Beyond Attachment: Psychotherapy with a Sexually Abused Teenager

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When children are abused they utilize strategies already in place to cope with stress. These strategies develop during early life within the family and may be part of the unconscious framework formed within attachments and relationships. The case presented illustrates a teen-aged girl who was the victim of sexual abuse and experienced depression, PTSD and substance abuse. This paper describes the psychodynamic psychotherapy used to examine the patient's coping skills, which predated the abuse, and how these coping mechanisms were used to ameliorate her symptoms.

KEYWORDS: psychodynamic psychotherapy; emotional conditioning; worldview violations; terror management

INTRODUCTION

All people develop ways of coping with life stressors beginning as children. These ways of coping can be overwhelmed by horrific events, which may lead to psychological symptoms. Yet, a child's life is underway, with some coping strategies in place, *before* a stressful event (or series of events) takes place. In this paper the first question asked is theoretical: What is it about our early lives that prepare us, for better or worse, for what comes after a period of abuse? The second question for exploration is: How does psychodynamic psychotherapy address pre-existing coping strategies? The third question: How does the psychotherapeutic exploration help the child heal?

Early coping strategies develop in the context of relationships. Attachment, beginning in infancy, forms the framework for later relationships with primary caregivers and others (Bowlby, 1969/1980). As portrayed by Fonagy and colleagues, attachment is key because it leads to the development of reflective functioning and mentalizing abilities (Fonagy, 2001; Fonagy, Gergely, Jurist and Target, 2002). One way in which trauma

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affects the self is by disturbing attachment and mentalization, resulting in psychopathological consequences. However, attachment theory alone does not suffice in explaining disruptions in development. We also know that some degree of role formation, personality development and emotional conditioning serve as filters and guides, and, if there is abuse, will contribute to how a child processes and attempts to cope with the abuse (Kernberg, Weiner, & Bardenstein, 2000; Homer Martin, MD, personal communication, 2006; Adams, 1994; Adams; 1996; Adams-Tucker & P. Adams, 1984). This paper examines two theories, Emotional Conditioning Theory and Terror Management and Worldview Violations Theory, which extend beyond attachment theory, and create and uphold these early coping strategies.

EMOTIONAL CONDITIONING THEORY

Emotional conditioning refers to the unconscious role (thought and behavior pattern) acquired early in a child's life, by age 3 years. Its origin derives from classical Pavlovian behavioral conditioning: one stimulus becomes associated with a second stimulus in a cueing fashion (Pavlov, 1927). It is a form of unconscious learning by association that results in conditioned responses that can be either physical or emotional in scope. The conditioned response is involuntary and occurs automatically when a stimulus is presented. Two events occur together and are automatically associated. No new behaviors are learned.

Subsequent to Pavlov, Burrhus F. Skinner, a behaviorist psychologist, created the theory of operant conditioning in which the individual performs an activity and is then rewarded for the activity by a reinforcer or reward. Operant conditioning thus increases the likelihood the activity will reoccur in the future. (Skinner, 1974) According to this theory the individual operates on his environment via reinforcement.

The Austrian ethologist, Konrad Lorenz, added to conditioning theory. He observed geese in naturalistic settings during early periods of development and offered a theory of imprinting. This theory concerned irreversible learning very early in development. Young birds raised with humans imprinted upon, or were conditioned to, people, instead of to other birds, as love objects (Lorenz, 1973). Classical, operant, and imprinted conditioning take place in animals and people in the same way. All three types of conditioning in humans begin as infant interactions with caregivers and serve to form early roles in relationships. Once conditioned, each person's set of responses to others remains relatively immutable and predictable throughout life unless psychotherapy is undertaken (Homer

Martin, M.D., personal communications, 1978, 1992, & 2006). Conditioning, being unconscious, cannot be forgotten.

Much has been written about skewed personality development ***from*** sexual abuse (Cohen, Mannarino and Deblinger, 2006; Pynoos and Nader, 1993). However, little is written about how early life conditioning experiences and early personality pathology form a template for later processing of sexual abuse trauma (C. Adams, 1994 & 1996; Adams-Tucker & P. Adams, 1984). Emotional conditioning theory encompasses this latter process. Dr. Homer Martin described two types of emotional conditioning, which he termed *"omnipotent"* and *"impotent."* (personal communications, 1978-2007). Both types of emotional conditioning are "acquired" by infants through an unconscious process from their caretakers or parents.

In omnipotent conditioning a person assumes responsibility for problems, whether real or imagined, of another person. The omnipotent child is highly responsible, dependable, rule-obeying, and desirous of pleasing or caring for others; he deals with problems on his own, and is a perfectionist. As a child his needs were minimally met by others. He was rewarded for precocity of thought and action. Parental actions confer, via projection, strength in his coping abilities. The omnipotent child becomes convinced of his invincibility.

Impotent conditioning creates a child who assumes little or no responsibility for himself, indulges in self-interest, and thwarts direction from others. As a child he was pampered and overindulged. Parental actions confer, via projection, his weakness and low-coping abilities. The impotent child is convinced of his own incompetence, and seeks out those with omnipotent conditioning to care for him throughout his life. Those with impotent conditioning act needy, confused, and unable to handle problems. Both impotent and omnipotent conditioning create relationships that are reflexive in nature, below any level of awareness, causing robotistic actions. Both roles are imbued with magical thinking.

TERROR MANAGEMENT AND WORLDVIEW VIOLATIONS THEORY

Application of the existential experimental social psychology theory of terror management is pertinent to trauma processing and recovery. This theory holds that individuals deal with the terror associated with the prospect of their death and overwhelming events via their "worldview" and capacity for self-esteem and its regulation (Greenberg, Koole and Pyszczynski, 2004; Horowitz, 1986; Pyszczynski, 2009). People become

anxious when threatened, and employ an anxiety buffer to defend against loss or disruption (Greenberg, Pyszczynski, Solomon, Pinel, Simon and Krista, 1993). The anxiety buffer disruption theory posits that a psychological break experienced with a traumatic encounter creates fear, helplessness, hyperarousal, and intrusive thinking, all of which are attempts to find meaning in the trauma events. These attempts to find meaning align with an individual's view of the world and its workings—including its order, meaning, and stability. Self-esteem is maintained by each person's belief of how he lives up to standards consistent with his worldview. Symptoms of PTSD occur when no meaning for the traumatic events can be found within the parameters of his worldview. The PTSD symptoms ensue when self-esteem plummets because there is a schism in the person's perception of his ability to live up to the standards within his worldview (Brewin and Holmes, 2003; Park, Mills and Edmonson, 2012).

The remainder of this paper is divided into four sections. The first presents the case of an adolescent girl who was sexually abused. The second section concerns the selection of psychodynamic psychotherapy in her treatment. In the third, I review the course of psychodynamic treatment. Lastly, we return to the two questions of interest: What prepares us early in life for traumatic events that occur later? And, how can psychodynamic psychotherapy use and alter this early preparation to ameliorate the suffering?

CASE HISTORY

History of Present Illness

Prior to my treatment of the patient, she was evaluated by another psychiatrist and referred for inpatient treatment. Mimi, a girl aged 14 years, 10-months, was brought by her parents to a psychiatrist for outpatient treatment of anxiety and depression. The psychiatrist evaluated Mimi once; based on the patient's symptoms of suicidality and depression, the psychiatrist referred Mimi to an inpatient unit where she was diagnosed with PTSD, depression, and alcohol abuse. The main trigger seemed to be sexual abuse.

Mimi's parents relayed that two weeks before the start of treatment Mimi confided in them that she had been abused. She first told a school friend of sexual abuse by a 42-year-old male cousin over a six-month period. She was reluctant to tell her parents and did so only after the school mate urged her. The abusive episodes began when Mimi worked part time in her cousin's trinket store. At first, Cousin Dave made sexual comments about Mimi's "fully-matured" body. Then he began dropping

trinkets down her blouse, fondling her breasts, and putting his mouth on them. He forced her to masturbate him and inserted his fingers into her vagina. Finally, he offered to pay her for sexual intercourse.

Mimi withdrew from family and friends and stopped going to school. She isolated herself in her bedroom, slept a great deal, had nightmares, and daily crying spells. She spoke little and had difficulty concentrating. She ate little, felt dazed much of the time, and drank alcohol (stealing from her parents' liquor cabinet) nights and weekends. Her academic grades fell from As to Ds and Fs. She removed the doors from her closet to feel more comfortable. Some three months after the onset of these symptoms, but before inpatient treatment, Mimi developed suicidal thoughts and had episodes of "catatonia" in which she was immobile and stared into space.

Mimi's hospital course was marked by challenges with the family. The referring psychiatrist at the hospital remarked that Mimi was quite ill and that it had been a constant struggle to keep her hospitalized for treatment. Mimi's father greatly minimized his daughter's distress and wanted her home to be "normal" again. He threatened to remove Mimi against medical advice almost daily. Mimi's mother had acquiesced to her husband's wishes on this. The parents could not understand the extent of their daughter's illness.

Testing Mimi underwent while an inpatient showed her IQ to be 120. While hospitalized, Mimi received an antidepressant medication and in individual, family and group therapies she began to talk about her molestation. Not much else is known regarding the inpatient treatment.

Personal History

Mimi was from a medium-sized city and lived with both parents and an older brother. She had no prior psychiatric treatment other than that already noted. She had no developmental delays as a baby or toddler. She was physically healthy. Her parents described her as a toddler as pleasing to others. At age three year she would get out clothes for her brother to wear and would pick up his toys. As she grew older, she did her brother's laundry, made phone calls to arrange rides for him, and cleaned his room. She performed any job her parents asked. She had few friends and only saw them in church; she read a lot or watched television, was never disobedient or mischievous and did not request to go on social outings with friends. In Mimi's early (and later) life, her mother was the primary caretaker. Her father was always present and interacted with Mimi, as did her maternal grandmother. There was no history of trauma. Mimi was a high-achieving student in a large co-ed parochial school.

Family History

Mimi's father, George, was a large, burly man who was a supervisor at a paint manufacturing company. He was 45 years old and had a high school education. He spoke in a loud voice that commanded attention. He was direct with others. His father, a railroad laborer, was by contrast, soft-spoken and quiet in his demeanor. His mother, a housewife and mother to five children, was harsh and no-nonsense in maintaining order in the household. George had no history of emotional problems or treatment.

Mimi's father noticed no problems in Mimi's functioning in early childhood. He indicated she was a bit of a tomboy, a very good student, and participated in many school activities. He wanted Mimi to attend college. He observed Mimi never balked at chores and did what was requested of her from an early age.

During parental sessions held prior to meeting Mimi, I observed George to be imperious, not only in how he talked about Mimi, but also in his actions toward Mimi's mother. He talked for her and over her and assumed he spoke for her without ever asking her point of view. During our first session he announced that he had filed a civil suit against his daughter's molester. I thought this indicated insensitivity to his daughter's emotional state since the law allowed him several years into the future in which he might file this suit.

Mimi's mother, Joan, was a very slender, tall, 39-year-old woman with short blonde hair and large eyes. She was a housewife with a high school education and participated in volunteer work at her church. Her primary job was homemaking for the two children and her husband. She had a close relationship with her own mother. Joan's mother (Mimi's grandmother) had been an alcoholic and was a victim of domestic violence at the hands of her first husband (Mimi's grandfather). As a youngster Joan strived to please her own mother by doing extra chores and by taking care of her four siblings, both younger and older. When she was seven years old Joan's father died and her mother remarried when she was nine years old. She said her stepfather was a much kinder man than her biological father. Joan had no history of emotional problems or treatment.

Joan acquiesced to her husband's loud voice and commandeering style. She immediately became quiet and automatically deferred her point of view in favor of his. In the preliminary parental sessions she did not offer anything new or different from what her husband said.

Initial Evaluation Sessions

Almost two weeks elapsed between the termination of inpatient treatment and commencement of outpatient treatment. This was because Mimi's parents insisted on a family vacation, which was planned at her father's behest with no regard for Mimi's fragile emotional state and need for ongoing treatment.

When she presented at my office, I noted that Mimi was a pubertal girl of average height. Her build was slender and she had long brown hair to the middle of her back. She wore jeans, a tee shirt, and makeup. She was quiet, withdrawn and inhibited, talking little at first. She sat in a large armchair with downcast gaze for a long time, playing with her hair and barefoot toes. When she did speak, she said she took three of her antidepressant tablets instead of the prescribed two. She said two pills made her feel angry at everyone. Three pills covered up her feelings. She elaborated: She did this because her father was upset about her crying and not talking to or engaging with the family. She said he was also angry at her repetitively squeezing grapes and going barefoot. She felt her parents and brother wanted her to be her "old" self and she was unable to do it. The family vacation had been dull, she said, because her brother complained all the time. Her anger was admixed with despondency and crying. However, her affect and mood brightened slightly over the course of our first session.

At the second evaluation session Mimi engaged quickly and talked about her anger with everyone, including some mild anger at her cousin Dave. There was less crying and withdrawal and better eye contact. She sat upright in her chair. She said she had been throwing pillows in her room and refused to talk with her family. She said her parents wanted her to bottle up her anger. Although she said she was unsure, she tentatively offered it might be better to talk out her anger than hold it in. Mimi was especially upset because Joan alleged that Mimi's anger at her was a sign Mimi no longer wanted to live with the family. In a conjoint session with her mother (at the end of the second evaluation session), Mimi told her mother she wanted to continue treatment with me and continue to vent her feelings so that she would not be so depressed. After the first session, the dosage of Mimi's antidepressant was set at three pills per day, and Mimi asked if the antidepressant medication could be reduced to two pills instead of the prescribed three pills.

Prior to the third session Mimi's father telephoned me. He was angry because Mimi had been crying all day. He was also angry with me because I had not increased the dosage of her medication. He alleged that holding

the medications at the same dosage communicated to Mimi that it was fine for her to be upset all day. He was distraught about what was happening to his daughter and wondered when it would end.

In the third evaluation session Mimi said she had been crying a lot because she was frustrated with her mother and brother. She appeared calmer, more engaged and talkative this session. We discussed her treatment and how we would proceed. Without hesitation she said she wanted to talk about all her feelings and not hold them in. Further, she wanted her medicines decreased. She was agreeable to working with her parents in family therapy. We decided on twice weekly sessions. Her parents concurred with this plan.

Why Psychodynamic Psychotherapy?

Psychodynamic psychotherapy following trauma seeks to return the individual child to a healthy state. Its focus is not so much symptom alleviation but the maintenance of healthy development and personality formation (Lieberman, Ippen, & Marans, 2009: Pynoos, Steinberg, & Piancentini, 1999; Roth & Fonagy, 2005). If the individual child never had a prior healthy state, all the more reason for psychodynamic psychotherapy to correct prior maladaptive patterns and promote better future functioning.

Gabbard (2005) writes that in order to undergo psychodynamic psychotherapy, patients should be able to regress, to tolerate frustration, to have intact reality testing, to be able to introspect and make use of insights, to form a good therapeutic relationship, to have solid object relations, to have a good observing ego and to lack prior traumas. Yet, what of such therapy with children who have been trauma victims? Many authors find psychodynamic psychotherapy useful for them (Adams-Tucker and Adams, 1984; Schottenbauer, Glass, Arnkoff and Gray, 2008; Terr, 1990). Family therapy in conjunction helps (Lieberman et. al., 2009).

What made Mimi a good candidate for psychodynamic psychotherapy? After overcoming her initial reluctance, she was able to talk through her feelings and abreact. Also, early on she was insightful about the connection between vocalizing feelings and reduction of symptoms. Her reality testing was intact. Based on the early childhood history taken, she did not appear to have attachment issues. She demonstrated that she was able to attach to an adult in an appropriate way, maintaining boundaries while demonstrating trust, and negotiating a space for herself in the relationship. She had no other history of trauma. She appeared willing to be assertive with her own thoughts, even over the objections of her parents, and to make changes in

herself. And, she appeared able to utilize me and the therapy sessions by raising questions and then by being introspective to gain understanding and answers.

The Psychotherapy

Treatment involved twice weekly sessions of fifty minutes for one-and-a-half years, a total of 111 sessions. Individual treatment predominated, with weekly family therapy sessions, usually with Mimi's mother.

Mimi continued to be increasingly vocal in her therapy, compared with the first time we met. Although inhibited and speaking in a low voice, twirling the ends of her hair and playing with her toes, her focus was on anger at her family for not wanting to hear her anger or her opinions about the molestation. They ignored her or told her directly to stop talking about Cousin Dave. She wanted to decrease and then discontinue her antidepressant medication because she associated it with covering up her true feelings. She observed that more talk led to feeling less depressed. In addition to talking, she wanted to yell, cry, throw pillows, and ignore her brother who was very demanding of her. She continued to sneak alcohol from her parent's liquor cabinet about four times a week to numb her feelings about the family's messages to her and to impede intrusive thoughts about Dave.

Early on in family therapy with mother and father, George (Mimi's father) remained fixated on two things—wanting Mimi's medications increased to suppress his daughter's feelings and for Mimi to return to school in the fall (3 months later). Joan (Mimi's mother), was slightly more tolerant of Mimi expressing her feelings and point of view, but Joan mostly went along with her husband's desires about not wanting Mimi to express her feelings so vocally.

At the sixth session Mimi relayed the events of the molestation. She described how, despite crying and begging him to stop, she felt pressure to comply with her cousin's desires: He wanted her to meet him in the park. He would pay her, "make it worth her while." He forced her to sit on his lap as he fondled her genitals. Mainly, she cried as she shared this with me but there was some glimmer of anger as she raised her voice at times during the telling. She asked why she felt she had to go along with her cousin and why he molested her in the first place. Did he not want her to be normal and learn about sex in her own way? Did he not respect her privacy by asking personal questions about her sex life? He didn't listen, she announced. She said everyone in the family did what *he* wanted. Even her mother also had worked for him. She recalled stories from her parents

about the legal problems Cousin Dave had with illicit drugs and the Internal Revenue Service. By the time she finished recalling the incident and asking questions she was no longer crying. She raised her voice and sat up in her chair as she expressed her anger. As her anxiety diminished, she twirled her hair less.

Legal preparations were underway with the civil suit against Dave, and by the tenth session Dave's deposition took place. Mimi said she felt sorry for him. He had acted like a child, stupid, and confused. She felt she was being cruel to him by pursuing the lawsuit. During family therapy with mother, Joan surprised Mimi by not confirming her guilt. Instead, Joan pointed out that Dave was a criminal and a manipulator. Mimi responded positively to her mother's support. They conferred conversationally much better than when Mimi's father was present and took center stage.

The sessions continued. Mimi revealed the confusion and exasperation she felt when trying to satisfy everyone else's wishes and expectations: her friends told her to get drunk to avoid her feelings. Her grandfather urged her to "forget" and "keep busy" doing something—a chore, a job. Her parents tried to divert her attention or ignored the crying and occasional anger outbursts. She said she just wanted to "forget" and have fun or to be another person.

We talked about her memories and what she was like as a little girl. She recalled never being a bother to anyone. As she described it, she did what she was told and was very "responsible" at a very young age.

Next, Mimi recalled her relationship with Cousin Dave before the molestation. She had liked him because he acted like a teenager and was playful with her. They discussed rock music; she cleaned his house, did his yard work, and maintained his boat. She recalled these events with fondness and wept. She feared that she would never again be able to talk to him. Mimi's positive recollections of Dave and her ambivalence about his prosecution initially aroused an angry countertransference in me. Once I processed this, I was better able to see the necessity of Mimi exploring her own ambivalence as a grief process and transference of the great relationship she thought she had with Dave prior to abuse and her unreasonable overvaluation of him.

Family Issues

As family therapy was underway, a separation began to occur in the parents' unified appearance. The father continued to be unsupportive of Mimi's vocalizing her emotions while the mother, albeit timidly, increased her support. Mimi and Joan discussed together their "perfection" roles in

the family, and how each wanted to meet all other's expectations and demands no matter how unreasonable: Her brother eschewed chores. Father wanted only his point of view heard. For the first time Mimi told her mother she did not want to stay home with the family all the time, but wanted desperately to have and be with friends.

The legal proceedings wore on. Cousin Dave's second deposition on the molestation was a litany of blame against Mimi: she wore the wrong clothes, was in the wrong place, and enticed him. This created an acute self-devaluation. Mimi again withdrew, increased her drinking and spoke harshly of herself because she could not stop Dave from sexually abusing her.

At times her mother refused to attend family therapy. She felt guilt for not preventing Mimi's molestation and for being a bad mother. One day Mimi told her mother how much her participation helped. After that Joan returned to the family sessions. Mimi and Joan continued to discuss their similarities in avoiding discussion of feelings, giving opinions, and focusing on their own welfare. The behaviors were intergenerational: Joan had learned them from her mother and, in turn, Mimi had learned these behaviors from Joan.

In treatment Mimi was hard-working and earnest. She sat up straight and no longer fingered her hair or played with her toes. She maintained eye contact with me and spoke in a firm voice. Mimi began to make connections with her past, and discussed how she acquiesced to her family members and to having so few friends. As Mimi felt slightly more accepted by the family for her voicing anger and frustration and for talking about Dave, she also felt more self-acceptance. Her moodiness, flashbacks, and crying spells lessened. She felt less depressed.

The family battle continued over the double standard that existed for her and her older brother. Mimi vociferously pointed this out to her parents in family therapy. She was expected to buy his clothes, help him with homework, and arrange rides so he would not have to drive the car and get it dirty. George bristled that she wanted a saner way to live within the family. Her mother, Joan, identified with the expectation of having to take care of other's needs and felt exploited. She also became more vocal about this.

About six months into therapy, Mimi saw Cousin Dave in town. She felt panicky and wanted to escape. The feeling passed and she did not withdraw to her room or use alcohol. She said she immediately felt devalued by him and guilty about the molestation. She observed that her self-esteem must have dropped and then she reminded herself she had it

backwards: he was the guilty one, not her. This led to a discussion of how much she had trusted and overvalued him as a person who would never let her down.

Mimi reported at one session that she had seen a television program in which parent-child disagreements and children's questioning parents was applauded. She broached the subject with her mother. In a family therapy session Mimi and her mother had a spirited discussion about why Mimi was raised by both parents never to question them or any authority figure. By now both of them were more uninhibited in conversation.

With requests to have a social life, came new parental reasons for Mimi not to be socializing. Her parents and attorney felt she would lose the civil case if she was seen by her cousin out socializing. This gave us a chance to reflect on the reasonableness of this thinking. Mimi felt her parents and attorney believed her cousin's point of view—that she was the culprit in the abuse, not her cousin. We took the opportunity to discuss the similarity of distorted views in the larger world outside her family—of attorneys, etc. She decided they were just as, or even more, confused than she was.

About eight months into treatment Mimi became overwhelmed and threatened to overdose. She was angry about many things: Her brother allowed girls into her room and they stole her clothes. Her parents told her not to be angry or moody. She was restricted to the house and uninvolved with friends. She emphatically wanted her cousin to be *criminally* prosecuted and she wanted *him* in treatment. We discussed these issues in family therapy. Her father banned the girls from the house. They discussed the criminal prosecution of and treatment for Dave with their attorney. George reiterated that he wanted Mimi in school and back to her old ways. Mimi struck back, saying she'd return to school when she was ready but she did not plan to be "a nerd" anymore. Still, she had little support from her father. She felt a failure because she was not living up to *his* expectations of her. We discussed her self-devaluation.

Next, a rocky course began as Mimi was allowed to go to friends' homes to spend the night, to go to concerts, and to get a part-time babysitting job. Yet, her parents found fault with every small step she took toward appropriate autonomy and maturity. They chastised her for returning home five minutes late or for not immediately confirming where she was when out. They told her she had bad judgment because she was "ill" and that she could not be trusted. Despite these attacks, Mimi managed to do things with friends. One day she announced to me that she had stopped drinking and instead talked to her friends about her feelings. I asked her

to consider whose standards were correct for her: her own or her parents'. She concluded her standards were best for her.

More depositions took place. Her father wanted to be in charge of who attended which depositions. However, Mimi wrested control from him. She told her father he *could not* attend her deposition or the ones by the psychiatrists who evaluated her. She said this was because George was critical of her and would use any information he heard against her.

She hoped her cousin would be uncomfortable with things he heard at her deposition about how she had suffered from his abuse. At Dave's second deposition Mimi observed he was "absurd," answering "maybe" to questions about things he had done to her. Her father also attended and she discussed Dave's lack of remorse with her father. He supported Mimi's viewpoint. He also praised how she handled Dave's deposition: it was because she was "strong," he said. Mimi felt the court proceedings interfered with her nascent social life and new-found fun.

Mimi said she had a difficult time "taking" money from others, even her mother. She was more comfortable "giving" she said. But when Mimi wanted to donate blood for spending money, her mother disallowed it, instead giving Mimi spending money. Mimi felt the same uncomfortable way when her grandparents gave her a limousine ride for her birthday. In our discussion it dawned on her that she gave too much to others (her cousin, her parents, her brother) and did not give much to herself. She shared this in family therapy with her mother, who observed the same basic issue in herself. Sharing this realization was supportive to Mimi. In fact, the learning was truly intergenerational: In family therapy Mimi and her mother observed that three generations of women—grandmother, mother, and Mimi had no independence from their families. Grandmother had adhered to the same double standard for her son (Mimi's uncle) and Mimi's mother. Mimi invited her mother and grandmother to a rock concert. They went and were delighted. Mimi observed that like her, neither her mother nor grandmother went out and had fun. And in family sessions both Mimi and her mother reported learning from each other.

Mimi underwent three independent psychiatric/psychological evaluations for the legal proceedings and did well. There was no resurgence of depression or PTSD symptoms, though she made note of one evaluation for the defense in which she felt abused. The evaluators asked if she enjoyed the molestation and if she provoked Dave. They denied her a lunch break, and kept her in one room for six hours. She also volunteered that she believed the judge was doing a good job when he became angry at her cousin and did not allow the psychiatric evaluation in which she felt

abused by her evaluators. She truly assessed her evaluators from what she had pieced together about herself, Dave, and her family.

Mimi's self-assertion grew exponentially. She and father prepared offers and counter-offers for settling the civil case. Mimi asked her father to include costs for college, psychiatric treatment, and pain and suffering. He complied. Most funds she would allocate for college and future psychiatric treatment, she said. She wanted to try acting and take public speaking classes. She got her hair cut short (something her parents had forbidden), and went shopping for clothes and shoes (something they had also disallowed). She came to therapy sessions glowing and appearing less ragtag.

In family therapy with both parents Mimi reminisced about Dave and the old days. But now they had progressed in their view of Dave: They all saw him more realistically as an immature, demanding, child-molesting drug dealer. "He throws food at other cars when he's on the road," Mimi offered.

With Mimi's progress, she became wary of demanding men such as her father, brother, and cousin. She volunteered that she had developed "radar" and an increased sensitivity because of the abuse by this type man. She felt she was taught to trust people like this too much.

Near the end of court proceedings Mimi wanted to take a break from treatment and live her life with what she had learned. However, she was reluctant to bring this up, fearing she would displease me. We discussed this transference as well as what she had learned from therapy. She offered that she had learned to be more comfortable having her own point of view and sharing it with others. She was better able to judge what to do for herself to meet her own needs. Disagreements with her parents no longer affected her as much. She was less inclined to be attracted to demanding people. She found it easier to ask for help from others, even if they didn't want to give it. And, she felt glad she learned these things about herself "even if it took the bad experience of being sexually abused to do it," she said.

Mimi refused her attorney's request to wear her school uniform to court for the trial. He did not argue. She settled her case before trial. Her parents were critical, saying she could have done better at trial. She acknowledged feeling happier now that she understood a lot about herself, her parents, her friends, the attorneys and her cousin. She was especially pleased the court proceedings were over. She pursued investment strategies for the money from the settlement with a friend of her father's. She

ended therapy and went with a friend's family on a trip to a big new city far from home.

DISCUSSION AND CONCLUSION

It is important is to make sense of what leads up to abuse while being very cautious not to engage (or appear to be engaging) in victim-blaming. For example, with Mimi, it is possible to examine how a role in life "prepared" her for the abuse, how her worldview made her vulnerable, how the coping strategies she had in place helped initiate, maintain and hide the abuse, but then also helped her through the experience.

In Mimi's life, before the sexual abuse, she was taught a very subservient role through modeling and through active shaping and omnipotent conditioning of her behavior by her parents. The abuse fit like a puzzle piece with her early role and personality formation. She was conditioned to and learned acquiescence to self-involved men and boys who expected to be the center of attention and have their desires gratified. She learned this reciprocally from her father and via identification with her mother. While enacting this role she devalued her own thoughts and wishes. She did not ask for emotional attention or support from others. Thus, when Dave began his sexual advances, Mimi's acquiescence and immediate nondisclosure to others fit the template into the unconscious emotionally conditioned role of her upbringing. Dave was narcissistic and like Mimi's father and brother, expected his needs to be gratified by others. Dave exploited her and she accepted the exploitation without complaint. She also accepted his projected guilt, which resulted in symptoms of depression and PTSD. Mimi did this for two reasons. One, she had been omnipotently conditioned to assume too much responsibility for others and to take *their* blame. And, two, because of her self-devaluation, sense of failure, ambivalence and self-derogation about falling into the abuse and not being able to extricate herself from it, she accepted inordinate guilt.

Conditioning, being unconscious, can endure a lifetime. Its relative immutability throughout life can only be changed with psychodynamic psychotherapy, which can locate these deep, unconscious processes from the past and bring them to life in the present. Psychotherapy is a place where conditioned behaviors and roles can be observed, discussed, understood, and, if necessary, resisted or adapted and deconditioned.

Accordingly, Mimi's self-esteem was high and resonated around seeing her role as gratifier of these narcissistic, demanding men. Her self-esteem fell whenever she could not fulfill her caretaking role of Dave. This

happened when she let others know of the molestation and, in effect told Dave, "no," to further sexual advances. With the plummet in self-esteem came the depression, self-loathing and the total self-devaluation with the belief she could do *nothing* well anymore, a collapse due to the failure of her coping strategies. She stayed home, took closet doors off because she feared hidden spaces, quit school and thought of suicide. She experienced total self-devaluation because she could not fulfill her prescribed role and keep her self-concept intact.

In addition to Mimi's conditioned role, also predating her abuse was Mimi's established worldview. This was a worldview in which adults could be trusted, should be obeyed, and protected children. Her worldview lacked autonomy or individuation. She was stuck in complete servitude to others. Her sense of self was squelched. She struggled not only with the crux of adolescence, to gain individuation and emancipation, but also with dissolving her role formed in her infant and toddler life.

The molestation breached Mimi's worldview. Her belief that adults function protectively toward children no longer held up. Traumatologists would say her worldview concept was challenged and shattered (Park et. al., 2012). She could no longer acquiesce to abuse. If she did she risked a sexual assault. Her beliefs and her role were displaced from her norm. Yet the action of disclosure, and of self-preservation, was outside her accustomed role. This created anxiety and symptoms formed. Affect dysregulation ensued. She had to alter her role and be assertive for her own needs in order to stop the abuse—something with which she had no experience. The role change and role confusion created anxiety and PTSD symptoms. She remonstrated herself for deviating from her worldview of accommodation to others and developed guilt and depression. She used alcohol to quell the anxiety, self-loathing, and post-traumatic intrusive thoughts. Mimi's anxiety buffer was exceeded and disrupted.

While Mimi's conditioned role and coping styles provided the germinal conditions for the sexual abuse to start and to be maintained, they also conferred a heightened capacity to engage in psychodynamic psychotherapy and to heal.

Omnipotent role conditioning early on taught her to gratify most others in relationships. She brought this conditioned role way of coping to therapeutic work—to be a good patient, to work hard to please me, and to cooperate in the therapeutic process. In treatment she was able to delay gratification and keep working, even when she was distressed and her symptoms were elevated. She was goal-oriented and able to be introspec-

tive, intuiting that her issues had emotional underpinnings. She did not settle for understanding herself halfway, but instead opted for more thorough investigation. All of these ways of functioning in psychotherapy came from her early omnipotent conditioning as a young child predating her abuse and helped her succeed as a psychotherapy patient via her transference of this role onto the therapy.

Psychodynamic psychotherapy for Mimi was efficacious in alleviating her depression, PTSD and alcohol abuse. Therapy looked at her early emotional conditioning and worldviews that formed before the abuse. Therapeutic work, both individual and family, increased her autonomy and emancipation from her family, facilitating age-appropriate developmental transitions. Family therapy with her mother aided in understanding her identification with her mother via their similarities in conditioned roles. Therapy took the form of deconditioning the compulsive caregiving role she had learned in her family as a young child. This successful deconditioning process, through psychodynamic psychotherapy, has been described with children who have experienced sexual abuse. (Adams, 1994, 1996). Next, therapy proceeded to help Mimi examine the transference of her worldview onto her relationship with Dave and how these views allowed the sexual abuse to begin and made her symptomatic when she disclosed her abuse.

Considering Mimi's upbringing and trauma she may be at future risk of replicating her early omnipotent emotional conditioning and childhood worldview, which may include becoming attracted to people who want to take advantage of her. However, she appeared to have a successful psychodynamic psychotherapy experience. She made such gains in insight and ego-strength that she grew in self-confidence and negotiated her world better by age sixteen. She spurned exploitation by others and refused to engage in self-devaluation and destructive symptomatology. There were clear indications that Mimi's continued ability to cope would be improved. We accomplished this within the intersubjectivity of the therapeutic relationship by listening to her, examining her past, and learning what came *before* her abuse in her early conditioned role formation, coping style, and interpretation of her childhood worldview. The transference of her early conditioned role in psychotherapy was used to aid Mimi in healing and to modify its deleterious influence in her life.

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