

A Two-Paper Conceptualization of Safety After Sexual Assault: The
Case of Edith

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ABSTRACT

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Establishing safety after a sexual assault is a central task of clinical social work with survivors of sexual violence. These two papers seek to build the argument that the concept of safety for survivors of sexual assault is profoundly nuanced and dependent upon a person's unique history, personality, and life circumstances, and that the establishment of safety for a survivor of sexual assault requires precise clinical attention to each individual. This theoretical-conceptual dissertation first explores the trauma treatment literature and the ways that safety is understood and prioritized, followed by a discussion of additional theoretical frameworks that can strengthen a clinical conceptualization of safety for survivors of sexual assault. This dissertation asserts that social work is uniquely positioned to attend to the construction of safety through its consideration of the impact of resource insecurity, and social disparities such as sexism, racism, and homophobia on a person's psyche. Using the case of Edith, the author will demonstrate the importance of an internal sense of safety in the mind of a survivor. With attention to the ethical implications of case writing with regard to Edith's confidentiality and consent, this dissertation uses a case study methodology to demonstrate a clinical conceptualization of safety after sexual assault relying upon the theoretical frameworks discussed. The description of the case of Edith focuses on the ways in which her character construction, attachment history, and current relational patterns are central to her experience of safety after a sexual assault.

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Table of Contents

Acknowledgements.....	ii
Abstract.....	iii
Table of Contents.....	iv
Introduction.....	1
Paper One: Safety After Sexual Assault: A Theoretical Review	
Treatment Literature.....	7
Eye Movement Desensitization and Reprocessing.....	8
Prolonged Exposure Therapy.....	9
Cognitive Processing Therapy.....	10
Safety Emotion Management Loss and Future Toolkit.....	11
Step-by-Dimension Protocol.....	13
Expert Recommendations.....	14
Discussion of Interventions.....	16
Theoretical Literature.....	17
Trauma Theory.....	18
Complex Trauma.....	22
Neurobiology of Trauma.....	24
Psychodynamic Theory.....	28
The Repetition Compulsion, Enactments, and Self-Harm.....	32
Attachment Theory.....	38
Relational Theory and Intersubjectivity.....	44
Feminist Theory.....	48
Institutional Racism and Barriers to Safety	51
Methodology.....	52
Use of the Single Case Study.....	53
Paper Two: Safety After Sexual Assault: A Clinical Conceptualization Using the Case of Edith	
Confidentiality.....	57
Case Conceptualization.....	61
Sexual Assault.....	71
Complex Trauma.....	74
Attachment Theory.....	77
Psychodynamic Theory.....	80
A Conceptualization and Intervention Regarding Safety.....	88
Relational Safety.....	97
Conclusion.....	110
Appendix A.....	113
References.....	114

INTRODCTION

The purpose of this dissertation is to explore the experience of safety for survivors of sexual assault through the study of the case of Edith¹. A compromised sense of safety is common in the aftermath of a traumatic event, but is especially complicated after a sexual assault because a sexual assault is among the most profound physical and personal violations (Campbell, Dworkin, & Cabral, 2009). The reality is that most sexual assaults are committed by a person to whom the survivor is related or who the survivor knows in some way, making it an attack on a person's ability to trust others, in addition to an attack on a person's body and personhood. Safety is thus compromised physically, psychologically, and relationally.

Even after a single incident trauma such as a sexual assault, the world can become an unsafe place for the person who was traumatized. The mind, also, feels like an unsafe place because survivors are haunted by memories of the trauma itself. Post-traumatic response is often marked by the presence of mental intrusion, nightmares, and a general preoccupation with the events of the trauma (American Psychiatric Association, 2013). While not every survivor of sexual assault will develop post-traumatic stress disorder or post-traumatic responses, research indicates that those who experience resource insecurity and insecure attachments are more likely to develop adverse post-traumatic reactions (Yehuda & LeDoux, 2007). The mental intrusions that accompany PTSD inhibit a sense of safety in one's own mind, just as the events of the trauma inhibit a sense of safety in the world. An experience of complex trauma, a type of trauma that occurs repeatedly over a period of time in particular social and relational contexts and especially during childhood (Courtois, 2004), compromises a person's ability to feel safe, as well. Rather than ripping the ground from under one's feet, complex trauma is akin to a gradual

¹ The name and other information about this client have been changed to protect her identity.

chipping away at a person's ability to live freely and without a sense of danger. Trauma theory offers a guiding framework for the clinical and theoretical study of safety after sexual assault by examining the usefulness of psychiatric models of trauma and post-traumatic response, as well as offering alternatives to medicalized deficit models that attribute symptoms to personal shortcomings rather than existential phenomena inherent in the human experience of trauma. This dissertation will rest upon trauma theory as a guiding framework, and trauma theory will be further discussed below.

This dissertation will discuss the complicated clinical task of sitting with a client who has been raped as she comes to understand what it means to feel safe in her mind and in the world. The establishment of safety is considered the first task in a linear model of psychotherapy with survivors of trauma across the most widely used clinical interventions, as defined by a study of expert recommendations to be discussed below (Cloitre et al., 2011). Eye movement desensitization, prolonged exposure therapy, cognitive processing therapy, the safety emotion loss and future toolkit, and the step-by-dimension protocol all agree that the establishment of safety is an essential step in clinical work with trauma survivors.

In my experience, as a clinical social worker who provides psychotherapy to survivors of sexual assault, I have found that safety is an elusive and nuanced concept. A sense of safety for some trauma survivors might ebb and flow, or might never have existed at all. The assumption that a client might have a baseline or a foundational concept of safety to which she can return does not necessarily describe the experience of the most marginalized clients who seek services from clinical social workers.

Clinical social work is a field that is deeply committed to honoring the economic, political, and social realities of each person (Kirst-Ashman & Hull, 2015). For this reason and

many others, social workers often find ourselves working with people who are among the most marginalized and oppressed in the world. Social workers are also responsible for providing more than 60% of mental health treatment services in the United States (National Association of Social Workers, 2015). Social workers are keenly and acutely aware of the role that racism, sexism, homophobia, poverty, educational disparities, food insecurity, barriers to health care, and other social determinants of health impact our clients (Kirst-Ashman & Hull, 2015). Many clinical social workers provide services to people who have had the least resourced histories. Whether the resources are material, like food and medical care, or are psychological, like an emotionally available and stable caregiver, many clients come to social workers having already survived immeasurable and innumerable aggressions – both micro and macro.

Many of the clients who see social workers for treatment after a trauma do not come to treatment with a baseline of safety to which they can return or access to psychological and pragmatic resources that would assist in the establishment of safety. The primary task of the clinician then, as I see it, is to not only sort through the traumatic experience of the sexual assault, but also to place it in a larger story of chronic exposure to trauma –whether that trauma is the result of failed or inaccessible attachments, chronic exposure to resource insecurity and scarcity, or on-going and overt threats to one’s ability to live. Perhaps the establishment of safety is not the first task of psychotherapy, but is the central purpose of therapy, happening simultaneously with other important tasks of treatment.

This dissertation asserts that social work is uniquely positioned to attend to the construction of safety through its consideration of the impact of resource insecurity, and social disparities such as sexism, racism, and homophobia on a person’s psyche. It aims to demonstrate that a thoughtful and careful conceptualization of a client and her treatment relies on a steady

clinical gaze on her ability to feel safe in the world and in her mind, and that every clinical decision and intervention must exist in the service of a slow and careful introduction to the experience of feeling safe. Just as there is no one-size approach to treatment, there is no one-size approach to safety.

For the purpose of this dissertation, the focus will be on the meaning of safety in the mind of a survivor of complex trauma, a type of trauma that occurs repeatedly over a period of time in particular social and relational contexts (Courtois, 2004), who was sexually assaulted in adulthood. A more precise discussion of complex trauma will follow. This dissertation will examine the conceptualization of safety in the mind of an adult woman who was exposed to chronic environmental and attachment insecurity as a child and who was later sexually assaulted as an adult. In addition to trauma theory, I will employ attachment theory to suggest that experiences of safety in the aftermath of sexual assault are influenced by the survivor's early attachment experiences and her attachment experience as an adult. This dissertation will argue that the way a survivor processes a sexual assault and experiences safety in its aftermath is influenced by her early attachment experiences and whether, as an adult, she has a secure attachment style (Main, Kaplan, & Cassidy, 1985).

Sexual abuse and assault are the most personal of violations. The survivor's control is debased and her physical integrity is intruded upon and penetrated. Survivors of sexual assault experience a violent removal of their right to bodily autonomy and their use and power of voice; their fundamental right to be respected as human is replaced with a profound bodily and psychic objectification and commodification (Vickerman & Margolin, 2009). A survivor of sexual assault is often left wondering whether safety is ever again possible, if it ever truly existed pre-assault. Trauma symptoms that are common for survivors of sexual assault include mental

intrusion, nightmares, flashbacks, hyper-vigilance, and a reduced capacity to self-protect and self-regulate emotional states (American Psychiatric Association, 2013). These symptoms directly relate to a person's sense of safety as well as understanding of the ability to safely live in the world. But the sparse research around these particular and nuanced experiences and their impact on a survivor's sense of safety is problematic. Clinicians are left working with the most basic definition of safety possible, as evidenced by the assertion put forth by Bloom (1997), Lebowitz, Harvey, & Herman (1993), and Shapiro (1999) that safety includes attending to bodily needs and then environmental needs. Many clinicians are trained to create a safety plan with their clients who are trauma survivors, or a plan for self-protection from external forces of danger or threat. These plans are important but typically only addresses the bare minimum of a person's safety needs. I will argue in this dissertation that many current models for the creation of a safety plan limit the clinician's capacity for a deeper exploration of safety. I will give examples, in existing treatment manuals to be discussed below, of how definitions of safety are most often limited to pragmatic issues of safety and symptom reduction and thus miss the nuance of safety as a multi-dimensional concept. In this dissertation, I intend to demonstrate that we as clinical social workers need a more robust conceptualization of safety. I will employ several theories, including the theories of complex trauma, neurobiology of trauma, psychodynamic theory and attachment theory, to construct a broader and deeper understanding of safety. In order to be accessible to a broad range of vulnerable clients, this understanding of safety will be guided by feminist and anti-racist thought.

The first paper of this dissertation will demonstrate that there are gaps in the conceptualizations of safety in the current treatment models and will introduce theories and concepts that lend to the creation of a more nuanced understanding of safety. The theory of

complex trauma (Courtois, 2004) will offer insight into the many reasons that some clients come to treatment without a baseline of safety to which to return. An exploration of the neurobiology of trauma (De Becker, 1997; Johnson, 2008; Lanius, Frewen, Vermetten, & Yehuda, 2010; Maier & Seligman, 1976; Panskepp, 1998; Van der Kolk, 1989; 2014; Yehuda & LeDoux, 2007) will offer a lens through which to understand complex emotional responses to traumatic stimuli. Psychodynamic theory, with particular attention to the concept of enactments, will lend understanding of the dynamics of re-victimization and the ways that safety is compromised in light of multiple assaults (Freud, 1914; Miller, 1994; van der Kolk, 1989). Attachment (Ainsworth, 1969; Bowlby, 1969) and relational theories (Mitchell, 2014; Benjamin, 2009) will strengthen the argument that the way a survivor processes a sexual assault and experiences safety in its aftermath is influenced by her experience of attachment. My clinical experience, consistent with research findings (Anderson & Alexander, 1996), has indicated that a survivor of sexual assault who had a secure attachment to a primary caregiver will fare better than a survivor of sexual assault with an insecure attachment style and is less likely to develop post-traumatic stress disorder. Because social work is committed to dismantling oppression, this dissertation will include a study and inclusion of feminist theory and critical race theory to offer insight into the ways that the political and social dynamics influence a person's response to trauma (Kirst-Ashman & Hull, 2015).

The second paper will use these theories as a framework for developing a robust conceptualization of how safety exists in the case of Edith, a young woman with complex trauma who is a survivor of sexual assault. A robust conceptualization of safety, in the case of the client discussed, includes attention to pragmatic safety concerns, an understanding of the presence and meaning of symptoms with a goal of reducing their impact on her ability to feel safe, and

attention to the role of safety in relational dynamics. I will highlight the reciprocal nature of the ability to safely dwell in one's mind and to safely dwell in the world. This case study aims to offer an example of the importance and utility of an individualized and on-going conceptualization of safety to clinicians who are developing their own complex understanding of safety in their clinical practice and to ground that conceptualization of safety in theoretical literature.

Paper One

Safety After Sexual Assault: A Theoretical Review

CLINICAL INTERVENTIONS FOR THE TREATMENT OF TRAUMA

While clinicians agree that safety is of great import, the conceptualization of safety as it currently exists in trauma treatment literature could be strengthened with a nuanced and robust exploration of safety across the many dimensions of a person. Judith Herman (1992) described the strong emphasis on safety as the primary task of the first phase of trauma treatment and theorized that the establishment of safety begins with developing control of the body through relaxation, exercise, hygiene, medication management and attention to physical injury if applicable, and nutrition. She argued that once bodily safety is achieved, the work of establishing safety includes slowly expanding that sense of internal control toward the environment through attention to a non-violent living situation, a plan for self-protection, mobility, and financial security. I suggest that we add to this seminal conceptualization of safety explicit and focused attention to a person's capacity to safely dwell in her own mind after trauma. It is critical to build upon this foundational understanding of safety to make the role that safety in the unconscious plays in both internal and external safety clear and explicit. This ability to safely dwell in one's own mind calls for a deeper understanding of safety and becomes particularly

relevant when safety is a central element in the treatment of trauma. Safety is considered the foundation upon which all future therapeutic work rests among the evidence-based and evidence-supported therapeutic modalities in the treatment of trauma (Cloitre et al., 2011), including Eye Movement Desensitization and Reprocessing, Prolonged Exposure Therapy, Cognitive Processing Therapy, the Safety Emotion Loss and Future toolkit, and the Step-by-Dimension protocol. Across these widely respected and regarded modalities, clinicians agree that the establishment of safety must be in place or experienced prior to implementing the intensive process of reengaging with the trauma in an in-depth, ideally healing or even curative way; the establishment of safety is a primary task of the first phase of the phase-based treatment approach (Cloitre, 2011; Courtois & Ford, 2012; Herman, 1992).

Eye Movement Desensitization and Reprocessing

In Eye Movement Desensitization and Reprocessing (EMDR) therapy, founder Francine Shapiro (2014) asserted that safety is of critical importance. Safety is explored and established through the resourcing phase of treatment, which comes second only to the history-gathering phase; its placement as the second of eight phases of treatment highlights its essential importance (Shapiro, 2014). During this phase of treatment, a clinician encourages a patient to call to mind a safe image and to become cognitively engaged with that imagery. This image becomes instilled in the mind and is used as a baseline, or a space to return to when the images of trauma that are addressed in later phases of treatment become too overwhelming. This baseline becomes symbolically significant to the process of EMDR and of conceptualizing the importance of safety for survivors of trauma. Shapiro wrote that treatment cannot progress beyond the resource-building phase until a person is fully able to engage in safe image building and is able to quickly call upon the image of safety that he or she has conjured in this phase of treatment.

The instillation of the image of safety is often challenging for people who have experienced trauma. Safety is particularly elusive for survivors of multiple or complex trauma, some of whom may tell the therapist that they have never experienced it previously (Courtois, 2011). Due to this simultaneous complication and urgent need, Shapiro developed a robust method for ensuring that completing the resource phase of EMDR treatment is possible, even for those who are most acutely traumatized. In her protocol, Shapiro suggested (1999) walking a patient through a guided imagery exercise that invites the presence of protective forces such as a lion, a beloved family dog, or a protective family member with a baseball bat to protect the patient as he or she wanders through treacherous mental terrain. The successful experience of this exercise can help the client in have a sense of physical and psychological safety when recalling previous trauma.

Despite this robust attention to the need for safety formulation and internal resource establishment, notably absent from EMDR protocol is a clear guide with which to measure an adequate sense of safety (Korn & Leeds, 2002). There is no definition of what constitutes safety or precisely which level of resourcing is adequate to ensure a patient's ability to proceed through the EMDR protocol without further traumatization. When clients live in environmental conditions that compromise safety such as ongoing community or domestic violence, warfare and political unrest, true safety may not be possible. Such circumstance need to be carefully assessed and is the first focus of therapeutic attention before proceeding with a specific treatment protocol, no matter which is used.

Prolonged Exposure Therapy

Prolonged Exposure Therapy (PE) is an evidence-based, manualized intervention (Feske, 2008) that was created by Edna Foa and colleagues that aims to reduce the distress caused by

previous traumatic incidents by exposing a patient to a verbal recounting of those traumatic events that is audiotaped, with the explicit goal of demonstrating to a patient that he or she can survive the feelings associated with the recollection of the event through counterconditioning or desensitization (Foa & Kozac, 1986). In consequence of the processing, common trauma sequelae, such as mental intrusion, flashbacks, and nightmares, will resolve and remit.

The establishment of safety in PE is demonstrated by the therapist and patient's collaborative creation of a hierarchy of fear and avoidance, which is used as a guide for selecting the traumatic triggers that a patient will either imagine mentally or expose herself to in person (in vivo) (Foa, Hembree, & Rothbaum, 2007). This hierarchy exists in part to create a systematic desensitization to traumatic triggers, but the hierarchy also serves as an attempt to build tolerance for a traumatic reminder. This tolerance is established by a slow and careful introduction to stimuli that are minimally traumatizing, slowly increasing a patient's ability to survive events that are more evocative of traumatic responses (Jaycox, Foa, & Morral, 1998). The hierarchy of traumatic reminders exists to keep a survivor safe from an overload of traumatic stimuli. Rather than introduce a survivor to the strongest reminder of a traumatic event immediately, the survivor is slowly introduced to stimuli through an intentional titration. This slow introduction is for the purpose of avoiding an experience of over-stimulation. Although PE does not use the language of safety, its related implications are clear: a clinician must remain aware of a survivor's regulatory capacity to engage in trauma treatment without becoming so acutely activated by an experience of fear that the survivor's ability to feel safe in treatment would be compromised.

Cognitive Processing Therapy

Resick and Schnicke (1993) also developed a treatment protocol that is evidence-based that centers on the establishment of safety. Cognitive Processing Therapy (CPT) is a manualized therapeutic modality that aims to reduce trauma symptoms over a twelve-week course of treatment (Rizvi, Vogt, & Resick, 2009). As per the protocol, the initial six weeks of treatment focus on psycho-education and an exploration of the impact that trauma has on a person's day-to-day functioning. As per the manual developed by Resick and Schnicke (1993), these first six sessions aim to desaturate the power that the trauma has over a person's mind by discussing common symptoms of post-traumatic stress disorder, identifying thoughts and feelings that often occur post-trauma, and by exploring the impact of the trauma on a survivor's life.

Unlike most models of trauma treatment, CPT addresses concerns of safety as secondary to an exploration of the trauma; in fact, it is not until session seven that the therapy manual discusses the role of a disruption of safety in a survivor's life (Resick & Schnicke, 1993). The remaining sessions explore safety-related themes such as a survivor's ability to trust others as well as the ability to trust his or her own judgement, wisdom, and intuition. These sessions focus on a survivor's ability to cope with a lack of power and control over a situation, either perceived or actual. It is important to note that the safety concerns addressed are both relational and situational and environmental; CPT addresses both safety in relational intimacy and pragmatic safety concerns.

Safety Loss Emotion Future Toolkit

A more holistic alternative for safety planning is that of Sandra Bloom (2008), as implemented in the Sanctuary Model. The Sanctuary Model is a tool, originally designed for creating emotional and physical safety in in-patient settings, that focuses on the way that trauma manifests itself in organizations as it impacts client wellness. The therapeutic intervention tool of

the Sanctuary Model is called SELF, which is an acronym for the following: safety, emotions, loss, and future. The SELF model differs from the therapeutic modalities discussed previously in that it is not a modality but is instead an intervention toolkit. The founder uses the term “toolkit” to explain that it is a set of interactive tools to change people’s minds about how to collaborate towards building wellness. The safety planning piece of that toolkit is widely used among therapists, case managers, and others who work with survivors of trauma in order to reduce risk of further harm.

The SELF toolkit as it relates to safety calls on a survivor of trauma to attend to his or her most basic needs: physical needs, including exercise, sleep, nutrition, and touch; resource needs such as a stable income, access to medical care, access to transportation or the ability to leave a potentially damaging situation, and stable access to food and housing; psychological needs including therapy, interconnectedness with friends or family, play and laughter, and expression; professional needs such as a sense of professional mastery, financial compensation that is commensurate with expertise and tasks performed, and the maintenance of collegial relationships (Bloom, 2008). This approach is among the most holistic approaches to safety in the trauma literature, as evidenced by its explicit reference to protecting and nourishing a survivor’s body, meeting a person’s resource needs, attending to social relationships, and supporting a person’s sense of purpose and skill, but I believe that it does not focus enough on the person’s ability to feel safe in her own mind after a traumatic event, which this dissertation will argue is important. While this approach is important for its holistic attention to safety, in my experience as a clinician at a sexual assault treatment facility, there was not adequate time or resource capacity to explore safety according to Bloom’s model. Instead, clinicians reduced the safety plan to a plan to flee physical danger. While the ability to flee danger is of critical importance, especially in a

crisis intervention setting, it should not eclipse the very real and acute needs of someone's emotional safety in the face of trauma, and attention to safety is not complete at this juncture. This is not necessarily a deficit in Bloom's model, but is instead a deficit in how it is implemented, raising concern about its clinical applicability in under-resourced practice settings.

Step-by-Dimension Protocol

Lebowitz, Harvey, and Herman (1993), who offered a step-by-dimension treatment protocol, posit that the creation of safety is the first goal of a trauma treatment model. They maintain that the creation of any therapeutic alliance that will lead to meaningful healing from trauma must be built around ensuring a degree of safety on which a survivor can rely when engaging in a discursive and affectual exploration of a traumatic event (Lebowitz et al., 1993). This suggests a relational element to safety because there needs to be safety within the relationship when the survivor is discussing and exploring her feelings, but that relational safety is not explicitly stated or discussed in the model. The authors describe the task of establishing safety as initially focusing on the experience of the body. Bodily safety is achieved through attention to physical needs such as nutrition, basic hygiene and self-care, sleep, exercise, and control of any self-harm, including suicidality, and addiction. Once body safety has been achieved, the authors posit that the patient is ready to explore environmental issues of safety, including adequate access to financial resources, a safe living situation, and a plan for self-defense or self-protection. The authors of this protocol do not discuss internal safety, which is a shortcoming of the model. To suggest that the establishment of safety is the first goal of treatment in this model is to deny the importance of integrating safety into every aspect of treatment and attending, simultaneously, to a person's need for safety and the other tasks of treatment.

Expert Recommendations

A 2011 study (Cloitre et al., 2011) initiated for the International Society for Traumatic Stress Studies (ISTSS) surveyed 25 clinicians who are recognized as expert clinicians in the treatment of complex trauma (C-PTSD) and 25 clinicians who are recognized as experts in the treatment of classic PTSD. These expert clinicians were selected by a team of leaders on the ISTSS Complex Trauma Task Force and were required to have published two peer-reviewed articles on the treatment of PTSD, C-PTSD, or Disorders of Extreme Stress Not Otherwise Specified (DESNOS). In this study, the clinicians were provided a symptom profile, including 11 common PTSD or C-PTSD symptoms, and the experts were asked to provide ratings regarding the most appropriate treatment approach for each symptom, as defined by the known effectiveness, safety, and acceptability of the intervention. Effectiveness of the intervention was defined as “likely to decrease trauma symptoms by 75% and improve general functioning,” safety as “unlikely to increase severity of symptoms, impulsive behaviors, or suicidality,” and acceptability as “likely to promote engagement, responsiveness, and retention in treatment” (p. 618).

In this study (Cloitre et al., 2011) all of the treatment modalities described above were judged appropriate for use in the treatment of trauma. Results demonstrate a consensus among the 50 clinicians surveyed that a narration of the trauma memory, emotion-regulation building, cognitive restructuring, and education about trauma are all “first line interventions,” meaning that more than 80% of respondents would classify these interventions as of primary importance. Approximately 60% of respondents agreed that in selecting a secondary intervention they would choose meditation and mindfulness, anxiety and stress management, and interpersonal skill

building. The tertiary interventions indicated by respondents include case management and bilateral stimulation as found in EMDR.

A 2002 study by Resick, Nishith, Weaver, Astin, & Feuer found that Prolonged Exposure Therapy (PE, discussed above) demonstrated a significant decrease in trauma symptomatology, along with decreases in depression, guilt, and attention deficit when compared with Cognitive Processing Therapy (CPT). The study demonstrated significant pre-post improvement in the areas of alexithymia, narrative cohesion, and trauma-specific anxiety through use of a PE modality.

The study included 64 women who had experienced trauma and required a PTSD diagnosis at the time of an administered pre-treatment test. The PTSD diagnosis must exist absent of signs of psychosis, the presence or history of suicidal ideation or para-suicidal behaviors, and substance misuse disorders. Of the 276 women who were screened for participation for the study, 181 women were accepted. Reasons for rejection from the study included the presence of suicidal ideation and substance misuse concerns, which are two common sequelae of trauma (American Psychiatric Association, 2013). Additionally, women who were in an abusive relationship or who were being actively stalked were not invited to participate in the study (Resick et al., 2002). If the woman's history of sexual assault was perpetrated by a partner, she must have been out of the relationship for six months in order to participate in the study. This study excludes many of the most vulnerable rape survivors because of the multiplicity of sequelae of complex trauma (Spinazzola, Blaustein, & van der Kolk, 2005). Therefore, the study does not address the modality's utility with multiply vulnerable or high-risk clients and raises questions about its utility in real world practice.

Of note is the inclusion in the study of women with PTSD symptoms as a result of both single-incident and chronic traumatic exposure. The self-report scales used included the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and the PTSD Symptom Scale (Foa, Riggs, Dancu, & Rothman, 1993). One group was treated with CPT and was compared to a second group treated using PE. According to Resick, et al (2002), both PE and CPT are effective therapeutic modalities in the treatment of trauma, with 53% of participants randomized into the CPT treatment group demonstrating a reduction in PTSD symptoms at the end of the study and 55% of participants randomized into the PE treatment group demonstrating a reduction of symptoms. However, PE demonstrated more favorable outcomes in the reduction of symptomatology over time, as evidenced by 50% of participants no longer meeting PTSD diagnostic criteria at 3 months post-test compared to 42% of participants in the CPT group. While these outcomes are statistically significant, it is important to note that 50% of the survivors of trauma in the first study and 58% of the survivors of trauma in the second study did not respond to the treatment provided. One must wonder what is missing from “treatment as usual” when at least half of the clients are not helped by the treatment (Beutler, 1995; 1998). The exclusionary criteria of the study means that the subjects included do not necessarily represent the multiply vulnerable clients who seek treatment, which further limits the applicability to clinical work (Spinazzola et al., 2005).

Discussion of Interventions

The presentation of safety as an important step in a linear model of recovery is uniform across these often evidence-based and evidence supported treatment methods for trauma survivors. Although CPT places attention to safety later in the process than the other modalities, the theme is the same: safety must be addressed, whatever the stage or phase of treatment. But

what is missing from these treatment conceptualizations is an understanding of trauma recovery as both multi-dimensional and non-linear, and by extension, of safety as a non-linear and constantly evolving issue within trauma treatment. These treatment modalities suggest that when safety has been compromised, the clinician must return to the safety phase in order to reestablish that phase of treatment before moving on to the next phase. However, the conceptualization of safety as an isolated phase of treatment rather than an evolving and constant task is problematic. These treatment conceptualizations and modalities fall short in providing a framework for an understanding of safety as an element that exists in multiple dimensions and that needs to be woven throughout the course of treatment.

In addition, absent is a special focus on the safety needs particular to sexual abuse and assault survivors. The most commonly used therapeutic modalities are generalized to trauma survivors as a whole but neglect the special considerations required in treating survivors of sexual trauma. Sexual assault is an interpersonal trauma that can profoundly impact the survivor's ability to trust others, and this relational impact can be a major complication in the recovery process (Herman, 1992). While many other types of trauma also have this relational impact on survivors, the intimate nature of the violation is important to consider and suggests the necessity of its inclusion in a conceptualization of safety.

THEORETICAL LITERATURE

Safety is an elusive concept for survivors and clinicians alike, and while leading theorists have stressed the importance of safety as a foundation for the healing process (Cloitre et al., 2011; Courtois & Ford, 2012; Foa & Kozac, 1986; Herman, 1992; Resick & Schnicke, 1993; Shapiro, 2014), there is a notable absence of consensus on the complexities of its definition

(Rothbaum & Davis, 2006). Social work is a field that demands attention to both a person's internal world and the way that the external world influences a person's emotional interiority. A social-work-informed conceptualization and intervention attends to the intersection of both the personal and socio-political factors that influence a person's life. Therefore, a social-work-informed understanding of safety will pay respect to the intersection of environmental and intrapsychic factors. Safety is often defined in the literature in terms of environmental and pragmatic safety and is also discussed in terms of symptom reduction (Cloitre et al., 2011; Courtois & Ford, 2012; Bloom, Fodarero, & Ryan, 2006; Foa & Kozac, 1986; Herman, 1992; Resick & Schnike, 1993; Shapiro, 2014). This dissertation will argue that since each client is unique, the dynamics of safety for that person will also be unique and must extend beyond a focus on symptom reduction. The following theories will offer a framework for the clinical task of developing a unique concept of safety for each client. The below theories will lend to a clinician's holistic understanding of what a client needs in order to feel safe. Safety means something different to each survivor and instead of depending on the existing protocols for the establishment of safety, this dissertation suggests using the theories described below as a conceptual map for clinicians to use when thinking about what safety means for each individual survivor. This conceptualization aims to enhance what is currently in the literature.

TRAUMA THEORY

Trauma theory is a framework through which a clinician can understand the impact of trauma on a person's physiology, development, and psychology (Bloom, 2008). Before discussing the physiological, developmental, and psychiatric impact of trauma, it is worthwhile to consider the social and existential impact of trauma, as this dissertation rests upon a

foundational curiosity about the impact of trauma on a person's socio-cultural position and context of emotional life (Brown, 2004; Burstow, 2003; Herman, 1994; Stolorow, 2007).

Trauma theory as it relates to clinical work with survivors of sexual assault is a framework that includes attention to the systemic dynamics that allow for violence against women and the personal impact of that violence (Burstow, 2003). Once considered a theory to understand the impact of combat on men, feminist theorists have expanded the umbrella of trauma to include macro and micro violence against women (Brown, 2004; Burstow, 2003; Herman, 1992). Similarly, systemically oriented theorists have called for the consideration of community trauma, or the impact of violence against groups of people (Erikson, 1995), and intergenerational trauma, or the impact of harm and responses to that harm that have been passed down across a group's lineage (Danieli, 1985). This dissertation will use trauma theory as a framework to unite the clinical aspect of supporting a survivor of sexual assault and the political and social context in which that survivor is functioning.

Trauma theory offers a clinician a framework to understand that traumatic events or occasions happen to people within a larger social, political, and cultural context (Bloom, 2008; Brown, 2004; Burstow, 2003; Herman, 1992). Trauma theorists assert that trauma inherently involves social structures and that even traumatic events of natural design or traumatic events that have no human involvement in the cause, such as hurricanes or tornados, are a microcosm for human-made traumas (Burstow, 2003; Herman, 1992). For example, the differential treatment of White and Black hurricane survivors is a natural disaster that illuminates human created dynamics that significantly impact the trauma itself. For the purpose of this dissertation, it is necessary to use trauma theory's attention to the social and political in order to strengthen a feminist study of the patriarchal dynamics of sexual violence and rape apologia, to be further

discussed. I argue that oppression is inextricably linked to trauma, and must be studied simultaneously.

There are a great many psychological impacts of trauma beyond the commonly discussed symptoms, such as mental intrusion, hyperarousal, and mood disturbances (American Psychiatric Association, 2013). This dissertation, while discussing symptoms, diagnostic qualities, and the developmental and physiological impacts of trauma in concrete terms, will rely on a foundational understanding of the existential and psychological impact of trauma that extend beyond a medicalization of symptomology. This dissertation will rest on a foundational curiosity about the very human implications of what it means to exist in the world as a person who has been traumatized. These ambient and pervasive impacts of trauma are many (Bloom, 2008; Brown, 2004; Courtois & Ford, 2012; Herman, 1992; Stolorow, 2007).

An “existential pull” is an ambient impact of trauma (Burstow, 2003, p. 1304). Survivors of trauma tend to feel pulled to flee the past while feeling simultaneously pulled to remain engaged with that precise past. Many trauma survivors numb themselves so profoundly that they eventually yearn to feel again (Courtois & Ford, 2012; Favazza, 1996). Coping strategies commonly used by survivors of trauma can display this polarity: self-injury, to be further discussed, is an example of a desire to both numb overwhelming emotional pain and to invite feeling. Engaging in sexually risky behavior is another example of this psychic imperative to both distance and experience traumatic stimuli, also to be further discussed (Davies & Frawley, 1992).

An existential sense of invisibility is another hallmark of the traumatic experience that extends beyond the symptomology that is often associated with trauma (Bloom, 2008; Brown, 2004; Burstow, 2003; Herman, 1992; Stolorow, 2007). Very often, the majority of the

traumatized person's community does not know about the trauma or struggles to fully appreciate its depths. This lack of external witnessing leaves the survivor feeling isolated and alien. It is this feeling of isolation and alienation that can then impact a survivor's ability to witness her own trauma, leaving the survivor with a conflicted sense of truth and fiction, especially as it relates to the trauma itself. My clinical experience demonstrates that many of the most acutely traumatized clients openly express that they feel as if they are fabricating the events; they feel as though they are unreliable witnesses to their trauma because it has become invisible, even internally.

A hallmark of trauma is the experience of an absence of grounding, or an experience of being disconnected from the self and the world (Brown, 2004; Burstow, 2003; Courtois & Ford, 2012; Herman, 1992). Traumatized individuals feel overwhelmed, unsafe, and see the world as dangerous, making trauma theory as a guiding lens particularly useful, as it presents an opportunity to discuss the impact of a traumatic event on the survivor's ability to feel safe in the world. One common view of post-traumatic response is that it alters a survivor's perception of the world and leaves the survivor with a distorted view that ultimately inhibits her ability to trust others (American Psychiatric Association, 2013). This view of traumatic response relies on the assumption that the world is a generally safe place to inhabit and that other people are generally trustworthy. It assumes that most people exist in the world with a sense of invulnerability and that vulnerability is lost at the moment of a traumatic event.

However, a belief in the world and others as mostly benign is not the reality for many people with marginalized identities who have experienced longstanding overt and covert threats to their existence (Brown, 2004; Burstow, 2003; Herman, 1992). This belief also ignores the possibility that a survivor of trauma might see the world more accurately after the traumatic event. While it is true that many clients do experience cognitive distortions after an assault

(American Psychiatric Association, 2013), it is important for a clinician to keep in mind that perhaps viewing the world as a less safe place after a trauma is a sign of resilience rather than deficit (Burstow, 2003).

This dissertation aims to demonstrate a deepened clinical exploration of the concept of safety for a survivor of sexual assault that takes into account these existential dilemmas, in addition to paying attention to the concrete medical, physiological, and developmental impacts of trauma to be discussed below. This dissertation aims to explore the necessity for and process of helping clients to safely inhabit the landscape of their minds through attention to the existential dilemmas of trauma, and will emphasize that the capacity to safely live in the mind relies on the realities of pragmatic safety and symptom reduction. Much attention has been paid to the psychological impact of trauma (Bloom, 2008; Brown, 2004; Courtois & Ford, 2012; Herman, 1992; Stolorow, 2007) and this attention can be strengthened by a commitment to grounding a person-centered approach in the cultivation of safety using the theories outlined below.

Complex Trauma

This dissertation aims to demonstrate that complex trauma, or a type of trauma that occurs repeatedly over a period of time and that exists within particular social and relational circumstances (Courtois, 2004), can profoundly inhibit a person's ability to establish a foundational level of safety upon which to return after a sexual assault. While originally referring to the sequelae of chronic abuse against a child, the term "complex trauma" is now used to describe attachment and relational trauma, other domestic violence or ongoing assault, chronic and acute illness and on-going medical treatment, post-combat experience, displacement of populations due to political and religious conflicts and upheavals, and other ongoing, pervasive situations (Courtois, 2004). The term was coined by Herman (1992b) when research findings

suggested that those who were chronically traumatized over the course of childhood or adulthood showed a symptom picture that differed in significant ways from the diagnostic criteria for PTSD. Clinicians who work with survivors of attachment trauma and other experiences of child abuse or ongoing exposure to trauma find that although the effects of child abuse include classical symptoms associated with the diagnosis of PTSD, additional symptoms are common. These additional symptoms include emotional dysregulation and difficulties with identity development and a cohesive sense of self; difficulty in establishing trusting and intimate relationships; alterations in consciousness (dissociation); and somatic distress, including illness (Cloitre et al., 2011; Herman, 1992b; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

A person who has experienced complex trauma, especially of the sort that begins in infancy or early childhood and who experiences additional traumatic events will likely present to treatment with a complex symptom picture and an unstable sense of self (Sands, 2009). It is possible that when a child develops in the midst of ongoing exposure to traumatic stimuli, he or she experiences an impaired ability to not only develop a secure and stable attachment to a person such as a caregiver, but also impairment in the ability to develop an authentic sense of self, or mode of being. It is very difficult to build a stable sense of self on an unstable foundation. Therefore, as adults, survivors of complex trauma in childhood often experience difficulty modulating affect, experience increased dissociative moments or episodes, and have difficulty identifying a true vs. false self (Winnicott, 1965), and relational instability (Courtois, 2004). It should be noted that experiences of or exposure to complex trauma can occur in adulthood for the first time. Traumatic events are not likely to compromise the self as directly when the adult has already developed his or her personality. However, if the adult had a history of

attachment/relational trauma or other ongoing trauma in childhood, he or she might have developmental deficits, including with identity, to begin with (Courtois, 2004).

Safety becomes a particularly elusive experience for people who, due to chronic and complex trauma, have not had the experience of constructing their own internal, safe world. Much of the literature concerning safety discusses the concept of reestablishing safety after a trauma (Cloitre et al., 2011; Courtois & Ford, 2012; Bloom, Fodarero, & Ryan, 2006; Foa & Kozac, 1986; Herman, 1992; Resick & Schnike, 1993; Shapiro, 2014). This dissertation will focus on understanding safety after a sexual assault for survivors of complex trauma and will introduce a discussion of the many factors that complicate the ability to return to a baseline level of safety for a survivor of complex trauma.

Neurobiology of Trauma

Neurobiology offers another useful lens through which clinicians can understand the ways that safety is compromised after a sexual assault, through its attention to the impact of threat against a person's safety and the biological predisposition to re-create and re-experience traumatic stimuli. The field of social work puts a strong emphasis on a clinical perspective that is informed by the biological, psychological, and social aspects of a person's life and functioning – the biopsychosocial perspective. Therefore, it comes naturally to a social work-informed understanding of safety after a sexual assault to include a study of the neurobiological impact of trauma. However, there exist critiques of neurobiological research among trauma researchers who believe the conclusions of the research to be speculative. The psychobiological model used is not uniformly accepted among trauma theorists and has been critiqued for not accounting for the complexity of the ways that trauma impacts psychosocial functioning and for describing only the psychobiological model rather than a cognitive approach to understanding what happens to

the mind of a person who experiences trauma (Vees-Gulani, 2003). In addition, the field of neuroscience is a relatively young science, and new discoveries will likely add to and perhaps change our current understandings of the neurobiology of trauma. Despite the critique of neurobiological findings, there is compelling research that is worthy of consideration and can enhance our understanding of the impact of trauma on a person's ability to experience safety after a sexual assault.

In response to threat, humans, like animals, have a defensive system designed to help them survive. Lanius et al. (2010) described it as an archaic biological system designed to respond to and counter threat in order to decrease the likelihood of bodily destruction and death and as an aid in escaping dangerous situations. This research indicates that fear regulation is connected to other emotion regulation systems, suggesting a need to locate our understanding of fear in a robust understanding of post-traumatic sequelae. Lanius et al. indicate that similar regions of the brain are involved in the response to threat and the regulation of other emotions. The findings are of great import, as trauma-related disorders are connected to extreme difficulty in regulating emotions.

In fact, Panksepp (1998) posited that the sensitization of the fear system that comes with exposure to traumatic events can lead to a destabilization of other emotional systems and inhibit a person's ability to achieve emotional regulation. Panksepp's research indicates that there are seven basic emotional systems in a person's brain: seeking or desire; rage or anger; fear or anxiety; lust or sexual urges; care or maternal nurturance; panic or separation distress; and play or social engagement. The emotional systems that are experienced by humans as negative, such as rage and panic, are activated by traumatic experience through the sense of abandonment and shame that are products of the panic and separation distress system; the anger that is a product of

the rage system; and the terror that is a product of the fear system. Panskepp's research suggests that an over-activation of these systems, in particular the fear system, caused by a traumatic event, can result in subcortical disturbances that make homeostasis of the emotional systems difficult. Additionally, Panskepp (1998) outlined four interactive emotional systems that are defined by neural circuits that lead to specific behaviors when activated that provide a model for understanding how the sensitization of the fear system can lead to a destabilization of other emotional systems, resulting in general emotion dysregulation. Panskepp discussed a fear system that is designed to minimize the likelihood of harm and that aids in fleeing dangerous situations. This fear system has the ability to activate the rage, seeking, and panic systems, while the rage and seeking systems are thought to deescalate the fear system, indicating a multi-directional relationship between the role of emotion dysregulation that accompanies PTSD and fear. Panskepp's research suggests that fear plays a role in a trauma survivor's ability to self-regulate and achieve emotional homeostasis after a single traumatic event, as well as after chronic exposure to trauma.

Some researchers have asserted that at the time of a single traumatic event, the amygdala over-functions (Panskepp, 1989; van der Kolk, 2014; Yehuda et al., 2015). There is a release of stress hormones such as cortisol and adrenaline, and there is an immediate activation of the autonomic nervous system. A person experiences a fight or flight response, which is an activation of the sympathetic nervous system, or the person experiences a freeze impulse, which is an activation of the parasympathetic nervous system. This process occurs unconsciously and happens instantaneously when the fear response is activated. When either of the sympathetic and parasympathetic nervous systems experience a surge, the neurobiology of the brain is altered. Cortisol levels remain elevated after each surge that the brain experiences (Yehuda et al., 2015).

Therefore, when a person experiences chronic exposure to trauma, or experiences multiple stimuli that cause a surge in cortisol, the person's levels are chronically elevated. Lanius, et al. (2010) put forth the hypothesis that this chronic elevation of cortisol impacts the brain's capacity to experience and regulate fear. Lanius et al. propose that there are two pathways that can solidify the relationship between fear and the other emotion regulation systems that Panskepp (1998) identified in his research. The first pathway views disturbance in emotional responses as an outcome of sensitization to chronic fear. This sensitization can lead to increased emotional reactivity and can lead to a generalization of a fear response, meaning that a person's ability to precisely name the source of her fear is inhibited, leaving her instead feeling a sense of ongoing, non-specific fear. The second pathway suggests that the disturbance in emotional responses that fear sensitization can cause through the first pathway can create a vulnerability factor that increases the risk of developing PTSD after exposure to a traumatic event.

In the case of survivors of sexual violence, clinical experience demonstrates that people who have experienced chronic exposure to fear-inducing situations describe a decrease in their fear response. Clinical experience demonstrates that survivors of sexual assault often engage in risky behavior, seemingly without fear for their physical or mental wellness. This phenomenon can be understood using Yehuda's research (2007), which indicates that the activation of the emotion systems that occurs after exposure to a traumatic event changes the neurobiological function of fear. The research of Lanius et al. (2010) also offers insight into this phenomenon by offering evidence to suggest that a person can become desensitized to chronic fear and can experience a generalized fear response, which leaves a person unable to identify a specific fear-inducing threat. When a person feels a general, non-specific fear at all times, it becomes difficult to weigh the risks of particular actions because every action feels equally risky. In clinical

practice, this tasks the clinician with the responsibility to help a client differentiate between risky and less-risky behaviors, despite a generalized fear that leaves her feeling that all behaviors hold the same level of risk.

Both De Becker (1997) and Panskepp (1989) claim that a person's capacity to sense fear is the strongest force that protects humans from danger. They share the hypothesis that when people are able to sense and protect themselves from danger, they are relying on their intuition. For example, a woman who senses that a man is "off" and might not be safe and on this basis declines an invitation to be alone with him is tapping into her innate ability to feel and honor her sense of fear. A person who gets a "bad feeling" from a situation is able to connect with a sense of fear that allows them to exit the situation. When the ability to feel this fear is dulled by chronic exposure to traumatic events, a person can lose the ability to self-protect from danger. This is particularly troublesome for the vulnerable population of survivors of sexual assault, who are more likely to engage in activities that others might view as high-risk, for reasons to be discussed. Because a survivor's ability to sense when a situation is unsafe can be compromised, a key task of therapy is to bring into conscious awareness the ways in which this is true for each client. Once the client is aware of the ways in which she cannot always perceive danger, it then becomes possible to help her develop coping mechanisms that will be self-protective. The idea of bringing critical material and information into conscious awareness is rooted in psychodynamic theories.

Psychodynamic Theory

Sigmund Freud, the founder of psychoanalysis, offers several compelling theories that offer insight into how a person's history of trauma can impact current and future functioning and how the uncovering of unconscious material can alter future functioning. Freud's study of the

mind brought him to understand the mind as multilayered (Freud, 1913). He suggested a topographical model of these layers. He explained that the deepest part of the mind, the unconscious, is the home of inaccessible and repressed wishes, impulses, and memories. He suggested that this unconscious layer of the mind exists hidden beneath the preconscious, which is the home of more readily accessible memories and desires. The preconscious exists between the unconscious and the conscious, which is the home of the most acceptable desires, fears, and memories. Freud hypothesized that memories that are repressed are stored in the unconscious because they are too painful to tolerate or know consciously, but that they can be brought to consciousness by giving voice to what is on one's mind with the help of psychoanalysis and free association.

An early patient of Freud's colleague, Breuer, helped to solidify Freud's belief that many symptoms are the result of repressed memories rather than nerves and that these repressed memories exist in the multilayered mind (Freud & Breuer, 1895). In an article based on Breuer's patient, co-written by Breuer and Freud, they stated that "hysterics suffer mainly from reminiscences" (p.7), meaning that hysteria was a condition caused by unconscious memories of psychological trauma. Rather than caused by an organic neurological condition, as was commonly believed at the time, Freud and Breuer maintained that hysteria was caused by repressed memories of traumatic events. Because repression does not successfully rid the patient of all unbearable affect, hysterical symptoms develop as a way to keep the forbidden, overwhelming feelings and memories out of consciousness. Freud believed that if those symptoms were traced to their origins – the repressed traumatic experience - their meanings would become apparent and the symptoms would be alleviated through catharsis – a coming into conscious and release of the feelings associated with the original trauma.

These early discoveries of Freud and Breuer (1895) - that hysterical symptoms could be alleviated when memories of the traumatic material and their accompanying feelings were brought back into consciousness and verbalized - became the basis of psychoanalysis as a theory and therapeutic technique. Freud found in his clinical work that his patients' recent traumas concealed major traumatic events of childhood, and that his patients' hysterical symptoms were not in response to recent traumas but instead were the result of early childhood traumas, the memories of which were coming into consciousness as the survivors entered puberty (Freud, 1896a). Freud asserted that these early traumatic experiences were occurrences of childhood sexual abuse, the ultimate source of hysterical symptoms. Freud developed a method for tracing these symptoms back to previously repressed memories of very early experiences of childhood sexual abuse and concluded that all cases of hysteria had their origins in premature sexual experiences. He called this theory the Seduction Theory. The Seduction Theory was the first systematic inquiry into the impact of childhood trauma on people and of how the content in repressed memories can cause symptoms.

Freud admits that not all individuals who experience childhood sexual abuse will display symptoms of hysteria in adulthood and explains this through his theory of repression (Freud, 1896b). Repression is the defense that keeps feelings and thoughts that are too painful for a person to tolerate out of consciousness. Those who remember the abuse they experienced have not repressed it; it is accessible to their ego and is part of their conscious awareness. This conscious awareness of the traumatic material protects a person from a display of hysterical symptoms. For a symptom to be considered a hysterical symptom, the memory must be stored unconsciously, meaning that hysteria only occurs when an experience is repressed. Freud

believed that entire experiences were repressed when the traumatizing impact of the experience was too painful to allow into consciousness.

For Freud to state that an illness that was as widely common as hysteria was the result of childhood sexual abuse was a bold and powerful statement (Herman, 1992). Freud did not have the political or cultural backing to support a statement that suggests that sexual abuse of children is common, especially among his peers in prestigious and respectable communities. Freud ultimately recanted this theory and stated instead that some memories of sexual abuse were imaginary fantasies. While Freud recanted his Seduction Theory, the role of the unconscious in the treatment of trauma remains relevant in contemporary clinical practice. This theory, and psychodynamic theories more broadly, encourage the clinician to explore the roots and meaning of a behavior through an exploration of a person's history. The relief of strong emotions associated with problematic behaviors comes through the experience of catharsis, which is when a person is able to unite a previously memory with its associated strong emotion.

Similar to the concept of repression, as discussed above, is dissociation. Freud and Breuer (1895) referred to the concept of dissociation in terms of a "second consciousness". The concept of a second consciousness is now understood in terms of dissociation, or a split between parts of the self or experience (Howell, 2005). These splits could relate to thoughts, consciousness, affect, or memory. The splits inherent in dissociation and repression differ (Mitchell & Black, 1995). The split in dissociation is considered a vertical split, meaning that the contents of a person's mind exist separately but in parallel. In contrast, repression is considered a horizontal split with a barrier blocking communication between what is conscious and what is unconscious. First noticed by Breuer in his work with Anna O., dissociation is present in trauma literature and is a term used to describe the experience of emotional or affectual states that can sometimes be

felt but not fully known. Both repression and dissociation are defense mechanisms, or psychological strategies that are unconsciously employed to protect a person from gaining access to thoughts, feelings, or desires that are unacceptable (Freud, 1894).

The Repetition Compulsion, Enactments and Self-Harm

Another of Freud's contributions includes the theory of "the repetition compulsion", or the unconscious tendency of an individual to repeat past experiences (Freud, 1914). Trauma theorists have coined the term "traumatic reenactment" to describe the way that the repetition compulsion exists specifically in the mind of a trauma survivor (Van der Kolk, 1989), and relational theories have coined the term "enactment" to describe the way that this unconscious material surfaces in the therapeutic context (Davies & Frawley, 1992; Jacobs, 1986). For the purpose of this dissertation, I will use the term enactment to describe the emergence of unconscious material into the patient's clinical presentation, as it relates to both the constellation of trauma symptoms, and its emergence into the treatment relationship.

Psychodynamic theory, as discussed above, is uniquely situated to consider the compulsion to enact trauma and the way that this enactment obstructs safety. Freud discussed a traumatic enactment process seen in survivors of trauma that he describes as a repetition compulsion, a trauma survivor's attempt to remember and recreate the traumatic event with the ultimate goal of gaining mastery or changing the outcome (Freud, 1914). Freud argued that children are unable to remember the events of early childhood because they occurred pre-verbally and often before a child could remember them due to infantile amnesia, something that usually changes 2 ½ to 3 years of age. These events are not truly remembered explicitly, but are later understood and interpreted inferentially through the process of analyzing the content of

dreams, fantasies, and actions as well as somatically. The memories are not recalled literally but come into consciousness as a result of what Freud referred to as a “memory trace” (Freud, 1896). Freud defines a memory trace as the persistent impact of an emotion that had been previously experienced. He believed that the memory trace leads to a release of affect, followed by further repression. To describe what happens during the emergence of a memory trace, Freud writes of the clinician as an explorer whose “interest is aroused by an expanse of ruins and who may start upon the ruins, clear away the rubbish, and, beginning from the visible remains, uncover what is buried...it may yield undreamed-of information about the events of the remote past” (p. 192). A clinician’s curiosity about the memory leads to a deep exploration of its origin, which ultimately uncovers its roots. Freud hypothesized that the primary task of therapy is to shift the behavior found in an enactment or in resistance into a remembrance that can be consciously articulated and processed in the context of the therapeutic dyad.

Freud (1914) believed that where there is repetition, there is an unconscious, distressing memory. He wrote: “He [the patient] reproduces it not as a memory but as an action; he repeats it without, of course, knowing that he is repeating... he cannot escape from this compulsion to repeat; and in the end, we understand that this is his way of remembering” (p.150). Therefore, it is the task of the clinician to gain an understanding of the meaning of the client’s behavior and how it reflects the nature of the original trauma.

The task of the therapist is to understand what in the patient’s unconscious is being replayed within the therapeutic relationship (Freud, 1914). The skill of the therapist and her ability to accurately understand what is being enacted, the level of trust within the therapeutic relationship, and the resilience of the patient will determine whether the patient can accept the therapist’s interpretation of the enactment, thus gaining access to feelings that have been

repressed. Once these feelings are conscious, the patient will no longer be compelled to act them out.

Relational theory is an additional useful tool through which to examine enactments, and adds to a robust understanding of enactments. A relational approach pays unwavering attention to the relational matrix of the client, which is defined as space for the clinician to understand the client within the context of the self, the other, and the macro systems that impact the client (Segal, 2012). The clinician enters this relational matrix and uses the clinical material to understand the client's history as it intersects with the present moment through attention to enactments (Ganzer & Ornstein, 2008). One goal of providing treatment within this relational matrix is for the client and the clinician to co-create an understanding of the intrapsychic conflict that fuels the enactment. Rather than avoiding enactments, a relational clinician will work with the client to understand the enactments and their meaning, with the ultimate goal of locating their origin in unresolved relational dynamics and offering a corrective relational framework for their exploration (Berzoff, 2012). The therapeutic task is to enhance a client's insight into her relational world by making meaning of the patterns they have created within the therapeutic relationships because that is a microcosm for how they engage with others (Glazer & Ornstein, 2005).

For the purpose of this dissertation, it is important to examine the role of enactments through a feminist lens. Feminist psychodynamic clinician Dusty Miller (1994) writes about what she termed Traumatic Reenactment Syndrome, which she defines as a connection between a woman's symptomatic behavior and her own unique story of childhood trauma that leads the woman to do something to her body that represents what was done to her in childhood. Miller borrows liberally from Freud's conceptualization of the repetition compulsion, and also suggests

that self-harm is a symptom that is an enactment. She wrote that self-harm tells a story of the childhood trauma and that it represents an adaptation to a traumatic environment that allows for a sense of control of the self and the ways that the self relates to others. The self-harming behavior, Miller theorizes, serves two primary purposes: to keep others at a distance and to keep the woman from feeling alone. Miller writes that the self-harming behavior should be understood as a process that helps a woman survivor to feel alive when she feels numb or deadened by blunting the overwhelming experiences of pain and grief. She offers the example of her patient with anorexia who was orally raped during childhood. The adult patient now uses her restrictive eating disorder as a tool for keeping objects out of her mouth. This is a strategy, albeit unconscious, that contributes to her resilience and construction of a self-defined sense of safety; no object can orally harm her if no object can enter her mouth.

Miller's conceptualization of self-harm does not encompass all of the clinical understandings of the purpose of self-harm. Favazza (1996) outlined the historical and cultural beliefs, attitudes, and practices of self-mutilation using a historical and anthropologic lens. Cultural commentary on self-injury spans centuries. Favazza found that the intentions and meanings of self-harm are wide-ranging, and that culturally sanctioned rituals of self-injurious behavior are linked to physical, spiritual, and psychological healing, while pathological self-mutilation is most accurately understood as a form of self-help that temporarily reduces painful symptoms of emotional distress and serves the deeper purpose of healing, salvation, and internal order.

Russell (2006) also encouraged clinicians to understand clinical concerns not merely as problems to fix, but as experiences of which to make meaning. Russell's theory supports Miller's: people with complex trauma remain engaged in and enact what pains them and it is the

role of the clinician to understand the contextual and symbolic significance of these enactments in order to support a survivor's movement towards meaning and safety. Russell stated that these enactments emerge most potently in the therapeutic dyad, a point with which Miller agrees, but Miller used a slightly broader field of vision and encouraged clinicians to remain aware of these repetitive patterns in other areas of a client's life. Russell drew particular attention to the relational implications of the enactments.

An additional body of literature exists to support the importance of dismantling the power of enactments as a means to limit the experience of re-victimization. There have been multiple quantitative studies on the link between sexual trauma and re-victimization with implications for a survivor's ability to experience safety after sexual assault. Tomisch (2013) explored the role of previous trauma in the rate of re-victimization and found support for a relationship between them through an ecological analysis. Similarly, Ruback, Clark, And Warner (2014) found the same correlational relationship between a history of sexual assault and engagement in risky behaviors such as substance abuse. Mato, Conde, Goncalves, and Santos (2015) highlighted the high correlation of re-victimization among women who have become isolated due to their traumatic response. These studies all support an understanding of enactments as an unconscious risk for re-victimization; until a client has worked through unconsciously held traumatic material, they will engage in enactments that compromise their safety. I suggest an expansion of the meaning of enactments to include the findings of these studies that show a link between unconscious traumatic memories and self-harming behaviors. These types of enactments compromise safety.

There is also speculative research that supports bio-chemical underpinnings of enactments. Van der Kolk (1989) wrote of the compulsion to repeat trauma in an article outlining the link between early trauma and re-victimization. Van der Kolk makes the compelling yet

incomplete argument that this compulsion to reenact trauma is rooted in an unconscious desire to experience harm: the repetition of trauma brings relief, however fleeting and painful. In his most recent book, van der Kolk (2014) built on his seminal 1989 article and wrote of a study that uses neurobiology to support Freud's theory of the repetition compulsion. Van der Kolk explored the research of Maier and Seligman (1976) on learned helplessness that studied experience of dogs who had been administered painful electric shocks and their response to those shocks. The study indicates that dogs who had been shocked responded to an opportunity to physically flee pain but remained frozen in their cages. Dogs were repeatedly given electric shocks while they were in their cages. When the researcher opened their cages to release the dogs, rather than running free, they remained still; they responded to recurrent electric shocks by remaining frozen rather than fleeing the pain and torture. The researchers hypothesized that the dogs did not move because they believed that nothing they could do would prevent future shocks. Van der Kolk expanded upon Maier and Seligman's (1976) research to include research on learned helplessness to include the brain's response (or, in this case, absence of response) to trauma. The brain, van der Kolk posits, is modified by experiences of trauma. Van der Kolk offers a neurobiological lens for understanding the compulsion to repeat and suggests that there is something about the trauma itself that is both safe and enlivening to people who have experienced chronic trauma. He explains that re-exposure to stress might provide a relief from anxiety through the release of endorphins. Van der Kolk (2014) wrote, "Fear and aversion, in some perverse way, can be transformed into pleasure" (p.16).

Panskepp's research (1998) on the emotional systems, discussed previously, also speaks to the bio-chemical underpinnings of the compulsion to repeat. Panskepp identified the seeking system, which is the emotional system that helps a person identify resources in the environment,

such as food and water, and gives energy to a person to pursue access to those resources. This system arises in the upper brain stem and stimulates the frontal cortex; the seeking system is fueled by a release of dopamine that occurs when what one has been seeking is found. The seeking system upregulates the other emotional systems, according to Panskepp (1989). Psychiatrist and analyst Brian Johnson (2008) posits that Panskepp's identification of the "seeking system" relates to the repetition compulsion. Johnson suggests that the energy of the seeking system exists in a "cathected state related to the memory of humans" (p. 202), meaning that the seeking system also seeks attachment and connection, in addition to resources such as water and food because the satisfaction of many basic needs involves other people. Johnson posits that the connections of the seeking system, sensory memories of previous experiences, and the dopamine stimulation in prefrontal areas of the brain all converge in a bio-chemical compulsion to repeat the upregulation of the emotional systems that are activated by traumatic events. This means that there is an upregulation of emotional systems in the brain that the brain is physiologically wired to recreate, even if the stimuli that the upregulation of the emotional systems respond to is traumatic (Johnson, 2008), offering neurobiological evidence for Freud's (1914) theory of the repetition compulsion.

Attachment Theory

Another theory that supports the clinical utility of looking at how the impact of how a person's past influences her current functioning is attachment theory. The theory's founder, John Bowlby, began his work on attachment theory in the 1940's and had the basics of the theory established when he met Mary Ainsworth in 1950 (Ainsworth & Bowlby, 1991). She became his collaborator then and designed empirical research to test his theory. Together they refined the theory. Attachment theory draws on theories of psychoanalysis, evolutionary psychology,

ethology, and information processing in order to deepen thinking about a child's way of relating to a primary caregiver (Bretherton, 1992). The foundational hypothesis of Bowlby's attachment theory is that humans have the innate motivation and capacity to create strong bonds with others and that psychological pathology is the result of unwilling separation from another person. It is this hypothesis upon which Bowlby developed his concepts of attachment styles and Internal Working Models, to be discussed below. Bowlby asserts that of great import in a child's development is the attachment figure as a secure base from which a child can explore the external world. The quality of the relationship between attachment figure and infant is determined by that figure's capacity to identify and respond to the infant's signals in an attuned way, which is reliant upon her previous attachment experiences; he proposed that attachment organization remains relatively stable across the lifespan and is transmitted intergenerationally, meaning that the primary attachment figure's experience of the attachment will influence her infant's attachment style. Bowlby's central belief was that in order to experience emotional wellness, an infant must experience "a warm, intimate, and continuous relationship with his mother in which both find satisfaction and enjoyment" (Bowlby, 1951, p. 13).

Ainsworth, a developmental psychologist who originally worked and researched separately from Bowlby, offered empirical evidence to support Bowlby's claims (Bretherton, 1992). She completed the first infant-mother attachment study in Uganda in 1953, the results of which advanced Bowlby's of conceptualization of attachment theory. She created a research protocol called the Strange Situation, in which a mother and child interact in laboratory playroom and are joined by a stranger. The stranger plays with the infant while the mother leaves and returns, then both stranger and mother leave then return. Ainsworth's attention to the responses of the infants to the presence and absence of mother and stranger and then the reaction

upon reunion with the mother resulted in the identification of two insecure attachment styles: avoidant and ambivalent. Avoidant infants did not display distress at separation from the mother and did not appear joyful when reunited with the mother. Ainsworth found that this presentation occurred most frequently among infants whose needs were frequently not met and who had come to believe that the caregiver would not be influenced by the infant's communication of needs. Ambivalent infants were upset when their mothers left and appeared eager at their mother's return, but were not easily soothed by their mothers. Ainsworth posited that the infant's ambivalence is in response to unpredictably responsive caregiving and that the infant's distress served to extend the availability and responsiveness of the caregiver. Bowlby and Ainsworth posited that these early attachment styles set the template for the child for future models of attachment, what Bowlby termed the Internal Working Model (IWM) (Bowlby, 1973).

When infants responded to the Strange Situation in a way that appeared inconsistent in their strategy of navigating their mother's absence, they were later categorized by Mary Main (1995), who was a student of Ainsworth, as having a disorganized attachment style. The disorganized attachment behavior includes walking towards the mother but stopping abruptly appearing afraid, walking slowly or with short, sharp, jerky movements. Main's research suggests that this disorganized behavior indicates a disruption or flooding of the attachment system.

Main (1995) also created the Adult Attachment Interview and used this research to extend Bowlby's concept of the Internal Working Model through adult life. The interview that she created calls on the researcher to listen to the way that a person discusses early attachments and suggests that the quality of the person's narrative is more relevant than the facts of the narrative in determining an adult's attachment style. Main found that an adult with a secure

attachment will describe early attachments with coherence, cohesion, the ability to modulate affect, and will demonstrate a level of self- reflection. In contrast, insecure, ambivalent, or disorganized attachments are demonstrated with narrative descriptions that display anger, minimization, lack of coherence, or flooded affect.

Anderson and Alexander (1996) performed a research study on attachment style in relation to sexual abuse. They noted that a secure early attachment can offer a protective element for survivors of abuse; even chronically abused individuals with secure attachment experiences that precede abuse can easily resume healthy attachments after their abusive experiences, whereas people with insecure attachment styles experience more difficulty in managing post-traumatic sequelae. They found this through a qualitative research study exploring the attachment style of 92 women who are self-identified survivors of childhood sexual abuse by a family member. Eighty-six percent of those women were white, 7% were Black, and 7% identified with another racial and/or ethnic identity. Of the 92 women involved in the study, 8 women reported the incest taking place over the course of less than one year, while 84 reported the incest taking place over the course of one year to 240 months, with a median duration of abuse being 72 months. The research involved a qualitative study performed by one of three researchers that lasted approximately 2-3 hours. The interviewers used the Family Attachment Interview developed by Bartholomew & Horowitz (1991), which is a semi-structured interview that measures attachment by eliciting specific memories of individuals' childhood and current attachment figures. The researchers divided attachment types into four categories and placed each woman in her appropriate category based on interview process variables such as elaboration, coherence, idealization, evidence of proximity seeking, and self-confidence. The four categories are as follows: secure attachment prototype, which is characterized by a valuing

of interpersonal relationships, coherence in describing attachment history, moderate elaboration, and the integration of both positive and negative memories of the attachment figure; preoccupied prototype, which is characterized by excessive elaboration in describing relationships; dismissing prototype, which is characterized by an unwillingness to acknowledge either the importance of close relationships or the impact of early attachment relationships on current relational functioning, as well as a lack of clarity and insight in the discussion of attachment figures from early childhood; and the fearful-avoidant category, which the researchers characterized by an avoidance of close relationships due to a fear of rejection, a sense of relational insecurity, and a profound distrust of others and is evidenced by a lack of interpersonal soothing by early attachment. The participants were assigned to each category by two of five independent coders who were blind to the participant's outcome measures. When assessed for attachment organization, the researchers found the following: 51% of the survivors were categorized as fearful-avoidant, 20% preoccupied, 12% dismissing, and 9% secure. They found that the 9% of women who were categorized as securely attached despite their history of sexual abuse demonstrated a sense of personal autonomy and agency and were less likely to present in a distressed or trance state that would indicate the propensity for dissociation. They were more likely to regulate their affect and were better able to request and accept support from their attachment figure in order to self-soothe as children, a skill that has allowed them the ability to independently self-soothe as adults, supporting the belief that attachment theory is a particularly useful lens through which to view a person's response to trauma.

Much of Bowlby's research focused on the impact of the trauma of separation and loss of the primary attachment figure on an infant's development. In fact, his belief that the trauma that results in psychopathology involved maternal loss or maternal deprivation rather than sexual

molestation which was a notable divergence from Freud's original trauma theory (Cleary, 1999). In contemporary parlance, one might refer to the loss or deprivation of the mother as attachment trauma. Attachment trauma is a term used to describe a severance that occurs between a person and a primary, central attachment figure. Examples of attachment trauma include a sudden or profound absence of a caregiver as per Bowlby's research, but also applies to situations of caregiving that can range from the dismissing of an infant's emotional needs to overt physical abuse. When caregivers are repeatedly non-responsive to infant cues or basic needs, mock or tease an infant for his or her needs, or offer mis-attuned responses to an infant's needs, or physically harm the child in any way, the possibility of a secure attachment pattern is compromised. For example, the infant will initially protest with a separation cry after being ignored or receiving a mis-attuned response, and if the non-response continues, the infant will begin to detach (Bretherton, 1992). It is this type of mis-attuned response that could be considered attachment trauma. Another type of trauma that occurs at the hand of another person is interpersonal trauma. Examples of an interpersonal trauma include sexual assault by a peer, partner, or stranger; domestic violence; and physical assault, community violence, combat, etc.

While attachment theory has become one of the foundational theories upon which clinicians build conceptualizations of a wide range presenting problems including domestic violence, substance use concerns, personality disorders, and other forms of psychopathology, it is not without its limitations (Cleary, 1990). Feminist critiques include the gendered use of the word "mother" to represent a primary caregiver. Even when the gendered word is substituted with a gender-neutral descriptor, the social and political realities of childrearing indicate that the mother is most frequently responsible for the child's attachment style. Further, the influence of the biological sciences in Bowlby's development of the theory mirrors a problematic tendency to

remove the philosophical and push the scientific in theories of human behavior. Doing so removes the subjectivity of the theory and instead elevates it as universally applicable. There also exists critique of attachment theory in regards to culture and ethnicity. In many cultures, attachment is not perceived as critical in raising children, limiting the theory's cross-cultural applicability. Several cross-cultural attachment researchers have suggested that although there are universally experienced attachment behaviors in infants, the selection, shaping, and interpretation of these behaviors over time is culturally patterned and a result of cultural constructs that prohibit universality (Harwood, Miller, and Irizarry, 1997).

However, for the purpose of this dissertation, I will conceptualize attachment within a Western socio-political context with awareness of the ways that attachment forms differently within the context of chronic resource insecurity and chronic exposure to violence. Although perhaps absent from the initial intent of the theoretical model, a social-work-informed use of attachment theory rests on the contextual understanding of the difficulty of forming an attachment to a caregiver in a context where basic resources are absent. In the absence of basic resources such as food, shelter, and medical care, it is difficult for caregivers to provide the attunement that is necessary for the establishment of a secure attachment (Segal, 2012).

Relational Theory and Intersubjectivity

Reliant upon and deeply connected to attachment theory is Relational theory. Relational theory is primarily a clinical theory; it is a theory of the therapy relationship. Relational theory is informed by the belief that it is through attachment and the establishment and maintenance of positive relationships that people are able to experience emotional growth, and it is this connection that is the primary force behind human behavior (Bowlby, 1969; Tosone, 2004). Despite its divergence with early psychoanalytic theories that believe that humans are motivated

by drives for sex and aggression, relational theory finds its roots in psychoanalytic thought and is considered a psychodynamic theory. It is different from classical psychoanalysis in that the therapist is not seen as a blank screen, interpretations are not mutative, and countertransference and transference are welcomed into the study of the clinical material (Mitchell, 2014).

According to the tenets of relational theory, at the core of human existence is intersubjectivity. Intersubjectivity is a term used to describe the unique relational field that exists between two individuals and the shared impact of the unconscious dynamics of each of the individuals (Benjamin, 1995; Tosone, 2004). Engagement between client and clinician, also referred to as intersubjective engagement, then, is the vehicle for therapeutic growth that therapy facilitates (Mitchell, 2000). Intersubjectivity grew out of infancy research and observations of the mutual influence of mothers and babies (Benjamin, 1990). Attention to these intersubjective dynamics is essential for understanding the clinical encounter, according to relational social work (Berzoff, 2012; Segal, 2012; Tosone, 2004). An intersubjective approach rejects the classical psychoanalytic notion of the therapist's objectivity, or the possibility of complete neutrality on the part of the clinician. Ferenczi, an early relational theorist (Berman, 1997), saw objectivity as a way of creating emotional distance from the client and the material that the client shares and suggested that this emotional distance often becomes most apparent when the client shares traumatic experiences. He believed that a relational therapist must join the client in living through the client's experience of trauma in order for the client to experience relief (Ferenczi, 1988).

Relational theorists believe that people grow as a result of their connections to others, and that by nurturing healthy relationships, people are able to find wellbeing (Jones, 2008). Relational social work honors the mutual and asymmetrical nature of the therapeutic dyad

(Ornstein & Ganzer, 2005). In relational theory, the dyad is mutual because both people are impacted by the connection; the connection is both felt and influenced by each person's subjectivity. The dyad is asymmetrical because there is a power differential between the clinician and the client, which creates hierarchy that cannot be fully eliminated. To balance the tension of maintaining a mutual relationship that is inherently hierarchical is a delicate process but is essential to the tenets of relational theory. This delicate balance of hierarchy is also important to the treatment of trauma survivors; a clinician must pay careful attention to power dynamics, as in many cases, and especially in the case of sexual violence, a power differential is the central force behind the trauma itself (Herman, 1992).

Attention to the dynamics of the therapeutic relationship allows space for both the clinician and the client to engage in a reciprocal meaning-making process, or a process through which the client and the clinician come to understand the material that emerges in treatment through a shared lens (Segal, 2012). This process is reliant upon the clinician's understanding of the relational implications of both transference, or the client's thoughts, feelings, and unconscious reactions to the therapist, and countertransference, or the therapist's thoughts, feelings, and unconscious reactions to the client, as tools that inform the process of treatment. Instead of viewing transference and countertransference as dynamics that must be eliminated, as in classical psychoanalysis, in a relational practice they are understood as pieces of clinical data that inform the clinician's understanding of the client's current and historical experience (Berzoff, 2012; Tosone, 2004).

Related to the concept of a reciprocal meaning-making process is the two-person approach, in which the internal and external worlds of both the client and the clinician contribute to the therapeutic dyad (Ferenczi, 1988). A two-person psychoanalytic approach is useful for

social work practice because it attends to factors such as race, gender, and socio-economic status as they exist within the therapeutic dyad (Altman, 2010). In classical psychoanalytic practice, the therapist aims to exist outside of the client's internal world and instead interpret the client's thoughts and behavior, building upon the already inherent hierarchical difference between client and clinician. The two-person approach requires the clinician to view the client within the client's environment while simultaneously understanding the client in the relationship, which allows for a less hierarchical relationship to take shape.

Relational theory offers an opportunity for the clinician to think systemically (Segal, 2012), further emphasizing its applicability in social work. The systemically oriented relational clinician recognizes the relationship between the oppressive dynamics in a person's social world and the way that those dynamics exist in a person's internal world. While not the intention of early relational theorists, contemporary relational theorists encourage a conceptualization of the impact of socio-cultural and political dynamics as relationships that enter the therapy matrix (Jordan, 2008; Mullaly, 2010; Segal, 2012). For example, in addition to considering the relationship between client and clinician as fertile ground for understanding a client's internal world, contemporary relational theorists call for the inclusion of the client's relationship to the system in which she functions. The theory encourages a clinician to consider the client's relationship to systemic forces such as racism, sexism, and homophobia. This act of identifying internalized oppression in the context of a relationally attuned dyad can enhance the process of healing (Mullaly, 2010). This attention to anti-oppressive methods of relationship-building can help clients to begin to trust their perception of reality and their psychological responses to that reality. This paradigm is of special import when engaging in clinical work with survivors of sexual violence. Although such work was once considered a form of feminist, political action, in

some domains it is becoming de-politicized and medicalized through its emphasis on connecting trauma recovery with mental health, reliance on diagnostic criteria, and payment of services through medical benefits (Sweet, 2015). Relational theory is an appropriate tool for uniting both the political and the psychological attention that a social worker must pay in order to fully support a survivor of sexual violence, as feminist theory calls clinicians to do.

Feminist Theory

Feminist theory unites the personal impact of sexual assault and the social and political structures that facilitate its occurrence. Feminist theory, inspired by social constructivism, challenges the notion of objective truth and instead supports the notion of the more nuanced subjective story of the individual in context (Brown, 2006). Feminist theory privileges multiple forms of knowledge, paying careful attention to the complex realities of women's lives. This aligns with the goal of this dissertation to create a space in clinical discourse for a survivor's own definition of what constitutes safety and to use that definition to customize clinical interventions and broaden the literature's scope of definition.

Additionally, feminist therapy aims to bring power to the powerless (Smith & Seigal, 1985), which is an important aspect of conceptualizing the healing process with survivors of sexual assault. To restore power to a survivor after an experience of powerlessness is to subvert the effect of violence and introduce space to heal. There are multiple versions of feminist theory, and the one that is perhaps the most simultaneously relevant and troubling as it relates to the multiple dimensions of safety for survivors of sexual assault is feminism's fourth wave. In particular, I will make the argument that fourth wave feminism's dismissal of the behavioral change aspect of the establishment of safety is problematic.

The feminist movement in the United States has been viewed as having four iterations or phases, commonly referred to as waves (Wyre, 2009). The first wave of feminism focused on voting rights for white women and broadening access to education for girls and young women. The second wave emerged in the 1950's and continued until 1980's with a focus on labor, economic parity, the import of solidarity and community among women, and began to tackle issues of sexual and domestic violence. The third wave began in the 1980's and continued until the early 2000's. It paid great attention to the prevalence and impact of sexual and domestic violence on women and girls and their origins in sexism and paternalism, advocated for freedom of sexual expression whether in straight or homosexual relationships, described the intersection of motherhood and career and the effect of one on the other, advocated for social justice, and began to examine the role of race and racism in women's spaces. The fourth wave, which began in the early 2000's with the introduction of online feminist discourse, focused on redefining gender, introducing gender pluralities, and enhancing an anti-racist lens in women's issues.

Fourth-wave feminism's attention to the many and multi-layered facets of victim-blaming has been notable (Munro, 2013). Victim-blaming is understood in fourth-wave praxis as any attempt to place the onus of personal responsibility to prevent sexual violence on an individual woman rather than on a potential (or actual) perpetrator.

An example of the broadening scope of the dismissal of women's capacity to protect themselves from assault in the offline-activism of the fourth-wave includes the movement to end sexual assault on college campuses. This movement is led by the activism of fourth wave feminists who are pressuring Title IX offices to act in protection of women on college campuses. In September 2014, President Obama and Vice President Biden release the "It's On Us" initiative that draws particular attention to ending a culture of rape apologia on college

campuses, calling on college students to intervene in instances of sexual violence, thereby placing the onus of prevention and safety on bystanders or community members rather than on survivors. The initiative also outlines legal responsibilities and measures that universities must meet in order to remain in compliance with Title IX regulations that prohibit obstruction to education and educational opportunities on the basis of gender, which advocates argue applies to the prevention of sexual violence. When describing the goal of the initiative, Vice President Joe Biden, a self-described ally and activist in the movement to end violence against women, borrowed from the language and values of the fourth wave by stating, “We will have won when every young woman in America knows it's never appropriate to ask, 'What did I do wrong?'”. Although it is true that Joe Biden cannot be tasked with incorporating psychodynamic literature into his political discourse, it is important to recognize that his stance amplifies the beliefs of the fourth wave of feminism as the sociopolitical context in which psychodynamic clinicians practice. Politically, this is an appropriate stance, but clinically, it leaves survivors wondering how they can protect themselves from future assault. Blame for sexual assault must fall solely and squarely on the perpetrator, but suggesting that survivors had no course of action but to be raped removes their ability to be anything but helpless when faced with the possibility of assault. Safety from assault is more complex than this narrative allows.

Establishing safety after sexual violence is a complex endeavor, as this dissertation aims to demonstrate, and safety cannot be fully actualized in the mind of a person who believes that she has no agency over whether or not she is harmed. Survivors are unable to cultivate self-protective behaviors if they believe that what they do has no impact on their safety. Attention to the role of self-protection is absent in fourth wave parlance, and this dissertation aims to reintroduce self-protection as one of many elements of safety after a sexual assault.

Institutional Racism and Barriers to Safety

Just as feminist theory informs an anti-oppressive model of clinical work with survivors of trauma, an inclusion of the role of race in a discussion of access to internal and external safety is useful. While it is true that there are examples of women of all races facing systemic barriers to safety, an analysis of the concept of safety would be incomplete without an acknowledgment of the role of race in determining who has access to safety from- and safety after- violence. A social work lens aimed at dismantling systems of oppression includes a focus on the ways that women of color are criminalized for using safety strategies that are largely sanctioned, both socially and legally, for white women, such as calling the police to intervene in violence and using a weapon such as pepper spray or a gun for self-protection. For example, strategies of survival and safety are criminalized at higher rates for women of color than for white women (Jackson, 2015). Women of color are jailed and prosecuted for murdering their abusers at higher rates than white women who commit similar acts in the name of self-defense. In 2015, the ratio of Black women to White women who were convicted of killing their abusive husbands was nearly two to one.

Women of color are disproportionately affected by mandatory arrest policies (Novisky and Peralata, 2015). A survey of survivors of gender-based violence in New York City found that of women who had been arrested with their abusers in a dual arrest case, or arrested as a result of a complaint by an abuser in a retaliatory arrest case, nearly 70% of the women were African American or Latina (Sokoloff & Dupont, 2005). Marcela Rodriguez is an example of this. She is a Latina woman who was arrested, detained, and forced into deportation proceedings by Immigration and Customs Enforcement after calling the police for protection during an

incident of domestic violence. She was charged with a misdemeanor and while in jail, her husband kidnapped her three children and fled to Mexico.

There are clear and well documented examples of women's claims of sexual violence being questioned and dismissed by agents of the criminal justice system (Brubaker, 2017; Felson, 2005; Sleath, 2017). Many women have been treated as though they are the perpetrators when filing reports with law enforcement officers; in fact, there are cases of women who have been jailed for non-compliance with criminal proceedings after reporting their rapes to the police and wishing to refrain from offering testimony (Shugerman, 2017; Victor, 2016). This mistreatment and criminalization of survivors is particularly troubling when considering that filing a report with the police is often done with the goal of putting a rapist behind bars so that the survivor will be safe from future assaults perpetrated by this person.

METHODOLOGY

I will submit a two-paper dissertation that is theoretical/conceptual in nature. The first of the two papers is a review of the clinical and theoretical literature related to safety after trauma.

The second paper is a case study that will describe the treatment of a current client who has experienced sexual violence as an adult and has a history of complex trauma. The case study pays particular attention to the developmental and attachment history of my client and offers a thorough explanation of my diagnostic process, as well as a process recording that introduces the voice of the client and insight into the therapeutic relationship. The case study combines theory and practice and demonstrate how I applied the theoretical framework of the first paper to the case of Edith. I show how I applied my enhanced conceptualization of safety in her treatment and highlight the aspects of my model that can be applied more broadly in the clinical social work treatment of sexual assault.

In this second paper, I offer a robust conceptualization of safety and offer an example of clinical application. This paper includes an analysis of the client's experience and perception of safety using a broad conceptualization of safety as a map or model for both conceptualization and treatment. Also included in the second paper is a discussion of my criteria for selecting this particular client and a discussion of the dynamic role that she will play in the dissertation's writing, including her involvement in revising and clarifying information and her approval of the ways in which her story is portrayed. This has been done to attend to the ethical considerations of sharing another person's story in light of the power differential that is inherent in a therapist/patient relationship as outlined by Carlson (2010), and to attend to issues of confidentiality and privacy, to be further discussed. In the second paper I explain in detail my thoughts regarding how to protect my client's confidentiality and the ways in which I involved her in making decisions about what to include in the case write up and how to disguise the aspects of her identity that she did not want revealed.

Use of the Single Case Study

The use of a single case study as a means of disseminating information dates back to the earliest roots of psychoanalytic practice and thought. While the precise date of the first psychoanalytic case study is unknown, the history goes back at least as far as Philippe Pinel's "little stories" in the early 1800's (Goldstein, 2001). Freud and Breuer used a single case study in their 1895 *Studies on Hysteria*, and after that, Watson and Rayner's 1920 case of Little Albert emerged as a widely regarded single case study. Melanie Klein contributed to the field of Object Relations through her 1961 *Narrative of a Child Analysis* and Winnicott also contributed through his 1977 case study of *The Piggle*. The single case study has a long history of providing useful insight into the practice of psychotherapy, and its continued use as a research methodology has

multiple benefits (Longhofer, Floersh, & Hartmann, 2017). It demonstrates that there is no singular most-effective therapeutic intervention or modality, but instead, there is great importance in negotiating the art and science of clinical practice because one size does not fit all. A case study allows a clinician to develop the capacity to focus on a question, problem, or concern that has arisen in treatment, and to explore the various methods and theories that a practitioner uses to access a range of outcomes. Because there is no single theory or methodology that accounts for one version of therapeutic success or outcome, the use of case study can serve as a means of accessing and gaining a wide base of knowledge.

Further, the use of a case study develops the practice of self-reflection and assumes that clinicians are fallible in both practice and theory (Alstein, 2016; Longhofer et al., 2017). The use of case study demonstrates a commitment to honoring the multiple perspectives that exists in any clinical dyad and allows space to explore how to make use of conflict, short-comings, and missteps. It is through this accountable and reflective process that a clinician can grow and a field can become informed. In fact, supervision and consultation often focus on the exploration of theory and intervention through the use of case studies, therefore one might argue that the case study is an important component of a social worker's professional growth (Floersch, 2000). In addition, the case study offers the opportunity to examine the moment to moment shifts in dynamics between a patient and a clinician. It offers the opportunity to witness the steady progression of the therapeutic dyad and the simultaneous shift toward wellness that exists in the client. A single case study methodology is often considered limited, though, because it is not generalizable because it is not based on a large sample size and is therefore not scientifically reflective of the experience of a large population (Schofield, 2009). Despite its limitations, the single case study remains a useful tool for clinical social workers.

The goal of this dissertation's use of a case study is to demonstrate a consideration of the safety needs of each client uniquely and to demonstrate an implementation of a unique model for addressing safety on an individual scale. It is through the deepening of the therapeutic relationship and the establishment of safety between therapist and client that the meaning of safety for each survivor can be discovered. In addition, this dissertation's case study aims to demonstrate that as the therapeutic relationship becomes safer for the client to inhabit, there is a sense that she is able to exist in her mind with a diminished perceived threat. A case study allows for a deep engagement with the clinical treatment process through use of a process recording, the clinician's exploration of counter-transference, and attention to the mutuality of the construction of the dyad (Alstein, 2016; Bernstein, 2008). It is the intricacies of these dynamics through which my practice is informed and this dissertation rests.

Paper Two

Safety After Sexual Assault: A Clinical Conceptualization Using the Case of Edith

This paper demonstrates that a thorough conceptualization of safety demands attention to both internal and external safety. It demonstrates that to develop a sense of safety is an evolving process, one that cannot ever be considered complete. This paper offers clinicians an example of the use of considering safety as an on-going, evolving, and dynamic process in treatment, one that informs every conceptualization and intervention, and suggest that a thorough conceptualization of the experience of safety for survivors of sexual violence requires consideration of multiple facets and must be tailored to each individual client. My clinical experience demonstrates that the early conversation of creating safety with a sexual assault survivor focuses on behavioral changes that limit the risk of further violence, such as locking doors, carrying pepper spray, walking in groups, and having a clear exit strategy when the potential for harm exists. These measures are central to creating external safety and are an important consideration in building a foundation upon which a survivor of sexual violence can build a sense of internal safety. However, in this dissertation, I have made the argument that a conceptualization of the experience of safety with survivors of sexual assault would be strengthened by the inclusion of a person's unique and idiosyncratic sense of internal safety. For the purpose of this paper, a sense of internal safety for a survivor of sexual assault refers to the ability to dwell internally in a way that feels both free of harm and relieving of emotional distress. The idiosyncrasies of that sense of internal safety will rely on an understanding of a person's unique history, character, and socio-cultural realities.

Much of the experience of life after sexual assault can include flashbacks, nightmares, and various forms of mental intrusion. For the survivor of sexual assault, there is often an

experience of fear that threat is lurking in hidden corners of the mind, and that dwelling in the mind is never quite restful due to the task of constant hypervigilance, protecting from threats that are both external and internal. Survivors have described in clinical sessions that there is a vague and disorienting threat that lives both in the world and in the mind, and many soothe that threat with reliance on other people, substances, or chaos to fill that internal space and to quiet that external threat (Herman, 1992). To safely dwell in one's own mind requires a certain level of trust that the traumatic material will not reemerge at random and that the mind can protect itself from unwelcome and dangerous thoughts, as well as the ability to remain confident that one can regulate emotions.

Confidentiality

This paper will explore the importance and relatedness of both internal and external safety for the survivor of sexual assault using the case of Edith. Edith is a client to whom I have been providing treatment for approximately two and a half years at time of writing. I have changed Edith's name, identifying information, and some of the details of her history and course of treatment to protect her identity and the identities of her family members, friends, and partners. Edith is aware that she is the basis of this case conceptualization and has offered informed consent to the use of her story. She has also signed a release stating that she is aware of her inclusion in this dissertation and that she has granted permission for publication on the University of Pennsylvania's open access, online dissertation repository. The signed copy of this release is stored in her confidential treatment file and an unsigned copy is included in this dissertation (Appendix A). She selected the name "Edith" to be used and has had an evolving role in the writing of this dissertation, both practically and therapeutically.

To write about a client's course of treatment raises several clinical and ethical concerns. Ackerman (2018) outlines the ethical issue of breaking the bond of confidentiality that is inherent when writing about a client, even when disguising personal information and concealing the client's identity. Historically, clinicians have avoided the potential breach in confidentiality by publishing the paper in a journal that is unlikely to be known by the larger public, by not writing about mental health professionals, and by publishing papers in journals that are far removed from the geographical location of the client or subject. However, in the age of the internet, this is an impossible task, and so the standard has become that the clinician tells the client of the intention to use the client as the subject of a case study, and has a conversation about the goals, risks, benefits, and purpose of that intention. Some therapists go beyond that and show the write-up to the client, and some involve the client in the writing process and collaboratively write the case. While this trend is in the interest of obtaining informed consent from the client, some (e.g. Aron, 2000; Goldberg, 1997) argue that informed consent is not fully possible due to the intricacies of the unconscious factors and transference dynamics inherent in treatment.

Aron (2000) summarizes the questions that a clinician must consider in accepting a client's consent - including the transference and countertransference implications of making this request of a client, and the role of unconscious internal conflicts and unconscious interpersonal dynamics that are at play in the request - questions whether it is truly possible for consent to be considered "informed" when in the context of psychotherapy, so much material is communicated unconsciously. Goldberg (1997) suggests that in order to protect a client, a clinician must consider how much information to disguise without veering away from the factual reporting of clinical material. Aron (2000) posits that brief clinical vignettes circumvent the issue of displaying a client's shame-ridden and unconscious material, but do not substitute for the value

of an in-depth study of long term treatment. Goldberg (1997) stated a similar belief that the use of a clinical composite sacrifices clinical value through the fictionalization of a case.

Despite the significant risks associated with the use of a client's story, there can be clinical benefit to the use of a single case study. One potential benefit is the demonstration of a commitment to excellence on the part of the therapist by being open to feedback and insight from colleagues (Ackerman, 2018). An intentional effort to ensure that one's therapeutic practice is in accordance with best practices and is held to the standards of one's community of psychotherapists might assure a client that her therapist is providing the highest quality of care, or is open to correcting mistakes. The distance that a therapist creates from her practice through writing helps the therapist to more thoughtfully appraise her practice, thereby enhancing the ability to articulate and understand the client and the treatment, and modify treatment as needed or as suggested by colleagues and readers. Writing about clients also allows the clinician to work through countertransference and provides ongoing learning about the therapeutic work, which is ultimately a benefit to the client herself.

Despite these benefits, I remained aware of the clinical risks of writing about Edith and attended carefully to the issue of consent. While Edith agreed to the use of her story for the purpose of this dissertation after several conversations about the purpose, methodology, benefits and risks, and amount of personal information to be shared, it is impossible to fully understand whether Edith, or any client in her position, can truly offer informed consent due to the power differential that exists between us. With these concerns in mind, and given the vulnerable and unprotected nature of Edith's history, I decided that in order to feel comfortable using the case of Edith, I needed to have not only her consent, but also her involvement in the writing up of her case. In our early conversations about using her as the focus of this case study, I expressed to

Edith that I would like to share a draft with her and would like to have an open dialogue about information that she would like revised, included, or omitted. This participatory process seemed like an opportunity for Edith to have as much agency and control as possible. She agreed to this and expressed a sense of flattery that I would be interested in her contributions to the work, which offered an opportunity to therapeutically process the difficulty she experiences in understanding herself as being of value to others. However, as we approached the deadline for this dissertation, Edith declined to read a draft and instead stated that she would like to wait until it has been published. I felt conflicted by this stance. On one hand, I felt that it was important to respect her decision and not create a parallel to her experience of sexual violence, to be discussed below, where I violate her boundary by forcing a document on her that she would rather not read. On the other hand, I felt uncomfortable at the possibility of causing harm by allowing her to feel surprised by something in the dissertation that has already been discussed in a scholarly discourse, posted online, and possibly distributed. To miss an opportunity to protect her from the pain of visibility or from the possibility of overexposure would be a profound clinical failure and ethical violation. I raised this dilemma with Edith and asked for her input, which offered another clinical opportunity to demonstrate the value and importance of her perspective. Edith ultimately decided that she would prefer to read the paper together and that she would offer feedback before publication. We read the paper together in session.

The majority of Edith's feedback came in the form of collaboratively finding ways to conceal her identity. An early draft of this paper included physical descriptors that were relevant in painting a holistic picture of Edith's presence, but that ultimately rendered her too identifiable, so we discussed ways to alter the descriptions. We collaboratively suggested ways to disguise her appearance. Edith also participated by introducing various forms of fictionalization into her

history and narrative. This negotiation of creating a fictionalized identity within the bounds of what is real and believable offered an opportunity to mutually protect her privacy.

Aron (2000) asserts that it is impossible to fully predict the long-term impact of using a client for a single case study. I am hopeful that my attention to opening an on-going dialogue with Edith about her feelings and experience will offer the ability to process what arises if she does become aware of complicated feelings about the inclusion of her story. I have also opted to embargo this dissertation on the University of Pennsylvania's *Scholarly Commons* for one year, giving Edith more time to consider possible ramifications of having her story available online.

Case Conceptualization

I met Edith at an outpatient mental health center where I provided psychotherapy services. This treatment environment played a central and formative role in the first year of my work with Edith. I had only been working at the center for a few weeks when I met Edith and I was feeling simultaneously energized and overwhelmed in my new role. I experienced a lot of chaos as I began work; the wait time for an appointment was long, my colleagues seemed skilled and well-intentioned but frazzled, and there existed a thematic sense that the goal of the treatment setting was to keep clients at arm's length in order to meet the incredible demand on services. Upon reflection, I understand that this treatment context offered the type of chaotic and relationally disengaged environment that Edith understood and could survive. The familiarity of the chaos and disengagement of the treatment setting offered a sense of comfort and safety because it enabled a continuation of Edith's ambivalence for attachment and wellness, which is a behavioral manifestation of her schizoid personality structure and psychological process.

Many clinicians in the mental health field are familiar with Schizoid Personality Disorder, which is defined as a pervasive pattern of detachment from social relationships and a

limited range of emotional expression, with behavioral manifestations such as engagement in solitary activities, demonstration of emotional coldness, and the maintenance of few relationships (American Psychiatric Association, 2013). People with Schizoid Personality Disorder often demonstrate such limited capacity for interpersonal engagement that they are sometimes thought to be on the Autism Spectrum, and because the behavior of a person with Schizoid Personality Disorder can be eccentric or unconventional, there is an assumption that the person is organized in a way that lacks sophistication, making it easy to pathologize the individual (McWilliams, 2011).

However, for the purpose of this dissertation, I will rely upon a distinction between Schizoid Personality Disorder and a schizoid personality structure, as outlined by Nancy McWilliams (2011). While Edith does meet the diagnostic criteria for Schizoid Personality Disorder, her personality structure is such that it is best explained as schizoid, using Nancy McWilliam's character diagnosis schema. McWilliams describes a schizoid personality structure as consistently defending against both abandonment and engulfment, and as needing to consistently self-soothe against overwhelming external stimuli. People with a schizoid personality structure understand themselves as exquisitely sensitive and easily overstimulated. Babies with schizoid tendencies are known to cry or shriek in response to too much noise or brightness. She writes (p.198), "It is as if the nerve endings of schizoid individuals are closer to the surface than those of the rest of us."

The primary experience of a person with a schizoid psychology concerns the negotiation of closeness and distance, and love and fear (Fairbairn, 1940; Guntrip, 1952; Seinfeld, 1991). A person with a schizoid personality structure presents as being simultaneously hungry for intimacy and dysregulated by the risk inherent in connecting with others. The split implied by the

use of the word “schizoid” exists as a split between a person’s internal and external worlds and refers to a sense of profound disconnection (Fairbairn, 1940). For Edith, this disconnection concerns the desire for closeness and distance. She desires closeness yet feels a constant threat of being consumed or engulfed by others. She seeks distance in order to feel safe, but that separation results in devastating loneliness and alienation.

Edith was twenty years old when we began our work together. She is a white, cis-gender woman who is able-bodied and does not identify with a religious or cultural background. Edith identifies as bi-sexual and has had relationships with both men and women during her treatment. I remember my first session with Edith very clearly. She wore leather pants, a leather jacket, and appeared daring, as if she had just gotten off her motorcycle. I felt intimidated by her appearance and I wondered if I would be tough enough to handle her, a thought that I later came to understand as attuned to her fears of connection and yet her buried longing to connect. This immediate reaction to her describes the intersubjective field, or unique relational field that exists and holds the shared impact of the unconscious dynamics (Benjamin, 1995; Tosone, 2004) between Edith and myself, which was palpable from the moment we met. She sat down, crossed her hands over her waist, and told me in no uncertain terms that she doesn’t believe in therapy, that she doesn’t think she has a problem, she has never met a therapist whom she has trusted before, and she believes that I will be as useless to her as everyone else has been. She stated that she was only attending treatment because her foster care social worker requested it and she told me not to expect her to cry because she never has and never will cry in front of a therapist. As she told me this, I felt a full body experience of tenderness wash over me. I simply did not believe that she did not want to connect, which suggests a connection to one of Edith’s dissociated self-states, or a part of a person that is hidden from day to day functioning due to the

affectual discomfort that it holds (Bromberg, 2000). I no longer feared that I wouldn't be tough enough for her, and instead felt a deep desire to pull her into my arms and stroke her hair. In that moment, I felt unsettled by the immediacy of the tenderness that washed over me and wished to withdraw. I attuned to both poles of Edith's schizoid defense by longing to connect through a fantasy of holding her and stroking her hair, followed by my wish to withdrawal from my connection to her due to my fear of the intrusiveness of that connection.

The early stage of treatment included a gathering of information regarding Edith's family relationships, history, and information relevant to her presenting concerns and hopes for treatment. Edith's responses to my assessment questions felt scripted and inauthentic in our early sessions. She described her childhood as if it had happened to someone else; sitting with her as she outlined the various attachment traumas that she experienced felt as if we were reading a tragic story that belonged to someone else, far away. Edith had been in and out of treatment for many years. She was technically still in foster care when we met, and she had several case managers who were intimidated by her independence and largely stayed away, leaving her basic needs for food and health care unmet. Despite the warm countertransference experience that I had, I was aware of her skepticism of direct service providers. I was surprised each week when she showed up for our sessions. In this early stage of treatment, her dissociation and disconnection were especially salient in my countertransference. I had moments of attuning to her warmth and engagement, and I had moments of attuning to her disconnection and avoidance.

Despite this disconnection from her own history and her disconnection from me, Edith was able to gradually share her story. Edith defines her family as her mother, her brother who is 12 years younger, her brother who is 2 years younger, and her brother who is 4 years older. Edith's mother is an alcoholic who has spent the entirety of Edith's life in and out of sobriety.

Her family has always been severely resource-insecure; Edith, her brothers and her mother have lived in various apartments and mobile homes with various roommates, many of whom were strangers. Edith characterizes her relationship with her mother as “horrible, awful, empty.” Her mother was addicted to opiates during her pregnancy with Edith, causing Edith to spend the first three months of her life in the neo-natal intensive care unit on methadone-assisted withdrawal. Edith’s mother continued to struggle with addiction after that, but Edith reports that her primary addictions shifted to alcohol and marijuana, one or both of which she was almost always under the influence of during Edith’s early years. Edith describes not knowing whether her mother would be physically present in the home after school most days of her childhood. Edith almost always assumed that even if her mother were physically present, she would be psychically absent. She would often spend her days smoking marijuana, drinking alcohol, and sleeping in bed. In short, most days, Edith came home from school to an unavailable mother.

Edith has strong memories of her mother getting in bed with her at night and tearfully apologizing for her negligent mothering while Edith pretended to sleep. Adding to the discomfort that Edith felt during those late-night confessions was the fact that Edith’s mother was often semi-nude and Edith could feel her physical body in a way that evoked a deep discomfort. Edith struggled to metabolize these experiences and was left feeling overstimulated and dysregulated. This tremendous impingement suggests a schizoid process as discussed above, meaning that for Edith, relationships are either absent, or when available, they represent an engulfing presence that is completely misattuned to Edith’s needs.

In addition to that intimately physical contact, Edith’s mother was so fearful that the men who were in proximity to Edith through shared housing, her mother’s possible sex work, or through drug trade, could sexually abuse her that she often forced Edith to undress and checked

Edith's vulva and vagina for signs of contact. Edith remembers these experiences as simultaneously soothing and violating; her mother cared about her, but exposed her to danger and evoked shame by intrusively viewing her body in order to ascertain that danger did not occur. Edith was desperately hungry for contact and connection but felt tremendously intruded upon when the connection was available. This was deeply painful and confusing for Edith and furthers the schizoid process.

While Edith denies experiencing these examinations as abusive, she endorses complicated feelings of being violated by her mother. Edith recalls early exposure to pornographic imagery; she shared an experience of having a friend visit and looking through a drawer to find a DVD that the two could watch. Instead of finding child-friendly films, Edith found several pornographic films, leaving her feeling ashamed and overstimulated in the presence of a friend. In addition to this experience, Edith also recalls pornography playing on a television in the apartment and struggles to understand and find a cohesive narrative to explain this. She cannot recall if anyone was watching the pornography or if it was simply background noise, but has expressed confusion about why her mother did not turn off the television to protect Edith from the adult content. Edith's difficulty with synthesizing this material demonstrates its overwhelming impact on her developing psyche. The early exposure to pornographic imagery is developmentally inappropriate. Edith does not have experiences of being overtly sexually abused as a child, and does not find that identifying as a survivor of childhood sexual abuse feels resonant. However, her relationship with her mother continues to feel fraught with sexualized shame and mistrust as a result of these early childhood experiences.

When Edith was slightly older, between the ages of 12 and 16, her mother entered court ordered residential treatment for her alcohol use disorder, leaving Edith and her brothers to live

with their devoutly Christian grandparents in foster care. As an early teenager, Edith was developing her sexual identity and was beginning to understand herself as a queer woman. She began to feel sexually curious about and drawn to girls at school and felt uncomfortable with this emerging sexuality in her new, conservative Christian environmental context. Edith resented her relatives for their conservative views and began acting out. She dyed her hair, got several tattoos, and started wearing all black. This created a tension in the house that led to Edith's total isolation. In order to protect herself from her grandparents' criticism, she locked herself in her bedroom and refused to speak to anyone, demonstrating an early schizoid defense. Her relatives responded to this behavior by alternating between behaving with a kindness that Edith describes as performative and yelling at Edith. She felt utterly alone and totally ashamed, and had little space to process the depth of her confusion and isolation that were the result of this profound misattunement. She did not have friends at school, in part due to the shame she felt at her family's circumstances and in part due to her inability to feel connected to other children. She has reflected on this social disconnection and explained that no one wanted to be friends with the "white trash girl, trailer park girl" and has shared that "even if they wanted to be friends, [she] hardly knew how, anyway. [She] was too worried about family stuff to be a kid with them." Edith described her worries as related to the incredible resource insecurity that her family experienced: she worried about paying bills, buying groceries, watching her younger brothers, and other developmentally misattuned concerns that left her profoundly parentified.

Now that Edith is in her early 20's, she has a very different relationship with her family. Her mother is out of residential treatment and is "mostly sober", though the years of alcohol abuse have taken a profound toll on her body and she has developed a rare and terminal disease for which she is being treated with chemotherapy. While the disease takes many years to end a

person's life, Edith carries the weight of wondering who will gain custody of and raise her youngest brother when her mother's health fails. Her mother rents an apartment where she and Edith's youngest brother live. Edith believes that her mother is healthier, but constantly fears a relapse and is deeply concerned for the wellness of her youngest brother. Edith limits contact and communication with her mother, stating that contact is overwhelmingly painful.

The beginning stages of Edith's treatment also offered an opportunity to understand Edith and how she exists in the world, outside of her family unit. Edith is temperamentally very sensitive and intense. She has described herself as born with the innate capacity to feel alternating experiences of great joy and deep sadness. This inborn emotional quality was likely intensified by her mother's limited ability to attune to Edith's emotional needs. When describing her emotional state, she rarely relies upon the language of the middle ground; she instead describes everything as entirely miserable and in shambles, or excellent beyond her wildest imagination. Edith exists in absolutes. Temperamentally, Edith is very different from other members of her family of origin. Edith describes her mother as depressive with a flat affect; her baseline is low and she rarely demonstrates a mood elevated above that depressive baseline. This could be her mother's own innate temperament, or it could be a result of years of substance abuse, depression, and/or her mother's own defenses, but regardless of its organic or environmental origins, Edith perceives herself to be temperamentally alien from her mother. Her mother has no ability to viscerally understand Edith's temperamental nature, leaving Edith feeling disconnected and misunderstood, which results in a belief that she is faulty in some innate way. She has long been accused of overreacting and being too sensitive by her mother, whose tendency is to remain flat in the face of almost all stimuli. Edith's vitality was threatening

to her mother, and her mother's inability to attune to Edith's emotional needs and experiences led to difficulty with self-regulation, which fuels Edith's fear of her internal world.

Although psychotherapy will not change a person's innate sensitivity and intensity, it can offer an opportunity to modify its behavioral manifestations and expressions, and help someone to develop a greater capacity for self-regulation (Benjamin, 2017; Davies & Frawley, 1992; Mitchell, 2014). Edith has painful memories of being very young and feeling overwhelmingly upset about something minor, and not knowing how to communicate the intensity of her feelings about the stimuli. She remembers a particular incidence of feeling very angry that her older brother ate the last cookie. Edith described an intense wave of anger that washed over her body and left her with a surge of powerful energy. She felt the impulse to rip out her brother's hair, and did just that. Although it is not abnormal for siblings to disagree and for that to occasionally become physical, the tremendous fear that Edith recalled during this incident is worth consideration, especially through the lens of a sense of safety. Edith felt entirely out of control of the intensity of her anger and felt, even at 4 or 5 years old, that if left uncontained, she could kill her brother. Of course, this was not true at the time and is unlikely to be true now, but the experience of the sheer force of her anger leaving her afraid of her own intensity remains. Edith is afraid of the power of her intense emotions.

While Edith understands her temperament as a great liability, she denies the presence of any physically limiting conditions or different abilities. There are no indications that her psychological concerns represent the presence of medical problems or a physical illness. She denies the history of any injury to her head that resulted in a concussion or loss of consciousness, which could increase the risk of suicidality (Brent & Max, 2017), and has not had any serious infections or major illnesses that might have altered her brain pathology. There is conflicting

research about the impact of neo-natal abstinence syndrome on development. Early literature on the topic suggested a causal link between early exposure and delayed cognitive and emotional development (Keller, et al., 2000; Singer, et al., 2002). However, more recent research has found that the cognitive and emotional developmental delays found in earlier literature can be better explained by the impact of poverty on development and the strong correlation between poverty and maternal opiate addiction during pregnancy (Konijnenberg, 2015; Messinger, et al., 2006; Thompson, et al., 2009). For the purpose of this dissertation in the field of social work, a strong emphasis will be placed on the role of poverty and access to resources in Edith's development.

A consideration of Edith's life in the present moment demands the inclusion of Edith's identity as a queer, cisgender woman. Edith understands herself as bisexual, though notes the limitations of the etymology of "bi" as indicating that there are two genders, when in reality, Edith is attracted to people of all gender expressions and gender identities. An acknowledgement of Edith's position in a socially marginalized group is important for a fully formulated clinical conceptualization. Her identity as a "bi" woman often leaves her with a sense of fraudulence and/or exclusion from both queer and straight circles. This impacts her sense of comfort and safety inhabiting either space, and lends itself to a sense of psychological homelessness. She consistently feels ambivalent about her ability to fully belong in any space, and has feared retribution or retaliation; she fears that she is "too gay" for straight spaces and "too straight" for gay spaces, leaving her straddling the middle and compromising her ability to safely inhabit a social world.

Diagnostically, Edith's behavior and presentation most closely resembles Bipolar II disorder. She cycles through periods of depression that leave her tired, disengaged, and anhedonic. This cycle is interrupted by an outburst that can be described as a tantrum: she feels

an acutely overwhelming sense of anxiety that fills her entire body and mind and leaves her yelling, crying, and sometimes thrashing on the floor. During these tantrums, she has thrown and broken objects, punched herself, pulled out chunks of hair, and scratched herself to the point of drawing blood. This is usually in response to rejection or abandonment by a partner, but is occasionally in response to disappointment by her mother. These episodes last for about 30 minutes, then require several days to be soothed and regulated before she returns to her depressive baseline. This is a younger self state, likely cordoned off from her day to day functioning because of the intense affect that it holds. She has responded well to Lamictal, a mood stabilizer typically used to treat Bipolar disorder, which has helped her to regulate those urges, though they are possibly a symbolic representation of an unresolved oral conflict to be discussed further. At the beginning of treatment, she reported that these outbursts occurred about once per week, but as treatment has progressed, the frequency has been reduced to about once every six weeks.

Sexual Assault

Edith has a long history of exposure to sexual content that was misattuned to her developmental status, as discussed above. However, the experience that she considers most formative in shaping her identity as a sexual assault survivor was when she was raped by a stranger while riding her bike in the city at night, approximately one year before she entered treatment.

Edith and her girlfriend had had an argument earlier in the evening, and despite Edith's best efforts, she remains unable to remember the content of the argument or its cause. What Edith does remember, though, is that she had a tantrum that included throwing objects around their shared home, crying, yelling, and thrashing around on the floor. Edith remembers her

girlfriend standing by idly, not knowing how to intervene or what to do, which left Edith feeling entirely alien, compounding the feeling of acute dysregulation. Edith recalls scratching her skin to the point of drawing blood, and then banging her head against the wall for several minutes. Edith describes feeling entirely unable to soothe herself in the midst of this episode and feeling abandoned by her partner who did not attempt to intervene and offer support, but instead stood her distance and watched the episode unfold. Edith clearly remembers an image of her girlfriend slowly inching backwards, away from Edith; the feeling of abandonment due to the intensity of her affect is salient in her recollection of this event while most other details remain fuzzy. Upon reflection, Edith understands that this was likely a terrifying scene for her girlfriend to witness and that her girlfriend simply had no idea how to interrupt Edith's violent thrashing. However, in the moment, she felt entirely undone by this perceived abandonment, and this only led to a more intensely terrifying episode of dysregulation for both Edith and her girlfriend. This is another example of Edith's schizoid defense; she demonstrated incredible desperation for love and concern, but her physical thrashing disallowed any intervention by the person from whom she desired soothing.

Edith was eventually able to achieve enough self-regulation that she was able to stop thrashing and harming herself. However, she felt so ashamed by her outburst and so injured by her partner's perceived unwillingness to offer support that she decided to leave their shared apartment and go for a bike ride. Edith shared that she had a fleeting moment of concern for her safety since it was 11pm in a section of the city that has had many incidents of violence, but that concern for safety was so elusive that she disregarded it almost immediately and carried on with her plan to ride her bike around the city.

While on her bike ride and stopped at a traffic light, Edith was approached by a large man

who first propositioned her for sex, then became angry when Edith ignored him, and then proceeded to grab Edith from her bike and pull her to a nearby alley where he raped her. Edith denies memory of the rape itself, suggesting a profound dissociative experience, but remembers feeling certain that he would rape her as soon as she saw him, and instead of rushing away, remembers feeling unafraid and resigned to that reality as he dragged her to the alley.

Edith has no concept of how long the sexual assault lasted or how it ended. She does not remember if anyone witnessed any part of the assault or the characteristics of the man who raped her. She does not remember if he spoke, or if she spoke or fought against it. Edith once described her memory of the sound of cars and remembered how eerie the city sounds late at night in the absence of most traffic. She described that silence as an opportunity to hear her own voice inside her mind but shared that she could not recollect what her voice said when she had that opportunity to connect with it, suggesting a deeply compromised ability to form an internal cohesiveness and dissociation. There is a general and thematic sense of absence and dissociation when Edith describes this experience of sexual assault; the absence of her voice, the absence of her consciousness, the absence of the sounds of the city, and the absence of dignity are all profound. When she describes this rape in session, I become engrossed in the story in such a way that I lose track of the sound of traffic outside of my busy city office and in such a way that the image that comes to mind when I recall these sessions is almost total darkness, despite having our sessions in the early afternoon. The way Edith describes this event leaves me feeling vaguely haunted, as if I had just heard a ghost story. This countertransferential experience of eeriness offers only a glimpse into the aftermath of the rape as it exists in Edith's mind. There is a lingering feeling that the world is dark and still when all facts point to bright vibrancy in the city, suggesting that this assault is lingering and that it has yet to truly end for Edith.

Edith initially described her decision to leave her home late at night to go for a bike ride as a healthy one, stating that she “wanted to blow off steam and release stress”. She initially maintained that she was seeking a feeling of relief by discharging stress, changing her physical environment, and separating herself from the argument with her partner. However, my suspicion is that there was an unconscious impulse to be exposed to danger in order to punish herself for acting out in a way that left her feeling ashamed and embarrassed. Edith was able to tolerate a dialogue about this possibility and agreed. I also have felt curious about the possibility that Edith unconsciously engaged in risky behavior to punish her girlfriend for what she understood as her girlfriend’s empathic failures. While the decision to rape Edith was no one’s but the perpetrator’s, it is within reason to imagine that Edith’s girlfriend may have felt a certain level of guilt or remorse for her involvement in the argument that sent Edith out the door, or perhaps for not more forcefully or effectively prohibiting Edith’s exit. It is within the realm of possibility that this was Edith’s unconscious identification with a victim emerging; in order to show her girlfriend the depth of the injury of their discord, she opened herself to the possibility of violence, which did in fact come to fruition.

Complex Trauma

As Edith began to trust me and as her treatment progressed, she more openly described the scarcity of resources that existed in her early life. Edith’s mother was unable to maintain employment during Edith’s childhood and therefore, the family did not have a reliable or steady source of income. Edith does not know how the family managed financial resources when she was very young; she assumes that her mother engaged in sex work for income. Edith has memories of strange men walking in and out of her home at random, and in a particularly high volume at the end of each month. While she acknowledges that her mother could have engaged

in selling drugs or other forms of labor for income, Edith's intuition is that her mother primarily engaged in sex work. Edith shared memories of combing the school playground for spare change a few times per week and proudly bringing it home to give to her mother to help with the family's finances. She does not remember how her mother responded to these gestures.

Edith recalls frequent moves from apartment to apartment in the small town where she grew up. She recalls a period of sharing a mobile home with her mother, three brothers, and another family of four, and has shared that there was almost always another person or people sharing each home that they occupied. Edith does not recall the longest amount of time that she stayed in any one residence before entering foster care, but shared that she does not remember spending an entire school year in just one home. Edith now has nightmares about moving during which she cannot find her wallet to pay for the moving expenses, signifying a connection between the extreme distress of frequent moves and the financial insecurity that she faced as a young child.

Similarly, Edith recalls multiple experiences of having lice as a child and feeling that the lice infestation was a physical manifestation of her poverty. She has described the experiences of having lice by sharing, "It was as if everyone could tell that my mom didn't work and that we had no money. Each individual lice-bug [sic] showed that to everyone and I could feel our brokenness crawling around on my head all day." Not only did she have lice, but her family struggled to afford lice-killing shampoo and laundromat fees, so the lice infestations were prolonged. Edith experienced her lice as an unrelenting visible display of her resource insecurity.

Edith remarks on her early experiences of poverty often in sessions and reminds me that her days of resource insecurity are not over. She is currently working multiple jobs and living paycheck to paycheck. She does not have health insurance, her phone often gets turned off

because she struggles to afford the bill, and she routinely borrows money from friends to afford groceries and rent. She often discusses the discomfort of turning down social events for lack of money and shares the loneliness that she feels.

Importantly, Edith demonstrates insight regarding the mental and emotional toll of chronic resource insecurity. She reflects on the great amount of real estate it occupies in her mind: “It’s like I can’t even think about anything else. I don’t know when I’m going to eat or how I’m going to pay my rent or if my roommates will get sick of covering for me and I’ll have to move out. But to where? I have no home.” Edith is able to draw a connection between financial resources and safety. The amount of time she spends contemplating her next meal or whether she has a stable home not only detracts from her capacity to assess for her own level of safety, but its constant intrusion leaves her with a sense that danger is imminent. If something goes wrong, she will have no way to handle its financial impact, a reality that leaves her in a state of fear from moment to moment that something disastrous could happen that would pull the rug out from under her. Not only is the achievement of external safety more difficult in Edith’s financial circumstance due to the impossibility of buying pepper spray or installing new locks on doors and windows, but internal safety is more challenging, as well. For Edith to live in a state of poverty where she does not know if she has a safety net of any kind requires hypervigilance in almost every aspect of her life. She rarely feels moments of emotional or mental rest.

This unrelenting and life-long concern about her access to resources is one of the dynamics in her presentation of complex trauma, a type of trauma that occurs repeatedly over a period of time in particular social and relational contexts (Courtois, 2004). Edith has spent a significant part of every day of her life on alert about the ability of her family and herself to live comfortably and safely. The prolonged adversity, in addition to other forms of trauma, including

attachment trauma to be discussed below, has resulted in a constellation of symptoms that can be explained by complex trauma. Edith struggles with regulating her emotions and affect, containing impulses, maintaining stable relationships, modulating a chronic sense of guilt, and experiencing emotional intimacy or connection. This experience of complex trauma leaves Edith with a compromised sense of safety. She has never truly known what it means to feel safe, either externally or internally. To work with Edith is to understand and honor the clinical significance of having no previous baseline of safety to which she can return after a traumatic event. Instead of working towards reestablishing a pre-trauma baseline of safety, clinical work with Edith has been honoring the realities of her complex trauma and the ways that has interrupted an early construction of safety, making it impossible for her to return to a baseline. Clinical work with Edith is an opportunity to view all conceptualization and intervention through a study of her sense of safety. In clinical practice, that means rooting every clinical conceptualization and intervention in the intention of building a sense of internal and external safety.

Attachment Theory

The presence or absence of safety as it relates to attachment carries a heavy weight in a conceptualization of Edith. Edith is someone for whom safety has always been elusive at best and absent at worst. An examination of Edith's attachment history allows for a robust understanding of Edith's psychological structure before she entered treatment. Edith had the early experience of being unprotected by her primary attachment figures and therefore, unsafe. Edith's mother did not protect her from the impact of her own mental health and substance use concerns from the time Edith was in utero and in the years following, necessitating an intervention by child protective services. There are tremendous structural and systemic breakdowns that allowed this to happen, of course, and to squarely place blame on Edith's

mother would be to neglect the failures of several social safety nets that exist, or should exist, to protect impoverished families from harm and distress. But these safety nets failed Edith's mother, and they certainly failed Edith, leaving her unprotected and endangered from her earliest moments.

Edith's personal history is characterized by misattunement, chaos, relational disruption, and abandonment. Her early attachment figures failed her dramatically; her father abandoned her at birth and has been absent for the entirety of Edith's life, and her mother has been profoundly absent, both emotionally and physically, throughout Edith's life due to substance abuse and depression. Her early attachment experiences led to a disorganized attachment style as a young adult. A disorganized attachment style forms when a child is without a reliable strategy for having her needs met by a stable caregiver (Main et al., 1985). A disorganized attachment style is often the result of having an unpredictable caregiver who is not able to attune to a child's emotional needs. The unpredictable caregiver is not able to offer a sense of safety to a young child, which results in the child feeling fearful and afraid when she is aware of her own needs without a clear path to having those needs met. Main (1995) found that unresolved trauma or unresolved loss in a caregiver's life is the strongest predictor of disorganized attachment between a parent and a child, which aligns with the description that Edith has shared of her mother. In adulthood, a disorganized attachment style is identifiable through several behavioral manifestations, including difficulty self-soothing, relational chaos, and experiences of intense and unpredictable affect (Main & Hesse, 1990). These hallmarks of a disorganized attachment in adulthood mirror the dynamics of her disorganized attachment in her childhood.

When Edith was born she was immediately separated from her mother, who was at that time her only possible attachment figure as her father had already left the family. Edith spent the

first three months of her life in the neonatal intensive care unit on methadone-assisted withdrawal as a result of neonatal abstinence syndrome. Despite the attention that many neonatal intensive care units pay to building attachment between a mother and an infant as outlined by Kearvell & Grant (2010), the reality of the hospital environment is such that in these early months, Edith lived in a plastic incubator under harsh lights in a sterile environment. Instead of having one primary caregiver to whom Edith could attach, she had a rotating staff of nurses, doctors, and technicians who fed her, held her, and changed her diaper. This rotating cast of caregivers likely set an early template for Edith's disorganized attachment style. In her earliest months, she had a disorganized presence of attachment figures; she was unable to predict who would feed her or clothe her, and many of her emotional cues were likely to have gone without response due to the nature of her hospital environment. Rather than one responsive caregiver in a stable environment, Edith was presumably surrounded by a chaotic environment.

When Edith was discharged from the hospital as a three-month old and in the care of her mother, her chaotic attachment experience continued. Her mother was largely unable to attune to Edith's emotional needs due to her own trauma history and substance abuse. Edith has early memories of crying in her crib without a response from an adult and having overwhelmingly intense emotional distress with no one to help her self-soothe. She has memories of waiting at school for her mother to pick her up, only to find that her mother had forgotten her. This repetitious failure to reliably attend to Edith's needs until ultimately placing Edith in foster care is the making of attachment trauma, or a severance that occurs between a person and a primary, central attachment figure causing significant distress and attachment-related sequelae such as difficulty trusting others, chaos in relationships, and disorganized attachment styles (Cleary, 1999).

Now, as an adult, Edith remains disorganized in her attachment. Main & Hesse (1990) explain that an adult with a disorganized attachment style will struggle in intimate relationships and will have limited ability to self-soothe when feeling a strong affect, which is aligned with Edith's experience. She does not know how to use others to co-regulate her emotions, and she has a difficult time trusting that another person could help her meet her own needs. A study of Edith's attachment finds that she simultaneously fears and craves connection. She has a history of alienating her friends with her voracious hunger for attachment and also has a history of entirely withdrawing from her social network for days or weeks at a time. This parallels her relational patterns in treatment, as well. There are times when Edith sends me multiple emails in a short period of time, both frantically and impulsively, in what she is able to articulate is a desperate attempt to feel closeness. She participates in the inverse dynamic, as well. There are periods where she misses sessions, arrives twenty minutes late, or late-cancels sessions. I understand these as the behavioral manifestations of her disorganized attachment style.

Psychodynamic Theory

Attachment theory has its psychoanalytic roots in the work of British analysts from the Independent School (Fonagy, 2001). What Bowlby describes as attachment, Winnicott describes using the term ego-relatedness, which is a central idea in Object Relations. A point of contact between Bowlby's ideas and those of Winnicott is in regards to sensitive caregiving. Attachment theorists stress the importance of moderate degrees of maternal responsiveness to infant needs, and Winnicott stressed the importance of a "good-enough" mother whose empathic failures are expected but are motivators for growth. These experiences of sensitive caregiving set the template for a person's process of identifying with or avoiding identification with her primary attachments. Identification is a term that describes the early process of incorporating an object

and the later process of taking in or emulating qualities of an object (Winnicott, 1969).

Introjection is a term that describes the early process of developing internal representations of external objects, while internalization is used to describe the more mature process of voluntary and discerning efforts to take on specific qualities of another person (Knight, 1940).

Edith does not remember ever wanting to emulate any of her mother's qualities. I have observed that she does, however, identify with her mother's victimhood. One way that I observe this identification with victimhood is through her use of the word "traumatic" to describe dilemmas. She has described her boyfriend as "abusive" in response to moments when he disappoints her, for example when he asks for time alone. She has described the experience of offering support to a friend after a breakup as "traumatizing". While it is true that Edith has experienced significant trauma in her life, including complex trauma and attachment trauma, the over-use of the language of trauma is important to note and can be understood in multiple ways. One possible interpretation suggests internalized content regarding her mother's chronic mistreatment by others and chronically debilitating addictions. Edith experiences exposure to traumatic material through the unconscious process of internalizing her mother that she developed the conviction that traumatized is her only state of being.

When Edith and I discuss the ways that she over-identifies herself as a victim, she suggests that there is a certain safety that comes along with it. A constant identification as a victim allows her a protection from further victimization through her perverse belief that she cannot be injured if she is already injured. Edith finds a sense of relief in feeling as though being injured is her primary or default state.

Edith, while reflecting on her dysfunctional relationship with her ex-boyfriend, once announced that he was abusive to her. I was surprised to hear this because during the many

months that they had been together and that I had been listening to the challenges and successes of their relationship, I had not heard of any indication that there was abuse. They disagreed often and he did not sound patient or especially kind, but what was absent was an indication of elements of power and control that are hallmarks of abuse. In fact, my interpretation of their disagreements was rooted in the misalignment of their attachment styles: her anxious wish for closeness to him resulted in constant attempts to pull him close, while his avoidance of her left him constantly pushing her away, which resulted in a deeply painful relational experience. The ways in which he pushed Edith away were unkind and included ignoring phone calls, cancelling plans, and making dishonest excuses to avoid her, but they did not appear rooted in concerted efforts to control, disempower, or otherwise harm Edith.

When I asked Edith to elaborate on her experience of abuse by her ex-boyfriend, she became visibly angry. She very pointedly asked me why I was questioning her experience of abuse and told me that a therapist isn't supposed to question abuse survivors, stating "it's real because I said it's real." This demonstrates the rigidity with which this identification exists. The over-identification with a victim identity seems to offer a sense of psychological safety. It helps Edith believe that she is safe from future abuse because she feels that she is already experiencing all the abuse that one can experience, limiting her ability to conceptualize the possibility of additional harm or pain. The over-identification as a victim also offers relief from the terrifying ambiguity of having to navigate and negotiate her identity in a world that feels profoundly unsafe. The formation of her identity gives her a sense of autonomy and control in a world where she is acutely aware that she can be harmed in any moment and in a world where she feels like she does not have a single safety net. Edith is very much alone in many ways – she does not have the emotional, financial, or material support of a family or parents to rely on, as many people in

their early 20's do.

There also exists a certain entitlement in her reaction to my question. Because she understands herself as a victim, she does not have to look at herself or take accountability for her actions. The victim is always right. The victim identity allows for protection from external danger, but also allows protection from internal threat. It offers the opportunity to avoid accountability for many aspects of her life, and rather than offer autonomy, it offers reinforcement of her feelings of helplessness and absence of agency.

Edith has demonstrated a conscious effort to be unlike her mother in respect to attachments. While her mother is cold and difficult to access, Edith overextends herself to her friends and partners in ways that ultimately leave her feeling victimized. In an effort to avoid recreating her mother's emotional misattunement, Edith is reluctant to create appropriate boundaries as an effort to distance herself from her mother, who was profoundly unreachable. Her lack of boundaries may be determined by efforts towards differentiation from her mother, but her schizoid personality structure ultimately prevent these conscious efforts from holding; she becomes enmeshed, which is a longstanding fear of hers, then retreats inward, which interrupts the enmeshment but opens her to a profound and debilitating aloneness.

In addition to its study of a person's identification, psychodynamic theory's commitment to honoring the role of the past in a person's present moment makes it an appropriate lens through which we can study the ways that Edith's history of trauma impacts her current and future functioning. Psychodynamic theory also offers an understanding of how the uncovering of a person's unconscious material can alter her future functioning (Freud, 1912) and ultimately elevate her sense of safety. To this end, psychodynamic theory is also a useful tool for studying

and making meaning of the symbolism of events and dynamics in a person's life.

An example of a psychodynamically informed study of psychological symbolism is a reflection on the many dental crises that Edith experienced during our work together and the impact of those crises on her sense of safety. The first crisis was the elaborate and chaotic experience of having her four wisdom teeth removed by a practitioner who appeared negligent at best, ill-equipped to practice dentistry at worst. For this procedure, Edith saw a dentist in the small, largely low-income town where she was raised. Edith remained awake during the procedure, which is normally performed under anesthesia, and described being aware of both pressure and pain in her mouth during the operation. She complained of excessive bleeding both during the procedure and for days afterward. She was not offered instructions for follow up care, information on what to expect after the procedure, or a follow up appointment with the dentist. Edith arrived to our session with a swollen mouth, various cotton balls and gauze stuffed in one cheek, and stated that she was in a tremendous amount of pain. Her whole face looked bruised. We spent the session discussing the way that she felt mistreated by the dentist and the way that her experience of living in poverty contributed to that. I spent much of that session managing my anger towards the dentist and trying to keep a firm and contained grasp on my desire to send Edith to my dentist and pay for her treatment. Edith reluctantly agreed to see a physician later that day, where she learned that she had an abscess in her mouth and her stitches were infected. However, that physician could not treat her for these problems, and stated that Edith instead needed to go back to the dentist who performed the procedure, a dentist with whom Edith felt unsafe and physically endangered.

There was another time in our work together when Edith had an abscess in her mouth, and obtaining treatment for this abscess followed a similar pattern, although there was a different

dentist involved. Edith also had a cavity that required a root canal. Even after all of these urgent dental procedures, Edith has several cavities that have not been filled and plans each and every meal around which foods her teeth will tolerate in terms of temperature, consistency, and sugar content. She has no immediate plans to have these cavities filled, although she is aware that ignoring the need to fill her cavities could result in the need for a higher level of dental care and/or another oral crisis.

I mention Edith's ongoing oral issues for three reasons. The first relates to the exploration of safety that is central to this dissertation. Edith has had a profoundly difficult experience of living safely in her body. While she denies history of overt childhood sexual abuse, Edith was exposed to developmentally inappropriate sexual content that has left her feeling afraid of her body and of her femininity. From an early age, she remembers seeing pornographic images and remembers hearing the sounds of her mother's sex work, which was overstimulating. She learned that to have a body is to feel afraid. For something to go wrong with her body, then to be unable to trust medical providers, leaves Edith feeling entirely out of control. On top of that, to not know how she will financially attend to her medical needs just exacerbates that feeling of fear and compromised embodied safety.

The second reason this is noteworthy is the amount of chaos that each oral episode invited into her life, and the predictable nature of the precise type of chaos. Edith is well acquainted with the experience of having profound needs that go unmet by authority figures who, by social contract in the case of her mother, or by law in the case of her dentist, should demonstrate a certain level of capacity to attend to those needs. Their inability to attend to those needs causes major disruption in Edith's life, demonstrating her vulnerability to dysregulation. With each oral episode, Edith struggled to find transportation to her dentist because her out-of-

state medical assistance required that she only see dentists within network; Edith's friend and boyfriend had each promised to drive her to the dentist but backed out with short notice, leaving her in a lurch because she could not afford her own transportation. That resulted in missed appointments and disdain from the administrative assistant at the dentist office that caused Edith great shame, which was syntonetic with Edith's idea that she is unworthy of help from people in her social world and unworthy of respect from authority figures. Edith, therefore, struggled to advocate for herself in scheduling appointments, missing classes, and asking for appropriate information from the dentist. What changed the nature of the enactment was my gaze on its unfolding. Edith had never had the guidance or support of a trusted person to navigate these crises, and despite the countertransferential pull to enter the chaos, I remained steady and removed, offering a bird's eye view of the situation and her reactions to it that Edith found reassuring. By refusing to enter the chaos, I became a different kind of object, or mental representation of another person (Winnicott, 1969), for Edith. The countertransferential pull that I felt to enter Edith's chaos indicates that she unconsciously wanted me to join her in experiencing distress and dysregulation. Instead, I remained differentiated from her in a way that was new and comforting, offering her an opportunity to internalize my steadiness and try a new way of relating to the chaos. As a result of this intersubjective shift, Edith was able to more appropriately respond to this dysregulation and disorientation of this experience.

The third noteworthy quality of these dental issues invites curiosity about how Edith navigated the oral stage of psychosocial development. In psychoanalytic theory, there is a naturally unfolding sequence of maturational changes in a person that determine how a person will receive, interpret, and shape experiences based on that maturational process (Freud, 1905). Each of these stages involves an erogenous zone, and in the case of the oral phase, that

erogenous zone is the mouth. An infant in the oral stage will experience stimulation through sucking their fingers, toes, and objects, and it is through sucking, biting, and chewing that babies experience pleasure and aggression. Infants discharge drive energy or drive tension through use of their mouths in the form of screaming, cooing, and gurgling. Contemporary theorists (Lichtenberg, 2004; McWilliams, 2011; Mitchell & Black, 2016) have expanded upon Freud's original ideas regarding the milestones of this phase and have included consideration of the infant's symbolic negotiation of self-expression and the needs of the self, and the means of connection with the mother, from whom the infant is not yet psychologically differentiated. The oral phase is an opportunity for the infant to negotiate a sense of existence and personhood. During the oral phase, infants are invested almost exclusively in themselves and in their own needs (Freud, 1905). The central dilemma at this stage of development is the urgency of having both loving and aggressive needs met. When the tasks of the oral stage are accomplished, an infant develops the capacity for trust, self-reliance, and self-esteem.

In the case of Edith, this process was thwarted by the presence of a parent who could not attend to Edith's most basic needs. Edith did not have the experience of being breast fed by a mother or of being routinely bottle fed by a parent; instead, she spent the first three months of her life being bottle fed by a rotating staff of nurses in a neonatal intensive care unit. Edith did not have the experience of depending on a relationship with a primary caregiver to help her regulate her tensions and discomforts, to feed and soothe her, or to provide reliable comfort in the form of offering nutrition to intake. The literal presence of the oral problems, as evidenced by dental crises, is an invitation to consider whether Edith accomplished the important tasks of the oral phase of psychosexual development, as defined by Freud (1905). Under stress, people are likely to use methods of coping that characterized an earlier developmental challenge that felt

similar to their current dilemma.

There has been a strong oral theme that has presented itself literally in Edith's life. The symbolic emergence is of note, as well. Edith's mother has had limited capacity to offer love and nurturance to Edith, so there has been a limited opportunity for Edith to practice intake, to learn how to safely take in. There has rarely been an opportunity to learn how to modulate and titrate her desire to consume. Edith tends to want without limit, a result of her anxious need for safety and her historically constructed belief that she can never be satiated. Edith's orality presents in an ongoing negotiation of her own needs to be soothed by others when experiencing what she refers to as "wild swings." Although Edith's orality is strongly present, I am reluctant to go so far as to state that her organization remains delayed in the oral stage of psychosexual development, or that she is entirely developmentally stuck in that phase. To do so would be to needlessly pathologize her and disregard her powerful resilience in the face of extreme developmental and environmental stress. Similarly, to ignore the symbolic presence of her orality would be to miss an invitation to attend to her lingering developmental needs for modulating the experience of intake and healing the developmental injuries that took place within the first 18 months of her life, namely the absence of a supportive and loving caregiver who could respond appropriately to her most basic needs.

A Theoretically Integrated Conceptualization and Clinical Intervention Regarding Safety

Edith's regard for her own self-worth lends itself to a complicated experience of protecting herself from harm. In order to protect oneself from harm, one must believe that she is worth protecting. Edith simply does not believe that. To take any sort of precautions that offer safety requires belief that she has a life that's worth living. When one has such little regard for one's own life, there is very limited impulse to protect or maintain it.

Shifting Edith's deeply held belief that she is undeserving of protection from danger requires attention to the symptoms that this belief produces. Although lessening the intensity of the symptoms is unlikely to change the belief itself, it does offer relief from some of the pain that is generated by this belief, allowing more space to thoughtfully and intentionally engage with the belief itself. To this end, attending to symptom reduction is central to a holistic consideration of safety.

The primary symptom of Edith's internal distress is extreme difficulty regulating affect. She goes through periods of intense and debilitating sadness during which she struggles to motivate herself to get out of bed, attend class and work, and take care of physical needs such as bathing and eating. These periods of depression are interrupted by tantrums, as previously discussed. These depressive episodes compromise Edith's physical safety, as she describes her depression as "a deafening fog" and reports that she is almost entirely unaware of her surroundings as she walks through the world in the midst of this fog. She does not notice when she feels instinctive bursts of fear and cannot recall any impulsive movements towards her safety when she is depressed, suggesting that she does not feel fear when depressed. She has recalled moments when she has noticed risk or threat, but has not taken action to protect herself, and has offered examples such as failing to instinctively step out of the path of a vehicle or to cross the street to avoid a group of men, movements that many people would describe as instinctive. This is exactly what happened to her when she was raped, as previously discussed.

Notably, Edith once shared an alarming experience when she was in a depressive state and resting in her bed. She was in bed, and was experiencing the softness of her blankets and the smoothness of her sheets. She was awake, despite being exhausted in body and mind. She remembers hearing her front door open and she remembers a fleeting moment of curiosity about

whether the door had been locked, but that curiosity quickly faded as she lay in bed listening to the unfamiliar footsteps of someone walking around her apartment. Edith is able to remember and describe her cognitive and somatic process in great detail: she experienced a visceral sense of impending doom. She relates it to a memory from her previous rape when she experienced visceral certainty that the rapist would grab her. Edith described that familiar certainty as intolerably painful. The next thought that she remembers is, “Whatever happens will happen,” and she realized that she has no way to protect herself from the stranger in her home and thought she should try to go to sleep. Edith reports rolling over in her bed to face away from her door and trying to soothe herself into sleep, despite the heavy footsteps that she heard below her bedroom. She remembers vacillating through moments of fear that she would be raped by the person downstairs and a total lack of concern or alarm that she now describes as genuine. She shared that these two experiences were not simultaneous but instead alternating, and that she shifted in and out of each absolute state 5-6 times before the person eventually left the house without harming her. Edith still does not know who this person was, but seemed to downplay the frightening nature of this situation by stating that it was likely a friend of a roommate. She described this incident in session with an alarmingly flat affect and appeared almost entirely disengaged from the severity of the situation, despite her cognitive ability to describe the risks; there was no unification of affect, cognition, and behavior in the moment of the incident or upon recounting this experience. Her lack of a sense of agency is profound and that, combined with her feeling that she does not deserve to be protected, leaves her at great risk. Her dissociation is a major factor, as well.

The neurobiological research of Lanius et al. (2010) also offers insight into Edith’s resignation to the risk of harm by a possible intruder. The clinical application of their research

suggests that Edith has likely become desensitized to chronic fear and might experience a generalized fear response, which leaves her unable to identify a specific fear-inducing threat, such as a possible intruder. Because Edith feels a general, non-specific fear at all times, her brain struggles to weigh the risks of particular actions because every action feels equally risky. In clinical practice, this neurobiological phenomenon tasks the clinician with the responsibility to help a client differentiate between risky and less-risky behaviors and situations, despite a generalized fear that leaves her feeling that all behaviors and situations hold the same level of risk. In order to do this, as Edith described her belief that the outcome of the situation was out of her hands and her accompanying sense of resignation, I gently offered a challenge. I shared with Edith that I was curious about whether it had occurred to her to quietly get out of bed and quickly lock her bedroom door, a feature that I know her bedroom offers based on previous conversations. Edith became visibly agitated when I offered this challenge and stated, “It wouldn’t be my fault if anything happened to me. Don’t victim blame.”

It wasn’t until this interaction, which was the fourth or fifth time that Edith accused me of victim-blaming when I suggested that she has power over the safety of her body, that I truly felt ready to challenge the inauthenticity and performance of victimhood that I intuited through these displays. She described her reasoning for stating that I was blaming the victim, and her description left my stomach feeling queasy. She had entirely erased her own sense of agency, control, and power, when I had witnessed such incredible resilience and forceful passion inside her. I felt a strong discomfort at the thought of sitting with Edith’s deeply unwell self-concept and decided to challenge it. I stated, flatly, “I hear you when you say that your belief was ‘whatever happens will happen’ and that the result of his presence was entirely outside of your control, but honestly, something about that just doesn’t sound true to me. Do you ever notice that

the truth has a certain sound to it? What you're telling me doesn't sound entirely true, and I wonder why." These words came out of my mouth somewhat impulsively, which is in stark contrast to the sometimes painstakingly slow thought process in which I usually engage before speaking in a session, which ultimately suggests a shift in a self-state for me. I simply could no longer tolerate the fabrications and disempowering inauthenticity that I felt fed, like the false confessions that her mother fed to her late at night while Edith pretended to lay asleep.

In addition to exemplifying Edith's victim identification, this is a clear example of a moment when Edith's interpretation of the fourth wave of feminist thought interferes with the great import of external safety. Edith is correct in her understanding that to blame a survivor for her experience of sexual violence is both inappropriate and injurious, but the assumption that victim-blaming and discussion of self-protection are synonymous is clinically problematic.

In this moment, I was faced with a decision to either collude with Edith's symptomatic disavowal of her fear that maintains the mythology of her insignificance, or to engage in a conversation that leaves her feeling blamed and that takes her outside of her own political and sociocultural context. Instead of overtly doing either, I opened a dialogue about the ways that she feels disinterested in protecting herself and the difficult position that I find myself in as a feminist clinician who does not want to victim blame but who also does not want someone about whom I care deeply to be injured. To demonstrate a willingness to engage authentically as a full person rather than a transference object is important with a trauma survivor, and especially one with a schizoid personality construction (Robbins, 1988). They, more than others, appreciate seeing that a therapist is a real person with an internal world, and that the therapist can protect the client from the intensity of that inner world. My willingness to openly share that I am fumbling with the best way to unite my politics and my desire for Edith's safety offered both a

moment of mirroring the shared tension and of twinship as a feminist. Edith was able to tolerate this disclosure. My quiet, steady willingness to accept her fabricated versions of her narrative mirrored her depressive episodes, while my impulsive and direct statement mirrored the intense outbursts that she has when disappointed. I was likely attuning in a right-minded way to her earlier states of affective dysregulation, which is explained by Schore (2000) as an attachment dynamic that operates at levels below consciousness and that underlies the dyadic regulation of emotion.

This intervention broke something open in our dyad. She looked down at her fingers and quietly nodded her head. This was the first time I had seen or felt any authentic affective experience from Edith as she considered her identity as a victim. Slowly, she began to use her voice to tell the truth in our sessions. She allowed me to access hidden parts of herself and her story. She was able to introduce me to the multiple self-states through which she vacillates, only one of them being a victim. I demonstrated that I can give her space in a way that is simultaneously not abandoning but not intrusive, upending the schizoid dynamic that she lived with while growing up. I felt something shift: she began to understand me as a person who will remain quiet and steady in her life until I perceive that something is false, at which time I will tell the truth as I see it. Edith's relationship with the truth has been historically distorted. She is unsure of whether she and her brothers have the same father; her mother insists that they do but the family resemblance is minimal. Edith remains unsure whether her mother was in treatment for the entire time she was away; her mother asserts that she was, despite the four years that passed and Edith's knowledge that inpatient drug and alcohol treatment usually lasts for a few months. Edith's capacity to determine what is true and what is false is tenuous at best and often leaves her feeling haunted and overstimulated, suggesting the remnants of the dissociated self-

states. Edith is hungry for a clear distinction between truth and fiction. Although unaware of it at the time, I now believe this to be the root of the intensity of my desire to stop hiding from the way that she diminishes her own autonomy and ability to self-protect. She certainly lacked attuned mirroring, which contributes to her inability to trust her own perceptions about what is true and what is false.

In addition to the political and sociocultural implications of Edith's decision not to take pragmatic steps to ensure her safety, it is worth considering through a clinical lens. While Edith did have moments of connection to the danger of the situation, these moments of awareness were dissociated and disavowed. Not only was it intolerable for her to prioritize her own safety over her depressive drive to remain in the comfortable cocoon she had made for herself, it was also unmanageable for her to remain present in the affectual experience of fear. Rather than allowing herself to fully experience her fear, the fear became dissociated, in the incident previously mentioned, allowing her to remain in bed and feel entirely unafraid. This can be considered through an understanding of defense mechanisms and trauma. Dissociation has become her first line of defense. When Edith senses danger, she dissociates, which drives her to remain in her cocoon.

Conversely, when Edith experiences the heavy presence of intensely painful affect, she loses access to her ability to self-soothe. She harms herself by scratching herself until drawing blood and banging her head against the wall. She describes these experiences as "entering darkness" and denies the ability to clearly see or hear external stimuli. In the midst of these episodes, she causes herself physical harm without conscious awareness and has limited ability to modulate the level of harm that she causes herself. She enters a dissociative state where she acts out an unconscious drive to experience harm. Van der Kolk's expansion (2014) of Maier and

Seligman's (1976) research on learned helplessness includes the brain's response (or, in this case, absence of response) to trauma, can help to understand the neurobiological underpinnings of Edith's engagement in this self-injurious behavior, which truly compromises her ability to remain safe. Van der Kolk's research suggests that there is something about the trauma itself that is both safe and enlivening to Edith because of her experience of chronic trauma. His research explains that re-exposure to stress might provide Edith with a relief from anxiety through the release of endorphins, which would explain the intensity of Edith's grip on exposing herself to harm.

This is especially terrifying, clinically, because there is a part of Edith that wishes to die, and because of the impulsivity of this self-state. Not only is Edith unable to take measures to protect herself when she has an episode such as this, but she actively seeks and causes harm while dissociated. Safety is a complete impossibility while she is in a dissociative state, which she is able to describe as "scary" in her more integrated moments. However, to be appropriately terrified by these out-of-control moments is elusive at best until she has become more integrated and can use higher level defenses than dissociation.

Throughout our work together, Edith has developed the capacity to experience intense affect in sessions and has had the positive experience of surviving that affect. She has slowly developed the ability to name a feeling state and connect that feeling state to a cognitive process, naming and articulating those processes. This sense of mastery has allowed for a corrective experience of being in control of the intensity of her affect, offering a sense of internal safety.

Throughout treatment, Edith has demonstrated an increasing ability to understand feelings as differentiated from actions. She is increasingly able to understand that her feelings

can be expressed through fantasy as a substitute for behavior. She is able to express a fantasy or verbally describe a feeling and can then feel relief from that act of expressing an intense feeling. Edith is able to represent affective experiences using words, though sometimes has demonstrated alexithymia, or a disturbance in emotional functioning that prohibits the verbalization of feeling states or emotions (Taylor, 1984). She is easily reachable when I ask her to describe her emotional experience, and even when struggling to name her affective state on her own, finds relief from debilitating somatic expressions of unnamed feelings through gentle guidance and steady attention to exploring her affectual state. Although there are many tasks of adulthood that Edith did not have an opportunity to master due to the early neglect she experienced, the ability to represent and elaborate upon her affect is well intact, as long as that affect is one with which she is largely comfortable, such as sadness and disappointment. She has developed a beautiful capacity to represent her internal experience using language when she is in a depressive state, but easily loses this ability when she feels threatened by abandonment or engulfment. At these times, she is much more likely to act out through the use of tantrums. A significant part of Edith's treatment has focused on reducing her alexithymic response to such distress, which has taken the shape of steadily offering herself internal kindness as she gains understanding of what lurks in her mind and finds the power of her voice to confidently assert the truth. Emotional awareness begins in the newborn in the form of awareness of either general contentment or general distress. The child with a normal developmental trajectory is able to understand the affectual experience of anger, fear, and sadness, and increasingly understand these feelings in nuanced and specific ways as she grows if there is the presence of an attuned caregiver. Edith, however, is learning to accurately represent herself now in the context of treatment, and this has ultimately enhanced her self-esteem and self-concept.

Relational and Intersubjectivity / Relational Safety

I ultimately decided to leave my position at the outpatient mental health center after just a year, in large part due to the feeling that I was causing more harm than good in connecting with clients with long histories of attachment trauma, only to need to terminate our work together in a time period that I experienced to be premature. Edith is one of the clients with whom I felt most compelled to continue working, due to her long history of abandonments. My desire not to terminate with her due to scarcity of resources in the treatment setting is in part an attempt to soothe my own narcissistic need to be “better” than the therapists who have failed her before and to defend myself against the feelings of guilt powerlessness, a pain that exists in Edith’s long history of abandonments.

A relational conflict that Edith and I encountered while transitioning Edith’s treatment setting demonstrates the great importance of relational safety in working with survivors of sexual violence and the ways that safety in relationships mirrors the experience of internal safety. Edith’s relationship with me became an enactment of her own relationship with herself and the way that her sense of her ability to dwell safety in her own mind is constantly negotiated.

This conflict emerged when I shared with Edith my plan to leave the outpatient setting and to enter private practice. Upon reflection, I am amazed at how calm and confident I felt entering the discussion about this change. I had assumed that she would wish to continue treatment with me and that she would have no issue with our transition. At the time, I was overwhelmed by the experience of switching jobs, terminating with other clients, and navigating the dynamics at work, so I felt relieved at the apparent simplicity of my relationship with Edith and allowed it to exist unquestioned, begging the question of what I was dissociating and what self-states for both Edith and myself were not invited into the conversation. In fact, although I

don't remember my precise language, I believe I may have even informed her that we would be moving her treatment from the outpatient mental health center to private practice, and that it was simply the new treatment plan. I do not remember if I assessed for her interest, willingness, or feelings about this change. I do not remember if I even asked if she wished to continue her treatment. A failure to obtain consent is the precise root of Edith's trauma history and the reason that she struggles to feel safe in the world and in her relationships. To fail to ask for consent from a survivor of sexual assault was uncharacteristically thoughtless of me and is important to understand as a foundational element upon which the enactment, or presence of unconscious material in the therapeutic context (Jacobs, 1986), that followed rests. In this session, though, Edith was eager and appeared carefree in response to the information I shared.

She stated, "Yeah, okay, so we're moving to private practice? Cool. Do you take my health insurance?"

I replied, "No, probably not. You have Medicaid through [a different state], right? She nodded. No, I can't accept that. But I know that you don't have any money and I'm totally not concerned by it. I figured that you would pay me what you can each week and that we just won't worry about that. Maybe it'll be one dollar, maybe it'll be twenty dollars. You can pay me what you can, and we just won't worry."

She laughed and said, "Yeah, okay, cool. That office is near where [my boyfriend] lives." She then launched into the topic of her boyfriend, and we didn't discuss the transition until several weeks later when we scheduled our first appointment in our new setting.

However, as we began treatment in private practice, Edith began to regress. She experienced more frequent episodes of acute dysregulation, and although her tantrums had previously become shorter in duration and farther apart in frequency, she was beginning to experience longer and more frequent episodes with limited insight about the root of her activation. Edith stopped doing school work, had disconnected from her friends, and recently had her hours cut at work due to a decrease in work performance. She was not doing well. Of critical concern, she had stopped eating. Edith was losing weight from her small frame at an alarmingly

rapid rate and couldn't pinpoint or describe the reasons for it. She denied concern about body image or intent to restrict her diet; she simply stated that she didn't have the motivation or desire to cook for herself, and didn't have the money to buy pre-made or takeout meals. Edith's psychiatrist and I engaged in numerous concerned conversations about her weight loss, while Edith appeared disconnected from the reality of her malnutrition and our concern. I felt her fading away, both literally and relationally. This was especially frightening for me as I was in the first few months of being on my own in private practice. I felt responsible for her well-being and experienced a scarcity of supportive resources myself. This was part of the enactment; I was living through what was likely her own experience of being in relationship with her depressed, alcoholic mother who was also fading away while Edith was left feeling responsible, frightened, and under-resourced. It wasn't until one session several months into the enactment that we began to fully discuss the dynamics at play.

Edith: Okay, I need to tell you something, but don't freak out. *She appeared nervous and vulnerable for the first time in several months.*

Sarah: Okay, I won't freak out. *I felt a little bit amused - when have I ever visibly freaked out in a session with her? What would that mean? I wanted her to just say whatever she wanted to say and felt almost dismissive of that request. I was in no way expecting what followed.*

Edith: I kind of hate coming here to see you here. It's so weird. It's like every time I come here, I hate it. I walk up the steps and I hate it. I can't figure out why I come here. But it's not like I don't need therapy, I do. Remember at school when I told you that I wanted to see you until you retire because you're the only good therapist there is? *I do remember that, and I loved hearing it, and this reminder of that sentiment was seductive enough to momentarily distract me from her words.* Well I do need to see you, I just hate coming here. It's like, what am I even doing here? Your stuff is so cute, with your flowered chair and your cute little bookshelf. I don't belong here. *Edith began to look around the room frantically and became tearful.*

Sarah: You don't belong here? *I felt my heart racing and felt entirely speechless. How could she feel like she doesn't belong here? She is one of the reasons that this private practice exists - so that I can see people for longer than the constraints of our previous treatment setting - how could she possibly wonder if she belongs?*

Edith: Yeah, I don't belong here. It's not safe for me. I can't even pay you. It's so weird that you want to see me. You don't have to. At school, you had to. But you don't have to now, so why do you? What are you getting from this? I don't even pay you. *She was crying now.*

Sarah: Edith, I see how much you're hurting and how deeply true this feels to you, but I'm honestly so confused by it. Help me to understand this feeling and how developed in you. *I was watching her cry and wanting desperately to soothe her pain by simply telling her that she does belong. I was so confused and disoriented, but wanted to remain open to her truth, despite the discomfort it evoked in me.*

Edith: No one has ever cared about me before and I can't handle it when someone does. Obviously, you do care about me or you wouldn't see me here for basically nothing. But it's so weird and it's so much pressure. It's like I have to be perfect for you now but I can't be because I don't know what you would think is perfect and I don't think you'd want me to pretend. But I can't just be myself because I'm a pile of shit and you'll figure that out and stop seeing me, and then what will I do? *She continued to cry as she said this, and I felt deeply sad. I was quiet before responding.*

Sarah: Edith, that sounds so unbearably painful, to wonder if it's safe here, and to wonder when I'm going to leave you. It must be disorienting, too, because I already had an opportunity to leave you and I didn't. As certain as you are that I will leave you, you must also have a suspicion that I'm not going to abandon you thoughtlessly. *I felt an impulse to tell her that I will never leave her, because in that moment it felt true, though I was still able to access the part of my mind that is aware that I will, one day, disappoint or abandon her. I wanted to soothe her fear without implying that I will never leave. I don't know if I did that here.*

Edith: Yeah, it just doesn't make sense, and I work so hard to figure it out that I kind of hate it here. You know how we talk about sorting through all the data before we make decisions about things? Well I can't make a decision about this. *She had stopped crying and looked tired. I was worried that I was losing her affective connection and wanted to invite her back into our shared space.*

Sarah: Edith, I'm so glad you told me this. It sounds like you have a lot of data but there's something blocking your ability to let it in. Does that feel true to you? *For some reason, as I started to speak, I had the image of a hamburger come to mind. I wondered if there was something symbolic about food, intake, nutrition seeping into the body, and allowing herself to feel the safety that another person wants to provide. I wasn't sure yet, but wanted to reach for it.*

Edith: Yeah, it's like I can see that you care. You look at me with that heart eyes emoji so I know you do but it feels so weird and I don't deserve it so I can't let myself know it. I just don't deserve it. You're going to find that out and you're going to be so disappointed in me. *She began to cry again and I felt her slipping away.*

Sarah: Edith, in all of this I'm hearing a really profound fear of letting yourself settle into a sense of safety here. It reminds me of act of intake. Do you know what I mean by that? *She shrugged.* It's as if I have a nutrient for you that might help, in this case the nutrient is safety, and your

mind wants it but it also doesn't feel able to let that in. Does it sound like I have that right? *She nodded.* Well it reminds me of the issues you've had with food. Do you feel like we could introduce that topic into our conversation? *I wanted to talk about food but didn't want to abandon her by changing the subject. She nodded.* Well, Edith, you know that you need to eat. You've told me that you don't like how thin you've gotten, you've told me that you're hungry, you've told me that food tastes good to you when you do eat it. It seems like a parallel to the safety that I want to offer you. You know it exists, you know it feels good when you do let yourself feel it, but something makes its intake difficult. *I was worried that I was telling her too much, that I was occupying too much space in this, that I was defining the narrative, but I also felt profoundly needed, like she really wanted me to take up the space I was occupying. I paused.* What are you thinking as you hear me say this?

Edith: It makes sense, I guess. It's like the effort of coming here feels almost as impossible as the effort of making food. But I know that I need to do both. They're both really good for me and important and it always feels better after I come here and after I eat. *She had stopped crying and appeared more grounded.*

Sarah: Edith, I'm so sorry for not putting more thought into what it would be like for you to see me here, and for not wondering what it would be like for you to pay me what you can, even when that means that you sometimes don't pay me. It was really thoughtless of me to overlook those things. Do you think it would be helpful if we talked about that? *She nodded. I took a deep breath.* The truth is, Edith, that our relationship is one that is so valuable to me that it never occurred to me that you would doubt that or believe it to be conditional. Our relationship is one that feels so protected and safe to me that it didn't occur to me that it might not feel that way to you. *This disclosure felt intimate and terrifying. Edith's gaze on me shifted, and I think she sensed the vulnerability that I felt.* I absolutely should have been aware of that. I bet that it's weird, though, to have someone care about you in this brand new way.

Edith: I know. It's like your heart eye emojis. I just don't get it. Maybe we need to work on that, on why I can't take it in, on why I never feel safe even when I know I should. *She looked genuinely engaged though I could see that she was waning. I knew that she meant that we would work on that in the future and could feel that the conversation was ending.*

Sarah: We can totally continue to talk about this. I so appreciate you telling me this. Is there anything else to say about it before we step away from it for the rest of today? *She said no and immediately told me about her boyfriend, but I could feel her relief.*

By starting the session by asking me not to "freak out", she began to express her deeply held fear that to assert her needs will kill me off, which is the dynamic she lived through with her depressed mother. She also fears that I will be dysregulated. My response to her concern that I will "freak out" was one of amusement and almost dismissal, which mirrored the invalidating

way that her mother responded to her attachment needs. I wished for her to just say what she needed to say with an urgency that I imagine mirrored the way that her mother wanted her to just hurry up and become an adult, as demonstrated by the rapid process of parentification that Edith's absent mother demanded of her.

It is of note that even when Edith described the intensity of her discomfort with seeing me, she still offered to attend to my narcissistic needs by reminding me of the time when she told me that I am the best therapist she can imagine. Edith took in my compassion towards her, which she referred to as a "heart eyes emoji" and extended a similar version of compassion to me by inserting a nod to her positive transference to me. This indicates that she correctly predicted that I would be injured by her ambivalence about remaining in treatment with me. Clinical work with trauma survivors demonstrates that they are attuned to their therapists' internal worlds (Davies & Frawley, 1992). Trauma survivors study their therapists, and Edith is no exception. It is also telling that she felt the impulse to protect me from the pain of hearing that she feels that she doesn't belong. This demonstrates the mutuality of the construction of the therapeutic frame, which Benjamin (1995) defines as the process of adapting and fitting the boundaries to accommodate for the needs and identities of both parties in the therapeutic dyad. Although my internal experience was characterized by deep sadness and disappointment that I had failed Edith, I intentionally modulated my sadness and disappointment in order to demonstrate to Edith that while her words impact me, I can survive the injury, and she simply does not need to attend to my own emotional safety at the expense of her own. I did this in an attempt to offer a correctional emotional experience to counter the profound parentification that she experienced as a young person caring for her mother's emotional and physical needs. I also continued to build upon Edith's development of a more secure attachment to a different type of object to whom

Edith can attach. I wanted to soothe her fear that any negative emotional experience would be read as hostile or dangerous in an intentional effort to limit her belief that not only is her safety compromised in the context of a dyad, but that the safety of the other person is compromised, as well.

For Edith to equate her sense of safety with an ability to pay for sessions suggests a need to feel protected from exploitation and consumption. The intensity of her insistence that there is no requirement that I provide her with treatment in private practice, and the profound affect that she demonstrated when demanding a reason that I see her for an extremely reduced fee, appear to exist in the service of offering protection against the feeling of being engulfed by our attachment. A payment offers a symbolic commitment to the frame of treatment; for the frame to feel absent or permeable creates a safety threat for Edith. She feels a need to offer nonmaterial compensation through offering a performance of the perfect patient, which is a truly impossible role to occupy authentically. The absence of a structurally sound frame demands the emergence of a false self, which is antithetical to emotional and relational safety.

This painful dynamic mirrors one that existed in Edith's early life: she denied her emerging queer identity in order to feel comfortable occupying space that she did not feel entitled to in her relatives' home, and she was in that home as a result of her mother's parental shortcomings. In this case, Edith felt compelled to deny her authentic inner world in order to feel comfortable with her need to seek treatment and occupy space in my practice, a need that she attributes to her mother's empathic failures. However, rather than feel paralyzed by helpless lamentation as she did when she was a teenager, Edith demonstrated an emerging capacity for mature dependence, or the ability to relinquish a fantasy of omnipotence in order to surrender to interdependence (Benjamin, 1995), on our dyad by naming this internal conflict and honoring

our shared commitment to the truth that insists that it is safe to speak every part of her experience. Although she shared that she did not feel safe entering our shared treatment space, the experience of tolerating mature dependence allows for a sense of competency. That precise sense of competency relates to a feeling of internal safety through an internal experience of being able to predict her limitations and strengths. When she is able to predict how she might respond to a relational exchange, she feels more in control of her response, which in turn leaves her feeling more relationally safe.

At the end of this conversation, Edith seemed to feel visibly lighter and seemed more energetic and engaged than she had in months. Over the next several sessions, Edith appeared better able to safely exist in the context of a dyad and the struggle that she had experienced with allowing intake, both literal and symbolic, seemed somewhat alleviated; Edith gained two pounds in the month that followed this conversation.

The central force to which I attribute this is simple: despite the discomfort that it evokes, Edith was able to feel seen in my presence. She was able to see that I have recognized her and that our relationship is in fact mutual. This is terrifying for her because it is unlike any relationship she has known, but it ultimately offers a sense of safety in knowing that she is a person who is worthwhile of care and protection from relational harm. Her description of my gaze as “the heart-eye emoji” is both endearing and telling: our right brain to right brain communication allows her to understand that my gaze is a tender, non-threatening one. This is an example of the principle of mutuality, defined as X by Benjamin (2004). The steady visibility that therapy offers Edith is an opportunity for her to play with the experience of being seen in a context where safety is, in theory, possible, and this process of safety in mutual recognition of feeling states broadens what Siegal (1999) refers to as the “window of affect tolerance”. Edith’s

early experience of lack of recognition contributed to her disorganized attachment, so the very act of mutual recognition is in fact healing.

Edith occasionally comes to session and boldly kicks off her shoes, boots flying across the room, then stretches across the couch. In other sessions, she slowly and quietly folds her arms over her stomach and hunches forward, avoiding eye contact. This is the emergence of the schizoid character organization: Edith wants to be seen, but the visibility and recognition it invites can be intolerable, and she feels a strong need to retreat inward. I modify the intensity and continuation of my eye contact with Edith based on her presentation. On days when she is sprawled across the couch, I know that she can tolerate steady eye contact, but on days when she curls into a small ball, I know that she is in need of a softer, less invasive gaze because recognition is overstimulating. The sessions when she curls into a small ball are the sessions when my countertransferential impulse is to pull her close and hold her steadily. In these moments, I am reminded of her early start in the neonatal intensive care unit. Edith was in a sterile environment where she existed as the object of a clinical, observational gaze, but what she developmentally needed was the tender touch of a steady caregiver, though her physiological needs prohibited that. Just as Edith's neo-natal experiences thematically shaped her experiences of physical safety, this neo-natal experience became emblematic of the ways her attachment style and personality structure have existed throughout the rest of her life. It becomes alive in the amount of space she feels safe to occupy from session to session.

In this dialogue, Edith had the experience of watching a trusted adult take ownership of mistakes. Beebe & Lachmann (1994) outline the importance of both rupture and repair on the therapeutic dyad. This specific form of rupture in our dyad followed by repair that Edith expressed ability to tolerate implies reorganization at a more complex level. I was exceptionally

thoughtless in my total disregard of the impact of switching treatment settings. I was also thoughtless in my disregard for the role of money in our new relationship in private practice. Edith knows that my fee is much higher than what she pays me, but we never made explicit the reason for my willingness to accept what she can offer me. Part of that willingness is that in order to remain social justice-minded, I have a limited number of pay-what-you-can spots in my private practice, and Edith fills one. But the truer reason is a combination of my deep love for her and my deep desire to shield her from disappointment. To leave this dynamic unspoken compromised Edith's ability to feel safe in the context of our relationship, and left her feeling lonely and raw, two self-states with which she is well acquainted.

Part of the loneliness of the person with a schizoid personality structure is the experience of feeling that their emotional and intuitive experiences are invalid (Fairbarin, 1940). For Edith to open herself to the possibility that I would invalidate her emotional and intuitive experience of coming to my treatment space, and the sensory experience of viewing items that she described as “cute” was an incredible act of brave vulnerability. Edith experiences considerable anxiety about her safety in the world and has historically hidden from the world to manage her overwhelming feeling, as evidenced by her history of hiding in her bedroom to avoid her grandparents, as previously discussed. Instead of hiding, she boldly approached the conversation, demonstrating considerable growth in her capacity to tolerate the discomfort and risk of invalidation, and also demonstrating tremendous faith in our capacity to mutually tolerate and survive her affectual experience. We had the experience of openly acknowledging that I had failed Edith, and I will likely fail her again, but that we can both tolerate and survive my failure. This is the heart of mutual negotiation. My willingness to take ownership of my failure as a therapist also offered Edith an opportunity to witness a person with power acknowledge shortcomings and demonstrate

tolerance of imperfection, which Benjamin (2017) asserts is central to a curative relational experience. My hope was that I modeled an ability to tolerate myself as less than perfect and that witnessing my tolerance of imperfection will allow Edith the space to play with her own ability to understand herself as imperfect but good enough, in the spirit of elevating her own sense of self-esteem and agency.

Edith's schizoid experience manifests through a sense of not belonging in my new office; she was attuned to a passive sense of danger that left her disconnected from the parts of her that could tolerate safe connection. Edith navigates her sense of internal safety through an unrelenting process of negotiating relational closeness and separateness. For Edith, that negotiation offers the opportunity to assess for internal safety by examining the following questions: What happens if her hunger for me is voracious and she swallows me whole? What happens if she makes me disappear? And worse, what happens if my hunger for her, as demonstrated by my willingness to see her without payment, swallows her? What if she becomes consumed or engulfed by the intensity of my hunger? What if she experiences my hunger as insatiable and limitless, genuinely posing a threat to her very existence? These questions are deeply human and universally relevant, but are essential when considering the experience of safety for a survivor of sexual violence with a schizoid personality structure. Guntrip (1969, p. 24) uses the phrase "love made hungry" to describe the schizoid self. Edith's desire for the safety of a mutually loving dyad leaves her feeling as if neither member of the dyad could possibly survive the depths of the mutually constructed hunger, and that both parties are endangered at all times.

This sense of constant endangerment elevates the need to link attachment and safety in a treatment environment, and the ways in which Edith modulates her internal desires and fears rely on her experiences of attachment. A clinician must consider how a client can most safely

construct an attachment in the context of a therapeutic dyad (Ainsworth, 1969; Bowlby, 1969; 1973). For Edith, a safe and secure attachment could only become possible when she felt and understood that her needs and concerns could be met with compassionate consideration. My consistent attempts to meet Edith's emotional needs with attunement will help to offer a corrective experience of attachment through an intentional attempt to build a secure attachment. The safety provided by a secure attachment is experienced through the relational process of negotiating the frame of clinical work (Benjamin, 2017). Edith needed to communicate her concerns about the role of finances in the construction of our frame, and I needed to tolerate the discomfort of that conversation in order to demonstrate that I can manage my own internal world while simultaneously attending to the needs of her interiority.

In order to fully hear the intensity of Edith's discomfort with our financial arrangement and her safety-compromising experience of my initial failure to thoughtfully discuss the financial piece of the therapeutic frame, I must locate the narrative in the context of her complex trauma. Edith has never experienced financial security, which has inhibited her ability to feel safe both externally and internally, as discussed previously. The added injury of feeling as though I viewed her as charity was painful and dysregulating, and it prevented her from feeling that she could safely exist in our dyad. Perhaps it was Edith's precise history of resource insecurity and complex trauma that made it impossible to feel safe without full transparency concerning the role of money in our dyad.

A consideration of safety in the context of the therapeutic dyad is incomplete without a study of its applicability outside of the context of treatment. This brings to context the idea of the corrective emotional experience, first described by Alexander and French (1946, p. 338) as the process of "re-experiencing the old, unsettled conflict but with a new ending." The corrective

emotional experience is the client's exposure to and internalization of a new and corrective relationship. In Edith's case, the corrective emotional experience is offered through moments of internal and external safety in the context of our therapeutic frame. The presence of the corrective emotional experience in the therapeutic frame allows for the integration of new, safer emotional experiences for Edith, which she can carry with her beyond the therapy hour.

A goal of therapy is for the client to take what she has experienced in therapy and apply it to- and experience it in- other aspects of her life (Alexander & French, 1946). For instance, Edith has experienced me as an attuned and sensitive person who is often able to meet her emotional needs; she has experienced me as a new object. This helps to heal her attachment trauma. Continuing this example to Edith's experience of safety, Edith has experienced moments in therapy when her mind and environment feel safe. It is these moments that she can carry with her in her imagination outside of my office through the process of mentalization, or the mind's representation of attachment (Fonagy et al., 2002; Schore, 2011). This is the process through which Edith can feel safe in her mind and in the world outside of the therapy office.

To this end, Edith's safety has also increased through an interruption of the various enactments in which she has engaged that have compromised her safety, such as her inability to lock her bedroom door when a stranger was in her home, as previously discussed. Edith has slowly loosened her grasp on her identity as a victim, which has offered her more space to act in the service of her own self-protection. After dissecting the dynamics of that enactment, Edith is able to more clearly name her self-worth and therefore take practical steps to protect herself. Now that she understands that she has value, she is more emotionally equipped to guard that value. While Edith is still at great risk of danger, she has made meaningful steps towards her ability to self-protect. This is the relief that comes with interrupting enactments: once the

dynamics are named and made meaning of, a person has more freedom to choose a different path forward through the process of formulating an experience (Stern, 2009).

CONCLUSION

Throughout our work together, Edith has had the experience of naming the affectual states that render her unsafe both in the world and in her mind. She has also had the corrective experience of naming that precise unsafety in the context of our relationship and using that relationship as lens through which she negotiates safety internally. She has explored the possibility that her thoughts and feelings are true, that there are self-states that are false but functionally appropriate, and that she is not so inherently flawed that she is undeserving of basic safety. Her increasing ability to name and regulate her feelings, her general increase in self-awareness and feelings of self-worth, and a sense of mastery over repetitious behavior, all translate through an intricate process of mentalization and corrective attachments, an increased ability to remain safely engaged with the world outside of the consultation room.

The concept of safety for survivors of sexual assault is profoundly nuanced and dependent upon a person's unique history, personality, and life circumstances, and the establishment of safety for a survivor of sexual assault requires precise clinical attention to each individual. This dissertation's exploration of Edith's experience of safety after a sexual assault is an opportunity to discuss the trauma treatment literature and the ways that safety is understood and prioritized, followed by a discussion of additional theoretical frameworks that can strengthen a clinical conceptualization of safety for survivors of sexual assault. This dissertation asserts that social work is uniquely positioned to attend to the construction of safety through its consideration of the impact of resource insecurity, and social disparities such as sexism, racism, and homophobia on a person's psyche. Expanding upon the ideas presented in eye movement

desensitization, prolonged exposure therapy, cognitive processing therapy, the safety emotion loss and future toolkit, and the step-by-dimension protocol, this dissertation offers a clinical example of an ongoing, continuous, and dynamic conceptualization of safety. The description of the case of Edith focuses on the ways in which her character construction, attachment history, and current relational patterns are central to her experience of safety after a sexual assault

Trauma theory as a foundational guide lends insight to the many ways that a person, at her core, is shifted and impacted by the experience of trauma, whether that trauma comes once or is continuous and exists over time. Similarly, the theory of complex trauma offers a framework for understanding that a client might come to treatment without a foundational understanding or experience of safety, and helps to challenge the notion that it is possible for all or most clients to return to that baseline. Attachment theory allows insight into the great import of human connection as a healing force after sexual assault and of a secure attachment relationship as an aspect of achieving a baseline of safety. Psychodynamic theory lends a deep understanding of the many layers of the mind that are at work in any given moment and helps a clinician navigate the many wishes, impulses, fears, and thoughts that clients share. Psychodynamic theory also informs a clinical appreciation of the role of enactment in the possibility of re-victimization after a sexual assault. Relational theory highlights the great import of attending to the intersubjective nature of healing from trauma and the mutual negotiation of a clinical dyad as a vehicle for that healing. An inclusion of feminist theory and critical race theory is also essential for a social work-informed conceptualization of safety after sexual assault, as they offer a framework for attending to the oppressive dynamics that make clients vulnerable to sexual assault and that can make healing more challenging.

Using these theories, this dissertation offers a guide to clinicians who provide therapy to survivors of sexual assault for whom safety is a complicated aspect of healing. Using these theories as a conceptual frame, this dissertation demonstrates how a clinician can construct a robust and dynamic view of what each client needs when cultivating her own experience of safety after assault. Each client's definition of safety will be different, and a clinician must rely on a solid theoretical foundation to meet the unique needs of each client. The above theories offer a useful foundation upon which a client and clinician can mutually construct an experience of safety after sexual assault in the context of clinical social work.

Consent to Publish

This is to confirm that I have read this document, which describes details of my psychotherapy with Sarah Trotta. Ms. Trotta and I have agreed on the ways in which she has disguised my identity and on the details that she has included in this case analysis section of her dissertation. I give my consent for her to publish this document in Scholarly Commons, the University of Pennsylvania's electronic repository for scholarly work. I understand that that she will embargo this dissertation for one year. During that time, if I decide that I would like her to change any of the details she has included, she will do so. If she plans to publish this document in any format other than in a peer review journal, she will need my further consent to do so.

Signature of patient

Date

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