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TRAUMA RESEARCH AND RECOVERY

Sexual Violence, Disidentification, and Long-Term Trauma Recovery: A Process-Oriented Case Study Analysis

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Psychotherapy for survivors of sexual assault often focuses on recovery from acute posttraumatic stress symptoms. Little research has investigated treatments conducted when an asymptomatic patient seeks treatment for a traumatic event that occurred many years prior to starting therapy. This study draws on current literatures about rape recovery to frame the case history of Michelle, a 30-year-old woman who was raped at age 17. Using Herman's trauma theory, Kohut's self-psychology, and feminist social science research about gendered violence, this case study illustrates the complicated dimensions of "trauma bonds," whereby rape survivors harbor positive feelings toward their rapists. Using detailed transcripts from the 50-week treatment, this study illustrates clinical strategies for helping a rape survivor move from intellectualizing and distancing to emotional connection, acceptance, and recovery. Particular attention is paid to Michelle's identification with her perpetrator and the clinical implications for the therapist–patient relationship in cases of long-term trauma recovery.

KEYWORDS *adult survivor; clinical issues, females, gender issues, intimate partner violence, mental health, rape, sexual assault, treatment*

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Whereas much research has examined the common tendencies for rape survivors to identify with their aggressors (Bollas, 1987; Loris, 1998), continue relationships with aggressors (Ellis, Widmayer, & Palmer, 2009), blame themselves for their rape experiences (Littleton & Breitkopf, 2006), suffer negative mental and physical health outcomes (Faravelli, Giugni, Salvatori, & Ricca, 2004), and engage in self-punitive behaviors following rape (Campbell, Sefl, & Ahrens, 2004; Deliramich & Gray, 2008), far less research has examined these themes from a case study perspective. Certainly, case study methods have been criticized for a number of reasons, including their overreliance on individuals rather than patterns among individuals (Creswell, Hanson, Plano Clark, & Morales, 2007), flaws of “uncovering” techniques (McCann & Pearlman, 1990), methodological complications like threats to validity and lack of statistical interpretation, ethical problems of deciding what is indeed representative, and relative disregard for existing research literatures (Dunbar, 2005). That said, the case study method is useful for a variety of reasons: It integrates theory with practice (Bennett, 2008; Donmoyer & Galloway, 2010), provides vivid illustrations of typical and atypical clinical presentations (Dunbar, 2005; Snow, Wolff, Hudspeth, & Etheridge, 2009), allows more depth than other research methods (Bennett, 2008), holds the interest of audiences and students (Dunbar, 2005) and, in clinical contexts, facilitates skill development for clinicians and students (Shontz, 2003).

In existing literatures, case studies rarely utilize process-oriented transcripts to illuminate their findings, often relying instead on the clinician’s memory of the therapeutic encounters. With awareness of the strengths and limitations of case study method, this article addresses these gaps in the literature by examining existing research on therapy with rape survivors, followed by a detailed transcript-heavy case study of a one-year course of therapy with a 30-year-old white female patient who had been raped 13 years prior to beginning therapy. Because this case maps onto, and diverges from, existing research on rape recovery, the use of detailed transcripts from sessions helps to illuminate some of the acute challenges of working with a relatively atypical patient who engaged in “loving hate” of her perpetrator.

Ultimately, the article is intended both as a training piece for clinicians—who often confront nontraditional cases in sexual violence work, yet rarely see case studies about these nontraditional cases—and as an illustrative example of how individuals are not always consistent with existing research. Studying sexual violence from a case study perspective is imperative to the process of moving beyond stereotypes and assumptions that classify rape survivors as universally (and similarly) impaired and universally able to feel outrage toward their rapist. Therapeutic work reveals the idiosyncrasies, exceptions, and new directions to taken-for-granted concepts. As such, this article asks sexual violence researchers to continue expanding their notions of how sexual violence histories, nontraditional posttraumatic stress disorder (PTSD) symptomology, and therapeutic alliances affect treatment outcomes.

RESEARCH ON SEXUAL VIOLENCE AND THERAPY WITH SURVIVORS

Research on rape has revealed sexual assault as an often normative experience in women's lives, particularly for disadvantaged women. One in four women are raped in their adult lifetime (Campbell & Wasco, 2005), although this number was higher for certain at-risk groups like women with sexual abuse histories (Sarkar & Sarkar, 2005); those under age 18 (Tjaden & Thoennes, 2000); or women in college who used drugs, lived in a sorority, drank heavily in high school, or attended a college with normative heavy drinking (Mohler-Kuo, Dowdall, Koss, & Wechsler, 2004). Further, nearly half of college women who described a rape experience did not label it as rape (Bondurant, 2001; Kahn, Jackson, Kully, Badger, & Halvorsen, 2003). Studies consistently show that women underreport rape and that existing rape statistics might reflect less than a third of actual rape events. Reporting rape correlates with women's feelings of shame, guilt, embarrassment, concerns about confidentiality, and fear of not being believed (Sable, Danis, Mauzy, & Gallagher, 2006). Women's experiences with reporting rape tend to be met with varied reactions, ranging from highly supportive and nurturing to complete disbelief (Guerette & Caron, 2007), implying that a therapist's relationship with a rape survivor can be particularly helpful or harmful to the process of rape recovery. Women described more positive mental health outcomes when reporting rape within one month of its occurrence (Ruggiero et al., 2004). Women were particularly likely to not report rape when it occurred with a family member or loved one (Monroe et al., 2005).

Attributions for why rape occurs and who is responsible for rape create contentious discourses surrounding sexual violence. Women are blamed for their rape experiences (e.g., for dressing too provocatively, for "asking for it," and a host of other reasons), leading to the phenomenon of "rape myth" beliefs (Haywood & Swank, 2008; Lonsway & Fitzgerald, 1994). Animosity toward women (Haywood & Swank, 2008), sexist attitudes, and distrust of women's decisions also predict endorsement of rape myth ideologies (Chapleau, Oswald, & Russell, 2008; Cowan, 2000). Certainly, women often minimize coercive experiences and undergo serious psychological fallout from sexual violence often in solitude and without much reprieve. Rape survivors experience a range of mental health consequences (Amaral & Serra, 2009), including PTSD, depression, anxiety, mood disorders, sexual disorders (Faravelli et al., 2004), and borderline personality disorder (Clarke, Rizvi, & Resick, 2008). Negative social reactions from others and avoidance coping correlated most strongly with PTSD symptoms (Ullman, Townsend, Filipas, & Starzynski, 2007). Unfortunately, women overwhelmingly did not seek mental health treatment following sexual assault (Ullman, 2007) and most often suppressed the event or resorted to self-blame and

self-loathing following sexual assault (Littleton & Bretkopf, 2006). Many rape survivors also reported more risky sexual health behaviors, including unprotected sex and substance abuse (Campbell et al., 2004; Deliramich & Gray, 2008). Compared to women without sexual assault histories, sexual assault survivors also had more marijuana use, diet pill use, eating disordered behaviors, and suicidal ideation, and were far more likely to experience sexual victimization again (Gidycz, Orchowski, King, & Rich, 2008). Survivors also reported more dissociation and more suicide attempts than others (Cloitre, Scarvalone, & Difede, 1997).

Given these negative mental health consequences, psychotherapy has often represented a positive step in rape recovery. A variety of treatment modalities have been found to be helpful in treating sexual assault survivors, including cognitive behavioral therapy (Clark et al., 2008; Nixon, 2007), psychodynamic psychotherapy (Barnette, 2001; Ror Malone, 1996), control mastery therapy (Pole & Bloomberg-Fretter, 2006), therapy using hypnosis (Matsuo, Barnier, & McConkey, 2000), feminist therapy (Webster & Dunn, 2005), and eclectic models of psychotherapy (Taylor & Harvey, 2009). Although group therapy can be a viable treatment option, a recent meta-analysis found that individual treatment modalities were more effective in treating rape survivors (Taylor & Harvey, 2009). Research has validated a multidisciplinary approach that focuses on minimizing stress, followed by reconstructing the patient's sense of self and helping the patient connect with larger communities of sexual assault survivors (Broaddus, Hermanns, & Burks, 2006).

Treatment approaches with rape survivors often prioritize corrective interpersonal experiences, new relationships, affect regulation skills, the development of feminist consciousness, and emotional processing, particularly surrounding themes of power, betrayal, self-blame, stigma, and negative emotions (Cohen, 2008). Further, long-term follow-up studies with rape survivors show that most survivors eventually identified positive changes from the sexual assault, particularly in domains of the self (e.g., increased assertiveness), spirituality (e.g., better spiritual well-being), and empathy (e.g., concern for other women's suffering, even while feeling less safe about the world in general; Frazier, Conlon, Steger, Tashiro, & Glaser, 2006).

In cases of rape recovery, the delicate relationship between therapist and patient (Saakvitne, 2002) and between the patient and perpetrator (Doyle, 2006) has been the focus of much research on sexual assault treatment. Lack of acknowledgment of the rape can lead to the most serious health and psychological consequences (Conoscenti & McNally, 2006), indicating that the patient's relationship with a therapist might buffer some negative psychological and physical fallout from the assault. Still, the retelling of the sexual assault story can revictimize the patient (Bruzuzy, Ault, & Segal, 1997). To complicate matters further, the patient might enter

therapy with acute PTSD, which also presents challenges for the therapist. Therapists working with sexual assault patients often struggle with secondary trauma (Moulden & Firestone, 2007), lack of awareness about sexual assault, victim blaming, and lack of adequate resources (Payne, Button, & Rapp, 2008). Therapists can too often construct rape as “sex” rather than as violence (Lea, 2007), indicating that specialized training in conducting therapy with rape survivors, particularly in a feminist model, could lead to better therapy outcomes (Webster & Dunn, 2005). Therapists are most effective when they do not blame the victims and when they create an open, safe space for the victim (Maltz, 2003; Moor, 2007).

Unique challenges are present when addressing rape cases that involve love feelings still directed toward the perpetrator. In addition to victims’ tendencies to blame themselves for the rape (Breitenbecher, 2006), many women also retain positive feelings toward their perpetrators.

Loris (1998) described this oft-occurring dynamic as “the eroticization of hate,” whereby those who have experienced sexual violence fuse love and hate together, both in their relationship to the perpetrator and, at times, with their therapist. Bollas (1987) coined this phenomenon “loving hate,” where survivors exhibit both loving and hateful emotions toward their perpetrator. Similarly, other research has indicated that sexual assault can produce “trauma bonds” in survivors, where they identify with a cruel, sadistic “internal object,” thus confusing eroticism, love, and aggression (Davies & Frawley, 1994; Gabbard, 1991; Hensley, 2002; Saakvitne, 1995). Women show particularly strong tendencies toward trauma bonds when their spouses or cohabitating partners raped them (Culbertson & Dehle, 2001).

This case study utilizes these findings—particularly research on women’s tendencies to minimize the significance of sexual violence, engage in self-blame and mislabeling, and embrace “loving hate”—as a framework for examining a one-year course of therapy through the lens of the *process* content, as transcripts of all sessions are considered along with this theoretical framework. Although this particular case had unique qualities that do not translate into most rape recovery cases (e.g., delayed PTSD presentation), many of the issues presented here are in line with what many rape survivors experience, and as such, the examination of her individual reactions and choices throughout the therapy process can prove useful to practitioners and researchers alike. The following case description is designed to *expand* existing notions of what a “rape survivor” feels, thinks, and wants from a course of therapy. Whereas the typical elements of the case (e.g., deep sadness about rape, “loving hate,” therapeutic alliance, and damaged construction of self) provide a vivid illustration of rape recovery, the atypical elements of the case (e.g., delayed PTSD symptoms, length of time between rape and therapy) provide a contribution to the case study literature on sexual violence.

CASE CONTEXT, METHOD, AND PATIENT PROFILE

This case study utilizes detailed transcripts from a once-weekly, one-year-long psychodynamic therapy with a 30-year-old white female patient who presented with feelings of sadness, anxiety, and posttraumatic symptoms related to a rape she experienced at age 17.¹ As previous research has shown, little case study analysis relies on detailed process content, particularly transcripts of sessions (Greenwood & Loewenthal, 2006; Watkins & Vitanza, 1993). This case is unique for several reasons: (a) All 50 sessions were recorded, meaning that the actual therapeutic discourse can be effectively illuminated; (b) It represents a distinctive case where a PTSD diagnosis was not initially warranted in her self-presentation at intake, yet the traumatic event figured centrally in her self-identity; and (c) It describes an often underrecognized phenomenon of a rape survivor idealizing, attaching to, and identifying with her perpetrator, and showcases the ways such idealization structured the treatment.

Michelle presented for psychotherapy shortly after her 30th birthday, saying that she felt that she was “finally ready” to address the trauma that had happened to her. She was tall in stature, average in build, and noticeably attractive. At the start of therapy, her appearance conveyed a careful desire to impress, as she wore a notably strong amount of perfume and dressed in designer clothing. In early sessions, she presented as talkative and optimistic about therapy. She exhibited an eagerness to start the treatment and share her accomplishments.

During our first session, she said that she worked as a nurse, but quickly followed that statement with the caveat that she also made a lot of money—somewhere in the \$100,000 range—and that she “loved her job.” She frequently worked 50 or more hours per week, taking on overtime nearly every week, but always came to therapy precisely on time and looking flawlessly put together. Coinciding with this external appearance, her intake evaluation forms revealed an equal desire to present herself as happy, adjusted, and not depressed.

Like many sexual assault survivors, Michelle spoke about her presenting problems in a manner that felt rehearsed, as if she had recounted her past trauma history with much frequency. She did not display anger, tearfulness, or sadness when talking about her rape experience at age 17, but rather, she

¹ Michelle provided consent consistent with the institutional review board protocol to have each session audiotaped and transcribed. She also provided written consent for subsequent research publication based on these transcripts. On beginning therapy at this clinic, Michelle completed routine intake assessment measures and provided access to her medical records. Consistent with the standards and practices of this clinic, measures to ensure anonymity were enforced and all efforts have been made to appropriately disguise the specific details of Michelle's identity.

had a robotic presentation when discussing her problems, often completely detaching from the stories. In fact, her initial complaints focused not on the rape itself, but on her perceived inability to connect with men in healthy ways, a pattern she saw as potentially connected to the rape. She described her past three relationships as characterized by frequent cheating, boundary testing, and chronic fighting, and she indicated that she was tired of feeling like she purposefully hurt the men she dated. She reported that she had wanted to attend counseling for a long time, and that her 30th birthday gave her the impetus to finally address her psychological pain. She referenced Dr. Phil, saying that she found him “inspiring” in the way he urged people to “get over their problems.” Something of this description indicated that Michelle thought about therapy as an item in life’s checklist, and that she would “conquer” the rape experience and move on. Michelle conceptualized her rape experience as a roadblock to her getting married, and said that she wanted to “get married as soon as possible.” She described her problems as something to “tackle” and she felt that her therapist could help her fix these problems. “Just tell me what to do” was something she frequently said in these early sessions. As a typical example of minimizing rape’s significance, consider the following exchange:

Michelle (M): I’ve told my mom I don’t feel like it was a back alley rape, but I didn’t have the option of my own body. I felt like I made myself defenseless by passing out. It was partly my fault. But he didn’t give me an option on one of the biggest choices in my life, and I was so emotional. I’m like, “You bastard.” It’s a good realization though. I’ll probably still do that until I put this wherever it belongs.

Breanne (B; author): I’m curious what you mean by putting it where it belongs.

M: I don’t know where it belongs but it’s still here with me. Yes, it’ll always be a part of me but I don’t want it to be driving my relationships and where they go. I don’t know where it’s supposed to go. I just don’t want to treat people like this anymore. I want to give myself more freely. I want to put [the rape] where it belongs.

Within the first two sessions, Michelle indicated that she sought therapy to help her reconnect with a therapist to facilitate better relationships with men, more healthy feelings about the trauma that occurred 13 years ago, and to “feel better” about her ability to “give” in the context of romantic attachments.

CASE CONCEPTUALIZATION

When initially conceptualizing Michelle's case and constructing a plan for treatment, it seemed immediately clear that the rape—a traumatic event that occurred many years prior—had disrupted her sense of attachment and engagement with future romantic partners, and had paralyzed her with regard to forming healthy relationships with men throughout the last several years. As such, Herman's (1997) classic trauma work figured centrally in conceptualizing the case, as Herman distinguished isolated incidents of trauma in which, for example, someone experiences something traumatic and quickly recovers (e.g., a car accident), from more complicated trauma cases, in which the trauma has a greater effect on the survivor's sense of self. Michelle fell into this latter category, in which the trauma complicated and damaged her understanding of herself on a more fundamental level. Michelle's treatment was designed as a process of acknowledging and recovering from her trauma, including those aspects of the trauma that are detached from the self in the process of surviving the trauma. In particular, Herman's stages of establishing safety, reconstructing the trauma story, and restoring connection between survivors and their community figured prominently in the case conceptualization. As a second organizing theory, self-psychology, particularly the work of Kohut and Goldberg (1984) and Jackson (1994) emphasized the importance of idealization and mirroring as healthy developmental strivings, in which patients come to internalize an idea of themselves as valuable, worthwhile, and capable. A major theme in my work with Michelle was to increase her awareness of her own internal emotional needs, rather than relying on others to validate her life experiences.

TREATMENT PROGRESSION

Initially, Michelle presented as happy, upbeat, and therapeutically curious, yet completely detached from the emotional content of her problems. In the first three sessions, Michelle gave a detailed account about what had happened during the rape. She reported that at age 17, a university football player, Pete, who she had idolized and worshipped since she was 13 years old, had raped her. Michelle remembered watching Pete on TV every football Saturday, and she remembered being attracted to what she called his "blackness and his aggressiveness." She admired his athletic abilities, and the fact that he frequently got ejected from games for playing too rough. Michelle contacted Pete by letter and they wrote to each other for three years, an exchange she remembered as a highlight of her teenage years.

At age 17, Pete phoned and asked if she would be able to meet him for dinner that next weekend at a local restaurant. She said,

M: My heart was beating out of my chest. . . . That day was fresh in my mind. A lot of the days. I can remember all the days when he'd call me, where I was at that exact moment. It was such a big deal for him to call me.

Later, when telling me about the details of that night, I asked her,

B: When you went to see him, did you think something could happen between you?

M: Well he drove here from far away, and I thought, he's coming to see me and we'd never had that kind of talk before—just on the phone, for 15 minutes, how was your day kind of thing. I had pictures of him on my wall. He was my favorite player. I cut out his pictures. My whole wall was full of them. On my way up there, I knew my parents wouldn't be there and I was thinking "What if he tries something? What will I do?" But then I thought "He's 23, what would he want with a 16-year old girl?" But then I got there and we played quarter shots and I puked all over myself. No moves were made then. I didn't think I'd wake up to the situation I was in. I did think, "Maybe he'll kiss me." But then I put it out of my head.

B: It sounds like it was such a feeling of innocence and excitement.

M: Oh yeah, god yeah. I didn't eat for 2 days straight in anticipation. I was so nervous to meet him without my parents around. He was driving just to see me. In pro league, they have only a few weekends off, and he was coming to see me. I told everyone at school that I was going to meet him. I remember going back to school the next day sitting in my political science class, and they were all like, "Hey how'd it go?" I said, "It was fine, he's cool." I remember this boy said, "Did you have *sex* with him?" and I said *no*. I remember I just didn't know how I felt at that moment. I knew, wow, this had been taken from me. I was just numb. I didn't know what my feelings were. It was so fresh.

Michelle described that night in detail, saying that she, Pete, and a friend went back to the girlfriend's house and drank a bottle of vodka. Michelle had never drank alcohol before, and vividly remembered her experience of losing control of herself and being unsure what would happen. The next thing she recalled about that night is that she woke up naked, to the sensation of being raped orally, then vaginally, then anally. She remembered saying no, but didn't remember how forcefully she protested, or what she felt like at the time. She recalled feeling numb and angry, but said she did not resist as much as she wished she did. Her memory of the night was shoddy, as she could only recall small pieces of the rape. She remembered thinking about how she was no longer a virgin. Early that next morning,

she also remembered looking at her bloody underwear and being afraid of what had happened. Michelle said that at the time, she felt immediate guilt for not telling her parents where she was, and says that she also felt hung over and sick. She returned home and did not tell anyone what had happened except the girlfriend who was with her. Her girlfriend responded, "It's not that bad. How many people can say their first time was with a famous football player?!"

Notably, and in line with existing research findings on long-term rape recovery, Michelle lacked any supportive relationships around the time of the rape. The single person she told about it essentially told her that she should be grateful for the experience. The sense of aloneness she felt after the rape is something Michelle had never fully acknowledged until coming to therapy. Even those she was closest to—her parents and her other close friends—were kept in the dark. Michelle told me that she decided not to tell her parents until after her 18th birthday, for fear that her mother would force her to press charges. Instead, she kept the vodka bottle and the bloody underwear for DNA evidence, and swore to herself that she would consider turning him in at a later time, but not then. During that year, she was frankly depressed, frequently tearful, and quite lonely. The following year, when she did tell her parents, her mother reacted with extreme rage and anger toward Pete, saying both that she would have forced Michelle to press charges, and that she was angry at Pete for betraying *her* as Michelle's trusting mother. Michelle remembered feeling baffled by her mother's response of anger on her own behalf, rather than anger on Michelle's behalf. She described this period as a time of "putting up walls" against everyone around her:

- M: I'm still the same person, I still feel like I have a good personality, that you should respect others, treat them good. That part of me didn't change. I just didn't have any relationship skills or anything like that. I think I started off on the wrong foot. I knowingly sought out and made bad relationships after that.
- B: What changed after the rape?
- M: I put a guard up after the rape. I never gave myself to anyone again. I had a pretty good relationship with one guy but I still didn't allow myself to give all of myself to him. I think I'm capable of doing this, but when it came down to it, I backed off and wasn't ready to get married. I broke it off. One thing I was thinking about is that I see black men and white men and I think of having, this is crazy, I think of black men as having good sex, but not being able to give me stable good relationships, just good sex. The white men are the opposite. The couple of white men I slept with, it's just not what I was used to.

This passage was indicative of her tendency to shift from emotional content to rehearsed stories about her current behavior with men. This perceived

difference between black and white men was a regular theme in our early sessions, and came up often in response to my questions about Pete. It seemed like a direct way to avoid the emotional experience of Pete, as it allowed her to intellectualize her feelings about men rather than address her emotions. This also points to the raced and gendered dimensions of the therapy, as Michelle managed her (highly gendered) sexual assault experience by engaging in subsequent relationships with other African American men whom she hoped would treat her with more kindness and sensitivity than did Pete. This phenomenon closely resembles therapeutic transference (whereby the therapist becomes the “safe” parent), and relationship transference (whereby people seek out a partner who can “repair” elements of their parental relationships).

As is typical for trauma victims, Michelle also tended to split people into “good” and “bad” categories, often failing to nuance the categories and appropriately gauge their responses and relationships with others. For example, Michelle described her parents as the “best parents in the whole wide world” and recounted her luck at having such a great family. Michelle’s overidealized relationship with her parents mimicked her idealized relationship with Pete. For example, when I asked if her parents had ever disappointed her, she always stated that they were the “greatest parents in the whole world” and that she had never been disappointed with them. This seemed clearly indicative of her general tendency to idealize all of her attachment figures, often at the expense of seeing them as full and complex people. She described how they treated her as the “perfect kid,” which might have made it harder for Michelle to disclose the rape experience and ruin this image. For Michelle, people were either “good” or “bad” and rarely occupied a nuanced place in the middle.

Consequently, the second phase of treatment focused on slowing down the rehearsed, “split” narratives of her life, and instead encouraging her to actually *feel* her emotions rather than intellectualizing or blocking them. This was an overt attempt to help her reconstruct the trauma narrative in a way that better addressed her emotional complexity. It was also designed to access her emotional relationship to the traumatic event, something that had been blocked by her previous lack of social support. Once our alliance had been established and we built good rapport with one another, as evidenced by Michelle’s increasing ability to take emotional risks and express connection with me as her therapist, Michelle began to cry during sessions, and reported feeling like being in treatment was a central aspect of her life. During this phase, the PTSD symptomology began to emerge, as if it had been hidden from view during her insistence on being “fine” and “high functioning.” She structured her week around sessions, disclosed to others about her therapy, and explained her lower work productivity by saying to her boss, “I’m going through something right now.” She described her emotions like a “dam breaking,” and would often come to sessions

looking tired, worn out, and exhausted. Her appearance conveyed a sense of disorganization and turmoil. I experienced her as exceptionally childlike. Indeed, Michelle frequently described her emotional state as “going back to being that 17-year-old girl” and often said that she felt like she was “right back there” during this phase. She also expressed surprise at how sad she still felt when thinking about Pete. Indicative of this, she sometimes said things like, “I want my Mommy,” and, “I’m just so sad.”

Sessions often included talk of her feelings of sadness and low self-worth, and she frequently cried throughout entire sessions—indeed, a more typical presentation for rape recovery than her initial presentation at the start of therapy. She told me about her significant weight gain and various somatic complaints. The transition between early treatment, where Michelle repeated her story in an emotionally detached way, and later treatment, where Michelle finally accessed her emotions, happened primarily around the increasing acknowledgment of her positive feelings toward Pete. As she started to acknowledge and remember the complicated emotions she had for Pete, she became more in tune with her emotional experience of the rape. As these narratives emerged, the words felt less rehearsed and less predigested.

During these sessions, Michelle described herself as “emotionally wrecked” and was quite tearful and distressed. In one session, she said she felt Pete was truly sorry for raping her. She told me the story of how Pete eventually apologized to her when she was 25, and had called and asked to meet her at a restaurant to talk. As we explored the possible meaning of this apology, we also tried to process the feelings she had for him prior to the rape, as a way to make room for the part of her that still longed to feel special, attended to, and loved (another typical example of “loving hate”). In the first session that she acknowledged these positive feelings, we had the following exchange after she started to cry when talking about the rape.

- B: What’s the sadness you just felt?
- M: I just feel like I’m 17 again, and my emotions are surfaced, and talking about how he raped me and then called me, I just feel like I’m back there. I have these wishy washy feelings about him sometimes. I just remember how the boys at school were so impressed that I knew him, and I remember feeling so confused, like that guy at school knew what had happened.
- B: Maybe you want yourself to see it in a different light, to be that boy at school who sees Pete as this great, famous guy.
- M: I do, but I’ve never allowed myself to. What’s funny is that people who are close to me know about the rape and they hear me say I was raped, but at the same time I still say the positive things about him and defend him and say good things. They’re always fine with it

so it made me feel like it was okay to act like that, and no one ever checked me on it. No one ever questioned those feelings. Only my mom and dad would say, “Are you sure you really want to say things like that?” None of my friends think it’s weird that I say good things about Pete sometimes.

- B: Those longings seem so vivid for you—that feeling of wanting him to still be present in your life, not necessarily showing up at the door, but—
- M: Yeah, I mean if he called and said he wanted to go to lunch, I’d still go. That’s what gets me. I have a problem. How could I say that to you?! Whoa. Michelle. Wow.

In a further exploration of these feelings, a few sessions later, I noted that she repeatedly said that her rape was not a back alley rape—a typical minimization technique employed by rape survivors to lessen the event’s impact—and I wondered aloud with her about the ways in which saying that made her rape allegedly less painful.

- M: I’ve never felt like it was a back alley rape. I felt like it was a rape, but I won’t forget the feelings I had for him for the four years previous toward him. Because of one night, no, that is still a part of me, too.
- B: Maybe that’s why it’s hard to think about what could have been, or how painful it is.
- M: Yeah, like I downplay my feelings of that, because he was so important to me, such an important part of my life, and just the phone calls and him being on my wall and I knew him, so yeah you’re right, I don’t like to think of him raping me. When I think of him now, I think about how he said he was raped, and I felt really bad for him, and it happened to him too, even though he did that same thing to me. I’m like, how can I feel sad for him when he did this to me? I still do feel that way. I still have, you know, nonnegative feelings toward him. For me to sit there and talk with him for an hour and a half eight years after it happened, I must have had positive feelings or else I couldn’t have gone through that. I would have been like, screw you, don’t call me again. You’re probably right. I do sometimes teeter on my feelings about it. Yes, I know it was wrong, but I still have the little feelings that I think about the previous years before that.

The most productive parts of these sessions with Michelle happened when she could explore the positive feelings she had toward Pete, rather than feelings of anger and victimization. It seemed that Michelle had always told herself she should be either angry and victimized, or perfectly okay with what had happened. With her friends, the rape was casual, minimized, and accepted. This represented, most notably, her identification with her

aggressor. With her parents, the rape was a brutal, vicious attack. Michelle had never been able to bring these two parts of her cognitive and emotional experiences together. When we did finally explore both the positive and the negative feelings she had for him, her emotional experience became amplified. Michelle clung secretly to feelings of love for Pete (identification with her aggressor), although she was surrounded by those who expressed anger and hatred toward Pete for raping her (e.g., her mother and subsequent boyfriends). At the same time, when she did express positive feelings toward Pete with certain friends, she intuitively felt like it was wrong.

This exchange illuminated complicated emotions she had around wanting to protect Pete:

- M: I remember bragging about him for years after the rape. My guy friends would come over. Oh, [Pete], I knew him, I would say. He's MVP. I could tell you every statistic about every accolade he does. I was still enshrining him for years, even though he had done that to me. People who didn't know about the rape, I'd stick up for him and say he's the best.
- B: It's almost like that's still happening now.
- M: Yeah, it is. Not to the same extent, though. I'm not wearing his jersey anymore. I used to wear it to school. I used to brag and say I'd known him since I was 13 years old. I still feel it.
- B: Why is a person who violently rapes a 17-year-old worthy of this much protection and praise?
- M: I don't know. I don't know why he's on a pedestal. I want him to be a good person. Even though he's not worthy of that praise I've given him, even in the letter, I said that. He didn't deserve it, and it wasn't right what he did. But as soon as those words are finished—. (Cries)
- B: Tell me about feeling really sad just then.
- M: I don't know. I know he doesn't deserve those feelings, but I'm still that 16-year-old when it comes to those feelings. I know it in my heart—I just always shed a positive light on him.
- B: It sounds like it makes you very sad when you think about doing that.
- M: I know it's totally absurd and wrong, but those feelings are still there.
- B: It seems to be confusing now, but also when you were younger.
- M: Yeah, I'd wear his jersey, I'd defend him to the end when I was young, and I think how could I do that?! I just felt special then. None of my friends knew someone like that, he chose me, but then again I feel like he was setting me up. I felt special because I had that in my life. I held onto it.

A few sessions later, Michelle arrived carrying a plastic bag full of what she called her "Pete things"; she wanted to concretely let go of Pete, a typical

impulse in the course of rape recovery therapies (akin to, e.g., writing a goodbye letter). In previous sessions, she had mentioned her desire to throw away things she associated with Pete, and had decided that this would be the right time to do this. Inside the bag were all kinds of artifacts, including the vodka bottle from that night, which she had saved for 13 years, pictures of Pete, his clippings, the jersey she always wore on the anniversary, letters he wrote to her, letters she wrote (but never sent) to him, and a stuffed animal called the “black sheep” that she associated with the rape (with notable racial connotations). This seemed to me a reflection of her tendency to act instead of feel, but also a representation of her belief that these things had intrinsic emotional value. Internally, I questioned the decision to throw these things away, but also wanted to attend to the way in which she was starting to integrate her emotions and her desire to act on her emotions. It seemed like a sign that she *wanted* to move forward with her emotional life. As we discussed what it would mean to her to throw this bag away, she took out the sheep and clutched it to her chest, talking to me while stroking the sheep in her arms.

- B: Imagining all this stuff in the trash, what would that be like?
 M: I’ll be fine with it. Before I don’t think I could have, but we’re here together, and I know I can do it with you here. I couldn’t do this alone though. They’re a reminder about things, and I don’t want that reminder. I want them to be gone from my life (cries).
 B: I see you holding that stuffed animal, and it’s so strange to see this stuffed animal, something that’s meant to be this soft cuddly thing, and it’s holding so much pain for you.
 M: Yes, because to me this is badness. It’s black and negative. All of it is negative. Its head doesn’t even stay forward right! Like the head is screwed on wrong. Like that night my head was screwed on wrong.

We went through each item together, with me asking what it meant to her, and what memories she associated with each item. She told me about the vodka bottle and how she had kept it in case she ever decided to turn Pete in to the police. She believed to this day that it had his fingerprints on it. She told me about the pictures of him she had kept taped to her wall, the clippings of his massive body running across the football field, the crisp letter he wrote to her. She told me how she had kept that letter in a frame until very recently, and said she was proud that it was still in perfect condition. When we got to the jersey, the last item in the bag, I asked:

- B: Does this jersey make you the most sad?
 M: I correlate that jersey with the sadness I’d feel on those days . . . I remember thinking when I wore that jersey later, “You bastard!” It was my badge of hurt and my badge of strength. I remember

thinking he hurt me worse than anyone could ever hurt me. I can remember that the last time I wore it I was with [my ex-boyfriend] and I was mean to him. I was hardened, and it was because of that jersey. I don't want to feel like that anymore. I want to love and extend myself and not feel like I have a barrier around me. I'm starting to feel that way in here. (pause) I was talking to this doctor today and he told me I have maternal instincts. He said I would be such a good mother. I feel like that. I could be such a great mother. I'm taking steps to get myself there. I don't know. (pause) I feel like when I look at that letter there, he should have wrote, "I'm going to mess up your life at some point." You son of a bitch. (cries)

B: It's so sad to think of you walking around in that jersey on the anniversary.

M: It's so sad. A sick sadness. How could I do that? I don't know why I didn't hate him. I just felt like I was so sad and so hurt. No hate or rage. Just sad. It felt natural to wear it. I'm so sad on the inside, so I'll wear his jersey and have that sadness be on me, too. It's in me. So it was okay to wear it.

B: And that wish of what would have been. That he was the kind of guy who'd send you a jersey or write you a letter and make you feel special.

M: Right. And I still think about that apology and I guess I feel a little satisfaction knowing it was still on his mind, too. That he knew he did wrong. He's living with discontentment about it (cries).

Although this concrete letting go of Pete did not cement Michelle's distance from the rape event, it did symbolize a typical pattern during rape recovery: minimization of trauma, acknowledgment of the trauma, traumatic symptoms, and letting go. Michelle's treatment felt successful to the extent that Michelle was able to better integrate her sense of self (i.e., her feelings of love for Pete, along with her sense of betrayal and need to grieve), and when she finally experienced the trauma in the context of social supports. Whereas she used to attribute many of her difficulties to her experiences with Pete, she began to conceptualize her problems as stemming from larger issues within herself. For example, in one session she remarked,

M: It's so scary to think I have to break down these ways of doing things. When I dealt with Pete, it was so painful. And now it's not just me and Pete. It's just me, in a bigger way than with Pete. Now the onus is all on me. Even though that day happened, he didn't tell me how to act or which way to turn. I've chosen this path, and that's scary for me to think about.

As we started to explore some of these issues, particularly around her increasing awareness of her sad and lonely feelings, she became quietly

emotional. I noticed that she cried during sessions, but not with the same intensity as she did while processing her love for Pete. She was able to slow down her narratives, think more reflectively about herself, and talk more openly about the parts of her that did not represent a “happy person.” Importantly, when she finally *felt* the trauma, its hold over her life lessened. In one of our last sessions, I was encouraged when she said, “I think I am lonely. I feel like I’m a flower and the outer layers have unfolded, and I’m raw and open, and starting to get that way. But it’s so hard to imagine facing these things fully.”

After 50 sessions, Michelle and I terminated treatment. Although she did not originally qualify for a diagnosis of depression or PTSD, it was clear that trauma, and the subsequent emotional detachment she experienced, figured centrally in her treatment and recovery. Although the time between the rape and recovery was atypically long, this process is similar to some other rape recovery cases. During the course of treatment, as she reconnected with her emotional self and processed the trauma, she became agentic and disidentified with Pete while reestablishing herself as the authority of her life. By the end of treatment, Michelle had bought a house on her own (something she expressed fear about before), and had started dating an African American physician’s assistant from her hospital, who she described as “kind and interesting.” She described her new relationship as “positive and connected,” yet still acknowledged that she had unhealed wounds that would take time to heal. Michelle described herself as “letting go, slowly.”

DISCUSSION AND CONCLUSION

Drawing on Herman’s trauma theory, Kohut’s construction of self-psychological transferences, and recent clinical research findings about the eroticization of hate (or “loving hate”), Michelle’s treatment was formulated as a process of helping her understand and process the impact of her previous trauma on her current patterns of behavior, both in terms of how she viewed herself and how she (dis)connected with others. Central to the course of therapy were several goals: (a) to create space where Michelle could openly express and process her feelings of love toward her rapist, despite her perception that such feelings were “taboo”; (b) to facilitate Michelle’s understanding of idealizing dangerous male figures as a central pattern in her life; (c) to help Michelle reconnect with her emotions, particularly any negative emotions that she might have perceived as threatening; (d) to facilitate, in the context of reconnecting with her emotions, a disidentification with her rapist as a representation of healing and recovery from her trauma; and (e) to construct space for Michelle to express anger about surviving sexual assault.

Michelle accomplished many of the initial goals of the treatment. She made significant progress in her ability to cope with, and emotionally experience, the rape. I watched her transition from being a very action-oriented problem solver to becoming more thoughtful and reflective about her experiences. Most important, she was able to disidentify with her aggressor, a task that entailed acknowledging and processing some of her most shameful and repressed emotions. Michelle moved through the stages of trauma and recovery. She established safety, reconstructed the narrative of the rape, and worked actively to connect more genuinely to others. My work with Michelle pointed also to the success of using self-psychological theory in tandem with trauma and recovery work. These techniques allowed a greater focus on helping Michelle to integrate the painful aspects of her emotional life. Self-psychology illuminated Michelle's struggles to seek approval and affection, and to find positive self-objects in her life.

Reflecting back on my work with Michelle, I see her as a woman who struggled for many years to "keep it together." This was directly connected to her need to perform happiness, to be happy about coming to therapy, to be happy at work, to be the happy, lovable child to her parents, and even in her perceived capacity to hold her parents' relationship together. Her emotional blocking and desire to present herself as "together" is in line with existing research on women who experience rape without social supports to process the trauma. Although the rape challenged Michelle's sense of safety and security, as well as her boundaries with men and her erotic life, it also reinforced Michelle's vision of herself as someone who had to "keep it together." Breaking down this pattern was an essential step in her treatment. In essence, helping her finally recognize her PTSD symptoms was a crucial step in the treatment.

Although this case study is unique in its lack of immediate acute PTSD symptomology, it offers insight into the importance of processing trauma that occurred in the distant past. Such trauma can dramatically disrupt the patient's sense of self and impair psychosocial relationships, even while the patient remains relatively "asymptomatic" at the start of therapy. This study also shows that consistent transcriptions of recorded sessions can offer a unique and complex window into the client's inner life. In taping and listening to these sessions again directly after conducting the sessions, I could pick up on some underlying emotional currents and narratives that I might have otherwise missed, which then facilitated better treatment overall. Taping sessions can be a useful tool not only in training and clinic settings, but also in continued therapeutic development for professional private-practice therapists. It also enriches the case study analysis process by focusing on the client's qualitative experiences and self-conceptualization. Continued efforts should be made to utilize precise transcriptions of process content when presenting case study analyses, as it allows discursive space for dialogue about cases while also implicitly lessening power imbalances

already present in the therapist–patient dyad (Neudert, Gruenzig, & Thomae, 1987; Jones & Windholz, 1990, also use extensive transcriptions of session content).

The story of Michelle seems to be the story of someone who has been essentially alone in her struggle to recover from a traumatic event. She had very little support to deal with the rape, aside from an unsupportive girlfriend who believed she should be grateful and a mother who was blindly enraged. She began her process of healing and recovery by allowing herself the emotional space to love, to grieve, and to share her pain with others. It was only in acknowledging her identification with Pete as an aggressor that she could detach from that identification and learn how to forge her own identity apart from this identification. This study illustrates the centrality of disidentification in the process of rape recovery (an area sorely in need of future research), and it emphasizes the urgent importance for therapists to create space for rape survivors to construct their own complex emotional narratives, even if those emotions include love and admiration toward the person who caused their emotional pain.

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