

THE BENEFITS AND RISKS OF PATIENT SELF-DISCLOSURE IN THE PSYCHOTHERAPY OF WOMEN WITH A HISTORY OF CHILDHOOD SEXUAL ABUSE

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This article explores the potential benefits and risks of patient self-disclosure in the psychotherapy of adult women survivors of childhood sexual abuse (CSA). Two primary questions frame this discussion: How are the primary benefits of patient disclosure influenced by CSA status, and what are the specific risks associated with each of these benefits in the case of CSA patients? The authors examine these questions by evaluating, from the perspective of clinical work with CSA patients, each of 6 putative benefits of self-disclosure in psychotherapy: self-awareness and identity formation, intimacy, validation and affirmation, differentiation, authenticity, and catharsis. The authors suggest that although clinical work with CSA survivors often necessitates encouraging these patients to discuss traumatic material, such disclosure may include substantial costs as well as benefits.

Keywords: childhood sexual abuse, psychotherapy, patient disclosure, therapist disclosure

The primary aim of this article is to explore the potential benefits and risks of patient self-disclosure, especially of the experiences of early abuse, in the psychotherapy of adult women survivors of childhood sexual abuse (CSA). Although several empirical studies have indicated that self-disclosure is not invariably beneficial in dealing with traumatic events (e.g., Depue, Curran, & Banich, 2006; Seery, Silver, Holman, Ence, & Chu, 2008) and that many individuals cope successfully by suppressing distressful thoughts and memories (Bonanno, Noll, Putnam, O'Neill, & Trickett, 2003; Stroebe, Stroebe, Schut, Zech, & van den Bout, 2001; Wortman & Silver, 1989), the assumption that treatment of CSA necessitates self-disclosure (i.e., recall of the early traumatic experiences) has survived for more than a century, both in the professional literature (e.g., Cloitre, 1998; Cohen, 2008; Davies & Frawley, 1994; McCann & Pearlman, 1990) and in popular books (e.g., Bass & Davis, 1988; Herman, 1992). Disclosure-based treatments continue to be a staple of clinicians of multiple theoretical approaches treating adult survivors of abuse (Bradley & Follingstad, 2001). That is, although different practitioners tout their own favored therapeutic interventions—including cognitive reappraisal, eye movement desensitization and reprocessing, stress inoculation training, two-chair techniques, guided imagery, and attachment-based treatments—virtually all assume that “reviewing and transforming trauma memories is a critical step in the treatment of abuse survivors” (Thomas, 2005, p. 31).

There is a moderate amount of indirect evidence that disclosure is an effective therapeutic strategy, at least for some CSA survivors, at least some of the time. This evidence is provided by studies wherein disclosure-based techniques are applied to survivors of various (i.e., not exclusively CSA-generated) trauma (Bradley & Follingstad, 2001) as well as studies that have used aspects of disclosure in the treatment of CSA-related posttraumatic stress disorder (e.g., Chard,

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2005; McDonagh et al., 2005). There are multiple theories as to why and how this approach works. The most widely held theory—expounded by proponents of prolonged exposure therapy and cognitive processing therapy (e.g., Foa, Keane, & Friedman, 2000; Resick & Calhoun, 2001; van der Kolk, 2002)—suggests that disclosure, within the safe and controlled confines of a therapeutic setting, provides the opportunity for individuals to rethink and reformulate the traumatic events in new, more adaptive ways. Maladaptive thoughts, feelings, and behaviors may be either extinguished (Foa et al., 2000) or confronted and replaced by more realistic schema and responses (Resick & Calhoun, 2001). Consistent with these views, Pennebaker (2002) noted that disclosure allows an individual to gradually become desensitized to previously toxic thoughts and feelings. From a contemporary psychodynamic (relational) perspective, disclosure allows the sharing of experiences and feelings with another (e.g., a therapist), thus contributing to a sense of interpersonal connectedness and a reduction in felt isolation.

As Bradley and Follingstad (2001) have noted, there is a need for further research on the process and outcome of self-disclosure in the treatment of CSA, including studies that identify the specific effective elements underlying this approach. In addition, more research is needed on identifying moderating and mediating variables, including the role of a patient's cultural background. Watters (2007), for example, has observed that “many East Africans . . . hold that the ability not to talk about distressing experiences is a sign of maturity” (p. 15). Given, however, the widespread adoption of disclosure-based therapies in contemporary treatment of adult survivors of CSA, a clinical examination of the value and the putative dangers of this strategy also seems warranted. Little research currently exists on this issue; thus, the hypotheses offered and conclusions drawn in this article are based primarily on theory, clinical reports, and our experience in working therapeutically with this population. It should be noted too that the decision to focus on women survivors of CSA was predicated on the fact that women have been shown to be at 2.5–3 times the risk for being abused sexually during childhood as men (Finkelhor & Dzuiba-Leatherman, 1994; Putnam, 2003) and that the great majority of the literature in this field, both professional and popular, has focused on women

survivors. Nevertheless, many of the issues we address in this article are relevant to both male and female survivors, for example, the fear of being revictimized as a consequence of being trusting and open to someone in authority.

We begin this article with an overview of the complications and general clinical dilemmas of disclosure-based treatment of women with a history of CSA. The body of this report examines the costs and benefits of CSA patients' disclosures of traumatic material, especially that connected to early experiences of abuse; specifically, we discuss how the usual clinical benefits of disclosure are almost invariably confounded with iatrogenic aspects in the psychotherapy of women who have been abused. We follow this with a short section on issues related to the therapist's disclosure of personal issues with this population and conclude with a summary and clinical suggestions.

Disclosure in Therapy Among Women With a History of CSA: General Clinical Considerations

Patterns of self-disclosure among women who have been sexually abused as children differ in key aspects from those of nonsexually abused women, even outside of therapy. For example, although research has indicated that disclosure about sexual themes is difficult for most people (Farber & Sohn, 2007; Hill, Thompson, Cogar, & Denman, 1993), it is especially so for those who have been sexually abused. Empirical data have shown that young women with a CSA history are less likely to be highly disclosing of sexual information to intimate partners and more likely to be highly disclosing of such information to strangers than are their nonabused counterparts (Nereo, Farber, & Hinton, 2002). Furthermore, these patterns are not limited to sexual matters. Women who have been sexually abused as children are less likely to be highly disclosing of general personal information to intimate partners, although not to strangers (Nereo et al., 2002).

The tendency to restrict disclosure to intimate partners while disclosing at high levels to strangers illustrates the special difficulties such patients may face in therapy. Disclosing to those to whom they feel close poses a high degree of vulnerability to individuals whose trust in close others has been so violated in the past. The shadow of the abuser's betrayal tends to haunt the therapeutic

relationship, especially in its beginning stages. But even as therapy progresses and the patient's relationship with the therapist becomes more trusting, she may still fear the consequences of disclosing "secret" material. Here, the belief often takes the form of "I'm still afraid the person who abused me will find a way to punish me for telling the truth; somehow, he's going to find a way to hurt me." This terrible apprehension has been described by Fairbairn (1943/1990) as the return of repressed bad objects to which the CSA survivor remains tenaciously attached: "The patient's devotion to his repressed objects . . . is all the more difficult to overcome because these objects are bad and he is afraid of their release from the unconscious" (p. 73). There is often, then, a palpable tension in CSA survivors between the wish to disclose and the fear that such disclosure will lead to exploitation or hurt, a tension intensified by the imbalance of power experienced in the therapist-patient relationship.

Research has also shown that the shame and vulnerability that tend to accompany emotionally laden self-disclosures in therapy often become magnified when discussing sexual issues (Hill et al., 1993; Kelly, 1998). Clinical reports have suggested that these emotions spike even higher when memories or feelings about sexual abuse are being revealed (Bass & Davies, 1988; Frawley, 1990). The patient's fear of appearing repulsive or culpable following disclosures of abuse may be especially strong. Shame following disclosure of abuse may result in multiple forms of acting out, from missing sessions to self-destructive behavior (e.g., cutting, risky sexual activity, or suicidal gestures or behavior). An additional complication is that the sexually charged atmosphere that results from discussions of sexual matters is likely to provoke a confusing, if all-too-familiar, jumble of feelings including disgust, anxiety, fear, and excitement.

Another clinical consideration in working with this population is that even when disclosure of abuse eventually results in better overall functioning, including a greater ability to relate to others, these benefits rarely occur immediately following disclosure. As a number of theorists and clinicians have posited, divulging the details of sexual abuse (or of other traumatic experiences, including natural or man-made disasters) may initially lead to an exacerbation of symptoms and a temporary worsening of functioning (Courtois, 1988; Gelinás, 1983; Herman, 1981;

Seery et al., 2008; Simha-Alpern, 2007). Thus, even those CSA survivors who have begun to experience the benefits of self-disclosure may be hesitant or uncertain as to how to proceed—that is, they may have trouble deciding whether, what, when, and how to continue disclosing to their therapist because they fear the immediate consequences of continuing to speak of their past tortures or present anguish. In our clinical work, we have observed survivors struggle with several other disclosure-related decisions, including Have I gone far enough such that I shouldn't risk going deeper? Is it worth it? What else do I need to disclose? Is it okay to leave things out? Should I actively try to remember more and more details of what happened? Should I come into sessions and report new memories or associations about my abuse, or should I wait to be asked? Should I try to find out from other family members more details about what happened to me? Should I share these thoughts and feelings with others outside of therapy?

Beneficial Aspects of Self-Disclosure and Their Attendant Risks in the Therapy of Adult Survivors of CSA

Jourard (1968, 1971), whose pioneering studies in the 1960s and 1970s laid the foundation for the field, believed that increased self-awareness was the primary benefit of disclosure. Essentially, he held that we learn who we are through disclosure to others. Extending Jourard's work, Farber (2006) theorized six potentially beneficial aspects of patient self-disclosure: (a) self-awareness and identity formation, (b) intimacy (i.e., experiencing emotional closeness to another), (c) validation and affirmation (i.e., being known and valued by another), (d) differentiation (i.e., developing a more differentiated sense of self), (e) authenticity (i.e., feeling genuine and open), and (f) catharsis (i.e., relieving the physiological and psychological pressures of painful and/or shameful experiences). Although this list has not been validated empirically, it can serve as a useful template for examining the multiple consequences of disclosure for CSA survivors.

Many of these benefits are interrelated: As they disclose to their therapists, patients may feel more self-aware, connected, cared for, strengthened, authentic, and relieved. Moreover, we believe that each of these benefits comes with its own risks and pitfalls. In general, even when

disclosure is experienced as moving and helpful, it may feel frightening and dangerous. We also believe that each of these benefits and risks cannot be easily disentangled from the usual salutary and potentially distressful effects of psychotherapy per se. Disclosure is central to the work of virtually all psychotherapies (Farber, 2006; Stiles, 1995), providing the material for often difficult clinical work.

How are the primary benefits of patient disclosure influenced by CSA status? And what are the specific risks attendant to each of these benefits in the case of CSA patients? We examine these questions by looking at each of the putative benefits of self-disclosure in psychotherapy from the perspective of clinical work with CSA patients.

Self-Awareness and Identity Formation

Self-disclosure in therapy, especially long-term psychodynamically oriented therapy, often leads patients to a greater awareness of who they are and, relatedly, to a more cohesive, clearly articulated sense of self. Although most contemporary therapists no longer believe, as traditional Freudians once did, that insight per se is curative, many do believe that learning more about oneself—especially how early dynamics continue to play out in life—is a valuable aspect of psychotherapy (e.g., McWilliams, 1999). Clinical lore has long held that the more one speaks about significant early experiences that shaped one's life, and the more one understands these formative experiences and the ways in which they influence current thoughts, feelings, and behaviors, the more likely it is that a clearer, more well-defined narrative and sense of self will emerge.

The potential of self-disclosure to forge a coherent sense of self out of an inner world of chaos and confusion is especially valuable for patients who have been abused. As these patients speak more about their experiences, they are likely to gain a greater appreciation of continuities in their life (e.g., "I tend to get frightened/withdrawn/seductive/in the company of older men") and may also begin to hold more stable images of themselves. In addition, greater understanding of their experiences—especially an increased ability to link thoughts and feelings to behavior (e.g., "when someone hurts my feelings, I lash out at others or want to hurt myself")—may help them

maintain a more consistent and realistic attitude toward self and others.

Not atypically, nor surprisingly, CSA patients have suppressed some traumatic experiences, although they have been left with troubling and unmanageable residues of these events (Olio & Cornell, 1993). Although it is certainly the case that suppression ("I don't want to think about these terrible events") and denial ("This didn't happen to me") can be adaptive for some individuals (e.g., Taylor & Brown, 1988), those who come to therapy are assumedly among the subgroup for whom these or other related defense mechanisms (e.g., minimization, compartmentalization, and dissociation) have not proven effective. Pervasive use of denial, as Olio and Cornell (1993) pointed out, often leaves survivors of CSA with intense, persistent self-doubt. Their sense of self tends to be diffuse and shifting. But when painful, only vaguely recollected memories and feelings are verbalized and made available to conscious scrutiny, they can become part of an emerging, more cohesive self. Thus, ongoing disclosure can foster a sense of meaning, order, and coherence among thoughts and feelings that were formerly inchoate, dislocated from any real sense of time and self.

Furthermore, greater self-awareness as a consequence of disclosure—especially in conjunction with the therapist's validation (see below)—can lead to self-forgiveness. Patients who have come to understand more about themselves, and more about their family and their role in it, are more likely to view what occurred to them in a realistic, nonblaming manner.

However, as Applebaum (1976) has noted, insight tends to have a dangerous edge. Becoming more self-aware may undo individuals' precariously held equilibrium. As they become increasingly aware of the details of the terrible events that have occurred, often at the hands of family members, some individuals will become more despairing (e.g., "So much of who I am has been shaped by years of abuse, and I'll never be able to change that") and self-deprecating (e.g., "There are so many things I did that I'm so ashamed of; somehow, I should have found a way out"). As Duval and Wicklund (1972) have shown, attention focused on the self often impels individuals to become acutely aware of what qualities and accomplishments they lack, resulting in decrements in self-esteem (e.g., "I know who I want to be, but that person is so far from who I am, and

I hate myself for that”). Similarly, Farber (1989) has pointed out the tendency of highly psychologically minded individuals—those who tend to focus on the dynamics of self and others—to become painfully self-conscious. In short, although self-disclosure may lead to greater insight and ultimately strengthen CSA survivors’ sense of self, it may also have distressing consequences: Knowing more, delving ever more deeply into traumatic material, may make one’s life and experiences feel even more debased and may lead to feeling even more hurt, neglected, and irredeemable than before therapy began.

Thus, in the beginning stages of treatment, therapists may need to explain to their CSA patients that difficult feelings are very likely to emerge in the course of their work and that they may feel worse before feeling better. The risk of CSA patients terminating treatment will be highest when they are feeling distressed, so it is critical to assure patients that these intense feelings are unfortunate but normative and that they tend to resolve over the course of therapy. Furthermore, because some patients hold unrealistically high expectations of the power of insight to effect immediate and lasting clinical improvement, the therapist may need to help adjust these expectations—for example, by explaining that greater insight or self-awareness is not a panacea for suffering but rather one of many potentially helpful ways of acquiring greater understanding and control of life.

Intimacy

Honest, meaningful disclosure almost invariably leads patients, including CSA survivors, to feel a sense of closeness to their therapists. Moreover, disclosing CSA experiences to a supportive, nonjudgmental, and believing listener is often considered the first step in a “process of healing that can reopen channels of intimate relatedness to self and other” (Frawley, 1990, p. 251). Feeling emotionally close to another may be a particularly significant achievement for CSA patients because of the isolation and alienation they have experienced as a consequence of their understandable lack of trust in other people and in the safety of the world at large. A progressive increase in intimacy, through sharing long-hidden aspects of one’s self, is one of the most significant, healing aspects of self-disclosure for CSA survivors. Thus, self-statements such as “I enjoy

the closeness I experience in telling my story” or, similarly, “It feels so good to share myself with someone who cares for me and believes me” testify to the great importance of self-disclosure in fostering more intimate connections with others.

The complement, however, of this experienced closeness is that intimacy feels so very frightening to most CSA survivors. In the past, being close to another and believing in that person’s essential goodness and integrity has been met with the most profound betrayals of trust. Indeed, CSA survivors have often experienced the contiguity of closeness and betrayal: fathers, for example, who raped them following the expression of endearments, compliments, and affirmations of their “special” relationship. To feel close to another again is to remember that this position is a dangerous one (Harper & Steadman, 2003), one that might lead to being taken advantage of. The belief often held by these patients vis à vis their therapists is “If I need you or get too close to you, I might let my guard down and you will hurt me” or, similarly, “If I tell you my true thoughts or feelings, you will use this against me.”

In addition, as clients feel closer to and more trusting of their therapists, they open themselves up to possible disappointment; that is, their expectations of the evolution of client–therapist intimacy—including extratherapeutic friendship or romance or even truly reciprocal levels of disclosure within the therapy setting—may well be unrealistic and ultimately hurtful. In either case, increasing levels of intimacy may feel risky and cause patients to protect themselves by closing themselves off and resisting further intimacy. Nevertheless, in many cases, there is a palpable tension between clients’ hopes or expectations of increasingly greater intimacy and fear of this occurrence.

An adult CSA survivor poignantly explained another complicating feature of self-disclosures that appear to enhance intimacy:

The ironic thing is, I tell people incredibly intimate things very quickly. It’s an appearance of intimacy. I’d hear myself saying these “really honest things.” But I said them so many times that they were just blunt instruments. The other person would react like I was taking them into my confidence, but I knew it was all fake. It was just an appearance of belonging to the human race. (Bass & Davis, 1988, p. 388)

Thus, when disclosure is not accompanied by a true emotional relatedness, the client’s sense of connection to her therapist may suffer. Instead of

fostering closeness, her disconnected disclosures may make her feel more alone in the world. Behind these stolid revelations, the true core of traumatic residues festers untouched, and the patient continues to feel incapable of being cared about or close to another. Over time, as the alliance deepens and the CSA client increasingly trusts the therapist, a greater degree of her true self emerges and a great degree of intimacy can occur. In the interim, however, disclosure of even seemingly intimate experiences may fail to effect a sense of intimacy, often leading to disappointment, shame, or sadness.

In general, not only can some disclosures fail to bring about a true sense of intimacy and relatedness, but they may result in rejection by the recipient of the disclosure who feels dismayed by what he or she is hearing. In a clinical setting, it is highly unlikely that a difficult self-disclosure by a CSA patient—for example, one that portrays a shameful act or reveals negative feelings toward the therapist—will lead to outright rejection by the therapist. However, it is not unusual for a therapist's response to such disclosures to be experienced by the patient as a sign of rejection. This is because the therapist's response to disclosure, often consisting of simple acknowledgment, a request for clarification, or follow-up questions (all perfectly reasonable behaviors) may feel insufficient to the patient. The patient is telling the therapist the most difficult and intimate parts of herself and may want the therapist to have an emotional reaction equal to her own, perhaps to hold her or cry with her. She may feel this presumed lack of emotional reaction as a sign of rejection or disapproval, even if she is cognizant of the fact that her wished-for reactions are not part of her therapist's professional repertoire. But when the expectation of rejection is based on a fundamental conviction that the disclosed self is repugnant and unacceptable, almost any response to disclosure can be misconstrued as evidence of the expected rejection.

Clearly, the therapist has to be acutely sensitive to the interpersonal consequences of disclosures, inquiring as to how the patient is experiencing their work together and whether and how her open expression of thoughts and feelings is affecting her perceptions of and feelings toward him or her. (This is the kind of inquiry that is the hallmark of contemporary relational psychoanalytic psychotherapy, e.g., Wachtel, 2008.) This task is especially important when the patient's

behavior seems to be changing, for example, when she is more than usually silent, she has missed a session or two, or the atmosphere in the room feels more charged (e.g., more erotic or more tense). Although it is unlikely that even the most skilled and thoughtful responses to intense disclosures will completely eliminate the experience of either threat or rejection, these fears are likely to attenuate over time in response to the therapist's persistent and thoughtful attention to the dynamics of their relationship.

*Being Known and Affirmed by Another
(Validation and Affirmation)*

It is human nature to want to be accepted and validated by others (Kohut, 1977; Rogers, 1961). But the process can prove difficult because virtually all of us struggle to believe that our most shameful experiences and feelings can be truly accepted by another. Still, when we risk sharing the deepest, most intimate parts of ourselves and when doing so is met with understanding, affirmation, and perhaps reciprocal openness and disclosure, the strong positive feelings that ensue can be exhilarating and life affirming. In fact, these assumptions form the basis of person-centered psychotherapy.

For CSA patients, the shame underlying their experiences is often so deep and the fear of not being affirmed so strong that allowing themselves to become known is often a terrifying prospect. Others, often close others, have not wanted to hear their story, have not believed their story, and/or have blamed them for the abuse. For this group of patients, then, the risk of not being heard or affirmed often feels like a matter of life or death. Not being affirmed is tantamount to the psychological annihilation experienced as part of the abuse. Nevertheless, ongoing disclosure of abuse and other painful experiences does occur in therapy—indeed, the opportunity to do so is typically the primary reason for seeking treatment among this group and the focal point of most sessions—and, when responded to sensitively and caringly by the therapist, can lead to powerful feelings of being taken seriously, cared for, and valued. The declaration “I finally feel heard and believed” may be a transformative moment in the psychotherapy of CSA patients.

Although the fear of nonaffirming therapeutic responses may be great among this group of patients, affirmations from the therapist may also

lead to frightening feelings. As noted earlier, closeness may easily segue to apprehension about its consequences. Indeed, any sort of affirming or validating response on the therapist's part—subtle or manifest, verbal or nonverbal—may trigger a reflexive fear that positive emotional expressions are merely a prelude to abuse and revictimization. When the therapist tells the survivor that she is likable or that she is courageous for sharing her story and attempting to work through her difficulties, the survivor may worry that the therapist is saying this for some other, more selfish reason, to feel personally gratified, perhaps, or, worse, to use her sexually. The survivor is used to people taking advantage of her (often within a cycle of caring and abuse), so why should the therapist be any different? This fear of manipulation can be quite strong and can prevent the therapist's validating and affirmative words from reaching her and having an impact. The inability to trust that affirmation and validation may be sincere and not inherently connected to the therapist's own needs and impulses may manifest itself in fear, emotional constriction, or even physical cringing on the part of the patient. In the past, being liked has proven to be a dangerous condition.

Furthermore, CSA patients often believe that they are (at least partially) to blame for the trauma they have experienced. They often feel that anyone who truly understands would never validate, affirm, or like them. Thus, these patients' feelings of unworthiness may result in an interpersonal bind: They may not be able to respect anyone who knows and respects them: "Only a fool would affirm or respect a loathsome person like me." This is somewhat akin to Groucho Marx's famous aphorism about not wanting to belong to any club that would have him as a member. If the therapist really understands what is being told to him or her and still continues to affirm the patient, then the therapist becomes the kind of person whose opinion is worthless. Or, in an attempt to protect the therapist's image and continue to idealize him or her, the patient may insistently try to believe that any affirmation or validation is disingenuous—an attempt, driven by pity, to make the patient feel better.

In a related manner, some patients' self-identity is so confounded with self-blame that they look to the therapist to validate only this aspect of who they are. Their implicit message to their therapist is often on the order of "Accept

that I am a miserable, hopeless person who coluded in my abuse; do not attempt to validate other aspects of my experience because I won't believe you anyway." Validation of more positive aspects of the patient's history and current presentation often irreconcilably contradicts messages from the internalized abuser.

The matter of self-blame is further complicated when a woman has a history of seducing her abuser as a way to partially control the abuse that she knew she would inevitably have to endure. For example, rather than waiting with terrifying anxiety for her father to rape her, she may have initiated sexual contact to make her life somewhat more predictable and thus marginally more bearable. It is understandable that a woman who engaged in this type of behavior might feel that the abuse was partly her fault instead of recognizing what her behavior really was: a logical coping mechanism that made survival possible. The therapist's validation here is not blind acceptance of the patient's attribution of blame; rather, it is an acceptance of the account of the events but with an emphasis on validating the awfulness of the choices available to her and the adaptive nature of the behavior chosen. An excellent example of this kind of validation can be seen in the movie *Good Will Hunting* (Van Sant, Damon, & Affleck, 1997). In the pivotal scene at the end, Will (who suffered physical abuse as a child) is told repeatedly by his therapist, Sean, that the abuse he suffered was not his fault:

S: Look at me. Son, it's not your fault.

W: I know.

S: It's not your fault.

W: I know.

S: No, no you don't. It's not your fault.

W: I know.

S: It's not your fault.

W: All right.

S: It's not your fault. It's not your fault.

W: Don't fuck with me.

S: It's not your fault.

W: Don't fuck with me, all right Sean? Not you.

S: It's not your fault. It's not your fault. [hug]

Although Will attempts to shrug off his therapist's words as obvious, the more his therapist insists that it is not his fault, the more we see just

how engrained Will's self-blame is. Although this process is far more arduous than Hollywood would have us believe, the movie accurately demonstrates the powerful effects of validation. To have another person, a respected authority figure at that, validate hard choices (sometimes by reframing negative biases about these choices), allows survivors of CSA to believe in their self-worth.

But, again, validation is a complicated process for a CSA survivor. The sequence often does not end when the survivor begins to believe the therapist's positive, affirming sentiments. Suddenly, she is believed and valued by a respected someone, but now she may be afraid of losing this newfound validation. She may feel the stirrings of seductiveness: "I feel like I want or need to give you something (sexual) of myself so that you won't stop caring or won't hurt me." Or she may feel that although the therapist has accepted some things about her, there are other things that she has done or feelings she has had which are truly "unforgivable," experiences that the therapist will never understand or accept. For example, a survivor may worry that although her therapist understood and validated the behaviors she engaged in as a child, the therapist will never accept some of her acting-out behaviors (e.g., drug or alcohol abuse, self-mutilation, risky sexual practices, or impulsive or spiteful acts toward others) as an adult. This fear that disclosures will not be met with the therapist's continued acceptance and that instead deeper, more shameful disclosures will damage the therapist's positive appraisals can surely interfere with therapeutic progress. In this regard, Kelly (1998, 2000) subscribed to the view that certain disclosures should be kept from one's therapist to safeguard the therapist's positive perceptions.

Although we do not subscribe to this idea, believing instead that the short-term goal of preserving the therapist's positive views is far outweighed by the long-term benefit of being more fully known and thus more fully accepted, we are nonetheless aware of the underlying dilemma for CSA survivors: Because they are acutely vulnerable to fears of being abandoned or being seen in less positive terms, they may let themselves be known to their therapists very slowly and very carefully. Our sense, then, is that therapists working with this group must be both patient and tactful, balancing the need of CSA patients to be understood with their even greater need to be

liked and affirmed. We also believe that it is important for the therapist to communicate to the patient that his or her validation is not contingent on approval of particular behaviors or feelings; rather, it is based on recognizing her essential, entire being as worthy and lovable—despite her inevitable imperfections.

Developing a More Differentiated Sense of Self Through the Process of Disclosing Multiple Aspects of Self (Differentiation of Self)

Aided by the therapist's questions, clarifications, encouragement, and own disclosures, patient disclosure often leads to a fuller, more complex sense of self. That is, patients become increasingly aware of their multifaceted nature and the multiple layers through which their lives can be understood; they become aware of their many feelings and self-states as well as how feelings, thoughts, and behaviors interrelate and manifest differently in different circumstances. As Geller et al. (1992) have shown, individuals can communicate an appreciation for the complexity of themselves or others in a number of ways: (a) by discussing a range of attributes or dimensions, such as physical, temporal, psychological, interpersonal, or behavioral; (b) by noting subtleties within a single dimension; (c) by describing the manner in which various dimensions compare with or interact with one another (e.g., the way psychological characteristics are reflected in physical appearance or that overt behavior contradicts privately held attitudes); and (d) by acknowledging that certain aspects of self are unknown or paradoxical.

Although there may be disparate aspects of self in the narratives of CSA patients, ranging from the abject to the grandiose, they tend to reflect a limited range of distressing feelings and experiences. Many CSA patients have a reflexive tendency to evoke either global negative self-representations (e.g., "I'm a worthless, unlovable victim of sexual abuse") or tenuously held overly positive ones ("I always know what others are thinking, I'm amazingly sensitive"). Over time, disclosure in therapy can lead to greater awareness of strong, positive aspects of the self. Moreover, CSA patients can progress from a near-exclusive sense of self as victim to one that incorporates multiple, well-articulated aspects of self as survivor. That is, by being able to see themselves in multiple, complex ways, survivors

can begin to realize that who they are is not synonymous with the abuse inflicted on them (e.g., “I’m not just a survivor of abuse, I’m also a reasonably intelligent person, an unpolished but dedicated piano player, and a loving and well-meaning mother”). The experience of abuse is part of who they are, an unfortunately traumatic and enduring part, but it does not constitute the totality of how they need to view themselves or how others ought or need to view them.

Patients with chronic medical illnesses also struggle with this issue. Although having a serious illness dramatically affects an individual’s life and sense of self, she or he does not want to be known only as the family member who’s had a heart attack or as the friend with diabetes. For CSA survivors, it is important to develop, strengthen, and hold in mind those aspects of themselves that have little to do with the abuse, for example, being a loving sister, a caring aunt, a good athlete, a fine artist, or an accomplished chef. Although a history of abuse is likely to have some enduring, negative effects on life, patients can still feel as though their sense of self is not defined by the abuse they experienced. Allowing the therapist access to a full range of experiences, roles, behaviors, feelings, and wishes enables a survivor to see herself as a complex person with multiple, interacting strengths and weaknesses. Doing so helps the CSA survivor develop a more realistic view of who she is and where she would like to be in her life.

But there are risks here for CSA patients. Global, mostly negative self-representations are what these individuals are accustomed to. When more complex, well-differentiated self-representations are formed, they may be frightening to hold on to, be experienced as illusory, or raise the specter of “asking for trouble.” Self-representations that now include more positive and/or complex elements may be in direct defiance of the internalized aggressor. The voice of the internalized aggressor (e.g., “You are a bad girl and need to be taught a lesson”; “You are asking for it and now I have to give it to you”) may be ubiquitously present, ready to battle or threaten any contradictory sense of self that is evoked. Thus, CSA patients may be quite ingenious in finding ways of minimizing, denying, or perverting self-representations that contain “too many” positive elements, or even those negative self-representations that are now more fully elaborated and harbor traces of self-compassion.

In a similar vein, positive self-representations, leading to a burgeoning sense of optimism, may undermine the patient’s familiar version of a sense of mastery: causing negative events to happen may be the only known way to experience a sense of control. At the very least, failure can be anticipated and controlled; success, or at least a more positive, well-articulated sense of self, can be terrifyingly alien.

There are other disadvantages to disclosures that facilitate a more differentiated sense of self. The CSA patient may feel that the therapist is minimizing the centrality of her abuse. As the therapist encourages her to examine other aspects of who she is, the patient may feel that the therapist is not giving her sufficient room to explore the abuse. In addition, the patient may feel manipulated in what she is “supposed” to be talking about, made to behave in ways that are more consistent with the therapist’s vision rather than with her own (e.g., “I know what my therapist believes I should now talk about—my newfound ‘successes’—and I’ll do it, even if it doesn’t feel quite right to me”). This may become especially painful because CSA survivors have been so ruthlessly manipulated in the past. Furthermore, patient disclosures that focus on greater recognition and acceptance of previously underemphasized skills and abilities may lead to shame and disappointment when efforts to incorporate these aspects of identity falter. This is especially true when the therapist has valued or reinforced these discussions. The patient, then, may want to please her therapist but feel unable to live up to the expectations she imagines her therapist has of her. In such situations, it may be important for a therapist to explain that therapeutic changes—including changes in the patient’s sense of self—are rarely linear and that the pace and difficulty of change are very different for each individual.

Yet another risk here is that as the CSA patient begins to view herself in a more nuanced, complex fashion, the world opens up in ways that can feel frightening. The discrepancy between how she now wants to live her life (more fully, with more possibilities) and how she has been living her life may feel vast. These realizations may make her angry or regretful for not living up to her potential in the past. The therapist’s task here is to remind her of how far she has already come and that continuing this (hard) work of critically examining and expanding on her sense of self may allow her to ultimately achieve her goals.

Achieving a Greater Sense of Authenticity Through Acknowledging and Sharing Deeply Personal Aspects of Oneself (Authenticity)

This beneficial effect of disclosure overlaps considerably with achieving greater self-awareness and forging a greater sense of intimacy with another through revealing personal aspects of oneself. Disclosures that feel deeply authentic are likely to engender a stronger sense of self as well as feelings of interpersonal closeness.

At its most powerful, feeling more authentic through honest, face-to-face disclosures contradicts the shame of past experiences of dissembling and hiding one's true self. Telling the truth, even when it is shameful or full of regrets (as the truth often is for victims of CSA), can make an individual feel more human and real. To present one's past in a genuine way, in contrast to presenting incomplete personal narratives or misleading information, can be a new, enlivening experience for those whose lives have been so full of forced lies and deceit.

The belief that honesty is always the best policy is consistent with Western values and Judeo-Christian doctrine ("the truth will set you free"). In real life, however, we are typically forced to compromise our ideals or best intentions and recognize that truth telling may have both positive and negative consequences. We also struggle to find the right words to accurately describe a confusing array of emotions; words can as easily obscure as they can illuminate. Moreover, the demand for truth is often mediated by the need for tactfulness; the value of total honesty is often balanced by the very human desire to present oneself in a positive light, and feeling virtuous and authentic can be experienced simultaneously with feelings of shame, doubt, fear, and anticipated rejection. Many of these conflicts are played out in the therapy of CSA survivors.

For example, there is the lamentable fact that some survivors are unable to self-disclose in ways that make them feel authentic or genuine. Sometimes, early traumatic experiences feel too far away, no longer accessible (if they ever were) to verbal recall. In addition, many CSA survivors have spent significant portions of their lives disclosing in exaggerated or ineffective ways, sometimes going through the motions of communicating without getting at the experiences or feelings behind the words, sometimes not being able to find the words to express the powerful feelings,

and sometimes by actually altering or inventing material to disclose. Not knowing how to share their most profound experiences with others, and being terrified of both the process and the results, many tailor their disclosures to the perceived sensibilities of their therapist (e.g., "I've learned what he most values in others, and I create stories where I have these qualities"). In the process, they succeed in accomplishing the exact opposite of what they set out to do: Instead of opening up to their therapist and feeling genuine in doing so, they bury their true self deep beneath a surface of masks and half-truths.

Winnicott (1965) explained this hiding of one's true core as a key feature of the "false self." Because CSA patients have such extreme fear of allowing others to see them as they truly are, it is inevitable that this false self will often be displayed in therapy, a self that discloses in a manner consistent with what the patient believes are the therapist's expectations. As noted earlier, the CSA patient may fear that if she is completely honest and tells her therapist everything about herself, then the therapist may reject her. Similarly, she may be convinced that her therapist would be overwhelmed by the horror of her unexpurgated story.

Even when the CSA patient attempts to be entirely truthful, she may encounter unexpected problems. For example, despite her truth telling she may not feel authentic, worrying (based on her history) that her honesty is only a ploy to evoke the therapist's support, compassion, or validation. Or after disclosing a difficult truth, she may remember additional details that she had failed to share and begin to feel as though she can never quite get to the truth because it is so constantly shifting. The failures of memory, the ineffability of certain experiences, and the elusiveness of truth may make her feel inauthentic even when she is trying to be genuine (e.g., "The truth of who I am and what I've been through is complicated and constantly changing, I don't have a genuine self anymore to be"). Disclosure may, indeed, lead to feelings of authenticity but there are often substantial obstacles along this path.

A therapist may help resolve these tensions by teaching the patient to conceptualize authenticity as varying along a continuum rather than as an all-or-nothing quality and, in a related fashion, helping her understand that seemingly incompatible feelings (e.g., genuineness and alienation)

can coexist in conversations and interactions with others. An acceptance of these ambiguities may preserve for CSA survivors the value of disclosures that may not be accompanied by a sense of perfect harmony between content and feeling or between herself and the therapist.

Relieving the Physiological and Psychological Pressures of Painful and/or Shameful Experiences (Catharsis)

The experience of abuse is, virtually by definition, painful and shameful, and the prolonged secret keeping and avoidance many survivors engage in may lead to extreme physiological and psychological strain. Many keep feelings bottled up for years. Some CSA survivors experience their feelings as blunted, confused, irretrievable, or inexpressible; for others, these feelings are horribly vivid but seem too dangerous to express. It is not surprising, then, that many patients talk about the relief they feel after disclosing such difficult material in therapy, expressing a sense of unburdening themselves and of great (cathartic) release. As Bass and Davis (1988) wrote in their seminal self-help book *The Courage To Heal*, "It helps to name your fears. Naming things gives them less of a hold" (p. 185).

The notion of catharsis is often credited to Aristotle, who used this word to describe the emotional effects on an audience of watching tragic plays. In contemporary times, the term has most often been used by classical psychoanalysts to describe the relieving effects of expressing deep and previously hidden feelings associated with events in one's past. The basic assumption is that as a result of the profoundly emotional process of disclosing traumatic experiences, energies that were previously used to suppress these painful secrets would finally be released, enabling clients to act, think, and feel more freely. Attempting to operationalize this idea, Kennedy-Moore and Watson (1999) proposed a venting hypothesis, suggesting that the expression of emotion reduces negative emotional experience and psychological arousal and that the greater the expression of distress, the greater the relief.

Whereas the idea of letting emotions out rather than bottling them up seems compelling, empirical evidence of the benefits of this approach has been lacking. For example, Tavis (1984, 1989) has shown that at least in the short term, expressing anger is far more likely to heighten tension

than it is to provide relief. And although extrapolating the results of lab experiments on the daily hassles of nonpatients to the experiences of psychotherapy patients who have suffered from CSA may be unjustified, there are still many unanswered questions about the assumed cathartic effects of disclosure of childhood abuse. We know little about why some emotional discharges feel therapeutic whereas others seem to exacerbate distress.

Good Will Hunting (Van Sant et al., 1997) left us believing that Will felt great relief at finally becoming emotionally aware that it (the abuse) was not his fault. Moreover, his cathartic moment seemed to translate to only good things, including an emotional calmness that allowed him a new start on life. But outside of Hollywood movies, many patients do not know what to do with the new feelings wrought by catharsis. Patients may well experience the feeling of breaking through walls but may still feel confused and uncertain. Similarly, they may feel immediate cathartic-like relief in one session but require a number of subsequent sessions to work through the complex emotions unleashed. But even when a patient feels significantly less distressed after an emotionally charged disclosure, he or she may still struggle with what-now thoughts, that is, with the uncertainty of how to translate a newfound emotional vitality into a plan of action or more adaptive ways of interacting with others. This confusion and uncertainty can certainly be addressed in therapy, but our sense is that for many CSA patients, emotional breakthroughs can feel strangely unsettling for days or weeks afterward—it takes time for thoughts and feelings to become aligned.

Cathartic experiences may also lead to expectations of cure that are unrealistic. Some patients, for example, become disappointed with themselves or angry at their therapist because their breakthrough has not changed their life considerably (e.g., "I've shared so much of myself with my therapist, have let all my feelings hang out, but nothing has improved in my life, and I feel as though all my work was in vain"). Moreover, cathartic experiences may overwhelm some patients, flooding them with emotions that are difficult to control. Immediate feelings of relief may segue into nearly uncontrollable sobbing, hyperventilation, or even greater intensification of the emotion that has been vented. Thus, in contemporary psychodynamic therapy, "the important

issue . . . is not to vent the anger in the moment but notice the feeling and find some way to use its energy in the service of problem solving” (McWilliams, 1999, p. 20).

Influenced by portrayals of therapy in movies or books, some patients imagine that catharsis is the most direct and effective path to therapeutic cure. In Bruce Jay Friedman’s (1995) story, *Mr. Pinzo’s Breakthrough*, the protagonist announces the following to his therapist: “Friends all about me are having their breakthroughs . . . and I don’t mind telling you I’d like to have mine. It’s high time” (p. 246). High-intensity disclosures that engender highly emotional reactions may be a positive consequence of disclosure, at least for some patients for some short interval of time. However, despite its appeal to the media and to patients’ wishes for sudden and thorough solutions to long-standing problems, other benefits of disclosure (e.g., increased differentiation of self or increased ability to feel intimate with others) are more likely to yield enduring results. Thus, therapists may need to temper patients’ unrealistic expectations that emotionally intense disclosures will have immediate and lasting clinical impact. These kinds of hopes for a “magic bullet” should ideally be addressed in the early stages of therapy, when the patient’s goals and expectations for therapy are first explored.

In addition to fostering more realistic expectations, therapists can help CSA patients harness the strong emotions triggered by their disclosures in practical, ongoing ways. Intense cathartic experiences can serve as stepping stones, contributing to greater emotional awareness and an increased ability to use such awareness in the service of making effective behavioral choices. By reconceptualizing catharsis as another stage in the healing process rather than as the end-stage achievement that inexorably provides enduring relief, therapists can both help reduce patients’ disappointments and increase the likelihood that the long-term benefits of cathartic disclosures will supersede their initial effects.

Therapist Disclosure With CSA Survivors

Distinct from patient disclosure, but never quite independent from it, is the question of therapist disclosure with patients who are CSA survivors. Should a therapist with personal experiences of past abuse (sexual or otherwise) disclose this fact to his or her CSA patients? Conversely,

should a therapist with no such experiences disclose to CSA patients his or her lack of first-hand knowledge of the feelings and consequences of abuse? More generally, should a patient’s history of CSA affect in any way the therapist’s disclosure patterns?

The issue of disclosing a personal history of CSA to patients who are also CSA survivors may be more pertinent, and common, than is often suspected. A number of studies have reported very high rates of CSA histories among mental health professionals; as many as one third of all female mental health professionals and one fifth of male mental health professionals report having been sexually abused as children (Elliott & Guy, 1993; Little & Hamby, 1996; Nuttall & Jackson, 1994). These prevalence rates are comparable to those reported for the general population, in both college and community sample surveys (Finkelhor, Hotaling, Lewis, & Smith, 1990).

The question of whether therapists should be more disclosing when working with CSA patients is a difficult one to resolve and one that research has yet to investigate. On the one hand, clinical theory suggests that a therapist’s self-disclosing, open, genuine, nondefensive stance may serve to model such behavior for these patients and may also foster the kind of supportive therapeutic environment that in turn facilitates patient openness and honesty (Chu, 1992; Herman, 1992). In addition, a therapist’s disclosures of personal reactions to the CSA survivor’s successes and struggles may affirm the legitimacy of the patient’s feelings and aid in the development of more accurate self-perceptions; furthermore, the therapist’s revelations about coping with normative life struggles may help CSA survivors develop more effective strategies for dealing with common human dilemmas (Knight, 1997). Finally, clinical reports have suggested that there are especially prominent risks associated with nondisclosing, or blank, therapeutic styles when working with abused patients (e.g., Chu, 1992). The pervasive mistrust such patients feel in any interpersonal setting often leads them to expect betrayal and abandonment. These fears are likely to be projected onto any therapist, and therapeutic neutrality or passivity will only encourage them. In a similar vein, because many victims of sexual abuse blame themselves for their experiences, silence by the therapist will almost certainly be interpreted as tacit acknowledgment of their guilt. Even patients who generally see the sexual abuse

of children as unequivocally wrong and undeserved often make exceptions when it comes to their own abuse. Thus, therapeutic neutrality is neither possible nor advisable with such patients; therapists must be willing to consistently communicate their feeling that such self-blame is wrong and misplaced.

On the other hand, therapists may face the temptation to be too disclosing and to become overly identified with their abused patients. The need to maintain a therapeutic perspective and avoid enmeshment with the patient is always present, especially in cases in which the patient's memories of abuse resonate with a therapist on a personal level, reawakening painful traumatic experiences in the therapist's own past. Pity for the patient and rage at the perpetrators of abuse may lead to infantilization of the patient and collusion with her continuing status of victimhood. In addition, a consistent breaking of therapeutic boundaries—whether in the form of overly intimate disclosures or allowing repeated phone calls or changes in scheduling—will likely be countertherapeutic in the long run. Broken interpersonal boundaries are precisely what lies at the source of such patients' victimization; a safe environment is one with constant and predictable limits and rules, not one that mutates uncontrollably. By establishing clear boundaries, the therapist fosters an environment wherein the CSA patient can feel comfortable enough to disclose and contained enough to limit acting-out behaviors (Harper & Steadman, 2003). In general, clear boundaries provide the context for appropriate interpersonal relationships.

Moreover, overextension on the therapist's part will likely lead to exhaustion, resentment, and lessened future helpfulness to the patient—especially because a pattern of disclosure on the therapist's part is likely to lead to persistent demands on the patient's part for greater, ever more intimate therapist disclosures or other relaxation of therapeutic boundaries. Finally, extensive and/or overly intimate therapist disclosures may place the CSA survivor in a caretaking role, one that may be all too familiar and unhelpful to many of these individuals (Knight, 1997).

The therapist, then, must maintain dual and sometimes emotionally conflicting roles. He or she must be an empathic, involved, and caring participant in the therapeutic process, one who can express a personal understanding of the patient's most difficult and painful experiences. At

the same time, he or she must maintain an unmistakable professional demeanor that bespeaks clear boundaries. Arguably, even more than is the case with nonabused patients, the therapist must constantly monitor the effects of his or her disclosures on the therapeutic process, acknowledging occasional but inevitable errors in the nature or extent of his or her disclosures (Safran & Muran, 2000) and assessing, with the patient's participation, whether these disclosures have been felt to be in the CSA survivor's best interests. In short, the unique dynamics resulting from the very nature of CSA serve to intensify normative therapeutic difficulties (including decisions about whether and what to disclose) and create others not routinely present in the therapy of nonabused patients.

Conclusions

As evidence-based treatments for trauma continue to emphasize the need for survivors to disclose details of their ordeal (DeAngelis, 2008), clinicians need to be aware of not only the benefits of this approach but its risks as well. These treatments offer child abuse survivors, among others, substantial hope for alleviating chronic suffering, but like all treatments, they also pose risks. From aspirin to selective serotonin reuptake inhibitors to psychotherapy, that which has the power to cure also has the power to harm.

Although clinicians are typically aware of the need to titrate certain interventions, for example, confrontations or silences or their own disclosures, they may be less aware of the need to monitor patient behaviors in therapy, especially those that seem therapeutically beneficial. Most adult survivors of child abuse seemingly need to speak of their experiences to better make sense of and cope with that which they have endured. In doing so, they may derive other therapeutic benefits, including developing a greater self-awareness, a more differentiated sense of self, and an increased ability to feel intimately engaged with others. Thus, clinicians are likely to encourage patient disclosure in the belief that, especially with this population, this is the royal road to healing. Even experienced therapists may overlook the substantial obstacles, risks, and pain involved in disclosing trauma. Not only, then, is a disclosure-based treatment not for all (Bonanno et al., 2003; Seery et al., 2008), but even among that large subgroup for whom it is the treatment

of choice, clinicians need to be aware of the great potential for the side effects of disclosure to be nearly as substantial (and sometimes greater) than the immediate benefits. Thus, we believe that it is imperative with CSA patients that therapists initiate discussions of the process, the risks, and the between-session effects of their disclosure of difficult material, especially that related to the experience of early abuse.

In general, patients find it difficult to let their therapists know when therapy is not going well (Hill et al., 1993; Rennie, 1994). Consistent with this tendency, they may be reluctant to let their therapists know when their appropriate and often encouraged disclosures are overwhelming them or leading to unexpected consequences. Because shame is such a central feature of the lives of abused patients and because shame inhibits disclosure in therapy (Farber, 2006), the task of informing their therapists that their disclosures have left them confused, troubled, or vulnerable may be particularly difficult for CSA patients. As Thomas (2005) noted, even the best therapists can be pulled into a dynamic with survivors of CSA wherein they (the therapists) control the sessions and miss patients' signals of needing to slow down the process. These patients, especially those with Axis II diagnoses, may act out their frustrations (e.g., by missing sessions, failing to pay bills, or terminating therapy) rather than speak of them to their therapists. Again, this points to the need for clinicians to actively monitor these patients' therapeutic experiences.

In this sense, what clinicians need to be aware of is not resistance per se, that is, the reluctance of these patients to fully enter into therapy, but rather the consequences of their doing so. Because disclosure can sometimes overwhelm these patients, confounding the gains wrought with the distress caused, clinicians may also need to be especially flexible in their therapeutic approach. In this regard, recent research has shown that among trauma survivors who do not drop out of therapy, Rogerian supportive treatment is as effective as an approach based on cognitive-behavioral therapy (Cottraux et al., 2008). Although not investigated directly, we imagine there to be considerable benefits in integrating these, and perhaps other (e.g., psychodynamic), approaches with CSA survivors, at times providing support and empathy, at times encouraging and working with difficult disclosures. In a related vein, case studies have suggested that in

work with traumatized patients, therapists often need to expand their tolerance for "not knowing" (Simha-Alpern, 2007, p. 310); that is, every memory, thought, and feeling does not have to be disclosed and explored for effective clinical work to occur. In short, our task with those patients who have suffered from early sexual abuse is to provide them with the benefits of disclosure without overwhelming them with its attendant risks.

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