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Bearing Witness to Uncorroborated Trauma: The Clinician's Development of Reflective Belief

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Clinicians should not reflexively accept or reject as fact a client's initial report of uncorroborated abuse. However, by maintaining a neutral stance, clinicians may fall short of therapeutic honesty and transparency, may fail to promote reality testing, and may not perform the necessary step of bearing witness to the client's victimization. Using a case of dissociative identity disorder, this article proposes the careful development and sharing of the clinician's reflective belief in the (in)validity of reported trauma. This process may assist clients in (a) reclaiming a sense of integrated personal narrative memory and identity, (b) correcting cognitive distortions, or (c) both.

When clients report childhood abuse, it is impossible—without corroborating evidence—for mental health care professionals to determine with absolute certainty that abuse has taken place, regardless of whether such memories of abuse are reported as always having been remembered or are so-called recovered or delayed memories (Pope & Brown, 1996). A significant clinical issue is how to treat responsibly and sensitively adult clients who report traumatic childhood events without independent corroboration or refutation. Clients and clinicians operate in a domain of uncertainty that entails two major risks. Valid memories may be denied (false negatives), and pseudomemories may be judged to reflect historical events (false positives). To complicate matters, some memories may include both historically true and false elements (Brown, 1995; Janet, 1932), and sometimes persons who have truly been abused deny traumatization (e.g., Lewis, Yeager, Swica, Pincus, & Lewis, 1997) or retract previous allegations. All this applies to continuous, fragmented, as well as delayed memories (Harvey & Herman, 1994; Herman & Harvey, 1997).

The clinician's judgment on the veracity of clients' memories is likely to affect clients' perception of their memories and, as a result, the therapeutic process and outcome. This judgment may also result in legal consequences (such as a client suing the alleged abuser or accused parents suing the therapist). Thus, there is a pressing need for guidelines to help clinicians avoid misjudgments of any type. However, clinicians have not yet reached consensus on the best approach. Some stress the need for the therapist to search for external evidence of reported abuse (McHugh, 1993). This requirement may result in significant rates of false negatives and in traumatized clients being discouraged from seeking treatment (Uyehara, 1997). Many others emphasize the need for the therapist to remain neutral with regard to the validity of (delayed) memories of abuse (e.g., Brown, Scheflin, & Hammond, 1998; Ganaway, 1989; Kluft, 1995b; Matthews & Chu, 1997; Simon & Gutheil, 1997). No matter how supportively applied, persistent neutrality may imply therapeutic failure to be honest and transparent, may not promote reality testing, and does not allow the therapist to bear witness to the client's traumatization (Herman, 1992; Laub, 1995). On the other hand, reflexively accepting or rejecting the validity of reported abuse serves no therapeutic function and unduly raises the false-positive or false-negative rate.

The goal of this article is to emphasize the initial need for therapeutic neutrality with regard to the validity of reported abuse, the subsequent importance of achieving reflective belief, and, if the report is considered partly or completely authentic, the importance of bearing witness to the abuse. The complexities of this stance are detailed in a case example of dissociative identity disorder (DID).

Reflexive Belief Versus Reflective Belief

In the face of trauma, particularly in cases of delayed memories of childhood sexual abuse, society and individuals have demonstrated a tendency to take extreme positions on a continuum of belief (e.g., Fredrickson, 1992) and disbelief (e.g., Ofshe & Watters, 1994). In DID, various identities also may engage in this type of reflexive thinking, resulting in internal conflicts of belief. These beliefs are of a sentimental, reflexive quality (Janet, 1926), as they are driven more by emotion, prejudice, and untenable or restricted views on the matter rather than by careful consideration of all evidence.

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Therapists should avoid such reflexive beliefs. The point of departure should rather be a supportive, neutral therapeutic stance on the veracity of uncorroborated trauma memories, characterized by an appreciation of the complexity of the question of "truth" (Ganaway, 1989). By adopting a scientific attitude or a stance of informed uncertainty (Kluft, 1995b), therapists should create "an *atmosphere of* support and faith in the patient's own ability to adopt a critical attitude in separating fact from fantasy" (Brown, 1995, p. 18).

However, persistent therapeutic neutrality often becomes problematic for the client, the therapist, or both. This approach ultimately may make the client feel doubted (Gutheil & Simon, 1997) or, worse, may be experienced as "actively malignant if it is felt to represent a repetition of the negation of his or her selfhood by victimizers" (Laub & Auerhahn, 1989, p. 392). The failure of others to bear witness to the clients' victimization and suffering can have devastating consequences for their ability to heal (Viederman, 1995).

Therapeutic neutrality may also be unsustainable, because it seems highly questionable whether therapists will in the long run remain totally neutral as to the (in)validity of the client's reports. There may come a point in the therapy when certain historical aspects are accepted as true by both client and therapist (Matthews & Chu, 1997). Emergent beliefs will be communicated at least implicitly. In fact, withholding them would be at odds with therapeutic transparency and honesty. Uyehara (1997) added,

> Once the patient has substantially resolved her ambivalence about the reality of certain experiences, and the therapist feels that sufficient work has been done to minimize distortions and to explore defensive functions of such memories, the therapist's persistence in interjecting doubt about the memories would be unnecessarily undermining to the patient. (p. 413)

Persistent neutrality may also imply failure to correct memories or ideas that, beyond reasonable doubt, are incompatible with reality.

Although therapists eventually cannot avoid acting in the face of ambiguity and uncertainty (Uyehara, 1997), they should delay forming a belief about the validity of reported memories of trauma. Instead, they should develop a reflective belief (i.e., "croyance réfléchie"; Janet, 1926) in collaboration with their clients. This type of belief is the outcome of interpersonal and intrapersonal deliberation involving a careful, ongoing analysis of all evidence and constant reconsideration of the hypotheses (Uyehara, 1997). Along the way, therapists maintain an open, accepting, and compassionate stance toward memories of trauma, without premature validation or disbelief. This stance supports the therapeutic value of making meaning out of one's experience and the human need to develop a sense of one's personal truth.

Bearing Witness

Writing about the difficulties of Holocaust survivors in experiencing the full weight of their misfortunes, Laub (1995) stated, "This loss of the capacity to be a witness to oneself and thus to witness from the inside is perhaps the true meaning of annihilation, for when one's history is abolished, one's identity ceases to exist as well" (p. 67). With particular relevance to therapists, he adds, "It is the encounter and the coming together between the survivor and the listener, which makes possible something like a repossession of the act of witnessing. This joint responsibility is the source of the reemerging truth" (p. 69). It leads to reclamation of the past and the development of a coherent life story, which foster and consolidate a stable sense of identity (Matthews & Chu, 1997), as well as to a return to current developmental tasks and challenges (Sauzier, 1997). Trauma survivors commonly cite the importance of the therapist's validating role (Herman, 1992; Phelps, Friedlander, & Enns, 1997). Therefore, therapists should be open-minded, compassionate witnesses who adopt a position of moral solidarity with the survivor (Herman, 1992). This stance involves constructing a new interpretation of the traumatic experience that affirms the dignity and value of the survivor.

Clients struggling with uncorroborated, but likely valid, memories of trauma may need validation of their experiences even more than clients with at least partly corroborated trauma, such as war experiences. This need for validation is especially true for clients reporting fragmented or delayed memories—often characteristic of memory process in DID—rather than continuous memories of abuse. The validation should rely on reflective belief in the client's traumatization. On the other hand, a reflective belief that the reported trauma is partly or completely invalid must be shared sensitively and compassionately in a timely fashion.

The Development of Reflective Belief

Under circumstances of uncertainty, a reflective belief regarding the likelihood of prior traumatic exposure must be based on indirect evidence. In order to avoid false negatives and false positives, there is a pressing need to know which symptoms and signs are more likely to accompany past traumatization and which are probable indicators of false allegations. Although producing such a list is beyond the scope of this article (cf. Whitfield, 1995), a few indications may be tentatively mentioned.

Severely threatening events are more likely to have occurred when the client exhibits emotional, behavioral, and somatosensory responses known to be highly consistent with traumatic exposure. These responses include conditioned startle response in anticipation of shock (Morgan, Grillon, Southwick, Davis, & Charney, 1995), analgesia (e.g., Van der Kolk, Greenberg, Boyd, & Krystal, 1985), and anesthesia and freezing (Nijenhuis, Spinhoven, Vanderlinden, Van Dyck, & Van der Hart, 1998). Other known posttraumatic stress responses are sensory-level reexperiences of the event and dissociative reactions occurring during or immediately after exposure to trauma (Marmar, 1997). These dissociative reactions may involve partial or more complete amnesia for the event. Failure to inhibit defensive and other emergency reactions to (conditioned) stimuli that no longer predict trauma or refer to past trauma are also mentioned as posttraumatic stress responses (Jacobs & Nadel, 1985; LeDoux, 1996).

To further reduce any chance of generating false beliefs in therapy, professionals should adhere to proper clinical guidelines. These guidelines (Brown, 1995; Brown et al., 1998; Courtois, 1996, 1997; Enns, McNeilly, & Gilbert, 1995; Kluft, 1996; Pope & Brown, 1996; Van der Hart & Nijenhuis, 1995) include the following: (a) avoid explicit and implicit suggestions while interviewing a client, (b) remain well informed regarding memory research, (c) avoid uncritical acceptance or rejection of statements by clients pertaining to memories for traumatic events, (d) avoid a presumption that trauma has or has not occurred in cases of

amnesic clients, (e) ask to be informed of all manner of relevant information and suggestions outside therapy to which a client may be exposed, and (f) remain alert that corroborated evidence for the occurrence of an abuse does not prove other allegations and, conversely, that a disproved allegation does not a priori invalidate other claims.

In short, the therapist's sensitive and ongoing analysis of complex indications both for and against prior traumatic exposure may yield a reflective belief that a reported traumatic event occurred, partly occurred, or did not occur. Communicating this reflective belief to the client involves bearing witness to traumatization, correcting cognitive distortions, or both.

The Report of Trauma in DID

The development of a reflective belief regarding the veracity of memories of abuse is probably the most complex in clients with DID: They usually manifest multiple, coexisting forms of knowing and not knowing trauma (F. W. Putnam, 1989; Van der Hart, Steele, Boon, & Brown, 1993). In general, some identities may report a continuous memory of an event, some are amnestic for it or "recover" it in treatment, and others demonstrate the effects of trauma on a purely sensory–motor level. Still others may exhibit a detached, cold perspective toward the alleged event or concurrently deny its validity.

Practically all clients with DID report extreme and multifaceted childhood traumatization (Boon & Draijer, 1993; Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden, 1998; P. Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross, Norton, & Wozney, 1989). Studies providing independent corroboration of DID clients' continuous as well as delayed traumatic memories support the hypothesized link between this disorder and trauma (e.g., Coons, 1994; Hornstein & Putnam, 1992; Kluft, 1995a; Martínez-Taboas, 1996; Lewis et al., 1997; Sar, Tutkun, & Yargic, 1997). Some clinicians still doubt that DID is a trauma-induced disorder (Frankel, 1993), but there exists no evidence that continuous or delayed traumatic recall in DID consistently results from fantasy or suggestion. Yet therapists should not automatically assume childhood abuse when DID is diagnosed.

Diagnosis and Treatment of DID

Extensive clinical guidelines for diagnosing the dissociative disorders have been developed (Loewenstein, 1991) and are most systematically presented in the Structured Clinical Interview for *DSM–IV* Dissociative Disorders (SCID–D; Steinberg, 1995). The SCID–D provides an in-depth assessment of five dissociative symptom clusters experienced in the daily life of the client: amnesia, depersonalization, derealization, identity confusion, and identity alteration.

Evaluation of dissociative clients is incomplete without an assessment of current personal and professional functioning. Important issues are the capacity to form a therapeutic alliance, abide by contractual arrangements, understand and tolerate other people's points of view, form supportive relationships with significant others, check impulses, and apply self-care. The presence of other Axis I and Axis II disorders must also be evaluated as must substance abuse, self-injurious behavior, and ongoing trauma (Van der Hart, Van der Kolk, & Boon, 1998).

The current standard of care emphasizes phase-oriented treatment of DID and related disorders, in which memory recovery is not the primary focus (Brown et al., 1998; Courtois, 1996; Herman, 1992; Horevitz & Loewenstein, 1994; Kluft, 1996; Van der Hart et al., 1993). The model involves three phases, with their own healing tasks (Kepner, 1995), as treatment foci and procedures: (a) stabilization and symptom reduction: overcoming the phobia of dissociative identities; (b) treatment of traumatic memories: overcoming the phobia of traumatic memory; and (c) personality reintegration and rehabilitation: overcoming the phobias of normal life, attachment (Nijenhuis & Van der Hart, in press), and intimacy. The model takes the form of a spiral. Earlier phases of treatment will be revisited periodically as learning experiences in more advanced phases allow for deeper work regarding previous issues (Courtois, 1996). Premature exploration and treatment of reported traumatic memories yield undue regression, decompensation, and suicidal behavior. Therefore, Phase 2 treatment is initiated only when the client has achieved sufficient stability, skills, and ego strength to manage and tolerate strong emotions (Courtois, 1995). This level of functioning remains beyond the reach of some clients (Horevitz & Loewenstein, 1994).

Human-induced trauma leaves a legacy of attachment conflicts and difficulties. Attachment disorders are a central force in maintaining dissociative defenses, amnesia of a painful past, and social isolation. Phase 1 treatment should focus on the facilitation of a gradual attachment with the therapist as a prerequisite for increasing degrees of vulnerability and trust (Barach, 1991). Such attachment would obviously depend on the therapeutic climate, including the therapist's reflective response to reported trauma.

Another major goal of Phase 1 treatment is fostering cooperation between identities that initially present with mutual states of conflict, misunderstanding, and fearful avoidance—hence the motto "overcoming the phobia of dissociative identities." A related issue is psychoeducation about dissociation and dissociative disorders. When therapist and client have developed a reflective belief in the client's traumatization, psychoeducation about trauma and posttraumatic stress disorder (PTSD) is also mandatory. Phase 1 treatment additionally includes cognitive therapy and teaching the client techniques for coping with posttraumatic stress symptoms, including management of stimuli that reactivate traumatic memories and containment of these memories. Phase 2 treatment involves controlled exploration of and emotional exposure to traumatic memories to achieve their synthesis.

Case Report

The following report describes the development—during prolonged Phase 1 treatment—of the therapist's and a DID client's reflective belief in this client's memory of being locked up in a closet by her mother. The importance of the therapist bearing witness to the client's victimization will subsequently be discussed. The client has given her consent for publication after careful reading of this text. Details of the case have been changed to protect anonymity.

Treatment History, Dissociative Symptoms, and Reported Abuse

Ettie, a college graduate, had a long history of treatment, which began in 1988 at age 18 when she was referred to a community

mental health center. She reported a history of twilight states, dissociative episodes lasting 1 or 2 days, and loneliness. In 1989, Ettie reported hearing menacing voices ordering her to commit suicide, which made her extremely anxious; as a result, she was hospitalized twice during 1990. After Ettie married in 1992, at age 22, she entered treatment with a psychologist (Onno van der Hart) who specialized in the treatment of dissociative disorders. Her main complaints were experiencing panic attacks, having amnestic episodes lasting up to several days, and hearing childlike voices crying and screaming in her head. Administration of the Dissociative Experiences Scale (Bernstein & Putnam, 1986), a self-report questionnaire assessing the frequency of dissociative experiences in the daily lives of clients, and the SCID–D confirmed the clinical picture of DID with persistent identity alterations and dissociative amnesia. Furthermore, Ettie's husband, John (who had known her a long time before they got married), had in the course of time observed many of these dissociative phenomena in her, including amnesia and strikingly different levels of proficiency while performing the same type of tasks.

In addition to her DID symptoms, Ettie exhibited many intrusion and avoidance symptoms consistent with the presence of chronic PTSD. These symptoms included startle responses in the presence of a perceived threat, as on those occasions when the therapist leaned forward in his chair to reach for a pencil. These symptoms became particularly pronounced when she became pregnant and, 1 year after the beginning of treatment, after giving birth to the first of her two children. In order to be able to continue to visit the obstetrician, she created a new identity who could endure being touched and examined.

Over the course of treatment, Ettie reported having been repeatedly abused sexually by her father from an early age on. This memory was delayed recall for Ettie, but when later questioned about it, other identities reported having always remembered this abuse. She described her mother's parenting as highly punitive and unpredictable. Ettie had continuous memories for this abuse, although she remembered more about some incidents than others.

During Phase 1 treatment, Ettie lacked the ego strength, life stability, social support, and emotional capacity to explore and process previously and newly reported multifaceted parental abuse. The emphasis was on mastering containment techniques to cope with daily reactivations of traumatic memories, a task that was complicated by Ettie's continued contacts with her parents. These contacts were extremely stressful, as the parents' controlling, critical, and often contradictory behaviors made her desperate and triggered various memories of abuse.

The following material is a systematic summary of the client's identity state-dependent reports of having been locked up in a closet, which, in reality, came in bits and pieces over a prolonged period of treatment. It also highlights the ways in which the therapist responded to these communications.

Recall of Confinement in a Closet

Early reports. During the assessment phase of treatment, a dissociative identity briefly introduced the closet when describing abuse by the mother. Two years later, a different identity wrote a concise history of closet-related abuse, keeping it rather shallow so as to avoid reexperiencing the events. Because these two identities did not consider Ettie's parents as their own, both referred to the mother by gender. One identity wrote,

> The woman has hated the baby from the first moment, and she tried to bend the child to her will. . . . Her severe approach resulted in an extremely quiet child. . . . When the brother was more than a year old and began to walk, the locking in the closet began. At first, she did this in order to prevent quarreling between both children, and to put the toys at the disposal of the brother. . . . Later on she did this because of indolence, habit and, especially, in order not to see or notice the hated child.

The therapist initially responded to these communications in a neutral and nonexplorative way. Wishing to avoid undue reactivations of traumatic memories, he only asked some open-ended questions for clarification. Ettie later stated that she had experienced his questions as being neutral and not supportive, bordering on not believing her.

Ettie's flashback experiences. Ettie's memory was more fragmented than those of identities, who were able to present a more complete account of past events, and most often Ettie was amnestic for experiences of other identities (including time in therapy). However, on many occasions when other identities suffered from traumatic memories, she also suffered. Ettie wrote,

> Again and again, the same images appear in my head . . . always about the same thing. In the past, I had to be in the closet sometimes. Don't know much about it anymore. Very long time ago . . . Now it returns everywhere in many different ways . . . most of the flashes in my head are so fast . . . they cannot really be seen or known.

Two months later, she wrote,

> Am afraid of closets, also of small spaces, of dark spaces. Become sometimes suddenly very scared in a shop, because of the smell of clothes, of material . . . Very often lose time. Know that it has to do with the closet, in which my mother locked me up . . . Can hardly remember it. But do know very certainly that it happened. A terrible kind of fear. Simultaneously knowing and not knowing.

Although Ettie was a highly talented woman, she completely lacked positive self-esteem, felt extremely uncertain about herself, and was unable to place any confidence in her own judgment about these experiences. Her uncertainty caused her to experience great difficulty in answering even the most neutral questions from the therapist. His tendency was then to let the matter drop, with the effect that Ettie felt left alone in her confusion and despair.

Drawings made by a child identity. The therapist allowed communication by writing or making drawings at home. Most of the drawings, made by child identities, pertained to various forms of alleged abuse perpetrated by the father and mother and included scenes of a child locked in a closet. The therapist did not suggest a content for these pictures or letters. Afterward, the client reported that this lack of direction discouraged her also from communicating pressing issues unrelated to this abuse.

A continuous sense of being locked inside the closet. From other identities, the therapist learned that one particular identity perceived herself, and was perceived by other identities, as existing without respite within the confines of the closet. In May 1995, the therapist proposed a session to help release this identity from her traumatic sense of being frozen in time. But another identity

strongly resisted, saying that if this release occurred, another identity would have to replace her.

Reports by identities of reexperiences of the abuse and transference reenactments. In November and December 1993, one child identity wrote about others,

> Always she is crying
> Then Tietie is afraid . . .
> She must be in the closet
> And she may not cry
> And not lie down
> And not call
> And she wants out of it
> But Mom says you have nothing to want
> Because faulty children have to be glad that she gets food
> Because only good children
> May say
> And play.

Throughout the first years of treatment, other child identities expressed their fear that the therapist would get angry at them for not obeying him and lock them in a closet. He empathized with these child identities and stated that parents should not lock up their children. As a result, these identities perceived him as a bit more as a safe person, but they remained amazed that the therapist did not regard the locked up identity as "bad," as the mother allegedly had asserted.

A distinction between the alleged unsafe past and the presumably safe present began to be established, but it was tenuous. When the therapist referred Ettie to a colleague who could provide treatment when he was on vacation, these child identities expressed more fear of being locked up, because the other therapist was a woman and there was a closet in her room.

Reactivating stimuli. Several child identities responded consistently with intense fear or freezing to other stimuli associated with the original closet experiences: darkness, mother, small beams of light, closets, and confinement. For example, throughout the years of treatment, several identities would respond fearfully to the small on-lights of electronic equipment, such as those of a computer in the therapist's room. While discussing these fears and taking drawings of being locked in the closet into account, the therapist wondered if these fears could be traced back to the experience of seeing light entering the closet through the keyhole. His repeated explanation of the differences between the light through keyholes and other lights caused a significant reduction of such reactivated fear responses.

Minimization by another identity. After Ettie had once brought up the issue of having been locked up in the closet, another identity indignantly responded,

> Why would she [the mother] lock up a little child? We left that house at age four-and-a-half. It is hard to say how things were exactly . . . And suppose that somebody ended up in a closet once or twice, then chances are very big that the joke ran out of hand. A small child can get frightened and lose sight, all out of proportion. Being frightened one time can lead to a story, a false memory in which it always happened.

The therapist initially felt it imperative to be open to this identity's point of view and eventually discuss various options with her. These discussions made her invariably angry and only fixated her more in her own views. This identity's point of view forced Ettie time and again to review her own uncertainties, and Ettie eventually concluded that her position (i.e., that the abuse had taken place) was right. However, Ettie's belief caused animosity between this identity and Ettie as well as other identities who believed the closet abuse took place. This animosity resulted in increased dissociative barriers that protected Ettie from the conflict.

The Therapist's Development of a Reflective Belief

In the course of Phase 1 treatment, it became increasingly clear that Ettie's shattered sense of self and social isolation were continuously reinforced by her bewilderment about her personal history, in particular her chronic traumatization. For Ettie to develop some sense of connectedness with at least a few other people, the therapist felt that she needed to have a minimum trust in her own memories and, therefore, in herself. Given his emergent reflective belief that abuse occurred, this trust could be promoted by the therapist bearing witness to her traumatization. He also felt his belief in Ettie's traumatic confinement had to be shared with her, as it interfered with sustained neutrality and therapeutic transparency.

Partial external corroboration and the status of denial by alleged perpetrators. As Ettie became more descriptive of her sense of having been locked up, she began to raise questions with her parents about the closet. Her father said that it had perhaps happened one or two times, and her mother agreed, dismissing the action as just a joke. The therapist learned another version from a colleague who was in contact with the parents: Ettie's mother had sometimes asked her to voluntarily sit for a short time in the closet in order to prevent a quarrel between the two siblings over toys.

Under circumstances where clinicians should not automatically accept the validity of alleged abuse, they should not reflexively believe in the validity of reports of those accused either (Courtois, 1995). Perpetrators have strong incentives to deny their actions and may even deny legally obtained and adjudicated evidence (Kennedy & Grubin, 1992), whereas some have dissociative amnesia for the abuse (Bliss & Larson, 1985; Pollack, 1996). A thorough assessment of Ettie's parents and their claims was unfortunately beyond reach.

Contradictory versions. Which version of Ettie's truth best approached the historical truth? The fact that several identities reexperienced the forced confinement as traumatic does not, in itself, contradict an interpretation of the events as a failed joke or as a kind request. However, even if the events were not intended to do harm, at least a severe form of neglect appeared to have taken place in the parents' failure to recognize the terrorizing impact of this experience on their daughter. In the therapist's opinion, historical examples, drawings, and unwavering assertions by some identities became mounting evidence for characterizing the experience as abusive. The descriptions of the mother's rejection and hatred of her unwanted daughter, and her extreme need to dominate the child, suggested the motives for her abusive behavior.

The minimization of abuse by one identity and Ettie's continued dissociation from traumatized identities conformed with clinical findings regarding the major developmental task of sustaining attachment (Bowlby, 1985). Denial, minimization, and dissociation have helped Ettie survive by maintaining a positive regard of

her parents, reconstructing history, and putting the blame on herself—something that was acknowledged by other identities (cf. Freyd, 1996). The stance of the identity who minimized the abuse could, therefore, not be taken reflexively for the historical truth.

Evidence of traumatic confinement included the disavowal of the mother by some identities, their (conditioned) fear of speaking and moving, their constant crying, and the failure to extinguish acquired associations between conditioned and unconditioned traumatic stimuli and adjust traumatic beliefs. Apart from this, the client's belief systems and fear were consistent with traumatic reenactments in the transference relationship. These reenactments constitute one particular form of reactivated traumatic memories (Dalenberg, 1996; Davies & Frawley, 1994). Furthermore, the client and her dissociative identities initially could relate only fragments of what appeared to be highly disturbing past experiences. This feature is characteristic of traumatic memories (Van der Kolk & Fisler, 1995).

Suggestion. The therapist refrained from making suggestive remarks, and he also considered other sources of possible memory distortion. He did not apply hypnosis or age regression, suggest a content for the client's pictures or letters, or use other means that could foster the creation of false beliefs. He made careful notes of reports and indications of abuse. Ettie continuously impressed the therapist with her honesty and lack of suggestibility. She did not reflexively believe the alleged abuse. Reframing her beliefs met with strong resistance.

The therapist's reflective belief. Having weighed all the evidence, the therapist concluded that the client's various narrative, psychological, and sensory truths were compelling. His emergent reflective belief was that the confinements were traumatizing, had occurred more than once, and, for the child, had been experienced as malicious in intent. He subsequently applied the same type of analysis to other forms of reported abuse. His conclusions were similar. Our own application of forensic criteria, developed by Elliott and Briere (1994) and by Rogers (1994) for evaluating allegations of sexual abuse, led to conclusions that support the therapist's position.

Bearing Witness to Traumatic Confinement

For Ettie, the admission by the parents was validating: "Now the story fits. Even though they twist it, it remains clear that what was remembered is true." The therapist's position that one doesn't lock up children was validating in another sense: In her experience, this rule applied to other children, not to herself. Taking this consistent stance reflected a first step of the therapist's bearing witness. It fostered clarity and, therefore, safety. As a result, various child identities began to feel more accepted when bringing up the subject. With the exception of the identity who minimized the abuse, they began to feel his comments as supportive and validating.

The importance of the therapist bearing witness became more apparent when, about 2 years after the beginning of treatment, Ettie was caught in persistent confusion about herself and her personal past. At this point, the therapist suggested collecting from her file the various bits and pieces of being put in the closet in order to make sense of them together. Ettie hesitantly agreed. Sharing all evidence and carefully discussing the various similarities and contradictions, the therapist reached with her an agreement about the likelihood of the abuse having taken place. Ettie experienced this reflective exchange as a validation of her memories and personal existence. It was the beginning of therapeutic progress in which the client's ability to self-validate began to develop.

Conclusion

The present case suggests that a therapist, by carefully developing a reflective belief in and subsequently bearing witness to reported trauma and promoting reality testing, assists a client in (a) reclaiming a sense of personal narrative memory and identity, (b) testing reality, and (c) moderating diverging dissociative identity-dependent memories, cognitions, and emotions. These are important goals of Phase 1 treatment. More complete relegation of traumatic memories to the past and integration of dissociative identities demands emotional processing of traumatic memories, which is the focus of Phase 2 treatment.

When exact knowledge about the validity of a traumatic memory is unattainable, achieving reflective belief, bearing witness to the client's abuse, and promoting reality testing may overcome the shortcomings of reflexive belief and persistent therapeutic neutrality. By bearing witness to the client's traumatization, the therapist provides the foundation of safety and trust and promotes the client's ability to validate self and adequately test reality.

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