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**PhD in Psychotherapy**

**Thesis Title:**

# A Qualitative Analysis of Athenian Psychoanalytic Therapists' Approach to Working with Adults' Child Sexual Abuse Memory

**Declaration of Authorship**

I ...Eirini Piki... hereby declare that this thesis and the work presented in it is entirely my own. Where I have consulted the work of others, this is always clearly stated.

Signed:

Date: 31/10/2018

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I would like to thank the individuals without whom this PhD thesis would not have been possible.

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**Abstract**

The historical background regarding proposed psychotherapeutic treatment of adults' child sexual abuse memory is bristling with obscurities. More recent relevant history involved the recovered-false memory debate, which also addressed but failed to answer certain questions regarding the handling of child sexual abuse memories. The present thesis attempts to explore literature gaps and controversial situations met by professionals working with adults who experience child sexual abuse memories. For this purpose 31 Athenian psychoanalytic therapists were interviewed, and the emerging data were analysed qualitatively using Content Analysis. Most of the key findings, regarding child sexual abuse memories in psychoanalysis, contradicted past research findings, emphasised difficulties and revealed that psychoanalytic therapy can be effective. The present study produced new ideas about unexplored areas in the psychoanalytic work with CSAM (e.g. the conditions under which the fantasy-realily distinction is the therapists' responsibility) and provided guidelines for various issues (such as how to facilitate the distinction between fantasy and reality in cases involving CSAM). Implications for clinical work with adults who suffer from child sexual abuse memories are examined and suggestions for future research are given.

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# Thesis Introduction

Memories of Child Sexual Abuse (CSA) may allude to real or fantasised material. They may be remembered, misremembered, or disremembered, due to their painful nature, or because of child amnesia. Adult sufferers of such memories are likely to see a therapist, typically requesting to cope with related symptoms. In therapy, these analysands are occasionally unaware, sometimes aware and expressive, and frequently aware but inarticulate about their actual or uncertain memories.

The subject of the current thesis concerns the approaches contemporary psychoanalytic therapists adopt when working with adults with memories of CSA. The aim is to develop sensitivity and awareness in psychoanalytic work involving Child Sexual Abuse Memory (CSAM). Before a more detailed introduction of the thesis is provided, the meaning of a few central terms will be explained.

The sense of trauma, as it is explored in the present text, involves an overwhelming experience most commonly resulting in intense and long-term emotional reactions. The term 'CSA', as employed in this thesis, alludes to any sexual interaction between an underage child and a much older person and it includes rape (violently coercion of a child to participate in a sexual act), non-contact activities (for instance, masturbating in front of a child) and seduction (persuasion of the child to get involved in a sexual act). The degree of the child's provocation of, and participation to, the sexual act can neither render this act as appropriate in any way, nor can any blame be attributed to the child for this act.

The term 'CSAM', as it is used in this text, aims to encompass all kinds of memory, including actual and fantasised, uncertain and certain, vividly and vaguely remembered, recovered while the person is in therapy or not, and so on. The term 'uncertain memory' is employed to express memory that has not been verified as authentic. The term 'false memory' is used to represent a memory remembered as genuine, while it is not. The terms 'dissociated', 'repressed' or 'recovered' memories involve forgotten traumatic memories which may be actual or unintentionally fabricated. The concept of the 'unconscious' is understood as a part of our personality to which we do not have access and to which dissociated and repressed memories are stored until they are subsequently recalled.

The aforementioned terms are closely connected to the subject of the current thesis, which involves therapeutic approaches to adults' actual memories and fantasies of CSA. In the forthcoming chapters, a qualitative study on how contemporary Greek psychoanalytic therapists approach difficult and complex issues regarding CSAM will be presented. The background of the thesis will be provided in the current section, elucidating the nature and importance of the relevant issues and the basis for selecting particular ways to explore them.

A reflective account will be provided below, explaining the nature of my own motivations to explore the topic of CSAM. I found out during my training that my choice to become a psychotherapist was a way of coping with my own early traumas. Due to personal reasons involving child traumas and memory issues I was also attracted to study this topic. These traumas helped me connect with other traumatised individuals. I started reading about early sexual trauma and memory issues as an undergraduate student. Today, almost twenty years later, I continue reading any relevant text I come across. I noticed my tendency to choose topics related to CSA whenever the coursework topics were optional. For instance, my MA dissertation focused on the effect of father-daughter incest on the mother-daughter bond. I understood that CSA may be the cause for many adult problems and I realised that by learning how to help people deal with these, often traumatic, experiences, their problems might be avoided or lessened.

My enthusiasm to read and work on related material grew even stronger while I was working at a helpline for abuse trauma. A regular caller, who was an adult female, said that she had experienced CSA by a personal school tutor. At some point she said that she could not really recall these experiences, yet, at other times, she thought about reporting the alleged abuser. She was struggling with her own truths, and asked me to help her clear things out, while I also felt confused about what was happening. After a few months she was still in despair, and she stopped calling. I felt deeply overwhelmed by my emotions elicited from this experience. My intellectual focus was thereafter dedicated to CSAM and fantasy, as I started my research for this PhD thesis.

The ensuing literature review was based on readings of key texts which were found through internet and manual searches. The ways these searches were conducted will be thoroughly explained below. Afterwards the most significant texts to CSAM and psychoanalysis were

tracked down. These texts led to an interest in other relevant texts too. After much searching and reading, I feel confident that most relevant texts on the subject are included.

The quest started from keyword searches and reading of resulting abstracts from the PsychInfo database, which grants access to numerous abstracts and index records of behavioural and social sciences texts. PsychInfo searches included keywords in terms relating to CSAM and psychoanalysis, such as 'childhood', 'seduction' and 'psychoanalyst'. More specifically, some of the searches made were the following:

- CSAM psychoanalysis
- CSAM psychoanalyst
- CSA false memory psychoanalyst
- Child seduction memory psychoanalyst
- Child seduction memory psychotherapist
- CSA uncertain memory
- CSAM harmful therapy
- CSAM real false

The most commonly searched keywords were closely related to real, false and uncertain CSAM, and psychoanalytic psychotherapy with adults. I subsequently made a more focused search regarding most of the important themes/topics of my thesis. For instance, while I was researching the nature of traumatic CSAM, the relevant neurological evidence, and the issue of dissociation, the specific keyword searches in the above-mentioned databases were as follows:

- Nature of traumatic childhood memory
- Childhood traumatic memories dissociation
- Childhood traumatic memories neuroscience or neurological
- Childhood sexual abuse memories neuroscience or neurological

The most relevant and interesting abstracts were identified, and this phase was succeeded by reading the corresponding full texts. In my critical appraisal of the literature, the choice of texts to be presented was based on how rigorous I found the text to be. If it was research-

based, I examined whether the research was convincing. If it was not research-based but theoretical, then I examined how scholarly is it. In other words, I assessed to what degree psychotherapists should base their thinking and practice on these texts. Certain texts have been included as relevant although they appeared to be biased, and my evaluation of them has been given earlier (see section 1.2.2.1) so as to caution the readers about the reliability of their conclusions.

Subsequent internet searches were conducted through google scholar, and the PEP-Web Archive (a website containing many psychoanalytic articles from 1918 to date). I also carried out relevant keyword web-searches in various relevant electronic publishing sources, like e-journal databases, on-line indexes, bibliographic databases, and the internet (such as Psychinfo, Psycharticles, PEP, Psychology and Behavioral Science Collection, Sage publications and google scholar). Furthermore, several U.K. libraries (e.g. British library, Senate house library and Goldsmiths, University of London library) were visited to obtain the most relevant texts to the current research subject, meaning psychoanalysis and CSAM. An important share of the following literature material additionally came up from references included in key texts.

The literature on CSAM involved many contradicting views, and as a practitioner, a researcher, and a reader, I felt frustrated and eager to keep looking for 'solutions'. The main contradictions were centring on examining whether a client's initial history assessment should include questions about CSA (Herman, 1992; Palm and Gibson, 1998; Madill and Holch, 2004; Loftus and Davis, 2006), on the reliability of traumatic memories (Freud, 1896a; 1918; Loftus and Pickrell, 1995; Brewin, Andrews and Gotlib, 1993), and on the therapists' responsibility and ability to distinguish whether a client's memory was true or false (Davies and Frawley, 1994; Loftus and Yapko, 1995). These debates, which may function as double-bind situations or headlocks for the therapist working with adult sufferers of CSAM, became my focus as a researcher and practitioner.

In my clinical practice, CSAM was not infrequent as a subject. The more I read about disagreements on how the therapist should or should not intervene, the less certain and prepared I felt regarding how to respond to the especially demanding work usually required in such cases (Olio and Cornell, 1993; Colton, 1996). At first, I believed that these demands referred to my clients' issues, such as their psychic vulnerability, their unconscious urge to

see me as a victim and/or as an abuser, their need to avoid or to recall what had happened to them and other pertinent matters.

As the subject of CSAM came up more often in my practice and clinical supervision both in individual and group settings, I realised that the high level of demand I witnessed in such cases arose out of my internal motives. More precisely, they referred to my own need to know how to handle myself during my interactions as a therapist with these clients, so as to minimise the perils and maximise the benefits of therapy. Knowledge and experience improved my resilience as a therapist, but several instances in the treatment of adults with CSAM repeatedly reminded me that a variety of issues, which were not settled through research, kept on amplifying my anxiety that my intervention (or lack of it) could prove harmful.

Whilst discussing this subject, I came upon many mental health trainees and professionals who were unaware of these important issues surrounding CSAM. As discussed in the forthcoming chapters, the therapists' lack of awareness may have been endangering themselves and others. Many others have shared my worries and would be very interested in understanding more about the subject. This enhanced my desire to reveal alternative ways of working through practical therapeutic responses to circumstances involving CSAM on which psychologists and psychotherapists still debate. Thus, I strongly believe that we ought to search for ways to inform practitioners working with child sexual traumatic memories of the related practical perils in the therapeutic encounters. There is an increased demand to better fill the gaps of the various puzzles in the domain of psychotherapeutic work with retrospective CSAM (Masson, 1984; Mollon, 2000; Rubin and Berntsen, 2009).

The origins of these puzzles probably lie in the complex theoretical history of thinking about childhood memories involving sexual trauma. The starting point of this history was Freud's (1896b) uncovering of CSA and its devastating and long-lasting effects. The second step was Freud's (1897b; 1897c) alleged denunciation of this ground-breaking idea as he (1905b) realised that CSAM may be based on fantasies.

This history regarding CSAM continued to 'overflow' with either absolute denial or unconditional acceptance of CSAM and/or fantasy. It allegedly involved, on the one hand, general tendencies to handle child sexual trauma as fantasised (Simon, 1992; Pope, 1996),

and, on the other, the need to view CSAM as a proof rather than an indication of actual abuse (Freud, 1896a; Forward and Buck, 1981). These origins will be briefly introduced below and then more thoroughly discussed in the following chapters of this thesis.

During the last few decades, child protection laws attempted to reduce child sexual maltreatment, and modern psychotherapy focused on alleviating the impact of actual early sexually traumatic memory and on distinguishing such memories from fantasies. For example, the contributing burdening role for therapists in such cases has also been articulated (Walker, 2012) and therapists have been more informed about the possibility of false memories of child sexual trauma (Alpert, Brown and Courtois, 1998).

Psychotherapists' increased awareness regarding both CSA and uncertain CSAM, shifted attention to more specific predicaments which may leave the therapist feeling insecure about how to respond in relevant cases. Therapeutic interventions included commonly in clinical practice could be considered as mistakes that may create serious problems in cases of CSAM (Yapko, 1994a). For example, therapists may be generally inclined or expected to observe the indications and point to possible aetiologies and solutions. When therapists notice that a client has serious problems in forming relationships, they may discuss early attachment bonds as an aetiology. Contrastingly, in cases of CSA indications, pointing to aetiologies and solutions, such as the existence of early trauma could be suspected as creating false memories through suggestion (Poole, Lindsay, Memon, and Bull, 1995; Mollon, 2000; Loftus and Davis, 2006). Interestingly, simultaneously therapists are strongly advised to ask about CSA as a potential risk factor in the clients' history (Pruitt and Krappius, 1992; Alpert, Brown and Courtois, 1998). The present thesis will attempt to elucidate how contemporary psychoanalytic therapists handle CSA indications in practice.

As a whole, this thesis relates to how uncertainties, such as the one described above, influence psychotherapeutic work today. Relevant general tendencies, literature contradictions, and psychotherapeutic predicaments will also be taken into account.

There are many psychotherapeutic schools of thought, some of which have contributed to the subject of CSAM. Although I am an integrative psychotherapist, psychoanalysis was selected as the subject area of investigation for various reasons, some of which are identified next. Firstly, Freud, the father of psychoanalysis, played a pioneering role in the revelation of

issues surrounding adults' memories of child sexual trauma in 1896 and 1897. Secondly, psychoanalytic concepts and points of focus, such as unconscious material, recovered memories, transference and countertransference, were at the centre of the more recent debate over false memories (Herman, 1992; Bowers and Farvolden, 1996; Geraerts, Schooler, Merckelbach, Jelicic, Hauer, and Ambadar, 2007). Thirdly, psychoanalysis is argued to be the most popular psychotherapeutic approach in modern times (Zerbetto and Tantam, 2001). Thus, I decided to focus on how psychoanalytic practice with adults who suffer from CSAM is currently being influenced by the aforementioned uncertainties on CSAM.

Psychoanalysis has also been claimed to be the most widespread psychotherapeutic treatment (Zerbetto and Tantam, 2001), indicating that this study could have been conducted in many countries. For reasons of convenience, and due to my place of residence, Greece was among the principal nominees for the country of study. Discovering how my colleagues and fellow-citizens dealt with my previously mentioned worries on the subject appeared exciting. Additionally, Greece is a country that lacks research data on this topic (Klontza, 2012). Greece, and more particularly its capital, Athens, was therefore chosen as the place to conduct this study.

There were many more decisions that had to be made so as for this thesis to be completed and they will be meticulously accounted for in the forthcoming chapters. Based on the decisions such as the ones mentioned above, (that is, subject, therapeutic approach and country of study) the following main research question was formed:

'How do current Athenian psychoanalytic therapists approach their adult clients' CSAM?'

The main research sub-questions refer to how recent psychoanalytic practice may be influenced by past debates on the topic of CSAM and how current psychoanalytic psychotherapists deal with relevant debatable situations in therapy.

The other questions and conundrums that arose from my journey into the various theoretical and practical approaches to CSAM, were all related to the research question, and shaped the main research instrument of this study: the list of interview questions (see appendix 4). The scope of the interviews was to see (a) how contemporary therapists feel when they are working with cases involving CSAM, (b) whether they are aware of the various pitfalls and (c) the ways they

approach certain ambiguous issues. Most of the questions of this interview instrument referred to issues regarding which the therapeutic response has been ambiguous, such as 'Do you believe that the fantasy-reality distinction (FRD) could be achieved?'. This question was formed to prompt each participant to comment on the importance or triviality of both the FRD and their personal therapeutic approach on the subject.

The list of interview questions was administered to analysts, psychoanalytic therapists and trainees in psychoanalysis in Athens, the capital of Greece. I will refer to my study's participants as 'psychoanalytic therapists', since this title can describe them in a shorter way. The method of interviewing was selected as the means to understand the participants' beliefs and experiences about CSAM cases. Interviewing was expected to facilitate the production of additional and unexpected data on the subject, through the interaction between the interviewer and the interviewee (Polkinghorne, 1983).

A Content Analysis (CA) of the findings facilitated my thorough comprehension of various aspects of the data. The analysis of qualitative data collected from a representative sample of Athenian psychoanalytic therapists, allowed for a deep-reaching exploration of various factors influencing the effectiveness of the therapists' work with CSAM sufferers.

The findings of this analysis were then compared and contrasted with past contributions, so as to discern the commonalities and differences, the continuity and progress, and the certainties and gaps between them. These findings would in turn both elucidate methods of handling CSAM cases and offer an opportunity of expression to the psychoanalytic group which has been judged and simultaneously under-researched (McGregor, Thomas, and Read, 2006).

A brief overview of this thesis would allow easy access to pieces of information recorded in each chapter as well as a sense of this work as a whole. The introduction of this thesis provided the background for this research, thus explaining why I chose this subject and how I decided to examine it.

In chapter 1 of this thesis, titled 'Literature Review', the historical background of CSAM will be explored. Freud's change of focus from his Seduction Theory to infantile fantasy will be examined, alongside pertinent criticisms. The recovered-false memory controversy will also

be accounted for and the resulting questions will be laid out. Other important contributions on the subject of CSAM will also be noted. The key issues to be examined in the present thesis as they emerged from the literature review on CSAM in therapy will be identified and explored.

In chapter 2, titled 'Methodology', there will be a presentation of the means and method with which the research question was investigated. The sampling and the interviewing procedure and material will be introduced. There will also be an analysis of the list of interview questions that was devised to explore the psychoanalytic practitioners' approach when encountering CSAM through their own responses (see appendix 4). The three parts of this chapter refer to data collection, preparation, and analysis, thus covering all the necessary steps required for a comprehensible and clear handling of the interview data.

In chapter 3, titled 'Analysis', an outline of the findings arising from CA of the interview data will be offered. The data has been arranged according to the participants' responses to interview questions. The interview questions concern the changes occurring in psychotherapists' practice in relation to CSAM, the introduction to CSA by the therapist, the symptom-CSA connection, the ways to examine the reliability of CSAM and the feasibility of the FRD.

In chapter 4, titled 'Discussion', the findings of the CA will be presented and examined in relation to the ideas examined in the literature review chapter. Emphasis will also be given to material that has not been addressed in past literature. Attention will be drawn to appropriate ways of responding to CSAM sufferers. The limitations of the current study will be accounted for, alongside the implications for therapists and the suggestions for future research.

In the conclusion of the thesis, the main findings of this study will be listed and the messages they convey will be accounted for.

This thesis as a whole is indented to shed light on contemporary psychoanalytic practice concerning adults' CSAM. Practical issues need to be identified and psychoanalytic therapists should be enabled to have a say in pertinent accusations.

These accusations and their alleged origins will be explored in the forthcoming chapter. More particularly, a review of psychoanalytic and other responses to CSAM will be presented so as to provide a clear outlook of the broader social and historical background of the more contemporary debates which led to the formation of the current study.

> "I admit that this [the question of retrospective fantasizing] is the most delicate question in the whole domain of psycho-analysis... what analysis puts forward as being forgotten experiences of childhood (and of an improbably early childhood) may on the contrary be based upon phantasies created on occasions occurring late in life... no doubt has troubled me more; no other uncertainty has been more decisive in holding me back from publishing my conclusions. I was the first — a point to which none of my opponents have referred — to recognise both the part played by phantasies in symptom-formation and also the 'retrospective phantasysing' of late impressions into childhood and their sexualization after the event" [mine].
>
> (Freud, 1918, p. 103)

## Chapter 1: Literature Review

### Introduction to Literature Chapter

Child sexual abuse (CSA) trauma has been ignored for far too long. The memories concerning it have been repetitively denied, forgotten, believed, supported, doubted, and disavowed throughout the last 120 years. The history of early sexual trauma has been interlinked with psychoanalysis in many different ways (Demause, 1974) starting from its initial uncovering as an extremely harmful experience. Understanding the effects of trauma, the nature of memory, and the appropriate role of the analyst are focal tasks of psychoanalysis since its birth (Target, 1998). There are practical issues perplexing today's therapeutic work with adults who suffer from CSAM. It is important to understand where these issues come from, how they may influence current therapeutic work and what contemporary psychoanalytic psychotherapists do to overcome them.

Kenneth Pope, an American Clinical Psychologist, and the Former Chair of the American Psychological Association Ethics Committee, has commented on the necessity to explore and understand issues perplexing current therapeutic work. Pope (1996) supported that complex factors, such as historical contexts, may sculpt the process by which published discoveries and conclusions either come across or escape scrutiny, and how these publications can have a bearing on the extent to which individuals are disposed, willing, and free to query on certain

claims. He added that such factors themselves ought to be a rightful and imperative focus of scientific questioning (Pope, 1996).

This chapter as a whole aims to explore how the controversies on Freudian and more recent works, regarding CSAM, occurred and how they appeared to have been dealt with so far. This will provide the contextual reference point for the research conducted for this thesis which aims to reveal how current Athenian psychoanalytic psychotherapists practice psychoanalytic psychotherapy when encountering issues involved in enduring controversies on CSAM.

### 1.1.0 Historical Background

The present chapter will initially focus on two phases of this history involving therapeutic approaches to CSAM. The first phase is associated with Freud's work in the late 19th century and the second phase relates to contributions near the end of the 20th century. Then, knowledge on specific issues that must be taken into consideration will be contemplated. The following discussion about the therapeutic approach to CSAM will form the context for the questions explored in the current study.

### 1.1.1 Freudian Theorising

The initial revelation of CSA, and uncertain CSAM will be presented here. Firstly, Freud's theory on actual abuse and its effects will be considered in the following section. Secondly, its alleged rejection and the reasons behind it will be discussed. Thirdly, Freud's later viewpoints will be presented.

#### 1.1.1.1 Seduction Hypothesis

Adult-child sexual contacts used to be veiled in secrecy and/or allowed until recent times (Miller, 1985). Incest, meaning interfamilial sexual interaction, was connected to its harmful effects approximately 120 years ago in Europe, by Charcot, followed by his two students, Janet and Freud. Freud collaborated with Breuer (1895) in the start of his discoveries and he reached similar conclusions with Janet, in terms of neurosis being the outcome of child sexual molestation (Alpert, Brown, and Courtois, 1998). After 1895, Freud continued his

developments alone. Janet's views were recognised as significant in recent times (Brown and van der Hart, 1998), however Freud's later theorising prevailed and his influence was remarkable, so it was decided to focus on his contribution, in order to understand current distorting tendencies in therapeutic work with CSAM.

Sigmund Freud (1896b) was an exceptional psychiatrist who linked child sexual seductions to severe adult psychopathology (more specifically, neurosis and hysteria, a rampant mental illness during Freud's era) in a piece of work that came to be known as the 'Seduction Theory' (ST) (Garcia, 1987). Freud (1896b) stated that he managed to carry out the work of analysis in 18 cases of hysterical patients and that all of them had experienced sexual trauma:

> "...The contents of the infantile scenes turn out to be indispensable supplements to the associative and logical framework of the neurosis … (p.205)".

Freud claimed that his patients had forgotten their painful experiences, and also that they managed to recall them through therapy. Thus, another amazing discovery linked to the ST was that of unconscious repression and later recall. Freud (1986c) additionally stressed seduction's horrific effects and characterised the child not only as vulnerable, but also as innocent.

According to Freud (1896a; 1897a), the abusers were frequently nursemaids and domestic servants, cousins, and most commonly the victim's very close relatives, fathers or underage brothers. While discussing cases of family members, Freud (1896a) noted that the circle of abuse begun from a nursemaid who seduced children, who in turn then seduced other family members, such as siblings. This observation of the circle of abuse highlights Freud's finding concerning the link between having been abused and becoming an abuser. This theory also led him (1920) to understand the compulsiveness of some seduced persons who repeat the repressed trauma by becoming victimisers. Later conclusions within (Ferenczi and Rank, 1924) and outside (e.g., Chu, 1991) psychoanalytic circles have also adhered to the prevalence of repetition compulsion in cases of CSA.

Jeffrey Masson (1984; 1990), an American author, trained as a Freudian analyst, and best known for his critique of Freud and psychoanalysis, eloquently argued that Freud's work was also influenced by writings of Brouardel's and Tardieu's books on physical and CSA.

Masson (1984) also supported that Freud based on his early patient, Emma, his ST and the concept of 'deferred action', meaning the phenomenon wherein an early sexually abusive experience is remembered sometime after puberty, thereby instigating a reaction that had not occurred during the original event. As the English psychoanalyst, and author of the book 'Freud and the False Memory Syndrome', Phil Mollon (2000) asserted, 'deferred action' refers to a familiar clinical observation for mental health professionals who treat CSA sufferers.

In Freud's early position (1896a), patients' denial to accept their unexpressed paternal CSA was viewed as their resistance and evidenced the actuality of the trauma. According to him, when this hypothesis was correct, the patient's symptoms would decrease or vanish. Therefore, Freud linked CSA to defense mechanisms that concealed the awful truth from the patient's consciousness.

Freud's ST encountered an icy reception, disbelief and total disregard from his contemporary colleagues (Freud, 1896d). The overall responses to the ST, back in Freud's era, involved avoidance, repulsion, rejection, reconsideration and mistrust. His professional status was nearly destroyed (Masson, 1984).

In more recent writings (Macmillan, 1977b), the seduction hypothesis has been criticised in relation to the reliability of its methodology. Other Freudian critics, like Allen Esterson and Frederick Crews, also maintained that Freud had fabricated the evidence for his ST, by forcefully constructing CSAM (Shamdasani, 2003). Freud, hence, supposedly pressured his patients to accept his hypothesis, triggering false CSAM as a result. Thus, Freud was probably the first therapist to be accused of producing false memories of infantile seductions during therapeutic procedures.

#### 1.1.1.2 The 'Abandonment' of the Seduction Theory

Freud (1897b; 1897c) 'denounced' his ST five months after its introduction, because he realised that traumatic CSA memories could be false. In their famous correspondence, Freud (1897c) revealed his reservations to his German Jewish doctor and dear friend, Fliess, in a letter which became known as the 'Equinox' letter:

> "I no longer believe in my neurotica..." (p.264).

He added:

> "The expectation of eternal fame was so beautiful, as was that of certain wealth, complete independence, travels, and lifting the children above the severe worries that robbed me of my youth. Everything depended upon whether or not hysteria would come out right. Now I can once again remain quiet and modest, go on worrying and saving" (p.266).

Freud, thus, explicitly stated that he was not certain that all of his patients' disclosures of father-daughter sexual experiences were true. He also stressed the difficulty in identifying reality in unconscious material. Freud (1897b) stated that his review was based on the inconclusiveness of his patients' therapy, on the father's blame for perversion, on the discovery that in the unconscious, one cannot distinguish between the truth and fantasy that is cathected with affect, and on the conclusion that the secret of the childhood experiences is not betrayed even in the most confused delirium.

The issue concerning the inconclusiveness of the therapeutic outcome of Freud's patients, was that he seemed to expect therapeutic results very quickly. In this respect, Stephen Mitchell (1997), an American clinical psychologist and psychoanalyst, writes:

> "Recall that Freud's early analyses lasted only several months. It seemed reasonable to assume that for curative insight to occur, the analyst needed merely to arrive at the correct interpretive understanding and convince the patient of its correctness. Freud and subsequent analysts discovered that useful interpretations were not a one-shot deal. They take time, lots of time. One makes the same or closely related interpretations over and over again" (pp.42-43).

So, while Freud initially anticipated fast therapeutic conclusions to support his growing theories, more contemporary professionals understand that this is an exhaustively time-consuming process. To be more specific, his unsuccessful therapeutic results were based on short-term therapeutic interventions, while successful results have been viewed as more possible in long-term (rather than short-term) therapeutic work (Tyson and Goodman, 1996;

Valerio and Lepper, 2009). This means that Freud may have been faithful to his original theory if he had more time to assess the successfulness of his approach.

The rest of the reasons Freud provided in his famous 1897 letter concerning his 'rejection' of the seduction hypothesis, may also be viewed differently when combined with contemporary awareness on CSAM. His confusion about both the frequency of occurrence and the causal significance of incestuous child seductions is understandable in light of the continuous overlooking of CSA in the past and the responses to his ST presentation (Masson, 1984). His inability to comprehend the real and fantasised memories of sexual trauma, and their connection to resistances and psychotic states, is also explicable, if we realise that not much progress has been made since his time in this domain (see section 1.2.1.3).

Psychoanalysts' reactions to Freud's review of the seduction hypothesis have been emotionally charged and polarised. Freud's 'abandonment' has been perceived through various lenses: the first being testing Freud's integrity (Jones, 1972), the second being the correct decision since the ST was proven wrong (Sulloway in Robinson, 1993), and the third, as a mistake by which Freud betrayed his patients (Masson, 1984).

I believe that the ST was abandoned by the whole scientific community. Freud was forced to conform with the opposing majority opinion so as to survive. He was sincere enough to continue thinking about it as we shall see next.

#### 1.1.1.3 Freud's Later Views

Subsequently, Freud (1905b) turned his focus to infantile sexuality as the basis of both personality and psychopathology. According to this theory, children go through certain psychosexual stages of development. During the phallic or Oedipal stage, the child, usually aged three to seven years old, desires the opposite-sex parent and is jealous of the same-sex parent, with whom the child eventually identifies, as those urges become repressed from consciousness. When recalled much later, the child's repressed fantasies may be mistaken for real memories.

The 'less known' part of the story is that Freud kept juggling between reality and fantasy in his thoughts concerning trauma, and the matter that constantly troubled him was the FRD

(Grubrich-Simitis, 1988; Masson, 1990). More than a century later, disagreements still swirl around whether or not Freud's patients had indeed suffered CSA (Gardner, 2003).

According to my opinion, both Freudian theories contained original ideas and were influenced by the socio-cultural climate of the era. ST offered an explanation for a mental disorder (hysteria) which was common at that time, through the uncovering of CSA which was also common – albeit taboo – at that time. The infantile sexuality theory was taking into account the effect of our internal world and our drives and provided us with an introduction to child sexuality and the power of unconscious fantasy.

After Freud's initial theorisation and review, CSA was again ignored for more than 80 years (Olafson, 2002), with a few noteworthy exceptions (such as Ferenczi, 1949). Freud's work had an astonishing and long-lasting impact, and has been associated with more recent controversies on CSAM, as well as with distorting tendencies in therapeutic work involving early sexual trauma (Simon, 1992).

### 1.1.2 Recovered Memory and False Memory of Child Sexual Abuse

The history of the more recent controversy on CSAM will be considered in the following sections. Various kinds of memory will be discussed, such as recovered, false, therapy-induced, and uncertain memory. The complications involving the influence of psychotherapists on the client's memory will be emphasised.

#### 1.1.2.1 Recovered Memory of Child Sexual Abuse

Following the re-revelation of CSA through media and professional interventions in the 1980's, many individuals, including famous people, mainly in the USA, reported recalling a CSA experience. Before long, publicly declaring oneself as a sexual abuse victim, which used to represent a secretive embarrassment, developed into something acceptable or even venerable (Yapko, 1994a).

The mental health community was besieged by the surprising number of people, mainly women, who recounted their experiences of CSA (Yapko, 1994a). Freud's ideas about repressed material and the psychoanalytic emphasis on the unconscious (Lear, 1995) offered

an explanation of what was going on. To cope with extremely devastating experiences, CSA sufferers may disconnect from the memory of the existence, bearing and/or meaning of their traumatic histories (Olio and Cornell, 1993).

Jennifer Freyd, who is a respected American psychologist, Psychology Professor and memory researcher, focused on the impact of trauma which involves betrayal on memory in her 1996 book *'The Logic of Forgetting Childhood Abuse'*. Freyd (1996) drew attention to both clinical and experimental memory research and claimed convincingly that sufferers need to forget their early sexual trauma due to betrayal by trusted caregivers. In her words:

> "Betrayal trauma theory posits that under certain conditions, betrayals necessitate a "betrayal blindness" in which the betrayed person does not have conscious awareness, or memory, of the betrayal. A theory of psychological response to trauma, betrayal trauma builds from the belief that the degree to which a trauma involves betrayal by another person significantly influences the traumatized individuals' cognitive encoding of the experience of trauma, the accessibility of the event to awareness, and the psychological as well as the behavioral responses" (p.9-10).

Freyd (1996) believed that traumas which involve betrayal as a primary element leave serious wounds in the victims and are more likely to be partially or totally dissociated from conscious awareness. Forgetting the abusive events may be an adaptive survival defence mechanism employed to deal with extraordinarily painful circumstances and can be viewed as a chronic 'Stockholm syndrome', where victims identify with their kidnappers, or as a 'double-bind' situation, where critical contradicting injunctions to the child (e.g. the injunctions 'you must be perfect' and 'you are useless') are disallowed from discussion (Spiegel, 1998). The victims who are amnesic about their abuse continue to endure its effects and may remember it again since its crucial information is altered but has not disappeared (Freyd, 1996).

Additionally, Mollon (1998) explained that an individual may be able to evade thinking about CSAM for some time periods and that this phenomenon has been called 'cognitive avoidance' by cognitive therapists. Moreover, when this phenomenon is associated with the defence mechanisms of denial, memories may become unavailable to conscious awareness (Mollon, 1998). Others (such as Olio and Cornell, 1993) maintained that CSAM retrieval is necessary in order for survivors to heal.

Authors additionally emphasised the assumption that CSA is hugely underreported. For instance, Almeida, Cohen, Subramanian, and Molnar (2008) argued that CSA cases are perceived by researchers to be widely underrated, due to the stigma, shame, and fear of formal accusations against abusers who are frequently family relatives. Prentky (1999) claimed that proof for this assumption can be found via offenders themselves, as they report that they have victimised far more individuals than they have been imprisoned for. Miller (1985) argued that the underestimation of the prevalence of CSA is due to memory repression.

The 'Recovered Memory Movement' was formed, and it consisted of lay people, and writers, but mainly therapists, who strongly believed in repression and its overcoming due to triggers or psychotherapy. Some of the writers cited in this thesis are clearly supporting the existence and authenticity of recovered CSAM (for instance, Miller, 1985; Olio and Cornell, 1993). The psychotherapeutic tendency of that era resembled Freud's initial insistence on the reality of childhood seductions nearly a century earlier. Up until this point, practitioners appreciated that, unless there was compelling proof of the reverse, every CSA allegation should be regarded as valid (Forward and Buck, 1981).

#### 1.1.2.2 False Memory of Child Sexual Abuse and the Memory Wars

Psychology's examination of human memory has generally brought disappointing results regarding its accountability (Kiefer, 1996; Geraerts, Raymaekers, and Merckelbach, 2008). Memory has been found to have limited trustworthiness, and to be dependably connected to both the quantity of emotion at the phase when the memory occurred and to the power of emotion when the memory was recollected (Siedlecki, 2015). Remembering involves reconstruction, that is to say, it resembles a story's narration more than an event's subjective retrieval process (Dobo, 2000).

Rationally, our perception influences both our long-term and short-term memory as it determines our sensory input. This indicates that, in false memory (or pseudo-memory) cases, the person is neither lying nor misremembering; the perception's input is distorted from the very beginning. Hence, false memories of childhood are possible and they could simultaneously be structurally true yet literally untrue (Mollon, 1998). Such a memory may

seem just as meticulous, vivid and credible as actual memory, and a memory may include literal reality, thematic reality, or no reality (Mollon, 1996). Furthermore, a 'memory' may be a fantasy fitting with a deep mental schema, rather than a genuine memory even when it coincides with a constellation of symptoms and signs (Mollon, 1998). The topic of false CSAM attracted much attention in the 1990s, and is still considered as controversial.

In more detail, subsequent to the emergence of the Recovered Memory Movement, described in the previous part, the issue on CSAM began climaxing once again but in the opposite direction (Forward and Buck, 1981): a new mental disorder, the False Memory Syndrome (FMS) was observed, reported and analysed. According to its supporters (such as Yapko, 1994a; Loftus and Yapko, 1995; Bernstein and Loftus, 2002; Gardner, 2003; 2004; Loftus and Davis, 2006), a remarkable number of false positives, that is false allegations, have been purportedly detected.

In spite of the widespread coverage of this matter in both scientific journals and the general media, it is hard to find a clinical definition of the FMS. Nor is it featured in any psychiatry textbook, or any official medical listing (Mollon, 2000). As a consequence, there is no formally trustworthy published material regarding this syndrome's avoidance, symptoms for identification or treatment. A few notable definitions, aetiological hypotheses and effects are listed below. Gardner (2004) discusses the phenomenon as follows:

> "False memory syndrome (FMS) is a psychiatric disorder that develops primarily in young and middle-aged adults, most often female. The primary manifestation is the persistent belief that one has been sexually abused in childhood, a belief that has no basis in objective reality. When bona fide sexual abuse has been reasonably validated, especially by external corroboration, the diagnosis is not justified" (p.83).

The FMS Foundation, which actually invented the term 'FMS', describes the syndrome in more emotionally charged words and includes effects on the social environment of the sufferer:

> "A condition in which the person's personality and interpersonal relationships are oriented around a memory that is objectively false but strongly believed in to the

> detriment of the welfare of the person and others involved in the memory". (Goldstein, 1992, p.iv).

The 'False Memory Syndrome Foundation' is one of the groups which were formed in the '90s to support the accused parents as well as individuals who retracted their accusations (Yapko, 1994a; Mollon, 2000). One of the main purposes of these groups was to spread ideas about memory unreliability, especially regarding memories usually recovered during psychotherapy (False Memory Syndrome Foundation, 2013). Interestingly, the 'False Memory Syndrome Foundation' was founded by Pamela and Peter Freyd, who were motivated to establish this foundation because their adult daughter, Jennifer Freyd who is discussed above (see section 1.1.2.1), privately accused Peter in 1990 of sexually abusing her as a child (Dallam, 2002).

Along the same lines, the FMS epidemic has also been intensely questioned, along with its frequency of occurrence (Brewin, Andrews and Gotlib, 1993; Pope, 1996; Palm and Gibson, 1998). Palm and Gibson (1998) found that very few cases of so-called false memory were recorded by the participating clinicians. A closer look into their findings revealed that these clinicians reported an average of less than five false memory cases in the past five years, and merely 6 of the 60 (10%) respondents doubted the validity of recovered memory.

There has been some attention devoted to the social and legal effects of false memory (Yapko, 1994a; Gardner, 2003; Lief, 2003). False memory cases may encompass false accusations. The detrimental and enduring impact of false allegations of CSA has been documented by many writers, and listed by Wakefield and Underwager (1996). For the psychoanalysts, the devastation to families has also been identified as one of the central issues concerning recovered and false memory (Lief, 2003).

As discussed later (see next section 1.1.2.3), the legal effects of false memory may involve the therapist. Legal actions for false memory creation by the client to the therapist are probably non-existent in certain countries, such as Greece, where the legal system is particularly slow (Papaioannou, 2011).

The existence of repressed memories and false memories, as a whole, has been doubted, on the basis of the unfeasibility of their scientific validation. However, Bowers and Farvolden

(1996) noted that one cannot deny other persons' experience or condition because of lack of supporting empirical evidence. In other words, a person may wholeheartedly believe in a false memory, although it is not recognised as a mental disorder.

As we saw above, there has been a huge controversy between the two camps – one, of recovered memory therapists and, two, of supporters of the FMS - and this led in 1990's to an unofficial war between them. Regarding these 'Memory Wars' between recovered memory therapist and false memory supporters, Fonagy (1998) wrote:

> "There is something akin to a religious war raging between those who wish to protect victims of childhood abuse and those whose declared allegiance to individuals claiming to be falsely accused... There must be a sensible and thoughtful middle road between extremes, and surely it is unacceptable for anyone who wants to occupy such a position to be accused of betraying one or other of these deserving groups. Yet I fear that this is very much what has happened so far in the 1990s. The objectivity of even the most of commentators is clouded by the emotional fervour generated by the issue of recovered memory of CSA and the excitement that is inevitably activated when the gratification of unconscious infantile incestuous sexual fantasies is contemplated" (p. xiv).

These memory wars apparently created a number of misinterpretations, many of which are still with us today. For instance, it has been argued that false memory can be implanted in the clients' mind by psychotherapists, an idea which is further analysed below (see section 1.1.2.3).

#### 1.1.2.3 False Memory of Child Sexual Abuse and Psychotherapy

Adult CSAM were allegedly iatrogenically produced, instead of recovered, by therapists who searched for the childhood basis of their clients' future psychopathology, often through controversial therapeutic techniques, such as hypnosis (Powell and Boer, 1994; Bowers and Farvolden, 1996; Mollon, 2000; Gardner, 2004). This part will draw attention to the abrupt emergence of professional writings on the subject of false CSAM during treatment.

The publications of well-known authors writing about the FMS during the 1990s were sizeable (Herman, 1992; Davies and Frawley, 1994; Loftus and Yapko, 1995; Pope, 1996; Bowers and Farvolden, 1996; Phelps, Friedlander and Enns, 1997), and its assumed frequency of occurrence was perplexingly high. In a relevant study with clinicians, Pope and Tabachnick (1995) found that nearly 21% of the participants had worked with one or more clients who, according to them, had a fictitious memory.

Pope (1996) casted doubt on both the motives and methods involved to advocate the arguments supported by the 'False Memory Syndrome Foundation'. To be more precise, regarding the motives, the theorists and practitioners, such as Goldstein (1992) quoted earlier (see section 1.1.2.2), who put these claims forward, were officially employed by the Foundation. Pope (1996) pointed out that:

> "Expert witnesses, therapists, policy makers, reporters, the courts, graduate courses, and continuing education programs could thus cite a growing literature accepting and helping institutionalise the notion that false memory syndrome was not only a scientifically validated disorder caused by psychotherapy, but that the number of documented cases was exceptionally large" (p.961).

According to Pope (1996), the foundation's representatives, and the studies they rely upon, have not provided sufficient evidence for their conclusions that a large share of therapists, alongside their techniques, are dangerous, and that therapists have to follow their professional guidelines so as to work ethically on the subject. They merely asserted that actual intense trauma cannot be repressed - or forgotten in any other way other than brain damage - and thus all recovered memories of abuse are false (Pope, 1996). The notion of false memory creation in therapy was itself perceived as another effort to conceal the prevalence of CSA (Bowers and Farvolden, 1996).

Although past research showed that therapists held that most CSAM recalled during psychotherapy are reliable, especially concerning memories of one's own clients (Poole, et al., 1995), more contemporary studies reveal that clinicians are sceptic about the validity of memories recollected in therapeutic treatment. To be more precise, Patihis, Ho, Tingen, Lilienfeld, and Loftus (2014) supported that clinical psychologists appeared to become increasingly and overly suspicious concerning repressed memory. In addition, while

researching recovered CSAM, Ost, Wright, Easton, Hope, and French (2013) observed, among other things, both that more than 80% of the participating clinical psychologists hold that a person may have false memory of repeated CSA that never occurred, and that less than 25% of the participants stated that CSA allegations based entirely on memories retrieved while the person was in psychotherapy, subsequent to complete amnesia, could be considered as essentially accurate.

In his key article regarding the clinical complexities of the memory debate, Mollon (1996) emphasised that, in contrast to others, he does not pretend to know what is happening regarding CSAM, and drew attention to the delusion and the debates in the USA:

> "I... plea for a tolerance of uncertainty. Cognitive psychologists - and therapists with simpler models of mental life, derived from but different from psychoanalysis - may believe they know what is going on in these debates about memory. I claim the right and the mental space not to have to pretend to know (to pretend to myself or to others). I really do not know what to make of recovered memories as they arise in clinical practice, nor how best to respond to these therapeutically. Although this uncertainty is not comfortable, false certainty can only lead to delusion and turmoil and the most appalling professional in-fighting, such as we find currently in the USA" (pp.199-200).

According to Powell and Boer (1994), some authors fell into the same trap that Freud did: they fail to take into account alternative explanations for the evidence they present when they claim that recovered CSAM are authentic.

As the overruling intention of psychotherapy is to do no harm, the pressing question is whether suggestions in therapy may cause false memories which may inadvertently harm both clients and the accused person, who may be part of their family environment (Poole et al., 1997; Rubin and Berntsen, 2009). As seen earlier (see section 1.1.2), on one side there are those who have trust in the authenticity of recovered memories, and on the other side there are those who hold both that recovered memories are false and embedded by malpractising psychotherapists (Mollon, 1996). Moreover, recent debates on CSAM epitomise an extensive chasm among scientists and practitioners (A.P.A. Working Group, 1998; Phelps, Friedlander and Enns, 1997).

Research has supported that suggestion may lead to false memory creation (Poole et al., 1995; Loftus and Davis, 2006). A Dutch clinical psychologist, Joost Hutsebaut (2001) also maintains that due to several factors, such as the avoidance of responsibility, CSAM is effortlessly modifiable, resulting in the phenomenon of false memory, which manifests "the internalization of an interpretation in which the patient and the therapist collude defensively" (p.77).

Mollon (2000) writes about therapy's possible influence in these distortions:

> "It is indeed a plausible possibility that certain kinds of 'therapy' or styles of interview that involve suggestion, exhortations to remember, group pressure or abandonment of a critical and thoughtful perspective by both patient and therapist could play on the deceptive plasticity of memory and lead to fallacious narratives of a person's childhood. However, these processes are complex, and there is considerable ongoing debate about what is involved in the forgetting and remembering of childhood trauma, and also about the nature and extent of harmful therapeutic practices" (p.6).

It could also be useful to know that the commonly used word "implanted" (Yapko, 1994a), in relation to false memory creation in therapy, has also been challenged. For instance, Hutsebaut (2001) advocated that a considerable misconception of the psychoanalytic literature is that these pseudo-memories are induced or implanted by therapists, as if they would insert an entirely pre-fabricated memory into the client's memory. The author proposed that the truth is that the client develops the false memory so as to fulfill a particular function. In that sense, the term "trigger" would be more appropriate, as it corresponds more to something that is internally developed, rather than implanted from an external source.

Actions cause reactions, and movements generate counter-movements (Yapko, 1994a). Silence brought about both real and false accounts and these, in turn, triggered an urge to identify the 'scapegoat'. Apparently, rather than Freud, therapists were the ones to be "examined under the microscope" this time, especially in cases involving recovered memories.

#### 1.1.2.4 Approaching and Elucidating Uncertain Memories in Therapy

Regarding ways to approach a disclosed or suspected CSAM in therapy, professionals seem to rely on their personal theories based on their clinical experience when approaching uncertain memories. For example, in Palm and Gibson's (1998) survey, some participating clinicians declared that if they believed that their client's CSAM is false, they would suppose that s/he had endured another harmful experience. Olio and Cornell (1993) argued that therapists must adjust their interventions according to each client's idiosyncratic needs and internalisations of early traumatic experiences.

Relevant literature material focused on the techniques employed by therapists while working with possible sufferers of delayed CSAM (Polusny and Follette, 1996; Poole et al., 1995). Moreover, Phelps, Friedlander and Enns (1997) supported that there is a lack of consensus about the suitability of techniques that have been considered as suggestive, indicating that this issue is far from clear-cut.

In relation to the FMS Foundation's directions for therapists to work ethically on potential CSAM cases, problems may occur during the application of their advice. For instance, I hold that the Foundation's guideline about therapists being required to seek the external validation of the client's family before applying recovered memory therapy (Pope, 1996) is in conflict with matters of therapeutic confidentiality, and may impair therapeutic trust.

On the topic of distinguishing between authentic and fantasised trauma, psychotherapists are seldom able to appreciate the actual reality of a client's early sexual trauma devoid of independent evidence (Mollon, 1996). Moreover, relevant literature material send mixed signals to therapists working with uncertain CSAM, as discussed below. In brief, on the one hand, irrespective of whether CSAM may be imprecise and confused, it may still be corresponding to trauma based on reality (Olio and Cornell, 1993; Davies and Frawley, 1994), and, on the other, therapists should abstain from supporting uncertain CSAM as there is a danger of inducing false CSAM (Loftus and Yapko, 1995).

To be more specific, according to Davies and Frawley (1994), in comparison to Freud, many modern-day clinicians would not require verifiable memories to be uncovered in order to trust the essential truths comprised in the analysands' CSAM reports. They added that an

analysand may, for instance, report a traumatic experience which includes pieces of victimising episodes clearly permeated with fantasy elaborations of the original trauma, so that the memory is inaccurate but the abuse is a fact. Others have additionally supported that a client's CSAM may include conceptions and fragments anchored in later insight and experience, and that the victim's imprecision and bewilderment regarding the specifics of the events should by no means lessen the actuality of the abuse per se (Olio and Cornell, 1993).

Loftus and Yapko (1995) expressed an opposing view, by stressing the limitations of our current knowledge on making this distinction, and proposed that therapists who work with CSAM should avoid both accepting unconfirmed recollections and employing controversial techniques:

> "As a first step, it is worth recognising that we do not yet have the tools for reliably distinguishing the signal of true repressed memories from the noise of the false ones. Until we gain these tools, it seems prudent to exercise caution when some presumed amnesic barrier is probed. Psychotherapists would be wise to be circumspect regarding uncorroborated repressed memories that return. Techniques that are less potentially dangerous would involve clarification, compassion, empathy, and gentle confrontation as patients sort out their personal truths" (p.184).

A related perspective indicates that patients may express their own truth but not necessarily the 'Truth', and therapists should trust the process of therapy, accept but not necessarily 'believe' their patients' memories. In relation to this, Mollon (1996) wrote:

> "It is crucially important to be open to a variety of possible understandings of the patient's history and development - and to help the patient to be open to these too. For the therapist to presume to know is to assume a quite unwarranted authority to define reality - a position that must be avoided, even though at times the patient may wish the therapist to relieve their uncertainty in this way. The only appropriate stance for the therapist is one of humility and modesty in the face of the vast unknown of the human psyche" (p.195-96).

The above-noted view states that it is harmful for therapists to presume to know while they cannot easily know what really occurred in the past. So what needs to be done for the therapist to be able to help the client clarify uncertain CSAM in a more informed way?

The required critical task, actually emphasised by both contrasting positions mentioned above (Yapko, 1994a; Pope, 1996), is to attain more accurate means of establishing what is true, and to impede the reliance on ambivalent theories or personal bias (like discomfort with the theme of CSA and professional status). Research is required to examine the degree to which recovered memories can be clearly substantiated and to set rules for differentiating between actual and fantasised CSAM (Powell and Boer, 1994).

Bearing in mind the reviewing of the psychotherapists' role in cases of CSAM, and given that there is lack of both consistent professional guidelines, and trustworthy scientific inquiry on the actual practices performed by therapists, it has been challenging for therapists to proceed with confidence and certainty in their work with clients who disclose a CSA experience (Phelps, Friedlander and Enns, 1997).

### 1.1.3 Other Key Issues and Contributions

The context regarding therapy on adults' CSAM would be incomplete, if we failed to thoroughly examine the complex relationship between fantasy and reality-based trauma, the influence of both on the the psychoanalytic therapist's beliefs, as well as the relevant neurological evidence.

#### 1.1.3.1 Fantasy and Real Trauma

The quandary between fantasy and reality will now be posed, appraising their individual significance and effects. Starting from the definitions of each term, there seems to be an issue with the usage of the word trauma. Keiser (1967) pointed out that in psychoanalytic literature the concept of trauma appears to refer to anything harmful to the psyche and that, in this sense, it is very broad.

The term 'psychical reality' has often been used by Freud:

> "To designate whatever in the subject's psyche presents a consistency and resistance comparable to those displayed by material reality; fundamentally, what is involved here is unconscious desire and its associated phantasies" (Laplanche and Pontalis, 1973, p.363).

In accordance with *The Language of Psychoanalysis*, phantasy[i] (or fantasy) could be described as an imaginary scene with the subject as a protagonist, representing the (unconscious) wish fulfillment, transformed - by defensive processes - in an enigmatic way (Laplanche and Pontalis, 1973). There are various types of phantasy, e.g. conscious and unconscious. Laplanche and Pontalis (1973) also note that Freudian, and generally psychoanalytic goals, focus on:

> "An explanation of the stability, efficacy and relatively coherent nature of the subject's phantasy life" (p.315).

These patterns in unconscious wishes may lead to traumas that distort the subject's perceptions, and thus prove valuable therapeutically. The writers add that Freud:

> "Refuses to be restricted to a choice between one approach, which treats phantasy as a distorted derivative of the memory of actual fortuitous events, and another one which deprives phantasy of any specific reality and looks upon it merely as an imaginary expression designed to conceal the reality of the instinctual dynamic" (Laplanche and Pontalis, 1973, p.315).

The above-noted quote expresses Freud's tendency to combine fantasy with reality in a balanced way. In other words, fantasies neither entirely originate nor are completely dissociated from reality.

[i] The term 'phantasy' with 'ph' is used mainly by Freudian and Kleinian analysts so as to designate the specific quality of unconscious wishes and desires so as not to be confused with conscious fantasies and day-dreaming. However, for the purposes of this section the terms 'phantasy' and 'fantasy' will be used interchangeably as, although Freud never used the term 'phantasy' as such, his descriptions and explanations of 'fantasy' seem to correspond to the unconscious significations of 'phantasy'.

The time has come to highlight the basic predicament regarding fantasised and actual trauma and their interaction in relation to CSA. In discussing paternal seduction memories, Freud (1917) noted in his *Introductory Lectures on Psycho-Analysi*s:

> "Up to the present we have not succeeded in pointing to any difference in the consequences, whether phantasy or reality has had the greater share in these events of childhood" (p.369).

Freud's argument may denote that the importance should not be laid on whether seduction really occurred or was merely imagined.

Roudinesco (2001) proposed that reliance on Freud's ST, may lead to the assumption that a trauma per se is accountable for a certain devastation of the person who has suffered it. In this case, individuals who have experienced abuse in extreme conditions would be determined to become abusive themselves or complain unendingly about an incurable wound. Freud may have opposed this obstinate unfairness when he supposedly 'abandoned' his hypothesis. In this line of reasoning, this misfortune is not physically predisposed and it should not define one's fate. Everyone has a unique history that makes them respond in a somewhat different way from others under exactly the same circumstances. Thus, an actual trauma is not on its own more harmful than acute psychical distress (Roudinesco, 2001).

Grubrich-Simitis (1988) illustrated Freud's battle with the quandary of developing a causative formula that could include fantasy together with external trauma, and experimented with several different solutions. His latest attempt was the concept of the 'complemental series', where the fantasy factor intermingles with reality - less fantasy, more trauma, is required to generate a neurosis, and the opposite (Freud, 1938). His phylogenetic assumptions reflect another endeavour of this kind. Grubrich-Simitis (1988) additionally reasoned that, after 1897, the mere ambiguity became a lifelong indistinctness regarding the role of real trauma. He repetitively claimed that there must be a combination of 'trauma and drive', although he also vacillated between 'trauma or drive' (Simon, 1992).

Memory and fantasy enhance and simultaneously threaten each other in such an oblique and indefinite way that no sole source can ever be irrefutably concluded among an instinctive wish and an empirical event (Bernheimer, 1990). Hence, Freud (1899), in his paper on screen

memories (pp.301-322), reported of having had to preserve the authenticity of an early memory his patient intended to decipher as a suppressed fantasy (Bernheimer, 1990). Freud (1899) objected:

> "This cannot occur, unless there is a memory-trace the content of which offers the phantasy a point of contact—comes, as it were, half way to meet it" (p.318).

Warner (1986) proposed that this midpoint, where the trace of what is external to the psyche comes across the internal projections, symbolises the central point of language, the avenue of psychoanalysis.

On the other side, Ferenczi (1949) drew attention back to external reality and argued that individuals become ill because of their actual experiences, rather than their fantasies. His notion of confusion of tongues between adults and children, emphasises that the adults' sexualised responses to children's sensualised callings, gravely affect their future development. Ferenczi's views have found support in more recent clinical observations; for instance the A.P.A. Working Group (1998) discussed how CSA can disrupt the nature and meaning of relationships, by rendering the victim's experience of being touched as dubious or bewildering due to sexualisation. Ferenczi (1949) explored the defence mechanisms that individuals employ to deflect the awareness of their child trauma. For instance, Ferenczi and Rank (1924) stressed the significance of the repetition of the analysand's child conflicts in the psychoanalytic interaction.

Regardless of Freud's initial intentions, the consideration of his two theories as complementary will be far more beneficial. Ulman and Brothers (1988) defined trauma as an actual occurrence, whose unconscious meaning destroys main organising fantasies and mechanisms of self-restitution, thus leading to dissociative disorder or PTSD. This definition shows the point where fantasy and reality interact in CSAM cases. If reality was the sole factor, every CSA victim would inescapably face the vast impact, which is unsupported by recent writings on the subject, further examining some persons' remarkable resilience (e.g. Whitelock, Lamb and Rentfrow, 2013; Rowan, 2006) or attributing the effects on family dysfunction (Bhandari, Winter, Messer, and Metcalfe, 2011; Nash, et al., 1993).

If only fantasy played a role, with regard to the alleged universality of the theory of sexuality, all human beings would become hysterics, which is disproved by common sense. Therefore, neither of them can stand alone, while their combination may both improve our awareness towards incest and assist the victim's potential for best possible recovery.

As Roudinesco (2001) proposed, the sole tendency corresponding to psychoanalytic thinking entails the recognition that fantasy and trauma co-exist in all cases of sexual abuse. Clinically, therefore, a psychoanalyst should accept both states of reality (psychic reality and the real event) and to understand that both may cause psychological anguish (Shengold, 1989). Disowning fantasy as a whole may trigger in a subject an affliction as potentially traumogenic as the repudiation of actual abuse (Roudinesco, 2001).

Following this review of psychoanalysis' history pertaining to CSAM, the reader should understand the origins of the debates and dilemmas around Freud's contribution on CSA and memory, regarding minimising fantasy, thus causing false memories, or conversely, ignoring reality. The matter that can now be presented is whether these matters remain unresolved and influence psychoanalytic therapists today.

Thus, the fantasy-reality predicament will be dealt with in more depth in the next parts of this thesis, as it is included in several of the interview questions, which psychoanalytic therapists were asked to respond to for this study. For instance, the interview questions about how interviewees would handle symptoms of CSA before the actual memory came up during the therapeutic process, and about how they would question the reliability of a CSAM, may demonstrate their overall approach to the issue concerning reality and fantasy in current psychoanalytic treatment. The questions aim to show whether these contemporary psychoanalytic therapists believe that false memories exist, whether they are inclined to accept each memory as true or not and, and whether they regard CSAM reliability as important.

#### 1.1.3.2 The Nature of Traumatic Memory: Neuropsycological and Other Evidence

Being a CSA victim is one of the most (if not the most) traumatic experiences that a child can endure. From both research and clinical evidence, there is plentiful data to back the existence

of various conscious and non-conscious memory processes for traumatic experiences. This section will focus on evidence, firstly, about important differences between traumatic and non-traumatic memory, and, secondly, about the remembering and forgetting of trauma. The connection between psychotherapy and this evidence will also be considered.

There is sizeable evidence that traumatic memory differs from ordinary memory on the basis of psychobiologic and cognitive characteristics (Chu, Matthews, Frey, and Ganzel, 1996). An Indian Psychiatrist working in the field of suicide behaviour, Amresh Shrivastava, and his associates claimed that CSA is responsible for various memory abnormalities based on neurological evidence:

> "Child sexual abuse (CSA) is an important public health problem with long-standing neurobiological, developmental, and psychiatric abnormalities... Serotonin abnormalities have been reported in various studies among participants exposed to CSA. Structures such as the prefrontal cortex, superior temporal gyrus, corpus callosum, parietal lobes, hippocampus, and cerebellum all demonstrate volumetric and structural changes in response to the trauma of CSA. Neurocognitive studies demonstrate memory and spatial awareness as well as decrements in general cognitive performance and memory when compared to normal individuals. The hypothalamic–pituitary–adrenal axis has also been implicated in CSA, and there is an alteration in corticotropin-releasing hormone response due to the continuous cumulative trauma of CSA" (Shrivastava, Karia, Sonavane and De Sousa, 2017, p. 4).

In a similar fashion, a Brazilian neuroscientist and psychologist called Julio Peres, alongside his associates, connected traumatic memory storage and retrieval to neuroscientific evidence:

> "Neuroscience findings have shown that the brain does not actually store memories, but stores traces of information that are later used to create memories, which do not always factually represent what was experienced in the past. To perform this process, different parts of the brain act as important nodes of the neural network that encode, store, and retrieve the information that will be used to create memories. Hence, whenever a traumatic or emotional event is retrieved, it may undergo a cognitive and emotional change" (Peres, Mercante, and Nasello, 2005, p.433).

The results of a study conducted by Porter and Birt (2001), who are Canadian psychologists, indicated that traumatic memories and non-traumatic memories varied both phenomenologically, such as in their vantage point, and qualitatively, such as in the number of their details. Nevertheless, traumatic and non-traumatic memories also shared essential similarities; for instance, they were both very vivid. Moreover, Berliner, Hyman, Thomas, and Fitzgerald (2003) found that the kind of trauma seemed to make a difference in memory features; most particularly, there was less vividness and coherence in memories of sexual trauma when compared to memory of non-sexual trauma. The results of the study of Berliner et al. (2003) demonstrated that when compared to memories for positive experience, traumatic memories involved less sensory detail and coherence, but included more meaning and effect. As indicated by the authors, the reported differences probably mirror either poorer encoding of traumatic experiences in the first place or less processing and rehearsal following the experiences. However, according to a different perspective, memory is more likely to be improved than damaged by high intensity of emotion and stress, therefore traumatic memories are distinctive, enduring, and effortlessly retrieved (Shobe and Kihlstrom, 1997).

As argued by an Israeli psychiatrist, brain researcher and psychoanalyst, called Yoram Yovell (2000), each individual has two separate memory systems which typically function effortlessly and in parallel: the explicit memory system, and the implicit one that mediates emotional memories involving fear and anxiety. These two memory systems are different both anatomically and developmentally: Explicit memory is mediated to a great deal by the hippocampus, and implicit memory is mediated, at least partially, by the amygdala (Yovell, 2000). The neuropeptides and neurotransmitters released when a person experiences high level of stress can influence memory operation, working along the lines of various brain regions implicated in memory including the hippocampus and amygdala (Yovell, 2000). Such release may hinder the assimilation of memory traces for episodes of early abuse (Bremner, Krystal, Charney, and Southwick, 1996).

Yovell (2000) explained that an excessive level of traumatic stress may provoke a fractional or total failure of the hippocampus, alongside a shutdown of explicit memory development. Consequently, very traumatic experiences may be recalled in an inconsistent, fragmented, partial way, or not at all. Nonetheless, the amygdala is not malfunctioning due to traumatic stress; quite the reverse, its activity is increased. This can give rise to circumstances wherein an actual recollection of a traumatic incidence is vague or absent, while its emotional

memory, which includes the anxiety and horror connected to it, may always be there or resurface at any time. Thus, neurobiology clarifies the defence mechanism of dissociation as an involuntary and pathological detachment of facts from its related emotions (Yovell, 2000).

In a dissociative state, imperative mechanisms are obscured. This results in disconnected fragments that are hard to recall, rather than naturally leading to effortlessly remembered memory entailing the experienced emotions (Schacter, Koutstaal, and Norman, 1996). Furthermore, when a traumatic memory is blurred and deficient, it might be recovered as an explicit memory merely under intensely emotional conditions, such as in the process of psychotherapy (Yovell, 2000). Therefore, neurobiology illuminates the clinical phenomenon of recovered memory in psychotherapy as a comeback of a previously misremembered trauma due to the intensified experience of a personal analysis.

As maintained by Zola (1998), experimental evidence indicates that traumatic memories may be modified by new experiences. Research has supported that whole incidents that never occurred may become integrated into memory, and that a person may mistake a false memory for a genuine one. Even lucid and subjectively persuasive memories can be inaccurate or completely fabricated. Human memory is flawed, and it commonly encompasses errors, distortions and dissociation. Additionally, memory shortcomings are more likely to be grave as the time period between a real event and its recall is expanded, and people are prone to memory distortion throughout their lives starting from their preschool years (Zola, 1998).

Peres, McFarlane, Nasello, and Moores (2008) clarified that memories would be clearer if PTSD symptoms are initially relieved:

> "Emotionally charged memories are subjective representations of an event, often distorted and distant from the original episode, but salient in their significance to the individual. Although there is a marked degree of inter-individual variability in the processing of memory of life events and basic emotions, the authors postulate that the re-interpretation and reconstruction of traumatic memories will be efficacious in relieving PTSD symptomatology. This process will influence the neural networks subserving these experiences, leading to the formation of new memories that are less fragmented and available for narrative expression, an idea that is consistent with neuroimaging and clinical observations" (p. 485).

Van der Kolk, Hopper, and Osterman (2001) claimed that all kinds of memory – rather than solely the traumatic ones – are usually distorted:

> "Like all stories that people construct, our autobiographies contain elements of truth, of things that we wish did happen but did not, and elements that are meant to please the audience. The stories that people tell about their traumas are as vulnerable to distortion as people's stories about anything else. However, the question whether the brain is able to take pictures, and whether some smells, images, sounds or physical sensations may be etched onto the mind, and remain unaltered by subsequent experience and by passage of time, still remains to be answered" (p.29).

To sum up, neurological and psychological evidence elucidate how both fantasy and reality can play a role in CSAM. More explicitly, they support not only that traumatic memory can be forgotten and re-remembered, but also that there can be false CSAM. On the whole, memory distortion is stressed by the evidence even in the constructions of memory that are not recovered. This is the reason why I chose to focus generally on all types CSAM, rather than recovered memories only.

#### 1.1.3.3 The Analyst's Influence

Another interesting inter-psychoanalytic controversy involves the analyst's influence on the analysand. Freud realised that some analysands could not benefit from hypnosis and that the influence of the analyst on the analysand was immense. For this reason, he fought to avoid the hypnosis technique, and to minimise the analyst's influence and countertransferential reactions (Freud 1910; 1912). In Freud's (1905c) gripping metaphor, hypnosis and suggestion function as painting, like colouring the canvas by modifying the personality, whilst psychoanalysis functions as if creating a sculpture, subtracting marble to unearth pre-existing personality forms (Etchegoyen, 1999). However, in this way, the influence of the analyst was present but not examined, which may have led to creation of false memories in therapy.

In this regard, Scotford, R. (1999) emphasised Freud's forceful application of the pressure technique:

> "With the aid of his quasi-hypnotic 'pressure technique' he tried hard to force his patient's to 'reproduce' the supposedly forgotten memories. Freud's own inaccurate reports of these episodes many years later led readers to believe that most of his female patients had told him spontaneously that they had been sexually abused by their fathers. But in the 1896 seduction theory papers Freud explicitly states that it required a forceful application of his clinical technique to induce the recovery of the early 'memories' he believed his patients had repressed" (p.47).

Ferenczi was not so frightened by the analyst's influence: in his attempt to accelerate the psychoanalytic process, he and Otto Rank (1924) encouraged a more active role for the psychoanalyst. This tenacity on the analyst's active role influenced their later discharge from the psychoanalytic community (Mitchell, 1997; Davies and Frawley, 1994; Hoffer, 2002).

More recently, other authors have contested Freud's adherence to the analyst's detached, non-involvement and the consequential negligence of countertransferential benefits in therapy. For instance, Olio and Cornell (1993) argued that the distant therapeutic approach proposed by Freud is inappropriate or even wounding for adult sufferers of CSA because it reproduces the denial, overlooking and obscured patterns of relating of the dysfunctional family.

Furthermore, short-term dynamic psychotherapy supporters argued that by remaining passive, psychoanalysts have pointlessly prolonged the duration of their intervention (Nichols and Efran, 1985). It is interesting to note that Freud (1913) used to have three to six sessions per week with his patients and the whole process usually lasted from six months to a few years. Nowadays, psychodynamic psychotherapy characteristically includes one or two sessions per week, and the average analysis usually takes approximately five to six and a half years (Doidge, et. al., 2002). Some analyses may even carry on for decades (Bernstein, 1995). Other psychotherapeutic disciplines typically involve weekly sessions for three to four years and do not encourage more frequent meetings (Bernstein, 1995).

Mitchell (1997), broadly acknowledged as a leader and promoter of the relational psychoanalytic approach, persuasively asserted that analysts unavoidably influence analysands. 'Relational-perspectivism' is a mixed, postmodern psychoanalytic approach, which has been influenced by interpersonal psychoanalysis, British object relations theory, self psychology, and interactionally oriented Freudian views (Stolorow, 1997). According to

a relational appraisal, the concepts of analytic objectivity or neutrality are imaginary and unacceptable in psychoanalytic psychotherapy, considering the unconscious analyst-analysand dynamic (Gillman, 2006). As Greenberg puts it (1986):

> "Many clinicians feel that as a term neutrality is too cold and aloof, that it doesn't convey the kind of affirmation that patients not only need but typically get in a well-conducted treatment" (p.138).

Freud struggled to keep the analyst outside the field of study in his effort to make psychoanalysis accepted as a science. In contradiction to this, the relational paradigm mainly focuses on the analysand's internal object world and the analyst-analysand interaction (Gillman, 2006). According to Mitchell (1997), the interactive experience also changes the analyst and the whole therapeutic interaction is the cornerstone of a successful therapeutic relationship:

> "Attention paid to interaction in the analytic relationship does not diminish or distract from the exploration of the patient's unconscious; it potentiates and vitalises it" (p.19).

Mitchell (1997) also holds that this newly welcomed influence of the analyst does not oppose the analysand's autonomy; on the contrary, the autonomy is an emergent property of interaction. From this perspective, both interaction and countertransference are required for the formation of autonomy and should be encouraged rather than avoided. In the therapeutic context, the analysand is given the opportunity to progressively develop an especially psychoanalytic type of autonomy, which transpires as the patient assimilates and is gradually more capable of dwelling on and restructuring the internalised image of his analyst and of their analytic bond. Hence, he supported that we must be mindful of this influence and use it in a way that would be valuable for the analysis:

> "Interpretations are central to the therapeutic action, but it is not the content of the interpretations alone that is crucial. It is the voice in which they are spoken, the countertranferential context that makes it possible for the patient's characteristic patterns integrating relationships with others to be stretched and enriched. To find the right voice the analyst has to recognise which conflictual features of her own internal

> world have been activated in the interaction with the patient, to struggle through her own internal conflicts to arrive at a position in which she may be able to interest the patient in recognising and struggling with her own (the patient's) conflictual participation, this makes the work, inevitably, deeply personal and deeply interpersonal" (Mitchell, 1997, p.6).

On the 'same page', Aron (1996) accounted for the therapeutic pair's co-construction of 'meaning' in analytic therapy:

> "Meaning, in the analytic situation, is not generated by the analyst's rational (secondary processing) of the analysand's associations; rather, meaning is seen as relative, multiple and indeterminate, with each interpretation subject to continual and unending interpretation by both analyst and analysand. Meaning is generated relationally and dialogically, which is to say that meaning is negotiated and co-constructed. Meaning is arrived at through 'a meeting of minds'" (p.xii).

In opposition to Freud's stance and more in line with a relational way of thinking, more contemporary minds both realise and take into account the influence of the scientist/observer. Psychoanalysts tend to acknowledge that the analyst's influence on the analysand cannot be avoided. Although there have been critiques of Mitchell's work (Stolorow, 1997), even the most conventional writers consider psychoanalysts as bearing a certain effect on the therapeutic process (Mitchell, 1997). Current psychoanalysts are encouraged to employ countertransference as a therapeutic tool in order to both understand the analysand's experience of the trauma, and to help the analysands realise the influence of the analyst in the therapeutic process (Courtois, 1997; Walker, 2004).

In addition, as this past tendency to secrecy and disowning of CSA has decreased in modern times, it has allowed the analysts' voices to start describing how demanding and agonising the analytic process can be for them (Mitchell, 1997). The current study attempts to communicate the anguish experienced by psychoanalytic therapists as well as analysands (as seen through the participants' views). It will also elucidate whether current psychoanalytic therapists embrace a more classical or a more relational psychoanalytic approach in their everyday practice.

All of the above give rise to many uncertainties about the analyst's role in CSA cases. This idea additionally furnishes the rationale of the present thesis, which targets a deeper understanding of CSAM sufferers and their therapeutic relationships. In a more all-encompassing and practice-oriented stance, accounts from varied sides could be explored. The thoughts of contemporary psychoanalytic therapists on the above-noted subjects may provide ideas about current in treatment handling and its apparent dangers.

#### 1.1.3.4 The Analysts' Belief or Disbelief in Child Sexual Abuse Memory and Its Influence on the Analysand

Literature from the last 25 years brings into light an important subject: the impact of the therapists' belief or disbelief in the client's allegations (Olio and Cornell, 1993; Brenneis, 1994; Yapko, 1994a; Bowers and Farvolden, 1996; Spanos, 1996; Goldberg, 1997; Lindsay, 1997; Palm and Gibson, 1998; Gore-Felton, Koopman, Thoresen, Arnow, Bridges, and Spiegel, 2000). This important subject focuses on whether therapists are inclined to take sides or to remain neutral, and to whether their beliefs about the veracity of CSAM may affect therapeutic effectiveness. The subject under examination can also be connected to the analysts' undermining of authentic early sexual trauma and overestimation of fantasised wounds (see section 1.1.4.1), as well as to the therapists' influence (see section 1.1.3.3).

According to a viewpoint, the therapeutic approach may be adapted to the clients' situation as assessed by the therapist. Gore-Felton et al. (2000) argued that therapists' evaluation of the reliability of CSAM is usually based on a probability decision and described how this may greatly influence the course of therapy. For instance, if the therapist believes in the authenticity of the client's CSAM, therapy may aim in working through the trauma, whereas if the therapist holds that the reported CSAM is fantasised, therapy may focus on the meaning of this false perception.

It is interesting to take into consideration that the analysts' beliefs or doubts do not need to be explicit to have an impact on the analysand (Brenneis, 1994). They may be completely unconscious and still affect the client and the shared therapeutic experience. In this regard, the impact of the therapists' personal beliefs on their clinical judgments must be taken into account as they may affect the client.

However, therapists may err. The risk of underestimating or overestimating memory veracity has been discussed (Polusny and Follette, 1996; Phelps, Friedlander and Enns, 1997). The most obvious involved risks are those of retraumatising a client due to repeating the circle of denial, and of inducing false memory.

Whichever way therapists decide to intervene or to avoid inervening, they appear to be destined to risk causing harm to their client as seen next. When they accept the clients' CSAM as authentic, they offer the foundation that clients may need to wholly acknowledge these false memories as actual. For instance, FMS advocates highlight that the therapist's trust on the authenticity of a CSAM, may trigger false memories, and even erroneous accusations and guilty legal pleas (Brenneis, 1994; Yapko, 1994a).

When therapists question their client's CSAM or do not show that they believe in him/her, they may retraumatise the client who needs to be believed. Gardner (1993) argued that with certain analysands, there has to be a particular phase wherein both analyst and analysand explicitly acknowledge the reality of the latter's CSA. In fact, in an often-cited conference report on research findings from 358 clinicians, it was discovered that 22% of them thought it was vital to recognise clients' CSAM as valid, even when there was no corroborating evidence (Bottoms, et al, 1995, as cited in both Lindsay, 1997; and Palm and Gibson, 1998). It should be noted that, unfortunately, I could not find the original paper (i.e. Bottoms, et al, 1995) so as to report what the findings for the majority of participants were in order to avoid a biased reporting of results.

In addition to this, the client may be retraumatised not only because of the therapist's disbelief, but also due to their neutrality or unwillingness to listen (Olio and Cornell, 1993; see section 1.1.3.3), or mentioning of false memory existence (Palm and Gibson, 1998; see section 1.2.1.2).

Nevertheless, others urge therapists to remain neutral. For instance, Bowers and Farvolden (1996) emphasised that a therapist may be empathic and close to clients without accepting their versions of the truth as self-validating. Moreover, Gore-Felton et al. (2000) cautioned clinicians to avoid being either unreasonably trusting or excessively doubtful, and suggested that an open-minded and exploratory approach without leaning on either side would be more beneficial.

Considering the above dilemmas, analysts can be accused for leaning in the direction of fantasy or reality even when they follow precisely professional guidelines written in the literature. As Brenneis (1994) cleverly puts it:

> "If one does not believe, no memory can be tolerated; and if one does believe, whatever memory appears is suspect. There is no obvious way to differentiate these paradigms on the basis of predictions, for they predict the same outcome, assigned inverse valence: belief (suggestion) leads to memory (false)" (p.1049).

All sides seem persuasive as it is important for analysts to recognise the analysand's pain, to avoid traumatising the analysand through disbelief and it is at the same time sensible for them to remain relatively neutral, as they would in any other case. Therapists are called to face the dilemma between a more neutral and a more intervening approach, while there is still so much controversy on the subject, and it would be important to find out how they would approach an analysand's CSAM.

### 1.1.4 Alleged Psychoanalytic Tendencies as After-Effects of the 'Abandonment' of Seduction Theory

From the time that Freud 'abandoned' his ST and presented his infantile sexuality theory up to the present moment, much progress alongside several mistakes have been made in the domain of CSA, within and outside psychoanalytic circles. Psychoanalysts have been accused for the following alleged tendencies, which have been associated in one way or the other with Freud's change of perspective. This part aims to investigate these accusations and their links to Freud's 'abandonment' and, where possible, to the post-Freudians' role and to this study's investigation.

#### 1.1.4.1 Psychoanalysts Overlooking Actual Child Sexual Trauma and Over-Emphasising Fantasies

One of the main accusations towards psychoanalytic theory and practice involves the undervaluing of real CSA cases, combined with an overestimation of fantasy.

In the progression of his theories, Freud turned his emphasis from mere actual event to a combination of reality with fantasy. He never said that CSA is non-existent or even rare, nor did he doubt the implicated grave effects as we shall see next. On the contrary, he had read, seen and heard actual CSA cases. Before his first psychoanalytic publication with Breuer (Mitchell, 1997), Freud studied with Charcot, a prominent neurologist interested in trauma as a determining factor of hysteria. Freud also witnessed a forensic psychiatrist's – called Brouardel – exhibition of the body of a girl who had been paternally raped and murdered (Masson, 1990). Furthermore, Freud had copies of the books Brouardel and his predecessor, Tardieu, had written about physical and CSA (Masson, 1984). As Levine (2012) wrote:

> "As for Freud himself, although his theory and practice of analytic technique underwent many productive changes as he vigorously pursued the implications of psychic reality and fantasy formation, he never lost sight of the fact that some patient had, indeed, experienced childhood sexual trauma (p.8)".

Freud also claimed that not all relevant reports are fantasies; he considered that a still unspecified proportion of them was actual and that actual memories are frequent (Abraham,

1927, as cited in Simon, 1992). Moreover, as seen from the following quote, Freud (1931) did not doubt the adverse effects of actual seduction:

> "Where seduction intervenes it invariably disturbs the natural course of the developmental processes, and it often leaves behind extensive and lasting consequences (p.232)".

Until his death, Freud repeatedly affirmed the existence, pervasiveness and pathogenic nature of seduction scenes truly suffered by children (Freud, 1905b; 1938). Rooting for this view, Warner (1986) stated that Freud:

> "Never accepts the idea that fantasy carries forward so much fictive revision that all contact with an 'actual event' disappears (p.51)".

What Freud probably did doubt was whether CSA was by itself the sole cause of hysteria.

Simon (1992) argued that the majority of the reports from Freud's patients dated from ages where he regarded one's memory as reliable, explicitly from late childhood and puberty. Simon added that what Freud probably considered as unlikely were the 'two traumas' theory, meaning his own reconstructions of parts of the patient's memories to show that an unregistered seduction had taken place earlier. The earlier seduction supposedly implemented its 'retrospective attribution' by deferred action during the phase of the second seduction, which was reliably remembered (Modell, 1990). Simon's hypothesis implies that, both before and after his change of focus, Freud accepted his patients' later seductions, and thus the consequences of actual CSA in future psychopathology. What did change in Freud's beliefs was that while he held that another actual seduction had occurred, he later thought that this very early experience could be fantasised.

Jones (1955) emphasised that most investigators would have no faith in the patients' accounts to begin with, based both on their unlikelihood, especially in the reported frequency of occurrence, and on the hysterics' unreliability. Freud believed in their trauma, initially as a literal reality and afterwards as potential fantasies which were also significant.

Conversely, the notion that Freud generated a critical and unwavering conviction on the topic of seduction, specifically that CSAM were, as a rule, imaginary, the hysterics' illusion, has become established within psychoanalytic circles (Masson, 1984). Even Princess Marie Bonaparte, who was a pioneer in recording this view when she purchased Freud's correspondence to Fliess, made an important mistake. Masson tracked down her misinterpretation of Freud's notes, which she made while encapsulating the content of the letters. Referring to the letter of the 21st of September, 1897, Bonaparte commented that Freud exposed the hysterics' 'lie', whereas actually Freud did not characterise this as a lie (Masson, 1984).

The misinterpretation may indicate an inclination to understand false memories as the patient's lie to the analyst, although there are cases where the person wholeheartedly believes in the reality of the false CSAM. The ensuing generations of psychoanalysts may have internalised it in this way, meaning, that they may perceive false memories as lies fabricated by mental health patients.

Michael D. Yapko (1994) a clinical psychologist and author from the USA has claimed that Freud's later focus on fantasy led to 'confirmation biases', because psychoanalysts observed merely what they anticipated to observe. The same author advocated that Freud had informed practitioners that while children's sexual fantasies about their opposite-sex parent were rather normal, solely a psychologically unsophisticated or seriously pathological individual could misapprehend them for reality.

On the same subject, Roudinesco (2001) noted that some classically trained psychoanalysts are largely not concerned with actual seductions and focus mainly on fantasy. Rachman (1989) argued that from the time Freud allegedly 'deserted' his ST and presented the Oedipus complex as an alternate justification for the CSA reports, psychoanalysis transferred its emphasis from the interpersonal to the intrapsychic matters of sexuality. According to the author, this change of emphasis led psychoanalysis to overlook the tangible occurrence of sexual experiences among children and adults.

It has additionally been claimed that when psychoanalysts encountered allegations of CSA which they could not overlook, they tended to ascribe them to fantasies. To illustrate, in Glaser and Frosh's (1993) words:

> "This was in many respects a crucial reinterpretation of material, marking the real beginning of psychoanalysis as a discipline devoted to the mapping and explanation of subjective experience. But, the critique runs, it also merged with cultural prescriptions to support the tendency among therapists to discount CSA accounts, perhaps in part because of their own personal or professional anxieties. Instead of being recognised as referring to real events, in many cases resulting in trauma and long-term negative consequences, reports of sexual abuse were often read by psychoanalysts as wishes, incestuous desires mistaken for reality" (pp.36-37).

Forward and Buck (1981) argued that there are three reasons for the propensity of some therapists to totally neglect incest for personal reasons, namely:

> "Personal discomfort with the subject, little training in incest treatment, and a psychoanalytic tradition that for many years regarded incest reports as fantasies rather than actualities" (p.153).

There have also been reports regarding therapists, not least analysts, forgetting that the client has disclosed a CSA history (Fine, 1985; Barande, 1985; Clement, 1993; Gast, 1993; Sabourin, 1988; Cheniaux, Zusman, de Freitas, de Carvalho, and Landeira-Fernande, 2011). For example, Barande (1985) discussed case studies regarding the therapist's unconscious tendency to forget the analysand's revelations. Fine (1985) stressed the effect of countertransferencial dynamics, the therapist's personal psychoanalysis and Freudian theories on the psychoanalysts' memory. Furthermore, Clement (1993) argued that psychoanalysts favour working with latent sexuality, thus leaving overt sexuality unexamined.

A qualitative study by an American psychologist, Lisa Gail Colton (1996), indicated that the participating psychoanalytically oriented professionals expressed disappointment due to their continuation of both the client's and his/her family's pattern of denial of the incestuous secret. In her research the accusations about therapists to overlook actual CSA were underlined, but no evidence was found that the participating psychoanalytic therapists were inclined to ignore or misinterpret the actuality of clients' incestuous memories. According to

her study, all participants explicitly recognised the actuality of incest and denied having reservations about clients' allegations of incestuous CSA (Colton, 1996).

In view of the above, it is important to understand whether and why contemporary psychoanalytic therapists may feel reluctant or obliged to either address suspected CSA before the client's disclosure or to attempt to distinguish between authentic and false CSAM.

#### 1.1.4.2 Psychoanalysts Blaming the Child Sufferer

Another supposed indirect consequence of Freud's endorsement of his infantile sexuality theory is the child-blame in CSA cases (Levine, 2012). Freud argued that sexual fantasies concerning the parent of the opposite-sex were developmentally natural so he has been repetitively accused (Yapko, 1994a) to have encouraged not only the disbelief of CSA reports but also the picture of the child seductress (Simon, 1992).

There are ample examples of such referrals in the literature. For instance, Briere (1996) discussed victim-blaming in relation to child sexuality:

> "It is a common practice in our society to blame the victim, including in those instances when the victim is a child. Therapists are no more immune to this bias than other groups, although they may be in a position to do more harm as a result of it. This tendency to assign responsibility for abuse to the victim frequently manifest in psychotherapy as questions, such as: "What was your part in all this?"... These questions or statements often reflect the traditional Oedipal notion that children wish for sexual contact from adults and thus to some extent are responsible for any sexual interactions that subsequently transpire" (pp. 77-78).

La Fontaine (1990) argued that the popular idea that children's CSA claims cannot be accepted because they fantasise, should be ascribed to Freud's grand impact on general thinking. She added that another gratuitous inference based on Freud's line of reasoning (about children's sexuality and powerful possessive feelings towards their cross-sex parent) is the view that children are at fault for their own sexual abuse, that they are seductive and invite sexual approaches.

In addition to this, Simon (1992) identifies various relevant problems in the psychoanalytic literature:

> "In contrast to the paucity of articles, let alone books (none!) by analysts about actual incest between the early 1900's and the 1950's... When analysts do write about cases of incest and seduction, the main thrust of the discussion is to emphasise the seductiveness of the child. Case material is sometimes cited to demonstrate the validity of Freud's hypotheses about psychosexual development and the sexuality of children! The focus of discussion is almost exclusively within the framework of the Oedipus complex" (p.964).

The above-quoted critique is rather stern and one-sided, yet Davies and Frawley (1994) also suggested that, with a few exceptions, such as Ferenczi, psychoanalysis has remained silent on the topic of CSA for many years.

Gast's (1993) foreign text, which discusses CSA reports in relation to internal vs external determinants and emphasises the irrelevance of children's sexuality to their sexual abuser's criminal responsibility. The writer also mentions that Freud's misinterpreted and qualified 'rejection' of his ST is still partially accused for the increasing investigation of CSA reports (Gast, 1993).

As maintained above, I believe it is unjustifiable to link Freud to the aforementioned tendencies for two reasons which largely depend on current common knowledge. Firstly, Freud's discovery that children fantasise does not rule out the possibility of actual CSA, and he never abandoned the actuality of CSA per se, as discussed earlier (see section 1.1.4.1). Children may have a vivid fantasy life alongside their actual reality regardless of the fact that a substantial number of these children have experienced actual sexual encounters with adults.

Secondly, the children's possible seductive qualities do not justify any appalling actions on the part of the adult (Glaser and Frosh, 1993). To demonstrate further, many children who have endured sexual assaults, tend to be seductive (Kendall-Tackett, Williams, and Finkelhor, 1993). However, adults are not excused for sexually abusing a seductive child, as they supposedly have self-control and personal judgement.

Freud's finding that children have sexual feelings could have been employed for their benefit, instead of using it to blame them. The concept of infantile sexuality decisively contests an unrealistic picture of childhood purity which in fact increases the children's defencelessness by disallowing them admittance to sexual awareness (Glaser and Frosh, 1993).

Acknowledging that children are actually born as sexual beings would affirm their right to become aware of sexual matters very early, which would in turn help them to avoid sexual harassments. In relation to this, Tobin (2001) pointed out that a fall of psychoanalysis as a foundation of knowledge and guidance, led to deteriorations and exaggerations in American preschools, concerning a 'moral panic' about CSA and physical contact.

Furthermore, recognising that children have sexual phantasies, could help the wrongly accused in retaining 'the benefit of a doubt'. All of the above depends on the way one wishes to interpret them.

In addition to this, Colton (1996) found that the five psychoanalytically-oriented therapists participating in her study, identified as responsible for the paternal CSA the fathers/perpetrators and not the clients/victims.

Thus, it seems more likely that insults to both seductive children and self-respected adults can be detected in more contemporary literature, rather than in Freudian writings per se. It would be useful to find out the role psychoanalysts tend to attribute to the victim of child seduction. In the current study, the psychoanalytic therapists who participated may reveal whether they blame CSA sufferers, through their responses to questions relevant to CSAM, shedding light, for instance, to the professional development of each therapist on this matter.

#### 1.1.4.3 Psychoanalysts Underestimating the Impact of Child Sexual Abuse

An additional pattern in the literature is stating that psychoanalysis both undermines the effects and exaggerates the child's resiliency in CSA discussions (Simon, 1992; Levine, 2012).

Simon (1992) wrote about the undermining of CSA effects:

> "Another trend in the writing is to emphasise that the outcome is not all that bad! The use of evidence in these works tends to be extremely sloppy" (p.964).

The tendency to undervalue the consequences of CSA can be found in Furst's (1967) contribution on this subject.

Colton (1996) also found that the overwhelming majority (80%) of psychoanalytically-oriented therapists have undermined the effects of incest in their work with victims. More specifically, following their clients' initial disclosure, the subject was never brought up again. This may show the therapists' resistance to explore the clients' traumatic experience during treatment.

Nowadays, we know that CSA is likely to cause long-lasting suffering and mental disorders (Molnar, Buka, & Kessler, 2001). However, there is a debate on whether CSA always has harmful consequences for the victim. One side of the debate emphasises that the impact is almost never neutral and that the clients' denial and dissociation may obstruct therapists from witnessing the suffering (Olio and Cornell, 1993). For instance, the A.P.A. Working Group (1998) argued that, among other factors, the developmental stage of the child at the time of the sexual abuse is critical to how such events will influence the victim's future.

The other side stresses that there are not always serious consequences for the survivors (Fonagy and Target, 1997; Gardner, 2003). In fact, Gardner (2003) noted that unbiased studies showing conclusively that some women who have experienced early sexual trauma never endure any immense suffering are overlooked, considered biased, or rationalised as being invalid.

Freud's opinion is also important in understanding the basis for the accusations regarding psychoanalysts' undermining of these effects. He expressed his thoughts about the immense impact of CSA twice. As seen in the first parts of the current chapter, he initially supported in his ST (1896b) that CSA was the sole source of a dreadful psychological disorder. Afterwards, he (1905a) asserted that even phantasising about incest, which occurs unconsciously during the Oedipal stage of development, positions the child in his/her most vulnerable and decisive phase.

In view of Freud's perception of the significance and struggle of incestuous phantasies in early childhood, he and most analytic therapists have habitually been particularly eloquent regarding the detriment of adult-child sexual contacts, especially for parents implicated in these affiliations with their children (Glaser and Frosh, 1993). Thus, Freud (1905a) inferred - though indirectly the second time - that actual incest would complicate the child's feelings so much that, in all probability, the effects would be grave, since this would intervene with the victim's 'normal' development.

Exploring whether contemporary psychoanalytic practice is inclined to underestimate the consequences of CSA for the victim appears important, considering that such an underestimation may result in the analysand's retraumatisation during the therapeutic procedure (Perlman, 1993). The present research will attempt to elucidate whether psychoanalytic therapists tend to undermine the effects of CSA on the victim's future life, by inquiring about their approach to their client's possible CSA symptoms.

#### 1.1.4.4 Psychoanalysts Avoiding the Subject of Actual Early Seduction

Several claims stress psychoanalytic deficiencies in terms of failing to address matters about actual CSA in both theoretical contributions and training programmes.

For instance, Simon (1992) emphasised the lack of detailed analysis of sexually traumatised patients:

> "Psychoanalysts, including Freud and Anna Freud, generally focused on the sexual sequel of incest and seduction. With a few exceptions, until recent decades psychoanalysis did not get close enough to the treatment of victims of incest to build up a detailed clinical picture of the consequences. For example, it is not until the work of Ferenczi in the early thirties, that there is a description of the shaky reality testing and shaky trust of these patients. Only in retrospect is it possible to realise that Freud's early patients, many of whom were unquestionably victims of incest, struggled, as have such patients since, with problems in reality testing as a consequence of the incest. Difficulties in differentiating fact from fantasy may be part of the clinical picture of the incest victim. In turn, the patient's difficulty is augmented by the analyst's uncertainty about what is fact and what is fantasy in the patient's account.

> The focus on sexuality, and on hysteria, inhibited a broader inquiry into the effects of sexual abuse" (p.965).

The claim about Freud failing to stress the CSA victims' difficulty of differentiating fact from fantasy seems unsound, as Freud was perhaps a pioneer in introducing these patients' shaky trust and confusion of reality. In his own words:

> "Having realised that there are no indications of reality in the unconscious, so that one cannot distinguish between the truth and fiction that is cathected with affect…" (Freud, 1897b, p.260).

A page later in the same article Simon himself referred to Freud's writings, which show his awareness of this symptom:

> "Proportion of the sexual traumas reported by patients are or may be phantasies: disentangling them from the so frequent genuine ones is not easy" (Abraham, 1927, as cited in Simon, 1992, p.967).

Ferenczi (1949) indeed examined this issue in much more depth but it would not be fair to ascribe to him the original revolutionary observation.

To return to the accusations, Freud went through ambivalent phases while he was searching for the truth in this subject, therefore he is held accountable for both the scarceness and the poor quality of relevant texts after his 'retraction' occurred. For example, Yapko noted that:

> "As a result [of Freud's views], for roughly the first seven decades of this century, the sexual abuse of children was rarely discussed even among practicing professionals, nor was it addressed in clinical training" (Yapko, 1994a, pp.114-5). [mine]

Indeed, in scrutinising psychoanalytic writings, the directory of the main psychoanalytic journals in English reveals that from 1920 until 1986 only nineteen titles of articles included either of the terms 'seduction' or 'incest' (Mosher, 1991). This may indicate that Freud inspired some of his followers to write on the subject, but the concern faded away as time

went on. This, in turn, may show the reluctance of post-Freudians in examining the most complicated matters regarding CSA.

Psychoanalytic studies about CSA have been scarce and this lack of contributions has been underlined recently (Colarusso, 2009; Parker and Turner, 2014). Parker and Turner (2014) searched in electronic bibliographic databases and web searches about the effectiveness of psychoanalytic/psychodynamic psychotherapy for sexually abused children and adolescents and found no eligible studies for their list of criteria. They concluded that this important gap stresses the need for further research into the effectiveness of psychoanalytic/psychodynamic psychotherapy in this population.

Colarusso (2009) shared treatment recommendations for four sisters around 60 years old, who recently disclosed experiencing CSA. The author stated that medication should be considered alongside intensive therapeutic intervention by an experienced therapist and that the selection of an optimal therapeutic intervention is difficult as there is absence of systematic treatment outcome research for such convoluted cases. Colarusso's (2009) recommendations included that there should be understanding of the enveloping nature of the psychopathology, and of the women's vulnerability, and sensitive and slow approach without premature undermining of critical defence mechanisms. Emphasis was drawn to the initial treatment phases, to transference and to an empathetic, real therapeutic relationship, rather than to analytic reticence, relative silence, and lack of face-to-face contact, as this could be depriving and amplify their stress and feelings relating to criticism and rejection.

There have been notable articles on clinical cases about adults who have endured CSA in the 90s (Josephs, 1992; Alpert, 1994). Josephs (1992) highlighted the usefulness of self psychology principles and the dual focus on such cases, taking into consideration, not only the idealisation of the abusive father, but also the failure of mirroring by the mother, from whom she felt abandoned. In this case, the provision of crucial mirroring functions was a key factor in aiding the analysand to reclaim a sense of self as worthy of constant acknowledgement and attunement.

Alpert (1994) presented the case of a 25-yr-old woman who had endured CSA and suffered from severe amnesia for the abuse, thus accentuating some of the lasting effects of untreated early trauma. In this case, a narrative was formed through recovered memory

fragments, dissociative behaviour, dream analysis, repetition tendencies, transference and other such material and following several months of treatment, the woman's symptoms were considerably lessened.

Others shared their knowledge concerning psychoanalysis and CSAM (Levine, 1993; Hegeman, 1997; Lief, 2003). Levine's (1993) brief discussion on actuality and illusion in the transference stressed that we cannot know the truth and that we must count on what we feel. Hegeman's (1997) book on psychoanalysis in recent controversy about incest and trauma was another valuable addition to the limited literature. More recently, Lief (2003) explored fundamental issues regarding both recovered and false memory for the psychoanalyst, such as damage to families, nature of memory, the impact of trauma, unconscious processes, repetition tendencies, therapeutic interventions, and reality definition. The author concluded that by assuming a skeptical approach, avoiding intense memory recovery techniques, and being aware of the influences between analyst and analysand, the integrity of analysis should be ascertained (Lief, 2003).

To sum up, Freud's preoccupation with the incidence of actual CSA caused only a few writers to be concerned about the topic. Gradually, things returned to how they were before Freud's theorising; CSA was again almost entirely ignored and hidden. There was a rejuvenation of published clinical explorations in the 1990s. The aetiology for these backward steps probably involves the same historical and cultural reasons that kept CSA concealed before Freud's discoveries. It took decades for someone to focus on the subject again and it happened in an era wherein people were becoming increasingly more open-minded and thoughtful towards children's rights, and CSA was gradually criminalised, nearly a century later.

#### 1.1.4.5 Psychoanalysts Triggering False Memories in Treatment

An inclination identified in literature material is to presume that Freud's method induced false CSAM. In this respect, it has been argued that a closer investigation of Freud's work demonstrates that in his effort to reveal child seduction memories, he frequently employed techniques, which would nowadays be considered as suggestive (Powell and Boer, 1994; Bowers and Farvolden, 1996). Tabin (1993) also said that Freud's clinical evidence was

elicited by his pressing of his seduction hypothesis on his patients, rather than by unprompted CSA disclosure.

Mollon (2000) contemplated upon this accusation:

> "Some recent commentators... argue that Freud first coerced his patients into producing false scenes of childhood sexual abuse, which were really his own inventions, and then, realising his error, he subsequently claimed that his patients had spontaneously told him of their sexual scenes, and in this way had given him the idea of childhood sexuality and the Oedipus complex" (pp.45-46).

As mentioned above, Freud was a pioneer in acknowledging both the existence of false memories and the influence of the analyst on the analysand. It appears that Freud has become the scapegoat for a number of interpreters in this field. The purpose of all the above is neither to falsely conclude that there is no harm done, nor to reallocate the blame from Freud to his successors. However, apparently for a long time, there was an undeniable tendency to deny and doubt CSA. In this sense, some subsequent psychoanalysts may have appeared unable to withstand the tension between reality and fantasy, thus over time relying on either reality or fantasy. Regrettably, psychoanalysts, being 'lost in translation' about Freud's reconsiderations, were understandably confused regarding the way they should treat victims of abuse or deal with their fantasies.

Issues about false memory triggered in treatment are featured in the relevant literature as evolving around whether and how memory can be developed owing to the therapist's communication, and whether this happens often in therapy (Brenneis, 1994; Powell and Boer, 1994; Enns, McNeilly, Corkery, and Gilbert, 1995; Poole et al., 1995; Ware, 1995; Bowers and Farvolden, 1996; Polusny and Follette, 1996; A.P.A. Working Group, 1998; Palm and Gibson, 1998; Hutsebaut, 2001; Loftus and Davis, 2006). The topic under examination may be related to various issues discussed elsewhere, such as countertransference responses, false memory, and fact-fantasy approach (see sections 1.1.2, 1.1.3.1, and 1.1.3.3).

First of all, suggestion could be linked to the technique of 'construction' in psychoanalysis. Analytic constructions are basically the therapist's assumptions on the analysands' incomplete input with the goal of temporary life history coherence (Rubovits-Seitz, 1992).

Freud (1937) proposed that analysts should construct the forgotten material based on its traces and he (1939) supported that analysands may end up believing the analyst's imaginative and impressive construction as actual. In more recent years, akin to Freud, more recent contributions advocate that constructions may later be substituted by actual recovered memories (Moller, 1991; Gardner, 1993). The likelihood of the analytic process being affected by suggestion has also been articulated and defined especially in association with analytic reconstructions (Brenneis, 1994). Analysts have been cautioned about constructions necessitating examination and openness to modifications, contrasts, and validation, as they are rooted in vague interpretations (Rubovits-Seitz, 1992).

On a different note, there have been contradictory findings about therapists' views on whether false memory about early sexual trauma can be triggered in treatment, at least with regard to the purported ease with which false memories can be created. For example, Poole et al., (1995) found that the majority of therapists hold that false CSAM is a reality, but that only a minority think that its emergence is strongly connected to therapy or their own suggestions. Contrastingly, other studies (Polusny and Follette, 1996; Palm and Gibson, 1998) pointed to therapists who believe that therapy is a possible trigger for false and recovered memory. More specifically, two American clinical psychologists, Melissa A. Polusny and Victoria M. Follette (1996) found that 61% of the participating practitioners held that it was possible, or very possible, that adult clients may be falsely convinced by a therapist that they experienced sexual trauma.

If one accepts the idea that false CSAM can be triggered in therapy, the next question must involve the conditions in which this can occur. Writers have attempted to explain false memory production in treatment using analytic concepts (Ware, 1995) or through the analysts' belief in repressed memory (Brenneis, 1994). A considerable fragment of the literature material has focused on the idea that certain therapeutic techniques may trigger false memories (Olio and Cornell, 1993; Powell and Boer, 1994; Polusny and Follette, 1996), while other research has focused on the power of suggestion (Poole et al., 1995; Hutsebaut, 2001; Loftus and Davis, 2006).

Hutsebaut (2001) noted that suggestion plays a role in psychotherapy, because of the asymmetrical nature of the analytic relationship, defined by the analyst's experience and knowledge, as well as the analysand's appeal for help. The same author also claimed that

"uncontrolled suggestive influence occurs when those influences remain active as veiled and thus as not analysed" (Hutsebaut, 2001, p.70). This indicates that the elaboration of the analyst's influences may diminish potential for false memory creation in therapy. Although it is important for therapists to be informed about memory and suggestion (Enns, et al., 1995; Enns, et al., 1998), suggested effects may still take place unintentionally (Bowers and Farvolden, 1996).

Concerning the incidence of occurrence of false CSA, the publicity surrounding the CSAM debate indicates that false memory is not a scarcely-met phenomenon. Nevertheless, as pre-noted, Palm and Gibson (1998) remarked that merely a few cases of false memory were reported by their participants. However, Barber (2012) found that clients tend to both avoid discussing the interventions that were unhelpful for them and argue that they want to stop therapy because they feel better. Thus, there may be a gap between what therapists are left to think about the progress of a therapeutic process and what has truly occurred. This may also leave room for error in the estimation of the prevalence rate of therapy-induced false CSAM.

The members of the A.P.A. Working Group (1998) also acknowledged the possibility of false memory, since they stressed that a main implication of their findings for clinical practice with CSAM is that:

> "Care, caution, and consistency should be utilised in working with any client, particularly one who experiences what is believed (by either the client or the therapist) to be a recovered memory of trauma. Moreover, clients in all circumstances must be given information about possible treatment strategies and should in turn provide informed consent for treatment" (p.935).

Similarly, Courtois (1997) argued that therapists have also been advised to battle suggestion through accurate recording of the material and to discern memory authenticity through collecting detailed history and observing possible memory issues. Sanderson (2006) also proposed that professionals ought to resist contamination by presenting leading and premature interpretations. The same author declared that the clinicians' work on memory issues must be paced kindly with the intention that clients have the opportunity to familiarise themselves with various early memories, which may subsequently be incorporated in their regained life history (Sanderson, 2006).

Winnicott (1971) had also declared that the analyst should abstain from intervening by containing the analysand's feelings, thus permitting analysands to gradually discover their own truth. Bion (1970) was a pioneer in drawing attention to the importance of containment in therapy and not offering rushed interpretations. The analysts' influence has preoccupied more recent writers, such as Goldberg (1997) who explored the role of the psychoanalyst when working with recovered memories of sexual abuse.

The above-noted points indicate that the subject is still a controversial one in psychoanalysis. When this is the case, misapprehensions may occur. Acknowledging more about these possible misconstructions would speed up the process of correcting them. Bearing in mind the still undetermined ways of false CSAM induced in analysis, analysts must become aware and careful about potentially risky methods and means of communication. Inquiring about whether psychoanalytic therapists may discuss with their clients their hypotheses about a CSA history may be useful in clarifying this issue further through the present thesis.

#### 1.1.4.6 Psychoanalysts' Returns to Seduction Theory

As seen earlier (section 1.1.1.3) Freud did not forget the seduction hypothesis, even after it was allegedly abandoned. More recent explorations also encouraged a reconsideration of the ST so as to elucidate pathological behaviour and to determine treatment (Kohut, 1984). The current section will present the revisiting of the seduction hypothesis from various perspectives, such as the views of some exceptional writers, Multiple Personality Disorder investigations, recovered memory therapists, and emotive approaches.

For different reasons, several theorists seem to have returned to Freud's ST after the 1980s, that is 85 years after its introduction. Masson's (1984) attack towards Freud's 'abandonment' of the ST, brought the 'substituted' hypothesis again in the forefront of scientific discussions. Miller (1985) also highlighted the merits of understanding the tremendous effects of child seductions. Moreover, feminists drew attention to the theory. For example, in Herman's (1992) revision of the history of hysteria, the opening point was when hysteria surfaced in Charcot's discussions (Roudinesco, 2001).

The phenomenon of Multiple Personality Disorder has also 'resuscitated' the ST and its supporters (Rosehan and Seligman, 1995), and led to a new and exceedingly observable awareness of CSA, as CSA is by and large asserted to trigger this mental illness (Ganaway, 1989). The disorder is in all probability the most acknowledged illustration of the long-term effects of CSA (Rosehan and Seligman, 1995). It is caused when additional personalities are created as a defence against a repressed early trauma (Loewenstein, and Ross, 1992). Current treatment includes cathartic absorption of the other personalities in the original one.

Multiple Personality Disorder (MPD) was renamed as Dissociative Identity Disorder (DID) in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV) in 1994 (Bowers and Farvolden, 1996). In brief, according to the DSM-V, the diagnostic criteria of DID are:

(a) Disruption of identity characterised by two or more different personality states,

(b) Non-ordinary recurrent gaps in memory recall,

(c) The symptoms provoke clinically major impairment in central areas of functioning,

(d) The disturbance is not an expected part of a largely acknowledged practice,

(e) The symptoms are not caused by the physiological effects of a substance or condition (American Psychiatric Association, 2013).

Dissociation is often-met in CSA victims and it encompasses difficulties concerning memory and reality. More particularly, with the employment of dissociation, at least one of our major sources used to understand ourselves and interact with the world - that is, affect, awareness, behavior, cognition, and identity - is separated from consciousness, producing a fragmentation of self and/or experience (Olio and Cornell, 1993).

During the past decades, psychoanalytic research has also exposed the connection between CSA and various adult diagnostic states, such as Borderline Personality Disorder (Herman, Perry and Van Der Kolk, 1989) and Post-Traumatic-Stress Disorder (Olio and Cornell, 1993). This also came to resurrect the seduction hypothesis, and to oppose Freud’s turn toward fantasised trauma.

At another end, inspired by Freud's ST, trauma or recovered memory psychotherapists began viewing several other adult problems, like anxiety, depression, eating disorders, and sexual dysfunction, as ensuing from CSA (Bradshaw, 1990). Advocates of this thesis argued that adults will be able to recuperate mental health, only if they deal with this primitive and regularly unrecognised abuse. Another reconsideration of the ST in more recent times derived from emotive approaches. According to Nichols and Efran (1985), Breuer and Freud's 'cathartic technique', and Freud's initial theorising, is the beginning of not only psychoanalysis but also of current emotive psychotherapy:

> "Ironically, many of the emotive therapies that were developed as a reaction against psychoanalysis rest on variations of Freud's early idea that neurosis results from repressed traumatic events and can be cured by remembering and expressing the associated affect" (p.49).

Apparently, the seduction hypothesis is compelling enough to be multiply reviewed both by its founder and by recent theorists and practitioners. The link between past experiences and current difficulties is undeniably included perhaps in most mental health professional minds for over a century now. It is unknown whether contemporary psychoanalytic therapists have also gone back to the ST, by ignoring clients' fantasy and its influence on memory and by focusing mostly on the causal effects of CSA. The present research will endeavour to illuminate this issue by examining whether contemporary psychoanalytic therapists would question the authenticity of clients' CSAM reports, thus showing an acceptance of false CSAM and the influence of fantasy on trauma.

### 1.2.0 The Current Research

The present thesis will attempt to work towards a deeper understanding of current Athenian psychoanalytic practice with adults who have CSAM. Earlier in the current chapter, I examined the alleged connection between Freud's turn from reality to fantasy and the recent debates in CSAM. Herewith, I will introduce the focus points of this thesis.

The rest of the current chapter will explain how the controversial issues on the subject of CSAM that are addressed in current literature provided the focus points for this study. Throughout the present literature review, the uncertainties which may confuse psychoanalysts

at present, will be pointed out, thus leading to the formation of the main research apparatus, that is, the interview questions employed in this thesis.

### 1.2.1 Key Issues to be Researched

Following my review of the literature as explained earlier (see thesis introduction), my first observation is that the connection between psychoanalysis and early sexual trauma has been a subject that was recently approached. This is apparent as psychinfo encompasses abstracts dating back to the 1800s, while the oldest year result in my searches was 1969.

My second observation is that psychinfo searches had noticeably few results, specifically 1 to 31, which points out that the subject of psychoanalytic approach of CSAM is underexplored. We have also discussed earlier (see section 1.1.4.4), a shortage of writings on CSAM in the post-Freudian era until the 1990s. This noteworthy fact may indicate the professionals' uneasiness to encounter the subject of CSAM as a whole.

My third observation is that psychoanalysts have been strongly connected to the topic of false memory, as indicated by the search of keywords 'CSA, false memory, psychoanalyst', which had the most results (that is, 24).

My fourth observation is that a remarkable amount of the texts were written in foreign languages which allowed readings only of the abstracts, rather that the whole text (e.g. Barande, 1985; Fine, 1985; Baranes, 1988; Sabourin, 1988; Clement, 1993; Gast, 1993; Harrus-Révidi, 1993; Galtier, 1994; Boller, 1995).

My fifth observation is that the Psychinfo searches indicate that, in literature presented within the last 50 years, various texts alluded to the great importance of Freud's influence on current practice (Lear, 1995; Spanos, 1996; Arlow, 2006), and other texts proposed the re-examination of the ST (Clement, 1993; Good, 2007; Rendon, 2008), sometimes as an initial understanding of memory flaws (Arlow, 2006; Sprengnether, 2012). There have also been several texts on Ferenczi's input (Fortune, 1994; Galtier, 1994; Emery, 1995), as well as on the theoretical and practical differences between Freud and Ferenczi (Ludmer, 1988; Aron and Frankel, 1994; Boller, 1995).

My sixth observation is that clinical cases have been the basis for various psychoanalytic presentations of hypotheses and theories regarding CSAM (Gardner, 1993; Ware, 1995; Goldberg, 1997; Arlow, 2006). While clinicians recorded case studies which prove or disprove the existence of either recovered or false CSAM, separately as if in a parallel universe, researchers attempted to explain memory processes. Sprengnether (2012) stated that classical analysts search for vulnerability in analysands' narratives and provide evidence in the shape of case histories. The same author emphasised Freud's groundbreaking understanding of the essentially malfunctioning and unpredictable nature of human memory, and both the peril and the inescapability of objective manipulation of client's memory. There is, however, a shortage of empirical research focusing on the effects of the CSAM controversy in contemporary psychoanalytic practice.

My seventh observation is that both sides of the recovered and false memory controversy have been rather extreme and blind-sighted in their support of their own views and their contempt of the opposite side's views. For instance, recovered memory supporters (i.e. Olio and Cornell, 1993; Poole et al., 1995), have been over-emphasising the clients' need for the therapist's acceptance of the recollection which was presumed as authentic. On the other hand, false memory advocates (Crews, 1995; Yapko, 1994a), over-stress the devastating effects of false memory. For example, Yapko (1994a) discussed how false accusations can ruin not only the balance of the family system, but also the accused person's professional reputation and personal life.

After I got an overall view of the most important contributions on psychoanalytic work with child seduction memories, I summarised the results of my searches, and then clustered all selected material in relation to their similarities and controversial points. The ensuing analysis was arranged according to modern-day hotbeds around early sexual trauma, especially in relation to past and recent psychoanalytic debates. As shown below, most of the key issues/themes emerging from the literature, take the form of professional dilemmas.

#### 1.2.1.1 Introducing Traumatic Memory

Several writers have addressed problems in the initial discussion of CSAM (Herman, 1992; Pruitt and Kappius, 1992; Olio and Cornell, 1993; Poole et al., 1995; Bowers and Farvolden, 1996; Palm and Gibson, 1998; Sullins, 1998; Mollon, 2000; Loftus and Davis, 2006; Follette

and Davis, 2009; Barber, 2012). Follette and Davis (2009) argue that the therapist may be led to the hypothesis that a patient has endured abuse in the past while attempting to comprehend his/her symptoms. The central question at that point is what therapists are supposed to do with this possible hypothesis: Should they express it or not?

Bowers and Farvolden (1996) proposed that therapists should choose between intervening and waiting on the basis of which stance would be less dangerous:

> "Conducting therapy... provides an important opportunity, challenge, and choice: Realising how difficult or impossible it will be to distinguish between true and false memories of abuse, the therapist should balance in each case the potential for harm that would result from not recovering true memories of abuse against the potential problems that would result from recovering false memories of abuse. Then the therapist should proceed in a fashion that is least likely to produce harm" (p.375).

Literature guidelines for therapists' handling of the initial discussion of CSAM are often contradicting. On the one hand, as seen below, writers encourage therapists to express this hypothesis so as to both avoid ignoring CSA and to help the client overcome the trauma. Trauma or recovered memory advocates (such as Herman, 1992; Olio and Cornell, 1993) declare allegiance to revealing the historical truth regarding a client's abuse, since they have concluded that, in CSA cases, directly addressing early traumatic memories and the associated affect is central to the resolution of the client's detrimental experience. Along the lines of this idea, CSA victims unrelentingly employ the coping strategies of denial, and therefore endure lasting self-doubt, and are inclined to underestimate, renounce and detach from their traumatic experiences, making it all the more important for the therapist to believe in them as a source of external validation (Olio and Cornell, 1993).

Relevant research supported that therapists may be reluctant to suspect or address CSA: Palm and Gibson (1998) identified a possible failure by therapists to address actual CSA and noted that when a client reveals a pattern of symptoms indicative of trauma, the therapist must regard an abuse history as a potential hypothesis. According to Barber's (2012) study, therapists may feel reluctant to ask clients about early sexual trauma for various reasons, such as confusing scientific debates, alongside guidelines alerting them towards unreported memory and leading questions, fear of losing one's professional licence, and wish to avoid

both session recordings and legal troubles. In her thesis, with few exceptions, both clients and mental health professionals held that it would be helpful if professionals asked about a CSA history through a hypothesis, meaning that therapists should suggest to clients that their symptoms might be the outcome of CSA. This hypothesis could reflect the clinician's ideas regarding the underlying aetiology for the clients' presented distress, and it could also simultaneously normalise the client's possible experience. Notably, clients said that they were likely to drop relevant hints before CSAM would be disclosed and professionals said that they de-emphasised psychiatric labels (Barber, 2012).

The idea about addressing CSA and believing the victims appears to be especially critical for psychoanalysts who have been accused of ignoring the reality of CSA in treatment (Forward and Buck, 1981; Rachman, 1989; Glaser and Frosh, 1993; Yapko, 1994a). Furthermore, as indicated from my previous review (see section 1.1.4.1), emphasis has been placed on the analysts' tendency not only to ignore but also to forget CSA (for instance, Fine, 1985; Barande, 1985; Clement, 1993; Cheniaux et al., 2011). Writers have also focused on the need to recognise CSA in certain cases (Gardner, 1993). Moreover, as pre-noted (see section 1.2.2.1), in a qualitative study with psychoanalytically oriented professionals, participants expressed disappointment due to their continuation of both the client's and his/her family's pattern of denial of the incestuous secret (Colton, 1996).

While discussing repetition compulsion, psychoanalytic writers mentioned implicit child memories which were reactivated by the resemblance bared among the roles assumed by both parents and analysts as caregivers, authority figures, and so on (Cheniaux et al., 2011). This may indicate that analysts are drawn by analysands to ignore and forget the abuse, so as to replicate past experiences with grown-ups who seemed to overlook related symptoms. The above additionally furnish the argument for addressing the trauma of CSA as soon as possible.

On the other hand, as analysed in the current section, it has been argued that CSA indications are too broad, and that if a therapist addresses CSA before the patient does, there is a danger of both retraumatising the client and creating false memory. Madill and Holch (2004) discussed how the phenomenon of self-fulfilling prophesies has implications for therapists who hold that past CSA can be recognised through a checklist of symptoms. Clinicians may make false correlations between the apparently wide-ranging symptoms of CSA and their

suspicion of CSA even after disconfirming evidence (Myers, 1999). Lindsay and Read (1994) concluded through their reading of the clinical literature on memory and early sexual trauma that it would be irresponsible if therapists diagnosed repressed CSAM only on account of presenting symptoms. Spanos (1996) argued that there is no precise psychological symptom or constellations of symptoms that can be used to unfailingly infer an abuse history.

The other two points, namely the considerable possibility that the client will be retraumatised and the rare but consequential possibility that the therapist's inquiry will contribute to the development of false CSAM, have both been addressed by Mollon (1996):

> "Patients abused in childhood are often extremely vulnerable and fragile, perhaps relying on dissociative defences to maintain their functioning. For these patients, the recovery of memories of abuse, even if true, may be highly traumatic and destabilizing. Searching directly for memories of trauma is inadvisable because: (a) the patient may generate false memories; and (b) the patient may be overwhelmed and retraumatized" (p.201).

As far as the possibility of the client's retraumatisation is concerned, Richardson (1993) had discussed the importance of timing and of the client's state of psychic functioning. According to her writings, traumatic memories emerging before the restoration of the client's damaged psychic functioning via the therapeutic action of analytic psychotherapy pose a possible danger for retraumatisation. Nonetheless, memories will emerge optimally in an analytic therapy with minimised danger of retraumatisation merely following an adequate restoration of the client's psychic capacity.

Barber (2012) also says that disclosing CSA may be stressful for the survivor. She added that:

> "The mental health professional may appear uncomfortable, assume a 'blank' therapeutic stance, or terminate therapy upon hearing the disclosure. Experiencing such negative reactions from the mental health professional has considerable detrimental effects on the survivor, including secondary victimisation" (Barber, 2012, p.46).

Thus, the therapist's response to the revelation appears critical for the well-being of the client and the evolution of the therapeutic relationship. Ideally, therapists should be well-prepared and should also know the client's coping mechanisms to help him/her through the recounting of such a painful experience.

The danger about therapy-induced false CSAM may also be involved especially when therapists address CSA first (Poole et al., 1995; Loftus and Davis, 2006). According to Mollon (1996), traumatised clients can be considerably susceptible and submissive in some ways. These characteristics bring the traumatised individual in a position which is more prone to create material that tally the therapist's hypotheses, biases, expectations, and so on. This indicates that, ironically, troubled and abused clients are more predisposed than others to fabricate false CSAM (Mollon, 1996; 2000).

On the same topic, Yapko (1994a), advised therapists to allow for the material to come from the patient, so as to avoid instigating false memories. Research has supported that therapists are careful about their potential influence on the client's material: Sullins (1998) found that in cases of clients with possible repressed CSAM, therapists seemed cautious, attentive and avoided suggestion and pre-supposing.

Bowers and Farvolden (1996) compared the therapists' tendency to dig in the past with Freud's persistence on the unearthing of traumatic childhood memories:

> "By proceeding in this fashion, modern trauma therapists recapitulate a century-old Freudian slip— from dismissal of suggestion as a powerful determinant of memory and experience, to misappropriating implicitly suggested abuse memories as independent evidence for the trauma theory that anticipates, seeks, and generates them" (p.369).

A way out of the therapist's dilemma about addressing possible CSA in connection to the client's symptoms, would be to follow other researchers (Pruitt and Krappius, 1992; Olio and Cornell, 1993; Palm and Gibson, 1998; Alpert, Brown and Courtois, 1998; Barber, 2012), who prompt therapists to bring the subject up while recording the patient's history during the initial clinical assessment, in order to show the therapists' openness in this discussion. In this

respect, three American psychologists, namely Phelps, Friedlander and Enns (1997), who investigated the issue of the retrieval of memories of CSA from a client's perspective, wrote:

> "In order to avoid underestimating or overestimating the likelihood that a client has been abused, therapists are encouraged to include questions about trauma and child sexual abuse within a comprehensive, holistic assessment that explores a wide range of experiences that may be related to a client's presenting problems..." (p.322).

A second suggestion about handling this dilemma includes the therapist's exploration of material that has already been presented. More specifically, when there are indications connected to CSA while the client has not disclosed such trauma, the therapist could work on the roots of the presenting symptoms rather than mentioning explicitly the symptoms' possible connection to past trauma (Enns, et al, 1998).

A third suggestion described next supports that a less-intervening therapeutic approach may also result in therapeutic effectiveness in relation to the client's symptoms. For instance, minority of practitioners in Barber's study (2012) did not believe in the advantages of CSA disclosure, were confident that the sufferer's distress symptoms may lessen without disclosing CSA, and stressed that it is unfit and condescending for therapists to articulate a judgment on when this discussion should or should not take place.

Thus, the literature on introducing CSA is controversial, so therapists, like Freud was, are left with no 'right' choice in the dilemma about asking, or refrain from asking, about CSA. They could be blamed for not inquiring about CSA, as this would be a sign of them continuing to ignore the reality of early seductions, thus potentially retraumatising the actual CSA victim. However, if they do ask about it, the client could be retraumatised and the therapist's inquiry could be considered as suggestion, possibly leading to false memory triggering. Interesting suggestions that could offer therapists ways out of this dilemma have not been explored through research yet.

#### 1.2.1.2 Questioning the Reliability of a Client's Child Sexual Abuse Memory

An important issue surfacing from the literature, concerns the therapists' handling of uncertain CSAM, and, more specifically, the questioning or doubting of such a report

(Sabourin, 1988; Olio and Cornell, 1993; Bowers and Farvolden, 1996; Phelps, Friedlander and Enns, 1997; Palm and Gibson, 1998; Gore-Felton, et al., 2000). It relates to the point where a therapist feels the need to explore whether the early traumatic memory is authentic. The complication of this situation is shown by the opposing sides of the debate described below.

On one side, the therapist may avoid questioning so as to not retraumatise the potential CSA survivor who will probably feel rejected if doubted. While identifying and changing distortions in thinking may be advisable in other therapeutic work (Draucker and Martsolf, 2006), in adults' CSAM cases such interventions could be considered harmful for the client. Writers have stressed how important it is for the client to feel believed by the therapist (Phelps, Friedlander and Enns, 1997) so as to avoid adverse effects such as retraumatisation (Denov, 2003). Even a skilful and considerate questioning of clients' personal experience may be perceived as challenging the clients' own truth, integrity and identity (Bowers and Farvolden, 1996). As aforementioned, survivors of early sexual trauma are described as notably sensitive to the therapists' disbelief, or avoidance, due to previous relevant experiences (Sabourin, 1988) and to their own tendency to use the defense mechanisms of denial and dissociation (Olio and Cornell, 1993). Moreover, therapists are not meant to play the role of the detective (Bowers and Farvolden, 1996), as expanded on later (see section 1.2.1.4).

The side in favour of the need to avoid questioning a client's CSAM, has been supported by various authors as argued next. Barber (2012) found that if the therapist does not validate, the client may feel betrayed and stop engaging in therapy. Follette, La Bash, and Sewell (2010) claimed that the treatment goal in CSA cases is to allow for disclosure and to acknowledge the pain. Droga (1997) emphasised that after the therapist's validation of the client's sense of there having been an immense injury of some kind, the client's actual memories emerged. However, this approach would be suspect for false memory development. As we can see from the above, these authors argue that therapists should not only avoid questioning a client's CSAM, but also that they should validate it.

As Bowers and Farvolden (1996) remark, especially in recovered memory cases, the inviolability of confided subjective experience is weighted against the comparatively distant qualities of research findings regarding both the power of suggestion and the unreliability of

memory. The writers add that research-based conclusions are not flawless, yet they are meant to protect us from the dangers of subjectivity. In support of this view, Poole et al.'s (1995) findings indicate that therapists tend to perceive recovered CSAM generally as valid, not least when they consider their own clients' memories.

Others believe that it is imperative for therapists to understand whether the client's CSAM are genuine. For example, Gore-Felton, et al. (2000) discussed how the treatment per se is influenced:

> "Therapists' assessment of the credibility of sexual abuse memories may profoundly affect the course of treatment. For example, if the patient is troubled by traumatic experiences that the therapist believes happened, the aim of therapy may be to facilitate working through and accepting less responsibility for the trauma. However, if the therapist believes the patient is falsely presenting a history of trauma, then the function and meaning of that presentation may become the focus of treatment." (p. 373)

Writers also urge clinicians to request a great deal of corroborating proof for the CSA (through court papers and medical reports), because clinical judgment is commonly influenced by personal beliefs when there is negligible evidence to support it (Gore-Felton, et al., 2000). Courtois (1997) also noted that the therapist's record of the information shared when incest is disclosed should be detailed, factual and objective in order to provide not only a baseline in the client's own words, but also a counter to the suspicion regarding suggestion by the therapist. According to the same author:

> "A description should be obtained in as much detail as is feasible without overly stressing the individual, including… whether there have been memory gaps or lack of memory accessibility" (Courtois, 1997, p.477).

This may indicate that when clients disclose a CSAM to the therapist, the latter should search for clues regarding memory reliability, unreliability and memory problems, in order to see whether there is reason to question this memory. Thus, an early traumatic memory would be explored as any other, or even more deeply in case other people's well-being (such as if there are possibly falsely accused parties involved) is also on the line.

Palm and Gibson (1998) found that when clinicians believe that their client has falsely recovered a CSAM, the majority of their study's participants, that is, 40% of the respondents would explore the memory as part of treatment, while 17% would address their thoughts to the clients via, for instance, confrontation and discussion on the fallibility of memory. The writers concluded that when the client reports a CSAM, which their participants consider as false, they tend to assume that s/he has suffered a negative incident in his/her live, and to focus either on different matters arising in therapy or on the client's allegations. The authors encouraged therapists to avoid informing the patient about false memory findings, and to find more respectful ways to demonstrate that memory is fallible in ways we do not completely understand (Palm and Gibson, 1998).

There is also the view that therapists should suspend the wish to know and doubt and that oftentimes they should help clients tolerate not knowing what happened. In this respect, Mollon (1996) supported that:

> "In relation to the literal truth of apparent memories, the therapist must be prepared to tolerate great uncertainty and to suspend the wish to know - and to help the patient tolerate this as well. There must be a willingness to explore a variety of hypotheses about the patient's development. In many cases it may be necessary to be prepared to face the possibility, and help the patient face the possibility, of never knowing what actually went on in the patient's childhood" (p.202).

Similarly Enns et al. (1998) wrote that the practitioner should:

> "Explore issues in an open-ended and nonsuggestive manner but, at the same time, demonstrate support for the client's search for answers and recognize and communicate that absolute answers or "truth" about what happened in the past may not be found" (p.248).

Berliner and Briere (1999) also support this opinion:

> "Therapists may need to inform patients that memory is subject to distortion and that in some cases it will not be possible to achieve certainty about exactly what happened or even whether a trauma occurred" (p.14).

In light of the material in the current section, psychoanalytic therapists may feel both reluctant and obliged to question the reliability of a CSAM. In both instances therapy could become harmful. Views stretch from waiting and preparing for never finding out, to investigating in details and asking for proof.

#### 1.2.1.3 The Psychoanalytic Therapists' Ability to Distinguish Between Real and False Memory

The topic of distinguishing between actual and false memory has been researched to a great extent, but it still appears as a challenging, or even unfeasible, mission for therapists working with CSAM cases (Brenneis, 1994; Powell and Boer, 1994; Gast's, 1993; Person and Klar, 1994; Yapko, 1994a; Ware, 1995; Gore-Felton, et al., 2000; Bernstein and Loftus, 2002; Gardner, 2003; 2004), as seen earlier in the current chapter (see sections 1.1.2, and 1.1.3.1). The impossibility of a definite FRD in patients' reports of CSAM had been pointed out by Freud (1918). His conclusion has also been largely supported by more contemporary writers (Loftus and Yapko, 1995; Pope, 1996; Bernstein and Loftus, 2002).

Gast's (1993) foreign article explored both internal and external determinants of CSA reports and focused on the part played by memory, reality, suggestion, sexuality and influence of early fantasies on children's retrospective accounts of sexual encounters. The retrospective account of decades-old abuse by adults in treatment poses additional obstacles in the differentiation between fact and fantasy. Additionally, both memory reliability and feasibility of FRD appear to decrease when the CSAM has been repressed and recovered in therapy (Person and Klar, 1994). Therapists' difficulty with differentiating between false and actual CSAM has been compared to Ulysses navigating between the two monstrous mythical rocks of Scylla and Charybdis (Ware, 1995). The therapist is thus perceived as being caught between a rock and a hard place, that is to say, s/he finds him/herself in the dilemma between challenging the truthfulness of a CSAM and accepting it wholesale.

In the domain of distinguishing between false and true early sex-abuse memory in adult analysands, Gardner's (2003; 2004) recent contributions stand out in terms of their specificity and abundance in professional guidelines. Richard Alan Gardner was an American psychiatrist and a professor of clinical psychiatry, and worked on the subject of children falsely accusing parents for incestuous abuse. Through his extensive experience in forensic cases, Gardner connected evidence into coherent advice for therapists working in this field and he repeatedly stressed possible exceptions to his claims, alongside an emphasis on the fact that his guidelines are not conclusive.

Gardner (2003; 2004) listed criteria proposing that false accusations usually include:

- Improbable elements, such as method of abuse that would not remain unnoticed and recollections occurring at a very early age, like before 2 years old, where memory is both inaccessible and unreliable
- Absolute rejection of the accused person, and refusal to confront him/her
- Absence of guilt regarding the grief caused to the accused person and the social environment
- Legal action towards the alleged perpetrator, which supposedly aims to support the healing process, and also to cover the cost of psychotherapy
- Recruitment of supporters of the CSAM's validity, including group members and relatives, who may also purport being survivors or may just support the accusations
- Non-supporters are also rejected by the person
- Over-sharing of the experience with the purpose to help other victims to realise what happened to them
- Employment of CSA as an explanation for every life problem, a tendency to pathologise normal manifestations or mild abnormalities, and an inclination to adjust known medical phenomena so as to accommodate their belief in their CSAM.

In his 2003 contribution, he also noted the following criteria:

- Strong resistance to consider logical evidence which challenges the CSAM's validity or pertinent unrealistic elaborations

- Variations in the story about the abuse from rendition to rendition. These variations often seem to accommodate previously identified contradictions
- The postulation that any CSA inevitably has injurious effects, which is not supported by scientific evidence and survivors claims
- Manifestation of hysterical symptoms, such as overreaction, and impairment of judgment, and/or paranoid tendencies, such as projection, and oversimplification. It is important to note that both hysteria and paranoia are likely to spread
- Diagnosis of the Multiple Personality Disorder (MPD), which was considered rare until recently, and has been associated with CSA, and with financial aid for its victims.
- Diagnosis of post-traumatic stress disorder (PTSD). This diagnosis is provided by overzealous evaluators and therapists, who may not adhere to DSM criteria, such as the requirement that there be a known trauma and certain symptoms.
- Lack of residua from the CSA in later sexual activities. (Such residua are often-met in genuine victims, who tend to be aroused with certain details enclosed in the early traumatic experiences.)

Gardner's later (2004) work additionally stresses the client's need to gain the attention of the overzealous therapist, who is now considered infallible. The author added that a person may be gullible to false memory creation, regardless of their educational level or age. In fact, he argued that after the 30-year-old milestone, many women strive to find scapegoats for their failures - an argument which sounds quite sexist. The final addition of this 2004 paper was the connection between false memory and the gratification of the Electra complex, that is, the girl's unconscious attraction towards her father.

Lavietes (2003) discussed the basis for the controversiality surrounding Gardner's work. Gardner was called as an expert witness in more than 400 child custody cases and held that children suffering from 'parental alienation syndrome' had been instructed by a revengeful parent to malign the other parent without reason. His theory provoked considerable opposition in terms of (a) lack of scientific basis and recognition, (b) biases against women since fathers are most commonly accused for abuse, and (c) its usage by lawyers striving to weaken the mothers' integrity in court. He committed suicide and his son said that his father

had been tormented due the escalating symptoms of a dreadful neurological condition (Lavietes, 2003).

Adopting a critical perspective on Gardner's aforementioned work, there are three points that drew my attention. Firstly, several references are missing from Gardner's (2003) paper, whereas his own texts are referenced thoroughly in many sections of the literature review at hand. Secondly, there are a few contradictions or exaggerations in Gardner's (2003) statements. For instance, he pointed out that in false allegations, there is belief that the mother or others facilitated the act by ignoring it, as part of a conspiracy to conceal it. However, the anger towards the mother who fails to notice what is going on has been identified by writers in cases of actual victims (Chodorow and Contratto, 1980; Haller and Alter-Reid, 1986; Olio and Cornell, 1993).

Thirdly, Gardner (2003; 2004) seems to disavow total repression of a CSAM until later in adulthood, although this issue is not actually addressed. For example, the author listed texts on false memories but not on recovered memories. He also argued that, in cases of false accusations, one can identify loyalty to the idea of memory gaps, where there is total amnesia about the CSA experience. Additionally, Gardner (2003; 2004) highlighted that in such cases, recall is initially stimulated by reading misleading books, or through "Repressed Memory Therapy", and questionable techniques, such as hypnotherapy. He added that in hypnotherapy-induced memory recall is less likely to be reliable than waking state memory recall, and individuals are more gullible when in a hypnotic state than in the waking state.

In support of the argument about the unreliability of totally repressed memory, Brenneis, who devoted his 1994 paper to the search for relevant responses, wrote:

> "We are in the difficult position of knowing that some, but in all likelihood not all, recovered memories may be valid. No blanket generalization is adequate or sufficient. Some patients, never having forgotten, recall further memories in analysis. Some patients, never having known as adults, recall details of entirely repressed abuse. The most comprehensive investigations of the recovered memory phenomenon... place a crucial dividing line between these two instances. No one seriously doubts the basic authenticity of the recollections of the former group who have retained some memory

of abuse. Such a distinction, however, is seldom made either in clinical or research work" (pp.1027-1028).

In truth, we do not know enough about totally repressed memories. Herman and Schatzow's (1987) study, based in the USA, included a completely amnesic subgroup. The authors had sessions for three months with groups including 53 incest survivors. In this short period, previously repressed traumatic memories came up and 75% of the clients were able to corroborate their memories by submitting external evidence. The members of the amnesic subgroup were portrayed as fixated with reservations regarding the authenticity of their recalled incest incidences, while a number of them attempted to elucidate these uncertainties employing debatable techniques, such as hypnosis. Herman and Schatzow (1987) also observed that as a reply to the powerful incentive of listening to other individual's narrations, the completely amnesic members provided details of newly recollected memories.

Other writers emphasise more the existence of substantiating proof in the FRD (Brewin and Andrews, 1997; Gore-Felton, et al., 2000). Brewin and Andrews (1997) argued that the therapists' belief in their clients' memory reliability may depend on the narration's consistency, the availability of substantiating evidence, and the relevant experience of the therapist, and the supervisor(s). Gore-Felton, et al. (2000) recommend that therapists should approach the complex task of discriminating between actual and fantasised CSAM through, for example, careful clinical assessments, including interviews, history details, and psychological tests, prior to determining the treatment plan, which should in turn involve frequency of therapeutic sessions, short-term and long-term therapy goals, and justification for treatment strategy.

Mollon (1996), who provided guidelines for the work of psychoanalytically-oriented therapists on CSAM, argued that an analytic construction may not entail actual truth even when it matches the therapeutic material, the transferential dynamic and the presenting symptoms. He bases his argument on the understanding that true and false CSAM differ in neither form nor quality. In his view, CSA narratives or images may appear as authentic memories while they are pseudo-memories reflecting a sexualised experience which felt as abusive whilst it did not truly involve sexual acts. Thus, there is no easy way of differentiating between genuine CSAM and fantasy and in many cases the objective reality of

an early traumatic experience cannot be reached as memory structures are essentially distorted. In his words:

> "We can never penetrate beyond the schematization and general structuring of 'memory' into which the 'raw' experience is incorporated. Structures of the mind give clues to early experience but our memories of early experience are distorted by these structures" (Mollon, 1996, p.200).

In view of the above, Mollon (1996) proposes that therapists ought to be prepared to endure immense uncertainty and to adjourn the desire to find out what actually happened in the past - and to aid the client in enduring this, too. Therapists need to be willing to explore various assumptions regarding the client's traumatogenic experiences and development. In certain cases, it may be crucial for the therapist to be ready to cope with the possibility, and facilitate the client's dealing with the possibility, of never discovering what truly occurred in the client's early years (Mollon, 1996).

In addition, Levine (1993) stressed the subjectivity of the experience and the objectivity of the therapeutic outcome:

> "For analyst as well as patient, the experience of the analysis is inexorably subjective. From a pragmatic point of view, then, the question of whether something is actual or illusory may be moot. Analyst and patient alike can only know and use what they feel. Subjectivity of experience is all that either party may possess. And while we may be discomfitted by this realization that we will never fully know the truth of our patients' lives, there is solace in recognizing that through our attempts to understand and articulate the experiences that arise from the radical subjectivity of the psychoanalytic process, objective change can occur" (p.389).

Studies indicating whether contemporary psychoanalytic therapists are aware of the above criteria and guidelines about the FRD, and about whether they tend to use these in treatment, would be valuable.

#### 1.2.1.4 The Psychoanalytic Therapists' Responsibility in Distinguishing between Real and False Memory

The therapists' role in the discrimination between authentic and fabricated CSAM has been a debatable subject (Olio and Cornell, 1993; Bowers and Farvolden, 1996; Palm and Gibson, 1998; Hutsebaut, 2001; Follette and Davis, 2009). As seen below, assumptions range from the argument that this cannot be included in the therapists' duties, to guidelines assuming this is a therapeutic obligation.

At one end, Bowers and Farvolden (1996) indicated that there is no way to distinguish real from fabricated memories inside the consulting office, without assuming detective tasks, which are not involved in the therapists' training and the result of which remains uncertain. According to this viewpoint, discovering definite ways of determining the reliability of a memory when required by experts may be more reasonable than suggesting that the therapists' job description should include detective duties.

On the other end, Olio and Cornell (1993) emphasise that therapists ought to assist survivors to recognise their dissociative tendencies and to provide adequate emotional grounding so as to smooth the progress of integration. Since there are no ways, as yet, to ascertain the reliability of a given memory, the authors seem to imply that the therapist should make suggestions that may contribute to false memory creation.

On the issue of the therapists' responsibility on the distinction, Gardner (2003) argued that:

> "'Rolling' with the patient into fantasyland cannot but be antitherapeutic" (p.298).

Moreover, as claimed by Palm and Gibson (1998), clinicians may be forced to contend with both accuracy and technique issues in case of legal proceedings, wherein their involvement in false memory creation may also be investigated.

More recently, it has been supported that clients may also be responsible for reliable distinctions between their internal and external truths (Hutsebaut, 2001; Follette and Davis, 2009). In this different perspective, the responsibility of the distinction is largely transferred to the client, whose memories are under examination.

If we accept as true the idea that distinguishing between real and false memory is the therapist's responsibility, the next question would be how a therapist could approach this issue when a client wishes to work on this in therapy. The FRD as a possible therapeutic goal has been dubiously introduced in past and more recent literature (Freud 1896a; 1897b; 1918; Olio and Cornell, 1993; Bowers and Farvolden, 1996; Polusny and Follette, 1996; Brewin and Andrews, 1997; Fonagy and Target, 1997; Phelps, Friedlander and Enns, 1997; Palm and Gibson, 1998; Prout and Dobson, 1998; A.P.A. Working Group, 1998; Gardner, 2003).

Freud's (1896a; 1918) great effort to comprehend the distinction of actual from invented memory, demonstrated that he thought this matter as core, even though he (1917; 1918; 1925) also declared that this distinction is not of crucial importance because psychical reality is traumatogenic. He also anticipated that when the source of the problem was correctly identified, it would be followed by a successful therapeutic conclusion (Freud, 1897b; 1897c).

The connection of distinguishing between authentic and fantasised memory to the purpose of psychotherapy in possible CSA cases has also been stressed by writers (Olio and Cornell, 1993; Brewin and Andrews, 1997; Fonagy and Target, 1997; Palm and Gibson, 1998; Gardner, 2003). Fonagy and Target (1997) highlighted that it is therapeutically significant to discriminate between fact and fantasy, as each has different implications and that this distinction would help the therapist to understand the client in more depth. For instance, a trace of an experience of abuse devoid of a relevant disclosure, should guide clinicians to examine both the client's ability to understand their internal state and his/her tendency to repress traumatic experiences. Olio and Cornell (1993) claimed that the victim's need for relief often results in enduring emotional disconnection, and that the "primary goal of the treatment process, therefore, must be to facilitate an integration of the trauma experiences" (p.515). Two British psychologists and psychology professors, Chris Brewin and Bernice Andrews proposed that the professional's critical task is to develop assumptions based on experience, reason, evidence and the client's remarks (Brewin & Andrews 1997). Furthermore, Palm and Gibson's (1998) findings indicated that most therapists argued for the importance of their clients' acceptance or recall of their traumatic experiences for therapy to be fruitful.

Gardner's (2003) position on the subject of distinguishing fact and fantasy as essential in treatment raises an important question: Would therapists regard this distinction as unimportant if the blame was to be placed on them? In the author's words:

> "…Analysts who take the position "It's not important what's true or false; what is important is the patient's perception" are doing their patients a terrible disservice. It is important to make reasonable attempts to determine whether or not a patient's perception is true or false. The analyst would certainly not take this position if a paranoid patient's delusional system focused on the analyst himself (herself). Under such circumstances, the analyst would certainly try to correct the distortion in order to be protected from the possible consequences of the delusion focused on the analyst. In the sex-abuse accusation the focus of the delusion might be a loving parent or other relative" (pp. 309-310).

According to Gardner (2003), both neurotic and psychotic analysands somewhat distort reality. Analysts must help them rectify these distortions so as to both identify the residual symptoms and to avoid an anti-therapeutic trip into a delusional world (Gardner, 2003).

Opposing views object to the significance of the FRD to therapy from various perspectives as we shall see next. Writers have highlighted that working on the client's subjective narrations, truth and meaning is enough for dealing with most issues in psychotherapeutic treatment, so there is no need to focus on a search for the historical facts (Olio and Cornell, 1993; Sanderson, 2006). Others have challenged whether determining the literal truth should be the analysts' main concern (Gardner, 1996; Perlman, 1996), or so imperative altogether, since psychically-based trauma has equivalent effects to reality-based trauma (Prout and Dobson, 1998). Researchers stressed that improvement of functioning, rather than remembering and integrating should be the main focus of therapy (Bowers and Farvolden, 1996; Polusny and Follette, 1996; Phelps, Friedlander and Enns, 1997; A.P.A. Working Group, 1998). Thus, the therapists' role may be to focus on avoiding causing harm, rather than on determining the truth.

As explained above, there seems to be an unanswered question regarding the responsibility of this distinction. If therapists are accountable for elucidating truth and falsity in their patients' accounts, training programmes must focus on this. In this case, research should also focus on

ways to accomplish this, since determining the validity of a CSAM is still not a conquered battle for psychology and psychoanalysis (see above section 1.2.1.3).

#### 1.2.1.5 Therapy Being Harmful

For cases involving CSAM, psychotherapy can be harmful towards clients (Freud, 1920; Ferenczi 1932; May 1971; Anzieu, 1987; Van der Kolk, 1989; Chu, 1991; Green, 1993; Gabbard and Lester, 1995; Dupont, 1998; Stocks, 1998; Tucker, 1998; Hopper, 2001; Cohen, 2003; Salter, McMillan, Richards, Talbot, Hodges, Bentovim, Hastings, Stevenson, and Skuse, 2003; Cheniaux, et al., 2011; West, 2013). As the first psychotherapy rule is to avoid causing harm, attention should be given to the possible retraumatisation of the client within treatment in CSAM cases.

Abraham in 1907 stressed upon actual CSA and traumatophilia, or else repetition compulsion, and faced Freud's criticisms (Good, 1995). Ferenczi (1932) asserted long ago that trauma is an inescapable feature of the therapeutic process, since regardless of the analyst's efforts to be a caring figure, there will be phases of emotional disconnection. Stocks (1998) argued that there is no empirical evidence to indicate that recovered memory therapy brings about improvements for participating clients and that this kind of therapy may be harmful to clients. The issue of the therapist's role in the client's retraumatisation is also addressed in more recent writings (Cohen, 2003; Aron and Harris, 2010).

The possibility of the client's retraumatisation has been discussed in the literature, and has been linked to various sources, such as:

- the disclosure of the CSA experience and the resulting reaction (Barber, 2012),
- the clients' repetition compulsion (Ferenczi, 1949; Anzieu, 1987; Van der Kolk, 1989; Chu, 1991; Green, 1993; Dupont, 1998; Tucker, 1998; Hopper, 2001; Salter, et al., 2003; Cheniaux, et al., 2011),
- the therapists' eagerness either to support or to determine memory authenticity (Polusny and Follette, 1996; Phelps, Friedlander and Enns, 1997; Gore-Felton, et al., 2000),

- as well as, both the therapists' inability to deal with such cases and the referral to another professional (Olio and Cornell, 1993; Barber, 2012).

The issues relating to the client's disclosure and the therapists' inability have also been discussed earlier (see section 1.2.1.6). Notably, Denov's (2003) findings emphasised the crucial importance of the therapists' response to the client's revelation of CSA. When professionals appeared supportive by validating the sufferer's CSA, the negative impact of the abuse was lessened. When professionals were unsupportive by minimising or doubting the actuality of the sufferer's allegations, the negative impact of sexual abuse was intensified, resulting on the client's retraumatisation. The reported consequences of the unsupportive therapeutic stance on the clients included an increase on both their distrust of professionals and on their anger, as well as a triggering of their own denial and questioning of the reality of their sexual abuse (Denov, 2003).

As mentioned above, intreatment retraumatisation has been more related to the defense mechanism of repetition compulsion, which includes unconscious re-enactments of traumatic situations. Freud (1920) developed the concept linking it to child trauma and attempts to self-heal, while research findings indicated that it usually causes further pain (Van der Kolk, 1989).

Adults with a history of early sexual trauma have increased possibilities to relive such experiences (Van der Kolk, 1989; Olio and Cornell, 1993), by either adopting the victim's or the aggressor's role in the behavioural re-enactment (Ferenczi, 1949; Van der Kolk, 1989; Green, 1993; Dupont, 1998; Salter, et al., 2003). Longitudinal studies on sexual abuse victims suggest that approximately 12% of CSA victims became perpetrators later in life (Salter, et al., 2003). Akin to their abusers, victims of CSA may decrease their anxiety levels by identifying with their aggressor, therefore providing themselves a way to actively dominate an unbearable trauma that they have suffered passively (Ferenczi, 1949; Green, 1993; Dupont, 1998).

The literature includes an emphasis on the central role of repetition compulsion in CSA cases and its interpretative value in therapy (Chu, 1991; Tucker, 1998; Hopper, 2001), as well as on the possibility of memory reactivation through the reliving of such experiences (Cheniaux et

al., 2011). According to Cheniaux et al. (2011) repetition compulsion and transference trigger implicit memory recall:

> "In an analytic setting, there is a regression to primitive phases of mental development that permits the reproduction of the dyadic relationship with the mother (Winnicott, 1965). Because of repetition compulsion, transference occurs during an analytic session. According to Freud (1914), transference represents a repetition of the patient's original relationship with parental figures that is experienced with the analyst. The patient is not conscious of this repetition and shows transference not through recollection, but rather through behaviours (i.e., acting-out). These behaviours, feelings, or thoughts express a stereotyped, automatic, and typical pattern of interpersonal relationships. Such characteristics clearly indicate that they were stored as implicit memories (Brakel & Snodgrass, 1998; Clyman, 1991; Gabbard, 2000; Lewis, 1995; Olds & Cooper, 1997) and were reactivated by the similarities between the roles played by the parents and the analyst as authority figures, caregivers, and so on (Levine, 1997; Westen & Gabbard, 2002)" (p. 421).

To re-enact the traumatic material in therapy, the client may provoke the analyst to play a complementary role, such as authority figure, caregiver (Cheniaux, et al., 2011), ally (Olio and Cornell, 1993), abuser, protector and all-giving savior (Davies and Frawley, 1994), as well as being forgetful (Fine, 1985; Barande, 1985).

In this context, there have been controversial guidelines within the same piece of literature material. For instance, Olio and Cornell (1993) highlighted not only that the therapist's over-involvement is perilous for retraumatization, but also that the therapist must unwaveringly acknowledge the reality of the abuse for the trauma memories to continue to unfold and for the survivor's trust in his or her perceptions to be restored.

Repetition compulsion has been associated with therapy's premature termination (Anzieu, 1987; Davies and Frawley, 1994) and only if the therapist realises that such a re-enactment is taking place, s/he may be able to deal with it (May, 1971). There have been psychoanalytic texts urging analysts to be aware of the danger of repetition compulsion (Hoffer, 1991) and of the possible boundaries issues, which complicate the situation (Gabbard and Lester, 1995; Colton, 1996). For instance, in Colton's (1996) study, all psychologists seemed to struggle

with the usual therapeutic boundaries, such as time and contact between sessions, only when working with women who have been sexually abused by their fathers as children.

The interpretation of repetition compulsion in treatment has been connected to successful therapeutic results. For example, a Dutch psychiatrist based in the United States (US), Bessel van der Kolk (1989) argued that by understanding the meaning of the compulsive re-enactment, the symptom can cease. Van der Kolk's view may be rather oversimplified, as having an insight into what causes a symptom is not in itself curative: in reality, this is when therapy starts. Nonetheless, therapy's curative process is based on the sharing of the experience, which lessens the effects of the intense solitude of helplessly suffering CSA (Chu, 1991).

Valerio and Lepper (2009) investigated the effectiveness of short- and long-term group therapy for adults CSA survivors. They proposed that while clients experience considerable distress when their relive their traumatic past, in the long-run this treatment phase is an imperative part of the 'working through' of their trauma.

In order to minimise the possibilities for client's intreatment retraumatisation, Courtois (1997) advised therapists to both assess and take care of themselves:

> "Therapists must begin by assessing their own professional and emotional competence to treat incestuous abuse. Because trauma (much less incest) and its treatment are topics that are rarely or adequately covered in professional training, therapists must avail themselves of specialized training, consultation, and supervision. They should also institute strategies for self-care, including systems of personal and professional support and monitoring… Not all therapists can handle the challenges presented by the treatment of incest survivors" (p. 473).

While psychotherapy aims to relieve, support or even heal the sufferer of CSAM, it may cause harm. The clients' tendency to repeat the trauma is often-met in treatment, and hopefully therapists will be aware of the suggested handling so as to minimise the risk of retraumatisation in therapy.

#### 1.2.1.6 Changes in the Therapist's Practice

Psychotherapy may prove harmful not only to the clients (see section 1.2.1.5), and perhaps even their social environment, but also towards the therapist. The subject of CSAM has been assessed as a very difficult one in modern psychotherapy and it has been argued that adults with a CSA history typically have problems with forming trustful, close, and positive relationships (Olio and Cornell, 1993; Colton, 1996).

In more details, during the last few decades, there has been some discussion about therapists' struggle - feeling fearful, unprepared, or inexperienced - while working with CSAM (Colton, 1996; Little and Hamby, 1996; Gore-Felton, et al., 2000; Barber, 2012). Most of these studies (that is, Colton, 1996; Gore-Felton, et al., 2000; and Barber, 2012) will be discussed in relation to my research later on in this chapter (see section 1.2.2.1).

Little and Hamby's (1996) survey of 501 (response rate for usable questionnaires was 41%) clinicians of various educational levels and theoretical orientations, investigated through mailed questionnaires in 1990-1991 the effects of CSA history, gender, and theoretical orientation on treatment issues associated with CSA. They found that compared with male clinicians, female clinicians reported that CSA was harder to treat, that they screened more often for CSA, that they felt more anger towards the perpetretors and that they employed more coping strategies.

An American psychoanalyst and clinical psychologist, Stuart D. Perlman (1999) reflected on how dynamics in such cases may challenge the therapists' ability to cope with their own emotions, as well as with the clients' tendency to incessantly share their anguish. A British psychotherapist, Moira Walker (2004) mentioned ways in which such trauma may confuse not only the victims' perception of their own boundaries, but also the helpful distance between therapist and client, which may result in the therapist experiencing isolation, dread, and ineptness. She argued that deep exploration of the intense countertransferencial reactions may turn these damaging effects into powerful tools (Walker, 2004).

Nonetheless, therapists may not know how to handle the special needs (such as additional requirements for a trustful and safe therapeutic environment), that CSA victims allegedly have when they enter psychotherapy (Olio and Cornell, 1993; Barber, 2012). The lack of

acquaintance (such as limited relevant knowledge or training) of mental health professionals with the handling of CSA cases may bring about substantial adverse effects for the client (Barber, 2012).

Approximately 20 years ago, Colton's (1996) research on psychoanalytically-oriented therapists' work on paternal CSA also found that all respondents reported feeling frustrated and enraged during their treatment relationships with post incest women. Moreover, these participants described the treatment to be more demanding than that with other patient populations.

In addition, there is evidence that past debates on the subject enlarged psychoanalytically-oriented therapists' confusion on the subject. Colton (1996) found that there was much ambivalence on analytic practice and discussed the impact of relevant debates on the quality of treatment:

> "Although clinicians evidenced contemporary thinking regarding definitions of incest and its etiology, their treatment behaviors revealed an ambivalence reminiscent of older attitudes and behaviors. Such a finding raises questions about the influence of the ongoing conflicts within the psychological community on the quality of the psychotherapeutic treatment provided to father-daughter incest survivors" (pp.190-191).

So even when clinicians have read about the subject, but they are still confused by past controversy. It appears important to find out whether the above is true for contemporary psychoanalytic therapists.

Colton (1996) concluded that treatment approaches must be changed so as for therapists to be sufficiently prepared and work effectively in cases involving paternal CSA. In her words:

> "The treatment of father-daughter incest survivors represents a challenge to mental health professionals. Standard treatment approaches fall short of alleviating the complex problems of this growing population and conventional training does not appear to adequately prepare clinicians to engage in such work. All of the countertransference issues mentioned must be confronted and examined before we

> can begin to effectively work with father-daughter incest survivors, whether it is as clinicians, researchers, or educators" (p.194).

It would also be important to see if during the last years, analytical therapists have found a way to be more effective in their work with clients who have experienced CSA.

My literature search about the changes in the therapists' practices regarding CSAM yield only a few results. A closer inspection of these texts showed that they were not relevant to my investigation, meaning whether therapists feel that earlier in the practices they used to handle CSAM differently. Polusny and Follette (1996) examined the effects of recent publicity concerning CSAM (rather than experience) on clinical practices. They found out that respondents detected few changes in their work as a consequence of the CSAM controversy. These changes included using increased caution in identifying their clients' early experiences as sexual abuse, and also being less likely to both use memory retrieval techniques and to help clients to recal CSAM (Polusny and Follette, 1996).

It would be beneficial to learn whether contemporary psychoanalytic therapists also report such changes in their practices.

On a different note, the literature contains guidelines for practitioners who handle recovered memory cases, and for CSAM cases. Palm and Gibson (1998) say that even though there are no certain answers regarding CSAM, practitioners ought to minimally endorse their guidelines so as to defend both the client and the status of the profession as a reliable and knowledgeable field. In brief, they advised therapists to update their knowledge on abuse, trauma, memory, and pertinent laws, as well as legal processes; to keep in mind that sexual abuse, the tendency to disbelieve it, and relevant amnesia, are robust findings; to consider taking an abuse history or inquiring about CSA; to ensure that they do not unsuitably direct the focus of therapy; to ask directly, rather than to suggest or apply pressure; and to reconsider employing debatable techniques. They additionally propose that clients should seek external corroboration for the abuse prior to entering litigation (Palm and Gibson, 1998).

The A.P.A. Working Group's (1998) paper shared some guidelines for clinicians, which focused only on recovered memories. In summary, the authors warn therapists, who encounter recovered memories to ensure that they do not impose any version of reality, in

order to lessen risks for false memory development. They also propose a focus on stabilising and containing the clients' functioning, on avoiding to support recollected memory as either clearly authentic or clearly fabricated, and on helping clients to form their own sense of reality.

In cases of CSAM, developing, monitoring, and maintaining the therapeutic relationship may be a remarkably arduous mission, involving extraordinary emotional challenges and strenuous duties for the therapist (Olio and Cornell, 1993). As discussed earlier (see section 1.1.4.1), Fine's (1985) foreign article argues that the analyst's memory may be affected by countertransference, the analyst's personal analysis, and Freud's concepts. The additional strains observed in cases of CSAM may point to an increased need for ongoing supervision (Gore-Felton et al., 2000; Walker, 2004). In Greece:

> "Psychoanalytic supervision is mainly implemented in outpatient clinical practice. Brief psychoanalytic psychotherapies are implemented in outpatient and inpatient setting" (Anagnostopoulos, Christodoulou and Ploumpidis, 2009, p.1).

As seen in the previous sections (1.1.1.3 and 1.1.4.1), both Freud and psychoanalysts were held responsible for both ignoring actual early sexual trauma and causing false memory and these points have been the basis for debates. He identified some riddles between fantasy and reality in cases of CSAM.

Overall, much progress in the domain of CSAM and psychoanalysis has taken place especially during the last few decades. Although the subject of CSAM has become 'a hot topic' during the past decades, the complication of these riddles in current psychoanalytical work, has not been clearly addressed until the present day. A comprehensive historical background and literature review on the topic of psychoanalytic work with CSAM shows that the analysts' assumed struggle in their work with patients with CSAM is based not only on the unclear history of such work, but also on current debates which provide opposing professional guidelines. Additionally, analysts have been urged to account for their work so as to protect their profession from accusations for therapy-induced false CSAM (Harris, 1997).

There is a rational requirement for more theoretical and practical clarity in psychotherapeutic efforts with CSAM of adult clients (Masson, 1984; Mollon, 2000; Rubin and Berntsen, 2009). Finding out what psychoanalytic therapists think about these issues adds value to the current literature. The need to appreciate the analysts' true voice about this debate has been underlined (Hegeman, 1997). As indicated above, additional research should focus on the debatable issues and a few underexplored subject matters and professional dilemmas.

### 1.2.2 The Focus of the Current Study

The issues to be explored in the current study were contextualised and addressed. The forthcoming sections will introduce research material relevant to the present study, and the study's questions.

#### 1.2.2.1 Similar Research

The present research focuses on past influences upon current Athenian psychoanalytic practice with adults' CSAM. Until now, I examined how the alleged connection between Freud's turn from reality to fantasy and recent debates on CSAM are interconnected. From here onwards, I will elucidate the underlying reasons for important research focus points, the originality of the present thesis, the controversial issues to be examined, and will briefly introduce the following chapters.

The current study shares a considerable amount of similar research interests with past writings (see Appendix 3: table 3.1 for a brief presentation of these relevant past research and my research) on the subject of CSAM and, more precisely, on the therapist's work with adult survivors (Yapko, 1994b; Poole et al., 1995; Colton, 1996; Polusny and Follette, 1996; Palm and Gibson, 1998; Sullins, 1998; Gore-Felton, et al., 2000; Barber, 2012; Ost, et al., 2013; Patihis, et al., 2014). Brief summaries of these contributions, alongside my evaluation of them, will be presented before the differences between them and my study are underlined. While some of these studies were judged as biased from my viewpoint, I will not exclude their material from a comparison with my corresponding material. In doing so, I hope to avoid leaving out anything that may increase knowledge in the under-researched domain of therapeutic practices involving CSAM. Nevertheless, the reader is cautioned to take into

consideration my criticisms when reviewing my relevant writings on the contrast between these studies' conclusions and my results.

Yapko's (1994b) study on therapists' beliefs about the clients' suggestibility and repressed CSAM, was conducted in the US. A large number (869) of psychotherapists were surveyed through questionnaires regarding their views on memory, hypnosis, and the possibility of creating false CSAM. Their data showed that whilst most psychotherapists appeared to approve hypnosis as a therapeutic technique, they frequently did so relying on misinformation. Misinformation may result in misapplications of hypnosis, potentially inducing the recovery of suggested instead of actual memories.

The only common ground between Yapko's study (1994b) and mine is the topic of interest as we both researched therapists' views on adult's CSAM. However, while he focused on repressed CSAM and therapeutic techniques, my study focused on analytic therapists positions on hot issues involved in their practice with CSAM. Both our methodology and place of research were also different as his study is quantitative and took place in the US and mine is qualitative and was conducted in Europe, and more particularly, in Greece. Our study's samples differed in terms of size and participants' theoretical orientation.

In my opinion, Yapko's (1994b) study and his other writings (1994a; Loftus and Yapko, 1995) were clearly biased in favour of the perspective that most of the adult client's CSAM – especially the ones recovered in psychotherapy – were false memories. His contributions emphasise the devastating effects of false reports not only for the clients themselves, but also for their social environment, and not least for the accused persons.

Pope and Tabachnick's (1995) US based study focused on recovered CSAM. It was conducted through questionnaires mailed to 900 licenced psychologists and they had 382 usable returns. The emerging data were analysed in terms of patient gender, therapist gender and theoretical orientation. Their findings suggest that the majority of therapists encounter at least one patient with recovered CSAM throughout their career. Thus, the authors concluded that describing recovered memories as an epidemic may not have been an exaggeration.

The two commonalities between Pope and Tabachnick's (1995) survey and my study are the subject of interest as we both researched therapists' views on adult's CSAM, and also that our

studies were conducted in a European country. The differences between our studies lie in that they used quantitative methodology and focused on recovered CSAM and its frequency of occurrence, while my study was qualitative and focused on analytic therapy involving any kind of CSAM. The place of study was also different as this was a US based study and my study took place in Greece. The sample also differed on the basis of both size and therapists' theoretical orientation.

As discussed earlier (see section 1.1.2.3), Pope (1996) had doubted the extent of the unreliability of retrospective reports, both the motives and methods entailed to advocate the arguments of the FMS Foundation, as well as the accusations and the recommendations offered to clinicians by the representatives of this foundation. He (1990; 1996) had also commented on the potential adverse impact on clients due to therapists' interventions when attempting to distinguish whether the client had suffered from actual CSA or not. His (Pope and Tabachnick, 1995; Pope, 1996) contributions appear in favour of the authenticity of recovered memory.

Poole et al.'s (1995) article regarding psychotherapy and recovered CSAM, focused on US and British practitioners' opinions, practices, and experiences. The study included three surveys of trained practitioners, concerning clients' CSAM encompassing the potentiality of memory reconstruction in treatment. From the 900 practitioners who were asked to participate, the study included overall 204 usable responses. The surveys were conducted through mailed questionnaires and the findings indicate that:

> "(a) some clinicians believe they can identify clients who were sexually abused as children even when those clients deny abuse histories, (b) some clinicians use a variety of techniques to help clients recover suspected memories of CSA, (c) such clinicians are often successful in these attempts, and (d) these interventions can have serious implications for clients (e.g., lead some clients to terminate relations with their fathers)" (p.434).

Their study, like mine, focused on therapeutic work on CSAM, and part of their sample also included European citizens. Unlike my study, their methodology was quantitative and they focused on recovered memories. Moreover, they did not involve psychoanalytic psychotherapists as my study did and they had a much larger sample.

Poole et al.'s (1995) contribution appears predisposed on the side of false CSAM and supports that therapists are inclined to induce false memory through dangerous techniques. As seen later on the current section, this study, alongside another study similar to mine, has been criticised by Brewin and Andrews (2017), in terms of their very low response rates.

Colton's (1996) PhD thesis is titled 'Incest Survivors in Therapy: The Therapists' Perspective'. The research was conducted in the U.S. with the aim of exploring the experiences of five female psychologists-psychotherapists who had worked with clients who had experienced father-daughter incest. Data were collected through personal interviews and were analysed qualitatively through grounded theory. This research was carried out in order to understand how women practitioners experience work with paternally abused female clients, and what they believe aids or obstructs their clinical choices and approaches with post-incest victims.

Colton (1996) gathered several writings concerning difficult and futile therapies, the strenuous and challenging characteristics of post-incest cases, and the therapists' inclination to avoid relevant memories. Her findings included that her five participants learned more from their clinical experience than from the pertinent literature and that they were not knowledgeable of the ST debate, or with any academic guidelines regarding treatment goals for such cases. She consequently supported that professionals need to work towards more theoretical and practical clarity (Colton, 1996).

Colton's (1996) study is probably the most similar research to my study, as it is also a PhD thesis, which focuses on the perspectives and experiences of psychoanalytically-oriented therapists. To be more precise, all five professionals who participated in her study in 1996 had PhDs and practical experience as therapists, four of them described themselves as psychoanalytically-oriented, while one of them was a candidate in a post-doctorate program in psychotherapy and psychoanalysis and only one was a candicate in a post-doctorate psychoanalytic training program. In summary, merely only one of these participants was a candidate in a training program and the rest did not have practical psychoanalytic training.

It also used interviews and qualitative analysis. However, there are important differences between my study and Colton's (2000) study. To be more exact:

- My study's sample is much larger (31 rather than 5 therapists)
- I interviewed already trained analysts and analytic therapists and trainees of both genders, while she interviewed only female psychoanalytically-oriented therapists
- Her research employed Grounded Theory, whereas mine used CA
- My research included generally CSAM issues, instead of focusing only on father-daughter incest
- The place of study was Greece, rather than USA.

In my perspective, Colton's research was coherent methodologically. However, while it focused on actual CSA, and aimed to understand the complications in the field, it was mostly silent towards memory issues involved on the topic in general. Notably, she did not appear biased in favour of the recovered memory side, or the FMS. However, her results may not be generalisable due to the study's small sample size.

Polusny and Follette's (1996) paper assessed clinical and counselling psychologists' clinical practices, beliefs, and personal experiences concerning clients' remembering CSA in therapy. This was a U.S. based study with 1000 invitations to participants and 173 usable questionnaires on the treatment of adult survivors of CSA. The survey was conducted through a mailed questionnaire and offered empirical evidence on issues connected to the repressed memory controversy.

As seen earlier (see section 1.1.4.5), Polusny and Follette (1996) found that 61% of the psychologists stated that it was possible, or very possible, that adult clients may be falsely influenced by therapists into believing that they had endured sexual trauma. Moreover, they emphasised that therapists should focus on improvement of the client's functioning, instead of remembering and integrating traumatic experiences.

Polusny and Follette's (1996) results, that are mostly associated with my research, underline their previously discussed (see section 1.1.2.1) advice for therapists to inquire about CSA within an extensive assessment connected to the client's presenting problems so as to avoid the danger of either underestimating or overestimating the possibility that a client has a history involving abuse. Moreover, they found that over three fourths of their participants did

not acknowledge a specific constellation of signs for detecting a CSA history, and that only a considerable minority of their participants claimed that there is a group of symptoms indicative of CSA. They also detected that women are significantly more likely than men to estimate that the CSAM of their adult clients are accurate.

My study and Polusny and Follette's (1996) study share a common focus on therapists' work on CSAM. Our studies differed in the rest of the characteristics, that is methodology, place the research was conducted, sample size, participants' area of expertise, and focus on specific memory issues.

In my opinion, Polusny and Follette's (1996) study was based on sound research and their discussion points were informative and unbiased.

Palm and Gibson (1998) conducted another US based study through mailed questionnaires, which were sent to 300 clinical psychologists. The response rate was less that 30%, as 88 participants (45 men and 43 women) replied. The study aimed to examine how the recovered memory debate has influenced the practice of these professionals with their clients.

Their findings, which focused on the clinicians' last five years of practice, alongside their guidelines for therapists working with CSAM have already been reviewed earlier in various sections. In summary, Palm and Gibson (1998) found that when clinicians believe that their client's recovered CSAM is false, 40% of the respondents would explore the memory as part of therapy, and that 17% would communicate their thoughts to the clients through, for example, confrontation and discussion on the shortcomings of memory (see section 1.2.1.4). They also found that from the participating clinicians, most claimed that their clients' acceptance or retrieval of their traumatic experiences would be beneficial for therapy (see section 1.2.1.4), some participants stated that if they held that their client's CSAM is fictitious, they would assume that s/he had experienced another harmful experience (see sections 1.1.2.4 and 1.2.1.2) and that only a few participants recorded cases of so-called false memory (see section 1.1.2.2) (Palm and Gibson, 1998).

Palm and Gibson's (1996) guidelines were aiming to the protection of both clients and the reliability of the profession. Regarding the participating clinicians' detected failure to address actual CSA, the authors noted that in cases involving indications for trauma, the therapist

must regard an abuse history as a potential hypothesis (see section 1.2.1.1.), and encouraged therapists to inquire about such history in the beginning of therapy (see section 1.2.1.1) The authors also advised therapists not to inform clients concerning false memory findings, and to respectfully convey both that memory is unreliable in ways we do not entirely comprehend (see section 1.2.1.2.) and that clients should seek external corroboration for the abuse prior to entering litigation. The authors additionally proposed that therapists should avoid suggestion and pressure, to acknowledge both the tendency to disbelieve CSAM and the existence of memory amnesia and to continuously update their knowledge on both CSAM and law implications (see section 1.2.1.6). They also reminded therapists that in case of legal proceedings, they may be called to explain their accuracy, techniques, and possible involvement in false memory creation (see section 1.2.1.4) (Palm and Gibson, 1998).

Palm and Gibson (1998), like me, researched how debates influence professional practice regarding CSAM. Unlike my study, their focus was on recovered memory, and their study adopted a quantitative approach, was based in US, and had a much bigger sample with clinical psychologists as participants.

In their text, Palm and Gibson (1998) emphasised the actuality of authentic recovered memory, the therapists' involvement in false memory development, and the damage that FMS advocates have done in the reputation of psychotherapy as a whole. In my view, however, their work did not seem too biased in relation to the memory debates. Moreover, I found their professional guidelines to be very comprehensive and thoughtful.

Sullins' (1998) contribution concerned suspected repressed CSA and investigated the effects of gender on diagnosis and treatment. Her sample included 269 members of the psychological association. Her quantitative study was based in the US and employed vignettes (hypothetical scenarios) and a series of questions. The aim was to look into therapists' approaches to clients' suspicions that they have repressed CSAM and to evaluate therapists' views about therapeutic goals and treatment plans, appropriate behaviours, and of suspicions. Her findings revealed that therapists appeared unlikely to overlook clients' symptomatology, emphasise memories, employ debatable techniques, comment on abuse using suggestion, or immediately infer that their clients have repressed CSAM.

Sullin's (1998) research and my research have only one shared characteristic, that is, an interest in CSAM treatment. Our study's differ in terms of the country of study, the methodology, the sample's size and psychological orientation, and the focus on specific CSAM.

In my viewpoint, Sullin's (1998) study seems both unbiased in relation to the memory debates, and methodologically reliable. On the other hand, I deem that their results appear too optimistic and positive with regard to the psychologists' practices and abilities.

Gore-Felton et al. (2000) explored psychologists' judgments and clinical characteristics on the subject of judging the actuality of CSAM. Their US based study was conducted through mailed questionnaires and quantitative methods. It included a survey of 1008 psychologists, with 630 usable responses. Their sample consisted of clinical and counselling psychologists. The goals of the study were:

> "(a) to examine the relationship between characteristics of sexual abuse memories and therapists' judgment regarding the credibility of sexual abuse memory, (b) to examine the association between therapists' judgment regarding the credibility of sexual abuse memory and treatment decisions, and (c) to examine the influence of therapists' beliefs on clinical judgment and treatment decisions" (p.373).

According to Gore-Felton et al. (2000), it appeared more possible for participants to believe that the early traumatic memory referred to real events when the memory was incessant, the age of the memory initially recollected was more than two years, it was quite vivid, and the aggressor was male.

Gore-Felton et al's (2000) study focused on therapists' approach to CSAM in the 21st century, like my study. It was different to my study in terms of the country where the research was conducted, the methodology used, and the sample's size and theoretical orientation of the participants.

In my point of view, Gore-Felton et al's (2000) study seemed sound methodologically, and also it did not appear biased in favour of any side of the memory wars. Their results can be

accepted as more generalisable since they had a better response rate than others (Poole et al, 1995; Polusny and Follette, 1996; Ost et al., 2013; Patihis, 2014).

Barber's (2012) PsychD work focused on the helpful and unhelpful practices of mental health professionals concerning the disclosure of early sexual assault by adults. Her qualitative research study, which took place in Australia, was designed to address the experiences of both clients and professionals. Her study was conducted via semi-structured interviews and used Thematic Analysis to analyse the data. Her sample was composed of three adult survivors of CSA and 13 mental health professionals, from which eight were psychologists (four of them clinical), three social workers and 2 'other'.

Barber's (2012) results are also spread throughout my thesis and the most relevant will be summarised here. In brief, she held that therapists may hesitate about asking clients regarding CSA for several reasons, including legal and professional problems, alongside confusion due to past writings on memory and suggestion. Most of clients and mental health professionals, who participated in her research, believed that it would be beneficial if professionals inquired about a history involving CSA via a hypothesis reflecting the potential aetiology for the clients' presenting symptoms. In relation to this, she pointed out that clients discussed dropping relevant hints in therapy before a CSAM disclosure and professionals claimed that they de-emphasised psychiatric labels. Merely a minority of the participating practitioners did not advocate for the benefits of disclosing CSA, were confident that the client's symptoms may decrease without revealing CSA, and underlined that it is not right for professionals to decide when this revelation may take place to articulate a judgment on when this discussion should or should not take place (Barber, 2012) (see section 1.2.1.1).

In addition, Barber (2012) found that clients may avoid talking about unhelpful interventions, and claim that they wish to terminate therapy as they feel better, thus misleading therapists into thinking that therapy progressed well, while, in fact, it did not (see section 1.1.4.5). She argued that disclosing CSA may be retraumatising for the survivor when therapists seem uncomfortable, assume a 'blank' stance, stop the therapy (see section 1.2.1.1), or appear unprepared regarding the handling of these client's alleged special needs (see section 1.2.1.6). She proposed that when professionals are not aware of the effects of CSA, they could state this and start learning about CSA. She concluded that even when therapists are not well-informed, they can still be effective in their work (Barber, 2012).

Like my research, Barber's (2012) contribution focused on mental health professionals' practices in cases involving CSA by adults. Furtermore, her thesis is long (much longer than the average size of a journal article) like mine and a couple of questions included in my thesis explored issues arising during in treatment CSA disclosures (see sections 3.2.0 and 3.3.0). Other communalities between our studies entail the semi-structured interviews, their qualitative nature, the time period that the data were collected, and the fact that they were not conducted in the US like most other studies presented here. The above-noted resemblances indicate that Barber's (2012) study in the second most similar to mine, right after Colton's (1996) study. The differences between our studies encompass the country wherein they were conducted, the specific method of data analysis, the sample size, the participants' profession and theoretical orientation, her more specific focus on both clients and disclosures, and my specific focus on related memory issues.

I believe that Barber's (2012) work is both quite trustworthy and unbiased as far as the memory debate is concerned. I found her dual focus on both clients and practitioners to be innovative and ingenious. However, I think that the variability of the participants' professions as well as the medium sample size lessened the generalisability of her findings.

A U.K. based online survey conducted by Ost et al., (2013) examined psychotherapists' (particularly Chartered Clinical Psychologists and Hypnotherapists) experiences of, and beliefs regarding, cases of recovered memory, false memory, satanic/ritualistic abuse, and MPD/DID. Overall, 302 therapists took part in the study (104 male, 196 female, and 2 of unknown gender) with a response rate 12,6%. Ost et al. (2013) found that more than 80% of the respondents believe that an individual could come to falsely believe that s/he had been repeatedly abused during childhood, even if no actual abuse had occurred. Moreover, less than 25% of the participants held that CSA reports made exclusively on account of memories recovered whilst in psychotherapeutic treatment, following a period of complete amnesia, could be perceived as fundamentally accurate (Ost et al., 2013).

The similarities between Ost et al.'s (2013) study and my study include the exploration of memory complication in therapists' work with CSAM cases, the time the researches were conducted, and the fact that they took place in European countries. The dissimilarities involve their focus on both satanic/ritualistic abuse and MPD/DID, the sample's size as well as

theoretical orientation, the methodology used, and the countries wherein the research took place.

Their findings imply that therapists largely believe in the possibility of false CSAM creation and that only a minority of the sample were overly suspicious towards CSAM which was previously forgotten and recovered in therapy. In my view, these results may be a sign of a propensity supporting the FMS.

In a recent US based study, Patihis et al (2014) explored beliefs in various groups (the public, undergraduates, psychology researchers, clinical psychologists and alternative therapists) concerning the workings of memory, in an attempt to find out whether views regarding repressed memory have altered during the last two decades. The study's survey which was completed by 1376 participants (with a response rate 15,5%) contrasted beliefs from the 1990s and until 2012 and showed that, as time went by, undergraduate students and clinical psychologists appeared to become highly sceptic regarding repressed memory. They found an important discrepancy in the beliefs between researchers and both practitioners and non-professionals. Many nonresearchers supported both the authenticity of repressed memories, to a certain degree, and their therapeutic retrieval.

The commonalities between Patihis et al.'s (2014) research and my study evolved around the attention in the workings of memory, and on the changes possibly occurring in therapists' views. Moreover, both studies included therapists in the early phases of their work: their study included undergraduate students, and my study included trainees in psychoanalysis. The differences between our studies include the places the studies took place, the methodology, and the sample in terms of both size and theoretical orientation.

I hold that Patihis et al.'s (2014) study entailed two interesting ideas as they compared both the views of their participants in the past and the present, and the views of researchers and therapists, between which there is allegedly a gap of thought. However, their study's sample is too broad to ensure high transferability of their results.

As commented by Brewin and Andrews (2014), the data reported by Patihis et al. (2014) do not reveal a wide rift between the beliefs of researchers and practitioners, as the authors claim, but instead indicate a notable disagreement among alternative therapists and clinical

psychologists, with merely the latter demonstrating adaptation of their practice in terms of contemporary evidence-based modifications.

The studies of Poole et al. (1995) and Patihis et al. (2014) have been discussed in relation to their response rate and the resulting conclusions. In another contribution, Brewin and Andrews (2017) discovered that at least 11 surveys from 1994 to 2017 have questioned therapists regarding their views on the genuineness of recovered or repressed memory and/or the likelihood that such memories could be false. The article did not mention all the surveys and it included only a list of 'key references' (which contained Andrews, Morton, Bekerian, Brewin, Davies, and Mollon, 1995; Poole et al.'s, 1995; Andrews, 2001; Ost et al., 2013; Patihis et al., 2014) instead of a full reference list. Brewin and Andrews (2017) cautioned readers regarding their interpretations and generalisability because they observed that the three surveys published after 2000 had failed to reach response rates beyond 17%, and that very low rates can be found in most relevant surveys. I must add that the same problem regarding low rates of response rates is evident in the studies conducted by Polusny and Follette (1996) and by Ost et al (2013).

As seen above, relevant research in Greece is rather absent, which underlines the originality of the current study. Nonetheless, there are many more differences making this study distinct from others, including a more general view of CSAM, therapeutic process and past influences, as well as a more specific view of therapeutic approach and the research method of this study.

In more detail, unlike other similar literature material, which mostly investigates recovered/repressed memory (such as Yapko, 1994b; Palm and Gibson, 1998; Sullins, 1998; Patihis et al., 2014), the present study will examine the history and treatment of CSAM in general (including certain, uncertain and false memory).

Furthermore, while much research has been warranted on therapists' techniques said to induce false memories (Yapko, 1994b; Palm and Gibson, 1998; Gore-Felton, et al., 2000), the current study will focus more on the general handling of difficult issues regarding CSAM in treatment. As Phelps, Friedlander and Enns (1997) have proposed, relational qualities of the therapeutic relationship appear more salient for clients working on early traumatic memory than the employment of certain techniques by the therapist.

Another choice made which differentiates the present research from previous ones, was to include in the exploration the influence not only of more recent debates (as done, for instance, by Poole et al., 1995; Polusny and Follette, 1996), but also of Freud's century-old dilemmas, together with their alleged after-effects. This was decided as a more all-inclusive view of the unsolved problems regarding CSAM would require a historically deeper understanding of the relevant issues involved.

Moreover, whilst most other research investigates the work of clinicians, therapists or mental health professionals, (Poole et al. 1995; Phelps, Friedlander and Enns, 1997; Palm and Gibson, 1998; Barber, 2012; Ost et al., 2013), and others examine only the work and beliefs of clinical and counseling psychologists (Polusny and Follette, 1996; Gore-Felton, et al., 2000), the present study focuses only on psychoanalysts, psychoanalytic psychotherapists and trainees of psychoanalysis. The more discipline-specific approach was chosen as, compared to other disciplines, psychoanalysis is more involved with past and recent controversies regarding CSAM, whilst there is not much research examining it.

Thus, the current study focuses on the analyst's and psychoanalytic psychotherapist's perspective when dealing with controversial issues while working with CSAM. While psychoanalysis is developing through clinical case material, as discussed in the introduction of the current part (see section 1.2.1), my study provides a more psychological and research-based focus, which hopes to fill in gaps between research and clinical practice. This combination of psychoanalytic experience with empirical research elucidated new ways of responding in psychoanalytic cases involving adults' early sexual traumas.

The originality of the present thesis mainly lies in the fact that rather than focusing on a few case studies, I went straight to the source, offering psychoanalytic therapists an opportunity to share their views in depth. This depth was accomplished through the collection and analysis of interview data, which has been done only once before with analytically-oriented psychotherapists (rather than psychoanalytic therapists) in a much smaller sample (Colton, 1996).

A qualitative methodology wαs adopted for reasons explained in the methodology chapter (see section 2.1). This made this thesis inherently different from, but also complementary to,

much other research which used quantitative methodological approaches (eg. Poole et al., 1995; Polusny and Follette, 1996; Gore-Felton, et al., 2000; Patihis et al. 2013).

The process included an in-depth reading of major texts and relevant keyword searches about CSAM and therapy, which facilitated identification of controversial issues in the treatment of CSAM. Greece was selected mainly because there has been no such research there and also because I (the researcher) reside in Athens, Greece, and this made the opportunity of selecting and recruiting participants more convenient.

The study involved interviews of psychoanalytic psychotherapists, with a purpose to both obtain quantifiable results and to grasp as much qualitative detail as possible. The CA employed was both research-driven and data-driven and will hopefully reveal the psychoanalytic therapists' proportionate focus on key aspects of the therapeutic work with CSAM, such as difficulties, changes, effectiveness, and addressing, questioning and distinguishing CSAM in psychoanalytic therapy.

The present study aims to enhance the knowledge of mental health professionals concerning the complications of CSAM in therapy. Therapists ought to be adequately informed about trauma and abuse, as the subject is so often-met with clients (Palm and Gibson, 1998). When lacking awareness and sensitivity for CSAM, therapists may break the foremost rule about causing harm through disbelieving or believing clients' CSAM. The results of this thesis informed us on strengths and limitations of therapeutic interventions, and available solutions for therapists.

#### 1.2.2.2 The Study's Questions

The main research question of the present study is:

'How do Athenian psychoanalytic psychotherapists approach their adults patients' CSAM?'.

As seen until now, retrospective CSAM is a topic with blind spots and gray areas in terms of therapeutic practices. Psychoanalysis, the oldest psychotherapeutic approach, involves much history in the topic under examination. The topic of retrospective CSAM in psychoanalytic practice has not been researched.

In the current thesis, the subject will be explored through a dual focus on past debates and controversial situations. A consideration of the influences of both century-old and of more recent debates on psychotherapeutic practice is essential so as to stop the repetitive circles of denial towards CSA experiences and fantasies. These debates led to theoretical and practical dilemmas in therapeutic work with CSAM and it would be useful to find out how psychoanalytic psychotherapists deal with controversial situations in therapy.

The literature gaps identified earlier (see section 1.2.1) involve the analyst's unpreparedness, the initial discussion of CSA, the analyst's belief and disbelief of CSAM in therapy and so on. These gaps are closely connected to my clinical worries (see thesis introduction), they are purportedly rooted in Freud's work and its 'effects' (see section 1.1.4), and they are mirrored in the interview questions of the current research as we shall see next. The aim of these interview questions points to a deeper understanding of how contemporary psychoanalytic therapists would respond in difficult situations.

As discussed earlier (see section 1.2.1.6), the first interview question to be explored in the analysis chapter (see sections 4.1.0) examines whether psychoanalytic therapists' handling of CSAM cases has changed. The goal of this general question involves facilitation for any possible results to emerge and an opportunity to comprehend how psychoanalytic therapists feel when initially encountering relevant CSAM cases, what they do when they regard these cases too difficult to deal with, the ways these feelings may change through the years of professional experience, and also in which factors they tend to attribute these changes. In the discussion chapter, my findings will be compared and contrasted to previous research (Colton, 1996; Barber, 2012) and writings (Olio and Cornell, 1993; Perlman, 1999; Walker, 2004), which have stressed the therapists' difficulties in such cases.

As pointed out earlier, (see section 1.2.2.1), qualitative research concerning disclosure of past CSA in psychotherapy is rather underexplored (Barber, 2012) and there are no qualitative studies focusing on the therapist's approach to CSA indications before such disclosures within psychoanalytic therapy. The third interview question to be looked at the analysis chapter is connected to how psychoanalytic therapists approach indications of CSAM, and more particularly, whether they would bring up CSA as a possible explanation for the analysand's symptoms before the analysand's potential revelation. These questions may serve

to elucidate how they would handle symptoms of CSA before the actual memory came up during the therapeutic process, as well as the circumstances where the possibility of a CSA experience would be offered to an analysand, as an explanation for the observed indications, by a contemporary psychoanalytic psychotherapist. In the discussion chapter, the responses of my study's participants will be compared to findings supporting that CSA should be inquired about before the client's actual disclosure (Barber, 2012), and that therapists avoid suggestive interpretations (Sullins, 1998), alongside writings proposing that there are no clear-cut indications for CSA (Lindsay and Read, 1994; Spanos, 1996; Madill and Holch, 2004).

As seen earlier (see section 1.2.1.5), the connection between psychoanalysis and CSAM could result in hurtful effects. The second interview question to be investigated in the analysis chapter, relates to the client's retraumatisation, especially during the revelation of CSAM. The responses of the psychoanalytic therapists who participated in my study will hopefully offer insight as to whether they acknowledge the possibility of in treatment trauma, and on whether they worry about their analysand's retraumatisation. My relevant results could be discussed in terms of writings about the connection of client's retraumatisation to the therapist's approach (e.g. Denov, 2003; Gore-Felton, et al., 2000; Aron and Harris, 2010; Barber, 2012).

Another point where therapists have controversial guidelines deals with the doubting or questioning of a CSAM in treatment (see section 1.2.1.2 above for more details). In the current study, analytic psychotherapists will also be confronted with an interview question concerning whether and how each participant would question a client's CSAM. Their replies may clarify not only in which cases contemporary psychoanalytic psychotherapists inquire about the veracity of a traumatic memory, but also the ways in which this exploration has been approached. Moreover, the results will point out whether these therapists believe that there are reliable indications of CSA, whether it is wrong to connect CSA to related symptoms, whether they hold that their approach under examination may contribute to the effectiveness of the treatment, and whether there is a tendency to lean on either direction or to remain neutral. The findings from this exploration will be compared to other research findings regarding what clinicians believe about their clients' CSAM (Poole, et al., 1995), and what clinicians do if they hold that a client's CSAM is illusory (Palm and Gibson, 1998).

As aforementioned (see section 1.2.1.4), there is a debate about whether the FRD is supposed to be carried out by therapists or not. The fifth question will address this issue, since analytic psychotherapists will be asked whether they accept the fantasy-reality differentiation as their own responsibility. The aim of this question is to reveal where current practical psychoanalysis stands with regard to validating CSAM as a professional task or a therapeutic goal. My findings will be compared with findings and writings claiming that the distinction is (Palm and Gibson, 1998; Gardner, 2003) or is not (e.g Perlman, 1996) the therapists' responsibility.

The FRD on retrospective CSAM, has been troubling therapists for more than 120 years, as we saw earlier (see section 1.1.13). Via the sixth interview question to be attended to in the analysis chapter, psychoanalytic psychotherapists will be asked to expand on whether they regard this distinction as feasible. This way the present study will attempt to illuminate whether contemporary psychoanalytic therapists believe that the FRD is feasible, and to understand both how psychoanalytic therapists cope with this unfeasibility, and whether they have found ways to determine CSAM authenticity in any cases. In the discussion chapter, my findings will be compared to relevant texts arguing that this distinction is not feasible in therapy (such as Freud, 1918; Bernstein and Loftus, 2002).

Other findings may emerge through the overall understanding of my data. For instance, the opportunity of discussing with psychoanalytic psychotherapists all three issues, about proposing, questioning and clarifying uncertain CSAM and trauma, may elicit answers to points presented earlier, such as the psychoanalytic therapists' more contemporary focus on countertransference responses (see section 1.1.3.3). This will be compared to past (Freud, 1910; 1912) and more recent (Mitchell, 1997; Courtois, 1997; Walker, 2004) texts on the role of countertransference in therapy.

My findings will also be associated with other more general findings on the subject of CSA. For example, with Colton's (1996) conclusion about psychoanalytically-oriented practitioners feeling ambivalent in the treatment of paternal CSA.

To sum-up, the interview questions were developed to explore contemporary Athenian psychoanalytic psychotherapists' handling of - genuine, uncertain and false - CSAM in cases

with adults, and to obtain an overview of their work in difficult situations identified through literature gaps and debates (see appendix 4: Interview Questions).

**Conclusion to Literature Review**

The present chapter introduced the historical background of the topic of CSAM. It included a focus on Freud's relevant writings, and the more recent contributions on the reliability of retrospective CSAM. The link between a recent literature review and the research questions involved in my study was explored. A comparison with similar research was also provided. This material formed the basis for the present research which will be the focus of the next chapters.

## Chapter 2: Methodology

### Introduction to Methodology

The present thesis attempts to clarify how contemporary Athenian psychoanalytic therapists deal with controversies around memory, reality and CSA. In the previous chapter, the past controversies were analysed so as to understand the context in which contemporary psychoanalysis and CSAM will be explored. The psychoanalytic history about CSAM appears full of great ideas and innovations, as well as confusion and disparity for the subsequent generations of analysts. This information provided a background for the relevant controversies (such as the clinical focus on fantasy or reality) and the reasons for the involved confusion (such as Freud's unsettled theorising). Thus, the history between psychoanalysis and CSAM has been reviewed, so the way contemporary psychoanalytic therapists handle the issues identified in the literature review, is yet to be discussed.

The current chapter will focus on the methods chosen to examine how current psychoanalytic therapists approach controversial issues around CSAM. More specifically, the strategy behind the search, around contemporary psychoanalytic work on CSAM, will be unfolded. The study, herewith presented, will adopt a qualitative approach, more specifically using CA, employing 31 in-depth interviews with psychoanalytic practitioners, working individually with adults in Athens, Greece. The rationale behind the choices of methodology, participant selection, design and research procedure will be provided.

As argued by experts (Miles and Huberman, 1994; Roulston, 2014) qualitative data analysis will be organised into three categories:

i) Research methods, accounted for in the present chapter (that is, number 2, entitled 'Methodology')
ii) Data analysis and organisation, which are coming up in the next chapter (that is, number 3, titled 'Analysis') and
iii) Data representation, findings and conclusions, included in the last chapter (that is, chapter 4, titled 'Discussion').

The current chapter explains the methodological reasoning under which this research was conducted. It involves details about the ways the data were handled from the moment the idea

of this topic was conceived, until they had been analysed and categorised. This data handling can be separated in three phases: collection, preparation and analysis. The first phase regards data collection and includes information concerning sampling, procedure, as well as both structure and content of the research questionnaire. The second phase relates to data preparation, and takes account of transcribing, summarising, initial coding, translating and numerical analysis of the data. The third phase considers data analysis and consists of particulars on CA and on the various questions of the present thesis.

The research as a whole was conducted under the recommended ethical guidelines and the anonymity and confidentiality of participants' data was protected (see ethics form in appendix 1). While conducting this research, I tried to be as objective as possible without believing that I could bracket off my influence completely. In other words, I attempted to minimise my personal influence while recognising that I could not completely avoid it. The analysis and findings of this search will be presented and discussed in the next chapters. This chapter will begin to provide information about the research methodology of the current study by explaining how the data was collected.

## 2.1 Data Collection

Details about the study's sample, choice of data collection method, questionnaire structure and content as well as the procedure will be discussed in the current section.

### 2.1.1 Sample

The subject of this research includes an analysis of a sample of the contemporary psychoanalytic practice with adults in Greece in the domain of CSAM. Thirty-one therapists participated in the current study. More specifically, the sample included 15 (48%) psychoanalysts, 10 (32%) trainees in psychoanalysis and 6 (19%) psychoanalytic therapists. From those 31 participants, 22 (71%) were female and 9 (29%) were male. They were aged between 26 and 85 (mean 55.5) years. Their clinical experience ranged from 3 to 50 (mean 26.5) years, and from the 31 participants, 19 (61%) had 15 or more years of clinical experience, 13 (42%) were also psychiatrists, and 16 (52%) had completed their training (see Appendix 3 table 3.2 for participants' information).

There were no other inclusion criteria for the participants, apart from their psychoanalytic orientation and training. This means that they were not exclusively chosen for their expertise in the topic of CSA or memory, but also for their ability to think about how they would handle such cases if they ever came up.

The specific therapeutic group, namely psychoanalytic therapists, was preferred on the basis of it being in the centre of past and recent controversy concerning CSAM, as discussed in the previous chapter (see section 1.1.2). Simultaneously, it has been described as both the most recognised and widely used therapeutic approach (Zerbetto and Tantam, 2001).

The choice regarding adults' rather than children's therapy was taken, mainly because the adults could work more retrospectively on their CSAM. Moreover, the relevant debates, which could be the source of the material for comparison with my findings in the future, focused on the CSAM of adults.

Individual and long-term therapy was chosen over group therapy or short-term therapy not only because it was easier to find psychoanalytic therapists working with adults who have CSAM using this type of therapy in Greece, but also because individual long-term therapy has not been researched. Moreover, the reasons for not choosing therapists working in brief- or in group- therapy settings will be explained below based on the accounts provided by previous and current research.

Regarding the results of therapeutic work with CSA survivors, contemporary research advocates the effectiveness of both short-term individual psychodynamic psychotherapy (Price, Hilsenroth, Callahan, Petretic-Jackson, and Bonge, 2004), and of interpersonal-psychodynamic group therapy (Callahan, Price, and Hilsenroth, 2004). As maintained by Callahan el al. (2004), group therapy has become the primary mode of treatment (sometimes in combination with individual therapy) because group treatment is considered especially suitable for survivors who frequently struggle with major social adjustment and interpersonal issues. Others (Tyson and Goodman, 1996; Valerio and Lepper, 2009) have supported that while very brief focused groups were beneficial to survivors, longer-term process-oriented or unstructured groups made a substantial difference in both interpersonal and social adjustment problems. Tyson and Goodman (1996) hypothesised that a reason for this is that it may not be curative merely to narrate the traumatic story and therapists should additionally focus on

unconscious reenactments by exploring the process of interpersonal relating within the group. According to Valerio and Lepper (2009), in the long-term, rather that short-term, groups for survivors, there is greater 'acting-in', that is, re-enactments of interpersonal difficulties.

In my research of previous and current studies, I found minimal evidence contradicting the statements that the mode and the duration of the treatment do not influence the outcome. More specifically, only Stalker and Fry (1999) found that individual and group therapy, both in brief mode, are equally effective for adult CSA survivors. Despite of their finding about equal effectiveness of individual and group therapy, they proposed that survivors of CSA should be encouraged to participate to brief group therapy, as it is efficient, cost-effective and suitable for most survivors. They proposed that future research should address, among other issues, the effects of longer treatments in order to improve therapeutic responses to this client group. For this reason, focusing on the effectiveness of a very long psychotherapeutic approach, namely psychoanalysis (Bornstein, 2001; Huber, Henrich, and Klug, 2013) would be useful for therapists who also work through long-term intervention with CSA survivors.

Greece was chosen as a research location since I was interested in seeing how my compatriot colleagues handled one of the most controversial therapeutic topics, and since there was no research on this subject in Greece compared to the UK (see section Thesis Introduction), which was my other feasible choice.

The city of Athens, which is the capital of Greece, was selected for many reasons:
1. Almost half of the population of Greece resides in Athens metropolitan area
2. Most Greek psychoanalysts and psychoanalytic therapists are working there
3. Most training centres are located there
4. It is my home town, so it was easier to conduct the time-consuming data collection.

According to Patton (2015), "there are no rules for sample size in qualitative inquiry'There are no rules for sample size in qualitative inquiry Sample size depends on what you want to know, the purpose of the inquiry, what's at stake, what will be useful, what will have credibility, and what can be done with the available time and resources" (p.311). The number of participants in this study was 31, which is the mean sample size in PhD qualitative and interview-based studies (Mason, 2010). Graneheim, Lindgren, and Lundman (2017) write regarding the important question of the number of participants in research using CA:

> "As content analysis emphasizes variation in content and multiplicity, there must be enough data to cover significant variations" (p.33).

Thus, 31 psychoanalysts (10 of which were still in training), working in Athens, Greece, have taken part in this research. They were located through the relevant Psychoanalytic Associations' lists and were recruited through emails and phone calls. I also invited a few psychoanalysts to participate after recommendation by other participants, because of their expertise on CSAM. This is in accordance with Graneheim, Lindgren, and Lundman's (2017) argument that to establish credibility in studies employing CA, it is imperative to include participants who most likely have experiences involving the phenomenon under examination and are willing to discuss it.

The Greek Psychoanalytic Association listed (in February 2008), 98 members and trainees, 74 of whom were based in Athens. The Hellenic Society of Psychoanalytic Psychotherapy listed (in July 2012) 34 members (the trainees were not included in the list), 25 of whom were based in Athens. As there appeared to be approximately 99 recorded psychoanalytic practitioners in Athens, and I interviewed 31 of them, more than 31% of their total number participated in this study. Thus, this study included a considerable percentage (more than one fourth) of the total number of psychoanalysts in Athens. Graneheim, Lindgren, and Lundman (2017) claimed that the choice and number of participants are crucial for the transferability of the findings.

Contrary to other similar research (Poole, Lindsay, Memon, and Bull, 1995), the present study included ten trainees in the sample, alongside 21 psychotherapists who had completed their training. This choice was made in order to create a more realistic scenario, based on the possibility that someone with CSAM could be treated not only by an experienced analyst, but also by a trainee. However, it should be noted that most of the participants who had not completed their training had many years of experience. They had finished their main training years back, but did not submit their final case study. In Greece a recognised undergraduate degree suffices for someone to become a licensed psychologist, so practitioners do not need to have special training in a specific therapeutic modality. The training in both psychoanalysis and psychotherapy is neither recognised nor necessary in order to practice. This means that psychologists and psychiatrists who attend psychoanalytic trainings do not

need to complete them so as to legally offer their services. In this sense, there was no point in comparing the results of therapists with trainees as this did not define their years of experience or psychoanalytic expertise.

### 2.1.2 Interviews

In the next few paragraphs the basis for the exclusion of other data collection methods will be presented and in the rest of this section the reasons why interviews were chosen as most appropriate for the current study will be explained.

Quantitative research tools, such as questionnaires, were not preferred as the broadness of the research question could not be matched with predetermined responses. The reasons why a qualitative analysis was selected over a quantitative one will be pointed out in the 'Qualitative Analysis' part below.

Literature-based research would be interesting, but would probably not cover all issues both implicated in past debates and examined in the present study. Focus groups seemed like a great source of such material, yet their actualisation may have been challenging, especially since there was not a reward for the participants. There would probably be less participation since it would involve asking psychoanalysts not only to devote so much more time than they already did, but also finding specific dates, times and places convenient for most participants. Observation of naturally occurring data, which, in this case, would involve recordings of therapeutic material or my presence in sessions entailing CSAM, would be very difficult, not only because of its comparative rareness and unpredictability, but also because of confidentiality issues.

Interviews are increasingly becoming the source of information for the media, human service professionals and social researchers (Holstein and Gubrium, 1995). This preference occurs regardless of the disadvantages of the interviews, such as lengthy processes, small samples, lack of total anonymity, and increased possibility for both biases and inconsistencies (Brown, 2001). As Polkinghorne (1983) argued:

> "The exemplar of data collection in human science is the face-to-face interview... The face to face encounter provides the richest data source for the human science researcher seeking to understand human structures of experience" (p.267).

The desired richness of the findings was the main reason interviews were chosen as the research tool in the current study.

### 2.1.3 Interviewing Style

The current research's interviewing style was semi-structured as explained below. Silverman (2011) wrote that in structured interviews the required skills include neutrality, no prompting, no improvisation and training to ensure consistency. He added that in the semi-structured interview the required skills are some probing, rapport with interviewee, and understanding the aims of the project. On this basis, the interview type used in the current research was semi-structured as it included occasional improvisation and rapport with the interviewee.

In addition to the above, although there was a predetermined set of questions, some questions and sub-questions were not used when I thought that they had already been replied to by the participant. I asked the participants the most important questions, yet not necessarily in the same order. The most important questions were the ones I had chosen to definitely ask in case there was plethora of data received during the interview, because I wanted to get specific responses to controversial topics. I included all these questions in the analysis chapter: that is, about the psychoanalytic therapists' changes in their approach towards CSAM, their potential proposal regarding CSA explaining the client's symptoms before the client's actual disclosure, the client's potential retraumatisation during a CSAM disclosure, and the possible questioning of the CSAM validity. The rest of the questions were considered as prompt questions and were asked only if the participants did not expand on the ones listed above, or when there was time left for the prompt questions to be answered. Two prompt questions - that is, about the therapist's responsibility in the FRD in CSAM cases and the feasibility of this distinction - were also analysed below as they revealed important findings. All the questions analysed later were closed questions, they did not include errors and ambiguity of meaning and their data revealed important findings. As there was flexibility and a lack of an overall consistency, the interviewing style was regarded as semi-structured.

Sensing (2011) noted the role of the interview guide in semi-structured interviews:

> "Somewhere between the structured and the free-flowing interview style are the semi-structured interviews. Specified themes, issues, and questions with predetermined sequence are described in the protocol, but you are free to pursue matters as situations dictate... An interview guide lists the questions or topics that the interviewer desires to explore... There are no pre-determined responses, and the interviewer is free to probe and explore for more depth... An interview guide ensures good use of time, makes the process more systematic and comprehensive, and keeps the interviewer focused on the purpose of the interview" (p.107).

Indeed, the interview guide helped in the exploration of important points of this research, while it allowed the interviewees to express their views on the topics they wished to discuss.

Selltiz et al. (1964) noted that compared to standardised interviews, unstructured interviews are more flexible and can 'dig deeper' but they often present a lack of comparability of one interview with another and their analysis is far more convoluted and time-consuming. This research was conducted via a semi-structured interview plan in an attempt to optimise the advantages and at the same time to curtail the disadvantages of both structured and unstructured interview plans. Although the data analysis was complicated, the aims of this research were accomplished as the findings were multiple and some of them were unexpected (for instance see section 4.5.4 on the therapist's effectiveness). Furthermore, an increase in the comparability between the interviews was sought as the data analysis was based on the same set of closed interview questions for each participant.

According to Brewin and Andrews (2017), therapists' replies to questions regarding false CSAM, appear to hinge critically on particular wording and may alter if they are allowed to elaborate or at least offered more options than the common yes/no tick-box answer. The present study used semi-structured interviews so as to provide the participants the chance to elaborate on their responses.

The research question itself, that is, how psychoanalysts approach CSAM, is an open question and hence calls for unrestricted responses by participants. The study aimed to address delicate issues relating to the participants' approach and treatment of possible CSAM

cases, the conveniences and difficulties regarding the treatment of CSAM sufferers, their suggestions for future practice and changes in psychotherapeutic training and social policy, especially concerning potential harmful therapeutic effects. Through semi-structured interviews, elaboration on the participants' responses and interpretations was possible (Barber, 2012) and unforeseen data were more likely to emerge, allowing an unfathomable exploration of this multifaceted subject.

Moreover, the dyadic encounter in psychoanalysis is more parallel to the interview procedure than any other data collection method. Since the participants were psychoanalysts, psychoanalytic therapists or trainees in psychoanalysis, they were used to the one-to-one meeting in which they reflect on issues, which makes the interview a good tool to get the material required for this study.

Furthermore, taking into consideration a more practical aspect of this method, there would be more material in the literature to get both ideas and directions from as most published qualitative scientific articles have selected interviews as their research instrument over any other method (Silverman, 2005). Finally, interviews are relatively economical in terms of time and resources (Silverman, 2011).

By framing the structure of the interview in a semi-structured way, the researcher was facilitated to (1) test how past controversies influence contemporary practice about adults' CSAM, (2) explore the participating therapists' approach on the subject, (3) facilitate unexpected data to be elicited, and also (3) allow for quantifiable data to emerge and be analysed through CA.

### 2.1.4 Interview Questions

The interview questions (see appendix 4) I developed were initially written in English, and after my research received approval by the Ethics Committee, I translated the interview questions into Greek.

This specific semi-structured interview plan was informed by past and recent literature and by my experience (Phelps, Friedlander and Enns, 1997).The interview questions were based on the literature gaps I found most interesting in the domain of CSAM and psychoanalysis.

They referred to the way psychoanalysts tend to perceive and handle CSAM, and each question triggered the revelation of the participant's opinion on debatable subjects, such as the analyst's responsibility concerning the FRD in adult client's CSAM.

In more detail, the interview list has been devised to elicit the psychoanalytic practitioners' approach to CSAM discussed by adult patients, through the practitioner' responses. This can in turn facilitate the understanding of how related controversial issues are dealt with within Greek psychoanalytic circles. Interviews will focus on the therapists' work with CSAM, the psychoanalytic practitioners' preparedness to distinguish fictitious from authentic CSAM, the advantages and limitations of the psychoanalytic approach on the topic, alternative ways of related responding and so on.

The list of interview questions was developed in such a way that participants could reply with a word or a few words, such as 'Yes', 'No', 'Maybe' and 'I don't know', as well as be able to expand on their initial answers with the aid of prompts and sub-questions. For instance, following the interview question 'Would you question the reliability of a client's CSAM?', if the participant had replied affirmatively and also if s/he had not covered this issue through his/her previous response, I also asked 'How would you do that?'. The initial question was posed so as to allow the participant to express him/herself in a more open and unbiased way on a broader matter. Then the following sub-question was used in order to examine specific matters in more depth. Thus, while the participants were asked closed questions, they were also encouraged to feel free to develop their own narrative and to follow their own pace and frame of reference.

The reason I included many questions in my interview list was that I wanted to find answers to specific questions originating from the many controversial topics entailed in the literature involving CSAM. Moreover, the choice regarding the amount of these interview questions was rooted in my worry about participants not being willing to expand on their responses or their potential wish to direct the conversation to irrelevant topics (see section 4.6.0 for the relevant limitations).

The reason why I chose to ask closed interview questions was because I intended to obtain specific answers from asking specific closed questions and also to see what emerges from the answers to both open and closed questions. Even in the closed questions, participants were

encouraged to analyse their responses by explaining the underlying reasons for these responses.

### 2.1.5 Procedure

Participants were approached through emails and phone calls (see invitation in Appendix 2). From the 99 therapists, who were contacted, 31 participated, meaning that the return rate was more than 31%. They were asked to participate, as psychoanalytic therapists, in a PhD research on CSAM, via a recorded interview, which would last approximately 45 minutes, wherever and whenever we arranged to meet.

Usually the interviews occurred in their private office or workplace. Their questions were answered through the phone or email and they were informed that their expertise in the domain of CSAM was not a prerequisite. In fact, they were told that their contribution would be valuable even if they never had a case involving CSAM, and they responded hypothetically. They were also told that the interview was informal and that they would be encouraged and allowed to express their opinions as they pleased.

Participants read and signed the consent/information form, which included all the required information (see Appendix 2) before their interview. This document was offered to be sent to each of them for their consideration prior to the arrangement of our meeting. Through the consent/information form participants were informed about their right to refuse to participate and to take with them any data relevant to them.

Interviews were conducted and audio recorded with each participant and they were told that the recording could be paused at any time for a break or any questions. Recording the interviews has been strongly advised by Silverman (2011). Only a few participants appeared hesitant about being recorded, possibly because this was emphasised in the initial communication. I explained that their data was protected through anonymity and that I needed the recordings so as to avoid missing out on any important details as recordings can be played back. This clarification facilitated their decision to continue the interview.

The first three interviews were initially considered as pilot. However, since they elicited no changes to the interview questions and schedule whatsoever, their data were analysed alongside all other interviews.

Before the commencement of the interviews there was an informal chat to reduce the stress and to increase the participants' openness. I also asked certain questions regarding their age, years of experience, whether they had completed their training, and whether they were also psychiatrists (see Appendix 3, table 3.2).

On the whole, the procedure lasted approximately 45 minutes, ranging from 25 to over 120 minutes. I informed the participants that the interview will last as long as a session (about 45 minutes) for practical reasons, but I did not stop any interviewee from carrying on discussing anything relevant beyond the arranged time frame. The duration of the interview was analogous to each participant's willingness to dedicate more time to the interview and to expand on the discussion during the interview.

The interviews have been conducted on the basis of the context of 'conversations with a purpose' (Burgess, 1984, p.102) and there has been an effort to create data through the interaction of the participant and the interviewee. I, in the role of the interviewer/researcher, allowed both myself and the participants to expand on anything so as to be able to raise interesting topics not included in the questions (Rapley, 2004). I also looked for opportunities to pick up on their replies to continue their discussions on topics relevant to this research (Rapley, 2004), such as cases involving CSAM.

At the time of the interviews, I was a 31-year-old PhD candidate in Psychoanalytic Studies with 10 years of supervised clinical experience. I was acquainted with the literature on CSAM and had handled a few relevant cases in my private practice. I was a licensed psychologist who had been trained as an integrative-systemic psychotherapist and was teaching psychodynamic theory/practice and other modules for academic degrees in Athenian institutions and colleges.

I believed that CSAM can be real or fantasised, that therapists ought to be aware and careful when handling such cases as there is a chance for client retraumatisation, that – at least for now - only the clients themselves can ascertain what happened to them and that in certain

cases we can never find out the actual truth. I also held that there are literature gaps, controversies and vagueness in the field of CSAM. I was open to see the reality through the participants' perspectives as I knew that our perceptions and experiences differ and that my relevant opinions could change at any point as they are depended on new reliable data.

During the interview I tailored my stance according to each participant and to Holstein and Gubrium (1995) who proposed an approach

> "...Whereby researchers acknowledge interviewers' and respondents' constitutive contributions and consciously and conscientiously incorporate them into the production and analysis of interview data" (p.4).

As far as the passivity-activity part of the interviewer is concerned, Rapley (2004) proposes that no single ideal gains better data than the other. In this study, something in the middle - not too passive or too active - was selected, although the result is probably slightly moving towards the latter approach as activeness matches more my personality style than passivity.

After I had asked all scheduled interview questions, I allowed for the participant to discuss anything else they wanted in relation to the topic or the interview process. Most participants wished to discuss further their relevant cases. Some said that they found the interview procedure very informative and the study very interesting, while others expressed regret for not having experience with CSAM cases. I said that their data would be very helpful in obtaining an overall picture of the relationship between psychoanalysis and CSAM in Greece. A few seemed worried about possible criticisms originating from my results towards psychoanalysis, but felt more at ease when they experienced my interview approach. I also assured them I would email them any resulting findings and reports. Although debriefing took place after each interview, no debriefing sheet was given to the participants as they knew all along what the interview was about (that is, CSAM in psychoanalytic therapy with adults). I thanked all participants wholeheartedly for their participation.

### 2.2 Data Preparation

The recorded data, which were collected from the interviews were transcribed, condensed and translated so that the translated summaries of the transcriptions would be analysed using CA.

According to Roulston (2014), there are no correct ways to transcribe and/or translate interview data, so I attempted to follow any guidelines found and fill in the blanks with as much consideration and reason as possible. While there may not be 'correct' ways, there are better ways to transcribe and translate interviews than others, so I both acknowledged and followed guidelines for quality of qualitative analysis. A numerical analysis of each interview question was also presented. More details about each of these steps can be found below.

### 2.2.1 Transcribing

Audiotapes of interviews and the resulting transcripts are commonly used as the main source of qualitative data (Bengtsson, 2016; Klenke, 2016). As soon as I started conducting the interviews, I thought of Silverman's (2011) advice about not delaying analysis while the interviews pile up. Thus, the conversion from recorded to written data was made as soon as possible after the completion of each interview, in order for my memories of the interview to be fresh. The transcribing was in Greek as the interviews were conducted in the participants' native language, which was Greek.

As there is no sole way to carry out qualitative analysis, there is not a single course of action to follow when transcribing material (Braun and Clarke, 2006). The interview recordings were thoroughly transcribed into Microsoft Word 2010 documents. Bailey (2008) advised researchers to carry out the transcribing process themselves. Computer programs or specialists can be used to transcribe the interviews, but I chose to do this myself so as to increase contact with my data set. The researchers' familiarity with the material and their focus on what is really there instead of what is expected to be found can allow for ideas elicited during data collection and analysis (Bailey, 2008).

Some researchers choose to transcribe interviews selectively, whereas others transcribe the entire interview discussion (Roulston, 2014). I preferred to transcribe the interview material verbatim (word-by-word) and then do the selection as a separate task, so as to minimise potential sources of error.

At a minimum, producing transcriptions requires a meticulous transcript – an accurate report of all verbal sounds - and should be done in a way which is genuine to its original nature (Braun and Clarke, 2006). Thus, every transcription was done by writing down every verbal

bit of the conversation, such as words and ‘hmms’. My speech was also transcribed so as to avoid leaving the interviewee’s talk as an abstract account instead of a specific reply to a specific question posed by a specific interviewer (Silverman, 2011). This whole procedure yielded almost 600 pages of transcripts.

Transcription requires close examination of data via repeated meticulous listening as an imperative initial phase in data analysis (Bailey, 2008). In my study, the recordings had to be played back several times so as to ensure each transcription’s accuracy. When I was unable to understand what was said, a note of this was made with dashes and the time of this in the recording, for instance “---2:04”. Brackets were used to indicate the beginning and end of the point at which someone’s talk was overlapped by another person’s talk (Silverman, 2011).

According to Stuckey (2014), the transcription process includes the deidentification of the recorded data, and the transmission of correct meaning to the text. As Bailey (2008) wrote, while transcribing seems to be a clear-cut technical task, in reality, it entails judgements, for instance, regarding data interpretation, that is, distinguishing between similar sounds, such as ‘I don’t, no’ from ‘I don’t know’. For the purposes of the current study, another researcher checked the transcriptions in relation to the recordings so as to both minimise misinterpretations and to correct errors in connection to the participants’ meaning.

Non-verbal utterances (apart from voices overlapping), such as marks for pauses, breaths, prolongation of sounds, possible hearings, author’s descriptions and stress via pitch and/or amplitude (Braun and Clarke, 2006; Silverman, 2011) were not included in the transcriptions as these would not be needed in the analysis. Nevertheless, the recorded transcriptions were maintained if a meta-analysis on them would be decided to take place in the future.

The transcriptions files were numbered and carefully assigned participants’ code names.

### 2.2.2 Data Reduction

As Miles and Huberman (1994) defined:

> "Data reduction refers to the process of selecting, focusing, simplifying, abstracting, and transforming the data that appear in written-up field notes or transcriptions" (p.10).

The challenge of qualitative analysis resides in perceiving and explaining enormous amounts of data, which includes decreasing the volume of unprocessed information, filtering the valuable from the negligible, detecting substantial patterns, and developing a framework for conveying the meaning of the revealed material (Patton, 2015). Qualitative interviews and their resulting transcripts add up to a great deal of raw material which must be abbreviated and grouped before they are interpreted, comprehended and well-expressed (Klenke, 2016). All processes start with an effort to organise and understand the collected data, and this inevitably includes some degree of data shrinking as data is coded and condensed (Scott and Morrison, 2006).

Guest, MacQueen and Namey (2012) argued about the usefulness of data reduction as a qualitative process:

> "Like coding, data reduction is an integral part of the iterative qualitative data process" (p.129).

The decision to perform data reduction or condensation was due to the following reasons:

- To have a more manageable data set (meaning for instance 5 rather than 25 pages from each of the 31 interviews),
- To bring all the responses for each question together, thus enabling me to identify the similarities, the differences, and the most popular responses,
- To avoid translating unneeded material (that is the whole interviews rather than the summaries),
- To provide the English speaking readers the opportunity to 'get a taste' of the overall interviewee responses to the interview questions as the initial data were in Greek,

- To familiarise myself with the interview material in more depth and
- To get a sense of what is happening both within the mind of each individual participant and within the sample as a whole so as to start thinking about emerging sub-categories.

While extended meaning units have to be reduced so that the ammount of words is lessened, it is important to avoid losing the content of the unit (Bengtsson, 2016). Thus, the purpose of the initial phases of the analysis was to form the data in a way that would be easier for me to handle and analyse while the meaning of each participant's response would remain unaltered. This is particularly significant since this was a research on psychoanalytic psychotherapy which has such depth and complex meaning, and works with contradictions and ambiguity of meaning.

Considerable effort was made to summarise the participants' responses without excluding any of their points or each reply's gist. A need was also noted to personalise these responses. It felt important to make sure that when someone reads these summaries s/he gets a very good idea of what the participants think and feel. For instance, as seen later Petros discussed one of his case studies wherein his female client worked on her long-term incestuous relationship with her cousin. Petros said that he was not enthusiastic about her therapeutic outcome, which was a detail that could be excluded from the presented material but it would reduce the meaning of what the participant thought and felt.

My data reduction process had three main phases each of which included a few steps: Firstly, I excluded the participant's comments that were unrelated to the interview questions, since I would apply a CA, which is based on the interview questions. Secondly, I lessened the words of each response by deleting unneeded material, such as repetitions, because they would not add essence to the participants' statements. Thirdly, I decided to focus on and analyse the participants' responses to most important interview questions. The importance of these questions was connected to the centrality of both the questions themselves and the emerging findings. Thus, I excluded the rest of the responses to the interview questions from the analysis. Each step will be further justified and explicated below.

Tesch (1990) invented the term 'data condensation', instead of 'data reduction', because in her words:

> "Of course, there is always material in the original data that is irrelevant to the research purpose, does not become assigned to a category, and therefore reduces the data mass... This is why I prefer the words data condensation, or data distillation as a description of the eventual outcome of a qualitative analysis. These words do not imply that the body of data has merely become smaller. Data condensation or distillation is a result brought about by interpretation" (pp.138-139).

Following Namey, Guest, Thairu, and Johnson.'s (2008) advice on effectively making large qualitative data sets more manageable, a series of 'structural' codes were developed and applied to the data. According to the authors, this approach works for data collected through structured or semi-structured interviews and question-based coding. Data reduction frequently occurs concurrently with data re-organisation wherein data are categorised and coded in relation to particular characteristics, consistencies, similarities, discrepancies, or other factors (Ravitch and Mittenfelner, 2016).

In the case of the present thesis, data reduction functioned as the first stage in the process of coding and CA of the whole set of interviews. To do this, I summarised all the participants' responses to each interview question. Thus, the coding in this initial phase of data reduction was question-based.

Taking into consideration the above, the first phase included the following steps:

i) Discussions irrelevant to the study's topic were excluded.
ii) An endeavour was made to find out whether each participant's reply could be expressed with a 'yes' or 'no' or a 'do not know', so as to prepare, for a descriptive analysis, their responses to my interview questions.

In the second step, all the responses were additionally summarised in order to prepare them for the qualitative analysis. According to Roulston (2014), interviews are edited to embody the central ideas and:

> "…Researchers reduce data by eliminating repetitive statements and data irrelevant to the phenomenon being examined" (p.304).

In this respect, the steps of the second phase were:

i) Repetitions of comments were excluded.
ii) Details of spoken language/ words of speech (like 'hmmm', 'err' etc) were excluded.

Thus, each interview question and its escorting probes/subquestions were assigned a code that was then applied or linked to the question and to each participant's response to this question in each data file. This led to a file which included all interview questions in the order they were presented to the participants, followed by a summarised, yet all-inclusive, version of each of the participants' replies to this question, in the chronological order that the interviews took place. A sample of the translated summaries of the participants' responses to interview questions can be found later (see Appendix 5).

Some groups of data were already being formed at this point. For example, the case studies, which were mentioned by the interviewees were moved to the end of the file (so as to find themes emerging from those, such as 'this number of interviewees mentioned one of their cases that were successfully completed') and noted for example 'please see CS (case study) [interview number], [page number]...' where this was relevant. The goal of this was to be able to see all the discussed case material together, so as to identify their commonalities and differences.

The huge amount size of the remaining data called for a kind of selective summarising, for the data to be lessened. Miles and Huberman (1994) described the meaning and choices of data reduction:

> "Data reduction is a form of analysis that sharpens, sorts, focuses, discards and organises data in such a way that 'final' conclusions can be drawn and verified... By 'data reduction' we do not necessarily mean quantification. Qualitative data can be reduced and transformed in many ways: through selection, through summary or paraphrase, through being subsumed in a larger pattern, and so on" (p.11).

In view of the above, for the third phase, further reduction of the data was succeeded by choosing my focus on certain interview questions. When I did the interviews I was unsure

about whether I would have so many interviewees or whether they would want to answer my interview questions. Since the size of the data resulting from those interviews was so large, I made a choice to focus mainly on the most central interview questions, rather than the prompt ones, and also to include the analysis of a few more questions that yield unexpected important findings. For instance, the interview question about the feasibility of an in treatment FRD, was not one of central ones, however, it highlighted participant's ideas about ways to elucidate clients' uncertain CSAM. As the participants' perspective showed how they approach CSAM, which is the key research question, and could also provide ideas about more effective work with sufferers of CSAM, the participants' responses to the interview question about the feasibility, was analysed in the analysis chapter.

Miles and Huberman (1994) maintained that:

> "...As data collection proceeds, further episodes of data reduction occur (writing summaries, coding, teasing out themes, making clusters, making partitions, writing memos). The data reduction/transforming process continues after fieldwork" (p.11).

Indeed, when something did not seem right at any later stage, I came back to these summaries and compared them to the original transcriptions.

### 2.2.3 Translating

On the subject of qualitative research including interviews and translations, Roulston (2014) wrote that:

> "Interviews conducted in languages other than the language of presentation involve further decision-making. Researchers let readers know the language in which the interview was conducted, at what point the analysis was undertaken and consider how translation impacts the overall presentation of findings" (pp.300-301).

Following the transcription and condensation of the interview data, the resulting material had to be translated from the language in which the interviews were conducted, that is Greek, to the language in which the analysis would be undertaken, that is English. This was an

important task so as to conclude their preparation for the analysis to occur. The impact of the translations will be discussed later (see section 4.6.2).

Simon (1996) stressed the importance of the researcher's understanding of various aspects so as to reconstruct the value of terms:

> "The solutions to many of the translator's dilemmas are not to be found in dictionaries, but rather in an understanding of the way language is tied to local realities, to literary forms and to changing identities. Translators must constantly make decisions about the cultural meanings which language carries, and evaluate the degree to which the two different worlds they inhibit are 'the same'. These are not technical difficulties, they are not the domain of specialists in obscure or quaint vocabularies. They demand the exercise of a wide range of intelligences. In fact the process of meaning transfer has less to do with finding the cultural inscription of a term than in reconstructing its value" (pp. 137–138).

Indeed, the precise translation of certain words was very hard to achieve. For instance, the Greek word 'θεραπευόμενος' means 'the one who receives therapy' and cannot be accurately translated by one English word. None of the terms used in the English language has the same connotation. For example, the word 'client' is also used in business transactions and the word 'patient' implies that the person is somewhat ill. I decided to use the word 'analysand' which is the one closer to the meaning of this Greek word and to the approach of this study's participants. Additional language issues will be considered later (see section 4.6.2).

Nikander (2008) underlines the magnitude of conveying the way choices were made regarding the translations:

> "Translating data extracts is not merely a question of 'adopting' or 'following' a 'transcription technique' but rather includes a range of practical and ideological questions concerning the level of detail chosen in the transcription, and of the way in which the translations are physically presented in print. The mundane and practical choices made as well as their analytic and theoretical implications are, however, often hidden from the reader and only rarely explicitly dealt with in research reports and written analyses" (p.226).

With respect to the above ideas, I tried to share as many details as possible in the current section. During the process of the Greek-English translation of the summaries the main way of thinking was the following:

The translations need not be very literal and flexibility was required as far as the use of the terms was concerned. Thus, importance was given to conveying the participants' meaning and not exactly what has been said by the participants (especially as these are summaries of the participants' replies). When something was not said but it was insinuated, it was put in brackets. For example, when I asked a participant, called Magda, whether she would question the reliability of a CSAM she said:

*"I started to question this [the reality of a CSAM] and to view it in a different light"...*

In order to avoid repeating the interview questions whenever I quoted participants' replies in the rest of this thesis, each sentence needed to make sense as separate extract. Hence, I thought it could be clearer if I mentioned in a bracket what the participant meant when she said 'this'.

I am not a translator, but I have been learning English since my pre-school years, my undergraduate and postgraduate studies were in English and I lived in London, UK, for five years. When I was unsure about the accurate translation of a word or phrase, I consulted various Greek-English dictionaries, that is, general, psychological and psychoanalytic. I also consulted the internet and a professional translator when it would be beneficial to do so.

### 2.3 Data Analysis

The current section will present the final stages of analysis and identify the ways the data were explored. The reasons why qualitative analysis was preferred will be explained and the study's ontological and epistemological positions will be clarified. The reasons why CA was chosen and the relationship between the different kinds of questions involved in the research will be offered.

### 2.3.1 Qualitative Analysis

As seen in the previous chapter (see section 1.2.2.1), qualitative research exploring CSAM and psychoanalytic practices has been scarce. The data of the present study will be analysed using a qualitative approach, more specifically, using CA, since it appeared important to understand the participants' views both qualitatively and quantitatively (see section 2.3.3). In this section, I will attempt to explain why I chose to analyse the interview data qualitatively.

It has been argued that, contrary to quantitative analysis, the results of qualitative analysis are not so generalisable and that they lack subjectivity (Taylor, 2005). This is the reason I decided to analyse my study's data through CA, so that the disadvantages of qualitative compared to quantitative research would be lessened.

Moreover, the quality of qualitative research, which refers to the transparency of the whole research process, has often been questioned (Seale, Gobo, Gubrium, and Silverman, 2004). This argument underlined my inclination to describe in detail the way the research question was addressed, put in context, approached and analysed.

Patton (2015) explained that qualitative analysis converts data into findings, while there is no specific formula for that conversion and straightforwardly advised the researcher as follows:

> "In short, no absolute rules exist except perhaps this: Do your very best with your full intellect to fairly represent the data and communicate what the data reveal given the purpose of the study" (p.522).

In accordance with the above, Klenke (2016) declared that:

> "An analysis of interview data should be sensitive to how the conversation is produced as interviews are social interactions. There is a general agreement that there are no fixed, predetermined ways to analyse interview data" (p.140).

In view of this argument, I allowed for these pieces of social interaction, their content and nature to affect my decisions regarding their analysis.

The subject of this research, mainly psychoanalytic practice, is one of reflective work involving unconscious material, thus the questions that would be asked are ones which require depth and thought rather than tick box answers. Moreover, qualitative inquiry allows both probing into responses or observations as required and obtaining deeper descriptions and more complicated explanations of experiences and beliefs in comparison with the quantitative approach (Guest, Namey, and Mitchell, 2012).

A mixed-method approach also seemed very mechanical and counter-intuitive to the subtleties of psychoanalysis. Psychoanalysis deals with in-between experiences among therapist and client, conscious and unconscious, past and present, fantasy and reality and so on. A mechanised method of analysis may not have the necessary sensitivity for dealing with the subtleties that will be present in the data about the actual practice of psychoanalysis.

The data was analysed qualitatively to enable the identification of the quality and complexity of the participants' responses. Qualitative analysis sheds light to participants' beliefs and reasons for their beliefs and offers the opportunity for deep understanding to the researcher (Barber, 2012). As McLeod (2001) clarifies:

> "Qualitative inquiry holds the promise of discovery, of generating new insights into old problems, and producing nuanced accounts that do justice to the experience of all those participating in the research" (p.1).

For all the other above-noted reasons, and not least to produce new insights into old issues, the data of the present study were analysed qualitatively.

### 2.3.2 Ontological and Epistemological Questions

According to Graneheima, Lindgrena and Lundmana (2017) the ontological positions of CA are open and fluctuate in line with the researchers' perspective. For this project, ontologically I position myself in the periphery of realism, assuming that reality could exist independent of interpretation, but aspects of reality are sometimes perceived subjectively through the individual's unique lens of meaning and influenced by the societal context within which s/he is functioning (see section 2.3.3.2 Between an Essentialist/realist and a Constructionist Approach).

Bengtsson (2016) explains accurately my main ontological position which is realist by describing the ontological stance of CA in the following quote:

> "All types of questions related to the aim of the study can be utilized when content analysis is used. Therefore, the researcher can never be certain that the method of data collection provides data that capture the real context of the informants. The words used by the informants may not correspond to the researcher's view of their meaning" (p. 10-11).

Thus, the words of the respondents may not be captured accurately by the interpretation of the researcher.

My epistemological stance is post-positivist, that is, data and knowledge collected reflects the reality and essence of the participants' position and experience. A description (either numerical or textual) is sometimes enough to accurately portray the knowledge offered by the participants. However, I also partially subscribe to certain elements of contextualism which take into account the context of the participants' reality in order to analyse the data (Madill, Jordan and Shirley, 2000).

Due to my epistemological position, I have chosen CA as my preferred method of analysis, so as to provide a rich description of the participants' position, the context of their position and my own position. In this respect, I can remain faithful to the reality of the knowledge offered by the participants but also acknowledge the context within which this knowledge was provided. Fundamentally, this is also my position regarding CSAM: although I understand that there are aspects of reality in the CSAM, these aspects need to be perceived and understood within the context of the intersubjective therapeutic encounter and the type and length of the therapy offered. This is why in this study I examine the participants' understanding of where psychoanalytic therapy in its specificity clarifies, and where it complicates, the nature of uncertain CSAM.

### 2.3.3 Content Analysis

As I was interested in getting specific responses to specific questions, a thorough analysis of the participants' replies to interview questions was provided. In this respect there was an attempt to describe the data through the use of numbers, for instance the numbers of interviewees who replied 'yes' or 'no' or 'uncertain/ do not know' to each question. Silverman (2011) proposed that:

> "Having discovered some phenomenon by qualitative means, there is every reason to see how frequently it occurs" (p. 4).

Additionally, Morgan (1993) had said that:

> "In essence, even the most qualitative of us often rely on an underlying logic of quantification to understand the patterns of our data" (p.117).

Thus, I also used numbers as descriptive percentages, such as the percentage of the participants who discussed a certain topic. This analysis was helpful as it revealed patterns in the participants' responses. These percentages were rounded up to the nearest whole number.

In exploring and analysing qualitative data, no recipes exist; only guidelines (Patton, 2015). Part of analysis includes uniting data units on the same subject, both within sole interviews and across many interviews (Klenke, 2016). The reasons why CA was chosen for this task as the most suitable approach for this particular data set will be presented below. The main methodological literature text this research was grounded in is a discussion paper by Graneheim, Lindgren and Lundman (2017), which mapped CA in the qualitative paradigm and explored methodological challenges in CA.

CA is a method of qualitative data analysis, which takes into account the quantity as well as the quality of evidence. The purpose of this method is to categorise the collected data and obtain meaning from it so as to reach realistic conclusions (Bengtsson, 2016). Bloor and Wood (2006) write about the aim, the application and the qualities of this kind of qualitative analysis:

> "The purpose of content analysis is to describe the characteristics of the document's content by examining who says what, to whom and with what effect. The method is

> performed by counting occurrences of themes, words or phrases within one or more documents. The approach is objective, systematic and concerned with the surface meaning of the document rather than hidden agendas" (p.58).

CA emphasises subject and context, as well as variation, such as similarities within and dissimilarities between parts of the text (Graneheim, Lindgren, Lundman, 2017). According to Mayring (2000), this method can be defined as a type of methodological, empirical, controlled analysis of material in terms of their framework of interaction. Bengtsson (2016) mentioned the importance and limitations of the researcher's knowledge when applying CA:

> "To have preconceived knowledge of the subject and to be familiar with the context can be an advantage as long as it does not affect the informants or the interpretation of the results" (p.8).

Thematic Analysis has been one of my options as a qualitative research tool for this study because it has been employed previously by researchers exploring experiences and needs of adult survivors of CSA when consulting mental health professionals and the latter's knowledge and experiences of working with cases of CSA (Barber, 2012). However, I chose CA over Thematic Analysis for two main reasons: Firstly, by using CA I was able to focus on the participants' actual repeated words and expressions, instead of grouping data according to emerging themes as is the case in Thematic Analysis. Secondly, in contrast to Thematic Analysis, CA allows for results to be described numerically (quantified). Vaismoradi, Turunen and Bondas (2013) write that measuring the frequency can be done through content (not thematic) analysis:

> "Measuring the frequency of different categories and themes is possible in content analysis..." (p.398).

Another important reason for choosing CA over other qualitative analytic methods concerns the sample size. It is true that if I had used an interpretative approach, such as IPA, or a biographical approach, such as narrative analysis, I would be able to explore the findings on a more personal level for each participant (Braun and Clarke, 2006). Nonetheless, I wanted to interview a large proportion of Athenian analysts, so as to grasp the gist and have a

representative picture of this contemporary practice in CSAM cases. My intention was not to have an idiographic view of each participant's views on CSAM, but to interview a large proportion of Athenian analytic therapists, so as to obtain an overall picture of an overall contemporary psychoanalytic practice in CSAM cases.

For the above-noted reasons, I believe that CA was the most appropriate as a method of analysis for the current research.

#### 2.3.3.1 Categorising

Following both the familiarisation with the literature on psychoanalytic practice in CSAM cases, and the collection and preparation of my data set, conceptualising possible categories and sub-categories was a rather uncomplicated task. Hence, I did not have to use computer-programs which would both speed up and facilitate the process by locating codes and categorising the data, as soulless software cannot substitute the human creativity of the researcher, who must still make the final decisions and draw conclusions (Σελίδα: 141 Bengtsson, 2016).

Klenke (2016) wrote that:

> "In addition to concepts derived from transcripts, field notes and ideas for themes relevant to the research question may also come from the literature. The concepts and themes identified by the researcher, in turn, may suggest new, related concepts and themes that can lead to the construction of a typology" (p.142).

In agreement with the above and as seen in the analysis chapter, the six categories were analogous to my interview questions and the grouping of these categories shaped the superordinate categories. For instance, the first category (see section 3.1.0) corresponded to my first interview question, explicitly regarding whether participants had observed changes in their practice involving clients' CSAM. This category, alongside two others, formed the superordinate category which involved the changes, dilemmas and risks entailed in the handling of CSAM (see also sections 3.20 and 3.3.0).

In contrast to other qualitative research methods, in CA, the researcher can add information by presenting some quantification in which categories and sub-categories are counted (Bengtsson, 2016). The first section in each category provided the numerical analysis of the participants' responses to my interview question, meaning the 'yes', 'no' and 'other' responses. For instance, in the first interview question, 90% of the participants stated that they had observed serious changes in their work involving CSAM, 3% that they have not observed changes, and so on.

Following the numerical analysis, the participants' responses to the interview questions were also presented in sub-categories which focused on relevant issues, such as expressing worry regarding therapists' depth of inquiry in cases relating to CSAM. Most of the participants' replies were partially quoted within these sub-categories and several replies were included in more than one sub-category. These sub-categories were derived from my literature review and research focus, alongside the participants' common ideas, as explained next.

Bengtsson (2016) argued that when the study has a researcher-driven or deductive reasoning design (see section 3.3.3.3), as my study mainly has, the researcher has to develop a coding list prior to initiating the analysing process. I tried to brainstorm ideas on sub-categories, which sourced back in already-read material from the literature, while I kept in mind my research question.

Graneheim, Lindgren, and Lundman (2017) wrote about categorising and having more than one person doing this to achieve dependability:

> "During the phase when categories are created, there is the challenge of deciding which codes and supporting quotes from the original text are to be included in a category. This is a matter of dependability... Another challenge to dependability is the view that the interviews are co-created between the researcher and the interviewee, and between the text and the researcher in the analysis process. It is therefore necessary to be aware of, and open about, the researchers' pre-understandings, as these can influence the way questions are asked, what follow-up questions are asked, and how the interviewees' narratives are perceived and interpreted. Including more than one researcher in the analysis is one way to address

> dependability as... a co-researcher can come up with alternative interpretations. This co-creation in the analysis is often described as consensus" (p.33).

In consideration of the above, two more coders proposed possible codes for sub-categories both before and after reading the interview material.

Therefore, the sub-categories partially emerged from my brainstorming, the literature gaps and the interview material as a result of direct questioning. For instance, the third sub-category of the first interview question/category focused on the participants' uncertainty in relation to the reliability of CSAM as an observed change in their relevant work. This issue has been explored in the literature as seen earlier (see sections 1.2.1.3 and 1.2.1.5).

The effect of the researcher on both the development and the selection of the sub-categories is acknowledged and absolute objectivity is impossible. All the participants' answers and referrals to the subjects of the sub-categories will have been influenced by my interview questions and unconscious communication. Moreover, my preferred topics could have also played a role later during the formation of each sub-category. In reality, the analysis of this study will include topics that have been either directly or indirectly elicited as responses to the interview questions I developed following my research on the topic I chose.

I had already detected certain sub-categories within the participants' responses to interview questions in my data set during the processes of interviewing, transcribing, summarising and translating. The most popular topics in the participants' responses to each interview question were clustered to create the rest of the sub-categories explored in relation to each interview question. For example, in response to the first question/category, most participants discussed what the cause of their change was, so this formed the second sub-category (see section 3.1.2).

As I could neither know nor control what the participants would reply to my interview questions, the resulting sub-categories were mainly based on the participants' desire to explore them. Significance was attributed to any issue – apart from the initial interests in the field - which emerges as an issue in this analysis. Indeed a few of the sub-categories analysed in this research, bear little resemblance to the content of the interview questions. For example, the fourth sub-category of the first interview question/category underlined the depth

of the exploration in CSAM as an identified change occurring in the participants' practice (see section 3.1.4).

Bearing in mind the researcher's impact, there was an attempt to maintain a way of dealing with the interview data which has been systematic and as objective as possible. Silverman (2011) affirmed that by focusing attentively on the co-production of interview talk, one can see the point of content without importing a more personal sense of what content is important. Hence, instead of searching only for pre-conceived themes in the talk, I needed to perceive when and how the participants allowed me to view particular features of their realities. Some of these features were communal among participants and appeared often in the data, and after many reads of the same material, I had created a sense of the most discussed topics.

In view of the above, the participants' views played an important role regarding which topics would be brought up as a response to my interview questions. I provided the context and they provided the content.

Silverman's (2011) writings influenced the presentation of the sub-categories presented in the next chapter:

> "Analysis should not just pick up 'themes' from what interviewees say. You need to show how your claims can account for the specifics of the talk, not just its broad themes" (p. 201).

Following the formation of the sub-categories, I presented the specific quotes wherein the specific meaning of each sub-category was being analysed so as to illustrate the participant's exact position. For instance, in the second sub-category of the first category, I included parts of some quotes that accounted for what brought about the changes in the participants' handling of clients' CSAM (see section 3.1.2). For instance, a participant, Takis, said that the changes he observed were a product of time and experience.

The consequent knowledge from the coding and analysis of the data will be presented and discussed in the following sections.

#### 2.3.3.2 Between an Essentialist/realist and a Constructionist Approach

One of the basic choices to be made when conducting a qualitative analysis is whether it will serve as an essentialist or a realist method, which reports experiences, meanings and the reality of participants, or as a constructionist method, which examines the ways in which events, realities, meanings, experiences and so on are the effects of a range of discourses operating within society (Braun and Clarke, 2006).

To begin with, while my study's approach contains elements of both methods, it is more essentialist than constructionist. This choice was made considering the great quantity of data that needed to be analysed, so it was necessary to simplify the tasks as much as possible. The essentialist approach was judged as simpler than the constructionist one, since it focuses only in the participants' meanings - and not in both the meanings and the influences of the societal context. Additionally, in comparison with a constructionist approach, which would be hard to combine with numbers, the essentialist approach matches more with the essence of CA. In other words, my research is more realist (ontological position) and aims to access the participants' meaning through interview questions.

Nonetheless, constructionism seems broader as it offers us a view of the interactional contribution of both participant and researcher, while it also takes into consideration the implicated cultural resources (Silverman, 2011). This study will focus on: contemporary psychoanalytic practice on CSAM and influences of past debates and contributions. The first point of focus, that is contemporary practice, could be more linked to an essentialist or realist method, which describes the participants' reality. The other point of focus, meaning the link between the history of Freudian ideas and contemporary psychoanalytic practice on CSAM, could be more linked to a constructionist method, which examines things from a more contextual viewpoint.

Moreover, part of the topic of this thesis is related to the effect one's words have over the other, explicitly on false CSAM creation during psychotherapy, allowing for the possible influence of both specific others and the society as a whole on the individual, which is also more linked to a constructionist method. Furthermore, this study's CA cannot be purely

‘essentialist’ in its character as my involvement in both the direction of the interview and its content is recognised. Silverman (2011) wrote:

> “According to constructionism, interviewers and interviewees are always actively engaged in constructing meaning” (p.169).

Simultaneously, there have been some points that involve the essentialist paradigms. For example, I created a long set of questions to be used in semi-structured interviewing. Moreover, I dealt with the interview data in a way as systematic and as objective as possible: although the categories described in the analysis chapter were corresponding to the interview questions, I chose to discuss the most popular responses among the participants in the sub-categories.

Bearing in mind the above, it seems that I have clearly steered the interview process in the directions I wanted to follow and was interested both in seeing how participants replied to these specific questions and in what ‘emerged’ from the participants’ replies when they were allowed to expand and explore further each question. Psychoanalysis is also ‘flirting’ with both sides. On one side, it involves psychotherapy, which has been defined by Frank (1986) as:

> “The attempt of one person to relieve another’s psychological distress and disability by psychological means” (p. 1).

This description involves the influence of one individual towards another, serving the constructivist viewpoint. On the other side, simultaneously, in the classical psychoanalytic therapeutic stance, the therapist tries to minimise his or her influence on the analysand maintaining a more neutral position (Laplanche and Pontalis, 1973), which is closer to an essentialist position.

Moreover, the participants’ statements were often contradictory on this. On one hand, participants reported feeling uncertain when working with CSAM cases (see section 3.1.3) which is closer to a constructivist way of thought. On the other hand, a few of the participants seemed to operate with an essentialist frame, where they talked about their patients with unquestioned pathologies (for instance, see section 4.2.1). Perhaps this also reflects

something about the way psychoanalysis, as a discipline, has changed over time alongside the development of ideas of social construction and intersubjectivity.

Overall, there are points where a constructivist approach (where the truth is co-constructed in the interaction between the researcher and the participant) is involved in this thesis, and other points where the approach is a realist/essentialist one (where the truth emerges out of the participants' replies as the researcher tries to bracket out or minimise his or her involvement and influence). Thus, this research lies between a realist and a constructivist approach. This is mainly so because the current research attempts to find out what analysts really think about their work in CSAM cases, while it also aimed to obtain specific responses to particular questions.

#### 3.3.3.3 Focus, Way and Level of Analysis

The focus of the present analysis involves mainly a meticulous account of certain particular aspects, and to a less extent a rich thematic description of the data. Thus, attention will be given to individual aspects, such as the FRD, through the analysis of interview questions. Individual details will also be highlighted where necessary, for instance, when I provide interesting information about a participant before his/her relevant saying. At the same time the topics identified, coded, and analysed will accurately reflect the content of the data (Braun and Clarke, 2006). To ensure an accurate reflection of the data, in the participants' quotes I put in parentheses the parts I summarised - rather than precisely translated. In view of the above, the reader is provided with the meaning of the prevailing or key themes and a fertile wide-ranging account is made, alongside a brief focus on special details.

As far as the way of the analysis in this study is concerned, categories and sub-categories within data were mainly identified in a theoretical, researcher-driven, deductive or "top down" way, while the sub-categories were also including an inductive, data-driven or "bottom up" way. In the deductive approach the way of analysis is more analyst-driven, while in the inductive approach, the themes identified are clearly related to the data per se (Braun and Clarke, 2006). The current study included both ways as pointed out next.

In my study, most of my findings were directly linked to my interview questions, which were in turn determined mainly by my theoretical interest in the area and, in a lesser degree, the

sub-categories were found in a data-driven way. In more detail, I grouped the participants' responses to the interview questions so as to inform my categories and subcategories as I was looking for specific answers and also to see what emerges from the answers. Therefore, my analysis did involve groupings in relation to the questions rather than a grounded theory approach where you tend to forget the questions completely. Thus, the way of the analysis was mostly research-driven, "top down", theoretical or deductive.

All categories were related to interview questions, yet the sub-categories were chosen more on the basis of the number of the participants' referrals to each subcategory's topic and not as much by the interview questions or by my interests. Therefore, a part of the specific research question has been explored through the coding process, which maps onto the inductive approach (Braun and Clarke, 2006). However, it is inevitable that my own assumptions partially both led my analysis in certain directions and excluded other directions in the discussion of the qualitative analysis. The issue about my influence will be additionally analysed in the self-reflexivity section (see section 4.7.0) of this thesis.

Graneheim, Lindgren, Lundman (2017) explained how a deductive approach is applied in research:

> "Using a deductive approach... researchers test the implications of existing theories or explanatory models about the phenomenon under study against the collected data. They move from theory to data or from a more abstract and general level to a more concrete and specific one" (p.30).

In my study, I examined the implications of previous writings against the collected data through a meticulous comparison between previous findings and my findings in the discussion chapter (see section 4.1.3).

In relation to the level of analysis, I had to choose between a manifest analysis or a latent analysis. According to Vaismoradi, Turunen, and Bondas (2013):

> "The use of qualitative descriptive approaches such as... content analysis... is suitable for researchers who wish to employ a relatively low level of interpretation, in contrast

to grounded theory or hermeneutic phenomenology, in which a higher level of interpretive complexity is required" (p.399).

As aforementioned, I wanted to obtain specific answers to specific questions, and I had to handle a large amount of both interviewees and data. In CA, the depth of the analysis depends on the way the data are collected, and I mainly worked through each identified category, so the current study relied on a manifest analysis (Bengtsson, 2016). In other words, it was decided to identify the sub-categories at a semantic or explicit level, that is, directly observable in the information, instead of a latent or interpretative level, that is, underlying the phenomenon (Boyatzis, 1998; Braun and Clarke, 2006). More specifically, as I preferred manifest analysis for the present research, I had to describe what the respondents really said, remain close to the text, use the participants' words, and illustrate the apparent material (Bengtsson, 2016).

A relevant issue is noted by Silverman (2011), who stresses that the kind of status attached to one's data must be justified and explained. In this study, interview responses were perceived more as offering access to 'experiences' rather than as constructed 'narratives' which are themselves in need of exploration (Holstein and Gubrium, 1995).

In further analysis, there is a debate about whether it is right to assess interview accounts as true or false, which poses the question about whether it is helpful to examine the accuracy of the participants' accounts (Silverman, 2011). In the current research this could be done, for example, by comparing their accounts to their case notes but something like this may have interfered with the analyst-analysand confidentiality agreement. This agreement mainly states that everything said between the psychologist (or analyst) and the client will remain confidential unless there is a risk of self-harm or harming others (Association of Greek Psychologists, 2014).

On a different note, it might be imperative to recognise the various social environments in which scientists report on their work (Silverman, 2011), although thorough inspection of these influences would form a whole other thesis. I hold that both the participants' and the researcher's accounts are influenced by each other during the interview process, alongside by the social environment as a whole.

### 2.3.4 The Relationship Between the Different Kinds of Questions Involved in the Research

> "There is a need to be clear about the relationship between the different questions involved in qualitative research. First, there is the overall research question or questions that drive the project. A research question might be very broad (and exploratory)" (Braun and Clarke, 2006, p.15).

In this study, the overall research question involved the current psychoanalytic approach to CSAM cases of adults in Athens, Greece.

In keeping with Braun and Clarke (2006):

> "Narrow questions may be part of a broader overarching research question, and if so, the analyses they inform would also provide answers to the overall research question. Although all projects are guided by research questions, these may also be refined as a project progresses" (p. 15).

In this research narrow questions involve the influence of Freudian theories and past debates regarding CSAM on contemporary practice. These are closely linked and add value to the main research question regarding Athenian contemporary psychoanalytic practice with CSAM of adult clients. Narrow questions were indeed refined during the initial stages of this research. For instance, an earlier version of this thesis involved the influence of other psychoanalytic theorists, such as Klein.

Braun and Clarke (2006) then go on to list the interview questions as the second kind of questions involved in qualitative research. The interview questions (see appendix 4) were rooted in both the research question and the narrow questions. For instance, the interview question "Would you question the reliability of a CSAM?" is meant to aid in introducing the therapists' position in cases involving uncertain CSAM, which is linked to the research question about psychoanalytic practice in CSAM cases. As another example, the interview question "Do you think that there is a possibility for the analysand to be retraumatised due to the therapists' reaction to the disclosure of CSAM?" is associated with the narrow question

about past psychoanalytic influences, such as Ferenczi's (1949) assumption that the patient could be retraumatised in CSA cases.

Braun and Clarke (2006) added that:

> "Finally, there are the questions that guide the coding and analysis of the data" (p. 16).

In this study, these questions included the sub-categories which seemed to be formed following the completion of the first dozens of interviews. The relationship of these questions with the research question is apparent, although it was not a pre-requisite.

## 2.4 The Validity and Ethics of the Current Research

In the present study, much attention was given in optimising standards relevant to both research validity and ethics as seen below.

### 2.4.1 Validity of Findings

There appears to be disagreement regarding which concepts must be employed so as to best evaluate the quality of research anchored in CA, as it has been argued that CA can be subject to either quantitative research criteria, namely validity, reliability and generalisability, or other concepts, such as credibility, dependability, and transferability (Bengtsson, 2016). Whatever the case may be, the choice of concept is not as important as to the way the concepts are discussed in association with 'trustworthiness', as in qualitative research there is no absolute 'truth', and the results are almost impossible to be replicated since the data emerge from a particular concept (Bengtsson, 2016).

In his discussion concerning concepts regarding trustworthiness, Bengtsson (2016) correctly underlined that every study should be receptive towards both assessment and criticism, and also that in the report the research process and the findings must be contemplated with respect to issues related to trustworthiness. First of all, I accentuated my own critique of my approach in the reflexivity section (see section 4.7.0). Secondly, I was open to every evaluation I was offered by supervisors, examiners, coders, translators, participants, and

colleagues. To facilitate both the participants' and every other evaluation, I used endnotes to state which participant(s) supported each view described later (see chapter 3), as well as samples of the participants' responses to my interview questions (see Appendix 5), so that the reader can see which responses were assigned to each sub-category. Credibility concerns the research process, and aims to determine the ways in which the procedures relevant to both the data and analysis are conducted, and the co-agreement achieved between experts was meant to advance the credibility of my study (Bengtsson, 2016).

Research credibility, which corresponds to validity (Bengtsson, 2016), was also increased by my acceptance and understanding of my influence in the data and the results. I have stressed this influence in various points throughout this thesis and did not shy away of considering my own flaws whenever necessary (see section 4.7.0). I did systematic work for this research, but this was obviously done to minimise my impact. Nonetheless, complete control of this impact is impossible.

As far as research validity is concerned Dale (1999) wrote:

> "Ultimately, the validity of qualitative research rests on transparent method and the plausibility of the analysis. The focus and goals of qualitative research vary from the level of detailed description of a phenomenon to abstract levels of theory generation" (p. 58).

The transparency of the method was prioritised and every process was portrayed in great detail in the present chapter.

The plausibility of the analysis was also underlined by various measures described next. The credibility of the coding and analysis procedure was increased by

- my studying of ways to achieve it,
- the expert supervisors who closely examined each process,
- the other coders whose work ensured that the sub-category selection was as valid as possible,
- the statements of the participants being directly quoted in the following chapter,
- the careful reading of the relevant literature presented in the previous chapter, and

- the thorough comparison between the findings and the literature material in the discission chapter (see chapter 4) (Barber, 2012).

Research validity was also enhanced as two colleagues, who were not involved in the study, went through the whole text, suggested revisions and finally judged that my findings were transparent and reasonable (Bengtsson, 2016).

To increase the level of dependability - which corresponds to reliability and is related to stability, meaning the degree to which data alter over time and the changes decided by the researcher throughout the analysing process – it is important to record both coding decisions and modifications since relabeling and re-coding are frequently essential (Bengtsson, 2016). I kept all previous versions of both my thesis as a whole and every step of all the procedures entailed, not least in relation to alterations in data and analysis. As mentioned earlier, dependability was also increased by having two more coders to help in the categorising of the data (Graneheim, Lindgren, and Lundman, 2017) (see section 2.3.3.1).

Transferability- which corresponds to generalisability and relates to the sample size and to the extent to which the findings may be applicable to other settings or groups– depends on how representative the sample is which determines how generalisable the results will be (Bengtsson, 2016). The large thesis size (when compared to a size of an article or a dissertation) allowed for me to include both the depth and the breadth of the subject being study, explicitly psychoanalytic practice involving CSAM. This was succeeded by having a large sample (in terms of qualitative analysis) which accounted to approximately 30% of the whole population of Athenian analysts. Moreover, I included analysts, analytic therapists and trainees in my sample because individuals may choose anyone from the above-noted categories when they choose to become analysands (see section 2.1.1). Furthermore, a detailed and precise account of the study's context was provided in the literature chapter (see chapter 1) and the methodology chapter (see chapter 2), as it is essential for the transferability of the findings (Graneheim, Lindgren, and Lundman, 2017). Lastly, as aforesaid (see section 2.1.1) the choice of participants is crucial for the transferability of the findings (Graneheim, Lindgren, and Lundman, 2017), so I managed to recruit very experienced psychoanalytic therapists and experts on the field of CSAM as participants in the present study. However, it should be noted that my sample was not a random one, which increases its representativeness,

but rather one of convenience, as I contacted the whole registered population (that is, Athenian psychoanalytic therapists).

According to Graneheim, Lindgren, and Lundman (2017) the researcher will ease the reader's judgement by ascertaining precision throughout the study's processes and by explaining how and why choices were made. The authors added that**:**

> "To ensure the overall trustworthiness of a study, it is also a challenge to make clear whose voice is heard in the various parts of a research report: the participants' voice or the researchers' interpretation" (Graneheim, Lindgren, and Lundman., 2017, p.3).

Taking this into account, I clearly differentiated my voice from the participants' voices throughout the text, and I explicated each step of the research procedure in great detail.

### 2.4.2 Research Ethics

Ethics approval for the current research was sought and achieved by the Department of Professional and Community Education Research Ethics Committee of Goldsmiths, University of London through a completion of a form which described all procedures and instruments in detail (see appendix 1). I also adhered to codes of ethics proposed by the British Psychological Society and the Association of Greek Psychologists, which are the main psychology groups in the country where I studied and the country where my research took place correspondingly.

All rules were followed meticulously as listed next: Participants were informed through the information/consent form (see appendix 2) about the purpose of this research, about their right to withdraw from participating. The participants were provided with the contact details of my supervisors and they were encouraged to discuss any issues emerging of the interviews with them. At the end of each interview, I reminded them that if anything was upsetting or unsettling for them they can contact me or my supervisors, and/or discuss it with their therapists and supervisors. All measures to achieve confidentiality and anonymity were taken.

The names of all the participants were replaced by pseudonyms and only I had access to the signed consent forms which were the only documents including the participants' actual

names. Furthermore, I did not use any interview material that could make the interviewees or their cases identifiable in any way. For example, participants' descriptions of their clinical cases were not quoted so as to exclude any material, such as their place of work, which could render either the participants or their clients as recognisable.

**Conclusion**

To sum up, the current chapter involved explanations for my research choices, such as why I interviewed 31 analytic therapists using a semi-structured interview plan. The interview procedure was also thoroughly presented, as well as other processes involving transcribing, summarising, and translating.

In this research CA was chosen as my method of research as it closely represented my ontological and epistemological positions explained above. The analysis will be conducted in a manifest or explicit level.

The current section also included the different types of questions employed in this research which have been presented, analysed and interlinked. Attention was drawn to the quality and ethics of the present research.

In the following chapters, I will concentrate the resulting findings and demonstrate whether the findings of this study, which will reflect current psychoanalytic handling and intervention of CSAM,
(1) contradict previous psychoanalytic and psychodynamic theories and research findings and
(2) reveal preferable ways of handling cases with CSAM.

## Chapter 3: Analysis

### Introduction to Analysis Chapter

This thesis aims in understanding the psychoanalytic approaches of Athenian analysts to memories of early sexual trauma. The main research question involves practical approaches in controversial issues. In the previous chapters I investigated the literature and the debates about CSAM and psychotherapy. I also explained the methodology and method of analysis I employed to explore this subject.

In the current chapter, the descriptive analysis of several related interview questions will be explored. As I am analysing the responses to my questions, I am finding out what all the participants seem to share, where they differ from one another and what is said by individuals only.

In each of the forthcoming sections I will analyse the participants' responses to one of my interview questions. I will present the products of my inquiry in relation to the following crucial issues:

1. the changes therapists have observed in their own professional practices,
2. their approach to suspected CSAM before its disclosure,
3. their views on the client's in treatment retraumatisation,
4. the possibility of questioning a client's CSAM,
5. their conclusions about the feasibility of the FRD in client's CSAM, and
6. their understanding of the therapists' responsibility in the FRD in client's CSAM.

In each category, firstly, the 'yes', 'no' and 'other' replies will be mentioned, and the reasons that the participants' approach changed will be presented. Then, other commonalities between participants' responses will be pointed out. These relate to the therapists' approaches, and feelings when working with CSAM. When the participants' responses have already been fully quoted earlier, they will be presented in brief in the following relevant sections. The results of the CA will be presented in two superordinate categories, each

including three categories, which entail three to six sub-categories (see table 3.3 in appendix 3).

## Superordinate Category A: Handling of Child Sexual Abuse Memory: Changes, Dilemmas and Risks

In my perspective the therapist's work, especially when it involves CSAM, is full of changes, dilemmas and risks. Changes are occurring because therapists should seek to professionally evolve continually, there are dilemmas troubling them since they cannot be certain that they have leaned on the right side of the endless debates within scientific circles, and risk-assessment usually plays a role in therapists' endeavours to avoid harming a client who has trusted them to help him/her be more content or at least more functional. The position of analytic therapists on such pressing issues will be explored in the current superordinate category.

### 3.1.0 Is Each Therapist's Handling of Child Sexual Abuse Memory Changing?

Participants were asked: 'Have there been any changes in the way you work with and handle CSAM?'. Most participants replied positively and their replies will be grouped and presented in the forthcoming sections.

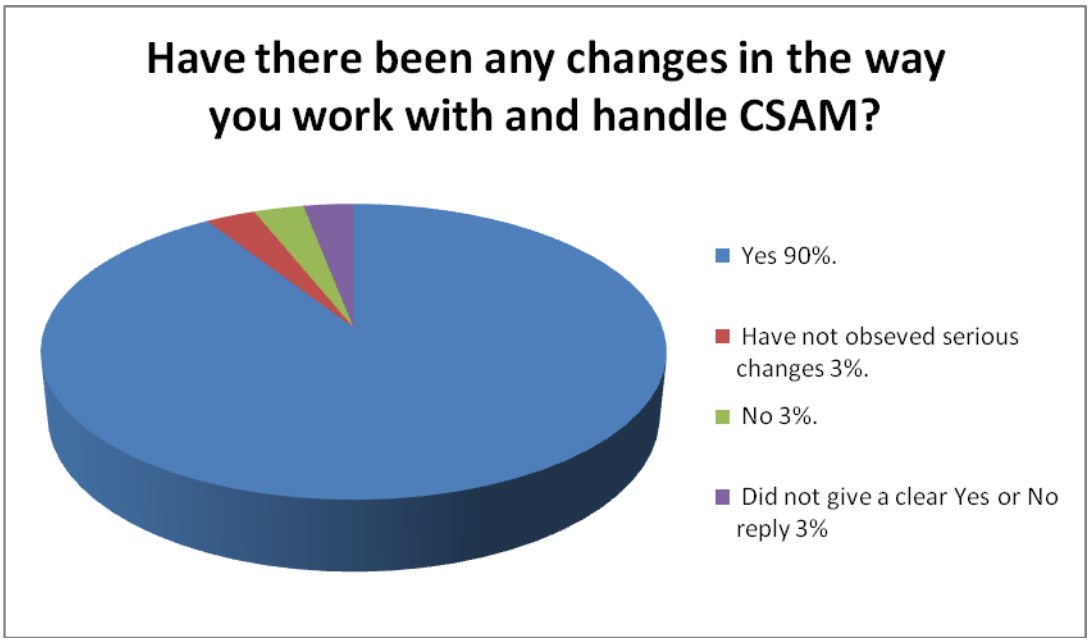
### 3.1.1 Numerical Description of the Responses

As seen in chart 1 below, out of the 31 participants, 90% ($28^1$) replied affirmatively. From the remaining participants, 3% per cent ($1^2$) replied very briefly that they had not observed serious changes, 3% ($1^3$), replied negatively, and 3% ($1^4$) did not give a clear yes or no reply to this question. The last two responses under discussion here were very brief. For instance, Mirsini[5], said that:

*"I basically work with children and adults and I have an overall view of my work."*

Thus, the overwhelming majority of the participants have changed the way they work as psychoanalytic therapists in CSAM cases.

Chart 1: Responses regarding changes in the handling of CSAM




### 3.1.2 Therapists Who Brought Up What Changed Them

Although this was not directly asked, 55% (17[6]) of the therapists who participated referred to the reasons for changing their approach towards CSAM. These reasons were connected to various elements. To be exact, a changed approach was connected to:

- practical experience by 23% (7[7]) of the participants,
- time by 19% (6[8]) of the participants,
- knowledge (including training and readings) by 13% (4[9]) of the participants,
- theory being different than practice by 6% (2[10]) of the participants,
- personal growth by 6% (2[11]) of the participants,
- the work done on myself as a therapist by 3% (1[12]) of the participants,
- supervision by 3% (1[13]) of the participants,
- cooperation by 3% (1[14]) of the participants,
- general unawareness about the topic at the start of the career by 3% (1[15]) of the participants,
- evolution of the technique by 3% (1[16]) of the participants.

Almost 67% (4 out of 6) of the participants who answered that time was a factor that made them change their approach to CSAM cases were male. This is a significant portion of the sample if we take into account that only 29% (9 of the 31) participants were male.

Quotes of the participants' responses relating to changes in their professional approach towards clients' CSAM can be found next. Antonis and Malvina discussed how their approach changed through their practical experience. Antonis[17] noticed multiple changes in his perception:

*"When I had less experience, I used to take things more literally and less seriously than I do now. Now, I understand this issue in its wider context, as I have in mind more levels, more categories and more cases".*

Malvina[18] observed that, in response to clients' disclosures, she gradually learned how to handle them, to become get less upset, and to have reasons to be calm:

*"Always, because at first the point is not only about what is brought up, it is about not knowing what to do with the information. Afterwards, it's like you learn, you obtain another viewpoint and perhaps certainty, the good kind of certainty not the I-know-it-all kind, you become less upset. It's like you move alongside these cases and you have seen results in others, so this calms you".*

Ilias[19] noted how time affected his approach as psychoanalysis facilitates more mature perspectives of one's own history:

*"Over time I think that gradually this has improved, meaning that within this psychoanalytic procedure one can have a more mature view of the past, and that this is the purpose of the meeting".*

Lefteris[20] said that sometimes theory differs from practice:

*"There have been changes that both confirmed and refuted specific theoretical views that I had learned during my training".*

Petros[21] accentuated the importance of both supervision and maintaining the analyst's neutrality:

*"Speaking in general terms, because I have done thousands of supervisions after all these years, therapy becomes more interesting [for the analyst] and the analyst's emotion is triggered. The analyst's neutrality is also needed here because it may awake within us [the therapists] corresponding memories of seduction that we experienced or wished for"…*

As seen in this sub-section, most of this study's participants discussed the source of the changes in their work with CSAM; and experience appeared to be the most popular source for the changes.

### 3.1.3 Therapists Who Expressed Uncertainty Towards the Reality of Child Sexual Abuse Memory

Although the interview question about the changes in handling of CSAM (that is, 'Have there been any changes in the way you work with and handle CSAM?') was one of the first questions the participants were asked, almost 22% ($7^{22}$) of them appeared uncertain about the veracity of CSAM. The relevant quotes will be reviewed below.

Nota[23] said that experience makes therapists more comfortable and less penetrating which is sometimes an instinctive reaction in order to distinguish between reality and fantasy in CSAM:

*"Certainly when you are more experienced as a clinician you do not feel awkwardness but also you do not become penetrating... Very often a sense exists that this may be a net of childhood fantasies and maybe you defensively press so as to understand how much reality the memory contains".*

Nota also advocated that this penetrating approach changes with time:

*"I think that this goes away with time, you know that... as long as you have a good therapeutic relationship, this will be brought up again, and you do not insist that much on the details of the narration".*

Magda[24] indicated that with time she became able to doubt CSAM:

*"I started to question this [the reality of a CSAM] and to view it in a different light. It could possibly be a false memory depending on the patient's pathology. While in the beginning such information was always too shocking to disbelieve, now I am in a position where I can also doubt it".*

Efi[25] argued that she became more careful because of the scientific attention to false and uncertain memories:

*"The technique, the knowledge and the approach of each therapist changes and improves over time… One becomes more careful since all these discussions, texts and situations regarding false or uncertain memories appear".*

Ira[26] claimed that although she became more reluctant toward CSAM, she attaches equal importance to the experience:

*"I hear the other person's account but I hold more doubts about whether this is an actual occurrence without attaching less importance to what is brought up as part of the experience. I keep in mind the possibility that s/he may slowly realise that the actual event may not be as traumatic as his/her narration would suggest".*

Aphrodite[27] explained that she used to focus on the client's exaggeration or in the actual event, whereas later she focused on how the experience has been internalised:

*"I think that like in all subjects, while you grow older and while experiences are added, psychological maturity is enhanced. Listening to someone, I was either thinking that s/he was exaggerating about it, as though I was seeing a hysterical part in it, or I was much more oriented towards the reality about what that person went through. Now I understand that the actual fact is not as significant as the way it has been internalised in the person and the way that this person brings it up".*

Aris[28] started working in the early 1980s, which was when the issue of CSA was starting to become known. He said that he used to treat such memories as fantasies or to overlook them:

*"When such memories came up in therapy during the first years [of my training] they were handled either as a fantasy or, when they came up in a more indirect way, I did not realise their existence"…*

Aris also maintained that he later became able to distinguish true from fantasised memory:

"*The most important change was that I became capable of detecting basic things on the issue, like when a memory is related to a fantasy that is experienced and presented for psychopathological reasons as a reality during therapy… Great experience is required so as to distinguish between reality and fantasy... Real CSA is disclosed after therapy progresses, not in the 1st or 2nd year".*

Aris remembered a case of a teenage girl who had supposedly been sexually abused by her father. Practitioners always had the principle of believing that the child was speaking the truth and they had started the processes of legal intervention. After 1-1.5 months of systematic hospitalisation within a psychodynamic context they recognised that this whole thing was a fantasised account. Then they changed the approach: the child entered a psychoanalytic psychotherapy, three times per week, she was allowed to leave the hospital and both parents started therapy. From the first year things had already changed, and gradually this child's symptoms were removed.

Vicky[29] discussed a case involving unclear boundaries and uncertain CSAM. Her female patient was in therapy for a very long time and suffered from borderline personality disorder. Her mother suffered from depression and used to put her to sleep with her father when she was younger. Her father presumably touched her inappropriately for a moment.

This sub-section underscored how contemporary psychoanalytic therapists connect their uncertainty regarding CSAM authenticity to the changes in their clinical approach.

### 3.1.4 Therapists Who Discussed the Depth of Their Exploration in Child Sexual Abuse Memory Cases

More than 19% (6[30]) of the participants appeared to worry about the depth of their inquiry in CSAM cases. As seen from her quote above, Nota[31] emphasised how inexperienced clinicians may become penetrating in their effort to understand how much fantasies have influenced a CSAM. The rest of the relevant quotes will be reviewed below. Stella[32] stressed respecting the clients' pace during the constant processing of early traumatic memories:

*"They [CSAM] inevitably constitute an object of constant processing, so I have to come back to them – a field that needs attention and respect to the other's [analysand's] pace".*

Sotiris[33] was also conscious about raising the issue of early sexual trauma less than he did before:

*"Obviously. As time goes by, I raise the issue [of CSA] less than I did before, I am trying to keep in mind small details that I will relate to it. I will not say anything, but I wait for it to come slowly".*

Rita[34] said that she used to hesitate deepening the inquiry in cases involving CSAM:

*"I hesitated to deepen the inquiry before, but now I [am not afraid to] ask and listen".*

Angeliki[35] highlighted the need to deepen the work with the family, and the issues that were difficult for her, like the patient's sexual fantasies regarding herself:

*"Before, I thought that finding the memories was the therapeutic solution per se. Now I believe that this is where the therapeutic work starts… More work is required with the setting, the family, especially in cases involving more serious psychopathology etc. I would explore more than I used to in the past, issues that used to be difficult for me, such as the patient's sexual fantasies about myself".*

Agapi[36] laid more emphasis on what is not told by the client:

*"I have changed… I may simply give even more importance to what is not told [by the analysand]... I have found to my amazement that while one would think that someone who has experienced something so traumatic… would have the need to say it in order to get over it and, in contrast, it is split [removed from consciousness]".*

As seen above, some psychoanalytic therapists tend to either avoid discussing CSA or to appear penetrating at their beginning of their career. They also seem to manage to avoid these reactions later in the professional lives.

### 3.1.5 Therapists Who Tend to Personalise their Approach in Child Sexual Abuse Memory Cases

Over 19% ($6^{37}$) of all participants call for a personalised approach of each client's experience relating to CSAM. Moreover, more than 83% (5 out of six) of these participants have not completed their psychoanalytic training (see section 2.1.1), while, overall, almost 52% (16 out of 31) of the participants had completed it and more than 48% (15 out of 31) of the participants had not.

Stella's[38] aforementioned quote accentuates the importance of respecting the clients' pace. As also shown above, Aphrodite supported that the significance lies in the internalisation of such an experience or in the way it is expressed. The rest of the relevant quotes will be presented below.

Two participants, Athina and Fenia stressed the significance of understanding the unique meaning of each client for their CSAM. Athina[39] said that there have been changes in every psychodynamic therapist, and that:

*"The basic position is for one to understand the meaning of... any experience, and especially one involving CSA, for that person… For each case I have seen with this type of history the meaning was different according to other factors, such as the structure of the patient's self up to the point of this experience. So every case is worth its own investigation"…*

Fenia[40] said that cases differ in terms of the point in therapy in which the clients discuss CSA and in terms of how central such a trauma is in the treatment. CSA could be the reason

patients went to see her, and she has had cases where they disclosed it for the first time in the 5th or 6th year of therapy. One of her analysands was a 35-year-old woman who suffered from phobias and eating disorder. The client had endured repetitive CSA by her uncle at the age of seven and this trauma was the main issue for the whole six years in her treatment until its successful completion. In one of her other cases, the client had been touched inappropriately by her father's friends. This CSA was not repeated, and was not a main issue, and, at the time of the interview, the analysand was on the eighth year of an ongoing treatment and still had much to work on, especially regarding the therapeutic relationship. She also declared that now she waits for memories to appear:

*"I am more careful now and I wait for memories to appear. I am not in a hurry. I think that the material is very traumatic and I think that therapy must have progressed a lot for analysands to come and discuss their issues"…*

Pantelis[41] talked about the importance of the experience in relation to the client's personality and life:

*"Of course the encounter is different in everything, with time, experience, training, cooperation, readings etc. As time goes by for instance I am interested in exploring a sexual experience in relation to the rest of the analysand's personality, web of associations and enactment, to the part assumed by it in the analysand's psyche, to what else it may hide and to what else is happening".*

Pantelis also mentioned that he would not stick on the experience of a CSAM:

*"…I will not stick on that experience especially when I see that my patient is stuck. It is like a symptom never ceasing if you are preoccupied with it".*

From a different perspective, Toula[42], 1 of the 3 participants who did not reply positively, said that CSA is not necessarily traumatic and may not become an issue in therapy:

*"I have not observed serious changes in the sense that I do not hold the sexual abuse itself as important so much as what the analysand conceives as having been traumatic"…*

Toula argued that she has had cases where sexual abuse was mentioned without it becoming an issue and changing the focus of the therapy onto something different, and that she would not insist on CSA becoming the issue. She also added that she would approach discussion of sexual abuse in cases involving neurosis differently than in cases involving psychosis.

In the current sub-section, participants' thoughts about the requirement for a personalised approach towards the analysand's CSAM, were addressed.

### 3.1.6 Therapists Who Feel Uncomfortable When Working with Child Sexual Abuse Memory Cases

Over 19% ($6^{43}$) of the participants mentioned that they used to feel somewhat uncomfortable when working with cases involving CSAM, or less comfortable compared to other cases. From the participants who mentioned they were feeling uncomfortable, 100% (six out of six) were female and had 15 or more years of experience.

Nota's reply, which has been quoted above, comprises her thinking that less experienced therapists may feel awkwardness during their encounters with CSAM. Isidora[44] stated that she used to worry about her handling proving hurtful to her clients:

*"..I felt awkward, uncomfortable, cautious, and afraid to handle this and not hurt the person facing me and I think this touched on my own worries and matters that made me quite unwilling to engage in this matter. Slowly, and mainly after the work I have done on myself, I feel more ready now"...*

Dina[45] said that handling cases involving CSAM were hard for her because she felt burdened even after the sessions:

*"It was hard during the first few years, meaning that I 'carried it with me' after the sessions. Of course, I worked with it a lot during my supervision because it 'touched' me, but during the last few years I have felt somewhat more certain in the sense that I definitely feel that I am not threatened. However... some cases have not ceased to shock me".*

Vicky[46] replied that she used to be impressed and alert when dealing with cases involving CSAM:

*"...The way I handle these memories now is more empathic… In the past, they might have made a great impression on me and I was very much thinking about what to say and how to say it; I think that now I am more direct and understanding in my interventions".*

Vicky also talked about one of her cases, which included unclear boundaries. In this case, the client left therapy and came back to her years later and remarked how different the therapist was. Vicky concluded that in the beginning of their careers, therapists may be harsh due to lack of experience and personal analysis.

Simela[47] said that she used to be more anxious when working with clients who experience CSAM:

*"...Now there is less anxiety, in the sense that the individuals that have been sexually abused bring into therapy a very current tension, as if they are seeking to be abused again. Their feeling is very direct and entails "rawness", but they do not transfer it through speech because they themselves have endured a psychical rape, something that overcomes and circumvents the boundary of verbal representation"…*

According to Simela, this directedness changes the nature of the stress, meaning that it mobilises the therapists, provoking them directly into their abuser's position.

Despina[48] recalled the one relevant case she had regarding a homosexual man who was sexually abused by his cousin. She said that she felt more comfortable than she used to:

*"I am more comfortable with therapeutic work related to sexuality and various fantasies, seduction and things like that. In general I have become a bit better through the years"…*

This sub-section drew light to how some psychoanalytic therapists feel uncomfortable while working with clients' retrospective CSAM. It also revealed how these feelings may alter as these same therapists gain experience.

To sum up the current section, in the present study, 90% of the participants had seen changes in the way they handle CSAM. They related their changes to practical experience, time and knowledge, and male participants were more inclined than females to view time as the reason for their change. While they discussed their changes, therapists expressed uncertainty toward the reality of clients' CSAM, worry about the depth of their exploration in cases regarding CSAM, discomfort when handling CSAM, and a tendency to employ a more personalised, rather than text-based approach to clients' CSAM. The above-noted results reveal two important findings. The first important finding is that participants seemed more inclined to base their approach on experience rather than knowledge, as observed from their discussions on both the roots of their changes, and their personalised responses to issues entailed in work with adults' CSAM. The second important finding is that participants reported unpleasant feelings and conditions, hence presenting the troubling nature of their practice concerning adult clients' CSAM.

### 3.2.0 Would Therapists Connect Child Sexual Abuse to Client's Symptoms before the Client's Disclosure?

Participants were asked: 'Have you ever thought of proposing CSA as a possible explanation for the analysand's symptoms - before the actual memory came up during the therapeutic process?'. If the participants answered positively to this question, meaning that they stated that they would consider proposing CSA as an explanation for the client's symptoms, I additionally asked about how they would do it.

### 3.2.1 Numerical Description of the Responses

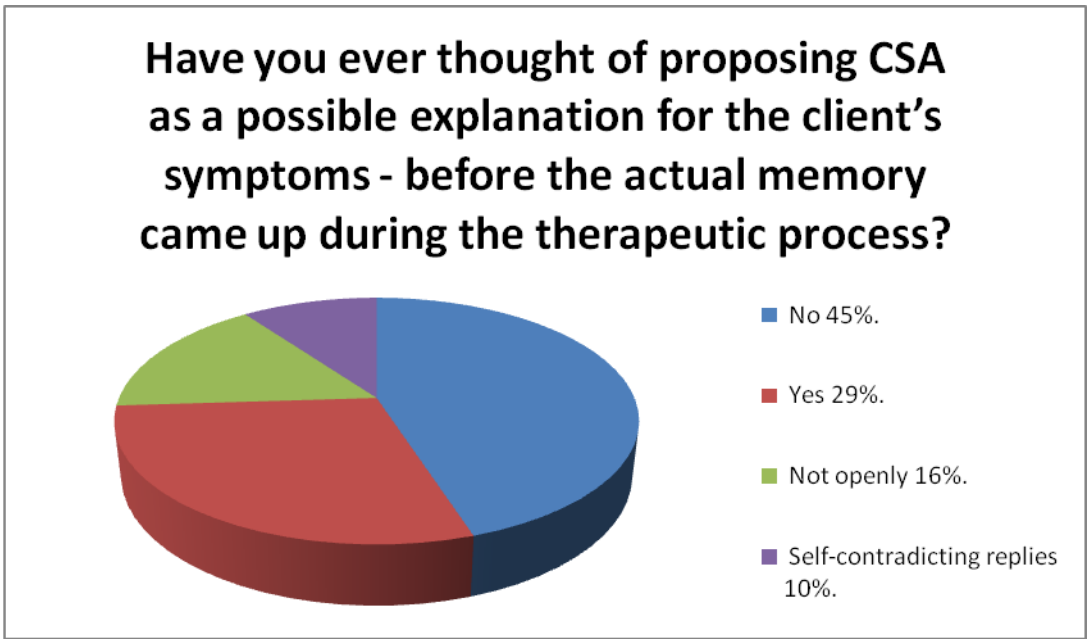
As seen in chart 2 below, in the interview question inviting participants to discuss whether they have thought of proposing CSA as an explanation for the client's symptoms before the client's disclosure, 45% ($14^{49}$) of the participants answered negatively. This was the most popular response and it insinuates that they would not attempt to explain symptoms through a CSAM.

In the same question, the second most popular response was 'yes'. More than 29% ($9^{50}$) of the participants replied positively, indicating that they would point to undisclosed CSA to explain symptoms to the patient, and that they would mention CSA before the patient does

under certain conditions. From the remaining participants, 16% (5[51]) have replied 'indirectly', meaning that they would indirectly or not openly propose CSA as a possible explanation for the analysand's symptoms. Almost 10% (3[52]) of the participants' replies were self-contradicting.

Therefore, almost half of the participants would not propose CSA as an explanation for the client's symptoms before the client's disclosure. The rest of the participants would propose it, or would not do it openly, or gave self-conflicting replies.

Chart 2: Responses regarding linking CSA to symptoms before disclosure




### 3.2.2 Therapists Who Stressed the Importance of Waiting for the Patient to Disclose the Child Sexual Abuse Memory

Over 25% (8[53]) of the participants' responses had a common point in their responses to the interview question about whether they would propose CSA to explain the client's symptoms before the client's disclosure. More specifically, these participants emphasised that the therapist must wait for the client to bring up a CSAM. Notably, the last reply in this section came from a participant who appeared in favour of connecting CSA to the client's symptoms before the actual disclosure, while the rest of the responses below were in favour of not making such a proposal.

Athina[54] said that she waits for the patient to discuss such material, no matter how long it takes:

*"I would not say it to someone of my own accord, only if it comes from them. That's why I did not propose it in previous cases (even if I knew it for 5 years)".*

Pantelis[55] argued that proposing a connection between symptoms and CSA would be too intervening, and that he would not bring up material that has not been verbally communicated by his analysand:

*"I will not propose it as a real historical fact… This would be very general… There are traumatic events in everyone's childhood… but I would not propose something so intervening, intense and actual, especially in association with reality… if this does not come consciously and in speech and communicated by my patient".*

Petros[56] indicated that he would ask a patient whether such a symptom-CSA connection is there only after the patient has already discussed the abuse:

*"Only if s/he talks to me about the abuse will I make very delicate connections, meaning, "I thought that maybe there is a relationship between this occurrence that you are discussing now and the corresponding symptomatology. I will let you think about it, I may be wrong". I shall express it as a hypothesis"…*

Petros had stated, earlier in the interview, in certain cases therapists should work only indirectly with immense trauma, in order to avoid triggering a psychotic episode. He also emphasised that matters concerning sexuality should be addressed after many sessions, since therapists should really know the client before they inquire about such a delicate issue.

Petros mentioned a case of a woman who had sexual encounters from the ages of 10 to 20 with her much older cousin. Through long-term therapy her perversion became milder and she was able to adjust to a group therapy environment. She got married, had a child, became a psychiatrist, a psychoanalyst and a university professor but she was rather distanced from her environment. Petros deemed that she has done adequately well, although he was not enthusiastic about the outcome.

Ira[57] also supported that she would stand beside the patients and wait for them to reveal their CSA:

*"Thinking about something is different from doing it. When I think about it [proposing CSA as an explanation for the client's symptoms] I decide that I must have the patience of the tree that grows and I stand beside them and wait for them. No, I would not propose that. I think that this has happened in the USA: we have decided that this is that, we propose it so everybody is found to have been sexually abused"…*

Timotei[58] stressed that there is a clear association between early sexual trauma and ensuing pathology, such as borderline disorder, but she would also avoid verbalising such associations to the patient before the latter brings up the material:

*"…In cases with borderline disorder, the trauma of sexual abuse is very common and in the literature sexual abuse is considered a causal factor… imperative and determinative in explaining the ensuing pathology and of course more things are needed… No, I would not say it if the material is not brought up".*

Ilias[59] claimed that therapists must wait for the patient to disclose, emphasising the possibility of the therapist being wrong in his hypothesis about the symptom-CSA connection:

*"…We will respect the patient's difficulty and we will wait for when s/he will be ready to tell us. We may suspect and hypothesise but sometimes we are also fooled. We cannot put across something that may not exist…"*

Magda[60] said that proposing CSA as an explanation would be unlikely, and that she would only ask about it only after many years of therapy:

*"I think that this is a very dangerous topic… I have certainly thought about it… It is highly likely to find sexual abuse in the background of individuals with hysterical personalities or psychosis. But I would never ask the patient except, maybe after many years of therapy, where I would feel that a safe ground had been created… I would wait for the material to come from the patient".*

As presented in this sub-section, several psychoanalytic therapists hold that they should abstain from intervening before the analysand comes forth with material involving CSAM.

### 3.2.3 Therapists Who Would Discuss Child Sexual Abuse Before it was Mentioned by the Patient

Over 25% (8[61]) of the therapists who participated had a commonality, apart from replying affirmatively to whether they would make a symptom-CSA connection in therapy: They also said that they would do it only under certain conditions. As we saw above, Magda[62] said that a condition would be the many years of therapy which would have provided a safe ground.

Takis[63] named the first condition which related to clinical diagnosis. He said that he would link a CSAM to internal conflicts or sexual trauma and that the clinical diagnosis would play a role:

*"I would propose it in terms of the Oedipal problematic or in the context of a sexual abuse or seduction, incestuous or not, from an adult. This… definitely depends on the clinical context in which it is mentioned… The sexual theme is different in neurotic cases, in psychosis or in a serious somatisation like cancer".*

Antonis'[64] response suggested a similar condition which is connected to the state of the patient's mental capacity. He said that discussing CSA as the basis of pathology could be traumatic, so he would wait for the patient to become mentally resilient:

*"Discussing sexual abuse as a basis of the pathology could be equally traumatic to the abused and it would additionally cause disorder to the patient's mental health state... Thus, firstly, you wait for his/her mental health to become adequately restored".*

Antonis added that he would link the consequences of CSA to the pathology of the patient's parents and grandparents:

"*I would link the CSA's consequences on the patient not to the actual CSA act per se, which is complicated enough for an analysand's mind and also has the sense of irreversibility, but*

*perhaps to the parents' and grandparents' psychopathology. In psychoanalysis, we know that it is more complicated when accusing and punishing someone".*

Rita[65], who is one of the most inexperienced participants of the current study, articulated a way to inquire about trauma before the patient discloses it. She also underlined other conditions relevant to the strength of the indications, the restrictions of an intervention, and the pace of the client:

*"If the indications were so strong that you could not ignore them, I would use them to ask if there is something difficult or 'bad' that s/he is afraid to discuss. It also depends on the time allowed for the therapeutic intervention, and on the analysand's pace. I do not think I have ever asked, or that I would ask something more specific about CSA".*

Malvina[66] argued that only if the patient would be able to listen to this proposal so as to move on, would she ask whether the symptom could be related to an actual experience:

*"I think that this could happen, as long as it happened in the moment when the other [the client] was able to listen to it and connect it in order to move on, that is to avoid retraumatisation. You can say sth in the beginning like: "Do you think that it relates, let's say, to an experience of yours, behaviour of yours? Could we think about that and discuss it?".*

Malvina also accentuated that therapists may make an intervention and then they let it sink in:

*"Depending on both how and if the other can stand listening to this proposal and to think about whether this may be connected, s/he may listen to my proposal and feel nothing the first time although [deep inside] s/he has this material, which may be unearthed at another time".*

Ilias[67] responded that he has never thought about proposing CSA without prior presentation in the patient's speech, and added that:

*"…It depends on the case, the phase of therapy or the analysis"…*

Aphrodite[68] would consider proposing this only if the analysand was really close to revealing CSA needed help with that:

*"Yes if s/he is very close emotionally to recognising this [proposal about CSA] and needs help in saying something but no if s/he is far away and I would just shock him/her. I would ease into it for him/her only if s/he is telling me through various [implicit] ways but may feel embarrassed to say it, if s/he feels guilty, afraid that s/he will be blamed"…*

In addition to the above, Aphrodite brought up a case of a woman whose family had unclear boundaries without a clear CSAM; for instance, the father made inappropriate remarks about sex to her mother in front of her. This woman felt angry, disgusted and confused and said that her parents were sick. However, she was simultaneously ambivalent about whether she was right to feel this way. Aphrodite then asked her "Why do you question how you feel?" and the woman had the courage to say, "I am more traditional than my parents. I will not do this with my children".

Toula[69] said that she could propose CSA among other explanations. She added that it is not necessarily a decisive fact, and that she cannot know whether an isolated memory is real and that she is not interested in this:

*"[I would propose this] Within other kinds of explanations. I hold that this fact is one among others; I do not think that it is decisive. Of course, the abuse can be long-term and may by itself be a serious issue. I mean that if a patient brings an isolated fact, which s/he felt that was traumatic, I cannot realistically confirm if the reality was such and I am not interested in that. I am interested in how s/he experienced it".*

Isidora[70], argued that she could propose CSA as an explanation for the analysand's symptoms without using the term 'CSA':

*"Exactly like this by using this term no. I could have mentioned it though; perhaps, it has never happened like this to me. Usually, they [analysands] say it themselves".*

To be fair, none of the participants said that this (discussing CSA before the patient does) had already occurred in their practice. On the contrary, three participants have stressed that this has not occurred in their practice:

1) Rita[71] declared that *"I do not think I have ever asked, or that I would ask something more specific about CSA".*
2) Isidora[72] also stated that "*it has never happened to me in this way".*
3) When asked about whether this has happened to him, Ilias[73] said *"Without prior presentation in the patient's speech, no".*

The statements included in this sub-section show that several psychoanalytic therapists have distinguished specific situations wherein they may connect possible CSA to the client's symptoms before the client openly addressed this issue.

### 3.2.4 Therapists Who Would be Indirectly Guiding the Client so as to Connect His/Her Symptoms to Child Sexual Abuse

Over 16% (5[74]) of the participants' responses were categorised as 'yes indirectly' or 'not openly' as they involved guiding the analysand indirectly through questions and implicit statements.

Like Isidora, Chrisa[75] said that you can talk around it, but you cannot use terms as CSA:

*"…One could talk around it but to explain it in terms of CSA is an extremely delicate matter because usually it is concealed. In some situations where it does not come up or if there is not something very heavy, it has occurred to me to think and hypothesise about it, and the confirmation came through a dream, but I could not approach it psychoanalytically".*

Chrisa also highlighted that the therapist should not impose anything and that in cases involving CSAM relevant discussions are forbidden:

*"The point is not to impose it; this is the point that memory has to be accessed a bit so as to do this consciously. In CSA… you cannot discuss it before they do".*

Chrisa mentioned two relevant cases she had. In the first one there was certain paternal CSA that went on for a decade. The second case was about a woman who was suicidal and had experienced inter-familial violence. Chrisa asked the woman whether something happened during childhood because she was sure that this was related to further sexual abuse in her life history.

Lefteris[76] said that he would help in the FRD through questions rather than directly providing it as an explanation:

*"I would not provide it as a possible explanation. Through questioning, I would help him/her distinguish fantasy from reality and see how this influences our relationship".*

Stella[77] said that she has guided indirectly to facilitate a possible disclosure:

*"I do not declare my personal stance and I have not mentioned it directly but peripherally, for example, by talking about a sexually arousing environment so as to allow the person to come forth with the material".*

Dina[78] clarified not only why she would not propose CSA openly, but also how she would imply it so as to optimise the benefits of her intervention:

*"I would not say this openly like that because I am afraid that I would become equally abusive. However, I have implied it through a [delicate] manner, for example "It seems like you want to say that something has happened during these years that you find difficult to discuss and remember again"".*

I asked her whether this approach helped and Dina replied that when the timing was right it did help to unearth the material:

*"It was different for each case. To start with, there was not always clear sexual abuse, all the times that I have used this approach. When it had been verbalised at the right time then the trust between us was not affected, to say the least, and sooner or later the traumatic material came up".*

Dina also mentioned a case of hers involving a young woman who suffered from an eating disorder. The woman repeatedly described – without an accompanying feeling - an event during which her drunk and half-asleep father kissed her because he confused her with his girlfriend and the next day they laughed about it. At some point, Dina said to this woman that apparently she had experienced this event as "a crossing of boundaries" and this worked in a very liberating way. The woman had successfully completed her therapy at the time of Dina's interview.

Simela[79] holds that the therapist should talk and assume a position only to avoid a repetition of trauma, and offers guidelines for this:

*"...To connect it with the discomfort s/he feels, for example that at some point s/he might have felt overwhelmed with excitations from the environment, from some adults, etc. I always mention it indirectly, without using such words as 'sexual abuse'. And when the material comes forth I stay with it, I hear it, but I do not openly talk about it. The therapist should talk and assume a position only to avoid a repetition, which is often encountered".*

Simela went on to give a more specific example of what she would say so as to avoid a retraumatisation:

*"The therapist might say that, "it is your right not to want this uncle in the house; setting a boundary is taking care of yourself". Then, as if speaking from the analysand's self, the therapist might say: "This will not happen again like that; you will not allow it", so as to encourage the analysand to protect him/herself".*

The current sub-section contained participants' replies which indicated that there are ways to indirectly approach a client's suspected CSA.

### 3.2.5 Therapists Who Gave Ambivalent Replies to Whether They Would Propose Child Sexual Abuse As a Possible Explanation for the Analysand's Symptoms

In reply to an interview question about whether participants would propose CSA as a possible explanation for the client's symptoms, almost 10% ($3^{80}$) of the participants gave a somehow self-contradictory reply.

Fenia[81] responded that she would offer CSA as a hypothesis for the patient's symptoms:

*"Yes, of course… I will bring it only as a hypothesis and not as something definite so as for him/her to be able to process it. This has not occurred in my clinical practice yet".*

There is a contradiction in one of Fenia's[82] earlier statements. More explicitly, Fenia said that she would wait for the material to come from the patient:

*"I would not handle it if the memory had not been revealed… I would not bring it up anyway. Unless maybe if someone was referred for this by the court, but even then I would wait for the patient to tell me".*

Agapi changed her response[83]: while she was saying that she would usually propose it in well-established therapies, a few sentences later she said that she does not propose it herself, and that the patients propose it:

*"Yes, but usually when therapy has progressed enough and not at the start… Some things may find their place more consciously so the things surrounding them begin to make sense… So I do not propose it myself, patients propose it. In the relevant cases, I've had... through the years, during therapy, they somehow manage to say that "I have encountered this [abusive] gaze before"…*

Agapi had been discussing that some abused patients tend to feel that people are looking at them as though they want to take advantage of them. In fact, in three of her cases in particular, about a male and two female analysands, CSAM had come up through discussions about sexualised gazes which made them feel uncomfortable when exposed in certain circumstances of social interaction. Their difficulty with others' gaze remained even after the rest of their symptoms had ceased.

Lastly, Aris'[84] statement quoted below includes his change from 'discretely searching' to 'considering the origins of my assumption':

*"…In the first years, I used to discretely search for it. Nowadays, in contrast, when indications occur, I contemplate on why and how I thought about it…"*

Aris said that he searches whether these indications have a meaningful connection to an occasion, or to a reference to reality, or to material concerning transference and countertransference, or to his own stuff, as he cannot avoid being influenced.

The present sub-section demonstrated that a few of this study's participants expressed ambivalent responses regarding their approach to undisclosed CSA.

In summary, the important results presented in this section suggest that 45% of the participants would not propose CSA as a possible explanation for the analysand's symptoms before the analysand felt ready to explicitly bring up CSA. Another important finding is that there was ambiguity among the data as notable minorities would consider exploring this possibility either explicitly (25%) or implicitly (16%), and some (10%) participants gave self-contradictory responses. Participants' responses differed from one another in terms of both the conditions under which and the ways through which they would link symptoms to CSA.

### 3.3.0 Do Therapists Believe that Clients May Be Retraumatised in Treatment?

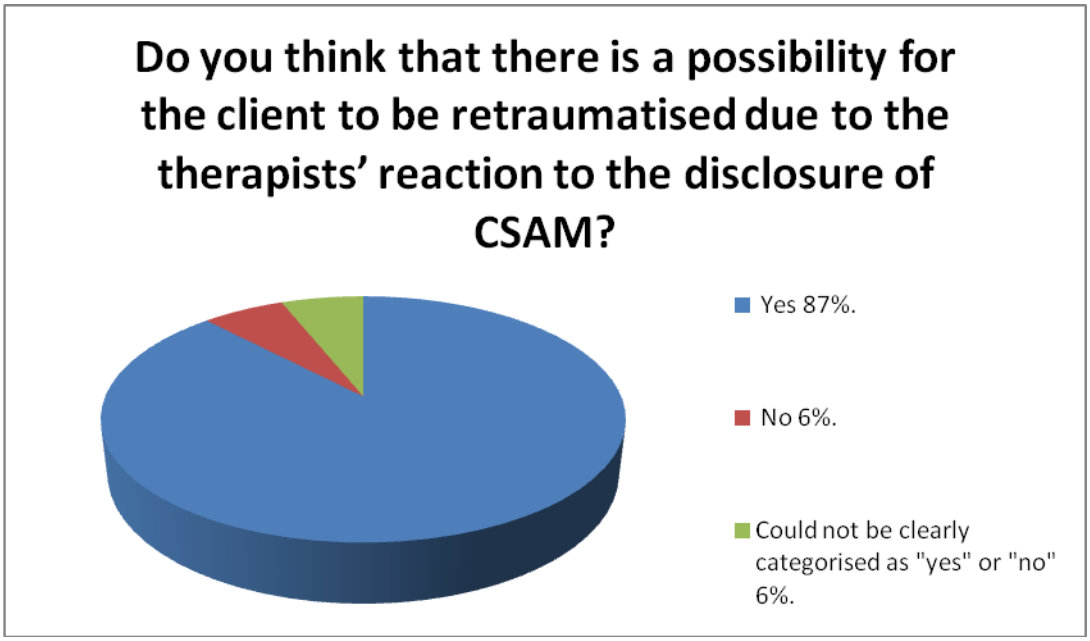
Participants were asked the following question: "Do you think that there is a possibility for the analysand to be retraumatised due to the therapists' reaction to the disclosure of CSAM?" As shown below, the overwhelming majority of the participants replied affirmatively, and there were commonalities across the sample in terms of emphasis on important issues, including the therapists' mistakes, repetition compulsion, and actual sexual abuse.

### 3.3.1 Numerical Description of the Responses

As seen in chart 3 below, more than 87% ($27^{85}$) of the participants stated that there is a possibility for the client with CSAM to be retraumatised due to the therapists' approach to the initial discussion of CSAM. Over 6% ($2^{86}$) of the participants replied negatively, implying that they do not think that there is a possibility for the analysand to be retraumatised because of their therapists' response to his/her revelation of CSAM. Over 6% ($2^{87}$) of the participants responded in ways which could not be clearly categorised as 'yes' or 'no'.

Thus, the vast majority of the participants believe that there is a possibility for in treatment retraumatisation of clients with CSAM.

Chart 3: Responses regarding the client's retraumatisation




### 3.3.2 Therapists Who Connected the Client's ReTraumatisation to the Therapists' Mistakes

In reply to an interview question about the clients' potential retraumatisation, over 61% (19[88]) of the participants associated the retraumatisation with the therapists' mistakes.

All but one of the participants' responses in this section replied 'yes', thus supporting that there is a possibility of retraumatisation. The following quote was Simela's[89], who was one of the two participants who replied in a way that could not be categorised as a 'yes' or 'no'. She said that there are two levels to take into consideration so as to avoid the retraumatisation, and both levels are related to the therapist's handling:

*"... [1] The therapist must be very careful with the words that s/he uses and whether they choose to talk or not, as s/he may only contain what the analysand brings to the conversation... [2] The therapist in the countertransference, in his/her work and internal*

*thoughts, is able to create an internal distance from this raw material that will come at a certain point within the therapy".*

All but one of the participants who replied positively to whether there is a possibility for in treatment retraumatisation, seemed to think that this occasion is quite common, at least in cases of CSAM. In addition, as we will see below, Magda deemed that retraumatisation would be highly likely. The different response in this group came from Mirsini[90] who said that retraumatisation would be highly unlikely if the analyst has been analysed and is ethical:

*"I have the feeling that an analyst is firstly an analysand, in the sense of his/her own analytic procedure, and is secondly ethical. I believe that it is highly unlikely for retraumatisation to occur because of the therapist's handling".*

Ilias[91] asserted that retraumatisation may occur because of wrong handling, and added what is needed so as to avoid this:

*"It may happen, through wrong handling… It requires strong psychic constitution, so as to respect what is happening at that time".*

Angeliki[92] said that therapists' ability to contain the analysands' feelings towards the disclosure is very important. She also supported that psychoanalytically-minded therapists are more prepared because they stay longer in therapy:

*"...What plays a great role is the therapists' personal therapy and their work on their own traumatic childhood experiences... and how much they can work on and contain the analysand's rage, anger, regrets, guilt, etc. when this whole thing surfaces… Psychoanalytically-minded therapists have worked more with themselves and are, thus, more prepared".*

Antonis[93] advocated that the client's retraumatisation may be caused when therapists mistakenly assume other roles:

*"Yes, if the therapist assumes, figuratively speaking, either the role of the neutral interrogator who examines whether this occurred, or the hypersensitive, over-identified*

*social worker who rushes to reinstate order in the house. Both roles are legal, yet both retraumatise".*

Further, Antonis advised therapists to focus on empathic attunement:

*"The golden rule is: empathic attunement. You try, especially in these cases, to perceive what is happening in the analysand's level of functioning what s/he is experiencing and after you succeed, things open up, enlarge".*

Rita[94] believed that pressure from the therapist towards the client, and a technical rather than empathic approach may lead to triggering false memory:

*"Yes, if the analysand is pressured to disclose too soon, if s/he is not [empathically] connected to the analysand or if s/he follows specific techniques".*

Later during the interview, Rita added that if a therapist is afraid of retraumatisation, s/he may urge the client to make sense of what is happening, which could also contribute to false memory creation.

Magda[95] claimed that retraumatisation is expected, and that therapists should aim in the corrective re-experiencing of the trauma, so it all depends on the therapist's handling:

*"…It is almost a given that this [client's retraumatisation] will happen… when the patient… remembers such an experience… It depends on the therapist's handling: the point is the corrective re-experiencing of this trauma… so that the patient will… re-experience this trauma… in a safe environment and thereafter be able to discuss it, maintaining as much distance as possible and without repeating it again and again".*

Toula[96] argued that this mistake is usually made by inexperienced clinicians and that the outcome is determined by various factors:

*"...It is a mistake that a new clinician may make, but if the therapeutic relationship is safe enough this will not have terrible consequences. It depends on the therapeutic relationship, the framework, and the therapeutic request. If the therapeutic request is about the sexual*

*abuse, our handling ought to be very delicate and careful. If this comes among other things it should be handled in an analogous way".*

Sotiris[97] indicated that disclosure of a CSAM is an intense situation in which therapists may make mistakes:

*"Yes, when something like this appears in the transference, it is usually quite fierce and this may be so traumatic and so intense, that various things may happen; a lot of sensitivity and also mistakes may occur on the therapist's part".*

Sotiris discussed one of his cases regarding a 50-year-old woman who surprised him in the third year of treatment when she revealed her incestuous relationship with her brother. At the time of the interview she was in the fifth or sixth year of therapy, they met less frequently than they used to and the therapy was near to completion but it was partially successful. She got over several issues but not those concerning her sexual relations.

Emelia[98] proposed that disclosures are commonly restorative for clients but retraumatisation is likely when therapists mention CSA first:

*"Perhaps, this [retraumatisation] would be the case if it [CSA] derived from the therapist; otherwise the analysand would be ready and it would be a rather healing and therapeutic experience".*

Pantelis[99] suggested that there is a crucial way to minimise the possibility of retraumatisation:

*"Such a possibility exists, of course it… requires special attention… If the analyst has adequately internalised the framework and can somehow transmit this to the process of analysis or therapy and to his patient, I do not think there is a great possibility of retraumatisation…"*

Pantelis also warns about the situations which may lead to retraumatisation:

*"[It is traumatising]... if the therapist fails to preserve his/her relevant position and to remain a reflective analyst, so s/he may not listen to his patient, s/he may ignore something or digress from the framework and from his/her role"...*

Dina[100] noted ways to both avoid and handle revelations of CSAM in her reply to whether there is a possibility for clients' retraumatisation in treatment:

*"Theoretically I am absolutely sure that this can happen. I want to believe that I have avoided that to the degree that I am able to be aware of it, because even at the start at least I was not talking even if I was not helpful. It needs special, huge attention from the time that the revelation takes place and at that point interpretations in transference and countertransference may help".*

Dina talked about a case wherein she had little time to deal with an ill-timed and unexpected revelation of CSA. More specifically, her female analysand was about to complete her therapy after five years, and was going to leave soon afterwards so as to study for a postgraduate degree in a foreign country. During the last month of therapy, she disclosed something that she said she had nearly forgotten: she had endured a sexual attack from the uncle that looked after her as a child. Dina believed her and worried about the time they had left to work on this revelation. Dina's interview took place many years after this therapy ended and Dina was able to find out that therapy worked for this analysand. She had indirectly worked on this through an incestuous type of relationship she had with her father, who was single, affectionate, handsome, seductive and treated her like a girlfriend. After the completion of her therapy, this analysand confronted her mother and her uncle.

Petros[101] took into account defence mechanisms, personality parts, and therapists' reactions:

*"Repetition compulsion will seek satisfaction. If the superego is strict enough and the therapy has progressed a lot it may not be put into action. If s/he [the therapist] does not ask, does not show an interest, then this is wrong; s/he will not traumatise him/her [the patient], unless s/he [the therapist] is very clumsy".*

Petros also recommended ideal responses from therapists towards the clients' untimely narration of a CSAM:

*"When it is too premature, we stop; we may propose to get to know each other more, perhaps try face to face rather than the couch. Or we may not say anything, we ask him/her to repeat it. From the moment we show our interest that is enough; s/he knows that we understood all that without him/her narrating the story and most times s/he will do the repetition compulsion only in fantasy with us".*

Ira[102] accentuated the child's tendency to repeat trauma:

*"It is absolutely clear that there is a chance of retraumatisation… I believe that the abused child participates in some way and for some reasons and because s/he provokes a repetition, the first abuse may not have been of a sexual nature, but something there attracts all this experience of abuse... of course without deserving it".*

Ira also notified about the limits of the therapist's power in regard to avoiding retraumatisation:

*"I do not believe that the therapist is all-powerful and that s/he is always able to do that, to protect the analysand. I think that the therapist must simply wait and respect the analysand's pace".*

Chrisa[103] pointed out the therapist's unconscious mistakes and their consequences:

*"Of course it [clients' retraumatisation] could happen. This is the case for all issues, since the therapist makes mistakes and since s/he can do something unconsciously. So the possibility for a therapy to go wrong and to change into a neurotic therapy, clearly exists".*

Despina[104] informed me about the therapist's mistakes that remain unconscious and unprocessed:

*"Yes [clients' retraumatisation may occur], with a mistake or an abrupt or ill-timed intervention from the therapist and, especially, if s/he does no realise it. When s/he realises it may even be a chance to work on that… If something bad happens at a later age, the psychic*

*structure will not be changed. The issue is when something from the past is activated or if the therapist is perverted"…*

Nota[105] saw the retraumatisation from three perspectives. The first concerned the clients' emerging emotions:

*"Of course there is a chance, because this may trigger not only memories but also very acute emotions of shame and humiliation".*

Nota's second perspective concerned the therapists' unintentional behaviours:

*"It has to do with what s/he [the analysand] will get from the therapist, who [the therapist] may... not be able to control feelings of distress and to withhold this traumatic atmosphere so that the analysand may experience much difficulty and once again feel rejected and retraumatised".*

Nota included the therapists' intentional actions as a third perspective:

*"A second sexual abuse may occur but now we are talking [only] about co-workers who have the sense of ethics and duty".*

Timotei[106] reported issues on client's seductiveness, and provoking of emotional abuse:

*"It [client's retraumatisation] may happen if the therapist is not careful. This type of patient tends to repeat trauma, meaning that in their effort to create a close relationship with you they may even become seductive. To get involved in a relationship with your analysand is unethical, disturbed, etc. However, they may put us in a situation in which we may somewhat traumatise them on an emotional level".*

Isidora[107] specified several circumstances wherein retraumatisation happens in treatment, especially when the therapist is not ready for a CSAM revelation:

*"Yes [client's retraumatisation may occur], if the therapist is not ready and hurts or questions or underestimates the analysand. Nothing like this has ever happened to me. The therapist may repeat the abusive experience very often and not only unintentionally".*

Isidora also revealed a case in which a lady that was harassed by her father, was also sexually abused by her second psychiatrist.

Bearing in mind the data exposed in this sub-section, most of this study's participants acknowledge an association between clients' retraumatisation and the therapists' mistakes.

### 3.3.3 Therapists Who Linked the Client's Retraumatisation to Repetition Compulsion

While responding to an interview question regarding the possibility of the client's retraumatisation when disclosing a CSAM to their therapist, almost 39% (12[108]) of the participants, pointed out the client's tendency to repeat the sexual trauma.

All but one of the participants who pointed out the tendency to repeat the trauma were advocating that the possibility of retraumatisation does exist. The sole exemption came from Apollonas who provided a response that I could not categorise as a clear 'yes' or 'no'. Apollonas[109] linked regression and repetition to retraumatisation:

*"What we call regression during the course of an analysis is a fact that may have a lot of possibilities that lead to a repetition. In transference an analysand who has special reasons to repeat it [the trauma], will tend to repeat it, to bring it inside the analysis"…*

Lefteris[110] brought up one of his cases which involved fraternal CSA, and possible paternal CSA. She was also raped by a partner, but did not experienced this as rape at the time it happened because she had an orgasm during the abusive act. Her narrations of the various sexual abuses were filled with either detachment or re-experiencing of the traumas. There were aggressive attempts to seduce the therapist, and it was hard for her to feel closeness to men without having sex with them. However, after working hard on these issues, she successfully completed her therapy within four years.

Malvina[111] argued that psychoanalysis takes you back to unpleasant situations so as to overcome whatever gets you stuck:

*"…I think that many times analysis takes you back to places which are hard to deal with… It is something that s/he must go through to see what happened then, how it happened, how it influenced him/her and how it is connected with all the actual things around him/her, and where s/he gets stuck".*

Aphrodite[112] said that patients tend to repeat their trauma in treatment so as to battle the badness:

*"I do not think it is weird for the analysand to experience a repetition at any level, even in the actual sense, because the psychic structures that have been abused have certain characteristics (for example, passivity), and in some ways these patients believe that through the repetition the badness will be battled. The patients also impel you and push you to become verbally abusive or to forget about it [CSA]"…*

Aphrodite discussed repeated real traumatisations within therapeutic boundaries, and mentioned a case about a woman, with whom she had a conversation. The woman had been sexually related with her psychiatrist and of course afterwards things became so mixed up that she left, feeling abused and looking for another professional. She could not go to Aphrodite so she was referred to another professional.

Takis[113] said that acting-out happens instead of remembering, so therapists should verbalise what is happening so as to help the patient remember:

*"…Instead of remembering, the patient acts out so as to make this experience current in the here-and-now, which is the main tendency. When the therapist interprets this, acting out is avoided… which brings things in the there-and-then. Thus, the therapist reinforces the patient's remembering. Continuously verbalising and de-dramatising the circumstances is my only stance when the analysand is acting-out".*

Vicky[114] referred to repetition compulsion from another perspective, as she indicated that therapists may repeat their own traumatisation from their own therapist's reaction to their traumatic narrations:

*"I think that this is related to the degree that the therapist has worked with his own traumatic experiences within his/her own analysis and perhaps it depends on how the therapist's analyst has reacted to his/her traumatic experiences... The training and the supervisions provide us with knowledge but I think that your own analysis is the one that plays the biggest part"…*

At different instances Vicky also said that therapists work on their own issues with every patient, and that due to their stance, therapists may abuse the patient a lot.

As seen earlier, Magda[115] argued that the patient re-experiences the trauma when the memory is recovered. Ira[116] said that abused individuals provoke repetition of trauma. Petros[117] noted that repetition compulsion will seek satisfaction in reality or at least in fantasy. Nota[118] suggested that disclosure per se may trigger acute emotions, or - depending on the therapist's response – retraumatisation. Timotei[119] said that patients with CSA in their history tend to repeat trauma and are seductive.

In view of the results discussed in this sub-section, a considerable minority of this study's participants suggested that client retraumatisation is linked to repetition compulsion and expanded on their related ideas.

### 3.3.4 Therapists Who Brought Up Actual Sexual Abuse by the Therapist

In response to the interview question concerning the potentiality of clients' retraumatisation in therapy, over 16% (5[120]) of the therapists who participated in this study called attention to actual sexual abuse of the client by the mental health professional.

As seen earlier, the following two participants discussed sexual abuse by the psychiatrist. Aphrodite[121] pointed out that repeated real traumatisations may occur within therapeutic boundaries, as in a case of a woman, who had been sexually related with her psychiatrist. Isidora[122] made clear that very often therapists may repeat the abusive experience even on

purpose, and talked about a case in which a lady that was harassed by her father, was also sexually abused by her second psychiatrist. Despina[123] articulated the possibility for the therapist to be perverted. Nota[124] clarified that she would not focus on a second sexual abuse that may occur from co-workers who lack a sense of ethics and duty. Timotei[125] explained that therapists who sexually abuse their clients are unethical, disturbed and so on.

The above-noted responses illustrate that some participants talked about actual in treatment sexual retraumatisation of clients.

### 3.3.5 Therapists Who Argued that the Right Timing is Important in Avoiding Retraumatisation

In their replies to the question about the possibility of retraumatisation of the client by the therapist's response to the revelation of CSAM, 13% (4[126]) of the therapists who participated in this study, stressed that timing plays a central role in avoiding retraumatisation.

Athina[127] laid emphasis on how crucial the right timing of the therapist's interpretations is in avoiding retraumatisation:

*"...Psychoanalysis tries to put things in words rather than action. One will not be retraumatised when s/he is ready to say it by him/herself. So the therapist should always wait for the material to emerge and the interpretations to be made at the right time… An interpretation that is untimely may be unnoticed or may infuriate the analysand".*

Earlier during the interview, Aris[128] had already started discussing the possibility of client retraumatisation in therapy. He maintained that in response to a CSAM revelation, therapists should not rush:

*"The emergence of such an experience is always an essential moment for both the therapy and the relationship. It requires the analyst's attention: not to rush in by interpreting the event, but to listen and to understand well. Analysts should maintain a context of security to the accompanying stressful emotions and personal difficulty. They should respect the possibly unconscious trust that this patient shows, referring to why s/he has built a whole pathology to hide something".*

Aris emphasised the analysts' experience and flexibility:

*"How you handle this changes through experience... There are no general rules; each case should be treated individually. The framework allows you to be flexible. The external framework (time, place, duration, cost, circumstances) is of less importance than the internal one, which you form with your patient".*

Aris talked about a case of a sexually abused man with whom he had been working for years before he attempted suicide. Aris interpreted this attempt as a message to himself in relation to how he tolerated the revelation of the sexual abuse. They continued the psychoanalytic psychotherapy in the hospital's garden in the predetermined frequency. The significance was that the therapy could continue despite of the attack it had received; the relationship could bear this, and this was the critical factor for its following success. In response to the interview question about the client's retraumatisation, Aris said that therapists should not draw out such a disclosure before lengthy holidays:

*"Clearly the possibility exists… If you suspect such a thing [CSA] before the holidays you do not draw it out… In that issue, what is important is personal analysis, supervision, case selection – meaning that we should not get involved in cases that are beyond our capabilities – and correct referrals".*

Aris described that he was working with a bulimic woman and the therapy was unsuccessfully terminated. Not only had she re-experienced the trauma, but she had also developed depression and guilt. This was not expressed as aggression towards Aris, but it was expressed in self-destructive way, as she did not see another therapist, as far as he knows.

As seen earlier, Ira[129] stated that it is imperative for therapists to respect the analysand's pace. Petros[130] discussed how therapists should approach a client who reveals a CSAM prematurely. For instance, he advised that therapists may propose to the client to get to know each other more before they analyse this matter, perhaps try face to face rather than the couch.

Taking into consideration the data included in the sub-section above, many of the psychoanalytic therapists who participated in the current study, appear considerate regarding the significance of the right moment to intervene so as to avoid client's retraumatisation during CSAM disclosure.

The important results presented in the current section show that 87% of the participants are aware of the possibility for the client with CSAM to be retraumatised during the initial discussion of CSAM. Most (61%) of the participants linked the client's retraumatisation to the therapists' mistakes. For instance, participants thought that a therapist may unintentionally assume a role that s/he is not supposed to, and also stated that factors, such as the therapists' therapy, play a role in this. Many (39%) of the participants connected the client's in treatment retraumatisation to the traumatised individuals' urge to repeat the trauma, for example, by provoking the therapist to somehow abuse them. Some (16%) of the participants drew attention to a pragmatic perspective as they mentioned cases involving actual sexual abuse of the client by another mental health professional. A few (13%) of the participants said that the right timing is crucial in the prevention of clients' retraumatisation. These modern-day therapists were contemplating their contribution, the related defence mechanisms, and both the reality and the prevention of clients' retraumatisation.

**Superordinate Category B:**
**Handling of Fantasy-Reality Distinction in Child Sexual Abuse Memory Cases**

Approaching uncertain CSAM is a field full of mines. In my opinion, the most difficult unanswered questions in psychotherapeutic circles involve whether doubting and clarifying clients' uncertain CSAM can and should be done by therapists. In the present superordinate category analytic therapists will articulate their thoughts, beliefs and worries concerning the quandary or fact versus fantasy in CSAM cases.

### 3.4.0 Would Therapists Question the Reliability of a Child Sexual Abuse Memory?

Participating therapists were asked 'Would you question the reliability of a CSAM?'. When I deemed it was necessary, I also asked prompt questions, such as "How would you question it?". In their replies, participants also explained how, why and in which cases they would question a client's CSAM, and also whether they have ever been in such a position.

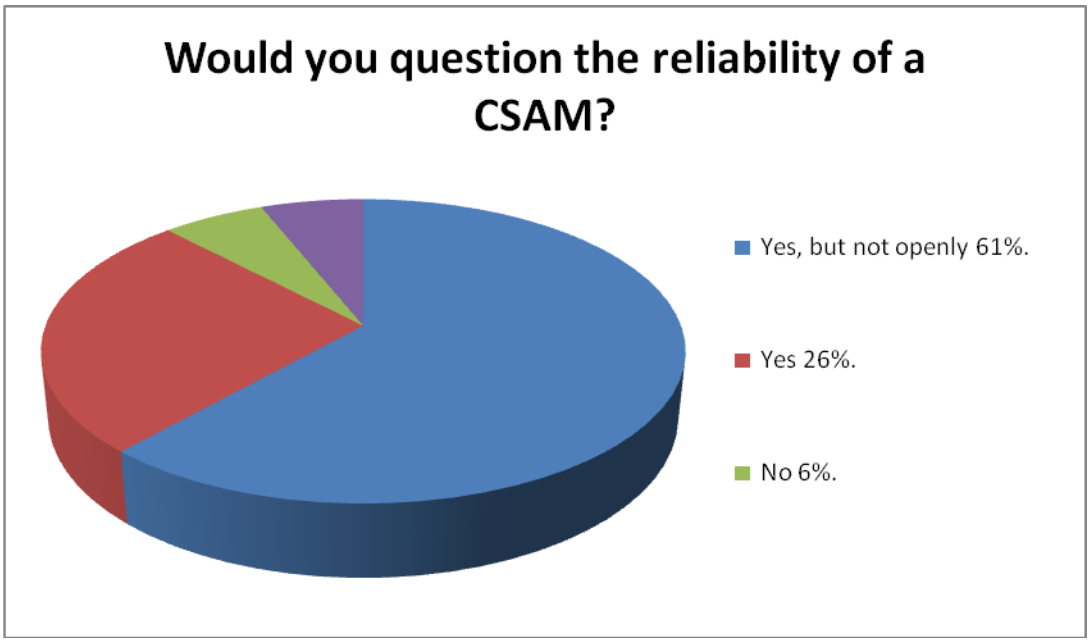
### 3.4.1 Numerical Description of the Responses

As shown in chart 4 below, over 61% (19[131]) of the participants stated that they would question the reliability of a CSAM, but not openly, and almost 26% (8[132]) stated that they would question it openly. Over 6% (2[133]) of the participants stated that they would not question it and over 6% (2[134]) of the participants' responses could not be categorised as 'yes, indirectly', 'yes', or 'no'.

Without being directly asked, more than 45% of the participants stated whether they have thought about questioning a client's CSAM or not: nearly 26% (8[135]) of them declared that they have not experienced this, whilst over 19% (6[136]) stated that they have been in such a position.

This means that most participating therapists would implicitly question the reliability of a client's CSAM, several would explicitly question it and a few would not question it.

Chart 4: Responses regarding the questioning of the reliability of a client's CSAM



### 3.4.2 Therapists Who Shared their Ideas on How to Question a Client's Early Sexually Traumatic Memory

Overall, more than 74% (23[137]) of the participants described how they would question their client's CSAM. Almost 42% (13[138]) of all the participants replied that they would question it through relevant explorations.

Rita[139] said that she would question a client's CSAM tactfully, through other ways, like contradictions in other matters:

*"I have not questioned it. If there were many indicators, and if s/he [analysand] presented a fake persona in his/her relationships and if the sexual abuse did not fit into his/her profile… if I felt that there are many things that do not connect, I would probably start with questioning other matters, like contradictions in other matters, because I think that it would be very traumatic to question this, if there was a chance for it to be true".*

Like Rita, Emelia[140] said that she would implicitly question it and that she would focus on the contradiction:

*"...I question the contradiction because we can never know the reality… and maybe it is not of interest whether things happened exactly like that or not. What interests us is… the way the analysand experienced it, so that s/he can also explore the wish. So I would not openly question it"…*

Emelia added that therapists are interested only in the client's general sense of reality:

*"We are interested in the existence of the context of reality but we are not interested in confirming if something like that has happened or if it is a fantasy".*

Magda[141] argued that she would doubt a client's CSAM within herself, and that she would help the patient distinguish whether it has been fantasised:

*"...I would question the reliability within myself... Even if it was false or if it was in the context of a delirium, I would not doubt it since it would be the patient's experience… It*

*serves something… The therapist in his/her own way, may slowly make the patient see which material refers to reality and which does not"…*

In addition to this, Magda used exploratory questions in order to help the client distinguish whether a memory has been fantasised or not:

*"When it happened to me, with many exploratory questions and the stability of the framework... the patient reached a point where s/he said: "It may not have happened. I may think that I remember this"... I always let the patient bring the material when s/he is ready and able".*

Toula[142] claimed that she would implicitly question a CSAM, and that she would accept it anyway:

*"I will accept it as a patient's experience of something erotic and traumatic even if it did not happen the way s/he describes it, in the sense that we accept psychic reality… In the case of adults, I question it, to be certain about whether it is a fantasy or reality"…*

Additionally, Toula explained that she would explore a CSAM and keep it in mind, rather than doubt it directly or search for the reality:

*"I would not doubt its objectivity directly to my patient, as I think that this is pointless… I would explore it more, as much as the patient could handle it. I would not try to find out the reality; I do not think that there is a reason [for this]. I would simply keep it in mind as a reference point in relation to everything else s/he [the patient] would bring up".*

Agapi[143] said that she has had cases in which, according to her, traumatic memory remained uncertain:

*"There have been cases… where I still do not know what has happened exactly, maybe even years after a period of therapy. In some cases… this complaint about [the parents'] indifference... may be… an effort to construct a very special happening [of the past], which also obviously corresponds to patients' fantasies"…*

Agapi added that she would not question a client's CSAM. She would use general questions:

*"Because we work psychoanalytically... I do not question it. This happens throughout the course [of therapy]. Maybe with questions... generally, not specifically".*

Ira[144] declared that she recognises the possibility of false memory, that she would not question a client's CSAM openly, and that she would attempt to enlighten more perspectives:

*"...I always keep in mind the thought that this may be fiction and not fact, but I well-respect the other's [the client's] feeling that has emerged from this fiction… Not openly because s/he experiences that so I respect it until s/he can reconstruct his/her own truth. I would... try to shed light on things in a way so that the other person can see them from different angles".*

Efi[145] highlighted that there would be a reason why the analysand falsely reports being sexually abused during childhood:

*"I could not believe it or question it with the analysand. This has not happened to me… I cannot say that I would never do it… If there is something that I believe is not true, I would think that there is a reason why the analysand says it… It is easier to say "I have been sexually abused" than to share something that is still very hard or traumatic".*

The next 4 participants replied affirmatively. Lefteris[146] would question a client's CSAM under the following conditions:

*"Not perceptibly. I would question it when the analysand's story does not include pain, if it did not fit with the person's history, if it emerged because of something else (e.g. because an analysand read a book or watched a movie)"...*

Lefteris additionally proposed various questions about the memory's emergence, meaning, convenience and so on:

*"I would do it by asking how come it emerged so suddenly, what the fantasy of abuse means to her, how can she use the position of the victim to avoid responsibility, what she wants me to do with this i.e, what this means for her, why she wants to do this and why it emerges right*

*now. I would do it not so much in order to question it, but to see what this provides her emotionally".*

Stella[147], who also replied positively in the question under consideration, maintained that she would mention the contradictions and exaggerations:

*"I would not question it more or less than another memory. If I had doubts, I would mention the contradictions. I had cases of CSA... and I questioned the extent to which it was indeed so barbaric or if the analysand felt it this way"…*

The reader should be reminded that, similar to Stella, Rita and Emelia, whose responses are presented above in the same section, also mentioned the usefulness of pointing out the contradictions asserted by the client in CSAM cases.

Sotiris[148] who also replied affirmatively, realised that CSAM may be screen memories and mentioned the possibility of retroactive construction:

*"...There is a danger with memories: they may be screen memories and one should be very careful because the primary memory may not be found… I would question it but it has a different magnitude, the analysand might have had a retroactive construction, a memory for a thing that never occurred"…*

In addition to the above, Sotiris indicated that he would explore a CSAM through the material, the contact, the dreams and so on:

*"It has not happened to me but I have a case of someone who was severely abused, and at first I thought that it was exaggerated; yet it turned out to involve so much abuse. I would explore it through the material, the contact, the cooperation, the dreams etc"…*

Pantelis[149] also endorsed the view that he should doubt the client's narrations, as he held that they contain unconscious fantasies in a condensed form. In his perspective:

*"Always, as I would question anything. My work is to keep in mind the external reality or the facts, to doubt and question consistently any narration that has to do with external reality as*

*traumatic or ostensibly simple as it might be. I always question the reality as it is always implicated with fantasies and with the rest of the patient's representational web"…*

Pantelis additionally said that during the disclosure of a CSAM he would pay attention to listening, feeling, and providing a holding environment:

"*I cannot give you specifics because they really depend on the case and on what I feel as right or necessary to do. If I heard such a traumatic narration for the first time, I would not intervene at first. I would stay there to listen and to think… and of course to maintain this holding environment... in which this would be heard".*

Afterwards Pantelis would think about all other parameters, and then he would endeavor to understand the related wishes and wounds:

"*…Of course I would openly question. I would think about all the other parameters because… if you pick this specifically, it's like scratching the wound… And of course behind any such narration especially when it has a sexual abuse nature, an analyst is always interested in seeing the patient's urge and wish and how his/her desire may have contributed in maintaining an open wound through guilt etc".*

The following two replies could not be clearly grouped. Isidora's[150] response stressed that she would explore, but without being negative:

*"I would not question it but I would explore it, without being negative… I have had the opposite: thinking that it may not all be true, but it was".*

Petros'[151] interventions would aim in both unearthing and alleviating the guilt:

*"I would handle a person's fantasy differently from a continuous occurrence; the number of occurrences is significant. What you must do, with much attention, is to bring up the person's guilt… to gain power… to add some logical rationales, different repetitions, dreams, so as for him/her… to see that fantasising, desiring, and… misbehaving a bit is not… terrible…The Job is not easy…"*

Petros emphasised that he would treat more cautiously clients who suffer from psychosis:

"*Only to the psychotic you will not pick at it a lot because the person cannot stand it, and instead of helping you will cause harm".*

The participants' quotes until the end of the current section elucidated how they would approach a CSAM, but did not involve exploration in their responses as the ones above. The next five participants responded that they would question a client's CSAM but not openly. Despina[152] understands that the client's traumatic memories of seduction can be untrue, and in such cases, she could pose an issue of trust:

*"We do not search for the historical truth... and there is subjectivity. If you realise that someone is lying, you could pose an issue of trust... The lie has a truth in it and it may be related to traumatic fantasies of seduction".*

Like Efi[153], whose relevant quote was noted earlier in the current section, Despina, underlined the reasons behind such a lie:

*"I had a case in which she told me, "There is something I have not told you but I cannot tell you". They may hold secrets from you. The lie is the same. It may be valuable to hold on to, a way to have something personal… I would not expose the patient's lie, at least for a long period of time".*

Antonis[154] would bring attention to the motives, rather than questioning the validity of a client's memory openly:

*"I would not question it. I do not remember a case where I questioned like that. I would put the damage and the occurrence at different levels. I would focus on the essence, for example, motives".*

Nota[155] accepted that some memories are questionable and simultaneously supported that she does not care about the verity of a CSAM:

*"There are cases where his/her memories may be like that, but questioning it therapeutically is pointless… The more unclear it [a memory] is, the more we... perceive it… as a memory of childhood fantasies... It is a doubt and a hesitation but it is not like I will say it to the analysand… [and] in no case will I confirm the truthfulness of the narration… Memories mostly lighten what your patient lives now, therefore we do not care about their verity".*

Vicky[156], who had 15 years of experience at the time of the interview, said that she had repeatedly thought about whether a client's CSAM is fantasised and explained when she doubts CSAM reliability:

*"... This has happened to me. Many times I have the feeling that it is a fantasy of sexual abuse that is taken for a real memory and this can also be found in [psychoanalytic] theory… Many times I have seen women with more of a hysterical background, who refer to such memories... very easily. This is when I would doubt what they have said"…*

Like Nota, whose quote is presented above, Vicky also said that she would hold this material in her mind:

*"The questioning happens within me, and I hold this in the back of my mind. I do not question openly because there is always a question mark... I always wait to hear more from the analysand, through the relationship"…*

Mirsini[157] mentioned that she would be in a position of doubt rather than directly questioning:

*"…I would not question my analysand directly; I would be in a position of doubt... We can clearly see that a high percentage of these experiences really have happened"…*

The next four participants argued that they would question a client's CSAM openly. Aris[158] said that ongoing CSA cases usually involve seductive situations rather than explicit CSA. He also emphasised evaluating and processing the material so as to understand various issues:

*"Yes... the reliability as far as the reality of the fact, not the reliability and its worth as a psychotherapeutic fact. You evaluate and process whatever is said… What you do is*

*understand what is happening... why this has a distance from reality, what it means... and you handle it accordingly. In the process, the patient him/herself realises this fact".*

The following three participants, all female and (professionally) experienced (ranging between 18 and 30 years of experience), highlighted that they would try to move the client away from whether something happened and more towards the trauma in relation to the feeling. Initially, Simela[159] elucidated why there is confusion between memory and reality in CSA cases:

*"…Often, when there is a sexual abuse trauma, the barrier of the preconscious, which protects us from external stimuli, has been broken and the person is constantly between reality and fantasy… While the preconscious is being healed, it suddenly breaks again. So you are not able to know whether… something happened, or happened again, or whether s/he relived the past experience as if it was happening now…"*

Afterwards, Simela clarified why the FRD is not the main concern in psychoanalytic therapy:

*"But this is not so important within therapy because therapy is not a search for truth; we work with how s/he experiences that moment… the contemporaneity with which s/he experiences it. Since s/he experiences it in this way, it means that whatever happened was either a specific act or occurred in a seductive atmosphere, which was so intense that it is as if it had indeed happened"…*

Then Simela made clear both when and how therapists can approach this distinction:

*"Only when the analysand has reached a [general] distinction between fantasy and reality will it be helpful to ensure the distinction [about the CSAM]. If we are sure, we may ask, "Possibly your fantasy had also scared you, then?" but not state that it never happened. We may never clarify exactly how it happened".*

Timotei[160] discussed issues about ascertaining and understanding the validity of a client's CSAM:

*"...I would question it... We are never certain about what has actually happened... In my experience with many borderline patients and many traumas, usually when the actual trauma is intense and extreme you understand it"...*

Subsequently, Timotei specified that she would approach a client's uncertain CSAM through confrontation and discussions on whether the client's experience albeit traumatic differed from the facts:

*"Lying has not happened to me... In that case I may indeed do what we call confrontation, with all the dangers this may entail. In a case where we may feel that someone experiences things in a very dramatic way… I would discuss with him/her how s/he may have experienced this in a very traumatic way but that it may not in fact have happened like that".*

Dina[161] demonstrated the wording she has actually used in the past to delicately separate the client's feelings from the event:

*"… In some occasions, such as hysterical types, when I am certain that it is more of an emotion of repressed desire which happened before and repeats itself, I have said: "Of course I understand that you feel the way you do but it sounds like that feeling is more intense than the actual event, no matter what that was". In other words, I am attempting to move her away from there without telling her that it did not happen".*

Additionally, Dina emphasised why this intervention should be done delicately and in due time:

*"I theorise that when you are absolutely convinced that the other person is exaggerating, you must take him/her away from it delicately; if you tell him/her right away they become defensive and we lose the opportunity to help".*

The participants' quotes from this sub-section point out ways to psychoanalytically approach questioning a client's CSAM.

### 3.4.3 Therapists Who Argued in Which Cases they Would Question a Client's Child Sexual Abuse Memory

Nearly 67% (21[162]) of the participating therapists mentioned under which circumstances they would or would not question the reliability of clients' CSAM.

- Psychopathology

While bringing to light when they would question a client's CSAM, over 16% (5[163]) of the participants pointed out issues about psychopathology.

Angeliki[164] argued that she would question an analysand's CSAM in cases of severe disorders, easy disclosures, and confused memories:

*"I will question it in severe disorders, such as psychosis or hysteria, where fantasy and reality become mixed up. When the analysand discloses it too easily to the therapist and expects him/her [analyst] to tell him/her [analysand] what's going on. To someone with confused memories"…*

Angeliki apparently meant that she would question CSAM only within herself as she added:

*"It [direct questioning] cannot be done and there is no point in anyone questioning it, neither the delirium, nor this information [CSAM]".*

Fenia[165] implied that the need to question a client's CSAM would come up in cases of psychosis, and when the client would not be persuasive:

*"I have not been in that position. They (analysands) were persuasive, there could be no doubt. I have not had a case where it was only imaginative. Anyway, I do not work with psychotics".*

Petros said that you are careful with what you pick in psychotic personalities. He also said that the number of occurrences is significant, implying that it is more probable to question a single CSAM, rather than a continuous experience. Simela emphasised the vulnerability of

the barrier of the pre-conscious in cases involving a CSA trauma. Magda[166] would question the reliability without expressing it, if it was in the context of a delirium.

- Other Indications for Uncertain Memory

The following participants brought up other indications for uncertain memory. Athina[167] accentuated the implications of fantasy on actual CSA:

*"…One of the reasons why sexual abuse is traumatic is because it intervenes in a delirium of fantasies... If a girl in the Oedipus stage fantasises about the father and a father-figure hurts her sexually, the fantasy's space is ruined"…*

Athina acknowledged the existence of fantasised, real and confused CSAM, as well as the psychoanalytic position on the fantasy-reality dilemma:

*"I think that there are cases where all this is only a fantasy, cases that are real and cases where reality intervenes in fantasy… Psychoanalysis supports that the construction of historical truth is not an absolute goal; fantasy also has an organisational role".*

Athina also referred to two of her cases which involved uncertain CSAM. In the first, Athina suspected that her female client may have suffered CSA since the first year of therapy. The client disclosed during the fifth year of therapy that a boy, 10 years older than her, harassed her as a child, and then Athina thought that this could be fantasised. The client did not want to call this abuse, while Athina held that it was abuse. When Athina recognised that this was a boundary issue, the client felt relief. At the time of the interview, the client was in the 7$^{th}$ or 8$^{th}$ year of therapy.

In Athina's second case, a female client had experienced CSA by her godfather who touched her genitals. Both the client and Athina were unsure about whether there was another CSA in her history.

Takis[168] would understand that a memory is questionable when there are screen memories and neurotic internal or external elements. In his words, he replied that he would question a client's CSAM:

*"In some cases where it seems to have the form of a screen memory. Living in a neurotic environment, in a neurotic context in a neurotic structure… I would not doubt it; I would just understand".*

Participants described other reasons for the therapist to be concerned about the validity of a client's CSAM. These may involve:

- Current danger: if this concerns a child who is currently abused and has to be removed from his/her home (Toula[169])
- Signs of deceiving tendencies or exaggeration: when therapists realise that the client is lying (Despina[170], Timotei[171]); if the client presents a fake persona in his/her relationships (Rita[172]); when therapists realise that someone experiences things in a very dramatic way compared to what has actually happened (Timotei[173])
- Signs of non-reality or false memory triggering: if the therapist has doubts (Stella[174]), or believes that something is not true (Efi[175]); if the memory emerges because of something else; for instance, because a client read a book or watched a movie (Lefteris[176])
- Signs of psychopathology or fantasy: when working with hysterical types, (Dina[177], Vicky[178]) who refer to such memories very easily (Vicky); when the therapist is certain that it is more of an emotion of repressed desire which happened before and repeats itself (Dina)
- Missing elements, such as correspondence with profile, clarity, detail or emotion: If the sexual abuse does not fit with the client's profile/history (Rita[179], Lefteris[180]) or when many things do not connect (Rita[181]); in case the described event is unclear (Nota[182]), when there is a screen memory (Sotiris[183], Ilias[184]), or when the analysand's story does not include pain (Lefteris[185]).

Ilias[186] added that in order to question such a hurtful topic, one must have worked very much on it, usually for many years. Pantelis[187] saw this in a more personalised way as he said that it really depends on the case and on what he feels as right or necessary to do.

As seen in the present sub-section, the majority of this study's participants explained in which situations they would question a client's CSAM memory, and most participants related these situations to the client's psychopathology.

### 3.4.4 Therapists Who Stated Why they Would or Would Not Question a Child Sexual Abuse Memory

While replying to an interview question about whether they would or would not question a client's CSAM, almost 68% (21[188]) of the therapists mentioned why they would or would not question it. More specifically, nearly 42% (13[189]) of the participants declared why they would not question a client's CSAM. Furthermore, approximately 26% (8[190] ) of the participants argued why they would question a client's CSAM, and 75% (6) of these (8) participants were male. The participants' responses will be grouped and presented below.

Almost 13% (4[191]) of the participants held that it would be pointless to openly question a client's CSAM. For instance, Nota[192] argued there are cases where memories may be uncertain, but you should contain the confused fantasy and keep a distance from it, rather than confirming or questioning it which is therapeutically pointless. As maintained by Simela[193], questioning a CSAM may not have a point because the issue in therapy is the contemporaneity with which the analysand experienced it.

Other statements by participants who explained why they would not openly question a client's CSAM will be presented next. In cases of memory fabrication, Malvina[194] pointed out that she would need to understand the reasons behind it, and that she can wait for the truth to appear later if there are no others influenced by that:

*"...Even if it was a fabrication s/he made-up consciously, why would that person need to make that fabrication, and why did s/he show that this thing is true at first? The truth will appear later, and many things will differ from what really happened. But, if these help him/her and do not worry others"...*

Aphrodite[195] emphasised that traces of CSAM indicate the existence of similar experience, and that it is not the therapists' job to find out the truth:

*"If a person has inside him/her a trace [of CSAM], in some way something like that has been experienced. Now it is not our job to find out, we are not judges"...*

Apollonas[196] stressed the unreliability of any memory:

*"We cannot question any memory in the sense that every memory is an expression- fantasy; that's the way they assume it so it stands. We are not detectives…. I have never questioned any memory".*

Rita[197] argued that she would not question a clients' CSAM openly because it could be very traumatic, especially if the CSAM was authentic. Similarly, Vicky[198] stated that she would not question openly because she could not be certain that it is not actual. Ira[199] would not question a client's CSAM openly since the analysand experiences it this way, so Ira respects this until the client can reconstruct his/her own truth. …

While replying about whether they would question the veracity of a client's CSAM, almost 10% (3[200]) of the participants of the present research, claimed that therapists can never be certain about the reality. As found in her reply quoted below, Chrisa[201], who would not openly question a client's CSAM, discussed the role of both fantasy and reconstruction in psychoanalysis, and reasoned that we cannot reproduce the biographical truth:

"…*In psychoanalysis, reality does not have the main role. If and why the reality distortion happened will be shown in the reconstruction. The usual thing is for such occurrences to emerge from amnesia. Remembering things that have not really happened is not rare… In the end we cannot reproduce the biographical truth of a person in analysis".*

Emelia[202] would not openly question since she claims that we are interested in the existence of the context of reality but we are not interested in confirming if something like that has happened or if it is a fantasy. She also said that therapists can never know what the reality was. Timotei's[203] statements were rather self-contradictory: She stated that she would confront, if needed, a client who lies about a CSAM, that we are never certain about what has actually happened, and that in some way and in some cases therapists can understand the authenticity of the trauma.

The previous response and the rest of the responses included in this section came from participants who explained why they would question a CSAM. In the beginning of his response to whether he would question a client's CSAM, Ilias[204] accepted both the existence of fantasised memory, and the existence of abusive experiences that contribute to the development of fantasised trauma:

*"Many times these memories derive from fantasy… It is not important if they have happened or not as far as the nature of the trauma is concerned. The trauma has been formed in an abusive experience"…*

Ilias described a case of a man who revealed that when he was seven years old his father sexually harassed him by fondling him. This individual developed a psychosis, and made a suicidal attempt while he was in crisis. According to the patient, after the crisis the father said that, "What happened to you may be my fault and I apologise". This apology helped the patient to restore his already good enough relationship with the father. This man was functioning well, and he concluded therapy normally. When there is a good parent-child relationship many things can be 'forgiven'.

Ilias said that he would carefully and indirectly question a CSAM since in some cases this may essentially offer a way out of the traumatic:

*"To question something we must have worked very much on it, usually for many years, because... [it] is very hurtful. This essentially may in some cases offer a way out of the traumatic but is a very hard topic that requires a great deal of attention. In certain times it is a screen memory that appears as pleasurable because it is so traumatic".*

Lefteris[205] would question a CSAM, not so much in order to doubt it, but to see what this provides the client emotionally. Aris[206] also said that he would attempt to understand what is happening because in the process, the patient him/herself realises that the role of the therapist is to explore all material. Sotiris[207] would question it because the client might have had a retroactive construction, a memory for a thing that never occurred. Pantelis[208] always questions the reality as it is always implicated with fantasies, and behind any narration about CSA, an analyst needs to see the patient's urge and wish and how his/her desire may have

contributed in maintaining an open wound through guilt. Agapi[209] would generally (yet not openly) question a client's CSAM as this may be a search for something which corresponds to patients' fantasies. Dina[210] would question it because sometimes it is more of a repetitive emotion of repressed desire.

Petros[211] would intervene in cases involving CSAM so as to unearth hidden feelings, to help the client to gain power, and to see that sometimes misbehaving a bit is not something terrible. Petros argued that therapists should not openly question such a memory because instead of helping they will cause harm.

The current sub-section united the participants' arguments both for and against questioning the reliability of a client's CSAM. Notably, more participants clarified why they would not question the reliability than those who clarified why they would question it.

In this section, interview material about the therapist's inclination to question a client's CSAM is presented. It appears that 61% of the participants would question the reliability of a CSAM, but not openly. In addition, a sizable minority (26%) of the participants would somehow consider questioning the reliability of a CSAM and some (19%) of the participants stated that they have been in such a position, whilst some other (26%) participants declared that they have not experienced this. Only a few (6%) of the participants stated that they would not question the authenticity of clients' CSAM, and a few (6%) others did not give a clear-cut reply. A great majority (74%) of the participants shared their ideas on how to question a client's CSAM and many (42%) of their replies involved exploring the relevant material. A remarkable majority (67%) of the participants had an opinion on when they would or would not question a client's early sexually traumatic memory and the participants' different opinions created a whole list of indications of uncertain CSAM. For instance, some (16%) participants argued that in cases involving psychopathology they would be more cautious about the validity of a client's CSAM. Most (68%) participants appeared aware of the reasons why they would or would not question a CSAM. For instance, participants' answers on questioning a client's CSAM ranged from this being therapeutically pointless, to it potentially being a way out of the traumatic.

### 3.5.0 Do Therapists Accept The Fantasy-Reality Distinction As Their Responsibility?

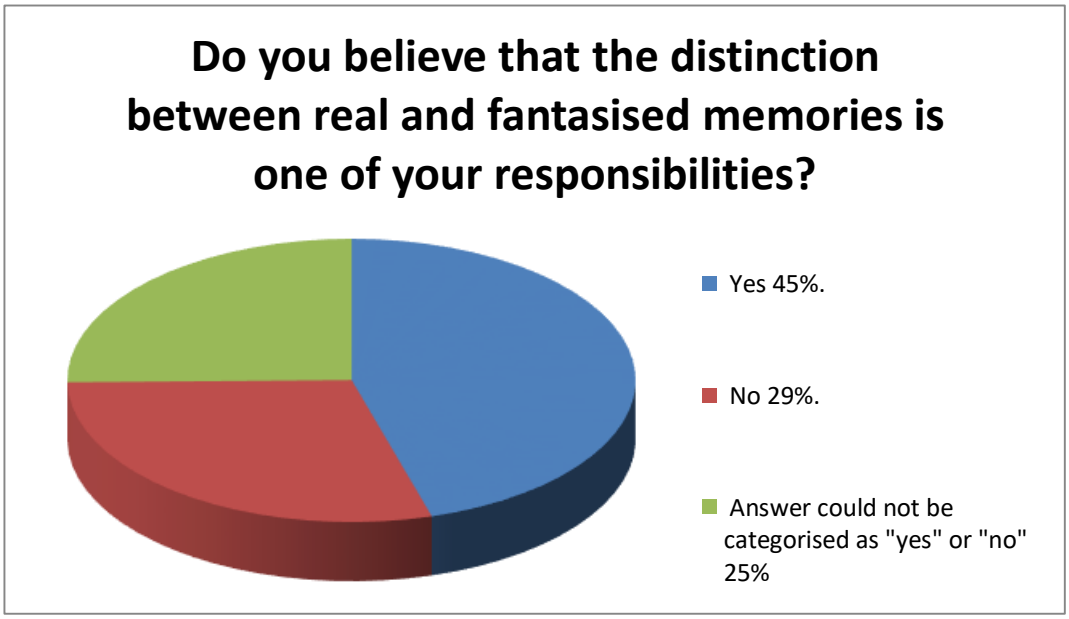
During their interview, the participating therapists were asked: "Do you believe that the distinction between real and fantasised memories is one of your responsibilities?" and most of the participants responded positively. The next sub-sections will accentuate both why and when this distinction is counted by the participants as their responsibility. The last sub-section will indicate statements in favour of the idea that reality is not the priority in psychoanalysis.

### 3.5.1 Numerical Description of the Responses

The results of the current study (see chart 5) suggest that over 45% (14[212]) of the Athenian psychoanalytic therapists, who participated in the current study, held that the distinction among false and actual CSAM is within the therapists' remit. Over 29% (9[213]) of the therapists seemed to believe that the FRD is not one of their responsibilities, since they replied negatively. Over 25% (8[214]) of the therapists' replies were not clear-cut enough to be categorised as 'yes' or 'no'.

The results propose that much more psychoanalytic therapists accept the FRD in CSAM cases as their responsibility than those who do not accept it. Uncertainty and divergence of opinions can also be observed among this study's sample.

Chart 5: Responses regarding the therapists' responsibility in the FRD




### 3.5.2 Therapists Who Explained Why the Fact-Fantasy Distinction is the Therapist's Responsibility

Over 35% (11[215]) of the participants clarified the reasons why they hold that their client's distinction between fantasy and reality is among their tasks.

As Rita[216] concisely argued, the FRD is the therapist's duty since the client's relationships and experiences are affected:

*"My responsibility is to be there for a person that needs to tell his/her story. However, it is my duty to distinguish reality from fantasy because his/her relationships and other experiences are influenced"…*

Aris[217] underlined that reality could determine different actions, for instance in cases involving ongoing sexual abuse:

*"...Reality determines different reactions, too. If an 18-year-old reveals that her father still rapes her, as a psychoanalyst are you not obliged to clear things up? Others will say that you… should not play the role of the protector, because this will destroy the relationship… but… You ought to do something".*

Aris also proposed how he thinks that a therapist should act in such cases:

*"The best thing... would be to help this young person to take responsibility and that is what you should try to do. But you may change your position, you may become an intervening and guiding presence but not as directly as to say "go to the police and report your father"".*

Angeliki[218] denied this distinction as a responsibility that therapists can have alone, and held that the clinical diagnosis would depend on the reliability of the CSAM:

*"It is [my responsibility] only when in a cooperation with a psychiatrist, a doctor or a clinic, and only when a diagnosis is required. The diagnosis is understandably different when the material is real and when they just relate to patient's fantasies".*

Nota[219] claimed that later on during therapy, the patient will tend to understand the memory and to make the FRD:

*"It is [my responsibility]... but in the sense that it is something that will come out of psychological work later. At the moment that he/she announces it, one should not… start asking questions so as to clarify. The patient's psychical tendency per se will be to bring it up again and to try to understand it and within the context of this understanding s/he will slowly start distinguishing fantasy from reality"…*

However, according to the same participant, Nota, this task should be done by experts– rather than psychotherapists- if there is the urgency of a prosecution:

*"…If the experience is to be brought up during a prosecution, he/she ought to have a series of interviews with a specialised psychiatrist, clinical psychologist, and/or social worker possibly. I mean that it is not a problem for the psychoanalyst to solve; if there really is some urgent issue it is good to see the specialists".*

Mirsini[220] initially replied negatively, but later on during the interview she changed her response. She also talked about showing the way for the client to think whether his/her memory is fantasised:

*"While working with an adult privately, yes, it is in your responsibility to make it easier for him/her to think that perhaps what s/he says and has fantasised is in the sphere of an Oedipal wish and that it is not sexual abuse that actually happened; but therapists cannot indicate this directly themselves".*

One of the participants who gave a not-clear-cut reply, Agapi[221], said that the FRD is not exactly her responsibility and that in one of her cases there was a need to clarify what had happened in the past, in order to stop putting herself in danger:

*"It depends, when we talk about psychoanalytic therapies then not exactly. However, what has happened in my experience is for a young woman who is in psychotherapy, has suicidal tendencies and plays with this abuse matter by putting herself in danger regularly, and that there it was needed to clarify what has actually happened to her and whether she is repeating this by putting herself in danger".*

Agapi added later during the interview that this young woman did not stop the repetitions and stopped therapy prematurely.

Vicky[222] declared that the distinction would help therapists understand the client's truth, and that the client's psychical part that resorted to fantasies of CSA could improve through therapy:

*"The truth and the lie... within psychoanalysis are relevant because we are looking for the analysand's truth. To resort to such fantasies is a part of his/her psychical reality, which could be altered within therapy... Depending on our experience, we may potentially abuse the analysand or we may create a 'holding' environment for him/her and understand him/her".*

Vicky also discussed a case of hers about a borderline female patient whose father had a maternal role with unclear boundaries. Vicky was inexperienced and became harsh, the patient left but returned and noticed that Vicky was different.

Stella[223], who supported that the FRD is not necessarily the goal, added later in the interview that when the relevant psychological investment changes, our whole outlook towards the event per se may change:

*"The goal is the differentiation of the psychological investment and that may change the event itself. Anyway, I hold this for a while and then we work beyond the event".*

The last two participants showed an optimistic view of what psychotherapy may accomplish towards the distinction (also see section 3.6.0).

Other participants' opinion on why the fact-fantasy differentiation may play a role in therapy can be summed up as follows. Takis[224] focused on the revelation of fantasy which will enable therapists to make the distinction, to see what its historicity was and where the client needed to develop such fantasy constructions so that s/he could handle the reality which deprived him/her of certain actual memories. Malvina[225] argued that it could be the therapist's responsibility and presented the therapeutic process as an interchange of going back and forth while trying to successively and repeatedly enter and exit the client's story. Lefteris[226] laid emphasis on the elucidation of the way that relationships should be at present, in the future and in the past.

As seen in the above-noted sub-section, a substantial minority of the psychoanalytic therapists, who participated in the present study, reason that the FRD is their responsibility; for instance, because the clients' lives are seriously affected, or when the CSA may be ongoing.

### 3.5.3 Therapists Who Discussed When the Fantasy-Reality Distinction is Or Is Not the Therapist's Responsibility

Over 35% (11[227]) of the participating therapists discussed the conditions under which the FRD is related or unrelated to the therapist's remit. Emelia and Agapi were the only participants who clarified in which cases the distinction would *not* be their responsibility, whilst in all other cases participants clarified when the distinction would be their responsibility. From these 11 participants, almost 73% (8) were not psychiatrists, and aproximately 73% (8) had more than 15 (actually 16 or more) years of experience (from the

remaining three participants, almost 67% (2) had unknown years of experience, and more than 33% (1) had seven years of experience).

Almost 13% (4[228]) of these participants connected the issue of the therapists' responsibility to the client's mental state and their statements will be reviewed first. Chrisa[229], who was one of the participants who accepted the therapist's responsibility in terms of the FRD, pointed out that this distinction is her responsibility in cases of psychosis. Nonetheless, she was comparing reality to non-reality, instead of reality to fantasy:

*"It is a matter of usefulness, not responsibility. There are cases where distinguishing reality and non-reality is useful. For example, in psychosis, with which I work a lot, a distinction must be made between what emerges from within and from outside the person... In neurosis, where we are talking about basic analysis, all this is worked out and I focus on fantasised reality".*

Like Chrisa, Dina[230] also accepted the responsibility of the FRD in cases involving psychosis. Dina additionally explained her different role in cases with neurosis and also linked the therapist's responsibility to the client's request:

*"Generally and vaguely, no. It is in my responsibility when this is entailed in the patient's request through an expressed or a latent way or in cases of psychosis. However, to a neurotic, who may repeatedly describe an erotic story of his/hers and where I understand that some details are not entirely as s/he has told them, this distinction would be pointless".*

Emelia[231], who discussed a similar position to both Dina and Chrisa, accentuated that the fact-fantasy distinction is not within the therapists' responsibilities when the patient is psychically organised, whereas in psychosis things must be worked on differently. Her response was grouped as a negative one (i.e. the distinction is not the therapist's responsibility), as she did not clarify whether she held that in cases of psychosis she accepts this duty as her own:

*"I feel that it is not within my responsibilities in an analysis, at least not when the patient has a psychic structure that allows him/her to regress safely. Depending on the pathology the way that therapists handle things, it will be different, for example they will not let an*

*analysand with psychotic structure regress that much and they will work on a better control of psychic life and reality".*

As one can see in her statements presented in the previous section, Angeliki[232] advocated that a FRD is done only in cooperation with others, such as a psychiatrist, when a diagnosis is required.

The following statements came from participants who discussed when they think that the division between fantasy and reality is the therapist's responsibility, without referring to the client's mental state. Toula[233] and Efi[234] argued that the reality-fantasy CSAM is the therapist's responsibility if the distinction is an issue within therapy.

Sotiris'[235] negative response highlighted that in issues that involve him as a therapist he attempts to have mutual understanding with his clients:

*"My first response would be 'no'. When things concern me, I try to find a way for me and my analysand to understand some things in the same sense. The distinction between reality and fantasy is chaotic".*

Despina[236] made clear that the actual-false memory distinction is not her responsibility, but added that she will do it if she judges that it is needed or if at some point something is very confusing:

*"It is not exactly within my responsibilities, but if I judge that it is needed, I will do it. If at some point something is very confusing, I could intervene… I would not care if it did not occur; if it happened for him/her, it would happen for me too".*

As seen earlier, Agapi[237] replied that the FRD is not exactly her responsibility when we talk about psychoanalytic therapy, and Aris[238] noted that in certain cases the psychoanalyst is obliged to clear things up. Mirsini said that it is the responsibility of therapists who work privately with adults.

This sub-section informed the reader about several participants' thoughts on the circumstances under which a FRD in client's CSAM would be the therapists' responsibility.

### 3.5.4 Therapists Who Stated that Reality is Not the Priority

Regardless of their position on whether they replied that the distinction between the actual truth and the fantasised truth is the therapists' responsibility, over 29% ($9^{239}$) of the participants stated that reality is not the priority.

Petros[240] said that the FRD is his responsibility, but that the meaning of - both false and actual - CSAM is more important than its reliability:

"*It is within our responsibility but it does not have special signification. What has signification is what is behind these real memories or fantasies, what role it has played, why it has become a psychological trauma".*

Ilias[241] also acknowledged his responsibility towards the truth, yet held that therapy is more important:

*"The truth is always a requirement, but I do not think that the search for truth should precede the therapy. Therapy is the priority".*

Fenia[242], who disagreed with the idea that the distinction between fantasy and reality is her responsibility as the therapist, proposed that fantasised and actual memories are equally important:

*"...I do not think they are my responsibility. Fantasised memories are equally important to real ones".*

Simela[243] maintained that therapy should focus on the client's investment in their experience, since nobody knows the truth:

*"No [it is not]. Because my approach is not to find the truth, which nobody knows because, one way or the other, the truth that will come out in therapy is what s/he experienced at some point plus the fantasies... the memories... what followed after the event... it is never the truth. The way s/he has invested in what s/he experienced, this is our work and our focus".*

Magda[244] said that the truth is the priority in courts, whereas in treatment therapeutic material should be accepted even if they are false:

*"No, I think that if such a case goes to court, it should be dealt with by the court. In the case of a therapeutic relationship, whatever comes as material... we accept it, we respect it and we deal with it as any therapeutic material, even if it is false. The therapist cannot take such a responsibility. The therapist can help the analysand to clarify his/her memory but it is not among the therapists' responsibilities".*

Like Magda, Pantelis[245] believed that therapists ought to accept the analysand's personal truth, rather than the actual truth:

*"…One would wish for it to be clear, simply to say that this was fantasy and this was reality. I think that I do not know… how one can be so sure, though s/he may be sure that these two are very implicated anyway… We will analyse what s/he brings to me... no matter if it is a fantasy or a reality".*

Stella's[246] stance towards the FRD as the therapist's responsibility was not clear-cut enough in order to be categorised as affirmative or negative. As seen previously, she argued that the goal of therapy is the differentiation of the psychological investment, not the potential truth and falsity in CSAM. Both Rita[247] and Nota[248] said that listening to the client's story was a priority compared to discriminating between fantasy and reality.

In the current sub-section, attention was drawn to some participants who declared that reality is not the priority in the psychoanalytic approach of clients with CSAM.

This section revealed findings concerning the therapists' possible responsibility regarding the FRD of clients' CSAM. The results demonstrate that there is ambiguity across the data as to whether this distinction is (45%) or is not (29%) the therapist's responsibility. There is also some confusion of responsibility as 25% of the participants responses were not clear-cut enough to be categorised as 'yes' or 'no'. Nonetheless, several participants were in a position to explain not only when they hold that the FRD is their responsibility, but also why they

hold that the FRD in clients' CSAM is their own responsibility, and why they declare that reality is not the priority in psychoanalytic psychotherapy.

### 3.6.0 What Do Therapists Believe about the Feasibility of the Fantasy-Reality Distinction in Therapy?

During their interviews, the participating therapists were asked 'Do you believe that the distinction between real memories and fantasies in CSAM cases could be achieved?'. In the following sections, the reader will find out not only how many therapists thought that this distinction is likely to happen during treatment, but also the ways through which they think that this would be achievable. Other relevant issues enlightened by the participants related to the difficulty and the uncertainty involved in the differentiation of fantasy from reality.

### 3.6.1 Numerical Description of the Responses

When the participating therapists were asked about whether they hold that the FRD is feasible in clients' CSAM, the results showed divergence of opinions (see chart 6). More particularly, almost 39% (12[249]) of the participants replied positively, indicating that they deem that the distinction can be achieved in therapy. As seen in the following sub-section, most of these participants named conditions, such as long-term analysis[250], under which the distinction would be viable.

Over 32% (10[251]) of the participants' answers could not be categorised as 'yes' or 'no'. For example, almost 10% (3[252]) talked about how they would distinguish true from false CSAM and did not specify whether they support its achievability.

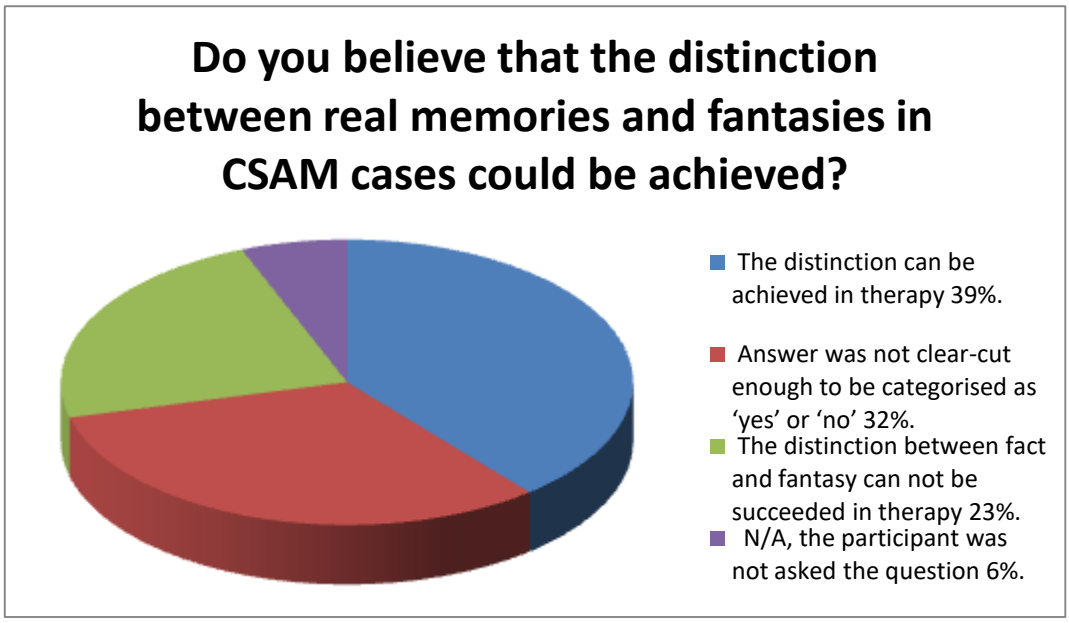
Nearly 23% (7[253]) of the participants replied negatively, signifying that they do not advocate that the distinction between fact and fantasy can be succeeded in therapy. For example, one[254] of the participants argued that the therapist's intervention regarding the FRD in cases involving CSAM, would be incompliant with a psychoanalytic approach.

Over 6% (2[255]) of the participants could not be included in any of the above-noted categories as the participants were not asked this question and they did not mention this issue by

themselves during their interviews. This probably occurred because I thought that they had already responded to this question, while they had not.

Hence, more participants tended to believe that the FRD is possible than those who believed that it is not. However, there was disagreement among the sample regarding this issue.

Chart 6: Responses regarding the feasibility of the reality-fantasy distinction




### 3.6.2 Therapists Discussed How They Would Try to Distinguish Reality from Fantasy

Over 77% ($24^{256}$) of the participants revealed their thoughts concerning the ways that the FRD would be accomplished in their (potential) work with CSAM.

- The Client will Make the Distinction

In their arguments about these ways, over 32% ($10^{257}$) of the participants focused on their attempt to help the patient clarify the memories.

As seen in the previous section (3.5.0), two participants, namely Nota and Mirsini, have declared their views on the matter of therapists helping the client in the elucidation of their memories. More specifically, Nota indicated that the distinction will emerge via psychological work later, that during the disclosure therapists should not question anything,

and that the client's psychical tendency would be to discuss it again, to understand it and to slowly distinguish fantasy from reality. Mirsini said that therapists should facilitate the client's consideration of the possibility of the memory to be false, without saying this openly.

When asked regarding whether she believes that a FRD is achievable, Rita[258] underlined that therapists should help clients to distinguish actual and fictitious memory for themselves:

*"It happens I imagine with time; it is part of the process. To stay with the uncertainty and your (plural) confusion, to follow the clues so as to separate reality from fantasy and help him/her [the client] separate them himself/herself".*

Later on during the interview, Rita remarked that there are clues to be connected by the therapist:

*"…You see how this works as a whole, if this information fits with the whole experience and the profile, how you and others experience his/her descriptions, if s/he is acting out something imaginary or if there is aggression towards someone… I think there are clues to be connected".*

Pantelis[259] claimed that therapists should not start investigating the client's narrations and that during the process the truth may be revealed through the therapist-client cooperation:

*"I cannot see how this can be done, unless I did the job of a policeman, asking third persons about it like a detective, etc… In the process of cooperation and the establishment of a working alliance, it may come out that s/he had created such an abuse because, at that time, it served his/her organisation, his/her defences, his/her sexuality etc. This may and will emerge if the analysis goes on, but if I start asking… I think that many defences will be triggered"…*

Vicky[260] also reasoned that the distinction between fantasy and reality in CSAM comes through the therapeutic process, and then separated her work in cases of psychosis, and stressed that therapists should assist the clients in the distinction and the improvement of fantasies:

*"This comes through the process of the therapy, through what we discuss, but I am not sure if that is what interests us. With a psychotic patient, we necessarily make the confrontation with reality... In a psychoanalytic context, I work more with the truthfulness of the reality and not as much with the examination of the memory's reliability. I think that the requirement will be to help the client to distinguish him/herself, to get out of the mass of fantasies, and to make other fantasies, which will be more alive and more creative".*

Emelia[261] hypothesised that the analysand will be able to distinguish memories based on facts and on fantasy, whereas therapists cannot be certain about the actual truth:

*"I think that perhaps this can be done by the analysand. By working and being in an analysis one can reach the level of thought that allows him/her to realise for example that this was my fantasy and hast never happened in reality. The therapist may think about it; I do not know if one can ever feel very certain".*

Earlier during the interview, Ira[262] mentioned differences between actual and false memory, and the reasons for each fantasy:

*"In cases of pseudo-memories, the way someone experiences this guilt is different and that's where one should help the other to see things and to see that he/she had reasons to create these fantasies and to live in these fantasies".*

In reply to whether she believes in the feasibility of the distinction, Ira expressed that the distinction occurs as therapists help clients to differentiate their feelings, to lessen their guilt, and to recognise more perspectives:

*"...By helping the other to see multiple perspectives and also by helping in the differentiation of the feeling. If we help the other to see the shades better, and we manage to diminish the guilt, this happens more easily".*

The next three statements could not be clearly categorised as 'yes' or 'no'. Ilias[263] accentuated that the therapist understands what happened only after clients distinguish between fact and fantasy in their CSAM:

*"When the analysand distinguishes them, the analyst will also distinguish them. The less traumatic the patient finds what we ask of him/her, the easier s/he will be able to distinguish fantasy and reality. It is a matter of processing the trauma".*

Agapi[264] asserted that clients come to realise what was traumatic for them:

*"...It is more that the patient perhaps realises at some point the notion of certain things. In the two cases I am telling you about, in the end it was not so much the occurrence that happened once or twice that was traumatic, it was more their own sense of themselves, including this continuous atmosphere around what they experienced as torture, and that they viewed themselves as being used".*

Dina[265] claimed that in certain cases therapists have to demonstrate the facts and the conflict for the client to see things more clearly:

*"Let's say in a psychosis or in a borderline psychotic condition, in a hysterical situation, I think that only if you connect things that s/he has said in relation to the facts can you somehow bring them to a position to see the exaggeration of a feeling that s/he describes or the contradiction or even the resistance"...*

Dina gave specific examples of what she would say in treatment to ease the client's FRD:

*"... For example one could say "I am trying to show you something and at this moment you probably do not want to see it, this confusion may serve something"... I handle the psychosis with my own feeling, for example I would say "You want to scare me now"".*

- Depth of Analysis

Over 19% (6[266]) of the participants linked the FRD to the depth of the analysis, and most of them to the duration of analysis. From these six participants, five were not psychiatrists.

As seen above, Rita and Pantelis indicated that the length of the analysis is important. More specifically, Rita[267] stated that a FRD is achievable with time, and Pantelis[268] claimed that the actual truth may come out if the analysis goes on.

Takis[269] argued that the different quality of fantasy and reality can be seen only after years in therapy:

*"Only after long-term analysis are you able to see the different quality. Fantasy is flexible, it involves only perception and it lacks representation, while reality has inflexibility, it does not change/fluctuate and there can be representation".*

Earlier during the interview, Takis went on to point out elements found in actual memories:

*"Two elements that may show you truthfulness: firstly… the quality of transference and countertransference, and secondly, the form of the dreams content, meaning whether there are traumatic dreams, anxieties, stress, nightmares or if they are dreams in the context of dream reproduction, the illusionary repetition of desire, so you see that the real element is not there and that it is more in the class of desire and fantasy".*

This indicates that therapists can be assisted in distinguishing reality not only by the transferential relationship, but also by the client's dreams, which may reveal more anxiety or desire, corresponding to actual and fantasised memory respectively.

Lefteris[270] said that the FRD becomes attainable through the therapeutic relationship:

*"…Indirectly this becomes feasible through the quality and the evolution of the relationship. When you follow ethically the therapeutic procedure and with empathy, and avoid to assume certain roles (detective, judge or ally) your patient will also recognise that the relationship with you is different and that s/he can feel close to you although you do not get involved, take revenge, co-act or repeat some things but you maintain the boundaries".*

Lefteris also elucidated the therapist's tasks in cases involving CSAM, and argued that the distinction between reality and illusory memories happens later on in therapy:

*"...Your task is to work, analyse, disentangle and interpret the memories but not to distinguish real from fake ones, this comes through the relationship later".*

At different points during the interview, Lefteris had identified specific differences between actual memories and fantasies:

*" The real memory has a different emotional intensity, that is, there are deep breaths, pauses, attempts to obliterate the memory, internal pressure, disbelief that a man can control his desire, difficulty in distinguishing desire and reality, difficulty in understanding the other's position and intimacy, and tendency to sexualise relationships… It is like a central memory that everything revolves around it, it is not unconnected to other memories and events".*

Lefteris accentuated that a total distinction is unattainable, but shedding light to CSAM is important:

*"They cannot be totally distinguished, fantasy colours reality, but it is important to know, for example, why we stress so much things that occurred or why we want things that have not occurred to have had occurred etc. One may over-emphasise a screen memory to a point that s/he perceives it as real to satisfy his/her own needs".*

Angeliki[271] associated the feasibility of the FRD to the depth of analysis, as she accentuated the intensity of therapy as a necessity:

*"One must work with the patient intensely. S/he must be very precise and careful towards whatever s/he is listening… The therapist must work with the transference a lot; what his/her own feeling is, meaning what s/he feels and thinks about the patient. In most cases it is good for one to ask for a psychiatric opinion".*

Malvina[272] stressed the magnitude of the therapists' deep personal therapy in terms of the FRD:

*"I think through knowing why they [the analysts] began doing this job, through having had a good analysis and having worked well with themselves and their difficulties, these are good guarantees for these things and their ability to "love" and respect the person they have in front of them. It is that simple in my way of thinking".*

- Transference and Countertrasference

Transference was connected to FRD in CSAM cases by almost 13% (4[273]) of the participants in their replies to whether this distinction is feasible. As seen above, Angeliki[274] said that therapists must focus on the transference and countertransference, Takis[275] indicated that one of the elements that may show you truthfulness is the quality of transference and countertransference, and Rita[276] emphasised the therapist's experience of the client's description.

Efi[277] indicated that the FRD is the main psychoanalytic task, which can be neither described nor ascertained, and that psychoanalysis is based on transferential relationships:

*"This is the whole work of psychoanalysis. Essentially this question cannot be answered; nobody can describe how it is done. The whole analysis is based on the triangle of transference, countertransference, relationships with objects today and history, all combined together. Although one can have a better sense of it, no one can be 100% certain".*

- Other Ways to Help in the Fantasy-Reality Distinction

While replying to the interview question about the feasibility of the FRD in therapy, almost 10% (3[278]) of the participants pointed out the role of other professionals, such as psychiatrists, in this task. As one can see from her quote presented above, Angeliki[279] said that in most cases it is good to ask for a psychiatric opinion. Nota[280] argued that when a person reports the experience and asks for practical help s/he must be with a specialist:

*"I think that the psychoanalyst cannot do that, that's why I said that the other must do it in exactly the opposite way, meaning that when the other goes to report the experience and ask for practical help s/he must be with the specialist, who can take a position, make many clarifying questions, and who is obliged to do it as the patient may be hallucinating; but it is not our job".*

Aris'[281] response to an interview question presented earlier (see section 3.1.3) was that the most important change he spotted in his work with CSAM was that he became capable of detecting actual from false memories. In the interview question explored here, concerning the feasibility of the FRD in psychoanalytic psychotherapy, Aris responded by listing the pre-

requisites for therapists, the entailed perils, and the information that a psychiatric evaluation should precede a FRD through psychotherapy:

*"There, it is a matter of experience, knowledge and capability; there is a danger of underestimating things. The other way of clarifying these things is the psychiatric one. It goes without saying that before you come to such a point in psychoanalytic psychotherapy, a psychiatric evaluation, examination, help, etc, has preceded it".*

In their answers to the same interview question, nearly 10% (3[282]) of the participants shared their thoughts on that a person with false CSAM needed to create fantasies for some reason. Pantelis and Ira supported this idea, as one can verify from their quotes presented above. More specifically, Pantelis[283] said that it may come out that the client had formed a CSAM because it served his/her organisation, defenses, sexuality etc. Ira[284] said that therapists should help the client to see that s/he had reasons to create these fantasies and to live in these fantasies.

Despina[285], whose response could not be clearly categorised as a 'yes' or 'no', discussed a case, where a girl had a fantasy that she apparently needed:

*"My supervisor had a case of a girl who had a fantasy that her mother wanted to have an abortion while she was pregnant with her because of marital problems. Her mother denied this when it was discussed, the girl believed that she had made it up, but after 3 months she came up with the same story again. When you use a lie a lot you end up believing it. This way you can see that it is a fantasy. She needed that lie".*

Other participants also had noteworthy views on the topic. Chrisa[286] was one of the participants who did not support that the FRD is feasible in psychotherapy. Like Vicky and others, Chrisa separated the cases involving more serious psychopathology. To be more specific, Chrisa underlined that, in contrast to other cases, in cases of psychosis therapists distinguish reality from non-reality and deal with perceptions, not memories:

*"Why do we have to distinguish?… In psychoses we do not talk about distinguishing between real and fantasised memories; we talk about distinguishing reality from non-reality, for example 'the waitress did not attack me by spilling my coffee on me, it was a mistake'. What*

*we have there is a reconstruction of the self; it is clear in that case. These are not memories, these are perceptions".*

In addition to the above, Chrisa discussed the limitations of the profession and a possible approach to fantasised material:

*"Nobody can know what happened in the past. If something is confusing, it may remain like that, unless it is clarified by other means. I do not think that the therapist has this ability. You intervene in the here-and-now, we cannot intervene in the past. If we have material, we show to the client that at that moment s/he is repeating something, that a reality is being obscured".*

Like Dina, whose response is presented above in the current section, Stella[287] responded in a way that could not be clearly categorised as 'yes' or 'no', although I repeated the question during her interview. Stella pointed out the idea that the therapist's questions towards the client could focus on the contradictions:

*"…In our questions we try to make things clear by pointing to the contradictions… without assuming the role of the policeman who will discover whether the accused person was guilty but to restore memories, fantasies and the investment in these".*

Antonis[288] mentioned two important criteria for memory clarification which were proposed in Charles Hanly's (1990) text on correspondents and coherence:

*"There are two important criteria: correspondence to other data and inner coherence. The more true and real a narration is, the more it corresponds to the rest of the internal and external data and the more inner coherence it has. That's why one must move between these two criteria".*

Magda[289], whose response could not be categorised as a 'yes' or 'no' said that a therapist could help a patient in distinguishing real memories from fantasies through questions and perhaps family therapy:

*"With exploratory questions, with a recursion in the past, in an effort to collect all the facts. If an issue like this [a CSAM] presents itself with great intensity, I might – with the permission of my analysand - bring in the family or refer the family somewhere for family therapy".*

Isidora[290] argued that ascertaining the actual truth is sometimes impossible, and that an experiential knowledge of the criteria could be fruitful for the FRD:

*"The truth is that it is not always possible and sometimes it may not happen. Vagueness may always be there. I think that if someone has a lot of experience on these issues (more case studies from which they attain the criteria)"…*

Apollonas[291] claimed that therapists can tell whether something corresponds to reality in certain cases, and that therapists should not doubt what clients say:

*"We can achieve this when it comes in a clear way and when it is already there, when the analysand brings it up, for example saying, 'Last night someone attacked me and raped me'. Then you will deal with that. If he/she says, 'When I was 8 years old my father attacked me and raped me and I want to talk about that,' I will not search whether s/he is telling truths or fantasies. There is no sense in that... Fantasy is their reality"...*

Mirsini[292] reasoned how a fantasy of CSA may emerge from lack of boundaries, and explained how she would approach uncertain memories:

*"…Often the fantasy may have been created… from an atmosphere of confusion regarding what is allowed, where the boundary is, for example touching, sleeping together… I do not know whether my work is successful; I just try to work with them. Never directly of course… I may say for instance, "It seems that the difficulty between your parents has upset you"; I will not try to import things so as to say that, indeed, this story was a fantasy".*

Timotei[293] held that a complete FRD is unattainable, especially with primitive memories, and emphasised the hints emerging from the unconscious in the therapist's work towards this distinction:

*"It is never completely done and I believe that the only way to do so is by listening to the patient, the way that the unconscious comes forth, for example, with dreams, free associations, meaning that it is not only the memories. Either way, the more primitive the memories are, the more they are constructed in some way".*

As viewed in the above sub-section, a significant majority of the participants offered ideas on how to achieve the FRD in therapy.

### 3.6.3 Therapists Who Mentioned How Hard and Uncertain A Fantasy-Reality Distinction Would Be

When asked about the feasibility of the FRD in CSAM, over 45% (14[294]) of the participants called attention to the difficulty and the uncertainty entailed in this distinction.

Some of the relevant answers have been articulated in the previous section (3.6.2), and will be partly repeated here. Lefteris[295], before he was asked the question about the feasibility of the fantasy-veracity distinction, claimed that they cannot be totally distinguished, as one colours the other. Emelia[296] stated that she does not think that therapists can ever feel very certain about the distinction. Pantelis[297] highlighted that he cannot see how this can be done, unless he asked questions to 3rd persons like a policeman or a detective. Efi[298] said that although one can have a better sense about the genuineness-fantasy distinction in CSAM, no one can be absolutely certain. Isidora[299] admitted that the distinction is not always possible and vagueness may always be there. Timotei[300] revealed that the distinction is never completely done and that memories are constructed in some way. Chrisa[301] stressed that therapists do not have the ability to know what happened in the past, and mentioned that the confusion may remain, unless it is clarified otherwise. Nota[302] also thought that the psychoanalyst cannot discriminate between actual and false CSAM, and had added that a specialist should assume this task.

Earlier during the interview, Takis[303] discussed both the difficulty and the feasibility of the FRD:

*"You just do not have the ability to see if it is or if it is not like that or if it has some basis on reality; this [conclusion] is very hard to reach".*

Also earlier during the interview, Athina[304] indicated that when working in retrospection, analysts cannot be sure about the FRD:

*"I do not think it is possible for an analyst who works in retrospection to be sure about this distinction. This retrospection is an issue in psychoanalysis. I mean, it is different when talking to a child brought to you because s/he has been sexually abused (where you know that it has happened) and when talking with an adult who mentions it on his/her own, and constructing the design is in the therapy of the past. I do not think that anyone can be sure".*

Aphrodite[305] argued that therapists cannot become certain about the facts:

*"As far as the facts are concerned, I think that you can never say with certainty. Okay, in certain moments you say that this must have indeed happened, but this does not mean anything; I mean that it means something and it does not mean something at the same time".*

Sotiris[306] pointed out not only that he does not believe in the feasibility of the actuality-illusion distinction, but also that he would be scared if someone responded affirmatively:

*"It is not feasible and I would be scared if someone was able to say yes. I move on and I am not interested in distinguishing between them because I discern a creative spirit there. To say to the other "this is a memory" and "this is not"? How do you know?".*

The results presented in this section indicate that almost half of the participating therapists recognised that an FRD would be hard and uncertain in cases involving CSAM.

This section's data are important because they reveal that there is disagreement across the sample about the viability of the distinction, since of the 31 participants 39% said that the distinction is feasible, 23% replied that it is unfeasible and 45% that the distinction is hard and uncertain. The participants' responses also showed that a considerable number of therapists presented ambiguity towards the topic since 32% of the participants' responses were not clear-cut enough to be categorised as 'yes' or 'no'. Another important finding is that 77% of participants had ideas about ways for therapists to facilitate the FRD in therapy.

These ways included helping the client to make the distinction themselves, aiming for intensity and depth of treatment and appreciating the transferencial relationship.

**Conclusion to Analysis Chapter**

There were some gender differences detected among the sample. My findings supported that male participants were more likely than female participants to attribute their changed practice in cases involving CSAM to the factor of time, to discuss their successfully completed relevant cases, and to explain why they would question a client's CSAM.

There were a few interesting observations in relation to the therapists' experience and their additional psychiatric profession. It appears that the more experienced the therapist was, the more possible it was to express feeling uncomfortable. Moreover, the more experienced a therapist is the more likely s/he will consider the circumstances under which they consider the FRD as related or unrelated to the therapist's remit. Participants who were solely psychotherapists were more likely than those who were both psychotherapists and psychiatrists to discuss the conditions under which they consider the FRD as related or unrelated to the therapist's responsibility.

In the present study, participants reported changes in their work with client's CSAM, based on experience, knowledge, and other factors. They also discussed unpleasant feelings and conditions, involved in their practice concerning adult clients' CSAM. Participants seemed alert towards the client's possible retraumatisation during the initial discussion of CSAM. In this respect, they apparently paid attention to the therapist's mistakes, the client's repetition compulsion, and the reality of sexual retraumatisation.

As far as their therapeutic approach to suspected and undisclosed CSAM is concerned, some ambivalence was detected both across the sample and interpersonally in some participants. Notably, participants were more likely to wait for the client to disclose before they would implicitly or explicitly connect the client's symptoms to early sexual trauma. As far as their questioning of clients' CSAM, several participants stated that they have thought about doing it, or have actually done it, some implicitly, others explicitly. Most of the participants would question the reliability of a CSAM, but not openly. Participants clarified how this questioning

would occur, when they would or would not question a client's CSAM, and why they would or would not question it.

The last two sections of the current study revealed the participants' approach to the FRD of their client's CSAM. Ambivalence was observed in participants' responses and across the sample regarding both in the participants' views on the therapists' responsibility in the FRD, and on their belief in the feasibility of the distinction. Regarding the therapist's responsibility in such cases, the most popular response given by the participants was that the distinction is their responsibility. A number of participants were in a position to explain not only when they hold that the FRD is their responsibility, but also why they hold that the FRD in clients' CSAM is their own responsibility, and why they declare that reality is not the priority in psychoanalytic psychotherapy. Regarding the feasibility of the FRD, participants were more inclined to accept the feasibility, but also stressed that such a distinction is difficult, uncertain and that it requires a lot of time and effort.

The above-noted results of the present study will be reviewed and interpreted in the forthcoming chapter, and they will also be linked to past literature presented in the first chapter, using the methodology explained in the previous chapter. This will offer the opportunity to understand in more depth the participating psychoanalytic therapists' approach to the controversial issues regarding CSAM, which were addressed in my thesis.

## Chapter 4: Discussion

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### Introduction to Discussion

Until now, I have reviewed past literature on the subject of CSAM and psychoanalysis, explained why and how I intend to explore the therapists' stance towards certain debatable issues, and also presented the participants' replies to my interview questions. Now, I will both explain what these replies indicate, and I will look to see where the results of my interview analysis concur or not with the literature. Following this, I will focus on the complications of the present research.

More specifically, the findings of my study will be presented in the following five sections (see table 3.3 in Appendix 3). They include, ways to approach hypothesised CSAM and uncertain CSAM, and the difficulties involved in cases concerning CSAM. Through the participants' sharing of their thinking and experience, therapists who work with CSAM will be offered with more ideas and therapeutic tools so as to understand and handle several of the most controversial issues encountered in modern clinical practice.

### 4.1.0 Introducing Child Sexual Abuse

This section includes the first important finding of my study, which concerns how Athenian psychoanalytic therapists approach indications of CSA and whether they would relate them to the client's symptoms. The participants' replies could increase our awareness concerning the risks of the first discussion of CSAM, informing us about whether therapists are likely to intervene in a perilous and thus potentially harmful way. As analysed below, regarding the therapists' optimal stance before a possible CSA revelation, this study's participants were divided between (1) not proposing CSA as an explanation for the client's symptoms and (2) doing so (a) conditionally and (b) indirectly. Most of the participants shared their original ideas about specific ways of dealing with their selected approach, and, interestingly, a few of them discussed how they have handled this in the past and the result of this approach. As we shall see next, my findings contradict previous writings and entail possible dangers. The results discussed in the current section can be related to implications for the accusation towards psychoanalysts regarding overlooking actual CSA and over-emphasising fantasies

(see section 1.1.4.1). These implications will be addressed near the end of this thesis (see Thesis Conclusion).

### 4.1.1 Ambivalence about the Introduction of Child Sexual Abuse

In relation to whether therapists would connect CSA to the client's symptoms before the client's disclosure, the results of this study (see section 3.2.1) suggest that 45% of the participants would not do this, 29% of the participants would do it, 16% would do it but 'not openly', and 10% of the participants' replies were self-contradicting (see section 3.2.1).

The results draw attention to at least two conflicting perspectives. According to the first perspective, the above-noted finding indicates that 45% of the participants would point to undisclosed CSA, in a more or less direct way, so as to explain symptoms to the patient, and that they would mention CSA before the patient discloses it under certain conditions. In this case, there is a lot of ambivalence as another 45% of the participants were arguing that therapists should not discuss CSA before the client discusses it.

According to the second perspective, the 'not openly' response also suggests that participants would consider this connection but that they would not share their thoughts explicitly with the patient. This means that overall (combining the 'not openly' responses with the negative ones) 61% of the participants are not likely to propose CSAM openly as an explanation for the analysands' symptoms. This result demonstrates the therapists' clear-cut propensity to avoid both openly connecting symptoms to trauma and/or discussing CSA before it is revealed by the client.

There were also some contradicting statements made by the participants regarding the therapists' work on CSAM following the client's revelation. According to a participant's (Petros) opinion, a connection between a symptom and CSA could be expressed as a hypothesis after the client's disclosure. More specifically a therapist could say: "I thought that maybe there is a relationship between this occurrence that you are discussing now and the corresponding symptomatology. I will let you think about it, I may be wrong". However, as maintained by Antonis, linking the CSA's consequences on the patient to the actual CSA act per se, would be complicated for an analysand's mind and the damage would appear irreversible. A possible way out of this predicament is to link the CSA's consequences to the

parents' and grandparents' psychopathology. In my view, the explanation involving the cross-generational inheritance may not seem as linked to the client as the explanation focusing on the CSA s/he has endured.

In any case, these results show that the Athenian psychoanalytic therapists are not unanimous about the controversial issues concerning both the introduction of CSAM and the proposal that the client's symptoms are indicative of CSA.

### 4.1.2 Waiting Unconditionally, Intervening Under Conditions and Guiding Indirectly

More than 74% of the participants expanded on their responses about their approach to a potential undisclosed CSAM which is hypothesised because of related indications. Over 25% of the participants stressed that therapists should not bring up a CSAM before the client reveals it and that they should wait patiently for the material to come from the client first (see section 3.2.2). At the same time, over 25% of the participants said that they would discuss CSA before the client's disclosure only under certain conditions (see section 3.2.3).

The former group argued (see section 3.2.2) that although there is a clear connection between psychopathology (such as borderline disorder, hysterical personalities and psychosis) and CSA, proposing CSA as an explanation the client's symptoms would be too intervening and that such an intervention may lead to false CSAM development. Emphasis was laid on the possibility of therapists being wrong in their hypothesis about the symptom-CSA connection. There were also examples of cases where the therapist (Athina) was aware of a CSA in the client's history but waited for the client to reveal this after many years in therapy.

The latter group of participants identified conditions under which they would allow themselves to discuss CSA before the client's actual disclosure by linking it to the client's symptoms (see section 3.2.3). These conditions were the following:

- The 'right time': (1) A long-term therapeutic relationship and a safe ground should have been established; (2) an adequate restoration of the client's mental capacity should have already occurred so as for the client to withstand the traumatic discussion of a CSA; (3) the therapist's discussion of CSA should correspond to the client's pace, the case, and the phase of therapy

- A requirement concerning: (1) A clinical diagnosis which would influence the client's sexual issues; (2) limited time allowed for the therapeutic intervention; (3) the patient's ability to listen to this proposal so as to avoid retraumatisation and move on
- To help with the revelation: (1) If there were very strong indications and the client was really close to revealing CSA and needed help with that; (2) if the client was implicitly revealing the CSA to the therapist through various indirect ways but felt embarrassed to actually say it.

Somewhere in-between the two above-noted positions, regarding waiting unconditionally or intervening implicitly in certain cases, there was a third group (16%) who supported the indirect guidance of the clients by their therapist (see section 3.2.4). More specifically, these participants proposed that they would indirectly guide the client in order to link his/her symptoms to his/her yet undisclosed CSA.

The participants who supported that under certain conditions they would discuss CSA before the client, offered ideas about the way this could happen, and these ideas were very close to the ideas expressed by the third group advocating for indirect guidance (see sections 3.2.3 and 3.2.4). All participants seemed unwilling to explicitly discuss CSA before the client's actual revelation because this would be very abusive. It was argued that when therapists make an intervention, the results may appear later on. The symptom-CSA connection could be proposed among other explanations and therapists should not impose anything to the client. Therapists should prefer questions rather than direct assertions and explanations.

It was especially highlighted that the term 'CSA' should not be used, but it could be rephrased. For instance, a therapist could ask: "Do you think that your symptom relates, for example, to an actual experience of yours, to a behaviour of yours? Could we think about that and discuss it?". It was also suggested that therapists could ask if there is something difficult or 'bad' that the client is afraid to discuss. In my opinion, the word 'difficult' would work here, in contrast to the word 'bad' which I would not encourage therapists to use, as it may augment the client's guilt and shame.

Two participants, namely Dina and Simela, stressed that a therapist can help the clients' expressed feelings to become articulated. Dina explained a situation which a client had

endured as a ‘crossing of boundaries’, and this worked in a liberating way. Simela said that in order to help the client understand the discomfort s/he feels, therapists may ask whether the client had felt overwhelmed with certain excitations from some adults. I think that the latter idea involves a risk of triggering premature disclosures or false CSAM and that this issue could be explored in more tactful ways, for instance, alongside other primary memories regarding excitations and feelings.

Simela also emphasised that in order to encourage the client to protect him/herself, a therapist may talk, assume a position and speak on behalf of the client’s self by saying: “It is your right not to want someone in the house; setting a boundary is taking care of yourself” and “This will not happen again like that; you will not allow it”. I believe that the former quote offers justification for the client’s feelings and that the latter can be used only after a client’s CSA disclosure, as it would seem too intervening, otherwise.

Three participants, namely Stella, Chrisa and Dina, discussed cases where they peripherally guided their clients to make a CSA disclosure. Stella remembered talking about a sexually arousing environment in order to facilitate the client to reveal the traumatic material.

Chrisa asked her suicidal female patient who had experienced inter-familial violence whether something happened during childhood because she was sure that this was related to further sexual abuse in her life history. In my opinion, this approach could also appear leading or risky as the client may not be ready to withstand discussing such a trauma at that moment. However, in cases involving suicidal attempts, therapists may work more paradoxically that they would in any other instance.

Dina stated that she had implied it delicately: “It seems like you want to say that something has happened during these years that you find difficult to discuss and remember again”. Dina considered her approach as helpful in unearthing the traumatic material when the timing was right.

As a closing point, certain instances of implicit discussions about CSA were presented by the participants. However, none of the participants said that explicitly discussing CSA prior to the client’s revelation, had already occurred in their practice, and three participants stressed that this has not occurred in their practice.

### 4.1.3 Comparison with Previous Literature

As seen in the literature chapter (see section 1.1.1.1), Freud's original position (1896a), supposedly perceived patients' resistances and denial as a proof of the actuality of abuse and pressured his patients to accept his hypothesis. More recent literature is controversial concerning whether therapists should always inquire about CSA (Herman, 1992; Barber, 2012), whether they should consider inquiring about CSA if there are indications for it (Palm and Gibson, 1998) or whether they should avoid drawing conclusions about CSA in the client's past, via his/her symptoms (Lindsay and Read, 1994; Spanos, 1996; Madill and Holch, 2004). At the same time the literature also includes views supporting that a proposal of CSA by the therapist before the client's disclosure would be considered suggestive and thus possibly lead to both the client's retraumatisation (Mollon, 1996), and false memory triggering (Bowers and Farvolden, 1996; Mollon, 2000; Loftus and Davis, 2006).

Most (61%) of the participants from the present study declared that they were unwilling to openly discuss CSA before the client's actual revelation (see section 3.2.1). This implies that they were in disagreement with Freud's (1896a) hypothesis about denial and resistances being the proof for CSA. They were also in disagreement with Herman's (1992) beliefs and Barber's (2012) findings that therapists should always inquire about CSA. A number (29%) of my study's participants (see section 3.2.1) could sometimes follow Palm and Gibson's (1998) recommendations but in an implicit way, that is, they would consider inquiring about CSA if there are indications for it.

Many (45%) of my study's participants (see section 3.2.1) stated that they would not propose a symptom-trauma connection before the client's disclosure. They seemed to support those (Lindsay and Read, 1994; Spanos, 1996; Madill and Holch, 2004) who advocated that therapists should avoid drawing conclusions based on indications. The opposite stands for the 45% of the participants who held that they would explicitly (29%) or implicitly (16%) inquire about CSA if there were indications of CSA.

It has also been recommended (Enns, et al, 1998) that if the client presents a set of symptoms often related to abuse but does not reveal such a history, the practitioner should not mention to the client that s/he was abused but should help the client to explore various circumstances

that may be connected to his/her symptoms. This recommendation is especially in line with many (29%) of the current study's participants who would implicitly facilitate the client's relevant explorations (see section 3.2.4).

The results of this study also suggest the ways through which such explorations would be advisable and how they would be accomplished. This is a new and important finding as there were no such specific recommendations in the previous literature. These entailed (1) the reasons why therapists should wait for CSA to be introduced by the client, (2) both the conditions under which and the ways in which therapists would propose CSA as an explanation for the client's symptoms and (3) ways to implicitly explore whether there is a CSA history and whether it should be connected to the client's presenting symptoms (see the previous section). By reading the above, clinicians can become aware of more relevant parameters, ideas and specific approaches before they make an informed decision about their preferred treatment plan in cases of suspected CSAM.

I found in the previous literature something related to one of the ideas put forward by my participants. In my study, it was argued that therapists could allow themselves to connect the client's symptoms to CSA before the client's actual disclosure if the time was right, that is if the client's mental capacity had been sufficiently restored so as for the client to withstand the traumatic discussion of a CSA. According to Richardson (1993), there is a peril for the client to be retraumatised when his/her memories emerge before his/her damaged psychic functioning is adequately restored through psychoanalytic psychotherapy. Nevertheless, following an adequate restoration of the client's psychic capacity, in analytic therapy, memories will surface optimally and will entail little or no peril of the client's retraumatisation. In this instance, the argument in my study and the argument from the literature coincide completely.

To compare with findings from similar research, Colton (1996) found that several allegedly psychoanalytically-oriented psychotherapists experienced disappointment as they felt that they had colluded with both the client and her family in the denial of the incestuous secret. Nonetheless, in my study there were no expressions of disappointment, even by the participants who said that they would not discuss CSA before the client addressed the topic.

The reason for the difference between my findings and those of Colton (1996), that is the lack of feelings about colluding in the denial noticed in my study's sample, could be due to the US participants' worry about possible legal precautions usually taken in their country. To put it simply, since in the USA therapists have been accused for triggering false memories, they might have intentionally or unintentionally avoid bringing up CSA, even when they would think that this would help their clients. Greek therapists, on the other hand, do not feel so threatened by this possibility, as in their country these legal accusations are not frequent, and therapists feel freer to address this issue or to avoid addressing it.

In my view, this result appears to address the concerns of USA therapists and the restrictions placed in their work by recent controversies. It calls for an effort to find ways to allow more freedom, or more specific guidelines, in ethical therapeutic work with CSAM. The specific guidelines would aim to provide the boundaries needed for therapists to feel confident while working within a steady framework. Thus, therapists would be able to apply more personalised responses, which is required as every case is different. The level of the establishment of the therapeutic alliance would also play a central role in whether therapists would address this issue when needed. In such cases, the question about whether it is right for therapists to talk around this issue remains. They could, for instance, make a comment or an interpretation about the client's fear, so as to avoid staying completed silent. This intervention would perhaps help to allow space for relevant discussions with the client, while it would avoid repeating the mother's overlooking of the abuse, and at the same time it would not be too intervening.

In Barber's (2012) study, it was found that all abused clients and the vast majority of practitioners felt it is imperative to inquire about any potential CSA. Moreover, proposing CSA as the basis of the client's symptoms has been declared as helpful by the majority of mental health professionals in Barber's (2012) study (see section 1.2.1.1). This opinion has also been supported by many other authors (Pruitt and Krappius, 1992; Olio and Cornell, 1993; Phelps, Friedlander and Enns, 1997; Palm and Gibson, 1998). However, such a proposal may be retraumatising (Mollon, 1996) and it would also be suggestive which may lead to false memory creation (Poole et al., 1995; Loftus and Davis, 2006; see section 1.1.2.3). It is important for therapists to remember not to bring CSA up explicitly before the patient discloses such a memory. Educational and training programmes could encapsulate

these important details as they may cause false memories and thus have detrimental consequences for the therapeutic process, the client, and his/her social environment.

Barber's (2012) findings contrast my findings. Most of all, it contrasts the majority of the therapists who seemed disinclined to bring the matter of CSA up. Moreover, the rest of the participants of my study also declared that they would explore only indirectly and conditionally.

This contrast may relate to the different places the studies were conducted, and to the interviewees' varying theoretical and practical orientation. Regarding the different places the studies were conducted, my study took place in Athens, Greece, a much smaller community where people are used to hide things from each other due to taboo on the topic, gossips, embarrassment, consequent repression and so on. This could be one of the reasons the Greek participants were more disinclined to bring this matter up than the Australian participants from Barber's (2012) study. Regarding the interviewees' varying theoretical and practical orientation, my study's sample included psychoanalytic therapists, while in her study various mental health professionals had participated. I think that the therapists in my study would be in less rush to discover the client's history compared to other professionals who will probably see their clients less frequently and for smaller periods of time than a psychoanalyst/ psychoanalytic therapists would.

The minority of practitioners in Barber's (2012) study, who did not believe in the benefits of disclosure of CSA, cited that the survivor's distress symptoms may be reduced devoid of disclosure of CSA, and that it is unhealthy and arrogant for therapists to have an opinion on when disclosure should or should not take place. This way of thinking is similar to a couple of the participant's view in my study, namely Petros and Dina. Petros (see section 3.2.2) held that sexual issues and CSA should not be mentioned in the beginning of treatment. He adhered to therapy being effective and complete without analysing sexuality issues per se at all, through employing techniques and meanings mastered while exploring other issues in therapy. Dina discussed a case wherein her female analysand shared a nearly forgotten memory concerning her CSA. They had no time to work on this but the client had indirectly worked on relevant issues because of a seductive relationship she had with her father. Retrospectively speaking, both Dina and the client felt that this client's therapy was successful. The minority opinion from Barber's (2012) study also coincides with the views of

most of my study's participants who held that therapists should not propose CSA as a possibility and should rather wait for the material to be discussed from the client, whenever s/he will be ready.

In my perspective, the view that clients should discuss their trauma if and whenever they wish is most respectful towards the clients' pace and decision-making. As long as therapists make clear that they are available to talk about any subject - no matter how uncertain, confusing or painful it is – I think that the client should have the final statement on when and what they decide to work on. It is important for therapists to remember not to bring CSA up explicitly before the patient discloses such a memory. Educational and training programmes could encapsulate these important details as they may cause false memories and thus have detrimental consequences for the therapeutic process, the client, and his/her social environment.

Sullins (1998) presented vignettes of clients who assumed they had repressed CSAM. Sullins found that therapists were unlikely to do any of the following: ignore clients' presenting symptoms, focus on memories, use debatable techniques, make suggestive comments about abuse, or instantly suppose that their clients have repressed memories.

If we categorise as potentially suggestive the intervention about proposing CSA to explain the analysand's symptoms, my study's results also support that therapists are unlikely to de-emphasise symptoms in favour of memories, use suggestive comments, or speedily presume that their analysands have repressed memories. However, if one thinks that by not addressing CSA as a possible explanation for the client's symptoms, the therapist may be ignoring the clients' presenting symptoms, my study's finding appear to contrast Sullins' (1998) finding about therapists being unlikely to overlook the symptoms. This issue remains unresolved and left for the reader's judgement, showing that the topic of the analyst raising the issue of CSA first, requires further empirical research.

While some participants did not rule out the possibility of being the first to bring up CSA in the therapeutic process, they emphasised that this raising of the issue should be done implicitly and conditionally, such as when they believed that the analysand was ready to listen to this. Dropping hints by the client to the therapist about CSA before it is disclosed has been mentioned by victims of CSA who were interviewed for another study (Barber, 2012).

This may indicate that if therapists are attentive to the client's hints, the discussion of CSA may come up at the right time.

In my research, participants were mainly in favour of an approach adjustable to the client's unique needs. Participants' responses as a whole presented their open-mindedness and eagerness to form a relationship that matches each client's needs, instead of one which matches the therapist's assumptions on the right path to follow when it comes to CSAM (Olio and Cornell, 1993). Those who advocated that they would not propose CSA as an explanation for their analysands' symptoms, based their opinion on how the client would be influenced if the therapist was penetrating, suggestive or wrong. It was also argued that therapists may guide the analysand peripherally, rather than proposing this CSA explanation unequivocally, and also that therapists may consider proposing CSA as an explanation only if the analysand was really close to revealing CSAM and needed help with this. The replies of this study's participants were very supportive and considerate towards the patient. They seemed to balance out many extreme views on the therapists' level of intervening albeit some of them could be judged as dangerous for false memory triggering. It was also argued that therapists should wait for the material to come from the client in order to avoid becoming suggestive and triggering false CSAM (see section 3.2.2).

Some of this study's participants stressed that the articulation of this proposal would depend on the patient's hints and ability to listen to it at that particular time and others that they would take great caution when exploring the subject indirectly. Notably, none of them said that they had already expressed openly a hypothesis about undisclosed CSA in their practice. Nonetheless, therapists who would bring up CSA as a possibility, even implicitly, before it had been articulated by the client, could be accused as potential instigators of false memories (Yapko, 1994; Poole et al., 1995; Loftus and Davis, 2006) or as risky for clients' retraumatisation and false memory creation (Mollon, 1996). It is true that my study's participants may not be fully aware of the great influence that psychoanalytic therapists have on their clients even when they just think that there is a CSA history (see section 1.1.3.4).

As seen above, the participants' responses in my study are ambivalent across the sample in relation to introducing CSAM. This may stem from the ambivalence entailed in the relevant literature emerging from both Freud's work and the memory wars, as well as the accusations towards analytic therapists (see sections 1.1.1, 1.1.2 and 1.1.4). Participants were careful

about their handling regarding the introduction of CSAM, but could not escape the potential dangers inherent in both psychological and analytic approaches, as some of them would introduce CSA before the analysand's disclosure, thus risking the client's retraumatisation or false-memory triggering. Their most popular response was that they have not thought about introducing CSA first in therapy so they could be judged as ignoring CSA or as adopting risky hypotheses, yet they would avoid the inherent dangers of such an intervention. All these different approaches to introducing or not CSA constitute important novel findings as to both how Greek psychoanalytic therapists tend to react and how therapists in general may variously respond to symptoms of CSAM before it is clearly disclosed in treatment.

Many (29%) of the participants chose the third proposed solution noted in the literature chapter (see section 1.2.1.1), as they were supporting the approach of exploring the origin of the presenting symptoms without bringing up CSA (Enns, et al, 1998). In this way they both avoid appearing in denial about such trauma and simultaneously avoid, up to a point, the perils included in openly addressing CSA before an actual disclosure.

Overall, these results underlie the necessity of theoretical elucidation about if and when it would be useful to address CSA. For instance, a solution could lie in the ideas of realising that a therapist cannot reach conclusions about the client's history based on indications (Lindsay and Read, 1994; Spanos, 1996; Myers, 1999; Madill and Holch, 2004), or in asking about CSA during the initial assessment interview (Barber, 2012), none of which was articulated by my study's participants.

### 4.2.0 Questioning the Reliability of a Client's Child Sexual Abuse Memory

An important finding of the present thesis concerns psychoanalytic therapists' approach to uncertain CSAM. The ambivalence entailed in the responses of this study's participants will be emphasised. Attention will also be drawn to their ideas concerning the reasons that could lead a psychoanalytic therapist to question the reliability of a client's CSAM. My findings contradict past literature material as demonstrated below.

### 4.2.1 Ambivalence about Questioning a Client's Child Sexual Abuse Memory

Through the participants' statements, it was reminded that the psychoanalytic position supports that the construction of historical truth is not an absolute goal. This statement does not utterly clarify the issue. It implies that the distinction is not the main goal, but is it a goal? As seen in the previous chapter (see section 3.4.1), minorities of this study's participants declared that they would not doubt (6%) or that they would question directly (26%) the trustworthiness of a clients' CSAM, while most (61%) participants would question the reliability, but not openly.

This study's results suggest that most psychoanalytic therapists are more likely to question indirectly the reliability of a CSAM, rather than either to question it openly or not to question it at all. This indicates that psychoanalytic therapists accept the existence of false CSAM and that they acknowledge that they do form opinions about the analysands' memory reliability, but do not think that expressing this opinion openly would be beneficial. In my view, the therapists' avoidance of direct questioning would allow analysands to separate reality and fantasy at their own pace during analytic therapy.

The above-noted groups of replies can also be seen from two other different perspectives, depending on whether the most popular response will be interpreted as 'yes, indirectly' or 'not directly'. The first perspective may imply that only a small minority (6%) of the participants, who would not doubt a client's CSAM, believe that fantasy is of equal importance with reality in psychoanalysis. At the same time, the overwhelming majority (over 87%) of the participants, who would openly (26%) or indirectly (61%) question a CSAM, accept the importance of the distinction between actual memories and fantasy. The second perspective may indicate that only a large minority (26%) of the participants would attempt to examine the reliability of a client's memory, whereas most participants (67%) would not (6%) openly (61%) try to distinguish whether their adult client's CSAM is actual or not, even if it seemed false.

**-Reasons to Avoid Questioning an Adults' Child Sexual Abuse Memory**

The participants of the current study (see section 3.4.3 and 3.4.4) claimed that therapists should avoid confirming or questioning an adult client's CSAM for several reasons which are related to various factors most of which are described below:

- The origins of the trauma: The point is to understand why that person needed to make that fabrication. Traces of CSAM may indicate the existence of similar earlier experience. Since the client experienced it in this way, it means that whatever happened was either a specific act or occurred in a seductive atmosphere, which was so intense that it is as if it had indeed happened
- The nature of memories: Every memory is an expression- fantasy, and memories mostly reflect the client's experience at present. The issue in therapy is the contemporaneity with which clients experience the memory
- The margin for error: It would be very traumatic to question a CSAM if it was actual, and therapists cannot be certain about the reality
- The therapists' stance: Therapists should respect the uncertainty until the client can reconstruct his/her own truth; and they should always wait to hear more from the client, through the relationship
- The therapists' role: It is not the therapists' job to find out the truth because they are not detectives. Therapists are interested in the existence of the context of reality but they are not interested in confirming if something like that has happened or if it is a fantasy.

The ideas of this study's participants (presented in the list above) about avoiding to question a client's CSAM, coincide with literature material (see section 1.2.1.2) suggesting that therapists are not meant to play the role of the detective (Bowers and Farvolden, 1996), and that it is crucial for the client to feel believed by the therapist (Phelps, Friedlander and Enns, 1997) in order to avoid harmful consequences such as the client's retraumatisation (Denov, 2003). These ideas also coincide with texts supporting that CSA survivors' are sensitive to the therapist's disbelief, or avoidance, due to their previous relevant experiences (Sabourin, 1988) and to their tendency to employ the mechanisms of denial and dissociation (Olio and Cornell, 1993).

The views of my study's participants in relation to the origins of the trauma (see first bullet-point in the above-noted list) contradict a finding by Palm and Gibson (1998). More explicitly, it appears that my study's participants think that traces of a CSAM may indicate the existence of similar earlier experience which involved either a specific act or an intensely seductive atmosphere. Palm and Gibson (1998) found that their respondents did not tend to focus on other issues, or generally believe that the client experienced some sort of negative event (see section 1.2.1.2). This disparity between my finding and Palm and Gibson's finding indicates that Athenian psychoanalytic therapists may be more inclined than US and UK therapists and psychologists, to believe that there are underlying reasons for a person to fabricate a CSAM. The reasons behind this disparity may involve psychoanalysts' turn towards the actual, with a simultaneous emphasis on its complication towards the client's fantasy and memory.

On a different note, I understand the idea of my study's participants (included in the above-noted list) concerning the margin for error, meaning that therapists cannot be sure about the genuineness or falsity of a client's CSAM, so they should not question it. Nevertheless, this view can be really supported by only the small minority (6%) of my study's participants who said that they would not question the client's CSAM in terms of its authenticity. The most popular view held by my study's participants, meaning that they would question an uncertain memory indirectly, does not take into serious consideration this margin for error.

- **Reasons to Question an Adults' Child Sexual Abuse Memory**

According to the participants' arguments (see section 3.4.3 and 3.4.4), issues prompting the therapists' questioning about their adult clients' CSAM may involve:

- General therapeutic work: Psychoanalytic therapists may explore a CSAM as they commonly do with therapeutic material. This questioning may offer a way out of the traumatic and help the client to gain power
- Attempts to unearth hidden feelings: It is important to understand what this CSAM provides clients emotionally, how their guilt, urge, wish and desire contribute in maintaining a trauma, and whether the CSAM corresponds to clients' fantasies and need for something special

- Signs of dramatising: These signs include therapists' views towards the client's presenting material, such as doubts, or beliefs that something is not true, or realisation that the client experiences things in a very dramatic way compared to what has actually happened, or that it is more of an emotion of repressed desire which happened before and repeats itself
- Symptoms of psychopathology: Therapists may be in doubt about the reliability of a client's CSAM when working with someone who is in a delirium or with hysterical types, and/or where the case points at a neurotic environment or neurotic structure. Notably, therapists are urged to examine doubts respectively when working with clients with psychotic personalities
- Correspondence to history: If CSA does not fit into the client's profile/history, and when many things do not connect, therapists may become doubtful
- Signs of false memory triggering: The client may be having a retroactive construction, meaning a memory for a thing that never occurred, especially if the CSAM emerged because of something else, such as a book or a movie
- Missing elements: These could entail lack of continuity, clarity, detail, emotion, pain, and time typically needed to trust the therapist. More suspicion can be elicited when there is unclear description, and confused or screen memory, or in easy and early disclosures, and when there is a single CSAM rather than a continuous experience
- Signs of deception: For instance, when therapists realise that clients are mistaken or fantasising or tend to present a fake persona in their relationships
- Current danger: CSAM should be questioned in case someone may be being abused at present and needs help.

A worth-noting point is that 'missing elements' as the ones listed above can be found in genuine CSAM (Olio and Cornell, 1989), and that the above issues are considered by this study's participants not as proof, but as indications.

The result that most (87%) psychoanalytic therapists are likely to question, implicitly or explicitly, the analysand's CSAM means that most psychoanalytic therapists believe that a CSAM may be unreliable. This result matches contemporary research (Ost, et al., 2013;

Patihis, et al., 2014) supporting that clinicians are sceptic concerning the validity of memories recovered during therapy.

The same result contradicts other research supporting that many therapists held that most memories of CSA recalled during psychotherapy are reliable, especially when it comes to memories of one's own clients (Poole, et al., 1995). In my study, the wide majority of the participants would openly or indirectly question a CSAM. Moreover, participants discussed their own cases wherein they had falsely thought that their clients' own memories were unreliable. Although my study did not focus only on recovered memories like the study by Poole, et al. (1995), it is clear that psychoanalytic therapists were inclined to somewhat question their analysand's CSAM, whereas in the other study's findings therapists presupposed that their clients' memories were reliable. Thus, there is a contradiction between our findings.

The contrast in their dis/belief concerning the reliability of patients' memory may be attributed to theoretical differences between the studies' samples. While my study's sample included analysts, psychoanalytic therapists and trainees of psychoanalysis, the samples in the study of Poole et al. (1995) included psychotherapists in a US study, and psychotherapists as well as clinical psychologists in the US and UK studies. My sample's increased likelihood to question a client's CSAM may be connected to the analytic tendency towards hermeneutic suspicion, meaning the inclination to critically evaluate all material coming from the analysand. In a deeper level, the participants' willingness to question an analysand's traumatic memory may also be linked to Freud's initial trust in his patients' memories and to his subsequent doubt about the reliability of these memories.

The comparison is additionally important because it shows the therapists' changes in tendencies and beliefs as time goes by: The intervening 17 years between my study and Poole et al.'s (1995) study, may have allowed therapists to learn more about the reasons to question- or to consider ways to question- clients' CSAM. This finding about therapists being increasingly more likely to somehow search for the truth is important as it shows that they are more open to accept not only the authenticity, but also the falsity of CSAM. The reader may be reminded that analysts have been repeatedly accused for overlooking each of these positions (reality/fantasy) in favour of the other, as seen in the literature chapter (see sections 1.1.4.1 and 1.1.4.6).

In Palm and Gibson's quantitative study (1998), clinical psychologists were asked through survey questionnaires "What do you do if you believe a client who has recovered memories of childhood sexual abuse did not actually experience the described events?". Most respondents argued that they would focus on the claims as part of treatment (40%), or address their concerns to the client through confrontation, explanation on the fallibility of memory and so on (17%).

In my study, 67% of the participants were more likely to focus on the claims as part of the treatment (rather than on questioning the material openly), as they responded that they would not question the material (6%) or that they would question the material only indirectly and through peripheral explorations (61%). This percentage (67%) is much higher than the percentage in Palm and Gibson's study (40%). Moreover, in my study 26% of the participants stated that they would address their concerns to the client, as they replied that they would question the trustworthiness of a client's CSAM directly. Again, the relevant percentage (26%) is higher than that found from Palm and Gibson (17%). To sum up, my study had higher percentages in both cases, that is, of participants who said that they would not intervene, and of participants who said that they would intervene.

The evidence that both findings refer to the same two answers (focus on the claims/ not question openly, addressing concerns/ question openly) as most popular for the participants may signify that therapists seem to occupy more intensely the same position as they used to in the late 90s.

The above-noted difference in the percentages may be due to the different theoretical orientation of the studies' samples and on the 14 years that lapsed between Palm and Gibson's (1998) study and the time that my data was collected (2012). This implies that therapists appear to be increasingly more certain about whether they would or would not intervene by addressing CSA before the client's disclosure of this trauma, while the most popular response remains on the side of not intervening.

A comparison between my findings noted above and Gardner's (2003; 2004) lists of criteria for false accusations signs, shows that there are only a few similarities. These signs include narrations with improbable elements, lack of emotion or guilt, the existence of

psychopathology, and recall stimulated by books etc. My findings also agree with Brewin and Andrews (1997) on that the narration's consistency is important in understanding whether a CSAM is uncertain.

This sub-section's results suggest that most psychoanalytic therapists are more likely to question indirectly (without disclosing) the reliability of a CSAM, rather than either to question it openly or not to question it at all. Newly documented reasons to avoid or to justify this questioning were expressed. The ideas of this study's participants on the possible questioning of a client's CSAM coincide with some literature material and disagree with other. These comparisons point to psychoanalysis' turn on fantasised material based on actual material, to increased propensity to search for reality, and to amplified awareness regarding their level of intervention in such cases.

### 4.2.2 Ways to Approach a Client's Doubtful Early Sexually Traumatic Memory

This study's participants advised therapists (see section 3.4.2) about how to deal with an adult client's questionable CSAM so as to avoid causing harm. Their suggestions are as follows:

1. Therapists should exhaust elements that are particularly found in the psychoanalytic approach, such as handling of this issue after many years of therapy and in due time. A hasty handling would trigger defences and, consequently, unsuccessful outcomes, and psychoanalysis is known to usually last longer than other approaches so there can be adequate time to deal with questionable memory. The special stability that psychoanalytic therapy offers, due to its boundary-based and long-standing therapeutic framework, will facilitate any handling of memories that an analyst will choose for each case.
2. There was a contradiction about whether the doubts should be articulated or not. Advocates of the view said that doubts should not be articulated, stated that questioning a CSAM is therapeutically pointless and risky and that therapists should just hold relevant material and signs in the back of their mind. It was even argued that the clients will not realise the doubts in such a case. Those who supported that doubts should be articulated claimed that therapists should evaluate, process and analyse material by focusing on contradictions, and confrontations, and using exploratory questions. For example, they could explore

how and why this memory emerged so suddenly and at this particular moment. If therapists realise that the client is lying, mistaken or fantasising, they could raise an issue of trust or ponder how the client can use the victim's position to avoid responsibility. The exploration should take account of relevant material, dreams, and repetitions, alongside the therapist-client contact and their cooperation. Another ingenious idea was to attempt moving the client away from whether something happened and more towards the trauma in relation to their feeling, for example by saying: "Possibly your fantasy had also scared you then?" or "Of course I understand that you feel the way you do but it sounds like that feeling is more intense than the actual event, no matter what that was".

3. Therapists should also work on questionable CSAM generally, not specifically; with care, tact, and delicacy. They aim is to illuminate things in a way so that the client can see them from different perspectives. They could attempt to elucidate what the fantasy of abuse means to the client and how s/he wants the therapist to approach the presented material.
4. Therapists should understand the limits of their role as they should accept that the effort to ascertain the reliability may not be clearly completed. CSA often leaves survivors with confusion about past and present as the barrier which protects us from external stimuli has been broken and became unstable, and the person is constantly between reality and fantasy. Participants also discussed cases where they thought that the material was exaggerated and they found out that it was all true. They also mentioned that they try to keep in mind that the lie has a truth in it and this truth is too hard and traumatic to be discussed and requires the therapists' utmost respect. The truth is often related not to actual CSA but something painful, such as vivid fantasies of seduction and/or to an unhealthy family environment involving unstable boundaries and seductive situations.

If we take into account Bowers and Farvolden's (1996) writings emphasising that even a tactful questioning of clients' CSAM may be perceived as challenging the clients' own integrity (see section 1.2.1.2), the view in my study's participants that the questioning should be done in a delicate manner (see number 3 in the above-noted list), may still pose risks for clients' retraumatisation.

However, in my viewpoint, the way my study's participants stated that they would explore an uncertain memory (see number 2 in the above-noted list) is very respectful towards the client's needs and sensitivity. Furthermore, this way of exploring the material is compatible with the analytic practice as a whole, so the analysand would not be alarmed by a turn in the therapists' stance. I mean that the clients would have been used to exploring all material in relation to unconscious meaning, so this traumatic material would be worked through as other traumatic material that the client would have brought up. There was no insinuation in my study's participants regarding extreme ways to discover the actual truth (see section 1.2.1.2), such as asking for corroborating proof, as suggested by Gore-Felton, et al., (2000), or meticulously searching for details and evidence of memory unreliability in the client's accounts, as proposed by Courtois (1997).

The revelation of my study's participants (see number 4 in the above-noted list) about cases where they falsely thought that the material was exaggerated, could be connected to the accusation towards psychoanalysis about overlooking actual CSA and over-emphasising fantasies (see section 1.1.4.1). Nonetheless, the fact that the participants believed in the actuality of the abuse and were just suspecting details of the presented material, shows that they were as a whole trustful and that they were open-minded enough to later ascertain the actuality of these details and also to review their conclusion about the overall truthfulness of the client's trauma.

The view of my study's participants regarding the idea that therapists should accept that their attempt to ascertain the reliability may not be clearly completed (see last bullet-point in the above-noted list), corresponds to Mollon's (1996) pre-noted (see section 1.2.1.2) view that therapists should suspend their wish to know and that they should help clients tolerate not knowing what really occurred.

A worth-mentioning point is that two lists in the previous sections (that is, the lists about reasons to question clients' CSAM and about ways to approach a clients' doubtful CSAM) include the idea that there is some truth in false CSAM, which may be related to a seductive atmosphere in the client's history.

### 4.3.0 The Therapists' Responsibility in the Fantasy-Reality Distinction

The current section will focus on my findings relating to the psychoanalytic therapist's responsibility regarding the clients' FRD in CSAM cases. The observed therapists' ambivalence will be pointed out alongside the guidelines resulting from the responses of this study's participants concerning the therapist's role in the clients' CSAM clarification. Most of the findings included in the current section provide support for past literature material.

### 4.3.1 Ambivalence about the Therapists' Responsibility in the Fantasy-Reality Distinction

As seen in the previous chapter (see section 3.5.1), 45% of the participants responded that they believed that the distinction between real and fantasised memories is one of their responsibilities. This result indicates that psychoanalytic therapists believe in the feasibility of this distinction, in the effectiveness of their treatment approach in this domain, and in their personal ability to reach a conclusion between the veracity and falsity of CSAM in treatment. As seen earlier (see section 1.2.1.4), Palm and Gibson (1998) found that 55% of the clinicians stressed the importance of their clients' acceptance or recovery of their traumatic experiences for therapy to be fruitful, which implied that the distinction is a critical part of therapy. Although the subject varies between these studies, their results (55%) match my results (45%) in terms of the significance attributed to therapists' role in the client's memory clarification. Furthermore, the view that the FRD should be attended to in therapy, has been advocated by some authors (Olio and Cornell, 1993; Gardner, 2003) and opposed by others (Bowers and Farvolden, 1996; Perlman, 1996).

The literature material (Bowers and Farvolden, 1996; Perlman, 1996) supporting the view that the FRD in CSAM should not be the therapist's duty, coincide with 29% of my study's participants who stated that the distinction is not their responsibility.

Additionally, 25% of the replies of my study's participants were not clear-cut enough to be categorised as yes or no. Thus, the topic appears to be controversial for this study's participants, as judged not only by the polarisation between the 'yes' and 'no' replies, but also by the number of unclear responses.

In my view, the issue concerning the therapist's responsibility in the FRD may also pose questions about the client's informed consent about this. For instance, clients may expect that their therapists will help them get closer to the actual truth, while their therapists will not consider this as included in their role. Since this therapeutic role is not adequately clarified through laws and codes of ethics, future research should attempt to elucidate this issue.

### 4.3.2 Resulting Guidelines Regarding the Therapist's Responsibility in the Fact-Fantasy Distinction

Through a combination of the participants' responses (see sections 3.5.2, 3.5.3 and 3.5.4), the therapists' responsibilities in relation to their client's FRD could be clarified:

- There are cases where therapists should let others assume the duty of distinguishing between fantasy and reality in their clients' CSAM and other cases where they could refrain from this task. In cases involving ongoing sexual abuse, or when there is urgency to determine the reality in a CSAM report, specialised professionals (such as forensic psychologists and expert witnesses) should take over the task of distinguishing whether a memory refers to facts. It should be noted that Palm and Gibson (1998) also proposed that clients should seek external corroboration for the CSA prior to legal procedures (see section 1.2.1.6). According to the responses of my study's participants, therapists should also abstain from an effort to make the FRD when the distinction is not entailed in the client's request through an expressed or a latent way and, simultaneously, when nobody suffers the consequences of this. A latent way of expressing that the FRD is needed would be, for instance, if a trauma led to repetitions, although the client had not connected the dots between his/her early trauma and present issues.
- Working towards the FRD regarding the occurrence of a CSA event (rather than the details of the event) is important, as the therapists' approach would be adjusted accordingly. Firstly, the clinical diagnosis would both depend on the reliability of the CSAM, and influence the therapist's approach. For instance, reality and psychic reality must be differentiated in the perception of individuals suffering from psychosis, and in these cases discussing the past should be avoided in contrast to clients with neurosis who can regress more safely. Secondly, there may be a need to

clarify what had happened in the past, in order for clients to be aided to stop putting themselves in danger through repetition compulsion, as discussed above in the current sub-section. Thirdly, therapists need to understand clients' truths and possibly the reasons leading them to believe in a fantasy so as to help them heal. Usually the reason why someone substitutes a reality for a fantasy is that this reality is unbearable and has to be worked through. Fourthly, the client's relationships and experiences are affected both by the distinction and by the failure to distinguish. Especially if the clients' issues concern the therapist, s/he should try to find a way for the therapeutic couple to understand things in the same sense. Therapy should aim in the elucidation of the way that relationships should be in the past, at present, and in the future. The aforesaid beliefs of my study's participants support previous writings regarding the multifaceted importance of this distinction. As mentioned earlier (see section 1.2.1.4), Fonagy and Target (1997) accentuated that it is therapeutically significant to distinguish between fact and fantasy, as this would both facilitate the therapist's understanding and would clarify the involved implications, since, for example, clients' false memory should urge therapists to appreciate their ability to understand their own internal state as well as their tendency to repress traumatic experiences. The effects of potential false memory on the client's relationships have also been highlighted in the literature (e.g. Yapko, 1994a).

- The main way therapists can help in the distinction is through showing the way for the client to think about whether his/her memory is fantasised at his/her own pace. This distinction should be attempted with the contribution of a psychiatrist, and only after a safe ground is achieved, which occurs later on during therapy. The therapeutic process can be seen as an interchange of going back and forth while the therapist tries to successively and repeatedly enter and exit the client's story. The client will tend to understand the memory and to make the FRD. Until the client makes progress in the distinction, therapists should respect any therapeutic material. The point about therapists helping clients to form their own sense of reality as clients are responsible for the distinction, has been addressed in recent relevant literature (A.P.A. Working Group, 1998; Hutsebaut, 2001; Follette and Davis, 2009) as discussed earlier (see sections 1.2.1.4 and 1.2.1.6).
    - The FRD can be chaotic and therapists may never find out the actual truth as fantasy always intervenes in reality and personal views cannot be absolutely

objective. Therapists should bear in mind that the search for truth should not precede the therapy. In psychotherapy, memory reliability is less important than the meaning of - both false and genuine – CSAM. Taking these points into account, fantasised and actual memories are equally important. The therapists' responsibility is to be there to listen to the client's story. The relevant goal of therapy is the differentiation of the psychological investment, not the potential authenticity of a CSAM. Likewise, as reviewed earlier, (see section 1.2.1.6) the A.P.A. Working Group's (1998) paper on recovered memories cautions therapists to focus on stabilising and containing the clients' functioning, thus prioritising the client's well-being over the FRD in cases entailing CSAM. The notion identified in the beliefs of my study's participants concerning psychically-based trauma having equivalent effects to reality-based trauma, has also been documented in past writings (Prout and Dobson, 1998).

The reader should be reminded (see section 1.2.1.4) that the issue of the therapist's responsibility remains controversial in the literature. That said, there is no right or wrong and, interestingly, most participants' opinions on the matter of the therapist's responsibility were not only articulated clearly, but they were also explained extensively.

The only issue found in the literature (see section 1.2.1.2) that the participants did not account for was that therapists should clarify to the client that therapy can facilitate but not guarantee a reliable FRD in CSAM as memory is subject to distortion. More specifically, therapists have been prompted to recognise and to communicate to clients that memory is flawed (Enns, et al., 1999).

However, such a professional intervention has been found to have adverse effects to survivors' well-being: Denov's (2003) findings accentuated that clinicians' unsupportive responses, which involved clinicians who minimised or doubted survivor's reports of sexual abuse, aggravated the negative impact of the sexual abuse alongside the feelings of distrust and betrayal, eventually instigating retraumatisation, whereas supportive responses, which involved the recognition and validation of survivor's memory of sexual abuse, relieved the negative impact of the trauma. As seen previously (see section 1.1.2.1), according to Freyd (1996), a trauma involving betrayal affects the traumatised individuals' perception and awareness of the trauma. A combination of the above-noted writings implies that therapists' doubt about the client's actual trauma may retraumatise the individual, this retraumatisation

may not be understood or expressed by the client so as for it to be processed in therapy, and the doubt may further confuse the client's uncertainty regarding his/her CSAM.

A worth-noting point concerns the input of this study's participants regarding the dilemma between the importance of fantasy compared to the importance of actual trauma. I believe that psychoanalytic therapists' value of actual reality is not underestimated although they hold that internal psychic reality is of utmost importance. Their stance appears to allocate equal (if not greater) importance to the fantasy side, as unconscious meanings may determine both the extent of the survivor's pain and the existence of psychopathology. The FRD is imperative in order for both the person to know what happened in his/her life and for the courts to decide about whether a person who was accused for CSA is guilty. I think that while psychoanalytic therapists care for the FRD as much as other therapists, they differ in that they also appreciate internal reality to a greater extent than the rest of the therapeutic community. While other therapists may not understand the trauma of the person with fantasy of CSA, analysts are more equipped to realise that fantasised trauma is hurtful for the individual.

### 4.4.0 Establishing a Fantasy-Reality Distinction in Psychoanalytic Therapy

A major finding of the current research, relates to how psychoanalytic therapists approach the FRD of adults' CSAM. More specifically, notwithstanding the involved ambivalence concerning the FRD, my study's participants managed to find ways around the presenting problems in situations involving this distinction as shown in the following sections. Contradictions with the literature are emphasised in the following sub-sections.

### 4.4.1 Ambivalence and Uncertainty Concerning the Feasibility of the Fact-Fantasy Distinction in Psychotherapy

Participants' responses showed ambivalence about whether they believed that the FRD of client's CSAM can be achieved in therapy (see section 3.6.1), as many (39%) of them thought that it is somehow possible, some (23%) of them thought that it is unfeasible or incompatible with a psychoanalytic approach, and the replies of several (32%) of the participants were not clear-cut so as to be categorised as above.

Almost half (45%) of the participants called attention to the difficulty and uncertainty entailed in the FRD of clients' CSAM (see section 3.6.3). In brief, it was argued that although one can have a better sense about the genuineness-fantasy distinction of an adult client's CSAM, the distinction is never completely done and nobody can be absolutely sure about the past because fantasy affects reality and memories are somewhat constructed. It was also stated that court-appointed specialists should assume this task, and that this distinction would be viable only if it was clarified otherwise, like if therapists played the detective's role and asked others.

### 4.4.2 Ways of Working Towards a Fantasy-Reality Distinction in Psychotherapy

Efi argued that the FRD is the main psychoanalytic task, which can be neither described nor ascertained. Regardless of whether they thought that the in treatment FRD of CSAM is possible (or their own responsibility), most participants (77%) discussed how they would attempt to facilitate the elucidation of fantasy and reality in cases concerning CSAM (see section 3.6.2).

Regarding the therapists' facilitation of the client's distinction of his/her CSAM, participants shared ideas and offered recommendations. During their client's CSAM disclosure therapists should not investigate the client's narrations. They should stay with the uncertainty and confusion, otherwise the analysis may not go on.

Following this phase, there was disagreement about the therapists' ideal level of intervention between the participants' statements. On one hand, participants indicated that therapists would firstly follow the clues so as understand what happened and would then assist their client's understanding. They would facilitate the client's consideration of the possibility of the memory to be false, without saying this openly.

On the other hand, participants seemed to think that the FRD is mainly made by the client as a result of his/her natural tendencies and combined with the power of the therapeutic process. In this view, the client is the first to realise what happened and then therapists can also realise the actual facts. It is hypothesised that the client will be able to distinguish between CSAM based on facts and on fantasy, whereas therapists cannot be certain about the actual truth in their client's life as they intervene in the here-and-now, rather than the then-and-there. The

client's psychical tendency would be to discuss it again, to understand it and to slowly distinguish fantasy from reality. By working and being in an analysis a client can reach the level of thought that allows him/her to realise, for example, that this was my fantasy and has never really happened. The distinction may happen with time, through psychological work, the establishment of a working alliance, and the therapist-client cooperation.

The therapists' position in the FRD of CSAM was presented differently in cases of more serious psychopathology where the therapist has to demonstrate the facts and the conflict for the client to see things more clearly. Participants maintained that in cases that do not involve serious psychopathology, therapists tend to work more with the truthfulness of the reality rather than with its examination. In cases involving, for example, psychosis, a borderline psychotic condition, or a hysterical situation, therapists necessarily make the confrontation with reality. Therapists may connect things that the client sayings about the facts, thus somehow bringing him/her to a position to see the exaggeration of a feeling that s/he describes or the contradiction or even the resistance. Chrisa underscored that in cases of psychosis therapists distinguish reality from non-reality and deal with perceptions, not memories.

Vicky argued that, in any case, the desired therapeutic outcome is not that therapists help their client to focus only on actual reality. The requirement will be to help the client to distinguish him/herself, to get out of the mass of fantasies, and to make other fantasies, which will be more alive and creative. From this perspective, the therapeutic goal could be the qualitative improvement of fantasies, rather than their substitution with reality.

Agapi mentioned that in two of her cases her clients realised the notion of certain issues. More particularly, they concluded that it was not so much the occurrence that happened once or twice that was traumatic. It was this continuous atmosphere around what they experienced as torture, that is, their own sense of themselves, meaning that they viewed themselves as being used.

Some (19%) of the participants linked the FRD to the depth of the analysis, and most of them to the duration of analysis. This means that therapists believe that this distinction is more likely to be achieved in deep and long-term therapy. This result implies that psychoanalytic therapists tend to attribute great importance to a couple of the characteristics (that is, depth

and long duration) of their own approach when it comes to the distinction between actual memory and fantasy in CSAM.

The participants argued that therapists are facilitated to elucidate the authenticity and fantasy in their client's CSAM through various elements, such as:

- The quality of the therapy: Only after long-term and intense analysis, the therapist is able to explore and understand any of the above-noted elements
- The quality of fantasy and real memory: Fantasy is flexible, it involves only perception and it lacks representation, while reality has inflexibility, it does not fluctuate and there can be representation. Furthermore, the real memory has a different emotional intensity, that is, there are deep breaths, pauses, attempts to obliterate the memory, internal pressure, disbelief that a man can control his desire, difficulty in distinguishing desire and reality, difficulty in understanding the other's position and intimacy, and tendency to sexualise relationships. It is like a central memory that everything revolves around it, it is not unconnected to other memories, events and the client's profile. The more true and real a narration is, the more it corresponds to the rest of the internal and external data and the more coherent it is
- The therapeutic relationship: When therapists follow the therapeutic procedure ethically and with empathy, and avoid to assume certain roles (detective, judge or ally), the client also recognises that the relationship with them is different and that s/he can feel close to them although therapists do not get involved, take revenge, collude or repeat certain patterns, but they maintain the boundaries. Consequently, the therapists' task is to work, analyse, disentangle and interpret the memories but not to distinguish real from false ones, as this indirectly becomes attainable later through the quality and the evolution of the therapeutic relationship. Moreover, psychoanalysis is based on transferential relationships and the quality of transference and countertransference may reveal whether a memory is reliable. Therapists must work with their own reactions to the client's transference, that is, their therapeutic tool is based on how they feel and think about the client. This idea is all about allowing the client to elucidate memories through the therapeutic relationship rather than using techniques which have higher risks

- General therapeutic work: The FRD is encouraged as the therapist can help clients to appreciate the complexity of their feeling, to decrease their guilt, to perceive multiple viewpoints, and to process their trauma
- Intense work on the subject of CSAM: Therapists must work with the client intensely, and must be very precise and careful towards whatever they are listening. They could attempt to revisit the past, in an effort to collect more material. If possible, therapists need to show evidence to the client that s/he is repeating something and that a reality is being obscured. For example, therapists could say: "I am trying to show you something and at this moment you probably do not want to see it. This confusion may serve something". Therapists may also try to point to the contradictions with the intention of restoring memories, fantasies and the client's investment in them. If a CSAM presents itself with great intensity, therapists can – with the permission of their client - bring in the family
- Understanding the underlying reason: A person with inaccurate CSAM needed to create fantasies for some reason. A client may over-emphasise a screen memory to a point that s/he believes it to be real in order to satisfy his/her own needs. It probably serves his/her organisation, defences, sexuality and so on. Often the fantasy may have been created from an atmosphere of confusion regarding what is allowed, where the boundary is, for example touching, sleeping together and so on. Therapists should avoid importing their own material and should help their client to see whether s/he had reasons to create these fantasies and to live in them. Therapists may say, for instance: "It seems that the difficulty between your parents has upset you", when they believe that this relates to the underlying reason for the false CSAM. They may help a client to explore why s/he overemphasises something that occurred or why s/he wants something that has not occurred to have had occurred.
- The client's unconscious material, feelings and acting-out: A way to distinguish between fantasy and reality is by listening to the way that the client's unconscious comes forth, for example, not only by checking the accuracy of memories, but also by exploring how material emerges through dreams and free associations. If there are traumatic dreams, anxieties, stress, or nightmares an actual CSA has probably occurred. If the dreams are in the context of the illusionary repetition of desire, the real element might not be there and this memory is probably a product of desire and fantasy. In addition to the above, to accomplish the distinction, therapists would focus on the guilt which is different in real CSAM and fantasy, and if the client is acting out something imaginary or if there is aggression towards someone

- Other professionals: In most cases it is good to consult other professionals and a psychiatric evaluation should precede a FRD through psychotherapy. Furthermore, when an adult reports a CSAM and asks for practical help s/he must be with (not a psychoanalysts or psychotherapist but with) a specialist who is obliged to pose clarifying questions as the adult may be hallucinating. Lastly, therapists should be aware of their own limitations and refer patients to colleagues who could help more. This includes family therapists if possible
- Therapists' ability: This involves the depth of the therapists' personal therapy and their level of experience. The therapists' good analysis amplifies the possibilities for the therapists' ability to respect the client. There was evidence to support that the therapists' ability to achieve the FRD can be improved: Aris noticed that he became able to differentiate between genuine memory and fantasy through his experience, knowledge and capability
- Other cases: In some cases, the authenticity of a CSAM is not doubtful. For instance, when someone endured continuous seductions as a child, or when there were court procedures back then, or in certain cases where the trauma is so intense that therapists feel sure that it had indeed happened.

As seen above, most participants had ideas on how to cope with the elucidation of uncertain CSAM.

### 4.4.3 Comparison with Previous Literature

An important result of the current study is that 77% of the Athenian psychoanalytic therapists discussed how the fact-fantasy distinction of CSAM can be achieved in therapy and, as discussed earlier (see section 3.6.1), more participants responded that they believe that the FRD is feasible, than those who held that it is unfeasible.

My finding seems to contradict Freudian and, to some extent, recent literature. To be precise, on the subject of the feasibility of this reality-fantasy division in therapy, more recent writers (Loftus and Yapko, 1995; Pope, 1996; Bernstein and Loftus, 2002) tend to coincide with Freud (1918) on that this distinction may be unattainable in therapy, especially when it involves recovered memory (Person and Klar, 1994).

Nonetheless, there are contributions supporting that psychoanalytic therapy fruitfully uses imagined material for the analysand's missing memories until the real ones can be clarified. For example, Moller (1991) writes that the psychoanalytic process is anticipated to result in gradual substitution of expressed analytical hypotheses, or else constructions, by actual memories of the analysand's forgotten experiences.

The above position and my findings imply that psychoanalysis may enable therapists and clients to eventually distinguish real from fantasised memory. In my view, this advantage of psychoanalysis may be due to five important reasons. The first is related to analysts' experience in the domain. Compared to other psychotherapeutic disciplines, psychoanalysis has the most long-standing tradition in this attempt, as this issue was initially accounted for by Freud (1918), the father of psychoanalysis. In addition to this, possibly due to all the criticisms psychoanalysts have encountered, psychoanalytic therapists have probably tried their best to professionally evolve in the area regarding fantasy and reality in CSAM.

The second reason is connected to pychoanalysis' focus on both fantasy and unconscious meanings (Lear, 1995). Freud was a pioneer in comprehending memory systems as inherently defective and unpredictable and in realising both the danger and the inevitability of objective manipulation (Sprengnether, 2012).

The third reason for psychoanalysis' beneficial position, compared to other psychotherapeutic disciplines, towards the FRD, involves the therapy's duration. This study's results suggest that clients can be assisted to make this distinction through long-term psychoanalysis. Thus, the difference between my findings and Freudian ideas may be associated with the fact that the duration of psychoanalytic therapy was shorter in time length as Freud was applying it back then. Moreover, the difference between my findings and most other ideas may be associated with the increased frequency of psychoanalytic sessions and/or the longer duration of treatment compared to other psychotherapeutic disciplines. That is, Freud's (1913) approach was three to six times a week for periods ranging from 6 months to a few years. Nowadays, the average analysis lasts about five to six and a half years (Doidge, et al., 2002), or even many years or decades, and usually includes one to two sessions per week, while most other disciplines do not advocate such a long-term therapeutic duration (Bernstein, 1995). Other psychotherapeutic disciplines commonly include weekly sessions and last three to four years.

The fourth reason for psychoanalysis' effectiveness in the fantasy-reality differentiation in CSAM cases, emerged from a participant's statements and concerns regarding the therapists' own psychotherapy. As Angeliki (see section 3.3.2) assumed, analytically-minded therapists may be more prepared than therapists from other approaches because the analysts' necessary personal therapy usually lasts longer and is more frequent. Vicky (see section 3.3.3) indicated that therapists work on their own issues with every client, and that they may abuse the client a lot through their stance. She also pointed out that the possibility for the client to be retraumatised during the therapeutic procedure, is related to the therapists' personal therapy. For instance, therapists may repeat their own traumatisation from their personal therapist's approach to their narrations of their traumatic experiences. In other words, the above-noted perspectives stressed the importance of the quality of the therapists' personal therapy in order to minimise the possibilities for the clients' retraumatisation in therapy.

The value of the therapists' personal psychotherapy has been highlighted. For example, Courtois (1997) strongly advised therapists who work with CSA to ensure they are caring for themselves through both "personal and professional support and monitoring" (p. 473). In my opinion, the therapists' therapy is of utmost importance and should not only be obligatory for longer periods but also recurring. The same would apply to the therapists' professional supervision. Future research could examine this approach by investigating the differences across disciplines and the influence of both quality and quantity of personal therapy on the therapists' success in the FRD in cases entailing CSAM.

The fifth reason for psychoanalytic therapists' ability to facilitate the FRD in cases involving CSAM, is associated with their emphasis on countertransferencial relationships and on the underlying meaning of repetition compulsion. As mentioned above, 13% of the participants focused on the analysis of their countertransference feelings as helpful in distinguishing fact from fantasy in a rather inexplicable and uncertain, yet remarkable, way (see section 3.6.2).

Countertransference was depicted by Freud (1910; 1912) as something to be avoided, alongside the analysts' influence, whereas more recent writings (Mitchell, 1997) have ascribed to it a place of honour in the milieu of the psychoanalytic profession, by bringing into play the multiple benefits of exploiting countertransference feelings (see section 1.1.3.3). The intense focus of this study's participants on countertransference is probably a sign of the

evolution of psychoanalytic thinking, showing that contemporary psychoanalytic therapists not only do not exclude, but also cherish, recent approaches from their practice, although these approaches are clearly opposing to more classical thinking.

Countertransference was additionally described by the participating therapists as part of the basis of the whole analytic technique. According to them, understanding countertransference would presumably also help therapists to comprehend the actuality or falsity of sexually traumatic child memory, through intense working through, and careful listening. This finding is important as it could highlight a facilitator for a main therapeutic problem, namely the FRD in therapy.

Countertransference has been contemplated as a valuable tool in comprehending the client's experience in relation to trauma work (Courtois, 1997; Walker, 2004). However, the particular link proposed by this study's participants between countertransference and the FRD has not been directly addressed in the literature.

It appears that psychoanalysis' focus on countertransference, which has increased a lot during the last decades, alongside my study's focus on CSAM, may have enabled the participants of the present research to make this innovative connection. The literature gap between psychoanalytic practice and CSAM could be the possible reason for this lack of connection between countertransference and FRD in recent literature. Colton's (1996) research, which, as aforesaid, was the only study involving participants of allegedly psychoanalytic theoretical orientation, focused merely on a few analytically-oriented therapists' experiences and also on real memory of incest (see section 1.2.2.1). My study is the only study interviewing psychoanalytic therapists on their work involving client's CSAM and this may have been the cause for similar research missing the point of countertransference facilitating the distinction between real and false CSAM.

Further research evidence could offer insight as to whether and how countertransference analysis can assist therapists in the FRD.

While psychoanalytic psychotherapists' explained their ability to distinguish between fact and fantasy in their clients' CSAM, the distinction was linked to repetition compulsion. Many (39%) of the participants highlighted clients' tendency to repeat the sexual trauma, which is

termed as repetition compulsion, and often leads to retraumatisation. As stated by participants, a client with a CSA history is likely to provoke others, including therapists, to become sexually, verbally and emotionally abusive, or to forget that they have been abused as children (see section 3.3.3). As aforementioned (see section 1.2.1.5), such provocation towards therapists has been discussed in relevant texts (Davies and Frawley, 1994; Fine, 1985; Barande, 1985).

According to my study's participants, psychoanalytic therapists should intend to facilitate the client's corrective re-experience of the trauma and then its subsequent discussion (interpretations in transference and countertransference may help), with the aim of stopping the repetitions (see section 3.3.2). As aforesaid (see section 1.2.1.5), the value of interpreting the client's repetition compulsion has been expressed in the pertinent literature (Chu, 1991; Tucker, 1998; Hopper, 2001).

Athenian psychoanalytic therapists, who were interviewed for the present research, additionally supported that articulating the repetition compulsion would also be helpful in facilitating the analysand's remembering. Malvina (see section 3.3.3) stated that psychoanalysis takes you back to unpleasant situations in order to understand what happened in the past, how it happened, how it influenced you, how it is connected with all the actual things around you, and where you get stuck. The way this occurs was also explained by two of this study's participants, namely Chrisa and Takis. Chrisa (see section 3.6.2) argued that when therapists have the necessary material to support this, they should show to the client that s/he is repeating something and that a reality is being obscured. Takis (see section 3.3.3) said that acting-out happens instead of remembering, so therapists should de-dramatise the circumstances by interpreting what is happening in order to reinforce the patient's remembering of the traumatic experience. The view that repetition compulsion facilitates recovery of repressed trauma has also been pointed out in the literature: Cheniaux et al. (2011) talked about the possibility of memory reactivation through the reliving of such experiences.

The opinion, about the role of repetition compulsion in trauma recall, of both my study's participants and Cheniaux et al.'s (2011) text needs to be researched further. It is reasonable to hypothesise that repetition compulsion has a potential to assist the therapists' role in

identifying CSA sufferers, helping the clients' recalling, and perhaps even distinguishing between actual and fantasised CSAM.

The participants' statements that both the duration and the depth of the analysis is important, are in accordance with research evidence supporting that long-term therapy is more effective than short-term therapy (Tyson and Goodman, 1996; Valerio and Lepper, 2009). It appears that a long duration of treatment offers additional opportunities not only for therapists to make a more accurate distinction, but more importantly for the clients themselves to realise what actually occurred in their early years and what scarred them from within. This is an important finding as it introduces ways to tackle the so far unresolved problem of FRD (Pope, 1996; Bernstein and Loftus, 2002; Gardner, 2003; 2004). The original part of this finding lies in that, according to my study's participants, the analysis' depth is important in the FRD in cases involving CSAM.

The focal ideas, which emerged from this study, and need to be researched further, are whether the FRD is indeed attainable within the psychotherapeutic frame, and whether the focus on unconscious meanings (involving countertransference and repetition compulsion), the quality of the therapists' personal therapy, and the length or quality of psychotherapy play a determining role in this distinction. All the above findings are probably missing from past literature material because the current study is the only qualitative study on this topic and it has a much larger sample than other relevant studies (Colton, 1996; Barber, 2012). Future research should, for example, focus on whether the FRD is more likely to be achieved – with minimal possibilities of client's retraumatisation - in longer therapeutic interventions. If this is supported by other findings, legal establishments should take it into consideration when asking for an urgent expert witness opinion as it is usually the case. If these focal ideas are true more time should be allowed for therapy before a practitioner is asked to evaluate a client's memory as true or false, and perhaps clients should be informed that they could visit a specialist if they wish for a faster way to distinguish between actual memories and fantasy.

### 4.5.0. General Findings

This thesis' general findings refer to results that did not emerge solely through the interview questions. For instance, gender and other factors appeared to have played a role in the responses of my study's participants in several questions. Moreover, my research data

confirmed all the writings about problems entailed in the work with clients with a CSA history. However, a closer inspection of the participants' discussion revealed more hopeful material. The second main finding in my study demonstrates that Athenian psychoanalytic therapists have found ways not only to acknowledge the difficulties, but also to professionally evolve, to prepare and most importantly to reach, in certain cases, a successful therapeutic conclusion.

### 4.5.1 Gender and Other Factors

As 74% of the participants of the current study were female and 26% were male, there is no point in pointing out the issues on which women therapists outnumbered men therapists. Three gender differences were, however, detected among the sample. Firstly, as seen earlier (see section 3.4.4), 42% of the participants discussed why they would not question a client's CSAM, and 26% argued why they would question a client's CSAM. From those 26% of the participants, 75% were male. This result implies that male therapists are more inclined than female therapists to consider questioning the reliability of a clients' CSAM.

Secondly, 19% of all participants replied that time is a factor which led them to alter their approach to CSAM cases. From these 19% of the participants, 67% were male (see section 3.1.2). This indicates that men therapists appreciate the changes brought by time slightly more than female therapists do.

Thirdly, 23% of the participants discussed a (at least one) successfully completed case of theirs in the field of CSA (see section 4.5.4). From these 23% of the participants, 87% were male. This may imply that in the therapy of adults with CSAM, men tend to realise or discuss their successes considerably more than women, or that men are considerably more effective than women.

There were several findings that implicated not only the gender factor, but also other factors, namely in relation to the participants' years of experience and professional title. From the 31 therapists who participated in the current study 42% were also psychiatrists, and 61% had 15 or more years of clinical experience.

The first finding about other factors involves the argument proposed by 10% of my participants who highlighted that they would try to move the client away from whether something happened and more towards the trauma in relation to the feeling (see section 3.4.2). From these 10% of the participants, 100% were (both female and) very experienced (ranging between 18 and 30 years of experience).

The second finding involves the 32% of the participants who mentioned the conditions under which they consider the FRD as the therapist's remit or not (see section 3.5.3). From these 31% of the participants, 72% were not psychiatrists, and another 72% have more than 15 years of experience. This implies that regarding this responsibility, psychotherapists clarified their position slightly more than psychotherapists-psychiatrists did, and more experienced therapists were more likely than less experienced therapists to share ideas on variables affecting the therapists' responsibilities in cases entailing CSAM.

The last result to be presented here, is not connected to the factor of therapist's gender, but to the factor regarding the therapists' years of experience. This result is associated with the 19% of the participants who brought up feeling uncomfortable (see section 3.1.6). From these 19% of the participants, 100% had 15 or more years of experience. Perhaps due to their extensive experience, it might have been easier for therapists to both realise and express feeling uncomfortable.

In summary, regarding the therapist's professional title, psychotherapists who are not also psychiatrists, are more likely than psychotherapists who are psychiatrists to discuss the conditions that influence the therapists' responsibility on CSAM cases. Regarding the therapist's years of experience, more experienced therapists are more likely than less experienced therapists to express feeling uncomfortable, to focus on the conditions that clarify the therapists' responsibility on CSAM cases and to emphasise that they would try to move the client away from whether something happened and more towards the trauma in relation to the feeling.

Compared to female therapists, male therapists are more inclined to consider questioning the reliability of a clients' CSAM, to discuss their own successfully completed case, and to recognise time as a factor that contributes to their changes. Overall, these differences indicate

that, in CSAM cases, when compared to female therapists, male therapists may value the truth and the virtues of time more, and be more effective in their work.

Bourdon and Cook (1993) had found that female therapists and more experienced therapists appeared to be more sensitive than male participants to loss issues associated with sexual abuse. Women's sensitivity has also been expressed in this study as more males than females were likely to question a client's CSAM, and female and very experienced therapists were more likely – than male and less experienced therapists - to move the client away from what actually happened and more towards the trauma in relation to the feeling. The last point about gently helping the client focus on the trauma, rather than its reality provides evidence regarding the sensitivity of more experienced therapists.

The finding about male therapists discussing their professional effectiveness more than female therapists may also be pointing to women being more troubled, as far as CSAM cases are concerned, which may be rooted in their own identification with sexual abuse survivors. Little and Hamby (1996) found that compared with male therapists, female therapists reported more frequently feelings of anger towards the perpetrator, which also shows that women are more troubled in such cases. Moreover, male therapists are less likely to overidentify with survivors of CSA, because of their gender and the fact that less men than women are likely to have a CSA history (Wellman, 1993).

Future research could examine further these complications of both gender and experience on therapists' approach of client's uncertain CSAM, and also the differences between psychotherapists and psychiatrists-psychotherapists.

### 4.5.2 Therapists' Difficulty and Ambivalence

As analysed below, this study's data entailed evidence for the therapists' discomfort, difficulties, worries, and uncertainties. Ambiguity was identified across the data set and also in individual statements. The possibility for the client's retraumatisation was also discussed and linked mainly to the therapists' mistakes and repetition compulsion. The following percentages refer only to the participants' responses to my interview question: 'Have you Observed Changes in the Way you Handle CSAM?' (see section 3.1.0).

A number (19%) of the participants declared that they have felt somewhat uncomfortable when working on cases which entailed CSAM, or less comfortable compared to other cases (see section 3.1.6). The participants' examples included personal revelations about feeling awkward, uncomfortable, cautious, shocked, burdened, threatened, and afraid about whether their interventions may be experienced as harmful. There were also statements about therapists being less empathic, direct and understanding, and more anxious, harsh, impressed, and careful, at the beginning of their practices. In one (Vicky's) case, the client insinuated how much the therapist changed through the years, from being harsh to being more empathic.

A number (19%) of the participants expressed worry about the depth of their exploration in cases involving CSAM (see section 3.1.4). Examples of participants' discussions about the depth of their exploration entailed fear about becoming penetrating, constantly reviewing the trauma, working with the family, discussing difficult issues like the patient's sexual fantasies about the therapist, and clients avoiding to discuss their trauma. There was also contradiction between participants: Sotiris said that as time goes by he tends to raise the issue of CSA less than he did before, whereas Rita argued that she used to hesitate deepening her inquiry in cases involving CSAM, but now she asks and listens more closely to what clients say.

Relevant writings (Olio and Cornell, 1993; Perlman, 1999; Walker, 2004) and findings (Colton, 1996; Barber, 2012) about the strains and frustration involved when CSA is therapeutically approached (see section 1.2.1.6) correspond to my above-noted findings pointing to therapists' difficulty in cases involving CSAM. My study's findings draw more attention to psychoanalytic therapists' uncomfortable feelings and to their concern about the depth of their exploration in CSAM.

Much ambiguity was repeatedly observed within the sample of my study, if one takes into account the participants' responses to several interview questions. The participants' answers revealed an undeniable ambivalence within the sample in three topics; (1) regarding whether they would discuss CSA before the client by connecting his/her symptoms to CSA and whether they would question a client's CSAM (see section 3.2.1), whether they consider the distinction their responsibility (see section 3.5.1), and whether the FRD is feasible (see section 3.6.1). While the responses were not exactly split they were also not unanimous. Regarding whether therapists should propose CSA as an explanation for the client's symptoms before the client's disclosure, of the 31 participants of this study, 45% answered

negatively, 29% replied positively, 16% replied ‘not directly/yes, indirectly’, and 10% of the participants’ replies were self-contradicting. Regarding whether therapists should consider the FRD as their responsibility, out of the 31 participants, 45% said ‘yes’, 29% said ‘no’, and 25% of the replies were not clear-cut enough to be categorised as ‘yes’ or ‘no’. Regarding whether the FRD is feasible in clients’ CSAM through psychotherapy, out of the 31 participants, 39% replied affirmatively, 32% of the answers were not clear-cut enough to be categorised as ‘yes’ or ‘no’, 23% replied negatively, and 6% were not asked this question.

There were examples of participants who made self-contradictory remarks. For instance, 10% of the participants gave an ambiguous reply or two contradicting replies to whether they would propose CSA as a possible explanation for the client’s symptoms (see section 3.2.5). Fenia hypothesised that she would propose CSA while allowing the client to process and, perhaps, reject the proposal, while at another point she said that she would wait for the patient to discuss this first, even in cases appointed by the court. Agapi said that she would usually propose it in well-established therapies, and immediately after this, she added that she does not propose it herself, but the patients propose it. Aris began by saying that he discretely searches for this type of trauma, and ended up focusing on why he contemplates suggesting the possibility of CSA. These self-contradictory results may indicate that there is much confusion to be resolved regarding the therapists’ approach to clients’ undisclosed CSAM.

One of the few topics that the participants seemed to be more unanimous (87%) was their belief in the existence of the possibility for clients’ retraumatisation in treatment due to the therapist’s approach to CSAM (see section 3.3.1), which may augment the stress for therapists who strive to avoid it. The finding that Athenian psychoanalytic therapists believe that there is a possibility for the client to be retraumatised in therapy due to the therapist’s approach, supports past (Ferenczi, 1932) and more recent (Cohen, 2003; Aron and Harris, 2010) writings as discussed earlier (see section 1.2.1.5).

In fact, only a couple of the analysts said that the patient’s retraumatisation would not occur on their watch or that retraumatisation is unlikely if the analyst has been analysed and is ethical. This means that some psychoanalytic therapists may worry about the retraumatisation but feel assured that this will not happen to them, thus perhaps becoming less cautious. It is interesting to point out that these participants apparently ruled out the clients’ repetition

compulsion as they responded negatively on whether there is a possibility for the clients' retraumatisation due to the therapists' response to the revelation of a CSAM.

There was divergence of opinion among participants' views concerning whether the client's retraumatisation is common or highly unlikely, dependable on the therapist or unavoidable, and expected or not expected when things fare well (see section 3.3.2). One of these points, explicitly the unavoidability of the client's retraumatisation, has been addressed in past research: Valerio and Lepper (2009) supported that the initial distress which group members inevitably endure while revisiting their abuse trauma, is an essential stage in a crucial 'working through' (see section 1.2.1.5.).

In the current study, the majority (61%) of the participants pointed out possible mistakes of the therapist, which may lead to the client's retraumatisation during the early traumatic experience's disclosure (see section 3.3.2). Examples of such mistakes included:

- Failing to function as an analyst: behaving as an interrogator, becoming hasty and over-identified with the client, ignoring something from the client's story, digressing from the framework, hurting or underestimating the client. As seen earlier (see section 1.2.1.5), the effects of the unsupportive and doubting clinician on the client have been addressed by contemporary research Denov (2003), alongside the effects of supporting a client's CSAM (Polusny and Follette, 1996; Phelps, Friedlander and Enns, 1997; Gore-Felton, et al., 2000).
- Not being ready for a CSA disclosure: being unable to control personal feelings of distress and/or contain the client's acute emotions of shame, humiliation, rage, anger, regrets, guilt and so on. In premature disclosures, therapists should slow down, proposing to the client to get to know each other more, without ignoring the material. The link between the clients' retraumatisation and their CSA disclosure due to the therapist's unhelpful practices has been emphasised in previous research (Barber, 2012), as mentioned earlier (see section 1.2.1.5).
- Being unhelpful: bringing up CSA before the patient does, being careless with what s/he will say and whether s/he will say it, pressuring the client to disclose too soon, urging the client to make sense of what is happening

- Not connecting empathically with the client: failing to show an interest, following specific techniques rather than having a personalised approach
- Failing to realise and correct unconscious mistakes: lack of appreciation about what is happening, and inability to make-up for their abrupt or ill-timed interventions.

The last three points (that is, about therapists' being unhelpful and failing to either connect empathically with the client, or to realise and connect unconscious mistakes) can be connected to previous writings (see section 1.2.1.1) regarding unhelpful practices (Barber, 2012) and the therapist's inability to handle these cases (Olio and Cornell, 1993).

A considerable number (39%) of my study's participants discussed repetition compulsion while responding to my interview question about the client's retraumatisation. These findings will be reviewed later (see section 4.5.3).

A different but also worth-noting point is that my interview question 'Do you think that there is a possibility for the analysand to be retraumatised due to the therapist's reaction to the disclosure of CSAM?', triggered a few thoughts about therapists sexually abusing the client (see section 3.3.4). To be more exact, a participant asked whether this question referred to patient's retraumatisation by actual sexual abuse by therapists. In addition to that, another participant, added in the end of her reply to the above-noted question regarding the client's retraumatisation:

*"A second sexual abuse may occur but now we are talking about colleagues who have the sense of ethics and duty".*

Participants also emphasised that mental health professionals who sexually abuse their clients are perverted, disturbed, unethical and irresponsible.

Thus, although the question clearly states that the retraumatisation would be due to the therapist's reaction to the disclosure of CSA, 16% of the participants connected it to the client's actual sexual abuse by the therapist. This could be related to the participants' focus on actual, rather than psychological, trauma. This confusion between the 'concrete' and the

metaphorical is crucial to the main research question under discussion, explicitly the therapists' inclination to perceive a CSAM as authentic or fantasised.

Overall, the participants of this study articulated a difficulty in their work with adults who have suffered CSAM. My results point out contradictions in analytic work and indicate that therapists who decide to work with CSAM find it quite burdensome.

Colton (1996) reached a similar conclusion about the treatment of incest survivors. She found that clinicians' practices revealed indications of older attitudes, such as ambivalence. Thus, my results indicate that about 20 years later, psychoanalytic therapists still show signs of ambivalence, which can be attributed to the lack of scientific clarity concerning approaching adults with CSAM.

These results are also in accordance with the commonly-held view of therapists feeling psychological pressure when working in CSAM cases (Courtois, 1997; Perlman, 1999; Walker, 2004). For instance, Perlman (1999) described how working with sexually traumatised individuals can both become a highly pressurised experience, and challenge the therapists' capacity to handle their personal feelings, as these patients tend to need therapists to constantly share their pain.

Regarding the participants' disagreement about the unavoidability of the client's retraumatisation, Valerio and Lepper (2009) observed that the initial distress which group members inescapably experience while revisiting their abuse trauma, is an indispensable stage in a crucial 'working through'. Thus, based on their clinical experience, they concluded that this difficult step is unavoidable, yet necessary for the treatment of adult CSA survivors.

To sum up the main points of this section, my findings about discomfort, ambivalence and difficulty appear to support previous writings on the topic of the psychotherapeutic treatment of adults' CSAM.

### 4.5.3 Therapists' Professional Development and Preparedness

Concerning the therapists' professional development, the overwhelming majority (90%) of the participants noticed changes in their approaches to clients' CSAM (see section 3.1.1).

Examples of these participants' relevant observations about the changes that occurred later in their practices included:

- Perceiving the clients' statements less literally and more seriously
- Increasing their knowledge (understanding the issue of CSAM in its wider context; keeping in mind more relevant clinical cases and therapeutic viewpoints; knowing what to do with the client's information; and gaining professional confidence)
- Managing their personal emotions (becoming less upset and remaining calm)
- Becoming less harsh and more empathetic towards the client's issues,
- Helping the client's mature reviewing of their past, and
- Increasing one's investment in the therapeutic process.

According to the participants, the most popular reasons for their change were experience, time, and knowledge (see section 3.1.2). It is worth-noting that therapists appeared more inclined to determine that their changes were a product of time or experience, rather than knowledge, although literature on CSAM is constantly evolving. This may reveal psychoanalytic therapists' both disappointment and low expectations towards the – rather confusing and inconclusive - relevant literature and/or professional training programmes. Further, while knowledge can be enhanced in the therapists' training, the virtues of time and experience cannot be easily provided early in the therapists' career. Perhaps additional attention should be given during training to familiarisation and supervision in cases involving CSAM. The familiarisation could occur through watching relevant clinical material via video-recordings, double-sided mirrors, as well as face-to-face observation of, and participation to, psychotherapeutic sessions.

While comparing my study's findings about the ways therapists' stance changes through the years to Polusny and Follette's (1996) findings about the impact of relevant debates on clinical work, I did not find any common ground between them. They concluded that therapists are more cautious about both CSAM and retrieval interventions, which are not included in the above-noted list of the changes identified by my study's participants. The roots of this difference may lie in the different focus of our questions, meaning about whether the changes were due to the years of practice as my study investigated or to the CSAM controversy as their study investigated. As indicated by my study's participants, the number

one reason for the changes in their approach top CSAM, was experience, rather than knowledge.

Regarding the therapists' preparedness to handle cases involving CSAM, in view of the participants' inclination (see section 4.2.1) to discuss their difficulties regarding CSAM issues in adults' psychotherapy, it is fair to report that they are aware of the related perils. This awareness may imply that psychoanalytic therapists are becoming increasingly more knowledgeable of these issues. However, it may also indicate that the psychotherapeutic profession as a whole has yet to elucidate the way of working with such cases while minimising the potential harm.

To compare with similar research findings, there were three main similarities between Colton's (1996) results and my results. Regarding the first similarity, in my study Athenian psychoanalytic therapists admitted that they often felt uncertain (see section 3.1.3, 3.6.3, 4.2.1). This uncertainty may be related to the possible complexity of CSAM cases and/or to the therapists' own feelings of inadequacy in relevant treatment endeavors. Colton (1996) highlighted the difficult and demanding nature of post-incest patients and their problematic and ineffective treatment by psychoanalytically-oriented therapists.

Regarding the second similarity, my study's participants stated that the changes in their approach towards CSAM were more a product of practical experience, rather than knowledge (see section 3.1.2). Likewise, Colton (1996) found that all her participants relied more on practical experience than relevant research. According to Courtois (1997), since the treatment of trauma involves issues that are seldom satisfactorily covered in professional training, therapists working with CSA ought to both evaluate and evolve their own professional and personal ability to therapeutically approach the subject, through specialised training, supervision and so on. I agree on that psychotherapists should learn and experience whatever they need in order to make them feel more confident for this task until the academic and professional diplomas will be able to allow them to work properly in cases of adults with CSAM. Needless to say that in order for optimised therapy involving CSAM to become possible, more research should focus on therapeutic approaches to CSAM.

Regarding the third similarity with Colton's (1996) study, she concluded that there is probably deficiency of theoretical clarity among her sample of psychoanalytically-oriented

therapists. As seen earlier (see section 4.2.1), there was much ambiguity across my study's sample (see sections 3.2.1, 3.5.1, 3.6.1), which may point to deficiency of theoretical clarity. This implies that the deficiency in theoretical clarity persists until now. Future research should focus on blind spots in the field of psychotherapeutic approaches to CSAM so as to increase the theoretical clarity and lessen the inter-disciplinary ambiguity.

### 4.5.4 Therapists' Effectiveness

Most available research evidence focuses on short-term individual psychodynamic psychotherapy (Price et al., 2004), interpersonal-psychodynamic group therapy (Callahan, Price, and Hilsenroth, 2004), the comparison between brief and long-term group therapy (Tyson and Goodman, 1996; Valerio and Lepper, 2009), as well as the comparison between group and individual short-term therapy (Stalker and Fry, 1999). This section offers evidence on the effectiveness of a very long-term individual psychotherapeutic approach, that is, psychoanalytic therapy.

In my study, participants were not asked about whether any of their cases involving adults' CSAM had been concluded successfully. Nonetheless, seven participants mentioned eight successfully completed cases involving CSA. These cases have been discussed in various sections of the previous chapter and they will be briefly repeated here.

Fenia (see section 3.1.5) discussed one of her cases which concerned a 35-year-old woman, and involved phobias, eating disorder due to repetitive CSA by an uncle at the age of seven, which was the main issue for the whole six years in treatment until completion. Lefteris' (see section 3.3.3) case included many repetitions and erotic transference and was successfully completed after four years of therapy. Aris (see section 3.3.5) presented a case of a man which involved sexual abuse, attempted suicide after years of therapy, interpretation of the connection between the client's attempt and Aris' response to the revelation of the trauma, and continuation of the psychoanalytic psychotherapy until it was successfully concluded. Ilias (see section 3.4.4) mentioned a case relating to a man who disclosed experiencing as a child erotic fondling by his father. The case also contained a psychotic breakdown and attempted suicide, which was followed by the father's apology, that helped him bring the issue to a closure and successfully complete his therapy.

Dina (see section 3.2.4) discussed two relevant successfully completed cases. The first case was about a young woman with an eating disorder, who emotionlessly brought up an experience during which her father accidentally kissed her and later laughed about it. Dina described this as "crossing of boundaries" and this worked in a very liberating way.

Dina's (see section 3.3.2) other relevant case involved an ill-timed and unexpected revelation of a nearly forgotten CSA by an uncle. The revelation took place just before the client's therapy was completed and she moved out of the country. The issue was probably worked on indirectly through the seductive relationship the woman had with her father.

The following two cases were completed but they were not identified as entirely successful from the participants. Sotiris (see section 3.3.2) revealed one of his cases which involved a 50-year-old woman who revealed in the 3rd year of treatment that she had a sexual relationship with her brother. At the time of the interview she was in the fifth or sixth year of therapy, and the therapy was nearly completed but it was partly successful as she did not get over issues relating to her sexuality.

Petros (see section 3.3.2) also brought up a case with an outcome he thought of as adequate rather than great. The case entailed a woman who had sexual relationships for a long time and from a young age with her much older cousin. Therapy helped her with her issues, she was able to enter and cope with a group dynamic. She also started a family, and progressed professionally. Nonetheless she remained distanced and aloof in her relationships.

To compare with past literature, in Colton's (1996) study, it was found that all the psychologists who participated felt unable to work effectively with women who had experienced paternal CSA, and these therapists viewed the treatment as failed. It should be noted that there are many differences between my study and Colton's study, such as in sample size, place of study, and in some cases relationship of sufferer to the abuser (see Appendix 3). This difference between our findings may also be evidence of the importance of actual psychoanalytic training on psychoanalytic work. As noted earlier (see section 1.2.2.1), most of Colton's participants described themselves as psychoanalytically oriented, while only one of them was a candidate in a psychoanalytic training and one other on an academic psychoanalytic post-doctorate program. Academic degrees usually offer much-appreciated theoretical knowledge on specific subjects, but lack overall theoretical knowledge and, most

importantly, practical experience with the subject under study, compared to actual training programs which focus on practice. In my study, participants were trained or trainees on psychoanalytic trainings, so they could have been more knowledgeable about and consequently willing to work with cases involving CSAM. From another perspective, the contrast between the findings of my study and those of Colton's study may also imply that therapists are starting to find ways to achieve successful therapeutic outcomes with adults who have experienced CSA.

To sum up this chapter so far, the participating therapists recognise that in CSAM cases there is difficulty and discomfort. There was also much ambiguity involved in important topics not only in individual statements, but also across the data. A considerable possibility for their clients to be retraumatised was also vastly acknowledged. On the other hand, the participants' discussions included eight examples of reportedly effective treatments of women survivors. While past evidence (Colton, 1996) with analytically-oriented therapists presented the therapy of incest survivors as unsuccessful, the cases presented in my study paint a promising picture of the future of psychoanalytic therapy for adults with CSAM. This implies that there is a lot to learn from therapists' practical experience and that there is a lot more to research about the topic of CSAM. Future research could focus on differences between approaches, or on what separates successful from unsuccessful cases.

### 4.6.0 Limitations

Identifying the shortcomings and limitations of a study is imperative in any research. In the forthcoming sections, I will address the limitations of this study which relate to various issues such as the time it took to both carry out and write-up this research, the nature and content of the interview questions and the methodology employed.

### 4.6.1 General Limitations of the Study

The five intervening years between data collection and the submission of the thesis is one of the shortcomings of the present study. More specifically, the interviews were conducted in 2011 and 2012, while the PhD thesis was submitted in 2018. This occurred as the academic programme was carried out in a part-time and long-distance mode, and there was much unavailability and changes of the supervisors occurring during this time.

During the last few years there has been a resurgence of interest in CSAM, which makes my thesis more topical. Famous people, like celebrities and politicians, have been accused for committing CSA in Greece, Europe and the US. For instance, Edward Heith, or else Sir Ted Heath, the former prime minister of the U.K., was posthumously accused of ritual CSA. However, according to a criminology expert, called Hoskins, the accusations were fantasised and a product of hypnosis applied by recovered memory therapists (Booth, 2016). The investigation about these allegations is still ongoing.

Since 2012 very few relevant studies have been conducted. In one of them it was recently supported that the gap in the beliefs of practitioners and researchers about recovered memory is still evident today (Patihis, et al., 2014). Other contributions warned that these conclusions were unjustified (Brewin and Andrews, 2014), therefore underlying the continuations of the 'memory wars'. Both papers noted above do not explore areas very similar to mine, yet they advocate the need for studies like mine to take place.

In the course of these five years, I may have lost touch with the interviewing experience, in the sense that it may have not been so immediate and alive in my memory. However, the repeated working through and re-reading of the data helped to maintain and renew the vigour of my analysis. Moreover, my constant involvement with my thesis informed my clinical work, while my increased involvement and experience of my clinical work allowed for new perspectives to be applied to my thesis. This gradually increased my confidence in both my thesis and my clinical work.

### 4.6.2 Limitations of Interview Questions and Language Issues

The interview questions were created through the overlapping of literature gaps, and my research and clinical interests. The limitations referred to in this section are the ones identified through the feedback of the participants and my mistakes regarding the interview questions.

Regarding language and translation issues, the list of interview questions was developed in English with the help of an English supervisor and then it was translated into Greek to be

used with Athenian psychoanalytic therapists. Although I did my best for accurate translations, certain meanings may have sounded awkward. A participant, Aris commented:

*"May I make an observation? The way you ask your questions is very 'English'. Is this a translation from English into Greek... Because they confuse me*[307]*"...*

This may have influenced the results as there could be less accuracy in the findings due to the translations. In view of this, there was an effort to establish as much accuracy as possible.

Accuracy was also sought when translating the interview data from Greek to English, yet some details could have been missed during this process. To minimise the impact of this translation, a certified translator oversaw my translations.

Moving on to terminology issues, I chose to use the term 'κακοποίηση' in Greek, which means 'abuse'. Some participants suggested that the terms 'αποπλάνηση', which means seduction, or 'παραβίαση', which means violation/infringement, would be more appropriate. To demonstrate, as soon as the recording of the interview started, Petros stated:

*"I would not prefer the term 'sexual abuse'; the Freudian term is 'sexual seduction'*[308]*".*

Indeed, the word 'seduction' would fit better in a thesis about psychoanalytic practice. Nevertheless, I also focused on recent controversies about CSAM, which were not confined only to psychoanalytic circles, so the word 'abuse' was chosen over terms largely associated with psychoanalysis. Furthermore, the term 'seduction' appears to imply sexual abuse without the involvement of violence, whereas the term 'sexual abuse' includes both violent and non-violent sexual encounters.

There was also a limitation regarding the number of the interview questions. As I was not expecting that the participants would have so many cases relevant to CSAM and that they would be so open while explaining their approaches, I created an interview list which included many questions and prompt questions. The analysis of my interviews suggested that I did not have to focus on all the questions, as the most important results were emerging only from the ones I ended up analysing. If I had fewer questions, I would have asked all the participants all interview questions in a more consistent manner.

The nature of the interview questions could also be improved when thought about in retrospect. If I did the interviews again I would ask for more details concerning cases where FRD occurred, and where false memory creation was handled. This could call for a follow-up research with some of the participants from the current research who unexpectedly shared briefly their experiences regarding these issues.

Another central issue concerned the nature of the interview questions, as they were very direct and closed, meaning that a 'yes' or 'no' answer could be given to them. This was probably restricting the sharing of the participants' responses and opinions that could have been developed had I asked them in a more open-ended way. My decision to use closed questions was based on my wish to produce specific results, such as the percentage of participants who would question a CSAM, so that a therapist will know what is effective and what is harmful in the treatment of these cases. The closed questions were also chosen in order to obtain quantifiable results which could be analysed through CA. This combination of closed questions and prompt open questions led to an in-depth exploration with a specific focus. To compensate for the caused restriction I used further prompts while interviewing and did not restrain the duration of the interview. Future research can perhaps try a more open-ended selection of interview questions.

In the second interview question explored in the analysis chapter (see section 3.2.0), participants were asked 'Have you ever thought of proposing CSA as a possible explanation for the analysand's symptoms - before the actual memory came up during the therapeutic process?'. If I did the interview all over again, I would probably pose it differently, such as 'Would you bring up CSA before you analysand's actual disclosure?' and as another question 'Do you think there are indications for CSA?'. This way I would miss the point of whether they participants would connect the client's presenting symptoms with CSA, but I would focus on one issue at a time, I would not have presupposed that there are indications for CSA and perhaps I would learn more from the participants' approach.

Future research will hopefully aim to include less complex questions so as to be able to understand more precisely what participants mean through their responses.

### 4.6.3 Limitations of Method

The limitations of the chosen methods will be considered next. For example, these include issues such as data translation, method of analysis, qualitative approach.

Regarding the data collection process, interviews are justly associated with disadvantages involving time-consuming processes, small scale researches, inability to be entirely anonymous, potential for the researcher's subconscious bias (or influences of the researcher's pre-determined views), and potential inconsistencies (Brown, 2001). In fact, the time-consuming processes lasted many years in my mode of studying for this thesis.

A larger scale research without interviews could involve for example more analysts from other places in Greece. The ability to collect data in an entirely anonymous way would probably also involve more participants, and more referrals to their clinical cases. To be more specific, my study's participants were contacted through phone calls as I did not receive enough responses through emails (see appendix 2.1). Moreover, several participants appeared more willing that the others to discuss their own cases, which may indicate that there could be trust issues involved towards me, or perhaps that the rest of the participants did not have relevant experiences. The potential for subconscious bias is always a possibility and it is also due to be discussed later (see section 4.7.0). Some inconsistencies about the participants' opinion on the quandary between fantasy and reality in the clients' CSAM, were noted earlier. I paid attention to asking a third party about replies that could be controversial or were not clear-cut enough and I also noted these in the transcriptions.

One of the main limitations of the method was connected to the data condensation process (see section 2.2.2) and to the fact that the place of study was in Athens, so the interviews were conducted in Greek, and then the data had to be translated in English so as to be analysed and submitted. After the data collection process, the interview material was transcribed and summarised, which excluded a large quantity of data. I decided to summarise the data, as choosing what aspects of the data to focus on was initially paralysing (Braun and Clarke, 2006). Thus, I translated the summaries of the participants' responses, rather than the whole interview material, which saved much valuable time. The data were then additionally condensed as several interview questions were excluded from the analysis because they were not clear enough. I excluded the material that was not a product of the participants' replies to

the interview questions, and certain questions as a whole, in order to minimise personal bias, which would be more evident if I attempted to keep only the material I regarded as valuable. This added a systematic approach to the selection of included data, but I may have erased additional valuable findings. This limitation can be minimised in future research if the topic is less broad and/or if the research tool contains less questions.

Additional shortcomings relate to the comparison between CA and other qualitative analytic methods. As seen earlier (see section 2.3.3), I chose this approach over thematic analysis, which has been used before on a similar topic, because CA allows for quantifiable findings to emerge from large data sets. However, Thematic Analysis would facilitate not only a more direct cross-research comparison, but also a higher possibility for unexpected results to emerge. Similarly, if I had used an interpretative approach, such as IPA, I would have to use a smaller sample but I would be able to see the findings at a more personal level for each participant, rather than as a group. In addition, contrary to Narrative or other biographical approaches, CA does not offer you the choice of exploring one participants' individual account, for instance, in terms of continuity and contradiction (Braun and Clarke, 2006). It would be beneficial if future research explored the topic through other qualitative and mixed-method approaches so as to be able to explore in more depth both unexpected findings and personal accounts.

Other worth mentioning limitations of the current study originate in the contrast between qualitative and quantitative analysis. For example, the variety of things that can be hypothesised regarding qualitative data is broad (Braun and Clarke, 2006) and the findings are not as generalisable as they would be in quantitative analysis. This implies that the findings cannot be applicable to other cities inside Greece or countries outside Greece, or other populations, or even therapeutic approaches. However, the strength of the current analysis and the validity of this study's findings provide support for future research to be conducted with other populations and national and cultural contexts. These populations could also involve the clients' perspectives which have been less explored than the therapists' ones.

Another noteworthy limitation of qualitative approaches, when compared to quantitative ones, is the level of objectivity that can be maintained (Taylor, 2005). However, I hope that I raised the level of objectivity as much as possible. My ideas which were relevant to the subjects under investigation were not conclusive, or absolute; sometimes they were not

formed at all. This allowed for an open-minded investigation. I also double-checked my coding with other coders for agreement with each other, so as to avoid reflecting my personal opinions.

Notwithstanding the above, I realise that my views have influenced the results and this will be additionally explored in the ensuing section.

### 4.7.0 Self-reflexivity

The way the researcher approaches self-reflection plays a chief part in every qualitative research, and in CA, the researcher must be aware of both the context and its influence per se, so as to minimise his/her influence on the study's process and findings (Bengtsson, 2016).

I tried to minimise my influence on the data through choosing a non-interpretative approach, explicitly CA. The idea about the researcher's objectivity can only be approximated; it cannot be fully achieved. Of course I unintentionally did influence the data. In fact, at the beginning I noticed that I articulated my interview questions in a leading way in some of the interviews. For instance, in the interview question 'Would you question the reliability of a CSAM?', mainly in the first interviews, I asked instead: 'When would you question the reliability of a CSAM?'. This insinuated my belief that there are cases where this reliability should be questioned and also my wish to know in which cases one questions this reliability. Since I realised this mistake early, I became more careful and I did not repeat it in the rest of the interviews. The tactic of bettering interview schedules and questions according to insights gained from previous interviews is compliant with suggestions from the relevant literature (Miles and Huberman, 1994; van Teijlingen and Hundley, 2002).

Another instance where I led the participants may have involved the sequence of the interview questions: 'Do you believe that the distinction between real and fantasised memories is one of your responsibilities?', and 'Do you believe that the distinction between real memories and fantasies could be achieved?'. When asked in this sequence, participants are guided to reply positively to the latter question because something cannot be your responsibility if it is unfeasible. In retrospect, I realised that this problem could be avoided if these questions were reversed, meaning if the question about the feasibility was followed by the questions about the responsibility.

I also made various mistakes during the interaction with my study's participants. For example, if I repeated the whole research, I would pay more attention to asking all participants the same questions, as the way I did it, rendered some replies as non-applicable, meaning that I did not hear the voice of some participants on specific topics. Failing to ask all my study's participants all the interview questions, left me with a few non-applicable responses. This occurred because at some points I thought that in their discussion on the previous questions, they had already replied to something before it was explicitly asked. Moreover, I was an inexperienced interviewer so in the first interviews I was not so familiar with prompts in order to relax myself and the participants. At the time that the interviews were conducted, I was at the early stages (10 years) of my clinical practise and I was interviewing some of the most experienced psychoanalysts, psychoanalytic therapists and psychiatrists. This made me feel honoured, but also intensely self-conscious when I had to set my boundaries. Therefore, I decided to allow them to talk as much as they wanted, without interrupting them, at least when their time was not an issue for them. This in turn led to a paralysing quantity of interview data.

A different topic of concern about my influence could be related to my opinions regarding the main subjects under investigation. To be clear, I was afraid about retraumatising clients, I did not know that fact and fantasy could be distinguished in adults' CSAM, and I felt frustrated as literature was not enough to help me feel confident when working with uncertain CSAM. The first point regarding the clients' retraumatisation indicates that I could have been prone to recognise the other therapists' fear and uncertainty, so as to identify with them. The second point about the FRD reveals a difference between my opinion and my finding, showing that I was open to receive new information while analysing the data. The third point concerning the literature gaps implies that I may have been keen to reach some conclusions on uncertain CSAM handling. These influences were probably contained because of the intervening time between data collection and submission which, alongside my clinical experience, helped me to view and to review the findings from different and more objective perspectives.

### 4.8.0: Implications and Suggestions

The implications of the present study for the field of psychotherapy and the suggestions for future research will be discussed here. I have already indicated during the discussion of my

findings the pertinent implications for clinical work, law enforcement agencies, and future research, and these points will be briefly reviewed below. In this section, attention will be paid to the implications and suggestions towards the most central findings, which involve psychoanalytic therapists'

1. Approach to their introduction of CSAM before the client's disclosure,
2. Approach to their questioning of the reliability of clients' CSAM,
3. Approach to their possible responsibility regarding the fact-fantasy distinction of clients' CSAM,
4. Approach to the FRD of clients' CSAM,
5. Ambivalence and effectiveness in their work with adults' CSAM.

Several participants said that my interview questions offered them 'food for thought'. The connections they made to handle such cases were very instructive. The findings of the current research bear remarkable implications for clinical practice with cases involving CSAM. Clinicians should be encouraged to become more aware of what we know and what we do not know in the domain of CSAM.

The reader of this thesis can gain considerable knowledge on how to cope with difficult situations and therapeutic dilemmas. Through the first central finding, therapists can find out why it is important to avoid bringing up CSA before the client's disclosure and how to explore the presenting symptoms. Through the review of the relevant literature and the discussion of the first finding, therapists can learn that indications of CSA are too broad to count on them, and that connecting these to the client's trauma may have adverse effects.

In the second central finding, therapists can understand why the internal questioning of the client's CSAM was the preferred position of the participating psychoanalytic therapists and also how one can work though this doubt while avoiding to articulate it directly to the client so as to prevent his/her retraumatisation.

Through the review of the relevant literature and the discussion of the second finding, it is indicated that the exploration of the client's uncertain CSAM should occur in a context wherein other therapeutic material are generally explored in terms of their connection to internal and external states, and that various clinicians have held, and increased throughout

the years, their preference towards abstaining from questioning (rather than questioning directly) their client's CSAM.

In the third central finding, the reader can realise why therapists may or may not accept the FRD in CSAM cases as their responsibility, and the conditions that should be kept in mind when assuming or denying this task as their duty. Through the relevant literature review and the discussion of this finding, therapists can ascertain the importance of prioritising therapy per se, and the client's well-being, over the FRD of a CSAM.

In the fourth central finding, therapists can both identify the difficulties entailed in their attempt to distinguish between fantasy and authentic CSAM in adult clients, and also discover ways through which the distinction can be facilitated in treatment. Through the overview of the relevant literature and the discussion of the fourth finding, the reader can comprehend how a practical approach may try to overcome the shortcomings of previous theories and literature gaps, in order to tackle century-old problems, like the differentiation of fantasy and reality in the clients' CSAM reports.

In the fifth central finding, the reader of the present thesis can see how practical approaches are affected by past debates and other factors, such as gender; what changes may occur in contemporary professionals' handling of CSAM cases; the therapists' mistakes that may lead to the client's retraumatisation; and the proposed handling of repetition compulsion. The comparison of these results to similar research findings will offer clinicians an opportunity to appreciate the ambivalence and uncertainty troubling practical approaches to CSAM for decades, and also to recognise that therapists can still evolve professionally and be successful in this field.

In view of the above, law enforcement agencies working on cases involving CSAM should become aware of the influence of therapist's implicit suggestions on the client's CSAM, the lack of definite CSA indications, and the factors facilitating the FRD. Law enforcement agencies and codes of ethics should also take into account the evident confusion of responsibility regarding the therapists' duties and the clarification of these towards the clients. If the FRD is eventually not regarded as the therapists' responsibility in CSAM cases, then specific guidelines about referrals to specific groups of experts should be provided.

However, if the FRD is eventually regarded as the therapists' responsibility in CSAM cases, specific guidelines on therapeutic work in such cases should be provided.

The implications of the above-noted findings also emphasise the need to address in training programs, psychological conferences and seminars as well as supervisory work many more issues together with those listed above. These issues include: the benefits of therapist's practical experience in this domain, the possibility of false memory triggering in therapy and its grave impact, the difficulties regarding the fact-fantasy differentiation in treatment, and alternative ways of responding in therapeutic dilemmas.

I suggest that future research should also draw attention to issues involved in my findings about certain unexpected factors that appear to have played a role in the therapists' responses. For example, it would be interesting to see the extent to which factors identified by the current research play a significant role in the FRD. These factors include the clients' ability to ascertain the reality of their memories under particular conditions, the time-length and depth of treatment, and the quality and duration of the therapists' own treatment, countertransference analysis, and repetition compulsion interpretation. Another relevant direction for future research would be to examine whether psychotherapists who have been treating a person suffering from CSAM for many years, would be more reliable in determining the authenticity of this person's CSAM, compared to an expert who was appointed to assess memory reliability in a short time.

Future research could also focus on the effects of the therapists' gender factor, which was found to play a role on the way therapists would approach the questioning of clients' CSAM, and on their discussion about effective treatment. Other factors, such as therapists' years of experience, also appeared to have played a part in the varied approaches of my study's participants, and could be researched further.

Future research may explore the subject of CSAM cases through other qualitative and mixed-method approaches in order to facilitate in-depth investigation of personal accounts and unexpected findings. Unexpected and clear-cut findings may also emerge if future studies concentrate on specific topics within the field of CSAM and involve some simple open-ended interview questions. Additional research on the psychoanalytic approach would be fruitful so as to compare our findings. Judging from my limited experience, this may not be the easiest

task, considering that most of my study's participants did not reply through email and I contacted them via phone to arrange our meeting. However, as discussed earlier (see section 1.2.1), the subject of psychoanalytic approach of CSAM is scientifically underexplored.

It would be very useful if future research could focus on the differences between successful and unsuccessful CSAM cases, and on the differences in the views of therapists and clients regarding the level of success in their cases. Moreover, the gray areas, blind spots and literature gaps could be addressed in association with therapeutic work involving CSAM in order to lessen the enduring deficiency in theoretical clarity. It would be useful if certain recommendations for technique were proposed, especially in controversial topics, so as to partly unburden the practitioner. Although guidelines can be theoretically contradictory to the philosophical basis of psychoanalysis, technical recommendations are very useful in such debatable issues. Research should also focus on discovering ways to minimise the potential of causing harm and the therapists' uncertainty.

Moreover, the strength of my research and the validity of my study's findings offer support for future research to be conducted with other populations and cultural contexts. A direct cross-national comparison between countries where professionals are likely or unlikely to be held accountable for therapy-induced false memory would provide evidence on the effects of potential legal problems on contemporary therapeutic work involving CSAM.

In summary, this study involved many implications, especially for psychotherapeutic work regarding CSAM. This study also laid the ground for relevant future research as it can serve as a point of comparison.

**Conclusion to Discussion Chapter**

Contemporary Athenian psychoanalytic therapists appear to approach clients with CSAM with thoughtfulness, honesty, ambiguity and difficulty. They agree on the effect of experience, time, and knowledge on their work with CSAM and they widely acknowledge the complexity involved in relevant cases, along with the high possibility for clients' retraumatisation. They appear to recognise the issue of uncertain CSAM as most participants stated that they would question the reliability, that they believe in the feasibility of the FRD and that they consider this distinction as their responsibility. They have divergent opinions

regarding the CSAM's introduction and its connection to symptoms, and regarding addressing as well as examining CSAM reliability. Many (3-32% depending on the question) of the participants' replies to my interview questions could not be categorised as 'yes' or 'no', which implies that the relevant answers are complicated and that the choices are not easy to make. While therapists' ineffectiveness has been emphasised in previous literature (Colton, 1996), several of this study's participants have found ways to be effective in certain cases.

A noteworthy finding emerging from the combination of two of my main findings (see sections 4.3.0 and 4.4.0), shows that from this study's participants' 39% said that the FRD in CSAM cases is feasible and 45% that it is their responsibility. This demonstrates that at least 6% of the participants hold that the distinction is their responsibility while they do not consider it as feasible. Future attempts to facilitate therapeutic work involving CSAM, must ensure either that the distinction is feasible and propose ways to achieve this, or that it is not the therapists' responsibility and communicate who is responsible for this, so as for therapists to know how to handle this matter.

Overall, the results of the current study show that therapists have taken into consideration the perspectives heard in past writings and controversies and attempt to fill in the literature gaps. At the beginning there was an emphasis on how excluded CSA was from public recognition, it then became very important because of the reported cases, and lately therapists were led to believe that CSA was present in every case because of recovered and false memories. Nowadays, psychoanalytic therapists seem to seek a more balanced view, since due to all these controversies they have become more mindful in their practice, they want to make distinctions, be more careful about fantasy and reality and pay attention to both internal and external reality.

To sum up, in their practice therapists apparently make substantial attempts to overcome issues not covered clearly in theory. Therapists can feel rightfully uncertain about the possibility of causing harm to the client with CSAM, as there are many blind spots and therapeutic traps in such cases that are already considered challenging, burdensome and difficult. These onerous spots include the situations of a therapist working with uncertain CSAM. The forthcoming section will involve both a summary of the present thesis, and a presentation of the messages conveyed by the main findings of the current research.

# Thesis Conclusion

Throughout history repeated patterns of hiding, recognising and rejecting CSAM have been revealed even in the fields meant to help individuals identified as emotionally vulnerable. CSA used to be largely ignored. Freud (1896a) initially held that neurosis is ridden by actual trauma, whereas later (1905a) he turned his attention to internal conflicts and fantasies, on which he based psychoanalysis. However, Freud did not formally retract his former perspective, and he remained preoccupied with the trauma-drive dilemma (Masson, 1990; see section 1.3). This subject dichotomised psychoanalytic theorists, and CSA attracted attention in the 1980s more than 80 years later. Shortly after, mainly in the 1990s, psychology experts challenged the validity of the traumatic memories and pointed out that false memory may be created in therapy (Poole et al., 1995; Loftus and Davis, 2006; see section 1.4.3.5). This burdening legacy left behind questions regarding the ability and responsibility of therapists in CSAM cases (see sections 2.1.6 and 2.1.7).

The present thesis explored current Athenian psychoanalytic therapists' approach to adults' memory of early sexual trauma. The main research question was 'How would Athenian psychoanalytic therapists approach controversial issues in cases involving CSAM?'. There was a dual focus on influences of Freudian views and more recent controversies about reality and fantasy on contemporary practice. The aim was to add to the understanding of these difficult issues, as they are explored in the literature, and to allow for this learning to be applied to relevant psychotherapeutic communities, educational and training programs and law enforcement agencies.

Interview questions were developed to explore psychoanalytic therapists' thoughts, feelings and practices about CSAM cases. The questions focused on the psychoanalytic therapists' changing perspectives, the dangers and responsibilities of the profession, alongside their responses to relevant controversial issues involving the introduction, questioning, and clarifying of uncertain CSAM. Athenian psychoanalysts, psychoanalytic therapists and trainees were interviewed in 2012 and the interview data were analysed using CA. The time lapse between the data collection and the thesis submission gave me a fresh perspective towards the understanding of underlining relevant issues.

The research methods included in depth semi-structured interviewing of psychoanalytic therapists and CA of the data which allowed for some interesting findings to be revealed. The superordinate categories as they emerged from the CA concerned the handling in CSAM cases in relation to professional changes, dilemmas and risks, as well as the FRD in treatment. Psychoanalytic therapists appeared concerned with various aspects of CSAM cases, which were not addressed through the interview questions. These included the therapists' mistakes, the clients' repetition compulsion, the actual sexual abuse by mental health professionals, the significance of the right timing, the implications of psychopathology and the priorities in therapy.

The discussion chapter explored the findings which either related to previous research results or were missing from the literature. The findings about contemporary thinking were also compared with and contrasted to both Freudian and other contributions on the domain of CSAM. Possible reasons for both the analysands' focus on major issues and the contradictions with past research were also introduced in the previous chapter. A brief review of the main findings will be provided below.

The first finding indicates that, in contradiction to other research (Sullins, 1998; Barber, 2012) and past theories (Freud, 1896a), most (61%) of this study's participants were not willing to openly introduce CSA before the analysand's disclosure and almost half (45%) of them would consider that there is a CSA history before the client's disclosure, which shows that they believe that there are indications of CSA. However, literature material stress that there are no definite indications for CSA history (Madill and Holch, 2004), and therapists' both implicit and explicit suggestions may retraumatise the analysand (Mollon, 1996) and/or trigger false CSAM (Loftus and Davis, 2006). The message conveyed by this study's participants is that therapists should not openly discuss any suspicions about a possible CSA history.

The second finding indicates that the overwhelming majority (87%) of psychoanalytic therapists would directly or indirectly question the reliability of a client's CSAM, and that they appear to be more inclined to avoid intervening (67%) than to intervene directly (26%). Comparison with findings from similar research (Poole, et al., 1995; Palm and Gibson, 1998) shows that analytic therapists may be more inclined to question the client's CSAM than other clinicians and that psychoanalytic therapists appear to be increasingly more certain about

whether they would or would not intervene by addressing CSA before the client's disclosure of this trauma. The message communicated through this finding is that therapists should question clients' uncertain CSAM while avoiding direct interventions.

My third finding shows that my study's participants were more inclined to accept (45%), rather to deny (29%), the FRD in CSAM cases as their responsibility. The participants' elaboration of their responses mainly supported previous writings (e.g. Palm and Gibson, 1998; Follette and Davis, 2009; A.P.A. Working Group, 1998) on the subject. The original ideas of this study's participants entailed assuming the task of distinguishing only when somehow requested by the client and in cooperation with a psychiatrist. The message expressed by this study's participants was that therapists should work towards a FRD in cases involving CSAM.

My fourth finding shows that although (45% of the) participants emphasised the difficulty and uncertainty entailed in the FRD of client's CSAM, more participants held that the distinction is feasible (39%), than those who held that it is unfeasible (23%), and most of them (77%) offered interesting ideas on how to facilitate this distinction. This finding mainly contradicts past contributions on the topic (Freud, 1918; Bernstein and Loftus, 2002) which emphasise the unfeasibility of this distinction. Possible reasons for psychoanalytic therapists' optimism regarding the FRD include psychoanalysts' focus on fantasy, unconscious meanings, objective manipulation, countertrasference and repetition compulsion, alongside their intensive and long-term nature of both their practical approach and personal therapy. I believe that psychoanalysis' long-standing attempt to establish the FRD, may also contribute to their increased understanding of the matter. The participants' highlighting of countertransference as an aid in the distinction is a novel finding and it differs from classical approaches (Freud, 1910; 1912). The idea that the long-term nature of psychoanalytic practice may provide an advantage, for the FRD in CSAM cases, over more short-term approaches is also an original finding. The message conveyed by this finding was that therapists can try to help their clients distinguish between fantasy and reality in their CSAM and that they may trust countertransference and time to facilitate their relevant effort.

The fifth finding of the current research indicates that notwithstanding the ambiguity and uncertainty reflected in psychoanalytic practice with adults' uncertain CSAM, psychoanalytic therapists have found ways not only to evolve professionally, but most importantly to be

effective in their relevant work. This contradicts the findings of the only other research (Colton, 1996) examining the views of psychoanalytically-oriented therapists, which supported that therapists with such orientation are completely ineffective in their relevant work. The message communicated by this finding is that regardless of the CSAM conflicts and their own uncertainties, therapists are encouraged to strive to be effective in their work with clients' CSAM.

Regarding the accusations towards psychoanalysts, I tried to identify any tendencies about them overlooking either fantasy or reality (see sections 1.1.4.1 and 1.1.4.6), blaming the child sufferer (see section 1.1.4.2), underestimating the impact of CSA (see section 1.1.4.3), avoiding the subject of CSA (see section 1.1.4.4), and triggering false memory (see section 1.1.4.5). A few participants asked me why I focus on uncertain memory, while there is so much actual CSA, which implies that they neither avoided the subject of actual CSA, nor ignored it. On the contrary, they discussed actual sexual abuse by therapists, while my question concerned the client's psychological retraumatisation. They did not over-emphasise fantasy, as most (87%) of them claimed that they would implicitly or explicitly question a client's CSAM, and that they (45%) feel responsible for the FRD in CSAM cases.

In this study's data, there was no evidence of either victim-blaming or underestimation of the effects of CSA. Interestingly, my study's participants did not show any signs of underestimating the effects of CSA fantasy either. It is essential to value both internal and external reality and to make sure that their distinction is attended to within the analysis or from an external agent alongside therapy.

However, it is true that considerable minorities of this study's participants would consider proposing CSA as an explanation for the client's symptoms either explicitly (29%) or implicitly (16%), while both of these approaches could be viewed as dangerous in relation to false memory triggering in therapy. This may mean that while psychoanalytic therapists have managed to evolve professionally and be effective in cases involving CSAM, they were not completely able to overcome problems that have been troubling therapeutic approaches to CSAM. This highlights the need for relevant future research about psychotherapeutic approaches to CSAM so as to increase the givens and to minimise the possibilities for therapy being harmful.

Overall, Athenian psychoanalytic therapists tend to adopt a more balanced view, which accepts both objective and subjective reality as well as the need to discriminate between the two. They appreciate the professional risks and the clinical traps, and they begin to reveal how uncertain CSAM should be handled in therapy. Furthermore, they tend to choose 'colors' – rather than the 'black or white' evident in past debates – as they personalise their approaches taking into consideration many conditions in the dilemmas they encounter. They also prefer to approach complex tasks, for instance introducing CSA and questioning CSAM, in implicit and probably safer ways.

There is so much more to learn in the domain of CSAM in psychoanalytic therapy with adults, especially when it comes to handling, distinguishing and approaching reality and fantasy in therapy. The reason I focused on the profession's difficulties was because we can learn from them. In this way, we will have acquired more knowledge and experience for next time, in order to be able to maintain our optimism when working with CSAM sufferers. Psychoanalysis has much to offer in such cases and contemporary psychoanalytic therapists appear eager to offer solutions. Differences in the sample and method would be most welcome in future research since they provide fresh perspectives on relevant issues. I did get satisfying replies to most of my own questions through the current contribution and I am confident that I opened pathways to respond to the rest of them.

On a final note, I would like to point out the importance of awareness and mental health education for CSAM sufferers. The indication for psychotherapy in these patients is of imperative importance as they will probably tend to repeat forming abusive relationships, thus repeating the traumatic experience, either by being once again the victim or by becoming the abuser. Repetition compulsion related to the analysands' trauma, is most likely to manifest within transference in therapy, even if that means the emergence of false CSAM. However, if an experienced, well trained and analysed therapist provides a good containing environment for the analysand, there will be a chance for this repetition compulsion to be interpreted and processed. This will hopefully turn therapy into a reparative experience rather than a harmful repetition of the trauma that might occur in life outside therapy where I suppose that there is a much smaller chance for the trauma to be worked through.

In conclusion, it is important for clients to seek therapy and important for therapists to have coherent guidelines, based on unbiased and valid research, to help them feel safe when

working with the difficult issue of CSAM. The participants of the current study showed pathways for future research to work on theoretical gaps relating to uncertain CSAM.

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# Appendices

## Appendix 1 Ethics Forms

### 1.1 Ethics Form Request

**Department of Professional and Community Education (PACE)**
**Postgraduate Research Students Ethical Approval Form**

**CONFIDENTIAL**

**GOLDSMITHS University of London**

**Department of Professional and Community Education Research Ethics Committee**

NAME OF APPLICANT .....Eirini Piki.....

Title of MPhil/PhD Programme .....Psychotherapeutic Studies.....

This form should be completed in typescript and returned to the Research Administrator, Maria Dumas. All students should have read the appropriate guidelines on ethics (such as the BPS, BSA, AAA or ASA) and the ESRC Research Ethics Framework document. The decision of the committee regarding your application for ethical approval will be communicated to you via email.

1. **Title of proposed project:**

*'Contemporary Psychoanalytic Practice as Influenced by Freudian and Post-Freudian Views on Child Sexual Abuse Memories'*

2. **Brief outline of the project, including its purpose:**

This study will work towards a better understanding of current psychoanalytic approaches in cases of CSAM, while determining their interaction with previous controversies and contemporary codes of ethics. This resolved the three dimensional focus on a) contemporary practice, b) history of Freudian and post-Freudian ideas and c) the relationship to a social policy context regarding CSA. Each point of focus is analysed in turn below.

The analysis of qualitative data collected from representative samples of Greek psychoanalytic therapists in Athens allows for a deep-reaching exploration of various factors influencing the quality and effectiveness of their work with adults who suffer from CSAM. For example, responses to questions such as: “How prepared and confident do you feel when working with CSAM?” will help to define the extent to which psychoanalytic professionals acknowledge the complications of working with such susceptible clients.

This self-reported data will be examined in relation to past theoretical and practical debates within psychoanalytic circles. In brief, Freud’s pioneering, yet ambivalent stance regarding emerging repressed memories more than a century ago influenced many important theorists that are still considered significant. To illustrate, Firenze’s lean towards actual trauma and Klein’s inclination to phantasm may have influenced current psychodynamic psychotherapists in multiple ways. As far as past psychoanalytic practise is concerned, therapists used to be accused for misinterpreting authentic memories of CSA as unconscious wishes and vice versa. Thus, the history of Freudian and post-Freudian ideas on the topic has been reviewed so as to determine their relation to current psychoanalytic practises. Answers to questions like: “In what circumstances might you consider challenging a recovered memory's reliability?” may shed some light on whether the psychoanalytic inheritance has shaped a suspicion toward memories involving CSA, thus being more inclined to overlook actual traumas.

More recently, relevant scientific reports have dealt with false memories created in therapeutic encounters and grey areas in clinical responses to child sexual abuse (e.g. inducing false memories through suggestion). Codes of ethics have been continually adjusted to assimilate changes but the degree of recognising a legal duty

to respond may differ cross-culturally. Moreover, after reading most relevant literature material, I realised that therapeutic concerns and public policy ones do not always overlap. Thus, the vulnerable sphere of child sexual abuse memories represents a double-edged knife for practitioners who may be unable to distinguish if these memories, especially when retrieved from the unconscious, correspond to real memories or fantasies. For instance, the participants' replies to the question: "Do you believe that uncovering the truthfulness of CSAM is within the therapist's remit?" could clarify their recognition of a legal and ethical duty to respond to the policy context.

The results of this project will inform the Greek Psychoanalytic Association regarding the difficulties faced by psychoanalysts dealing with such cases, while determining the degree to which psychoanalytic approaches may be effective for the treatment of CSAM sufferers. These findings will in turn both elucidate methods of distinguishing and handling real recollections and false memories in such cases and draw attention to more appropriate ways of responding to CSAM sufferers.

### 3. Description of Methods of Data Collection:

The study will adopt a qualitative approach, employing in-depth interviews of a representative sample of psychoanalytic practitioners, working with adults in Athens, Greece. Participants will be approached through post administrations of consent forms, which include all the required information (please see attached consent form).

A semi-structured interview plan has been devised to elicit the psychoanalytic practitioners' preparedness when encountering CSAM discussed by adult patients, through the therapists' responses. This can in turn facilitate understanding of how related controversial issues are dealt within the Greek psychoanalytic circles. Interviews will focus on the influence of the practitioner's training and theoretical approach on how they respond to CSAM, the psychoanalytic practitioners' preparedness to distinguish fictitious from authentic memories of sexual abuse, the advantages and limitations of their approach on the topic, alternative ways of related responding, methods employed to ensure confidentiality and legal obligations and so on.

The interview will include approximately 10-15 mostly open questions regarding the topic and a set of standard social background (i.e. gender, age, ethnic status) and curriculum vitae questions (e.g. relevant training, educational details and previous work experience) so as to investigate potential underlying and interacting factors. The collected demographic information (gender, level of training, etc.) will be useful in the discussion of the interview data.

**If the research involves human participants (whether living or recently deceased) or animal subjects, please continue. If the research involves historical, textual or aesthetic data or secondary data already in the public realm and does not directly involve the observation or direct engagement with human or animal participants, then please jump to Question 19.**

4. **Specify the number of and type of participant(s) likely to be involved.**

In view of the small number of (psychoanalytic - and the control group) therapists working in Athens, Greece, we do not foresee any difficulty in locating participants who fulfill the criteria. According to Zerbetto's and Tantam's 2001 study, the total number of therapists in the Greece is 700, adding up to 0.07% of total population. The Greek Psychoanalytic Association lists 98 members and trainees, which correspond to approximately 0.01% of total population respectively. The number of participants in this study will be analogous to their proportion from the total population of psychoanalysts. Participants will also be categorized and matched in terms of gender, degree and place of education, age and level of experience. The biases and interactions of certain factors (e.g. specific theoretical approach) will also be taken into consideration.

A sample of participants will be selected for interviews to explore their preparedness in greater depth. On average, interviews with minimum of 24 participants will be undertaken.

5. **State where the data collection will be undertaken.**

The consent form will be administered and collected through the post.

Qualitative data collection will be accomplished through 1-hour interviews, which will take place at the participant's office. This will ensure a quiet, comfortable and natural environment for the research to be undertaken for all the above noted reasons.

6. **State the potential adverse consequences to the participant(s), or particular groups of people, if any, and what precautions are to be taken. If any potential adverse consequences, please state how you will address these.**

Participants' confidentiality will be protected in both studies according to the recommended research ethical standards. Anonymity will be used in any published results. This will avoid any kind of potential adverse consequences.

Particular groups of people (specifically Greek psychoanalytic practitioners working with adults in Athens, Greece) will also be protected by drawing light mainly to inefficiencies in training and community, rather than on psychoanalysts' individual approaches.

Moreover, participants will be informed of future publications that will come out of the research. This may serve as a positive result of practitioners who would like to develop their professional capacity when dealing with such cases.

7. **State any procedures which may cause discomfort, distress or harm to the participant(s), or particular groups of people, and the degree of discomfort or distress likely to be entailed. Please also state how you will address these.**

The only case imaginable, in relation to causing discomfort to the participants, is when a psychoanalyst has him/herself experienced CSA. Nevertheless, as psychoanalytic psychotherapists, they'll have worked on their experiences during their personal therapy. Even if something comes up it is expected that they'll take it to supervision, as ethics' code suggest. Furthermore, it's up to them whether they'll discuss their personal experiences and their impact on their therapeutic work with other victims (i.e. countertransference) and whether they'll participate after they learn what the interview will be about.

The interviews will address issues relating to the participants' approach and treatment of possible recovered memory cases, the conveniences and difficulties regarding the treatment of CSA sufferers, their suggestions for future research and changes in psychotherapeutic training and social policy (i.e. necessity of more experts (on CSA and memory reliability), especially in tackling stigma and potential harmful therapeutic effects.

8. **State how the participant(s) will be recruited. (Please attach copies of any recruiting materials if used).**

A sample of psychoanalytically- oriented participants will be recruited through the post for interviews in order to explore their responses towards CSAM cases in greater depth. More specifically, a consent form introducing the subject of my research will be posted to every potential participant in a pre-paid envelope so as to sign and return. The purpose of this letter is to identify a representative number of psychoanalytic therapists who work with adults in Athens, Greece and are willing to be interviewed about their relevant views, knowledge and experiences regarding patients with CSAM.

9. **State the manner in which the participant(s) consent will be obtained (please include a copy of the intended consent form and cover letter).**

Participants' consent will be obtained in written form before each interview through the post. Please consult the attached consent form for more details.

9a. Will the participant(s) be fully informed about the nature of the project and of what they will be required to do?

Participants will have all necessary information and awareness regarding the proposed area of research before they decide whether they would like to be interviewed.

9b. Is there any deception involved?

Not at all. Even debriefing them after the interviews will be unnecessary.

9c. Will the participant(s) be told they can withdraw from participation at any time, if they wish?

Of course participants will be informed about their right described above – namely their right to withdraw at any time - before they participate and will also be aware of their right to take along with them any data they have contributed (i.e. my notes on their answers and the recorded data).

9d. Will data be treated confidentially regarding personal information, and what will the participant(s) be told about this? How will data be stored and what plans do you have for eventually destroying it?

Participants' confidentiality will be protected according to the recommended research ethical standards. Anonymity will also be stressed for participants' clients, meaning that information provided by the participants will be anonymous in the first place. Thus, confidentiality will be a given, to begin with, and this will be stressed in their consent forms.

Of course, anonymity will additionally be used in any published results. This will avoid any kind of potential adverse consequences.

The data will be stored though numerical lists, the records of which will be kept safe and locked and nobody but me will have access. Five years after the completion of my PHD, all confidential data will be destroyed. This time period will allow sufficient time for any publication(s).

9e. If the participant(s) are young persons under the age of 18 years or 'vulnerable persons' (e.g. with learning difficulties or with severe cognitive disability), how will consent be given (i.e. from the participant themselves or from a third party such as a parent or guardian) and how will assent to the research be asked for?

None of the participant(s) will be underaged or considered to be vulnerable.

**10. Will the data be confidential?**

10a. Will the data be anonymous?

Yes. Please see also 9d.

10b. How will the data remain confidential?

As noted above all interview material will include merely anonymised information and participant consent will also be sought for the future publication of any research material. Please see also 9d.

11. **Will the research involve the investigation of illegal conduct? If yes, give details and say how you yourself will be protected from harm or suspicion of illegal conduct?**

The investigation will NOT involve any kind of illegal conduct.

12. **Is it possible that the research might disclose information regarding child sexual abuse or neglect? If yes, indicate how such information will be passed to the relevant authorities (e.g. social workers, police), but also indicate how participants will be informed about the handling of such information were disclosure of this kind to occur. A warning to this effect must be included in the consent form if such disclosure is likely to occur.**

The current research will include experts discussing their personal views and clinical material involving child sexual abuse memories, respecting the patient's anonymity in the first place.

13. **State what kind of feedback, if any, will be offered to participants.**

I intend to inform the participants about future publications, as noted above.

14. **State your expertise for conducting the research proposed.**

Most of my BSc and MA coursework in which I had the opportunity to develop the topic, entail memory issues and CSA (for example my MA dissertation examined the mother- daughter bond in paternal incest cases).
I have had training on domestic violence and watched live relevant sessions during my clinical training.
I have had a few CSA cases during my clinical practice (specifically in my office, in phone counselling and in the nurseries I work for).
I teach relevant university modules (i.e. Codes of Ethics, Counselling Skills, Human Growth and Development and Psychodynamic Approaches).

I have had the opportunity to read all data of a long trial that involved false CSAM.

15. **In cases of research with young persons under the age of 18 years or 'vulnerable persons' (e.g. with learning difficulties or with severe cognitive disability), or with those in legal custody, will face-to-face interviews or observations or experiments be overseen by a third party (such as a teacher, care worker or prison officer)?**

None of the participant(s) will be underaged or considered to be vulnerable.
Thus, there will NOT be anybody observing the interviews.

16. **If data is collected from an institutional location (such as a school, prison, hospital), has agreement been obtained by the relevant authority (e.g. Head Teacher, Local Education Authority, Home Office)?**

Data will NOT be collected from an institutional location.

17. **For those conducting research with young persons under the age of 18 years or 'vulnerable persons' (e.g. with learning difficulties or with severe cognitive disability), do you have Criminal Records Bureau clearance? (Ordinarily unsupervised contact with minors would require such clearance. Please see College *Code of Practice on Research Ethics*, 2005). Please provide evidence of such clearance.**

None of the participant(s) will be underaged or vulnerable.

18. **Will the research place you in situations of harm, injury or criminality?**

No, the research will not place me in any situations of harm, injury or criminality. The interviews will take place in the participants' office, where only myself and the interviewee will be present.

19. **Might the research cause harm to those represented in it? If so, how?**

During the interview process, the participants will be simply asked to express their views on therapeutic work with CSAM sufferers. Thus, no, no harm will be caused to those represented in it.

20. **Will the research cause harm or damage to bystanders or the immediate environment?**

No, it will not cause harm or damage to bystanders or the immediate environment. As noted above, the interviews will take place in the participants' office, where only I and the interviewee will be present.

21. **Are there any conflicts of interest regarding the investigation and dissemination of the research (e.g. with regard to compromising independence or objectivity due to financial gain)?**

No. There will be neither conflicts of interest, nor financial gains.

22. **Is the research likely to have any negative impact on the academic status or reputation of the College?**

No. On the contrary, a positive impact, in terms of high-quality and original research, is anticipated.

_____

**ALL APPLICANTS**

**Please note that the Committee should be notified of any adverse or unforeseen circumstances arising out of this study. Significant changes to the research design should be notified to your Supervisor and relayed to the Committee.**

**Signature of Applicant** **Date**

_____ _____02/07/10_____

_____

**TO BE COMPLETED BY PRINCIPAL SUPERVISOR**

**Please note that the Department Research Ethics Committee should be notified of any adverse or unforeseen circumstances arising out of this study or of any emerging**

**ethical concerns that the Supervisor may have about the research once it has commenced.**

**Has the student read the appropriate guidelines on ethics (or equivalent ones, such as the AAA or ASA) and the ESRC Research Ethics Framework document? [Approval will not be granted unless the student has demonstrated to the supervisor that they have read such documents.]**

**Yes/No (Please circle)**

**Has there been appropriate discussion of the ethical implications of the research with yourself as Supervisor?**

**Yes/No (Please circle)**

**Are the ethical implications of the proposed research adequately described in this application?**
**Yes/No (Please circle)**

**Signature of Principal Supervisor** **Date**

**2/7/2010**

## 1.2 Email with Ethics Approval

**From:** Maria Dumas <m.dumas@gold.ac.uk>
**Sent:** Thursday, 21 of October 2010
**To:** eirini_piki@hotmail.com
**Cc.:** Anastasios Gaitanidis; s.skaife@gold.ac.uk
**Subject:** Ethical approval form

Dear Eirini,

I am pleased to let you know that your ethical approval form has been approved and you may continue your research.

Best wishes,

Maria

Maria Dumas
Centre for Lifelong Learning and Community Engagement
Department of Professional and Community Education (PACE)
Room G12, Deptford Town Hall Building
Goldsmiths, University of London
New Cross
London SE14 6NW
020 7919 7212 (Wed, Thurs, Fri)
m.dumas@gold.ac.uk
www.goldsmiths.ac.uk/pace

## Appendix 2: Invitation, Information and Consent Form

### 2.1 Invitation to the Participants

Email to Participants

Hello,

I hope this finds you well.

The present email concerns my earnest request for your valuable participation in a semi-structured and audio-recorded (roughly 45-minute) interview on the subject of 'Childhood Sexual Abuse Memories'. In the context of this dissertation/thesis, I am already conducting interviews with psychoanalysts working with adults in the area of Athens. The meetings are held in places and hours that suit you (such as your office). This innovative research will meet all English and Greek ethical and confidentiality requirements and will be part of my PhD in Psychodynamic Studies at Goldsmiths (College), University of London.

For further information, please consult the attached information and consent form and do not hesitate to contact me at the current email address or by phone: 2106084499 and 6937132921.

Thank you very much in advance for your attention and your - as prompt as possible - reply.

Eirini Piki.

B. Message for Potential Participants' Answering Machine

Hello, my name is Eirini Piki and I am calling with regard to an innovative research on the psychoanalytic approach of childhood sexual abuse memories taking place for my PhD at Goldsmiths, University of London. In the context of this thesis, I am already conducting semi-structured interviews with members of the psychoanalytic society, working with adults in the area of Athens. Each interview lasts approximately 45 minutes and is usually conducted at your place. If you are interested in learning more and/or participating, please call me at 6937132921 or 2106084499, so as to arrange an appointment that will fit your schedule. Thank you very much for your attention. Goodbye.

## 2.2 Information and Consent Form

**Information / Consent Form**

My name is Eirini Piki and the qualitative research described below is for my PHD in Psychodynamic Studies at Goldsmiths, University of London. My thesis intends to investigate various issues surrounding **Child Sexual Abuse** (CSA) memories. My aim is to work towards a greater understanding of traumatic memories for both therapists and sufferers of CSAM.

The therapists' position in these situations should be examined, as it may significantly affect CSAM sufferers. The subject of this study involves the evaluation of current Greek psychoanalytic practice with adults in the sphere of child sexual abuse memories. The particular group of therapists, namely psychoanalysts, was chosen on the basis of being the most acknowledged and commonly employed psychotherapeutic approach[i].

An adequate number of psychoanalytic psychotherapists, who work with adults in Athens, will be invited to participate in the study. The sample will hopefully be representative in terms of gender and level of experience. **Semi-structured interviews** are aimed to be carried out with each participant. The interviews will be conducted under the framework of 'conversations with a purpose'[ii], and will attempt to generate data through the interaction between the participant and the interviewer. Questions will address earlier debates and contemporary difficulties with regards to how psychoanalysts tend to view and handle memories of CSA. The whole procedure will last approximately **one hour**.

The data collected from the interview will be analyzed using probably grounded theory. Grounded theory is a theory generated by or grounded in an interactive process involving continual sampling and analysis of qualitative data. The discussion that will follow will reveal whether the results of this study, which will reflect current psychoanalytic responses and interventions to CSA, support previous psychoanalytic/dynamic theories and findings and reveal better ways of handling CSA cases.

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[i] Zerbetto, R. and Tantam, D., (2001) 'The Survey of European Psychotherapy Training 3: What Psychotherapy is Available in Europe?' *European Journal of Psychotherapy, Counselling and Health*, Vol. 4, Issue 3, pp. 397-405.

[ii] Burgess, R. G. (1984). *In the Field: An Introduction to Field Research*. London: Allen and Unwin, p.102.

Of course, this study will meet all ethical and **confidentiality** requirements. A research report will be part of my doctoral dissertation and may be published but the information will be anonymous and disguised so that no identification of the participants or their patients will be possible. The participants' responses will be used for research purposes only.

You have the right to refuse to participate and withdraw from the study at any time without giving a reason for withdrawing and you will be free to take with you any data you have contributed. Should you have any worries or complaints concerning the study please contact me (email-address: eirini_piki@hotmail.com) or my supervisors, Dr. Anastasios Gaitanidis (email-address: a.gaitanidis@talk21.com), Sally Skaife (s.skaife@gold.ac.uk) and Sofia Antypa (antypaki1@gmail.com). Do not hesitate to ask any questions you might have regarding the study and clarify any points.

Thanking you in advance.

I _____ consent to participate in Eirini Piki's study. I have received a copy of this letter and had a chance to read it.

Signed_____ Date_____

## Appendix 3 – Tables

### Table 3.1: Similar Research

| | Focus | Place | Sample size (Gender)/ Responded | Theoretical Orientation | Method of Data Collection | Method of Analysis |
|---|---|---|---|---|---|---|
| **Piki, 2018 (in press)** | Psychoanalytic Approach to Adults' CSAM | Greece | 31 (22F, 9M) | 21 Psychoanalysts & psychoanalytic therapists & 10 trainees of psychoanalysis | Semi-structures interviews | Qualitative Content Analysis |
| **Patihis, et al., 2014** | Study 2 is an investigation of views regarding memory repression among psychologists, researchers, the general public, & undergraduates, % a comparison of current beliefs with past beliefs | U.S.A | 83.291/ 1376 completed the survey (41% M, 59% F) | Practicing psychotherapists, research psychologists, alternative therapists, undergraduate students, & individuals from the general population | Survey Questionnaire | Quantitative |
| **Ost, et al., 2013** | Examines psychological therapists' experiences of, & beliefs about, cases of recovered memory, satanic/ritualistic abuse, Multiple Personality Disorder/Dissociative Identity Disorder, & false memory. | U.K. | 1946/245 completed the survey & 57 who responded to an advert in a monthly publication. Overall, the participants were 302 (104M, 196F) | 183 Clinical Psychologists & 119 Hypnotherapists | Survey Questionnaire | Quantitative |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Barber, 2012**<br><br>Psychd thesis | Explores experiences & needs of adult CSA survivors when consulting MHP & MHP's knowledge & experiences of working with such cases | Australia | 13 MHP (mental health professio-nals) (12F, 1M), 3 CSA Survivors (F) | 8 psychologists (4 of them clinical), 3 social workers, 2 'other' | Semi-structured interviews | Qualitative/ Thematic analysis |
| **Gore-Felton, et al., 2000** | Veracity of CSAM | US | 1008 (504M & 504F)/ 630 usable responses (51% F) | Clinical & counselling psychologists | Survey question-naire | Quantitative |
| **Palm & Gibson, 1998** | Recovered memories of CSA | US | 300/ 88 responded (45M & 43F) | Clinical psychologists | Survey question-naire | Quantitative |
| **Sullins, 1998** | Repressed memories of CSA | US | 269 | Members of the psycho-logical association | They were assigned to vi-gnettes, & then que-stioned. | Quantitative |
| **Phelps, et al., 1997** | From the client's perspective, how the therapeutic process is associated with the retrieval of CSA in psychotherapy | US | 11 (F) | Sexually abused as children | 1-3 hour interviews | Quali / identi-fying codes & themes |
| **Colton, 1996** PhD thesis | Experiences of psychologists who have treated father-daughter incest survivors | US | 5 (F) | Psychoana-lytically oriented Psycho-therapists | Intensive in-depth interview | Qualitative/ Grounded theory |
| **Polusny & Follette, 1996** | Professionals' clinical practices & beliefs about the treatment of adult CSA survivors, & clients' remembering CSAM in therapy | US | 1000/173 usable responses (53% M 47% F) | Clinical & counseling psychologists | Survey questionaire | Quantitative |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Poole, et al., 1995** | Psychotherapy & the recovery of CSAM | US/ UK | Survey 1: 300 US psycho-therapists, Survey 2: 300 US psycho-therapists & 300 British clinical psycholo-gists/ 86, 59 57 usable responses respecti vely | Doctoral level US psychothe-rapists & UK Chartered clinical psychologists | Surveys question-naires | Quanti-tative |
| **Pope & Tabachn ick, 1995** | Recovered memories of CSA | US | 900 (450M & 450 F)/ 382 usable returns (173M & 205F) | Licensed Psycholo-gists | Survey question-naire | Quanti-tative |
| **Yapko, 1994b** | Memory, hypnosis & the possibility of creating false CSAM. | US | 869 | Psychothe-rapists in clinical practice | Survey question-naire | Quanti-tative |

**Table 3.2: Basic Interviewee Details**

| | **Code names** | **Sex** M9 F22 | **Age** | **Experience** (years of psycho-analytic work) | **Completed Psychoanalytic Training** (yes, no) | **Psychiatrist** (yes, no) |
|---|---|---|---|---|---|---|
| **1** | Angeliki | F | 34 | ? | Y | N |
| **2** | Athina | F | 45 | 10 | N | N |
| **3** | Takis | M | 56 | 24 | Y | Y |
| **4** | Chrisa | F | 55 | 20 | N | Y |
| **5** | Fenia | F | 52 | 16 | Y | N |
| **6** | Despina | F | 53 | 16 | N | N |
| **7** | Antonis | M | 55 | 3 | Y | Y |
| **8** | Rita | F | 26 | 3 | N | N |
| **9** | Magda | F | 32 | 10 | N | Y |
| **10** | Toula | F | 38 | ? | N | N |
| **11** | Lefteris | M | 42 | 12 | Y | N |
| **12** | Stella | F | 50 | 10+ | N | N |
| **13** | Sotiris | M | 60 | 30+ | Y | N |
| **14** | Isidora | F | 49 | 17+ | Y | N |
| **15** | Emelia | F | 49 | 7 | N | N |
| **16** | Pantelis | M | 40 | 13 | N | N |
| **17** | Agapi | F | 54 | 20 | N | Y |
| **18** | Malvina | F | 43 | 3-7 | N | N |
| **19** | Aphrodite | F | 43 | 11 | N | Y |
| **20** | Dina | F | 44 | 18 | N | N |
| **21** | Ira | F | 62 | 15+ | Y | Y (and child) |
| **22** | Apollonas | M | 55 | 20 | Y | N |
| **23** | Petros | M | 85 | 50 | Y | Y (and child) |
| **24** | Nota | F | 53 | 20 | Y | Y |
| **25** | Vicky | F | 50 | 15 | N | **N** |
| **26** | Simela | F | 60 | 30 | Y | Y |
| **27** | Aris | M | 59 | 30 | Y | Y (and child) |

| | | | | | | |
|---|---|---|---|---|---|---|
| **28** | Mirsini | F | 54 | 25 | Y | N |
| **29** | Efi | F | 56 | 30 | Y | N |
| **30** | Timotei | F | 56 | 23 | Y | Y |
| **31** | Ilias | M | 42 | 6 | N | Y |

**Table 3.3: Topics, Findings and Discussion Points**

| Research Topics | Most Important Findings (Analysis Chapter - 3) | Discussion of Findings (Discussion Chapter - 4) |
|---|---|---|
| Have you ever thought of proposing CSA as a possible explanation for the analysand's symptoms - before the actual memory came up during the therapeutic process? (sections 1.2.1.1, 3.2.0, 3.2.0, 4.1.0) | - 45% of the Ps would not propose CSA as a possible explanation for the analysand's symptoms before the analysand explicitly brought up CSA.<br>- There was ambiguity among the data as notable minorities would consider exploring this possibility either explicitly (29%) or implicitly (16%).<br>- Ps' responses differed from one another in terms of both the conditions under which and the ways through which they would link symptoms to CSA. | - 61% of the Ps were not willing to openly introduce CSA before the analysand's disclosure, which contradicts previous theories Freud (1896b), beliefs Herman (1992), and findings (Barber, 2012).<br>- 45% of the Ps would consider that there is a CSA history before the client's disclosure, which shows that they believed that there are indications of CSA, contrary to contemporary thinking (Lindsay and Read, 1994; Spanos, 1996; Madill and Holch, 2004). Moreover, this study's Ps both implicit and explicit suggestions may retraumatise the analysand (Mollon, 1996) and/or trigger false CSAM (Poole et al., 1995; Loftus and Davis, 2006), and they contrast previous findings (Sullins, 1998).<br>- Relevant guidelines are provided. |
| Would you question the reliability of a CSAM? (sections 1.2.1.2, 3.4.0, 4.2.0) | 61% of the Ps would question the reliability of a client's CSAM, but not openly, 26% would question it directly, and 6% would not question it.<br>42% of the Ps discussed why they would not question a client's CSAM. 26% argued why they would question a client's CSAM, and six of these eight Ps were male. | - My finding about 87% of the psychoanalytic therapists (openly or not openly) questioning an analysand's CSAM, contradicts previous research (Poole, et al., 1995) supporting that therapists presupposed that their clients' memories were reliable.<br>- Compared to Palm and Gibson's (1998) study, my study had higher percentages in both cases, that is, of Ps who said that they would not intervene (67%-40%), and of Ps who said that they would intervene (26%- 17%).<br>- Relevant guidelines are provided. |
| Do you believe that the distinction between real and fantasised CSAM is one of your responsibilities? (sections 1.2.1.4, 1.2.1.6, 3.5.0, 4.3.0) | - There is ambiguity across the data as to whether the FRD is (45%) or is not (29%) the therapist's responsibility, and the replies of several (32%) of the Ps were not clear-cut so as to be categorised as above.<br>- In relation to the FRD in clients' CSAM, many Ps explained when they hold that it is their responsibility, why they hold that it is so, and why they declare that reality is not the priority in psychoanalytic psychotherapy.<br>- Ps' responses differed in relation to whether the therapist or the client makes the fr in CSAM, and some Ps discussed the differences in cases involving more serious psychopathology and the idea that the length and intensity of the treatment, as well as other elements, contribute to the distinction.<br>Nearly one third (32%) of the Ps mentioned the conditions under which they consider the fact-fantasy distinction as related or unrelated to the therapist's remit. From these Ps, 73% were not psychiatrists, and 73% had more than 15 years of experience. | - My findings show that my study's Ps were more inclined to accept, rather to deny, the FRD in CSAM cases as their responsibility. This finding supported previous findings (Palm and Gibson, 1998) and writings (e.g. Gardner, 2003) and opposed to others (e.g Perlman, 1996).<br>- The polarisation illustrated by the close percentages of those who replied 'yes' and 'no', as well as by the number of unclear responses given to the interview question about the therapist's role in the RFD, shows that further research is needed.<br>- The ideas of my study's Ps about the therapists' role in the RFD agree with writings on the subjects of passing over this task for specialised professionals when required (Palm and Gibson, 1998), of the therapeutic significance on the RFD (Fonagy and Target, 1997), of the effects of potential false CSAM on the client's relationships (e.g. Yapko, 1994), of the responsibility of the client in this FRD (e.g. Follette and Davis, 2009), of prioritising the client's well-being over the FRD in cases entailing CSAM (A.P.A. Working Group, 1998), of psychically-based trauma having equivalent effects to reality-based trauma (Prout and Dobson, 1998). The original ideas of this study's Ps included assuming the task of distinguishing only when somehow requested by the client and in cooperation with a psychiatrist.<br>- Relevant guidelines are provided. |

| | | |
|---|---|---|
| Do you believe that the distinction between real memories and fantasies in CSAM cases could be achieved? (sections 1.2.1.3, 3.6.0, 4.4.2) | - there is disagreement across the sample about the viability of the fact-fantasy distinction, since of the 31 Ps 39% said that it is feasible, 23% replied that it is unfeasible, and 32% responses were not clear-cut enough to be categorised as 'yes' or 'no'.<br>- 45% of the Ps mentioned that such a distinction is hard and uncertain and that court-appointed specialists should assume this task.<br>- 77% of Ps had ideas about ways for therapists to facilitate the fantasy-reality distinction in therapy, i.e. 32% helping the client to make the distinction themselves, 19% aiming for intensity and depth of treatment, and 13% appreciating the transferencial-countertransferencial relationship. | - Although 45% of the Ps emphasised the difficulty and uncertainty entailed in the fantasy-reality distinction of client's CSAM, more Ps held that the distinction is feasible (39%), than those who held that it is unfeasible (23%), and 77% offered interesting ideas on how to facilitate this distinction. My finding seems to contradict Freudian (1918) and, to some extent, recent literature (Loftus and Yapko, 1995; Pope, 1996; Bernstein and Loftus, 2002) proposing that this distinction may be unattainable in therapy.<br>- The Ps' emphasis on countertransference can be connected to more recent writings (Mitchell, 1997; Courtois, 1997; Walker, 2004), rather than more classical approaches (Freud, 1910b; 1912). The idea that the transferential dynamic can help the therapist with the distinction is a novel finding.<br>- The Ps' statements that both the duration and the depth of the analysis is important, comes in accordance with research evidence supporting that long-term therapy is more effective than short-term therapy (Tyson and Goodman, 1996; Valerio and Lepper, 2009). The original part of this finding lies in that, according to my study's Ps, the analysis' depth and duration is important in the distinction between fantasy and reality in adult survivors of CSA.<br>- Relevant guidelines are provided. |
| Have you observed Changes in the Way you Handle CSAM? (sections 1.2.1.6, 3.1.0, 4.5.3) | - 90% of the Ps had seen changes in the way they handle CSAM, i.e. uncertainty toward the reality of clients' CSAM<br>- Ps were more inclined to base these changes on experience rather than knowledge<br>- Ps reported unpleasant feelings and conditions in their practice about adult clients' CSAM<br>- 100% of the Ps who brought up feeling uncomfortable had 15 or more years of experience. 67% of the Ps who replied that time is a factor which led them to alter their approach to CSAM cases were male. | - This study's data entailed evidence (see sections 4.2.1 and 4.2.2) for the therapists' changes (90%, see section 3.1.1), discomfort (19% see section 3.1.6), difficulties (see section 3.1.6), uncertainties (see sections 3.1.3, 3.1.4), and worries (19% see section 3.1.4). This finding corresponds to relevant writings (Olio and Cornell, 1993; Perlman, 1999; Walker, 2004) and findings (Colton, 1996; Barber, 2012). |
| Do you think that there is a possibility for the analysand to be retraumatised due to the therapists' reaction to the disclosure of CSAM? (sections 1.2.1.5, 3.3.0, 4.5.2) | - 87% of the Ps are aware of the possibility for the client with CSAM to be retraumatised during the initial discussion of CSAM.<br>- 61% of the Ps pointed out possible mistakes of the therapist, which may lead to the client's retraumatisation during the early traumatic experience's disclosure.<br>- 39% of the Ps linked the client's retraumatisation to the client's repetition compulsion. | - My relevant findings agree with literature material discussing the client's possible retraumatisation due to the therapist's approach (e.g. Aron and Harris, 2010; Barber, 2012), and to the effects of the therapists' stance on the client (e.g. Denov, 2003; Gore-Felton, et al., 2000).<br>- My findings also coincide with past writings on repetitions compulsion and its involvement in therapy (e.g. Davies and Frawley, 1994), its central role in both therapy (e.g. Hopper, 2001) and the client's remembering (Cheniaux et al., 2011).<br>- Relevant guidelines are provided. |

| | | |
|---|---|---|
| Factors:<br><br>Therapists' gender, experience, professional title (section 4.5.1) | Gender and other factors, which were found to influence the Ps' responses, were discussed in various parts in the analysis chapter (see sections 3.1.3, 3.1.5, 3.4.2, 3.4.4, 3.6.2). | - Psychotherapists who are not psychiatrists are more likely, than psychiatrists-psychotherapists, to discuss the conditions influencing the therapists' responsibility on CSAM cases.<br>- More experienced therapists are more likely than less experienced therapists to express feeling uncomfortable, to focus on the conditions that clarify the therapists' responsibility on CSAM cases and to emphasise that they would try to move the client away from whether something happened and more towards the trauma in relation to the feeling.<br>- Compared to female therapists, male therapists are more inclined to consider questioning the reliability of a clients' CSAM, to discuss a successfully completed case of theirs, and to recognise time as a factor that contributes to their changes. |
| Psychoanalytic Therapy's Ambivalence (see section 4.5.2) | Ambiguity was identified across the data set (see section 3.2.1, 3.2.2, 3.5.1, 3.6.1) and also within individual statements (see sections 3.1.6, 3.2.5) | - My findings about the therapists' ambivalence appear to support previous findings (Colton, 1996) on the topic of the psychoanalytically-oriented therapy involving adults' CSAM. Thus, my results indicate that about 20 years later, psychoanalytic therapists still present ambivalency. |
| Psychoanalytic Therapy's Effectiveness (see section 4.5.4) | Seven Ps mentioned effectively completed cases in their responses to my interview questions. Six of these cases were assessed by the Ps as successfully completed (see sections 3.1.5, 3.2.2, 3.2.4, 3.3.3, 3.3.5, 3.4.4), one as sufficiently completed (see section 3.3.2) and one which was nearly completed (see section 3.3.2). | - While other approaches (such as brief and group) have been explored, the literature lacks research evidence on the effectiveness of a long-term individual psychotherapeutic approach. Colton's (1996) findings indicate that all the participating 'psychoanalytically-oriented' therapists assessed their own work with paternal CSA survivors as ineffective. However, my findings offer evidence on the effectiveness of a long-term individual approach, that is, psychoanalytical therapy. Without being asked about their effectiveness in CSAM cases, 7 Ps mentioned 8 effectively completed cases involving CSAM. |

* Child Sexual Abuse Memory – CSAM, Ps = Ps

## Appendix 4: Interview Questions

1. Have there been any changes in the way you work with and handle CSAM?
2. Have you ever thought of proposing CSA as a possible explanation for the analysand's symptoms - before the actual memory came up during the therapeutic process?
3. Do you think that there is a possibility for the analysand to be retraumatised due to the therapists' reaction to the disclosure of CSAM?
4. Would you question the reliability of a CSAM?
5. Do you believe that the distinction between real and fantasised memories is one of your responsibilities?
6. Do you believe that the distinction between real memories and fantasies in CSAM cases could be achieved?

**Appendix 5: Sample of Translated Summaries of Interview Data**

**Interview question:**

Do you believe that the distinction between real and fantasised memories is one of your responsibilities?

**Participants' Replies:**

i) It is *[my responsibility]* only when in a cooperation with a psychiatrist, a doctor or a clinic, and only when a diagnosis is required. The diagnosis is understandably different when the material is real and when they just relate to patient's fantasies.

*ii) (also in reply 8b:* I do not think it is viable/possible for an analyst who works in retrospection to be sure about this distinction. This retrospection is an issue in psychoanalysis. I mean, it is different when talking to a child brought to you because s/he has been sexually abused [where you know that it has happened] and when talking with an adult who mentions it on his/her own, and constructing the design is in the therapy of the past. I do not think that anyone can be sure.)

iii) Of course, the emergence of fantasy will enable you to make the distinction, to see what its historicity was and where s/he needed to develop such fantasy constructions so that s/he could handle the reality which deprived them of certain issue/s. These are two different situations, which can often be experienced as reality.

iv) It is a matter of usefulness, not responsibility. There are cases where distinguishing reality and non-reality is useful. For example, in psychosis, with which I work a lot, a distinction must be made between what emerges from within and from outside the person. More specifically, we work a lot and we reinforce the distinction between 'what happens' and 'what I feel that happens', for instance one may be scared of someone but that does not mean that this someone is trying to scare them etc. In neurosis, where we are talking about basic analysis, all this is worked out and I focus on fantasised reality.

v) No, I do think they are my responsibility. Fantasised memories are equally important to real ones, aren't they?

vi) It is not exactly within my responsibilities, but if I judge that it is needed, I will do it. If at some point something is very confusing, I could intervene by positioning myself for example by saying "OK, this occurred, I may think about all the rest". I would not care if it did not occur; if it happened for him/her, it would happen for me too.

vii) Yes, not in the sense of a microbiological examination, but the issue of what is real and the truth is also the therapist's responsibility.

viii) My responsibility is to be there for a person that needs to tell his/her story. However, it is my duty to distinguish reality from fantasy because his/her relationships and other experiences are influenced. This is very hard to achieve.

ix) No, I think that if such a case goes to court, it should be dealt with by the court. In the case of a therapeutic relationship, whatever comes as material, we listen to it, we accept it, we respect it and we deal with it as any therapeutic material, even if it is false. The therapist cannot take such a responsibility. The therapist can help the analysand to clarify his/her memory but it is not among the therapists' responsibilities.

x) I think so, since this comes in therapy. It should be dealt with at the analysand's pace.

xi) It is not within my responsibilities but I think it is not totally outside my responsibilities either, meaning I think that to a certain degree the therapeutic relationship does not have a direct impact on distinguishing what is real and what is fake but the relationship itself, the way it evolves and as it unfolds it starts to elucidate the way that all other relationships should be at present, in the future and in the past.

xii) It is not a goal in itself. Let me think about it… this question confuses me. (*from 8b:* The goal is the differentiation of the psychological investment and that may change the event itself. Anyway, I hold this for a while and then we work beyond the event.)

xiii) My first response would be ‘no’. When things concern me, I try to find a way for me and my analysand to understand some things in the same sense. The distinction between reality and fantasy is chaotic.

xiv) I think it matters.

xv) I feel that it is not within my responsibilities in an analysis, at least not when the patient has a psychic structure that allows him/her to regress safely. Depending on the pathology the way that therapists handle things, it will be different, for example they will not let an analysand with psychotic structure regress that much and they will work on a better control of psychic life and reality.

xvi) We are talking about a topic that is of course specific enough now and one would wish for it to be clear, simply to say that this was fantasy and this was reality. I think that I do not know how this is possible, how one can be so sure, though s/he may be sure that these two are very implicated anyway so when the other brings you such a memory, always fantasies have played their role. Now up to which degree this is a reality I do not know, it is a question which at first does not concern me so much to do it. If it is his own fantasy let’s say that he has been abused etc we will analyse what he brings to me, like that, no matter if it is a fantasy or a reality.

xvii) It depends, when we talk about psychoanalytic therapies then not exactly. However, what has happened in my experience is for a young woman who is in psychotherapy, has suicidal tendencies and plays with this abuse matter by putting herself in danger regularly, and that there it was needed to clarify what has actually happened to her and whether she is repeating this by putting herself in danger.

xviii) I think that we must have the ability to be able to enter the analysand’s story, and to be able to come out and to stay there. To wit, that it is one of the good cards that one should have to be able to do this job. It’s a marathon, you lose it and you find it again, you do it and you find it again; it is hard but this is what it is. [*After repeating the question:]* Yes.

xix) No.

xx) Generally and vaguely, no. It is in my responsibility when this is entailed in the patient's request through an expressed or a latent way or in cases of psychosis. However, this distinction would be pointless to a neurotic who may repeatedly describe an erotic story of his/hers and where I understand that some details are not entirely as s/he has told them.

xxi) Yes.

xxii) No.

xxiii) It is within our responsibility but it does not have special signification. What has signification is what is behind these real memories or fantasies, what role it has played, why it has become a psychological trauma.

xxiv) It is [my responsibility] yes, but in the sense that it is something that will come out of psychological work later. At the moment that he/she announces it, one should not enter a diagnostic relationship, meaning to change the style and the tone of what is happening and to start asking questions so as to clarify. The patient's psychical tendency per se will be to bring it up again and to try to understand it and within the context of this understanding s/he will slowly start distinguishing fantasy from reality.
- *[I asked: "If it is urgent because of for example a prosecution?"]*
This is not in the context of a psychoanalytic psychotherapy because I hold that if the experience is to be brought up during a prosecution, he/she ought to have a series of interviews with a specialised psychiatrist, clinical psychologist, and/or social worker possibly. I mean that it is not a problem for the psychoanalyst to solve; if there really is some urgent issue it is good to see the specialists.

xxv) The truth and the lie regarding our 'internal objects' within psychoanalysis are relevant because we are looking for the analysand's truth. To resort to such fantasies is a part of his/her psychical reality, which could be altered within therapy. One of our 'internal objects' is also our work, with which, depending on our experience, we may potentially abuse the analysand or we may create a 'holding' environment for him/her and understand him/her.

Xxvi) No *[it is not]*. Because my approach is not to find the truth, which nobody knows because, one way or the other, the truth that will come out in therapy is what s/he experienced

at some point plus the fantasies, plus the memories, plus what followed after the event; as we say, it is never the truth. The way s/he has invested in what s/he experienced, this is our work and our focus.

xxvii) Of course, because reality determines different reactions, too. If an 18-year-old reveals that her father still rapes her, as a psychoanalyst are you not obliged to clear things up? Others will say that you should keep it to yourself because you should not play the role of the protector, because this will destroy the relationship, etc. They have a strong theoretical base, but I now speak as I feel… You ought to do something. The best thing, the ideal would be to help this young person to take responsibility and that is what you should try to do. But you may change your position, you may become an intervening and guiding presence but not as directly as to say "go to the police and report your father.

Xxviii) No. (from Q8b: While working with an adult privately, yes, it is in your responsibility to open a road for him/her to think that perhaps what he/she says and has fantasised is in the sphere of an Oedipal wish and that it is not sexual abuse that actually happened, but not to indicate this directly yourself.)

xxix) It could be, if it is an issue within therapy.

xxx) I do not coincide much with the term 'responsibility'. I imagine that within the psychoanalytical procedure, as we do the other things, this may also happen. I do not say from the beginning that my goal is to make this happen, but it is something that may occur within the procedure and if so I deal with it.

xxxi) The truth is always a requirement, but I do not think that the search for truth should precede the therapy. Therapy is the priority.

Notes

[1] Interview numbers: 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 23, 24, 25, 26, 27, 29, 30, 31.
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[307] From Aris, interview number 27, as part of the reply to question 2a (i.e. How would you handle symptoms of CSA before the actual memory came up during the therapeutic process?).
[308] From Petros, interview number 23, as part of the discussion before the interview.