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# SURVIVORS OF CHILD MALTREATMENT: DIAGNOSTIC FORMULATION AND THERAPEUTIC PROCESS

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*Control-mastery theory, a distinctive psychoanalytic theory, provides the basis for a diagnostic formulation of the psychological effects of child maltreatment with direct implications for psychotherapy with survivors. These effects are explained as the result of pathogenic beliefs regarding self-worth and entitlement developed by the maltreated child. When the patient's pathogenic beliefs are disconfirmed through psychotherapy, progress can continue toward mastery of developmental goals.*

Within the field of victimization, the type of victim most likely to be encountered by the psychotherapist is the survivor of child maltreatment: physical, sexual, or psychological abuse; physical or emotional neglect; or any combination thereof. The incidence of child maltreatment in the general population is sufficiently serious to warrant attention by the mental health community, with reported cases of 1.7 million per year (Hart & Brassard, 1987). However, it is of particular importance to the individual clinician that survivors of child maltreatment represent a significant portion of the psychiatric population.

A psychotherapist can expect that a minimum of one-third and possibly as much as two-thirds of his or her patient caseload will have experienced either physical or sexual abuse or both (Beck & van der Kolk, 1987; Bryer et al., 1987; Cavaiola & Schiff, 1988; Cole, 1988; Herman, 1986; Kazdin et al., 1985; Schaefer, Sobieraj & Hollyfield, 1988). Some additional proportion will have experienced physical neglect, emotional neglect, and/or psychological abuse. Therefore, it is likely that the majority of patients seen in a general outpatient therapy practice will be survivors of some form of abusive or neglectful parenting. In low-fee clinics, substance abuse treatment centers, and inpatient psychiatric units, the proportion of maltreatment survivors may approach 100%.

The common phenomena in all forms of child maltreatment are the lack of parental nurturance and the failure of parents to provide sensitive, supportive care to their children. Children who have experienced different forms of maltreatment show more similarities than differences in their psychological functioning and development (Erickson & Egeland, 1987). Research and clinical studies indicate that the cognitive, affective, interpersonal, and social/behavioral functioning of surviving children and adults reflects the earlier experience of maltreatment. In addition, maltreatment survivors are at increased risk for several psychological disorders.

## Effects of Child Maltreatment on Psychological Functioning

The cognitive development of maltreated children is delayed or impaired as a result of their maltreatment. This effect has been demonstrated in the areas of intelligence, academic achievement, language, coping skills, and readiness to learn (Aber & Allen, 1987; Ammerman et al., 1986; Augoustinos, 1987; Brassard & McNeill, 1987; Erickson & Egeland, 1987; Lamphear, 1985). Negative self-perceptions also result from child maltreatment, with sexually abused girls particularly at risk (Browne & Finkelhor, 1986; Ney et al., 1986; Tong, Oates & McDowell, 1987; Zimrin, 1986).

Affectively, survivors of maltreatment are characterized by high levels of negative affect and low self-esteem (Ammerman et al., 1986; Au-

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goustinos, 1987; Browne & Finkelhor, 1986; Erickson & Egeland, 1987; Lamphear, 1985; Vargo et al., 1988; Zimrin, 1986). Additional long-term effects of maltreatment on affective functioning are blunted or constricted emotional expressiveness and difficulty in accurately identifying emotions in self and others (Augoustinos, 1987; Barahal, Waterman & Martin, 1981; Cicchetti, 1987).

The interpersonal relationships of maltreatment survivors are also negatively affected by their abuse and neglect. As children, they are likely to have insecure attachments to caregivers, poor peer relationships, either highly dependent or pseudomature relationships with adults, and specific social skill deficits (Ammerman et al., 1986; Augoustinos, 1987; Barahal et al., 1981; Cicchetti, 1987; Erickson & Egeland, 1987; Garbarino, Guttmann & Seeley, 1987; Gelardo & Sanford, 1987; Lamphear, 1985; Mrazek & Mrazek, 1987). These interpersonal difficulties continue into adulthood, leading to social isolation and unstable relationships (Kempe, 1987; Rocklin & Lavett, 1987; Vargo et al., 1988). Adult survivors of child sexual abuse are particularly at risk for later relationship problems and sexual dysfunction (Browne & Finkelhor, 1986; Harter, Alexander & Neimeyer, 1988; Johnson & Shrier, 1987; Russell, 1986; Tsai, Feldman-Summers & Edgar, 1979; Walker et al., 1988).

The social behavior of physically abused and sexually abused children often reflects inappropriate aggressive or sexual behavior (Ammerman et al., 1986; Browne & Finkelhor, 1986; Erickson & Egeland, 1987; Lamphear, 1985). Survivors of physical abuse and neglect are likely to be aggressive toward peers as children, and survivors of physical and/or sexual abuse demonstrate various antisocial behaviors as adolescents and adults (Ammerman et al., 1986; Browne & Finkelhor, 1986; Cavaiola & Schiff, 1988; Conte, 1985; Lamphear, 1985; Schaefer et al., 1988). Survivors of all forms of maltreatment show increased levels of aggression toward self, in the form of self-destructive thoughts and behavior (Ammerman et al., 1986; Briere et al., 1988; Briere & Runtz, 1986, 1988*a*; Browne & Finkelhor, 1986; Burnam et al., 1988; Cavaiola & Schiff, 1988; Conte, 1985; Ney, 1987*a*; Ney et al., 1986; Walker et al., 1988).

There is overwhelming evidence that child and adult survivors of maltreatment experience significant levels of general psychological distress (Ammerman et al., 1986; Augoustinos, 1987; Briere et al., 1988; Briere & Runtz, 1988*a,b*; Browne & Finkelhor, 1986; Lamphear, 1985; Mannarino & Cohen, 1986; Rimsza, Berg & Locke, 1988; Tong et al., 1987). In addition, child and adult survivors of maltreatment are at increased risk for developing depression, anxiety disorders, psychosomatic symptoms, and dissociative symptoms (Briere et al., 1988; Briere & Runtz, 1988*a,b*; Bryer et al., 1987; Burnam et al., 1988; Kashani et al., 1987; Kazdin et al., 1985; Mannarino & Cohen, 1986; Rimsza et al., 1988; Tsai et al., 1979; Walker et al., 1988). Severe physical, sexual, and/or psychological abuse has been related to the development of multiple personality disorder (Coons, 1986), and early sexual abuse has been related to the development of borderline personality disorder in women (Barnard & Hirsch, 1985; Bryer et al., 1987).

In summary, children and adults who have experienced one or more forms of maltreatment are characterized, in the most serious cases, by impaired cognitive development, negative self-perceptions, high levels of negative affect, low self-esteem, difficulty in identifying and expressing emotions, poor interpersonal relationships and skills, aggressive and self-destructive behavior, high levels of psychological distress, and increased risk for a number of psychological disorders. Even in cases with a relatively positive outcome, difficulty in identifying and expressing emotions, aggressive behavior, and poor interpersonal relationships are evident (Mrazek & Mrazek, 1987; Zimrin, 1986).

### Diagnostic Formulations of Maltreatment Effects

Since child maltreatment affects every aspect of psychological functioning, psychotherapy with maltreatment survivors should be guided by an integrative diagnostic formulation which explains the effects of maltreatment, both as a general phenomenon and in an individual case, and which guides the psychotherapeutic process. Two general approaches to diagnostic formulation can be found in the literature: a developmental perspective and perspective based on adaptation to trauma.

From a developmental perspective, child maltreatment is seen as interfering with the normal course of development, leading to failure of the individual to master the developmental tasks of childhood, adolescence, and adulthood. This approach has been applied to the definition of maltreatment (Garbarino et al., 1987), to the study

of infant attachment (Aber & Allen, 1987; Cicchetti, 1987; Erickson & Egeland, 1987), and to treatment of individuals and families (Azar, 1986; Daldin, 1988; Kempe, 1987; Ney, 1987*b*).

A second approach to diagnostic formulation involves viewing the psychological effects of the maltreatment as adaptive coping strategies employed by the child in order to survive the traumatic experience of maltreatment. This approach has been used in the evaluation of sexually abused children (Sink, 1988), in diagnosis and treatment of adult survivors of physical and sexual abuse (Herman, Russell & Trocki, 1986; Rieker & Carmen, 1986), and in studies of resilience factors which ameliorate the effects of the trauma (Mrazek & Mrazek, 1987; Zimrin, 1986).

Each of the approaches described above can contribute significantly to a diagnostic understanding of child and adult survivors of maltreatment. However, the connection between these diagnostic formulations and psychotherapeutic treatment is somewhat vague and may not be directly applicable to specific individuals or families. Control-mastery theory (Weiss, Sampson & the Mount Zion Psychotherapy Research Group, 1986) provides the basis for a diagnostic formulation of the psychological effects of maltreatment with direct implications for psychotherapy with survivors.

The theory contains some aspects of both approaches reviewed above. Trauma is considered central to the development of psychopathology and the psychotherapeutic process, and adaptation to traumatic experience is seen as the source of psychopathology. In addition, the primary effect of early traumatic experience is viewed as the inhibition of the individual's pursuit of developmental goals and mastery of developmental tasks. The variability among different survivors in the psychological effects of maltreatment can be explained by variations in the severity of the trauma, in overall family functioning, and in the child's cognitive processing of traumatic experience. All of these factors have been shown to be related to the nature and severity of later effects of maltreatment (Conte, 1985; Fromuth, 1986; Harter et al., 1988; Newberger & De Vos, 1988; Ney, 1987*a*; Pelletier & Handy, 1986; Russell, 1986; Tsai et al., 1979; Walker et al., 1988).

### Principles of Control-Mastery Theory

Before applying control-mastery theory to understanding the psychological effects of maltreatment, a brief summary of the general principles of the theory will be given. Control-mastery theory is a distinctive psychoanalytic theory developed by Joseph Weiss, based on the later writings of Freud, and studied empirically by Joseph Weiss, Harold Sampson, and the Mount Zion Psychotherapy Research Group (Weiss et al., 1986). A basic premise of control-mastery theory is that children are motivated both to pursue developmental goals and to maintain good relationships with their parents, on whom they are dependent for survival. When the child's pursuit of developmental goals seems to be upsetting to the parents or seems to disrupt the child's relationship to the parents in some way, the child will give up the developmental goal temporarily and comply with what he or she infers the parents' wishes to be. For example, a girl whose parents are warm and affectionate when she agrees with them or expresses opinions similar to theirs, but cool and distant when she disagrees or differs from her parents, may infer that her parents want her to agree with them rather than having her own ideas. She may then comply with this inferred wish of the parents and only express ideas and opinions similar to theirs. This type of inference and compliance happens in numerous ways throughout the course of development, shaping the personality and behavior of the child, but not necessarily leading to psychopathology.

The development of psychological symptoms and disorders occurs, according to the principles of the theory, when a parent consistently reacts to the child's pursuit of developmental goals in a way which is a source of trauma for the child. Examples of such reactions by a parent would be rage, anxiety, rejection, or withdrawal. In such cases, the child infers that the pursuit of his or her developmental goals is dangerous and potentially harmful to the parent. This type of inference is called a pathogenic belief, and such pathogenic beliefs lead the child to inhibit the pursuit of certain developmental goals in order to protect the parents and the child's relationship with them.

These pathogenic beliefs are usually unconscious, although they may be partially within conscious awareness. They heavily influence both conscious and unconscious cognitive and affective processes and behavior. The beliefs and the subsequent internal and external inhibitions resulting from them lead to psychological symptoms and disorders. Continuing the earlier example, if the girl's parents were not only cool and distant when

she expressed her own opinions, but became enraged, anxious, or withdrawn, she might develop an unconscious pathogenic belief that it was dangerous and harmful to her parents for her to have ideas or opinions of her own. She also might generalize this belief and inhibit herself from thinking clearly and independently and from making evaluations or judgments based on her own perceptions. Such inhibitions then could lead her to become confused and anxious when required to make decisions and to comply with the ideas and opinions of others rather than making and following an independent plan for her life.

In control-mastery theory, the principles of psychotherapeutic process are directly connected to the above principles regarding development of psychopathology. It is believed that patients enter psychotherapy with an unconscious plan to disconfirm the pathogenic beliefs which are inhibiting further growth and mastery of developmental tasks. Patients work in therapy to carry out this unconscious plan, by testing the therapist and by developing insights, in part with the help of the therapist. Following a passed test or development of insight, patients may remember previously unconscious or undisclosed material.

When a patient is carrying out a test, he or she behaves in a way that repeats a traumatic interaction with the parents. The therapist's actions in response to the patient either disconfirm the patient's unconscious pathogenic belief, thereby passing the test, or confirm the patient's pathogenic belief, thereby failing the test. Patients test in either of two ways: transference testing or passive into active testing. In a transference test, the patient behaves in a way that endangered him or her as a child to assess the therapist's reaction in comparison with the parent's traumatic reaction. In a passive into active test, the patient behaves as the parent did, in order to unconsciously appraise and identify with the therapist's ability to not be traumatized in the same way as the patient.

Patients also work in therapy by developing insights. Some insights may be conveyed by the therapist, either directly in the form of interpretations or indirectly in the form of questions or comments. The therapist may directly interpret the effects of past trauma, the meaning of psychological symptoms, or the causal relationship between past experience and current behavior. By comments or questions, the therapist may challenge the patient's inferences or assumptions and convey a different point of view. Patients also develop insights independently, without prior interpretation, which serve the same purpose as the therapist's interpretations. These insights provide the patient with a greater understanding of psychological symptoms and inhibitions.

After a passed test or development of insight, the patient will often remember previously repressed material related to earlier traumatic interactions with the parents. This lifting of repression enables the patient to make connections between present and past experiences, analyze internal experience and behavior, and disclose new material to the therapist.

Control-mastery theory has been empirically investigated more than any other psychoanalytic theory of psychotherapy (Weiss et al., 1986; Weiss, 1988). The theory has been supported by findings in a number of studies carried out by members of the Mt. Zion Psychotherapy Research Group. These studies have used verbatim transcripts of brief psychotherapy cases, as well as process notes and verbatim transcripts of psychoanalyses. All of the research was done following the termination of treatment, and the therapist in each case conducted the treatment without knowledge of the research group's case formulations. The results of a few of these studies are summarized below.

One study tested the control-mastery hypothesis that the patient exerts unconscious control over the emergence of previously repressed mental contents against the alternative (traditional psychoanalytic) hypothesis that these contents come forth by pushing through the patient's defenses. The results show that a patient, as a consequence of unconscious control over repressed mental contents, may become aware of such contents without their being interpreted, and that the patient can do so calmly and without conflict (Gassner et al., 1982).

Silberschatz (1986) tested the control-mastery hypothesis that an unconscious demand of the patient represents an unconscious test which the patient presents the therapist in an effort to disconfirm a pathogenic belief. This hypothesis was tested against the alternative hypothesis that such a demand represents the patient's unconscious effort to obtain the gratification of an unconscious impulse. The results supported the idea of unconscious testing.

A number of studies have demonstrated that comprehensive psychodynamic formulations of the patient's plan may be made reliably by independent judges from the first ten sessions of an analysis

or from the first three sessions of a brief psychotherapy (Caston, 1986; Curtis et al., 1988; Rosenberg et al., 1986).

Additional studies have demonstrated that interpretations that should help the patient to carry out the patient's unconscious plan have several immediate effects. Following pro-plan interpretations, the patient shows an increase in the level of experiencing and a decrease in defensiveness (Fretter, 1984). The patient also demonstrates an increased level of insight following a pro-plan interpretation (Broitman, 1985).

Other studies, based on samples too small to demonstrate statistical significance, have shown that the extent to which the patient receives pro-plan interpretations correlates with the outcome of brief therapy, as assessed with a battery of outcome measures six months following termination (Norville, 1989; Silberschatz, Curtis & Nathans, 1989; Silberschatz, Fretter & Curtis, 1986).

Finally, investigators have compared the effect on the patient of interventions which pass a test (presented by the patient to the therapist in an effort to disconfirm a pathogenic belief) with interventions that do not pass the patient's test. These studies demonstrate immediate patient progress following passed tests, including specific effects of increased level of experiencing and decreased defensiveness (Hamer, 1987; Kale, 1986; Silberschatz, 1986), decreased anxiety as measured by voice stress (Kelly, 1989), increased development of insight (Linzner, 1987), and the capacity to undergo controlled regression (Bugas, 1986).

The studies cited above, as well as others, provide empirical support for the control-mastery theory and demonstrate its predictive power.

### Application of Control-Mastery Theory to Survivors of Maltreatment

The principles of control-mastery theory can be used by clinicians in formulating a diagnostic understanding of the effects of child maltreatment and in understanding the therapeutic process with individual maltreatment survivors. The diagnostic formulation of the effects of maltreatment begins with an examination of the unconscious pathogenic beliefs likely to be developed by a child who is abused or neglected by the parents. Due to the egocentric cognitive processing of young children and the strong need of children to maintain positive relationships with and positive perceptions of their parents, it is likely that any child will believe that he or she deserves the treatment received from the parents. Therefore, abused or neglected children are likely to believe they deserve their mistreatment and to form a set of pathogenic beliefs regarding self-worth and entitlement.

The pathogenic beliefs developed by an abused or neglected child might include such ideas as "I deserve to be treated badly and to feel bad," "I am at fault for my parents' behavior toward me," "I am not worthy of love and caring," and "I am a bad person and should not have good things in life." There may also be specific pathogenic beliefs related to abusive and neglectful acts themselves, such as "I cannot protect myself from being harmed by others," "I cannot ask or expect others to provide for my needs," or "I am not entitled to privacy or protection." These pathogenic beliefs are part of the individual's self-concept and continue to be active in influencing thoughts, feelings, and behavior through adulthood. One of the primary consequences of this set of beliefs about self-worth is that the individual experiences guilt when seeking and receiving good treatment (i.e., caring, support, love, nurturance) because the good treatment is believed to be undeserved.

The set of pathogenic beliefs regarding self-worth, resulting from the child's cognitive processing of abusive and neglectful parenting, can be viewed as the mediating link between the abusive experiences and the psychological effects of maltreatment. The pervasiveness of the psychological effects of maltreatment documented in research and clinical studies can be explained by the underlying beliefs of lack of self-worth or entitlement. It would not be surprising that a child with such beliefs would inhibit the use of cognitive and intellectual skills, form negative self-perceptions, display negative affect, have low self-esteem, inhibit conscious awareness and expression of emotions, be mistrustful of others, have poor relationships, demonstrate maladaptive behavior as an identification with the abuser, and experience self-destructive thoughts and feelings. High levels of psychological distress and symptomatology and specific psychological disorders could also follow from pathogenic beliefs that one is undeserving of good treatment or good feelings.

The above application of control-mastery principles provides a general diagnostic formulation of the psychological functioning of maltreatment survivors. In this general formulation, a set of pathogenic beliefs regarding self-worth has been identified, resulting from the child's conscious

and unconscious interpretations of abusive or neglectful parenting. It would be predicted that an individual who has experienced one or more forms of maltreatment would hold pathogenic beliefs about self-worth as well as other pathogenic beliefs based on the individual's unique experiences, including but not limited to maltreatment. The variability in traumatic experience as well as the unconscious cognitive processing of experience would account for the differences in the type and severity of psychological effects seen in individual survivors of maltreatment.

Moving from diagnostic formulation to the psychotherapeutic process, control-mastery theory would predict that the individual maltreatment survivor who enters psychotherapy would have an unconscious plan to disconfirm one or more of the pathogenic beliefs which are inhibiting developmental growth. The patient's plan might be relatively specific and circumscribed or might be more open-ended and general. Examples of circumscribed plans would be a survivor of sexual abuse wanting to enjoy her sexual relationship with a caring partner, a survivor of physical abuse wanting to appropriately set limits with his or her child, or a survivor of neglect wanting to feel free to pursue a stimulating career. Open-ended, general plans would include broader goals such as increasing ability to enjoy accomplishments, seeking a satisfying intimate relationship, feeling a greater sense of self-worth and self-confidence, or overcoming a debilitating psychological disorder. In addition, some patients enter psychotherapy with a circumscribed plan and then continue with a more general plan after establishing a positive therapeutic alliance and achieving the original goals of treatment.

When an individual enters psychotherapy with a childhood history of maltreatment, the underlying pathogenic beliefs regarding self-worth will be related to the patient's unconscious plan in some way. In some cases, the pathogenic beliefs regarding self-worth may be central to the patient's pathology, and disconfirmation of those beliefs will be the central task of the therapy. In other cases, the pathogenic beliefs regarding self-worth may be less intense or of less immediate concern to accomplishing the patient's plan. However, with any patient who has experienced abuse or neglect, it is critical that the facts of the maltreatment be recognized and acknowledged by the therapist when the patient describes his or her past experience. If the therapist is not alert to direct disclosure or even subtle indicators of past abuse or neglect, an important test is failed and the patient will experience confirmation of the pathogenic beliefs regarding lack of self-worth or entitlement.

During the course of psychotherapy, the patient will work on the pathogenic beliefs resulting from maltreatment in the two ways outlined above: testing and developing insights. The following case illustrations illustrate patients' therapeutic work.

### *Case Illustration*

A 25-year-old female patient entered psychotherapy because of indecision regarding her career. In an early session, she said that her relationship with her father had always been poor, though she was unsure why. As she discussed the details of that relationship, she went on to talk about an incident that occurred when she was about 10 years old. She said that her father hit her during an argument, knocking her head into the hood over the stove, which caused a constant ringing and loss of hearing in her left ear for several months. She then said that she had been hit with a belt by both her mother and her father when she was a young child, and that she remembered sometimes going to school with welts on both legs.

After describing these incidents, the patient stated, "So I guess my parents were kind of harsh with me, not that it was child abuse or anything, but they did punish me physically." The therapist asked, "Why do you say it wasn't abuse?" The patient responded, "Well, I just never thought of it that way, I guess it really was, wasn't it." She then went on to talk more about the fact that her parents had treated her younger sister better than they had treated her. The younger sister was not punished with a belt and her social activities were not restricted as severely as the patient's were. She went on to say that she had never figured out what was different about her that led to her parents' treating her differently than her sister. In response to the therapist's questions and comments about this, the patient became aware that she had felt responsible for the abusive way she was treated and that she believed there was something wrong with her, causing her parents to treat her differently than her sister.

This illustrates a therapeutic sequence beginning with a transference test. The patient describes the parents' behavior but denies that it was abusive. Her inability to accurately perceive her abusive treatment endangers her because she then blames herself and believes she deserves the abuse. The therapist passes the test by challenging her denial of the abuse, which enables the patient to feel a greater sense of safety. The passed test is followed by a lifting of repression, in which the patient remembers and evaluates the difference in her parents' treatment of her and her sister.

### *Case Illustration*

A 24-year-old female entered therapy after a divorce. Over the course of several months, she reported a history of severe physical and emotional neglect from both parents, physical

and psychological abuse from mother, and sexual abuse by several of mother's boyfriends. During an intensive therapy, 2–3 times per week for several years, she repeatedly engaged in a passive into active test of the therapist's ability to tolerate feeling responsible but powerless. In one sequence, the patient was starting her own business after several prior attempts and failures. She had become aware, through analyzing her prior business attempts, of her potential to sabotage her efforts. She repeatedly told the therapist over several sessions that she really wanted to be successful this time and that she knew she needed the therapist's help in order to catch herself before "shooting herself in the foot."

About two months later, she began to miss sessions frequently without contacting the therapist before or after the session, and she failed to meet her financial agreement with the therapist regarding payment of her current and past-due bill. During the sessions she did attend, she talked mostly about her live-in relationship and somewhat superficially about her business. After several weeks of sporadic attendance, she told the therapist that she had not been managing her business well and was in another financial crisis, as had happened numerous times in the past. She went on to say she was disappointed that therapy had not helped her to stay on top of things as she had hoped. She described thinking that the therapist was not on the right track with her. The therapist asked her to talk more about what had happened in her business and whether the missed sessions were connected in some way with the crisis she was now facing.

The discussion of this took place over several more weeks as the patient began to describe feeling like an "irresponsible little kid" during the time of her sporadic attendance but not wanting to acknowledge those feelings at the time. When the therapist encouraged the patient to talk more about the irresponsible little kid, the patient remembered an incident that happened when she was 9 or 10 years old. The patient's mother had gotten a job after a period of unemployment, during which time the patient was very worried about their financial state. After her first day at work, mother stayed out very late and was still in bed when the patient returned from school the next day. When the patient awakened her mother, reminding her that she should be at work, her mother said that she had been fired that day because she had slept with her boss the previous night. The patient remembered feeling angry at her mother's irresponsibility and helpless that she had not been able to prevent what had happened. Her attendance and her payments in therapy became more regular for a short period of time, until another similar testing sequence began.

During this passive into active test, the patient first gives the therapist responsibility for something over which the therapist has no control. The patient then undermines the therapist's efforts, both passively by not attending sessions or making the agreed-upon payments on her bill and actively by mismanaging her business. The therapist learns of the problem after the damage has been done and is also blamed for not doing enough to prevent the crisis. The therapist passed the test by not feeling overly responsible as the patient had felt in relation to her mother and by not feeling either helpless and angry or responsible and guilty when undermined and blamed. The passed test is followed by the memory of a traumatic incident in which the patient felt both responsible and helpless.

### *Case Illustration*

A 43-year-old man came into psychotherapy with a history of physical and emotional neglect from both parents, psychological and sexual abuse by mother, and physical abuse by father. The details and the extensiveness of the abuse and neglect took a number of years of therapy to uncover. From the beginning of the therapy, the patient reported numerous incidents in which he would feel humiliated by someone or would feel someone was taking advantage of him. These incidents seemed to be paranoid distortions of the actual incident, but the patient was unable to engage in any realistic evaluation of the events because of the overwhelming nature of his affective reaction. The therapist began interpreting that his early abusive experiences had led him to believe that he should not protect himself from danger and that he did not have a right to feel safe. The therapist also said that these ideas were incorrect and that it was important for him to find ways of feeling safe rather than in danger of humiliation or abuse.

Gradually, over the course of many months, the patient began to report incidents in which he anticipated some danger and decided on a course of action to protect himself. The therapist encouraged his efforts and continued making the same interpretation when the patient reported additional incidents in which he felt humiliated or abused. In time the patient began to ask the therapist's help in planning how to accomplish an important task in a way that protected his sense of safety.

The above illustration describes the gradual assimilation of an insight conveyed by the therapist directly in the form of interpretation and comment. As the patient assimilates the insight, he is able to recognize his internal feelings of safety and danger rather than projecting them onto others. He is also able to place importance on protecting himself from danger and to ask for and use the therapist's help in planning for anticipated events.

## Conclusion

Survivors of child maltreatment comprise a significant proportion of the clinical population in all treatment settings. The long-term psychological effects of the maltreatment may be found in an individual's cognitive, affective, interpersonal, and social functioning and may result in psychological distress, symptoms, and disorders. Thus, it is important for all psychotherapists to be sensitive to signs of abuse or neglect in the history of patients entering therapy, to have an integrative diagnostic understanding of the effects of abusive and neglectful parenting on psychological development and functioning, and to incorporate this diagnostic understanding into psychotherapeutic treatment.

This article has presented the application of control-mastery theory to the diagnosis and treat-

ment of maltreatment survivors. Several strengths of this theory make it particularly useful with this population. First, the diagnostic formulation of psychopathology integrates aspects of a developmental perspective and a perspective based on adaptation to trauma, the two general approaches found in the literature. Secondly, the theory considers the dual roles of external events and internal processes in the development of psychopathology. Last, there is a direct connection between diagnostic formulation and therapeutic process. By using this theory in clinical practice, therapists can be better equipped to assist their patients in overcoming the effects of maltreatment and achieving their developmental goals.

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