Psychiatric Press.
- Wallerstein, R.S. (1986). *Forty-two lives in treatment: A study of psychoanalysis and psychotherapy*. New York: Guilford.

- Weinbach, R.W., & Curtiss, C.R. (1986). Making child abuse victims aware of their victimization: A treatment issue. *Child Welfare*, 65, 337–346.
- Wertsch, J. (1985). *Vygotsky and the social formation of mind*. Cambridge, MA: Harvard University Press.
- Wertsch, J. (1991). *Voices of the mind: A sociocultural approach to mediated action*. Cambridge, MA: Harvard University Press.
- Wilson, A., & Weinstein, L. (1990). An investigation into some implications of a Vygotskian perspective on the origins of mind: Psychoanalysis and the Vygotskian psychology, part 1. *Journal of the American Psychoanalytic Association*, 40, 349–379.
- Winnicott, D.W. (1965). Ego distortion in terms of the true and false self. In *The maturational processes and the facilitating environment* (pp. 140–152). New York: International Universities Press. (Original work published 1960.)
- Zimrin, H. (1986). A profile of survival. *Child Abuse & Neglect*, 10, 339–349.

ACKNOWLEDGEMENTS. We want to thank the anonymous reviews for their constructive comments that helped us to clarify our main points of critique of memory recovery therapy for clients severely abused during childhood.

RUTH MILTENBURG is a management consultant and therapist. She is currently researching survival strategies of adult survivors of childhood abuse. She specializes in brief psychotherapy for survivors with social-emotional and moral problems at work and has developed a model for short-term therapy based on (Vygotsky's) activity theory. With Elly Singer she has published several theoretical and clinical papers on issues concerning basic assumptions in psychotherapeutic theories, learning and developmental processes in therapeutic settings, and moral dimensions in emotional problems of abused clients. ADDRESS: Hoenderkopershoek 9, 3981 TD, Bunnik, The Netherlands.

ELLY SINGER lectures at the University of Utrecht (Department of Developmental Psychology). She has written on the history of child care in Europe and the United States and its relationship to values and policy initiatives affecting families and theoretical fashions in developmental psychology. She is currently researching the development of self-regulation of (adult) survivors of child abuse; and their moral development in relationship to the moral problems they have to face. Her writings include the book *Child Care and the Psychology of Development* (1992). ADDRESS: Department of Developmental Psychology, PO Box 80.140, 3508 TC Utrecht, The Netherlands. [email: E.SINGER@FSW.RUU.NL]