

# The Understanding and Treatment of Betrayal Trauma as a Traumatic Experience of Love

Laurie Kahn, MA

*Abstract.* When a parent or caregiver whose charge it is to love and protect is also a perpetrator of abuse, love and abuse become acceptable partners. The child's world is changed. The blueprint for loving relationships includes the acceptance of harm and betrayal without accountability. Betrayal trauma theory (Freyd, 1996, p. 10) explains "the ability to detect betrayal may need to be stifled for the greater goal of survival." This article will explore the impact of betrayal trauma on our clients' experience and understanding of love. Issues of love and betrayal are frequent in our clients' trauma stories, and in their presenting problems as adults. Where love is addressed in our professional literature, however, it is mostly in the context of warning about boundary violations and reenactments. This article shows how the therapeutic relationship provides opportunities to reshape our clients' traumatic understanding of love and discusses why love needs to become a central theme in our treatment of survivors of betrayal trauma.

## *Introduction*

As trauma therapists we are challenged to read between the lines, to decipher throughout the therapeutic relationship our client's understanding of the complex human experience of love. We cannot successfully treat clients who have experienced profound betrayal in their childhoods without understanding the beliefs that emerge from their experience of love gone wrong. Love cannot be left to the pages of poets. The richness of therapy is in its opportunity to open the door to an experience of love where voice and connection are no longer at odds, where the rewards of love are many and the costs are not crippling. Therapy can teach an ethics of love, a definition of love where abuse is unacceptable and respect, responsibility and mutuality are foundational.

## *The Trauma of Betrayal*

A traumatic experience of love can occur when a child's experience of love, caring and affection collides with an on-going experience of abuse and betrayal. The union of love, trust and safety becomes fractured, while notions of love and betrayal become linked in tragic partnership.

Freyd (1996) suggests that betrayal is the violation of implicit or explicit trust. The closer and more necessary the relationship for the child, the greater is the degree of betrayal. Betrayal trauma theory explains "the ability

to detect betrayal may need to be stifled for the greater goal of survival. A child who distrusts his or her parents risks alienating the parents further, and thus becomes subject to more abuse and less love or care" (p. 10).

Herman (1992) speaks of the double bind of the child of betrayal trauma: "The child faces a formidable developmental task: to find a way to form primary attachments to caretakers who are either dangerous or negligent. She must find a way to develop a sense of basic trust and safety with caretakers who are untrustworthy and unsafe" (p. 101).

Dissociation allows the traumatized individual to continue functioning in these double bind relationship without having to notice the inherent contradictions (Spiegel, 1986). "The child maintains and protects the situation of tenderness by keeping it apart from the memories of the abusive situation..." (Howell, 2005, p. 167). To know the extent of the abuse or malevolence of one's caretaker is incompatible with the child's desire to experience love.

The child both longs for the love of the parent and fears it. The child, and later, the adult, is cursed with compelling ambivalence: seeking and desiring love and closeness while simultaneously dreading and fearing it. The child is left to make meaning of a world where attachment and trust, their psychological oxygen, are in jeopardy.

The impact of betrayal trauma has been explained in terms of its effect on memory, cognitive encoding and amnesia. Traumatic experiences involving a betrayal of trust, particularly childhood abuse, can cause severe suffering, impair daily functioning, increase risk of further victimization and perpetration of abuse, and create diverse mental health and societal problems (Freyd, DePrince, & Zurbriggen, 2001, p. 6).

The multitude of relational injuries does not elude us, yet the specific and often crippling impact on the understanding of love is under explored.

## *Why Talk About Love*

Our trauma literature is not shy to explore attachment issues both within and outside of the therapeutic relationship. References to love, however, are conspicuously sparse. Where love is discussed, it is mostly in the context of warning. Chu (1998) writes, "Although some care taking is inevitable and respect is essential, these patients cannot be loved into health" (p. 87). Pearlman and Saakvitne (1995) warn "A therapist

may explicitly express caring and respect for her client; however, the power and valence of words must be considered. The term 'love' is often sexualized and may imply possessiveness or eroticism, and therefore generally is misleading rather than clarifying in the therapeutic relationship" (p. 85). Anna Salter (1995), from her knowledge of perpetrators, reminds us that when children are abused in their families, "the child's love is both the gatehouse of access and a guardpost against disclosure" (p. 182).

Love and betrayal is a common thread in the trauma stories that inundate our practices. The warnings in our literature rightfully encourage us to stay mindful of our clients' toxic experiences of love and invitations for reenactments. Reenactments are more likely to occur, in the case of many survivors of betrayal trauma, as a result of their inability to verbalize their traumatic experience. "Memories of abuse become trapped, encased within a wordless world" (Davis & Frawley, 1994, p. 210). The client is unable to symbolize with language and reenacts an aspect of the dissociated trauma. Because reenactments for the survivors of betrayal trauma often have to do with love, eroticism and boundary violations, the negotiations of these reenactments can challenge even the most experienced therapist. "A surprising number of therapists commit grotesque errors; among the most egregious is having sex with clients" (Salter, 1995, p. 253). "The factors most associated with therapist/client sexual contact seem to be, first, the client's sexual abuse as a child, and second, the severity of her symptoms" (Kluft, 1990, p. 264). Our primary mandate is to avoid retraumatizing our clients.

However, is it possible that in our vigilance to avoid being caught in destructive reenactments and the blurring of boundaries, we inadvertently avoid the opportunities to explore the meaning of love and its potential to heal? Is the abuse story between us eclipsing important therapeutic opportunities to know and experience love without abuse or malevolence?

Fosha (2000) suggests "Therapists seem to be at a loss as to how to deal with positive patient responses, such as love and gratitude" (p. 178). These basic feelings are the best the patient has to offer. Nothing is more emotionally devastating than having one's loving feelings treated as toxic (Guntrip as cited in Fosha, 2000). "When loving is met with derision, rejection, or humiliation, it becomes equated with loss, abuse, or self-annihilation" (Fosha, 2000, p. 144). "Difficulties with accepting and receiving love more readily come into view with a therapist who can initiate a loving exchange than with a withholding therapist" (Coen as cited in Fosha, 2000, p. 178). For those who experience the trauma of betrayal in childhood the therapeutic relationship may present the first experience of love free of exploitation. For clients betrayed in their early

relationships with their caretakers, forging this new relatedness is often foundational yet filled with trepidation. Responsiveness by the therapist to the client's tentative gestures of love and tenderness is even more crucial.

James Gilligan (1996) reflects on his experiences working with those that are severely traumatized, and in prison for murder:

"The soul needs love as vitally and urgently as the lungs need oxygen; without it the soul dies, just as the body does without oxygen. It may not be self-evident to healthy people just how literally true this is, for healthy people have resources of love that are sufficient to tide them over periods of severe and painful rejection or loss ... when one has worked with deeply and seriously ill human beings, the evidence of the need for both oxygen and love is overwhelming" (p. 51).

To speak of love opens therapeutic opportunities to co-create with our clients both new meanings and experiences where love and the survival of self are no longer at odds. Pearlman and Saakvitne (1995), speak of the therapist's expression of love: "When a therapist is able to hold a client lovingly in her eyes as the client tentatively explores and becomes acquainted with herself, the client internalizes a benevolent receptive witness to her self-exploration and affirmation. This love takes the form clinically of acceptance and warmth and affirmation" (p. 87).

Betrayal trauma is a traumatic experience of love. Love deserves to become more central in the discourse of therapy and trauma.

#### *Challenging the Bystander Dynamic*

Caring, love and protection are often an unknown combination for the survivors of betrayal trauma. As many traumatologists have noted, neutrality is not an appropriate response to our clients' trauma stories. "Working with victimized people requires a committed moral stance. The therapist is called to bear witness to a crime" (Herman, 1992, p. 135). A moral stance, empathy, and affective response are crucial to bearing witness. Empathy may be incorporated in a clear message that what happened to the client was wrong, unjust, an atrocity, or criminal behavior, and this communicates a sense of care. It is also crucial that the therapist not be a blank slate, but be fully present, allowing the affective responses that are appropriate when hearing about an atrocity that happened to someone that the therapist cares about. "Nonresponse [to the disclosure of a trauma] can transform appropriate emotion to mortification in a patient already predisposed to view his or her distress as weakness" (Dalenberg, 2000, p. 37). For our clients "the trauma after the trauma" is equally and sometimes

more devastating. “Bearing witness is the willingness to hear with your heart another’s experience of pain and suffering. It is an act of compassion that can transform both those being witnessed and those doing the witnessing. It is the willingness to be disturbed by someone’s life experience: it is the opposite of indifference” (Kahn, 1999).

Love coupled with indifference is the dynamic experienced by trauma survivors from the bystander parent or family member, and often expands into the larger social system. The simple understanding that indifference to abuse is incongruent with caring, can be transformative for the client who has been betrayed in childhood by those who were supposed to love them.

#### *Betrayal Trauma and the Therapeutic Relationship*

Our clients’ most frequent presenting problems are not the many symptoms of PTSD, but rather their failed or failing relationships (Briere, 2002). They want to love and be loved by someone, and it is not going well. Our clients often enter our offices with a sense of hope and dread. Therapy evokes the most challenging dilemmas for survivors of betrayal trauma. Turner, McFarlane, and Van der Kolk (1996) write: “The process of entering and maintaining a treatment relationship is always extremely complex. However, it becomes even more so when a patient has been humiliated, hurt, and betrayed, often by people whom the patient counted on to provide safety and protection” (p. 541). Many survivors of betrayal trauma come to therapy with the belief that abuse is “a dreaded but unavoidable fate and is acceptable as the inevitable price of relationship” (Herman, 1992, p. 112). The therapeutic relationship for these clients can mimic the dynamics of their experience of betrayal trauma; as therapists we also profess to care as did the caretakers who abused them. Our relationships are behind closed doors, confidential, evoking their experience of the secrets and silencing of their abuse. The client’s fears of the inevitability of abuse are mixed with hope and longing. “What sustains the client ... is the smallest evidence of an ability to form loving connections” (Herman, 1992, p. 194).

When a client’s primary experience of caring and dependency is paired with abuse, the establishment of trust in therapy is a continuous challenge. When we listen for our clients’ stories and their beliefs about love, we discover embedded in their distrust an unfolding of a narrative about relational traumas. It is where our clients begin to tell us what they know about love gone wrong.

One client told me how her father taught her about sex. “He showed me how to please men. He bought me sexy lingerie to wear for him. Was this love?” she asked me.

Not only was the client betrayed by her father violating her sexual boundaries, she was also left with no blueprint for safe loving relationships.

When our clients cannot tell us about their experience of love gone wrong, they will show us. “Such re enactments are crucial disclosures about unintegrated, unsymbolized, unformulated experience” (Gartner, 1999, p. 242). These therapeutic moments provide “a powerful ongoing source of data – a forced invitation into the patient’s inner world” (Bromberg, 1995, p. 148).

“I don’t trust you,” another client said after four years of our work together. “Last week when you said goodbye to me I saw romance in your eyes”

I assured her that I did not have romantic feelings for her.

My client had never known love or caring from adults that was not laced with seduction and sexual exploitation.

“I do cherish you and the work we do together,” I told her.

Dalenberg (2000) speaks of trauma clients displaying ambivalence about attachment which can look like “an allergy and an addiction to closeness” (p. 15). The therapeutic relationship can seem turbulent at best. However as the client and therapist develop an understanding of the client’s well earned ambivalence about love and attachment, the therapeutic alliance becomes strengthened, giving both therapist and client an anchor as they navigate the inevitable difficulties of sustaining the therapeutic relationship.

#### *New Paradigms of Love*

“How is it possible for a girl to see what she sees to love in a way she is suppose to love” (Morrison as cited in Carol Gilligan, 2002).

A client’s model of love can leave him maimed in his most important relationships. One client of mine had learned in his family that “when you love someone, you can say anything you want, without any regard for the impact.” It was as if his family hurled hand grenades at one another, leaving self-esteem and trust in the wreckage. He came to therapy believing his behavior might be putting his marriage in jeopardy. He described his childhood: “It wasn’t just the abuse I endured but what I saw all the time. Yelling, hitting, and humiliating each other was part of the daily family diet. My mother would call my sister a bitch and then resume a friendly phone conversation. I saw my parents in the kitchen screaming, pushing, shoving each other and I recall the fear and disgust I felt when I watched my father hit my mother. Now I yell at my kids and my wife and I hear those horrible words come out of my mouth and it’s not who I want to be.”

Clients internalize what they have known from their formidable “loving” relationships. Therapy can teach a new ethic of love, in which love includes respect and accountability.

Our trauma literature and the relational frameworks we employ as therapists do not define a model of healthy love. Therefore we may need to search outside of our theoretical frameworks to define such a model for ourselves and our clients. Hooks (2000), a cultural critic and feminist theorist, tackles notions of love in her book *All about love: new visions*. She defines love as “a combination of care, commitment, trust, knowledge, responsibility, and respect” (p. 11). When love is understood as an intention, rather than just a sensation, she suggests, it cannot be devoid of responsibility and accountability. Hooks’ framework suggests that love and abuse may be incompatible.

For survivors of betrayal trauma, new definitions of love, such as Hooks’, can be enlightening. Words and definitions can begin to provide a bridge to change the beliefs embedded from the childhood experiences of betrayal and help create new paradigms of love. However, words are only useful when coupled with action. The therapeutic relationship can begin to lay the tracks for an experience where hooks’ definition of love can be learned. “A history of betrayal is likely to mean that the client will need both the therapeutic word and the therapeutic act to feel safe” (Dalenberg, 2000, p. 230). The teaching of love becomes a subtext within the treatment of betrayal trauma.

#### *Teaching New Paradigms of Love*

The therapeutic relationship becomes an arena in which to learn about love and connection. Chu (1998) describes the therapeutic relationship with trauma survivors: “There is the ‘therapeutic dance,’ a seemingly endless cycle of disconnection and reconnection ... this process provides a new model of relatedness that is in sharp contrast to the abusive style of relatedness that the patient has experienced and expects” (p. 85). The frame of therapy provides the beginning foundation for new understandings of relationships that nourish with clear boundaries, assumptions of mutuality, permission and protection.

*Boundaries.* The articulation of clear boundaries is not only good clinical practice, it is a manifestation of a new kind of relationship. Explicit contracts about time, availability, touch, and money are the beginning of providing an experience of the coexistence of safety and care. We provide safety by not giving the client evidence that the clinician is prone to potentially abusive or neglectful or boundary violating behavior (Briere, 1996, p. 123). Predictability, consistency and clarity challenge what many have known previously in their “trusted” relationships.

*Mutuality.* Modeling mutuality is essential to building a new paradigm of caring relationships. Herman explains that the therapeutic relationship “must be painstakingly built by the effort of both patient and therapist. Therapy requires a collaborative working relationship in which both partners act on the basis of their implicit confidence in the value and efficacy of persuasion rather than coercion, ideas rather than force, mutuality rather than authoritarian control. These are precisely the beliefs that have been shattered by the traumatic experience” (Herman, 1992, p. 136).

In addition to modeling mutuality, teaching a new set of skills is often necessary “most survivors have never learned the skills necessary for interactions marked by cooperation and mutuality” (Gold, 2000, p. 113).

Teaching mutuality involves, in addition to the therapist’s mindfulness in avoiding or repairing any minor or major abuse of power, the willingness to challenge the client’s learned relational strategies that do not allow for mutuality. These strategies may involve intimidating, bullying, or humiliating the therapist or discounting the therapist’s needs or perspectives.

Harriet had become very anxious in group therapy and had informed me that it was too difficult for her to continue. I reminded her that the contract for group therapy included that participants give a minimum of two weeks notice. Harriet replied that the distress was too great for her to honor the agreement. She explained that her panic attacks during and after group were making it difficult for her to stay present. I suggested that she take three weeks leave and work with me individually to see if we could discover more about the source of the anxiety. We agreed that after three weeks she would either return to group or terminate, honoring the established two weeks notice. I would inform the group of her plans. After three weeks, and some successful exploration of how the group recreated for her an experience of forced intimacy, Harriet was able to return to group. She recalled how her father would insist on family meetings for “sharing feelings” even while his abusive behavior continued.

In her group therapy, Harriet challenged me on our conflicting needs: hers to leave and mine for two weeks notice. “Why do your needs come before mine?” she asked. I explained that to respond to her request that she not give two weeks notice meant violating an important value of mine that

accounts for the group members and their attachments. I explained that the contract was to help provide a safe environment. In Harriet's family there were always the bullies and the victims. I suggested that we find a formula where being in relationship with each other would not be costly to either of us. "That's a radical idea" Harriet acknowledged.

"An essential aspect of mutuality is the capacity to engage in interpersonal conflict in a way that honors the connection as well as the possibly diverging individual needs that are striving for expression" (Jordan, 1990; Miller as cited in Jordon (1991). "Without the capacity to engage in growth promoting conflict, authenticity and thus mutuality are jeopardized" (Jordan, 1991, p. 2). "Power over" is defined by Jordan (1991) as when "only one person's goals and subjectivity are honored and notably missing is the empathic concern for the other" (p. 2). The "power over" dynamic is the bread and butter of abuse present in betrayal trauma and the opposite of mutuality. The therapeutic relationship offers a new model.

As Herman (1992) reminds us, "the work of therapy is both a labor of love and a collaborative commitment" (p. 147).

*Permission.* The negotiation of permission exemplifies another essential component of a collaborative relationship. Any techniques that are outside the normal frame of talking therapy (e.g. visualization, EMDR) are ordinarily preceded by informed consent. The message to the client is "This is not something that is done to you; it is something we will discuss and if you are then interested and give your permission, we will proceed together."

Permission is negotiated in minor transactions as well as more significant aspects of treatment. A simple statement such as "Tell me as much or as little as you are ready to share about this" communicates respect.

The requesting of permission communicates an ongoing assumption of interpersonal boundaries, challenging a model of entitlement and boundary violation common in abusive relationships.

*Protection.* The absence of protection often haunts our clients. It is the trauma after the trauma. Where was everyone? An empathic and protective response can make an enormous difference in the trajectory of symptoms and impairment. "The critical positive mediating influence on the impact of the abuse on the child centers on her relationship to a safe caretaking other" (Sheinberg and Fraenkel, 2001, p. 199).

That bad things happen to people is hard to swallow. Yet when bad things happen to you, and the people who say they love you don't care, turn the other

way, collude, or protect their own self interest at the expense of yours: these are the crippling life lessons for our clients. The therapeutic relationship provides many opportunities to replace a bystander response with a protective one. Protection may be in the form of refusing to collude or be passive in the face of behaviors or situations that threaten the well-being of the client.

A client called me from her car in distress, asking to talk for five minutes. I said I had time to talk with her, but I would not talk to her while she was driving. "Why, what's the big deal?" She asked. I replied, "It's not safe." "What's it to you?" she quibbled. "I care about your safety and I am unwilling to talk to you while you are driving." The client pulled her car over and called me back a minute later. The next week she commented on how strange it was for someone to express concern for her safety.

Responding to a client's self harming behavior with a "protective presence" (Miller 1994), can provide a new and corrective relational experience. "I want your life to be free of abuse from self and others" is a therapeutic stance that offers a protective presence. Insisting on medical attention to wounds of self injury while exploring the meaning and function of the self-harming behavior models protection based on care and concern.

These are the responses that begin to shift the client's understanding of what healthy loving relationships are like. It is the corrective experience particularly crucial for those abused in the context of relationships where their caretakers are their abusers.

*Love in the Therapeutic Relationship: Cycles of Break and Repair.*

A clear framework for treatment with attention to boundaries, contracts, mutuality, permission and protection begins to provide an experience of safety for our clients. Yet it is in the messier parts of the therapeutic relationship, the dance of sorting transference and countertransference, and in the inevitable empathic breaks that the lessons of love and safety deepen, and new relational paradigms unfold. The opportunities to walk into a minefield of invitations of power abuses, boundary violations, betrayals of trust and safety are ubiquitous. Walking through a precarious relational minefield, avoiding the mistakes of distancing or over identification (Wilson & Liddy, 1994) and reenactments, provides unlimited material for consulting rooms. Warnings fill the literature of the trauma field and documentation of therapeutic disaster is most prevalent in the treatment of trauma survivors (Dalenberg, 2000). However, it is in this same precarious relational minefield that we find

a gold mine of teaching, not in the didactic sense but experientially, the meanings of intimacy and love.

The successful management of complex emotions in the therapeutic relationship is an opportunity to create a blueprint for trusting and loving relationships. The mindful avoidance of interpersonal and therapeutic missteps is the opening of the experience of new relational possibilities and of safety. Dalenberg (2000) gives a window into this field of possibilities as she speaks to the case for countertransference disclosure. Disclosure is not promiscuous sharing of the therapist's inner life or historical injuries that may be provoked by the client's projections, but rather a transparency and authenticity which allows for the complexity of human intimacy that is free of danger or exploitation.

Dalenberg (2000) says, "Countertransference disclosure models a willingness to critically analyze internal experience" (p. 40). It is an essential skill for the establishment of mutual and intimate relationships, a skill often absent from the repertoire of our clients who had caretakers who acted on impulse with little regard for the impact their behavior had on others. After reporting an incident of violation and severe abuse Sarah expressed her disappointment and anger at my inadequate emotional response. "You said so little. It was like you didn't care. It is hard to trust you now." I listened intently and then empathized with how horrible it must have been for her to experience my diminished response. "I find myself wordless sometimes when I hear about the horrible things that happen to people I care about." I explained that I notice that it is often after the session of disclosure of horrific abuse that my feelings become more apparent to me. A kind of emotional thawing happens.

This moment of counter transference disclosure serves many functions for the survivor of betrayal trauma. It provides an opportunity for the therapist to model a capacity for reflection and the use of language rather than action for communicating one's internal experience. Simultaneously, it communicates the therapist's involvement by allowing the client a window into the emotional impact they have on the therapist. "The therapist's involvement with the client and the client's perception of this involvement are obviously separable dimensions, but both seem critical to successful therapy" (Dalenberg, 2000, p. 44). Dalenberg (2000) also reminds us that countertransference disclosure is a necessary tool for communicating honesty, thus enhancing the client's experience of the therapist's trustworthiness. "Within trauma therapy, such honesty, linked as it is to trustworthiness, is even more critical, particularly for clients whose traumas were dealt out at the hands of attachment figures" (p. 41).

It is important not to underestimate the "power of the honest apology" when the therapist has shamed, humiliated or injured her client (Dalenberg, 2000).

Dalenberg describes what constitutes a true apology: "the willingness to listen to the individual who has been harmed and to understand the harm, a display of remorse, and the commitment to learn from the mistake" (p. 248). In addition to sustaining a therapeutic alliance, the apology models an essential pairing of love with responsibility and accountability, an ingredient devastatingly absent in abusive relationships.

After explaining my lack of affect to Sarah, to make repair, I promised her that I would journal about my emotional reactions in between sessions and share them with her at our next meeting.

It is tempting to believe that as therapists we can transform our clients' stories and experiences of love gone wrong, by being paragons of caring and compassion consistent, empathic, and nurturing, never missing an emotional beat. However, it is often in our mistakes that we have opportunities to build new possibilities for love and trust. "Psychotherapy does not promise perfect attunement or mirroring, but entails repeated cycles of connections and disconnections and then repair and reconnections" (Pearlman & Saakvitne, 1995, p. 17).

Shifting to new paradigms of love is an arduous process for the client, requiring an exploration of the unfamiliar and a resisting of familiar patterns.

My relationship with Sarah was an ongoing sequence of felt injury and repair. Over time, Sarah's relationships improved. She learned not to tolerate abusive relationships and to be more tolerant of the inevitable black and blue marks of imperfect relationships when coupled with repair and responsibility. She also learned to take responsibility when she injured someone else.

Sarah described the process. "I feel like you're my Annie Sullivan when it comes to relationships. You keep putting my hand under the water and saying W\*A\*T\*E\*R\* W\*A\*T\*E\*R and again, W\*A\*T\*E\*R\*, trying to get me to make the connection. I think I get it—it's water. I am finally learning something about how to love and be loved."

As Gilligan eloquently writes in her book *Birth of Pleasure* (2002) "It is the cycles of break and repair that build the vocabulary of love and trust" (p. 176).

Therapy at its best manifests the qualities hooks (2000) says are an essential part of love: care, commitment, trust, knowledge, responsibility, and respect. Therapy teaches about love. A new kind of

love where the knowing of truth and self are not sacrificed for love but are crucial, where vulnerability facilitates closeness and trust not humiliation or danger. Therapy can move clients from the ravages of “betrayal blindness” (Freyd, 1996) developing their capacity to perceive the absence of mutuality in abusive relationships and encouraging them to recognize a model of love where relationships are predicated on mutuality and respect.

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Received 1/28/05  
 Revised 9/11/05, 2/24/06  
 Accepted 4/5/06