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Protection, Dissociation, and Internal Roles: Modeling and Treating the Effects of Child Abuse

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This article presents a theory of the long-term effects of child abuse that emphasizes the development of internal working models of protection. The theory proposes that abused children do not receive adequate caregiver protection and do not form internal representations of an effective protector. As a result, they have ongoing difficulty defending themselves against interpersonal aggression and internal self-criticism. The model integrates current research and theory in attachment behavior, developmental psychopathology, trauma, dissociation, and experiential psychotherapy. It accounts for many of the clinical symptoms presented by adult survivors of child abuse and suggests specific strategies for treatment. The author provides 3 examples of psychotherapy interventions derived from the model, distinguishes protection and "rescuing," and suggests directions for future research.

Abused children do not receive protection when they need it. As noted by Herman (1997), "At the moment of trauma the victim is utterly helpless. Unable to defend herself, she cries for help, but no one comes to her aid. She feels totally abandoned. The memory of this experience pervades all subsequent relationships" (p. 137). For child abuse survivors, problems with protection persist into adulthood. They often have difficulty setting limits in interpersonal relationships, defending themselves in conflict situations, and guarding against repeated victimizations (Briere, 1992). In addition, many have trouble protecting their own children from abuse (Goodwin, McCarthy, & DiVasto, 1981; McCloskey & Bailey, 2000; Oates, Tebbutt, Swanston, Lynch, & O'Toole, 1998; Spieker, Bensley, McMahon, Fung, & Ossiander, 1996).

Many trauma researchers have recognized a connection between receiving protection in childhood and feeling protected in later life. For example, according to van der Kolk, van der Hart, and Marmar (1996):

> As long as people are able to imagine some way of staving off the inevitable, or as long as they feel taken care of by someone stronger than themselves, psychological and biological systems seem to be protected against being overwhelmed. Much of human activity seems to involve . . . the creation of more or less predictable stable social environments for protection. Developmentally, these processes start with children's reliance on external caregivers who supply basic security. (p. 303)

Surprisingly, few psychologists have studied the effects of caregiver protection on the development of interpersonal self-protection skills. A search of the PsycINFO database using the subjects *development* and *self-protection* revealed only two published documents addressing the development of interpersonal self-protection. Another search with the subjects *child abuse* and *protection* revealed 12 published studies of parental protection in abusive families, but none of them related failures of parental protection to the aftereffects of abuse or to deficits in self-protection. Theories of the long-term impact of child abuse typically stress concepts such as affect regulation, identity, cognitive schemas, and interpersonal trust (e.g., Alexander, 1992; Briere, 1996; Cole & Putnam, 1992; Horowitz, 1997; Janoff-Bulman, 1992; Linehan, 1993; van der Kolk & Fisler, 1994). I know of no theories of child abuse that emphasize the development of self-protection.

This article presents a case for interpersonal protection as an organizing construct in abuse research and treatment. After a general intro-

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duction to the problem of child abuse, I draw on the literature in attachment behavior, developmental psychopathology, trauma, dissociation, and experiential psychotherapy to argue that abused children do not receive adequate caregiver protection and do not form internal representations of an effective protector. As a result, they have ongoing difficulty defending themselves against interpersonal aggression as well as internal self-criticism, and this difficulty accounts for most of the clinical symptoms presented by adult abuse survivors. I suggest that dissociation, an intriguing but poorly understood clinical phenomenon associated with abuse survivors, reflects immediate failures of self-protection. I discuss treatment implications and give three examples of psychotherapy interventions derived from the model. I also address a possible objection to this approach based on concerns about therapeutic neutrality and the dangers of overprotection. Finally, I suggest some directions for future research.

Child Abuse

Definition

Although child abuse has been the subject of much scientific research, the concept is rooted in historical and social policy developments of the past half-century (Wekerle & Wolfe, 1996). It is probably not possible to define child abuse without reference to community norms and professional judgments (Garbarino, 1991).

> Maltreatment is a social judgment regarding the appropriateness and likely outcome of parental behavior, a community's assertion of minimal standards of care. It is a social judgment that arises as a kind of negotiated settlement between "culture" (as represented by community standards that are articulated through a political process) and "science" (as made incarnate in "professional expertise"). (Garbarino, 1991, p. 45)

As the term is currently used in developmental and abnormal psychology, child maltreatment refers to actions of caretakers that are deemed, by a combination of community and professional standards, to be inappropriate and to endanger a child's health and development (National Research Council, 1993; Zuravin, 1991). Abuse refers to maltreatment through acts of commission, and neglect refers to maltreatment through acts of omission. Researchers and clinicians typically distinguish three categories of abuse: physical (e.g., severe corporal punishment or infliction of bodily injury), sexual (e.g., intercourse or other genital contact by a caretaker), and emotional (e.g., terrorizing or systematic belittling). Although there appears to be a consensus among professionals and the public (at least in the United States) as to which acts are abusive (Portwood, 1999), scientists are not consistent about operational definitions. As a result, research findings are often difficult to integrate (Cicchetti & Manly, 2001; National Research Council, 1993).

The argument presented in this article is relevant to all types of child abuse, as the case examples in a later section illustrate. However, most research has focused on sexual or physical abuse, and the literature on emotional abuse is sparse, in part as a result of difficulties in operationalizing the concept (Barnett, Manly, & Cicchetti, 1991). For this reason, the research data cited in this article are drawn from studies of physical and sexual abuse.

Prevalence

Firm estimates of the prevalence of child abuse have been difficult to establish owing to a variety of methodological problems, not least of which, again, is inconsistency in definitions (Goldman & Padayachi, 2000; National Research Council, 1993). Nonetheless, it is clear that serious forms of child abuse occur and are not rare.

A comprehensive health survey conducted in Ontario, Canada, elicited retrospective reports of what the authors deemed serious physical abuse from 11% of male and 9% of female respondents (MacMillan et al., 1997). The same survey revealed that 11% of women and 4% of men reported a history of sexual abuse involving physical contact. In a rigorously conducted survey of adult women (Russell, 1999), 16% and 12% of the respondents reported contact sexual abuse by a family member before the ages of 18 and 14 years, respectively. Gorey and Leslie (1997) reviewed surveys involving North American community samples and estimated that 15% of women and 7% of men had experienced contact sexual abuse when they were children. Rates in Europe, Latin America, Africa, Australia, and New Zealand appear comparable to those in North America (Fergusson, Lynskey, & Horwood, 1996a; Finkelhor, 1994).

Most of these studies relied on retrospective reports. However, follow-up studies of adults with well-documented histories of childhood abuse indicate that retrospective reports are likely to underestimate actual occurrence (Femina, Yeager, & Lewis, 1990; Williams, 1995). In their review of methodological problems in child sexual abuse research, Goldman and Padayachi (2000) concluded that "despite a variety of methodological problems . . . most researchers believe that the rates reported in their studies are conservative figures" (p. 313).

Impact

The personal and social costs of child abuse appear large. A substantial body of research links child abuse with a variety of short- and long-term psychological disturbances (National Research Council, 1993; Wekerle & Wolfe, 1996). Although it is highly correlated with other factors (such as family dysfunction) that are known to place children at risk (National Research Council, 1993), abuse appears to have an independent influence on outcomes (Dodge, Bates, & Pettit, 1990; Fergusson, Lynskey, & Horwood, 1996b; Mullen, Martin, Anderson, Romans, & Herbison, 1993). Many survivors do not seem adversely affected (National Research Council, 1993), but clearly abuse—especially severe and chronic abuse—poses significant risks (e.g., Fergusson et al., 1996b; Manly, Kim, Rogosch, & Cicchetti, 2001).

In a follow-up study of young adults abused or neglected as children, almost 80% of the sample failed to meet criteria for successful psychosocial functioning (McGloin & Widom, 2001). A longitudinal community study of young adult abuse survivors found approximately the same proportion meeting clinical criteria for one or more psychiatric disorders (Silverman, Reinherz, & Giaconia, 1996). Child abuse has been linked with some of the most severe and intractable psychiatric and social problems, including borderline personality disorder, dissociative identity (multiple personality) disorder, suicidality, substance abuse, sociopathy, and violence (Herman, Perry, & van der Kolk, 1989; Johnson, Cohen, Brown, Smailes, & Bernstein, 1999; Kluft, 1996; National Research Council, 1993).

In addition to posing psychological risks, child abuse can have serious medical consequences (Berkowitz, 2000; Wharton, Rosenberg, Sheridan, & Ryan, 2000). Many physically abused children suffer neurological or neuropsychological impairment, severe injuries, or even death (Ammerman, Cassisi, Hersen, & Van Hasselt, 1986). Teicher et al. (1997) found evidence suggestive of abnormal cortical development in nearly three quarters of their sample of sexually and physically abused children. Fellitti et al. (1998) reported that childhood exposure to abuse, domestic violence, and other adverse experiences is strongly correlated with major risk factors for adult deaths and linked with histories of heart, lung, and liver disease; skeletal fractures; and cancer. The authors concluded that "the impact of these adverse childhood experiences on adult health status is strong and cumulative" (p. 251).

Finally, child abuse jeopardizes not only its immediate victims but also the following generation. In their review of the evidence, Kaufman and Zigler (1987) estimated that 30% of abused children later abuse their daughters or sons.

Intervention

For all of these reasons, child maltreatment has been termed "a devastating social problem" (National Research Council, 1993, p. 1). Nevertheless, after several decades of intensive clinical and scientific interest, we still know little, empirically speaking, about effective ways to prevent abuse or moderate its effects (Ratiner, 2000). It is possible that greater theoretical clarity would bring us closer to that goal. In the following sections, I argue that theory, research, and practice can benefit from attention to the key role played by protection in parent–child and other human relationships.

Attachment and Protection

Protection is a central concept in the influential attachment theory of John Bowlby (1982). Bowlby drew on animal behavior research, cybernetics, and systems theory to reformulate psychoanalytic thought along empirical lines. He agreed with psychoanalysts that children's relationships with their parents crucially influence their later development. However, he challenged the assumption, common to both psychoanalysis and learning theory, that infants

bond with their mothers to satisfy physiological needs for warmth and nourishment. He cited evidence from animal research (Bowlby, 1982, pp. 210–216) that infants will bond with surrogate parents who do not provide food or warmth and in some cases prefer them to surrogates who do. He also noted that animals sometimes attach more strongly to punishing surrogates than to rewarding ones and often respond to aversive stimuli from parent figures by clinging to them more intensely. These and other findings led Bowlby to conclude that attachment to caretakers evolved to keep offspring close to their parents and safer from predators. He reasoned that the paradox of clinging to a punishing parent was "an inevitable result of attachment behaviour's being elicited by anything alarming" (Bowlby, 1982, p. 216).

Bowlby suggested that children whose parents respond supportively to their distress will display *secure* attachment, confidently exploring strange environments but seeking comfort from their parents when alarmed. On the other hand, children whose parents do not reliably support and protect them will demonstrate *insecure* attachment, exploring new environments reluctantly, failing to seek comfort when frightened, or failing to respond to parents' comfort when it is offered. He further argued that children form mental representations or *internal working models* (*IWMs*) of themselves and their parents based on their attachment experiences and that these representations shape their ongoing expectations of safety.

> It is on the structure of those models that depends [whether a child] feels confident that his attachment figures are in general readily available. . .. Intimately linked to the type of forecast a person makes of the probable availability of his attachment figures, moreover, is his susceptibility to respond with fear whenever he meets any potentially alarming situation during the ordinary course of his life. (Bowlby, 1973, p. 203)

Once established, IWMs generalize to other relationships and organize the individual's interpersonal experience by biasing perception:

> Cognitive and behavioral structures determine what is perceived and what ignored, how a new situation is construed, and what plan of action is likely to be constructed to deal with it. Current structures, moreover, determine what sorts of person and situation are sought after and what sorts are shunned. In this way an individual comes to influence the selection of his own environment; and so the wheel comes full circle. (Bowlby, 1973, pp. 368–369)

Thus, IWMs, formed during a developmentally sensitive period in childhood, tend to perpetuate themselves. In Bowlby's view, they can be modified by later experiences but have the potential to function as self-fulfilling prophecies throughout a person's life (Bowlby, 1973, pp. 202–203).

A large body of research has accumulated that generally supports Bowlby's theory (Cassidy & Shaver, 1999). Investigators have found that parental responsiveness predicts children's attachment security, that children's attachment behaviors are correlated with their mental representations of themselves and their caregivers, and that both attachment behaviors and representations predict competence in other relationships. Consistent with Bowlby's thesis that IWMs are self-conserving but not irrevocably fixed, research suggests that attachment representations are moderately stable throughout childhood and into adulthood but can be modified by significant life experiences, including psychotherapy (for reviews, see Bretherton & Munholland, 1999; Hesse, 1999; Solomon & George, 1999).

Many of the associations reported in the attachment literature are modest, however, and at least one reviewer (Bolen, 2000) has argued that the data are equivocal. In this regard, it is interesting to note Goldberg, Grusec, and Jenkins's (1999) observation that most investigators have departed from Bowlby's original emphasis on caregiver protection and measured parental sensitivity in a more general sense. These authors suggest that attachment theory may receive stronger empirical support if caregiver protection is distinguished from other supportive behaviors. Crittenden (1999) made a similar point, reminding investigators that "attachment theory is a theory about protection from danger" (p. 145).

Abuse, Attachment, and Internal Roles

From the perspective of attachment theory, abused children face a painful dilemma: They are "hard-wired" by evolution to stay close to parents who are unable to protect them and may themselves be dangerous. Between 80% and 90% of abused infants in research studies display a class of behaviors termed *disorganized* when rejoining their parents after a brief separation (see Cicchetti, Toth, & Lynch, 1995, for

a review). The incidence in nonabused infant samples is much lower (approximately 15%) and appears to be associated with parents who are frightening (Schuengel, Bakermans-Kranenburg, & van Ijzendoorn, 1999; Schuengel, Bakermans-Kranenburg, van Ijzendoorn, & Blom, 1999; van Ijzendoorn, Schuengel, & Bakermans-Kranenburg, 1999). Disorganized attachment behaviors—which include freezing, approach/avoidance, dazed expressions, and fragmented or bizarre movements—suggest conflict among mutually exclusive behavioral systems and resemble the dissociative symptoms demonstrated by many adult survivors of abuse (Main & Morgan, 1996). In fact, they have been shown to predict dissociation (Carlson, 1998; Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997), and some researchers have suggested that they are precursors of clinical dissociation (Liotti, 1999; Main & Morgan, 1996).

Attachment theory predicts that abused children will form IWMs of themselves as victims and of their parents as threatening (in the case of a perpetrator) or ineffective (in the case of a nonprotecting parent). Furthermore, these IWMs will generalize to other relationships and bias individuals' perceptions so that they select relationships, and act in those relationships, in ways that tend to re-create victimization. Studies to date have provided tentative support for these predictions. Abused children, as compared with nonmaltreated children, have more negative and confused representations of themselves and their parents and have poorer relationships with peers and adults (Lynch & Cicchetti, 1998; Milan & Pinderhughes, 2000; Shields, Ryan, & Cicchetti, 2001; Toth, Cicchetti, Macfie, & Emde, 1997).

Bowlby proposed that children base their self-concepts on internal representations of themselves in interaction with caregivers. Recent theorists have extended this argument, speculating that children identify with their representations of their caregivers as well. Thus, the self-concepts of abused children include elements of victimizer as well as victim, and both aspects organize their interpersonal behavior. "An abused child may become both a battered spouse and a battering parent by actualizing opposite poles of a single dyadic model in different relationships" (Lyons-Ruth, Bronfman, & Atwood, 1999, p. 39; see Blizard, 2001, for a similar conception). Liotti (1999) has argued that abused children internalize not two but three roles: victim, victimizer, and protector. These roles, of course, correspond to the dramatis personae of the archetypal encounter among predator, parent, and child that Bowlby placed at the center of his theory.

In other words, attachment researchers are beginning to conceptualize IWMs as a constellation of dynamically related roles, all of which serve as templates for self-concept and behavior. According to this view, inner models of a child, a caregiver, and an assailant are activated in situations of real or imagined threat and, when activated, organize an individual's behavior, emotion, and thought. Understood in this way, IWMs are similar to many constructs derived from psychotherapy practice, for example *psychodramatic roles* (Moreno, 1946), *ego states* (Watkins, 1993), *parts* (Schwartz, 1995), *selves* (Polster, 1995), *subpersonalities* (Assagioli, 1965), and *dream figures* (Mindell, 1986; see also Bretherton & Munholland, 1999, for a discussion of IWMs in relation to concepts in social and cognitive psychology).

I suggest that children who experience adequate parental protection will internalize the roles of (a) an effective protector, (b) a safe child, and (c) a contained aggressor. Unless these roles are altered in response to later trauma, these children will continue to feel generally secure, defend themselves effectively when challenged, and contain their aggression so as not to injure others or themselves. Abused children, in contrast, will internalize the roles of (a) an ineffective protector, (b) an endangered child, and (c) an out-of-control aggressor. If the models are not reformed by new experiences, these children will feel chronically threatened, have trouble protecting themselves in interpersonal situations, and act aggressively in destructive ways.

Results of one study (Macfie et al., 1999) suggest a slightly modified view. The authors used a projective story technique to compare the role representations of maltreated and nonmaltreated preschoolers. As expected, maltreated children were more likely to depict parents as unresponsive to a child's distress. In some circumstances, however, these participants described children adopting the protector role. Abused children were more likely than other participants to reverse family roles and portray child characters defending mothers against fa-

thers during a parental argument. Maltreated individuals more often appeared to confuse fantasy and reality by entering a fictional story as themselves to relieve a child character's distress. These results seem consistent with findings that children classified as disorganized in infancy demonstrate a "controlling" style of interaction by the age of 6 years (Lyons-Ruth & Jacobvitz, 1999). Jacobvitz and Hazen (1999) have argued that this style, in which children and caregivers essentially reverse roles, is associated with parents who experience themselves as helpless and reflects their children's fear and need to assume control. In summary, children who are not reliably protected may form some inner representation of a protector, but it is likely to be confused and inappropriate in possibly complex ways.

Long-Term Effects of Child Abuse

Early experiences do not determine adult functioning in a linear fashion. Instead, childhood risk factors are associated with a range of adult outcomes. Abused children may follow a variety of developmental pathways, some leading toward competence and others toward dysfunction (Cicchetti, 1996; McGloin & Widom, 2001). The present model suggests that early abuse experiences increase the likelihood that children will follow a pathway in which inadequate models of protection constellate further abuse experiences, which in turn reinforce the models. At the same time, later experiences of protection by supportive individuals may alter internal models. If so, new pathways can open in which adequate inner protectors and successful interpersonal experiences mutually support each other.

In fact, adult abuse survivors vary considerably in their psychosocial functioning (Martin & Elmer, 1992; Russell, 1999). Some mediating factors have been identified, including type and severity of abuse, the child's relationship to the victimizer, and the overall level of functioning in the child's family (Browne & Finkelhor, 1986). One recurrent finding is that abused children who have a close relationship with at least one supportive adult are more likely to function well later in life (Luthar, Cicchetti, & Becker, 2000; National Research Council, 1993). Perhaps protective experiences in these relationships specifically mediate positive outcomes.

The inner protector model provides an elegant explanation for a range of problems experienced by abuse survivors. The phenomenon of dissociative identity disorder (DID) is particularly instructive. More than 90% of North Americans diagnosed with DID report histories of child abuse (see Kluft, 1996, for a review). Because of the severity of their symptoms and the extreme abuse they report, "clinicians in the dissociative disorder field, by consensus, regard DID as the paradigmatic example of the psychological response to severe, chronic childhood trauma" (Ross, 1996, p. 16). Patients with this disorder experience a fragmented identity in which distinct personality states (*alters*), often separated by amnesic barriers, take executive control of their behavior (American Psychiatric Association, 2000). The three most common alter types are inadequate or confused protectors, terrified children, and persecutors who act out violently and drive patients to injure themselves (Putnam, 1989; Ross, 1997). These alter types closely match the three internal roles proposed here.

Non-DID patients who report childhood abuse also present symptoms consistent with the model. Most long-term effects of child abuse reported in the literature correspond to one of these same three roles (for reviews, see Briere, 1992; Browne & Finkelhor, 1986; Courtois, 1997; van der Kolk, 1996). Anxiety attacks, phobias, chronic insecurity, hypervigilance, need for control, mistrust of others, feelings of betrayal, loneliness, and fear of intimacy all characterize the endangered child. Passivity, failure to maintain clear interpersonal boundaries, disregard for personal safety, and risk for repeated victimization are consistent with an inadequate inner protector. Self-injury, suicide, victimization of others, and a grandiose sense of personal evil reflect an uncontrolled aggressor.

A common clinical symptom among abuse survivors is depression, characterized by low self-esteem, guilt, and intense shame (Ammerman et al., 1986; Browne & Finkelhor, 1986). It is best understood, I believe, not as the expression of a single role but of interaction among all three. The idea that internal representations can "interact" is not new. Bretherton and Munholland (1999) observed that "operations on working models may at times seem to take the form of inner conversations" (p. 98). They also cited the speculations of social psychologist George

Herbert Mead: "Thought, for Mead, consists of inner conversations with imagined others or oneself. For young children, he suggested, these inner conversations should be viewed as 'dramatic', literally involving reenactments of conversations between the child and a parent" (p. 96).

Experiential therapists frequently work with depressed patients by dramatizing inner dialogues between an abusive critic and a passive, childlike personality (Greenberg, Watson, & Goldman, 1998; Levitsky & Perls, 1970). Cognitive therapies, which treat depression by modifying negative self-talk (Beck, Rush, Shaw, & Emery, 1979; Whisman, 1993), seem to address a similar dynamic. Among DID patients, persecutor alters often manifest as inner voices demeaning and harassing child personalities (Putnam, 1989; Ross, 1997). The depression of abuse survivors, therefore, may reflect an inner "drama" in which the aggressor berates the child while the protector fails to intervene (see the first case example below for a treatment intervention based on this perspective).

Dissociation and Protection

Child abuse is also associated with disorders of dissociation in later life (Briere, 1992). Dissociation refers to a complex and fascinating range of phenomena, not well understood, that involve alterations in the normal integration of consciousness and a reduction in or redirection of ordinary awareness (Lynn & Rhue, 1994; Michelson & Ray, 1996). Dissociative phenomena include mild, everyday events such as confusion, memory lapses, and blank spells; more pronounced conditions such as shock and hypnotic trance; and extraordinary disturbances such as fugue states and alter personalities.

Many investigators consider dissociation, at least in its more extreme forms, to be a psychological defense mechanism protecting individuals from overwhelming experiences (Cardeña, 1994). Incest victims, for example, frequently report that they left their bodies and felt no sensation while they were sexually abused (van der Kolk et al., 1996). As noted earlier, researchers have found that most abused infants demonstrate disorganized attachment behaviors that may be prototypes of dissociative states. Some forms of dissociation, therefore, appear to be responses to threat when ordinary sources of protection are unavailable.

In terms of the present model, abuse survivors may dissociate when their internal models of attachment are activated in alarming situations. Lacking an adequate inner protector, they feel unable to defend themselves, and dissociation allows them to avoid painful and overwhelming feelings. Interpersonal situations (boundary challenges, conflicts, or attacks) or internal events (inner critic assaults) can act as triggers. Unfortunately, dissociation leaves individuals even more vulnerable to harm. This fact, rather than the classic idea of a compulsion to repeat the trauma (Freud, 1920/1961; van der Kolk, 1989), may explain why many abuse survivors continue to be victimized. Consider the following account:

> When Jodie told her college boyfriend that she had been raped by his best friend, he was quiet for a long time. When she got up to leave, he told her she should spend the night in his room, that he wouldn't touch her.
>
> "During the night, I woke up to find him on top of me. At first I thought [the rapist] was back and I panicked. My boyfriend said that he was just trying to get me 'used to things' again, so that I wouldn't be frigid for the rest of my life. *I was too drained to fight or argue, so I let him. My mind was completely blank during it. I felt nothing* [italics added].
>
> "The next day I took my last exam, packed up my things, and left. I broke up with my boyfriend over the summer." (Warshaw, 1988, p. 76)

Jodie's description of her inner state in response to her boyfriend's violation is a typical description of dissociation. The narrative suggests that her dissociation and her failure to defend herself were linked ("I was too drained to fight").

The current perspective, incidentally, suggests a connection between dissociation and depression. Trauma survivors become depressed when they lack protection against inner critic attacks, but this condition also triggers dissociation. Depression is often accompanied by cognitive impairments, such as difficulty thinking or concentrating (American Psychiatric Association, 2000) and memory difficulties (Burt, Zembar, & Niederehe, 1995). Could these impairments indicate a dissociative response to ongoing inner criticism?

An Internal Role System Theory of Abuse

The present model can be summarized as follows.

1. Children form internal representations of three dynamically related roles—child, protector, and aggressor—based on their early experiences of caregiver protection.

2. These role representations are activated in situations of perceived threat, including conflict, personal boundary violations, and direct assault. When activated, they organize emotion, thought, and behavior.

3. Role representations are relatively self-conserving but can be modified by significant experiences, including psychotherapy.

4. Children who receive reliable caregiver protection form role representations of an effective protector, a secure child, and a contained aggressor. Abused children, on the other hand, form representations of an inadequate protector, an endangered child, and an uncontrolled aggressor.

5. Abuse survivors who subsequently experience protection are more likely to reform their internal models than survivors who do not have corrective experiences.

6. Without corrective experiences, abuse survivors are at risk for a large number of psychosocial problems. These problems reflect the activation of their internal attachment representations in response to threat.

7. Without corrective experiences, abuse survivors are likely to dissociate when their internal models are activated. Dissociation in dangerous situations can lead to further victimization and thereby confirm maladaptive models through a positive feedback loop.

Implications for Psychotherapy

What treatment strategies does this theory imply? Greenberg, Rice, and Elliott (1993) have proposed a psychotherapy process model that offers clues and provides a framework for testing the theory. They argue that client difficulties are rooted in information-processing problems and that therapists can intervene most effectively at those moments in therapy sessions when these problems are active. "The therapist identifies the markers of currently operating information processing problem [*sic*] and its manifestation in therapy, and differentially intervenes" (Watson & Greenberg, 1996, p. 263). From this perspective, an internal representation system organized around inadequate protection is an information-processing problem, and client dissociation is a marker signaling the problem may be "currently operating" and available for intervention.

Following Greenberg et al., I suggest the following hypotheses:

1. When clients dissociate, it is likely that their internal models are activated and organizing their experience so that they feel unable to defend themselves in that moment.

2. Therapists can use client dissociation as a signal to intervene and immediately provide a model of effective protection and an experience of being protected. Over time, a series of these interventions may modify clients' internal models so that they are organized around an effective protector.

3. If therapists do not provide protection when clients dissociate, clients will feel retraumatized and their IWMs will be confirmed.

The question of how therapists can provide models of protection is taken up in the next section. For these hypotheses to be useful, however, dissociation that signals IWM activation must first be clearly identified and distinguished from other client behaviors. This is especially challenging in cases of mild dissociation. An illustration may be helpful.

> Client L. sat upright in her chair, looking at her therapist and answering his questions about her abuse history. When he asked her to describe an incident in which she was sexually assaulted, her demeanor suddenly changed. She broke eye contact, looked down and to the side with an unfocused gaze, and her mouth dropped open slightly. She was silent and still for two or three seconds. Then she looked at her therapist again and responded in a tentative voice, "Uh, OK."

In my experience, abuse survivors typically respond in a similar way when they are uncomfortable with a request from a person in authority but feel unable to say no. (They often report

afterward that they felt helpless to defend themselves against what seemed a powerful intrusion.) Although this response is subtle and fleeting, and thus easy to overlook, I believe it is dissociative. Taken together, L.'s behaviors suggest a sudden and apparently involuntary state change in which her attention to the environment is reduced and her connection with the therapist disrupted. When she returns to the conversation, her hesitant response suggests that her attention is still divided. In colloquial language, she is "not all there."

Fortunately, it is not necessary for therapists to rely solely on inference. I have found it useful to ask clients directly for feedback (e.g., "You seem a little in shock. Is that right?"). In most cases, clients readily agree and express relief that their experience has been identified. However, if they disagree or agree hesitantly, I assume my interpretation is wrong.

As this illustration suggests, the problem of identifying dissociation as an intervention marker might be dealt with by defining several necessary and sufficient conditions. First, clients display a cluster of behaviors that, taken together, suggest an abrupt and relatively automatic state change in which their awareness of the environment is reduced. Second, this behavioral cluster occurs in immediate response to events that are likely to challenge their ability to self-protect (e.g., that require assertiveness or boundary setting). Finally, they give clear agreement when asked if they are (slightly) in shock or a similar altered state.

I know of no systematic research concerning the reliable identification of major dissociative episodes, much less subtle states such as these. From a clinical point of view, I believe therapists who rely on clients' feedback to confirm their inferences will minimize the likelihood of mistakes and adverse consequences. Researchers have learned to reliably observe and code the often fleeting behaviors associated with disorganized attachment, which, as previously noted, are similar to dissociative states (Main & Morgan, 1996). This fact suggests that it is possible to train researchers and clinicians to accurately recognize dissociation in the psychotherapy context.

Case Examples

Simply put, the model proposes that abuse survivors need the experience of being protected before they can protect themselves. The following case examples (composites drawn from clinical practice) illustrate three techniques for offering protection in the context of psychotherapy. In the first example, a therapist takes the role of protector in a dramatic enactment of the client's self-criticism. The second example shows a therapist helping a client reconstruct a traumatic memory by introducing an imaginary protector. In the third case, a therapist discovers he has unwittingly occupied the aggressor role with his client; he fluidly changes course, in effect protecting the client against himself.

Example 1: Managing Internal Criticism

Marian, a 53-year-old woman subjected to emotional abuse in childhood, told her therapist how lonely she felt without a life partner. Suddenly her voice hardened and she added, "You must think I'm a wimp!" The therapist suggested she role-play her internal dialogue using the two-chair technique. Marian readily agreed and sat in one of the chairs. She said, "I love my work and my friends, but I feel empty inside when I come home at night."

Then she moved to the second chair and spoke in a harsher voice: "You're such a weakling, I'm disgusted with you. You need a man in order to have a life!" She moved back to the first chair, hesitated, and turned to the therapist. "I don't know what to say; she's right." The therapist suspected that the role in the first chair was a child who was unable to defend herself. She decided to test the hypothesis and offered to take over the role of the critic. Marian agreed.

The therapist sat in the second chair and repeated the critic's last words in a scornful voice ("You're such a weakling" etc.). Marian, in the first chair, appeared slightly stunned. She had a glazed expression, and she was completely still for a few seconds. The therapist commented that she appeared "slightly in shock," and Marian looked at the therapist again, smiled, and nodded. Taking this as a sign that Marian had dissociated, the therapist asked whether she needed protection. Marian nodded energetically and seemed relieved.

The therapist stood in front of Marian (still in the first chair) and faced the now-empty critic's chair. She extended her arms, shielding Marian, and addressed the critic. "I'm not going to let you speak to her that way! Maybe you mean well, but you're hurting her. She has a normal human desire, and you have no business shaming her for it."

The therapist looked over her shoulder and saw that Marian was crying. She commented gently on this, and Marian replied, "No one ever took my side before." The therapist ended the role play and returned to her seat. For the rest of the session, they discussed what had happened.

In the following session, Marian reported that her inner critic had been quieter during the week and that she had surprised and pleased herself by speaking strongly for her viewpoint during a conflict at work. During the next few months, she reported a growing sense of self-confidence in her relationships and less anxiety concerning dating relationships and her desire for a partner.

Example 2: Processing Trauma Memories

Adam, 26 years old, complained of nightmares in which he relived painful memories of physical abuse by his stepfather when he was an adolescent. His therapist suggested they "recreate" the memories in guided imagery with a protector intervening to stop the abuse. Adam liked the idea and agreed. After helping him relax, the therapist asked Adam to "think of someone who could have stood up to your stepfather; it could be a real person, or a character in a story." Adam chose his natural father, who died when he was 7. The therapist asked Adam to close his eyes and visualize his father. "Look at him carefully, and tell me what you see." Adam said, "He's smiling, he has a kind face, and I can see he loves me."

The therapist invited him to remember an incident when his stepfather assaulted him and watch the entire scene as if it were playing on a large movie screen. "Start at the beginning and notice everything that happens. Take a good look and tell me what you see."

Adam described the argument, with his stepfather getting flushed and beginning to yell and then raising his fist to strike. At that moment, the therapist told Adam to see his father entering the scene. "Watch closely. What does he do?"

Adam saw his father run over, stand in front of him, and push the other man away. "I've never seen my dad so mad. He's reading him the riot act. He's saying that if he ever touches me again he's going to jail. My stepfather looks scared. He's running out of the room. [*Pause*] Now my father is hugging me. He says he's missed me for a long, long time."

Adam was quiet for several minutes and seemed deeply moved. Following this session, his nightmares stopped. One year later, they had not recurred.

Example 3: Protecting Clients From the Therapist's Own Power

Shawn, a 32-year-old woman, was in the early stages of treatment when she revealed that her older brother Damon had molested her when she was young. The therapist asked her to tell him what happened. Shawn abruptly looked away and seemed dazed for several seconds. Then she looked at the therapist again and said in a toneless voice, "OK." The therapist noticed that she seemed to have dissociated. He guessed he had moved too quickly and that Shawn was not ready to tell her story but felt compelled to agree. He suspected that if he allowed her to continue she would dissociate further and feel retraumatized, forced once more into an intimacy she did not want.

He tested his hypothesis. "Let's wait a moment. I noticed you hesitated a little before you agreed. I'm glad you did that. Perhaps it's too soon to tell me what happened."

Shawn nodded immediately and looked relieved. "Yes, I don't want to talk about that yet. But I figured, you're the therapist, you know what I need."

"I know some things, but you're the expert on what's right for you. Congratulations for hesitating! It's a first step in protecting yourself with people who have power, like me." Shawn looked pleased and took a deep breath. She later reported that she felt more trust in her therapist after this conversation. The therapist noted that she seemed less guarded and self-disclosed more freely.

Rescue or Protection?

Aspects of this approach appear to conflict with a prevailing clinical belief that therapists

should remain neutral (that is, adopt an observer position and not take sides with respect to clients' inner conflicts). Maintaining neutrality is believed to guard therapists from the dangers of acting on the basis of countertransference feelings (therapists' emotional reactions to clients' disturbances based on their own psychologies; see Pearlman & Saakvitne, 1995). According to Ross (1997), "the most common countertransference error made by DID therapists is to get into the rescuer role . . . [thereby] losing neutrality and looking at the patient's problems from a vantage point inside the patient's personality system" (p. 281). Herman (1997) observed that

> the therapist may try to assume the role of rescuer. . . . By so doing, she implies the patient is not capable of acting for herself. The more the therapist accepts the idea that the patient is helpless, the more she perpetuates the traumatic transference and disempowers the patient. (p. 142)

Certainly, emotionally overinvolved therapists can lose their effectiveness and in some cases do considerable harm to their clients. On the other hand, absolute therapeutic neutrality does not exist. If it did, I believe it would traumatize patients in a different way, by confirming their belief that others will stand passively by while they are being hurt. Pearlman and Saakvitne (1995) argued that parental responses can be useful as well as problematic: "It is helpful for a therapist to note and model appropriate parenting to a client who has lacked that in her life" (p. 83).

The present approach provides a criterion—dissociation—for determining when clients are likely to benefit from protection. By drawing attention to specific process markers, it encourages therapists to provide protection, when they do so, in a deliberate and circumscribed way. Therapists who notice a dissociation marker can intervene immediately to provide protection and then resume an observer position and help clients reflect on what they experienced during the intervention. Conversely, when clients do not dissociate in a potentially threatening situation, they signal that they are able to defend themselves. In such cases, therapist protection is disempowering.

Research Directions

Ultimately, the value of this approach must be determined empirically. In the following discussion, I distinguish three broad issues for research: (a) the theory's validity, (b) its usefulness, and (c) its implications for other psychological models, especially attachment theory.

Validity

The theory predicts that caregiver behaviors influence children's internal models of protection, which in turn influence their psychosocial development. It also predicts that protection experienced in noncaregiver relationships (including psychotherapy) can influence models of protection at later developmental stages and alter psychosocial outcomes.

Cross-sectional studies can provide preliminary tests of these hypotheses. It was noted earlier that a close relationship with a supportive adult is associated with better outcomes for abuse survivors (Luthar et al., 2000; National Research Council, 1993). It is unclear, however, whether specific types of supportive relationships influence outcomes. Investigators could compare abuse survivors at high and low levels of functioning with regard to protection and other forms of support they have received, and assess their internal models of protection using self-report and projective measures (e.g., story completion tasks). Evidence that received protection, as compared with other positive relationship experiences, is specifically associated with internal models of effective protection and with higher levels of functioning would provide support for the theory.

Even if experiences of protection, internal protectors, and psychosocial adjustment are correlated as expected, cross-sectional data cannot establish causality. Other factors (e.g., child characteristics) may precede and influence all of these variables. Prematurity, low birthweight, illness, disability, and aggressive temperament have all been linked to caregiver abuse, although there is no conclusive evidence that they cause it (see Knutson & Schwartz, 1997, for a review). It is possible that some of these factors influence caregiver behavior and also children's internal models and later adjustment. For example, disabled children might be less likely to form inner representations of safety regardless

of their caregivers' behavior, and they might be more susceptible to later victimization. Alternatively, aggressive children could be attracted to belligerent peers and violent media entertainment and thereby internalize images of victimization. At the same time, their aggression could frustrate parents and lead to caregiver abuse. These and other hypotheses can be tested in longitudinal studies by observing the variables over time.

Treatment implications can be tested in psychotherapy outcome studies, but again researchers should be careful about causal inferences. Raters could review videotapes of individual psychotherapy sessions and code client dissociation and therapist interventions that provide protection. The theory predicts that protective interventions immediately following client dissociation will be associated with positive changes in clients' internal protection models and successful treatment outcomes. Another approach could involve enacting abuse scenarios dramatically in adolescent or adult treatment groups with opportunities for clients to "receive" and practice protection. Investigators could measure changes in internal models as well as other treatment outcomes in comparison with control groups. Any therapy outcome study, however, would need to demonstrate that changes in internal protectors precede improvements in psychosocial functioning to provide support for the theory.

Usefulness

Even if the theory proves valid, subtler questions remain about its usefulness. Scientific descriptions of human development are moving beyond linear causal models to systemic conceptions that recognize ongoing complex and bidirectional influences among variables at the physiological, psychological, and environmental levels (Cicchetti, 1990). From this perspective, it is probably not possible to isolate one or a few factors that mediate the effects of abuse. More likely, abuse affects many aspects of children's physical, emotional, and social functioning, all of which influence one another on an ongoing basis. Crittenden (1998) has suggested that we need to identify *critical causes*, those "aspects of functioning that, if changed, would lead to a concatenating set of changes throughout the set of factors supporting [a specific] behavior" (p. 14). In other words, our challenge is to discover those variables that provide the greatest leverage for intervention.

Whereas this article highlights internal models of protection, other theories have proposed different mediators of the long-term effects of abuse, including emotional regulation (Schore, 2002; van der Kolk & Fisler, 1994), self-concept (Cole & Putnam, 1992), and sense of self-efficacy (Janoff-Bulman, 1992). Because each of these factors may well influence and be influenced by the others, all of the theories may be valid. They may not propose different realities so much as different perspectives on the same reality (rather like the story of the blind men touching different parts of an elephant). Those theories that highlight critical causes, however, will prove most useful.

Key research questions to test the current theory's usefulness would be the following: (a) Do caregiver protection and internal models of protection have more robust relationships with key psychosocial outcomes than do other organizing constructs that have been proposed? and (b) Are interventions targeted toward providing protection (e.g., teaching parents of at-risk children protection skills or providing experiences of protection in psychotherapy) more beneficial than interventions targeted toward other mediating variables?

Implications for Developmental Theory

The current model is grounded in attachment theory, but returns to Bowlby's initial emphasis on protection in contrast to parental sensitivity. Validation of the model would suggest that attachment research in general could benefit from this sharper focus, as others have recently argued (Crittenden, 1999; Goldberg et al., 1999). Relevant research questions would include the following: (a) Does parental protectiveness predict children's attachment classification more strongly than parental sensitivity? (b) Do abuse history and disorganized attachment classification predict children's representations of caregiver protection more reliably than they predict representations of other caregiver qualities? and (c) Do representations of caregiver protection predict psychosocial competence more reliably than representations of other caregiver qualities? For example, several research studies have assessed internal models using story completion

tasks, but few of their items involved interpersonal aggression and protection (e.g., Macfie et al., 1999; Shields et al., 2001). If the current theory is accurate, using stories about protection in future studies should elicit more significant results.

Conclusion

This article has presented an argument for using protection as an organizing construct in research and intervention in the area of child abuse. This approach has the advantage of parsimony. Internal representations of protection, which have implications for arousal, emotion, cognition, and self-concept, have the potential to illuminate a wide range of phenomena, including most of the consequences of abuse. Another advantage is that the model is based on attachment theory, an extensively researched and widely accepted developmental framework. Finally, because preservation of the young is fundamental to species survival, focusing on protection grounds psychological science firmly in ethology and evolutionary biology.

Whether or not its predictions are confirmed, the model can serve a useful heuristic purpose. It directs our attention to an area of human experience that has been oddly overlooked. Interpersonal violence poses enormous psychological and social challenges. Surely our capacity to confront aggression effectively—in our relationships and within ourselves—is worth studying and nurturing.

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