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EXISTENTIAL PSYCHOTHERAPY WITH ADULT SURVIVORS OF SEXUAL ABUSE

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Summary

This article explores existential psychotherapy as an effective approach to working with survivors of childhood sexual abuse. Focused on being in the world, the existential approach addresses the very issue that torments many survivors: To be seen and exposed in the world invites not only danger but possible annihilation. The article touches on the broad range of symptoms or manifestations of childhood sexual abuse as they may surface in the adult's life, specifically how it compromises one's relations with oneself and others. It examines three critical elements that arise in the therapeutic relationship: trust and betrayal, protective internal structures, and dissociative patterns. The article then discusses existential therapy, emphasizing the unifying themes of presence, authenticity, and awareness, and referencing specific tools like awaring, focusing, and bracketing to explore how this approach helps clients engage in their processes and assists the therapist to skillfully manage transference and countertransference issues unique to this population.

Keywords: *existential; resistance; sexual abuse; therapeutic alliance; transference; trauma*

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Buber (1970/1996) wrote, "In the beginning is the relation" (p. 69), and "the relation is reciprocity" (p. 58). Human beings encounter each other not simply to experience the other but to actualize themselves and their world. Buber's view of relatedness calls for an individual's vulnerability to be with what is truly present rather than escaping into a world of intellectual constructs and ideas. Survivors of childhood sexual abuse, specifically incest, experience great difficulty touching the vulnerability necessary to actualize their lives, as the adults to whom the child looked for comfort and support were the abusers and the family environment that should have provided safety and love trapped the child in a fog of secrecy and terror.

This article explores existential psychotherapy as an effective approach to working with survivors of childhood sexual abuse. Based on survivor profiles described by Armsworth, Stronck, and Carlson (1995); Bass and Davis (1994); Courtois (1988); Davies and Frawley (1994); Herman (1981, 1997); Kafka (1995); Kalsched (1996, 2000); Putnam (1997); and van der Kolk (1987, 1996a, 1996b, 1996c), this article examines three critical elements that arise in the therapeutic relationship: trust and betrayal, protective internal structures, and dissociative patterns. By focusing on the individual's sense of self and relation to the world, the existential approach addresses the precise quagmire that torments many survivors: To be seen and exposed in the world invites not just danger but possible annihilation.

Kalsched (2000) discussed the fault line created within the psyche of a trauma survivor that can be healed through the painful and potentially terrifying journey into the survivor's subjective experience. If supported by the therapist's authentic presence and tender, tenacious tracking of the client's resistances, the client will be able to more fully embrace life.

For clarity, this article focuses on women's experiences, recognizing the gender bias in the literature that predominantly explores issues of female survivors and male perpetrators.[1] Exploration begins by looking at the impact of trauma in arresting one's ability to be in relation to oneself and others. The survivor's struggle with intimate relations is paramount in therapeutic work. As the client begins to open up to herself and another person—perhaps for the first time in her life—early trauma is likely to be reactivated. This section also presents a profile of a "typical" survivor of

childhood sexual abuse. Although women's experiences and coping mechanisms vary, there is an identifiable constellation of traits among survivors of childhood sexual abuse (Kafka, 1995; Courtois, 1988; Davies & Frawley, 1994; Freyd, 1996; Herman, 1981, 1997; Miller, 1981, 1994; Putnam, 1997; Shengold, 1989; Simonds, 1994; van der Kolk, 1987, 1996a, 1996b, 1996c) that fit loosely under the rubric of posttraumatic stress disorder (PTSD), introduced into the *Diagnostic and Statistical Manual of Mental Disorders, 3rd edition* (*DSM-III*; American Psychiatric Association, 1980) in 1980. More recently, Herman (1997) refined the PTSD diagnosis by developing a new concept for sufferers of prolonged, repeated trauma: "complex post-traumatic stress disorder" (p. 119).[2] This article also explores other affect manifestations of childhood sexual abuse that often surface in adulthood.

The second section focuses on existential therapy—work that is "marked by an explicit lack of techniques" (Gelso & Hayes, 1998, p. 227). According to May (1958, 1969), existential therapy is not a system of therapy but an attitude. Yet, there are unifying themes within this approach, such as an emphasis on presence, authenticity, and awareness as well as trust in the client's inherent knowing. This article examines the appropriateness of this orientation with the survivor population by demonstrating how it helps the client engage in her process and allows the therapist to manage the transference and countertransference issues unique to this population.

TRAUMA

Trauma is a Greek word originally meaning *wound*. The wounds arising from childhood sexual abuse take many forms, but they all represent profound changes to the individual's experience and her relationship to the world. Kalsched (1996) wrote that trauma means "any experience that causes the child unbearable psychic pain or anxiety" (p. 1). He defined *unbearable* as "overwhelm[ing] the usual defensive measures which Freud described as 'a protective shield against stimuli'" (Kalsched, 1996, p. 1). Kalsched also referred to Kohut's disintegration anxiety, defined as the "unnamable dread associated with the threatened dissolution of a coherent self" (1996, p. 1). Trauma can also be viewed as an

attack on a child's sense of security. Bowlby (1988) found attachment to be a vital biological component for survival. Children attach themselves to a powerful protector to develop a secure base and engender a sense of self-reliance. When the caretaker is the perpetrator, the child's sense of security is shattered. Tragically, for some children, abuse occurs before they have the opportunity to develop an initial sense of security. Studies show that the earlier the child experiences abuse, particularly in cases of severe or chronic abuse, the more potentially devastating its impact (Courtois, 1988; Davies & Frawley, 1994; Herman, 1997; van der Kolk, 1996a, 1996b, 1996c).

When a child grows up in a home marred by sexual abuse, her world is turned inside out: What is true becomes hidden, and a lie becomes reality. Out of necessity, the child turns her back on her experience of what is occurring and accepts the family myth that nothing extraordinary is happening. This subjugation of the intuitive self can lead to profound difficulties in navigating adult life, as she is unable to access her internal compass. Without this internal guide, her capacity to trust and form relationships is limited, likely resulting in isolation that will affect her sense of being in the world.

This inability to establish healthy relationships with herself and others calls for an examination of the trauma of childhood sexual abuse through the lens of existential psychology given its emphasis on being in the world. According to Bugental (1981), the word *being* "needs to be broken into its two syllables: be-ing: the process of be-ing is the process of life" (p. 27). May (1958) equated *being* with the "source of potentiality" (p. 41). He further stated,

> My sense of being is my capacity to see myself as a being in the world, *to know myself as the being who can do these things*. . . . But the awareness of one's own being occurs basically on the level of the grasping of one's self; it is an experience of Dasein, realized in the realm of self-awareness. (May, 1958, p. 46)

May viewed this awareness through the I-am experience—the opening of oneself to instantaneous existence with another. Schneider and May (1995) posited that

> Trauma originates, not in relation to parents, peers . . . but in relation to being, to the groundlessness that is our condition. Hence, it is

> not so much the specific content of the abuse or pain that unnerves us so, but the implications of that content for our being in the world. (p. 145)

The therapist's work is to assist the survivor in discovering and trusting her internal sensing—the key to her connection to herself and others.

The client's lack of connection to herself originally ensured her survival by creating distance from the overwhelming pain of the abuse. In his 1997 article on PTSD and the existential-humanistic approach, Greening explained that when we are traumatized,

> We experience a fundamental assault on our right to live . . . on our sense that the world . . . basically supports human life. Our relationship with existence itself is shattered. Existence in this sense, includes all the meaning structures that tell us we are a valued and viable part of the fabric of life. (p. 125)

Therefore, the existential-humanistic approach must consider "the loss and restoration of meaning and human connectedness, and the role of the I-Thou encounters in healing" (Greening, 1997, p. 130). Although Greening's article focused on war veterans and survivors of natural disasters, his thinking is equally applicable to survivors of childhood sexual abuse:

> [PTSD] is not just a disorder occurring in the veteran, but a disorder in the social organism of which he or she is a part. It may be therapeutic to help vets see their personal "disorder" in this larger context and to realize that the traumatic "stress" did not result only from the past, but also from aspects of current life that need to be recognized, avoided or creatively transformed. (Greening, 1997, p. 127)

Like war veterans, survivors can view their experience in the larger context given society's history of denial and repression regarding childhood sexual abuse.

Greening (1997) also discussed the trauma of holocaust survivors like Primo Levi, describing the author's suicide as not only a "particularly tragic example of PTSD . . . but the subsequent reinforcing effects of an existential lack of meaning and connectedness" (p. 130). Existential therapists not only help to repair the individual's psyche but foster a sense of connection thereby allowing her to discover her faith in being in the world.

THE IMPACT OF TRAUMA ON THE DEVELOPING PSYCHE

The field of psychotherapy is moving away from the traditional psychoanalytic belief that the goal of maturation is individuation and separation. Many schools of thought, including the self-psychologists and developmental psychologists, now set the therapeutic goal as that of developing interdependence. Developmental psychologist Stern (1985) sounded like an existentialist when he said that the development of "a sense of emergent self is in the process of coming into being" (p. 11).

The intersubjective experience of a child influences her ability to self-regulate and develop a coherent sense of self. More than four decades ago, Bowlby (1988) wrote about an infant's biological need to attach to a stronger individual with whom the infant can form a secure base. He and other object-relations theorists view infancy and early childhood development as an ebb and flow of the manifestations of the need to be attached, whether it is to the "good breast," the "good-enough mother," or the "selfobject." Kohut (1971) wrote that individuals, especially young children, draw from aspects of other people to sustain their sense of self. Relationships with others yield the necessary "regulatory structures that maintain and/or enhance self-cohesion" (Stern, 1985, p. 242). These early relations with parents or caregivers also help the child to regulate his or her internal experience through a process that begins with what Stern (1985) called "affect attunement" (p. 138). This attunement allows the child to have a shared, intersubjective experience that forms the building blocks of the developing sense of self. There is reciprocity between the infant and adult with the child internalizing the affect of the adult to better regulate his or her emotional state. Early attunement "combines with temperamental predispositions to 'set' the capacity to regulate future arousal" (van der Kolk, 1996b, p. 186). This regulation is believed to be pivotal to an individual's core concept of self.

Atwood and Stolorow (1984) viewed personality development as the structuralization of personal experience, and they believed that the initial task of infancy is to build self-object boundaries:

> The child's incomplete attainment of self-object boundaries makes it both necessary and possible for him to rely on parental figures as "selfobjects" [defined as "an object that a person experiences as

> incompletely separated from himself and that serves to maintain his sense of self" (Atwood & Stolorow, 1984, p. 39)] whose idealized attributes and mirror functions provide him with the self-cohesion and self-continuity that he cannot yet maintain on his own. (p. 37)

Next, the child will begin to integrate and differentiate between himself and the selfobject with a goal of achieving "object constancy" and a stable psychological organization (Atwood & Stolorow, 1984, p. 38). According to Atwood and Stolorow, personality structures—the distinctive configurations of self and object that shape and organize a person's subjective world—are critical to understanding the individual's experience of themselves and their world. The authors

> conceptualize these structures as systems of ordering, or organizing principles through which a person's experiences of self and other assume their characteristic forms and meanings. Such structures of subjectivity are disclosed in the thematic patterning of a person's subjective life. (Atwood & Stolorow, 1984, p. 34)

Atwood and Stolorow (1999) wrote,

> The intersubjective contexts in which conflict takes form are those in which central affect states of the child cannot be integrated because they fail to evoke the requisite attuned responsiveness from the caregiving surround. Such integrated affect states become the source of lifelong inner conflict, because they are experienced as threats both to the person's established psychological organization and to the maintenance of vitally needed ties. And thus begins the "defensive sequestering of central affect states." (1999, p. 182)

Aspects of the child's experiences, emotions, and personality are denied to maintain the connection to parent/perpetrator and to an external world that can be understood and survived.

When the child does not learn how to work with her internal states, the inner conflicts manifest in her life in different ways. Her relationships may be marred by distrust and isolation, she may be aggressive to herself or others, and her sense of self may be compromised by "a sense of separateness, loss of autobiographical memories, and disturbances of body image" (van der Kolk, 1996b, p. 187). According to van der Kolk (1996b), the "lack or loss of self-regulation is possibly the most far-reaching effect of psychological trauma in both children and adults" (p. 197).

Trauma overwhelms the child's psyche, and to respond to the inundation of stimuli, the child alters her perception of the world. Herman (1997) found that a child suffering from parental child abuse "must develop a capacity for intimacy out of an environment where all intimate relationships are corrupt, and an identity out of an environment which defines her as a whore or a slave" (p. 102). When the child relinquishes her sense of the world and adopts her family's distorted view, she steps into the looking glass and enters a personal hell.

Herman (1997) wrote about the child's existential task to forge meaning. She will alter her view of the world in a way that "absolves her parents of all blame and responsibility" (Herman, 1997, p. 102). According to Herman, amidst the trauma of abuse,

> All of the abused child's psychological adaptations serve the fundamental purpose of preserving her primary attachment to her parents in the face of daily evidence of their malice, helplessness or indifference. . . . Unable to escape or alter the unbearable reality in fact, the child alters it in her mind. (1997, p. 103)

This alteration takes place through a profound change in the internal structure of the psyche and manifests in a variety of defenses.

Although the child may use denial, repression, or regression, dissociation is often the most effective defense. Kalsched (1996) wrote that

> The psyche's normal reaction to a traumatic experience is to withdraw from the scene of injury. If withdrawal is not possible, then a part of the self must be withdrawn, and for this to happen the otherwise integrated ego must split into fragments and dissociate. . . . It is the trick the psyche plays on itself. (pp. 12-13)

This intrapsychic split is a "violent affair—apparently [involving] an active attack by one part of the psyche on other parts" (Kalsched, 1996, p. 13). The dissociative states allow the child to "ignore severe pain, to hide their memories in complex amnesias, to alter their sense of time, place or person" (Herman, 1997, p. 103). Essentially, they allow the survivor to withdraw from herself. This estrangement can lead to a feeling of disembodiment or what Winnicott (1945/1975) called a lack of indwelling. Atwood and Stolorow (1999) noted that the "origins of what has traditionally been called the dynamic unconscious" (p. 182) lie in the partition-

ing of the central affect states that protect against retraumatization.

The traumatized child's inability to regulate her internal state is further compounded by her neurological responses to chronic, unbearable anxiety. Davies and Frawley (1994) wrote,

> Autonomic arousal occurs again and again in an ongoing situation of physical and relational impingement, in which the child cannot intervene effectively. Autonomic arousal becomes a generated organismic reaction to stress, in which the connection between the severity of the perceived threat and the degree of arousal is broken. (p. 30)

This disconnect has a profound impact on working with the adult survivor. The persistent state of hyperarousal and/or hyperviligence, coupled with the client's inability to accurately discern the danger of a situation or encounter, may seem incomprehensible to the therapist and the client.

Trauma also affects a child's neurological processing as traumatic memories are processed differently from nontraumatic memories. The *DSM* acknowledges that trauma can "lead to extremes of retention and forgetting: terrifying experiences may be remembered with extreme vividness or may totally resist integration" (van der Kolk, 1996c, p. 282). van der Kolk (1996c) remarked that "traumatic memories may be encoded differently from memories for ordinary events—perhaps because of alterations in the focusing of attention, or perhaps because of extreme emotional arousal interferes with hippocampal memory functions" (p. 282). The hippocampal system is believed to "record in memory the spatial and temporal dimensions of experiences" (van der Kolk, 1996c, p. 231), but "severe and prolonged stress suppresses hippocampal function and potentiates the taxon system (which encodes information according to quality), leading to unsymbolized, context-free encoding of traumatic experiences that renders the memories unavailable to linguistic retrieval" (Davies & Frawley, 1994, p. 28). Thus, these experiences are initially "imprinted as sensations or feelings states and [are] not collated and transcribed into personal narratives" (van der Kolk, 1996c, p. 296). According to van der Kolk, "traumatic memories are timeless and ego-alien" (1996c, p. 295).

To explain the profound effects of abuse, Davies and Frawley (1994) examined the overstimulation and flooding of the ego

functions by the "psychological regression precipitated by childhood abuse and by the physiologically mediated hyperactivity secondary to experiences of childhood terror" (p. 44). They stated,

> With no self-reflective observing ego to provide even the rudiments of containing, meaning, and structure to the traumatic events, the child remains in a timeless, objectless, and selfless nightmare of unending pain, isolation and ultimately psychic dissolution. Traumatic experiences remain unsymbolized, they lie encrusted in a primitive core of unspeakable terror and phenomenologically meaningless panic, intrusive ideation and somatic sensation. (Davies & Frawley, 1994, p. 45)

The authors maintained that the inability to integrate trauma may result in the child "becom(ing) encased in her own world—a world that admits only abusers, victims, saviors and those who choose to stay defensively uninvolved or unaware" (Davies & Frawley, 1994, p. 55). The experiences remain outside the child's sphere of understanding, and the subsequent lack of symbology and language related to the events impedes the child's ability to talk about what happened. Particularly challenging to therapeutic intervention is the often-intractable silence or the discourse of "polished verbal proficiency" (Simonds, 1994, p. 4) that holds little or no connection to the individual's internal experience.

"Forgetting" childhood sexual abuse has long been a subject of debate. To explain the "logic of forgetting," Freyd (1996) wrote about "betrayal blindness" in which the betrayed person loses conscious awareness of the betrayal. Freyd compared the process of forgetting to the human immune system that responds to infection with fever and inflammation. But in the face of a greater threat, the immune system will trigger the body's fight or flight response and redirect the energy fighting the infection to suppress the awareness of pain and facilitate survival. The betrayed child "cannot afford *not* to trust" (Freyd, 1996, p. 10) her abusive parent(s). The circumstances of abuse require the child to abandon a healthy response to betrayal in the interest of survival.

Writing about childhood amnesia, van der Kolk (1996c) called for further research and admitted that this state is not well understood, for the child "has fewer mental capacities for constructing a coherent narrative out of traumatic events" (p. 283). He explained that "it's likely that [the children's] autobiographical memory gaps and their continued reliance on dissociation make it very hard for

these patients to reconstruct a precise account of both their past and current reality" (van der Kolk, 1996c, p. 283). The impact for the client and therapist of working with these noncontextualized, yet-often palpable memories is discussed more fully below.

In addition to relying on dissociation, the child develops what Herman (1997) referred to as "a double self." A young girl may assume that she caused the abuse because she is bad; she

> seizes upon this explanation early and clings to it tenaciously, for it enables her to preserve a sense of meaning, hope and power. If she is bad, then her parents are good. If she is bad, then she can try to be good. (Herman, 1997, p. 103)

This also helps maintain the familial status quo: She will sacrifice herself to maintain the family illusion that nothing is happening and nothing is wrong. This adaptive behavior reflects the child's overarching need for the parental relationship. The child's need for a connection to her parent, however tenuous or illusory, compels her to subvert or destroy her fledgling sense of self.

Herman (1997) described how internalizing the "bad" leads the child to incorporate aspects of the abuser into herself: "The profound sense of inner badness becomes the core around which the child's identity is formed" (p. 105). Furthermore, this internalization is masked by the child's continual efforts to be good. Even when the child succeeds, she may perceive her "performing self as inauthentic and false. [And that] the appreciation of others simply confirms her conviction that no one can truly know her and that, if her secret and true self were recognized, she would be shunned and reviled" (Herman, 1997, p. 105). If the child maintains a positive identity, it often involves "extreme self-sacrifice," as the child constructs contradictory identities: "a debased and an exalted self" that cannot be integrated (Herman, 1997, p. 106). Unfortunately, the victim's sense of self remains "rigid, exaggerated and split" (Herman, 1997, p. 106).

Kalsched (1996) explored the inner world of trauma from a Jungian perspective. He discussed these disparate selves in terms of daimons and looked to the development of an internal structure as a self-care system designed to prevent the murder of the personal spirit. He wrote, "Instead of the mind being used to make meaning out of sensate experience, the mind imposes the meaning it has made in the initial traumatic situation" (Kalsched, 1996,

p. 63). He likened the self-care system to the body's immune system and argued that

> Just as that system can be tricked into attacking the very life it's trying to protect (auto-immune disease), so the self-care system can turn into a self-destruct system, which turns the inner world into a nightmare of persecution and self-attack. (Kalsched, 1996, p. 24)

In Kalsched's (1996) model, the internal figure acts as protector and persecutor:

> Once the trauma defense is organized, all relations with the outside world are "screened" by the self-care system. What was intended to be a defense against further trauma becomes a major resistance to all unguarded spontaneous expressions of the self in the world. (p. 4)

According to Kalsched, at the time of the trauma, there is a regression that holds the memories and maintains the innocent spirit of the child and a progression—a part that grows up very fast, takes residence in the mind, and identifies with the father. Thus, the duality of the self-care system rests with a caretaking self that is chronically distrustful of all intimate or loving impulses and the childlike part that longs to reach out and connect. Kalsched (2000) discussed the mythological quality in the abuse of children who are preverbal at the time of trauma. He said the child has a porous ego structure that is open to the transpersonal side—the side of angels and demons and an intermediate level of daimons. The protected child part of the self lives in this mythic world, protected by a daimon infused with positive and negative omnipotent powers. Consequently, the child's two selves—the vulnerable innocent and the tyrannical protector—live side by side. Thus, "the child lives like a hydroponic plant—in an inner sanctuary in which (she) loses ability to root in real soil" (Kalsched, 2000).

Kalsched (1996) divided the trauma into the "outer traumatic event and the *psychological factor*. Outer trauma alone doesn't split the psyche. *An inner psychological agency—occasioned by the trauma—does the splitting*" (p. 14). Atwood and Stolorow (1999), Herman (1997), and Kalsched (1996) agreed that the internal reaction to split dissociatively is defensive in nature; therefore, it arises out of the choice to survive. This is not to suggest that the developing mind makes the decision consciously but, rather, the mind, or the "inner psychological agency," inherently builds a life-

sustaining edifice: a partition, wall, or cave that keeps out that which cannot be integrated. This belief further holds that at a later and safer time, the mind can also choose to raze these constructs.

A "TYPICAL SURVIVOR"

Every female incest victim has distinctive scars. No clearly observable set of traits is displayed by all incest survivors. Survivors are African American, Asian, Caucasian, Latina, and Native American. They are timid, outgoing, beautiful, plain, thin, and overweight. Their parents may be millionaires or receive public assistance. And the impact of environmental factors such as positive role models, educational opportunities, and inherent resiliency cannot be underestimated regarding their life outcomes. However, there is agreement regarding a general constellation of characteristics shared by adult survivors of childhood sexual abuse. This article does not provide a full scope of the symptoms and effects of the trauma, but presents a brief overview of the traits of a "typical" survivor.

Many survivors reach adulthood with their secrets intact, because their coping mechanisms and adaptations allowed them to survive childhood and maintain an appearance of normalcy. Herman (1997) outlined three adaptive techniques that bolster the child into adulthood: the elaboration of dissociative defenses, the development of a fragmented identity, and the pathological regulation of emotional states. She wrote that "the preservation of normality requires tremendous effort and often in the third or fourth decade of life, the defensive structure may begin to break down. The façade can no longer hold, and the underlying fragmentation becomes manifest" (Herman, 1997, p. 114). Fear and anxiety may often accompany the surfacing fragmentation as the survivor loses the assumed safety of appearances.

Chronic anxiety, panic attacks, depression, and substance abuse are common affective states powerfully underscored by a distorted sense of self. Bass and Davis (1994) wrote about a constant feeling of worthlessness that haunts many survivors. There is "a nagging voice that tells you you didn't do enough, you didn't do it right" (Bass & Davis, 1994, p. 188). One woman wrote, "Survivors are programmed to self destruct. You learned to put yourself down so effectively, that the abusers don't even have to be around anymore.

They can go off and play golf while you do yourself in" (Bass & Davis, 1994, p. 189). This "doing yourself in" can take a variety of forms from a berating internal monologue consisting of phrases such as, "I hate myself" and "I can't do it" (Bass & Davis, 1994, p. 191), to eating disorders and self-mutilation. Anorexia and bulimia may provide the individual a sense of mastery or control otherwise denied of her body. Furthermore, "anorexia may [be] an alternative way to not be sexual or sexually attractive by reversing secondary sexual characteristics" (Courtois, 1988, p. 98). Similarly, deliberate weight gain may serve to make oneself sexually unappealing. Self-mutilation, like eating disorders, can yield a sense of control of one's body and a means for coping with overwhelming emotions.[3] These disorders allow survivors to reconnect with themselves, to feel *something*. Herman (1997) quoted one survivor, "I do it to prove I exist" (p. 109). Not surprisingly, survivors tend to use and/or abuse drugs and alcohol to escape, numb, or stave off the pain. They may also experience persistent suicide ideation, and tragically, some will commit suicide.

In the book, *Splintered Reflections, Images of the Body in Trauma*, Armsworth et al. (1999) explored the physical manifestations of childhood trauma. They discussed Anzieu's concept of a "skin ego,"

> a psychic structure providing containment and enabling definition and protection of psychic functions. In the absences of containment, disturbances in reality functioning related to "what is inside me" versus "what is outside me" develop, setting the stage for projective identification and identity disturbances. (Armsworth et al., 1999, p. 140)

The authors cited Atwood and Stolorow's emphasis on the extreme states of disconnection that may arise from the failure to achieve indwelling:

> [It] leav(es) individuals vulnerable to states of depersonalization, mind-body disintegration or disidentification with the body. With specific reference to childhood sexual abuse, they believe that "separation between mind and body may serve as a form of defensive disidentification ensuring psychic survival in the face of unbearable conflicts and bodily experiences." (Armsworth et al., 1999, p. 140)

Survivors are plagued by intrusive flashbacks (nonpsychotic episodes in which the person relives the abuse), nightmares, night

tremors, heightened startle responses, and nonepileptic seizures. They also tend to repeat the trauma through life choices. One survivor wrote, "Repetition is the muted language of the abused child" (Herman, 1997, p. 110). This can take the form of revictimization in the choices of lovers, significant others, and/or in their choice of work environment.

The survivor's ability to form and maintain intimate relationships is greatly compromised. Davies and Frawley (1994) described the survivor's

> painstakingly constructed public persona that is superficially friendly, vibrant and efficacious [yet it] is experienced as inauthentic and extraordinarily fragile. Just below the surface of this often impressively functioning veneer, the trauma survivor is trapped in an inner world of fragmentation, dissociation, terror and rage. Often frightened that others will discover the hidden truths about them, trauma survivors . . . remain essentially disconnected from others. (p. 33)

The ramifications of the trauma—the lack of a secure base, the psychic split that exiles the wounded parts of herself, the creation of an insubstantial false self, the negative introjection of the perpetrator, and the permeation of shame and guilt into core aspects of herself—combine to form a seemingly impenetrable and often undecipherable wall between the survivor and her significant others. This compromised ability to trust and engage with others yields the fertile, challenging ground for therapeutic work. Herman (1997) wrote,

> The survivor is left with fundamental problems in basic trust, autonomy and initiative. She approaches the tasks of early adulthood—establishing independence and intimacy—burdened by major impairments in self-care, in cognition and memory, in identity and in the capacity to form stable relationships. (p. 110)

Putnam (1997) found that "therapy with maltreated individuals is always concerned with trust and never moves very far from this basic issue" (p. 281). In saying that "the most powerful influence in overcoming the impact of psychological trauma seems to be the availability of a caregiver who can be blindly trusted when one's own resources are inadequate" (1996, p. 32), van der Kolk and McFarlane implied that the therapist serves as a means for the

adult to experience the early sense of affect attunement and an intersubjective connection denied to the young, traumatized self.

This issue of trust, combined with the obstinate internal adaptive structures created to ensure the child's survival, leads to an array of resistances. Wrote Kalsched (1996), the "resistance thrown up by the self-care system in the treatment of trauma victims is legendary" (p. 4). The resistances are active and therefore can be met and worked with, yet caution and respect must be exercised by the therapist as the resistances have long protected the abused child.

HOW EXISTENTIAL THERAPY WORKS WELL WITH SURVIVORS

Existential therapy emphasizes human potential and growth. It recognizes the freedom and will of an individual to create her life and take responsibility for her individual path. This orientation demands the presence and authenticity of the therapist as a gateway for the client to uncover her sense of self. van Deurzen-Smith (1997) wrote that the goal of existential therapy is to "help people uncover the everyday mysteries in which they are enfolded and in which they may have become entangled" (p. 177). Bugental (1976) asserted that "psychotherapy [is] an evocation: a calling forth—of the life that is stifled within us, of the inner sensitivity we have learned to suppress, of the possibilities for being which we far too seldom bring into actuality" (p. 9). Existential therapy is designed to "help the patient achieve his most authentic personhood" (Bugental, 1981, p. 72).

Existentialists see individuals struggling with four main concerns in the pursuit of an authentic life, freedom, isolation, meaningless, and death (Yalom, 1980), and survivors of childhood sexual abuse face them in an unusually stark and pervasive manner. They have often lived in a world characterized by isolation and fear. As children, their very existence was overtly or covertly threatened, their sense of freedom was limited by a world constricted by lies, and their search for meaning was impaired by a disconnection from their own truth. Schneider and May (1995, p. 171) believed that meaning comes from intentionality or inward realization. The survivor organizes her life denying this sense of inward realization thereby robbing her life of meaning.

The survivor's childhood experience demanded that she create her own reality to survive, yet this reality becomes irrelevant and harmful in her adult life. And it is precisely this point that makes an existential approach a compelling fit with childhood sexual abuse issues. Yalom (1980) explained that existentialism views a person "as a consciousness who participates in the construction of reality" (p. 23). The survivor's inability to participate fully in her internal and external world drives much of her behavior. Thus, existential work can help the survivor acknowledge and embrace her autonomy by allowing her to reconnect with her inner knowing and begin to trust her perceptions of the world.

Presence and authenticity are cornerstones of existential work. According to Bugental (1987), presence is the "quality of being in a situation or relationship in which one intends at a deep level to participate as fully as she is able" (p. 27). Schneider and May (1995) viewed presence in terms of the "pause [that] calls forth continuous unrealized possibilities; it is in the pause . . . that people learn to listen to silence" (p. 153). Presence has also been defined as dasein, which literally means to "be there" (Schneider & May, 1995, p. 153). This fully being with the client creates "an attitude of palpable attention" (Schneider & May, 1995, p. 154), which in time will allow the client to experience herself and her relationship to another in a radically different manner.

Presence has two interwoven, yet distinct features: accessibility and expressiveness. Accessibility calls for the intentionality of the therapist that the exchanges between client and therapist matter, and in this vitality, each will open to the other's influence (Bugental, 1987). Expressiveness seems to demand a certain transparency: The therapist intends "to let oneself be truly known by the other" (Bugental, 1987, p. 27). Presence requires the courage to show up fully and undefended and to willingly seek to enter into the world of another and share the space in between. In Buber's (1996) words, "meaning is to be found, neither in one partner nor the other, nor in both together, but only in their dialogue itself, in this 'between' which they live together" (p. 75). van Deurzen-Smith (1997) maintained that this in-between place is formed when the therapist "moves towards the other with the explicit intention of cooperation. When I do not rob you of your space and you do not rob me of mine, space between us is created and in this we can generate inter-action" (p. 225). As therapists, she continued, "we must create a space and time where it is clear that we put our cards on the table

in order to play with what we have got, rather than in order to observe, judge and attack" (van Deurzen-Smith, 1997, p. 225). Such encounters may be completely unfamiliar to the survivor and potentially unnerving or frightening. Openness and vulnerability in her world may have become synonymous with the threat or actuality of harm. Thus, therapists must exercise caution and patience as they seek to cultivate and encourage these qualities, as the client successfully navigated childhood by not participating fully in life.

Authenticity, "a way of being in the world in which one's being is in harmony with the being of the world itself" (Bugental, 1981, p. 33), is a vital component of existential work and equally vital to survivors whose early internal and external worlds were dominated by disharmony. Authenticity extends to the client, the therapist, and the therapeutic relationship, for "the process of building the therapeutic relationship is the therapy with trauma survivors" (Pearlman & Saakvitne, 1995, p. 16). Authenticity also calls for awareness regarding how one participates in life. This emphasis on awareness has important implications for survivors, as their world arose out of their intentioned, although unconscious, blindness. According to Bugental (1981), awareness is characterized by four main qualities: (a) finiteness: the acceptance of the limitations of our awareness; (b) the potential to act, or our responsibility to our life; (c) choice and the recognition of our autonomy; and (d) separateness: the awareness that we are "separate yet related to others" (p. 57). Bugental cleverly referred to our "a-part-ness" (1981, p. 39) to capture this duality. Authenticity arises from the weaving together of these aspects thereby enabling the individual to stand in her truth and embrace the richness of life.

Trust is an essential component of the therapeutic relationship through which clients can experience a sense of spaciousness and freedom regarding their deeply held, often erroneous beliefs. Bugental (1978) wrote,

> The humanistic stance is that when human beings are given trust, when they are helped to confront all of their feelings and impulses in an atmosphere that is not judgmental, and when they have an opportunity to weigh alternatives without premature pressure to act, then and only then, can human beings be relieved of the age-old fear of their own nature and begin to live as whole persons, and then and only then, will they work out ways to heighten the synergy in which they live with their fellows. (p. 71)

This gift of trust, the trust of another and of herself, is priceless for survivor clients.

Existential therapists strive to enter the private world of the client rather than focus on the manner in which the patient has deviated from the "norms" (Boss, 1963; Bugental, 1978; Yalom, 1980). They assist in validating the woman's experience and allow her to begin to feel a connection to herself and to another. However, these challenges to her sense of being in the world may not be well received. She survived the horrors of her childhood by relying on this way of being, so loosening these defensive structures will not come easily. The client's resistance to change will likely challenge the presence and authenticity of the therapist. Given the client's hyper-attentiveness to the therapist's way of being, any inauthenticity may be detected, and if it endures, it may threaten the success of therapy. If the therapist is able to remain solidly present and open in the face of the client's resistances and transference, he or she serves as an anchor thus grounding and calming the client.

Therapeutic Tools

Several tools can assist in the deepening of the relationship between client and therapist. The first is what Bugental (1981) called "awaring" or heightening one's inner knowing; he also called it "coming home" to one's true self (p. 219). This is a poignant concept regarding the survivor population, as the client has likely spent most of her life guarding against this. To achieve a sense of coming home, individuals must reveal and face the silenced, abandoned parts of their young, traumatized selves. Bugental (1999) further explained,

> (a)waring is a range of subjective experiencing. From minimal chiefly bodily awareness—which may not be fully conscious—to highly focused, intense perception, awaring of some order is present whenever there is life. . . . Consciousness is a characteristic of a limited span of the total range of awaring. . . . What affects consciousness affects awareness and thus affects the life of the conscious being. It follows that consciousness is continually evolving and irreversible experiencing. (pp. 50-51)

A dynamic, changing consciousness may help shift the survivor's sense of herself and allow her to begin experiencing herself as malleable rather than rigidly hemmed in by defensive structures. Ac-

cepting this sense of internal movement may encourage her to embrace life as a continually evolving process.

Bugental (1976) also stated that

> Each of us has an inner sense . . . but that far too often we have not learned to value and use that vital element of our being. As a result, we are lost in a desert of objectification without the guiding star of our own identity to give us a true course to fulfillment. (p. 292)

The survivor client has been without a guiding star for most of her life, as her childhood was traumatized by deception, terror, and isolation. As the therapist and client work together to identify the layers of abuse and understand their import, the client's inner light can begin to shine and guide her along a more connected, authentic path.

Phenomenologists offer the concept of bracketing or epoché. Spinelli (1989) wrote that epoché

> urges us to set aside our initial biases and prejudices of things, to suspend our expectations and assumptions, in short, to bracket all such temporarily and as far as is possible so that we can focus on the primary data of our experience. (p. 17)

A more authentic encounter arises when the therapist focuses on the awareness of his or her experience of the client in the room, as the client is then being seen for herself rather than through the therapist's projections. Wegela (1996) described this notion as a "touch and go," allowing sensations and thoughts to surface and fall away without judgment.

Spinelli (1997) explored the "un-knowing," or the attempt to view "the seemingly familiar as novel, unfixed in meaning, accessible to previously unexamined possibilities" (p. 8). This concept implies that

> the therapist's willingness to explore the world of the client in a fashion that seeks not only to remain accessible to, and respectful of, the client's unique way of being in the world, but also to be receptive to the challenges of the therapist's own biases and assumptions that this exploration may take. (p. 8)

This idea is similar to what Suzuki (1998) called beginner's mind: an empty mind, "free of the habits of the expert, ready to accept, to doubt, and open to all the possibilities" (p. 14). Both epoché and un-

knowing invite therapists to be authentically who they are without trying to repress their notions about the client.

Epoché allows the therapist to acknowledge his or her biases/fears/assumptions and set them aside. Survivors have spent their lives not being seen, and the therapist who can accept and release his or her own feelings and issues about incest can openly invite the survivor to share her isolated world of pain. This also holds true for the therapist's reaction and/or biases about the "truly spectacular array of self-damaging behaviors" of the survivor (Davies & Frawley, 1994, p. 34).

Focusing is another tool available to the existential therapist. In the 1960s, Gendlin (1978) and others sought to understand why therapy worked for some people yet failed for others. They discovered that the key aspect of successful therapies lay not in the technique but in the clients' internal growth. To increase internal awareness, Gendlin developed the technique of focusing, defined as "a process in which you make contact with a special kind of internal bodily awareness. This awareness [is called] a *felt sense*" (1978, p. 4). It is further defined as "an internal aura that encompasses everything you feel and know about the given subject at a given time—encompasses it and communicates it to you all at once, rather than detail by detail" (Gendlin, 1978, p. 33). He wrote, "Nobody can figure it out, intellectually, all the details of a personal problem. No therapist can. You can't—neither for yourself or someone else. The details are in your body. The way to find them is through focusing" (Gendlin, 1978, p. 39).

Gendlin (1978) outlined six steps to hone this skill: (a) clearing a space: allowing space between you and that sense of "what's going on"; (b) felt sense: embracing the unclear sense of all of that; (c) finding a handle: let a word, phrase, or an image come up from the felt sense itself—such as tight, sticky, scary—and stay with the quality of the felt sense until something feels just right; (d) resonating: vacillate between the felt sense and the word and see if they resonate; (e) asking yourself questions like, "What is it about this whole problem that makes this quality?" "What is this sense?" and then being with the felt sense until something comes along with a shift, a slight "give" or release; and (f) receiving: let yourself receive whatever comes with a shift in a friendly way (pp. 43-64).

Focusing can be an effective technique for contradicting the survivor's lack of internal awareness. Working with survivors involves allowing or teaching her to find and trust her internal guide. How-

ever, because her body holds the memory of abuse, she may be ambivalent about "listening" to her body, as the sense of pain from the past may emerge and feel overwhelming. Patience and respect are crucial in the therapist's efforts to rekindle the survivor's internal awareness.

Resistance

The adult survivor lives in a distorted world with a fragmented sense of self originally formed in response to the chronic threat of harm. The terror she experienced consciously or unconsciously as a child still governs much of her adult life. Bugental (1981) likened an individual's characteristic distortions to resistances; they are constructs designed to keep away that which feels overwhelming. He cited Hora's use of the words *inventions* or *assumptions* to describe these inauthentic ways of being developed in response to a fictional world unconsciously created by the client. Thus, resistances represent the client's inauthentic relation to herself and her world. Yet, as Bugental stressed, resistances are a creative response to a real or perceived threat to the individual's existence. He wrote, "Every resistance is a compromise with the giveness of experience, in which the patient has sought to preserve as much as he could of what was authentic in himself and his experience" (1981, p. 102). Resistances are life sustaining and life destroying; in childhood, they framed the survivor's safety, and in adulthood, they frame her prison.

Working through resistances is critical for genuine growth (Bugental, 1978, p. 7). One way to work with them is to tag them, simply noting when they arise. As the therapeutic alliance strengthens, the therapist may begin to push against the function and effect of the resistance. Schneider and May (1995) discussed working with resistances as akin to holding a mirror up to the client to help her see the world she created. They wrote, "It helps clients hit bottom in their lives and then mobilize their commitment to change" (Schneider & May, 1995, p. 168). Inviting clients to "hit bottom" can be risky, especially with survivor clients who may have a history of suicide ideation, impulsivity, or rely on self-harm for self-regulation. A strong therapeutic alliance and confidence in the client's commitment to the work must be established before escorting the client into potentially perilous waters. Dismantling the resistances of a survivor must not be rushed, as the therapist is

essentially asking the client to stand before him or her undefended for perhaps the first time in her life. Consciously or unconsciously, when the client feels frightened, uncertain, or threatened, resistances will surface to slow down the therapeutic process. Resistances exist in the therapy room as they do in the client's everyday life, and consequently, they help the therapist to understand what is most "alive" and terrifying for the client. Bugental (1981) wrote that "resistance is anti-authenticity" (p. 103), yet in the therapy office, resistances and transference provide the therapist with both insight into how the client functions and a visceral sense of her childhood reality.

Transference and Countertransference

One of the most powerful and provocative resistances is transference. Bugental (1981) defined transference as "a patterned way of being in the world that involve(s) a significant other and that is reactivated in the patient's relation to the therapist" (p. 138). He explained that "transference is not just the patient's way of perceiving and responding to the therapist. It is an evocation of the sub-self of the patient that has been symbiotically related to the earlier figure" (Bugental, 1981, p. 138). Transference offers a live demonstration of the internal, unconscious workings and experiences of the client by providing the therapist with a "felt sense" about how the client functions in relation to significant others. It is a critical part of the therapeutic relationship, signaling a sufficient level of trust or engagement on behalf of the client with the therapist in that the therapist is seen as or is confused with important individuals from the woman's past. Through transference, especially in the early stages of treatment, the client indicates a willingness to work on a deeper, less conscious level.

Spinelli (1989) stated that the transference relationship also signifies the "analysand's acceptance that no revelation will threaten the analytic relationship and by implication, the analysand's sense of being" (p. 169). Transference is a protective mechanism; according to Bugental (1981), it is a way of relating to the therapist to constrain the "contingency-emitting potential the therapist is seen as having" (p. 137). It is a means of control, albeit unconscious. The suggestion that it represents full acceptance by the client regarding the stability and sustainability of the relationship and her sense of self seems optimistic, particularly for the sur-

vivor population. Yet it is important to hold the transference in the context of the progression of the therapeutic alliance.

Spinelli (1989) also noted that clients may be "testing" the therapists' unconditional positive regard and authenticity. In one sense, testing is a process of elimination that allows the client to unconsciously discover the therapist's authentic self. For example, if the client regards the therapist as her father, she may attribute a set of behavioral expectations to the therapist. Through repetition, the therapist is able to distinguish himself or herself from that projection by acting differently. These corrective emotional exchanges allow the client to build trust and appreciate the power of the transference. The therapist's true nature is obscured by the transference, and the therapeutic relationship is clouded by the shadow of a past, abusive relationship. Hence, the work is to highlight and clear away that which interferes with a full engagement. Bugental (1981) stated, it "requires repeated exposure and working through for dissolution" (p. 139).

van Deurzen-Smith (1997) defined countertransference as the therapist's bias. She wrote, "If we are simply willing to recognize that our work is inevitably selective and distorted by our own biases and perspective on the world, we can usefully begin to make some distinctions between different levels of distortions" (van Deurzen-Smith, 1997, p. 219). Mirroring Spinelli's (1989) notion of epoché, this concept frees the therapist from "the attractive but illusionary notion that we could ever take a neutral stance towards any client" (van Deurzen-Smith, 1997, p. 219). She acknowledged the influence of the therapist's attitude, theoretical orientation, state of mind, and reaction. The challenge, she said, "is to distinguish what is part of our response and what is generated by the client" (van Deurzen-Smith, 1997, p. 219). van Deurzen-Smith also expanded the notion of transference to include the client's attitude, orientation, state of mind, and reaction. She then focused on the importance of the space created between the therapist and client. She wisely noted that "the message we try to convey never fully reaches its destination and is translated into compatible language by the other" (van Deurzen-Smith, 1997, p. 225). Thus, the work of therapy is to reach an acceptable level of communication to allow the two subjective forces to optimally understand each other and relate. This endeavor is facilitated by the existential therapist's willingness to be present with his or her internal experience and open to experiencing the world of the client.

Trauma adds another layer of complexity to the transference/countertransference. According to Herman (1997), "Trauma is contagious" (p. 140). The therapist is asked to bear witness to a crime and can become "emotionally overwhelmed. To a lesser degree, she experiences the same terror, rage and despair as the patient" (Herman, 1997, p. 140). As a witness, "she is caught in a conflict between victim and perpetrator. She comes to identify not only with the feelings of the victim, but also with those of the perpetuator" (Herman, 1997, p. 144); as a witness, the therapist "must affirm a position of solidarity with the victim" (Herman, 1997, p. 135). The role is enhanced by a common desire of the therapist to rescue the client or take on excessive responsibility for the client's life. The therapist may further be called upon to hold the emotions the client is unable to bear: pain, grief, rage, and shame (Pearlman & Saakvitne, 1995). The client may actually be unaware of these emotions, and the therapist may tap into her own reactions to help elucidate the client's internal experiences. Care must be taken to avoid being suggestive and provide an avenue for the client to become more connected to her own emotional states.

Much has been written about trauma transference (Courtois, 1988; Davies & Frawley, 1994; Herman, 1997; Lister, 1982; Pearlman & Saakvitne, 1995), the client's "emotional responses to any person in a position of authority have been deformed by the experience of terror. For this reason, traumatic transference reactions have intense, life or death quality unparalleled in ordinary therapeutic experience" (Herman, 1997, p. 136). Lister (1982) explained its uniquely provocative nature:

> [It cannot] be understood as solely a dyadic transference phenomenon. The terror is as though the patient and therapist convene in the presence of yet another person. The third image is the victimizer who demanded silence and whose command is now being broken. (p. 875)

The survivor client may look to her therapist as the "omnipotent rescuer" and/or view her with relentless suspicion and doubt. Herman (1997) noted the survivor client's "exquisite attunement to unconscious and nonverbal communication" (p. 139). This can understandably lead the therapist to feel like he or she is under the glare of an interrogation lamp with his or her every move, phrasing, or gesture scrutinized for potential betrayal. "Whereas in

other therapeutic relationships some degree of trust may be presumed from the outset, this presumption is never warranted in the treatment of traumatized patients" (Herman, 1997, p. 138). This raises the issue of testing, as the client needs continual reinforcement regarding the reliability, intentionality, and overall trustworthiness of the therapist. It is important to stress that the therapeutic relationship may be the woman's first experience in trusting another person thereby fueling the palpability of the life-and-death nature of the client's traumatic transference. Her cries as a child went unheeded, and she subsequently constructed a way of being in a world that would not answer her cries. In reaching out to her therapist, she is challenging this supposition. Repeated failure to connect in the therapy sessions, for whatever reason, may feel like confirmation that the world does not care and that she is ultimately alone. However, if the therapist and client have a sufficiently strong alliance, they can examine the actions and reactions driven by the habituated stance of distrust.

Kalsched (1996) cautioned therapists against reproaching the client for her transference resistances:

> To hold patients responsible for this resistance is a terrible mistake, not just technically but structurally and psycho-dynamically as well. The patient is already feeling blamed for some nameless "badness" inside, so interpretations which emphasize the patient's "acting out" or avoidance of responsibility merely drive home the conviction of failure. In many respects, it is not "they," the patients, who resist the process at an ego level. Rather their psyches are battlegrounds on which the titanic forces of dissociation and integration are at war over the traumatized personal spirit. (p. 26)

The therapist may find himself or herself performing triage: tending to the various wounded parts of the client's psyche while allying more strongly with the healthier parts to ensure the client's physical and psychic survival.

Herman (1997) wrote about working with survivor clients suffering from complex PTSD. The therapist may experience "the inner confusion of the abused child in relation to the patient's symptoms" (Herman, 1997, p. 146). As noted above, the client may be unable to formulate memories in a sequential, narrative form and instead convey her experience in a free-form association that is intense yet somehow vaporous. This may prove challenging for

the therapist, as orientation within the client's explication may seem impossible. Herman also described how therapists may experience a "feeling of constant suspense" that "reflects the victim's constant state of dread in relation to the capricious, unpredictable perpetuator" (1997, p. 147). She continued, "The therapist's task is to identify the actors, using countertransference to understand the patient's world" (Herman, 1997, p. 147).

Hamburger (2000) referred to the "trauma triangle" in which the therapist and client alternate playing the roles of victim, perpetrator, and savior. These shifting roles reflect the inner world of the survivor, but their impact may be unsettling, particularly when the therapist is cast as the perpetrator. The roles require the therapist to maintain a strong sense of self and an ability to distinguish his or her reactions from the client's projections.

Pearlman and Saakvitne (1995) wrote about vicarious traumatization: the "cumulative transformative effect upon the trauma therapist with survivors of traumatic life events. [It] is the transformation in the inner experience of the therapist that comes about as a result of empathetic engagement with the client's traumatic material" (p. 31). This concept consists of two components: (a) vicarious traumatization is particular to trauma therapists and (b) the therapist's engagement is with the client's material, not the client. Focusing on this "inevitable" seduction by the horror of the material, rather than focusing on the resiliency and humanity of the client, would lead to a negative transformation of the therapist's sense of self. The existential emphasis on presence and the intersubjective field shared by two people may help combat the difficult, pervading impact of constant exposure to the client's traumatic life experiences. The therapist must be willing to "see" each client for who she is rather than for her life experiences. Given the evocative nature of sexual abuse, the therapist must be honest about his or her feelings and able to set them aside to courageously sit with another, witness, and experience her pain to some degree.

The transference/countertransference dynamic is an integral part of the therapeutic relationship with survivor clients. The intensity that accompanies the transference issues of the client may trigger reactions in the therapist. Yet, by embracing the basic existential tenets of psychotherapy and relying on presence and authenticity, the therapist and client can continuously examine and reexamine the forces at play with the goal of clearing the client's path home to herself.

CONCLUSION

"[A] great deal of distress which so many people experience may be traced in no small part to our living as exiles from our own homeland, the inner world of subjective experience" (Bugental, 1978, p. 124). Adult survivors of childhood sexual abuse banished themselves from their internal experience as a means to navigate their lives. The terror, isolation, confusion, and other emotions could not be tolerated by the developing psyche and were walled off to ensure the child's survival. The child further sealed away parts of herself in the hope of maintaining some connection, however illusory, to the parents who betrayed her.

The battleground of the psyche is drawn, as the exiled parts do not remain in silent isolation but raise their voices and demand to be heard. When the cacophony becomes intolerable, the survivor may seek therapy. The existential therapist focuses on being in the world and is inspired by a belief that people can choose and act with intentionality. By modeling how to listen and be with one's experiences and emotions, the therapist helps to mend the client's internal rift. Engaging fully with the client, the therapist enters her world and draws out the disparate aspects of the client's self. The presence and authenticity of the therapist helps to ground the client during the defensive storms that arise, as the client struggles to simultaneously shed and hold onto old ways of being. As their alliance strengthens and deepens, the client and therapist forge a relationship of trust and honesty—likely the first of its kind for the survivor client.

The existential approach to psychotherapy is effective with survivors because it emphasizes the internal capacities of the client. She is given the opportunity to tap into her own resources and find her way home to herself in the presence of a guide. The therapist/guide clears away the brambles, helps her when she stumbles, and, most importantly, accompanies her on the journey back from hell.

NOTES

1. A few notable books on male survivors include Lew (1990) and Hunter (1991).

2. In defining posttraumatic stress disorder for the *Diagnostic and Statistical Manual of Mental Disorders, 4th ed.* (*DSM-IV*; American Psychiatric Association, 1994), the committee sought a more comprehensive defini-

tion and proposed "Disorders of Extreme Stress Not Otherwise Specified (DESNOS)," which included a more complex bevy of symptoms. It was ultimately incorporated in the *DSM-IV* under the section "Associated Features and Disorders" (van der Kolk, 1996b, p. 203).

3. For an excellent discussion of self-injury in general, see Strong (1998).

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