The Revictimization of Adult Women With Histories of Childhood Abuse

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Both clinical experience and recent research statistics support the observation that childhood abuse survivors are vulnerable to revictimization as adults. The responsibility for revictimization, such as physical or sexual assault, belongs to the perpetrators. However, the factors that make abuse survivors more vulnerable to exploitation need to be examined and understood in order to provide adequate treatment and protection. This discussion integrates an understanding of three powerful forces—the repetition compulsion, post-traumatic syndromes, and profound relational disturbances—that permit the process of revictimization to occur.

The revictimization of adults who have previously been traumatized as children appears to be an all-too-common occurrence. In clinical work with adults who have been severely abused as children, mental health professionals have repeatedly observed revictimizations such as physical or sexual assault, some of which seem to mirror the traumatic childhood experiences.

Research statistics support this apparent high incidence of revictimization. In Russell's study of a nonclinical population, women who had been victims of childhood incest had far higher rates of adult sexual assault than women who had no incest history (65% versus 36%).[1] Women in that study with histories of childhood incest were found to be significantly more likely to be later victims of marital physical and sexual abuse, to be sexually approached by an authority figure, or to be asked to pose for pornography. In reviewing records from a psychiatric emergency room, Miller et al. found evidence that women who had been raped more than once had a higher incidence of incest than those who had had a single rape experience.[2] Similarly, Briere and Runtz's study of a crisis center comparing women with and without histories of childhood sexual abuse showed a significant asso-

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ciation between adult revictimization and childhood victimization.[3] In Chu and Dill's study of adult female psychiatric inpatients, women who had been victims of early sexual abuse were more than twice as likely as non-abused women to be sexually abused in adulthood (2.36:1), and those who had been physically abused in childhood were dramatically more likely to be physically abused as adults (17.33:1).

Paradoxically, even in the "safety" of psychotherapeutic settings, patients with a history of childhood sexual abuse are more likely to be the victims of therapists' sexual misconduct.[5,6] Therapists who have sexually exploitative attitudes and therapists who are repeat sexual offenders pose serious risks to all patients but particularly to those who have been previously victimized.[7]

This article focuses primarily on how previous abusive experiences predispose people to be similarly exploited later in life. Issues concerning the perpetrators of abuse are not addressed. This should not be construed, however, as supporting attitudes that blame the victim; the responsibility for exploitation belongs to the exploiter, not the victim. In fact, as Kluft implies in his anecdotal description of common incestuous events,[8] perpetrators of abuse are extremely prevalent in society, and the responsibility for victimization and revictimization clearly belongs to those who seek out vulnerable persons and to the societal attitudes that reinforce such behavior.

The circumstances and mechanisms of revictimization must be understood in order to protect and properly treat childhood abuse survivors. Previous discussions of how women are revictimized have focused on the intrapsychic effects of trauma,[1] dynamic and biologic factors,[9] and patient characteristics.[6] This article integrates these understandings in investigating the role of three powerful factors—the repetition compulsion, posttraumatic syndromes, and relational disruption—that permit the process of revictimization to occur.

THE REPETITION COMPULSION

The repetition compulsion in relation to childhood trauma is a key concept for understanding revictimization. Severe abusive experiences overwhelm the limited ego capacities of young children, leading to repression and dissociation of such experiences.[10] As described by Freud in terms of the repetition compulsion,[11] such repressed experiences do not remain unconscious, but emerge into current experience:

> The patient cannot remember the whole of what is repressed in him, and what he cannot remember may be precisely the essential part of it. He is obliged to *repeat* the repressed material as a contemporary experience instead of *remembering* it as something in the past. (p. 18)

Freud originally discussed the mechanism of the repetition compulsion in relation to repressed conflicts over instinctual drives. However, it is clear that there are applications in modern trauma theory as well, concerning both people who have experienced trauma as adults[9,12] and those traumatized as children.[9,12,13]

In his discussion of the repetition compulsion, Freud speculated about the motivation for this need to repeat.[11] He postulated an organic "need to restore an earlier state of things" (p. 57) that is curiously apt in light of recent ideas about possible underlying biologic factors.[9,12] Freud thought that the repetition involved a need for the person to rework the original experience, specifically taking an active versus a previous passive role, as a way of gaining a sense of mastery over the experience. Finally, Freud noted that repetitions allow the repeated expressions of affects associated with the repressed experience, particularly sadism and hostility.[11] These last two dynamic issues—the active mastery of prior passive unpleasant experiences and the expression of affects associated with past ex-

perience—are important in understanding the way in which the repetition compulsion is manifested in clinical settings.

In the clinical setting, Freud's observations about the repetition compulsion are remarkably accurate. In a variety of ways, patients with histories of childhood abuse commonly reexperience the repressed traumatic events of the past.[11] Such reexperiences may take the form of vivid flashbacks or, even more commonly, the return of overwhelming affects and sensations associated with the original trauma. In addition to this passive reexperiencing, the compulsion to repeat may also involve taking active measures to reenact prior traumatic events, as in the following case example:

Case 1. A 27-year-old married woman with a childhood history of extreme physical and sexual abuse was being treated in psychotherapy for chronic dysphoria and self-destructive behavior. Frequently, when overwhelmed by her feelings, she felt compelled to hitchhike at night on deserted country roads. She was unable to understand why her therapist remonstrated with her about this behavior, saying that she only wanted someone to pay attention to her. After one episode in which she was picked up and assaulted, she withheld this information from her therapist, feeling angry that the therapist would probably say "I told you so."

Perhaps the clearest examples of the repetition of early sexual trauma come from the reports that have linked prostitution with childhood sexual abuse. James and Meyerding's comparative study of prostitutes and "normal" women showed a far higher incidence of both incest and rape in the prostitute group.[14] Silbert and Pines's investigation of street prostitutes also found extremely high levels of childhood sexual abuse.[15] This early abuse was felt to have had severe negative emotional, physical, and attitudinal impacts, with 70% of the subjects reporting that the sexual exploitation definitely affected their decision to become prostitutes. Herman documented both promiscuity and victimization in women who had been sexually abused.[16] Finkelhor and Browne proposed traumatic sexualization and stigmatization as mechanisms for the association of sexual abuse and prostitution.[17] In clinical situations the elements of repetition are clearly evident, as in the following case:

Case 2. A 22-year-old woman with a history of extended sexual abuse by her father and older brother reported that she frequently prostituted herself. She explained this behavior by saying, "When I do it, I'm in control. I can control them through sex." Her contempt for the men who used her was evident, and she was only minimally aware of how she was being exploited.

In this case illustration, it is clear that there is not only a repetition of the sexual exploitation but also an attempt to have active control of a previously passively experienced victimization, and that a great deal of the affect (contempt and hostility) connected with previous sexual abuse is expressed.

One of the most painful dilemmas for both patients and therapists concerning the reexperiencing of dissociated childhood trauma has to do with the way children mentally process and subsequently remember their experiences. Van der Kolk and van der Hart,[18] synthesizing various theories of the way young children encode memory, suggest that as they mature, children "shift from sensorimotor (motoric action) to perceptual (iconic) representations to symbolic and linguistic modes of organization of mental experience" (p. 1534). Thus, early childhood abuse is encoded in memory and later reexperienced as sensations and images rather than in verbal or linguistic form.

This is consistent with clinical experience of patients who are just beginning to remember their abuse; such patients are unable to find words for their traumatic experiences. Many patients who have enormous difficulty recalling and expressing their abuse in words instead behave in ways that communicate a great deal about their previous experiences.

As with patients who have been traumatized as adults, these behaviors are often reenactments of the abuse or of abusive situations. Because sadism, intrusion, and isolation were often elements in the original abuse, these qualities are reflected in the reenactments. The dilemma is made even more difficult because severe childhood abuse is nearly always accompanied by either partial or complete psychogenic amnesia,[19,20] which makes the behavior seem to have no reasonable etiology. Perhaps this is why Russell[1] found that none of the women in her study consciously connected their early abuse and subsequent revictimization.

The repetition of past abusive experiences might result in favorable outcomes if people were actually able to master past aversive experiences through reenactments. Unfortunately, these attempts are usually doomed. The inherent interpersonal betrayals of childhood abuse frequently lead adults to avoid supportive alliances. Hence, when they are confronted with overwhelming repetitions of past abuse, they have only their own resources to draw upon and are frequently again overwhelmed, traumatized, and victimized. Moreover, the venting of dysphoric affects often results in further disruption of the interpersonal ties that might otherwise protect and support. In this way, the unprotective and abusive childhood interpersonal environment is recreated and reexperienced, ultimately leading to isolation, helplessness, and despair.

POST-TRAUMATIC SYNDROMES

Women in whom overwhelming life events are repressed and dissociated not only are compelled to repeat the events, but may also experience additional post-traumatic syndromes that place them at risk. As Kluft[6] notes:

> They often have dissociative defenses that cloud their perceptions and leave them with a discontinuous experience of themselves and their mental contents. ... Their defenses leave their sense of self and identity fragmented and experience becomes more compartmentalized than integrated. (p. 487)

Such women who are unable to bring their full experience to bear on a potentially dangerous situation may act with less than the best judgment, and this may result in revictimization.

Many survivors of childhood abuse continue to show evidence of a chronic post-traumatic stress disorder in adult life.[21–22] They often show the classic biphasic post-traumatic response of periods of intrusion alternating with periods of avoidance and numbing.[23] During periods of intrusion, they experience recurrent intrusive reexperiences of the traumatic events, along with associated affect. In these periods there is often autonomic arousal and hypervigilance. People who are actively reexperiencing abuse are unlikely to be revictimized. In fact, they may be hyperreactive even to circumstances that contain no real threat.

However, during the numbing phase, when individuals avoid recalling their abuse, when they have markedly constricted affect and are detached from others, they are at high risk for revictimization. The memory of past traumatic events and the associated affects (including fear and anticipatory anxiety) are quite dissociated from conscious awareness. Thus, a person in a threatening situation may seem to be unaware of potential danger, as in the following case example:

Case 3. A 31-year-old woman, who was in treatment for the sequelae of extensive childhood physical and sexual abuse, was accustomed to taking long walks through the woods around her home. She found these walks to be quite soothing and particularly helpful in allowing her to block out painful memories of her childhood. One evening while she was walking along a trail, her path was blocked by a young man riding a motorcycle and dressed in Army fatigues;

> he was apparently from a nearby Army base. With no qualms, she stopped and allowed him to engage her in conversation, and she was shocked when he subsequently made sexual advances and raped her.

The dissociation and the unavailability of normal anticipatory anxiety are most marked in patients with multiple personalities or other similar dissociative disorders. The relatively rigid compartmentalization of experience and identity in patients with severe dissociative disorders places such patients at substantial risk for revictimization. Not only are traumatic experiences repressed from consciousness, but many dysphoric affects (including anticipatory anxiety) are split off into separate self-states or personalities. These kinds of circumstances are quite likely to result in revictimization.

One other post-traumatic phenomenon is of note. The model of "inescapable shock" described by van der Kolk and others[24,25] is based on situations where the victim of trauma is helpless to prevent or escape from the aversive events. Inescapable shock leads to an impairment of the ability to learn how to escape from new aversive experiences.[25] Thus, when women with histories of childhood abuse are faced with potentially threatening situations, they may feel extremely constricted in their choices and helpless to escape. Not only do they have difficulty conceiving of new ways to deal with traumatic circumstances, but they often feel overwhelmed by the return of feelings of helplessness associated with the original abuse that are triggered by the current trauma. This is often manifested in patients' descriptions of going limp, freezing, or showing automatic submissiveness in the presence of a powerful, threatening, and abusive person.

RELATIONAL DISRUPTION

Abusive childhood experiences do not seem to be the sole determinants of lasting psychological harm. Investigators such as Bowlby,[26–29] van der Kolk,[25] and Rutter[30] have described how disturbances of attachment, particularly separation and disruption of early childhood nurturant relationships, leave individuals vulnerable to being overwhelmed both in childhood and later as adults. The implication is that children who are subjected to traumatic experiences within the context of inadequately protective social environments are at greatest risk for psychological damage.

Unfortunately, childhood trauma seems most often to occur in grossly dysfunctional families, where a lack of adequate protection is more the rule than the exception. For example, in cases of overt physical and sexual abuse of children, the clear majority of perpetrators are family members. Carmen et al. reported that 90% of inpatients they studied who were abused as children had been abused by family members.[31] In Bryer et al.'s study of psychiatric inpatients, substantially more than half of the subjects who reported physical and/or sexual abuse named family members as perpetrators.[32] In a similar study of psychiatric inpatients, Chu and Dill found that 92% of those who reported childhood physical abuse and 77% of those who reported childhood sexual abuse named family members as perpetrators.[4] In that study, adult patients who reported only abuse by extrafamilial perpetrators showed significantly lower levels of dissociative symptoms than those who were abused by family members. This is hardly surprising, for intrafamilial abuse implies a far greater level of psychological violation and betrayal, resulting in a greater need to distance and dissociate the experience.

Many investigators have found relational disruption, with effects on ability to relate to others, in abusive families.[1,3,16,17,33–36] Finkelhor and Browne[17] state the relational effects of traumatic childhood abuse, citing betrayal as a major dynamic issue:

> Sexual abuse victims suffer from grave disenchantment. In combination with

> this there may be an intense need to regain trust and security, manifested in the extreme dependency and clinging seen in especially young victims. This same need in adults may show up in impaired judgment about the safety of other people. . . . An opposite reaction to betrayal—characterized by hostility and anger—has also been observed in sexually abused girls. Distrust may manifest itself in isolation and an aversion to intimate relationships. . . . Thus, betrayal seems a common dynamic behind a number of the observed reactions to sexual abuse. (pp. 536–537)

These observations concerning the effects of relational disruption due to childhood abuse seem to be remarkably congruent with recent research, which has found a very high rate (upwards of 75%) of childhood trauma in patients with borderline personality disorder.[37–40] As Ludolph et al.[39] note:

> Variables most likely to predict borderline personality disorder included history of disrupted attachments, maternal neglect, maternal rejection, grossly inappropriate parental behavior, number of mother and father surrogates, physical abuse and sexual abuse. (p.470)

Herman et al.[38] have suggested that borderline personality disorder is a complex post-traumatic syndrome. It appears likely that the disruption of early attachments in abusive families has a heavy impact on normal ego development, particularly in the areas of interpersonal relatedness, affect tolerance, behavioral control, and identity, all of which are impaired in borderline personality disorder.[23] An environment that is not appropriately supportive and that may even involve actual abuse by caretakers seems clearly implicated in the inability to sustain stable interpersonal relatedness. When normal parental protection against extreme aversive experiences is lacking, children, instead of gradually learning to tolerate intense affect and to control their behavior, are constantly overwhelmed. Of course, traumatic and abusive experiences create enormous difficulties in self-image and identity, with the frequent result being self-hate.[1,16,17,31,35,36,41–46]

The deficits associated with disruption of early relationships predispose individuals to revictimization. Supportive relationships allow individuals to consult the perspective and judgment of others, to share and dilute the intensity of powerful affects, and to control behavior. In contrast, people with a history of massive relational disruption may feel compelled to engage with others in ways that recapitulate the hostile-dependent and abusive nature of their early relationships. Discussions of so-called traumatic bonding suggest that prolonged exposure to intermittent abuse predisposes people to form powerful emotional bonds to abusers and later to others like them.[47] Alternatively, people with a history of profound relational disturbances may flee into dysfunctional isolation as a way of avoiding potentially painful interactions. This isolation clearly places such people at risk of being overwhelmed by dysphoric affects, and they are prone to action and flight into ill-considered and potentially dangerous situations.

There are also particular difficulties with people who have negative self-images. As Rutter[30] observes, good self-esteem and a sense of self-efficacy are powerfully protective mechanisms that help provide resilience in adverse circumstances. People who have been subjected to abuse and victimization and who have not received positive reinforcement and validation are likely to have extremely negative self-regard and to view themselves as powerless.[1,16,17,31,35,36,41–46]

Often such individuals believe that they were responsible for the abuse that they suffered (no matter how severe), and they see themselves as loathsome and defective. They often cannot conceive of situations in which they would be regarded with esteem and respect. Hence, it is hardly surprising that peo-

ple who hate themselves often allow themselves to become involved in situations in which they are revictimized. The role of victim, although painful, is familiar and consistent with their self-image.

IMPLICATIONS FOR PSYCHOTHERAPY

Psychotherapists who work with survivors of childhood abuse need to be aware of the dynamic factors behind revictimization. It cannot be assumed that, with the help of passive support from the therapist, patients will be able to break the powerful bonds that link their traumatic pasts with their current patterns of relating and functioning. On the contrary, such patients will continue to repeat and reenact abusive situations and abusive relationships unless active measures are taken by both patient and therapist to ensure personal care and safety as well as more productive ways of relating. Even in therapeutic interactions, therapists must be aware of any recapitulation of patterns of abuse or victimization in the therapeutic relationship.

Patterns of revictimization driven by unresolved past abuse are likely to remain problematic until the past experiences are worked through. Unfortunately, the profound relational disturbances of many abuse survivors interfere with their ability to make use of supportive relationships, including the therapeutic relationship, to resolve the past. The definitive abreaction and working through of past abuse often is not possible until after extensive preliminary work on building trust and solidifying the therapeutic relationship. Thus, both patients and therapists are caught in the painful dilemma of trying to control revictimization before the traumatic antecedents are clear. Moreover, because the process of revictimization is driven by powerful psychological forces such as the impulse to repeat and reenact previous traumatic experiences, patients are often ambivalent about the need to take adequate measures for self-protection. One of the more damaging aspects of childhood abuse is that the victim often becomes the facilitator of new abuse, sometimes long after the original perpetrators are no long actively abusive. However, as with abused children, any current abuse or revictimization must cease before exploratory psychotherapy concerning it can begin.

For patients with a probable history of childhood abuse and patterns of revictimization, there are specific psychotherapeutic stances that should be taken. Therapists should acknowledge the traumatic antecedents of revictimization but should be highly sensitive to the benefits and risks of exploring the actual abusive experiences. Pacing the therapeutic work is essential to avoid overwhelming patients' ability to cope with extremely painful feelings; premature uncovering work is likely to precipitate regression, with potentially damaging symptoms and behaviors. With many patients, there must be an emphasis on building an adequate psychotherapeutic foundation prior to any extensive exploratory work.

Building adequate psychotherapeutic foundations is often a complex task. The basic tenets of psychodynamic psychotherapy, including empathy, understanding, and interpretation, remain central to the process. However, the often intense psychological compulsion toward revictimization makes it necessary for therapists to use psychoeducation as well to teach patients about the process of therapy and to confront patients about potentially self-damaging or dangerous behaviors. Even in the process of education and confrontation, therapists must maintain and communicate an empathic understanding of the powerful traumatic antecedents of revictimization. It is, of course, the art and practice of psychotherapy to blend and balance empathy, acceptance, psychoeducation, and confrontation to achieve maximal therapeutic growth and progress.

The building of psychotherapeutic foundations prior to exploration and abreaction of traumatic experiences must emphasize relationships based on mutuality, as opposed to

those that recapitulate abusive experiences. The psychotherapeutic relationship is particularly important because it provides both the interpersonal support necessary to do exploratory work and a model of relating that patients may be able to extend to other relationships. Negative transferences in which the therapist is seen as abusive or exploitative are particularly common in patients who have been abused and exploited by important people in their lives. As these negative transferences arise, therapists should understand them as sequelae of early abuse and should engage with patients in such a way as to restore a sense of mutuality and therapeutic alliance.

Before exploring overwhelming and abusive early experiences, patients must also work with therapists on becoming able to tolerate dysphoric affects and to control dysfunctional behaviors. This is often problematic for survivors of abuse who have been repeatedly overwhelmed and who have never had the opportunity to master affect tolerance and behavioral control. Therapists should understand that the therapy may involve providing support during a lengthy process in which patients are increasingly able to cope with extremely dysphoric affects and strong destructive impulses. In the early stages of therapy, patients should gradually move toward an increasing ability to engage with therapists and others to promote self-care and personal safety, including minimizing the likelihood of revictimization. Finally, every effort should be made to identify situations, internal emotional states, and triggers that are connected to revictimization, as well as important protective defenses such as anticipatory anxiety. Only when these steps are taken can the more definitive work take place in which past abuses are explored and worked through, thus diminishing the compulsion to repeat and alleviating dissociative and post-traumatic symptomatology.

Psychotherapists should be aware that patterns of repeated victimization may provide a clue to childhood abuse that is repressed and dissociated from conscious awareness. Because dissociative symptoms, specifically including psychogenic amnesia for traumatic events,[4,12,13,19,20] are commonly found in survivors of childhood abuse, the traumatic antecedents of adult victimization may not be obvious to either patients or therapists. In such situations, mental health professionals have too often ignored or dismissed the primary importance of childhood abuse and have simplistically labeled such patients as "masochistic" or have seen them as inherently deviant or defective. Such attitudes not only are destructive but also impede the therapeutic task of promoting the understanding of current behavior as being determined by past experience.

Many patients with no clear history of abuse show evidence of possible traumatic antecedents, such as repeated victimization, dissociative or post-traumatic symptoms, fragmentary memories of abuse, patterns of current severe relational disturbances, past history of extensive family dysfunction and chaos, and a devalued and debased sense of self. In such situations, psychotherapists should emphasize an active and diligent search for evidence of past abuse. Such an active position is clearly indicated in the face of profound resistances such as patients' need to block out their past experiences. Moreover, the failure to interpret such a crucial potential link simply allows the unconscious facilitation of revictimization to continue.

The following case example illustrates some of the psychotherapeutic issues concerning revictimization.

Case 4. A 27-year-old single woman entered psychotherapy for treatment of her chronic dysphoria and bulimia. The patient also reported long-standing difficulties with risky behavior such as driving too fast and numerous casual sexual contacts. She admitted to having problematic interpersonal relationships. Often when feeling too close to a friend she would find herself doing something that would alienate the other person. In addition, she had several inti-

mate relationships in which her partner was clearly abusive. The therapist wondered about the possibility of past abusive experiences that were being repeated.

Although the patient described a somewhat chaotic early family environment, she had little clear memory of events prior to age 11. Other possible post-traumatic symptoms included episodic depersonalization and derealization and markedly poor sleep. Over the course of several weeks, the therapist asked questions to elucidate more fully the patient's early history. Gradually, the patient was able to describe a family environment which was quite obviously emotionally abusive and in which physical violence was common.

The patient began having an increase in her symptoms, with more despair and self-destructive impulses. She described being flooded with uncomfortable feelings and being extremely "jumpy." She became quieter and more obviously defensive in therapy sessions and accused the therapist of scolding and mocking her. Sleep deteriorated to the point that she awakened multiple times each night in a panicked state. Her bingeing was out of control, as was risk-taking behavior. One night, the patient was pulled over by a police officer for speeding. Feeling panicky, she jumped from the car and attempted to flee. She was wrestled to the ground, handcuffed, and arrested, although she was then able to summon a friend to bail her out.

The therapist felt strongly that the patient was having reexperiences of past traumatic events but that she was once again overwhelmed. Although he acknowledged the reality of the patient's past abusive experiences, he strongly recommended limiting exploration of the patient's past. Instead, he engaged her in a process of building relationships (including learning trust in the therapeutic relationship), maintaining self-care through reducing risky behaviors, and helping the patient monitor her behavior and relationships for dangerous situations. This period of foundation-building proved to be both difficult and lengthy, particularly in the area of building healthy relationships. However, the patient was eventually able to achieve some overall stability.

Approximately 2 years following the beginning of therapy, the patient was able to tolerate the process of starting to fully reexperience some of the past abuses that she had repressed and dissociated. Once again, she felt overwhelmed. For the most part, however, she was able to maintain her sense of alliance with her therapist. Although she again had markedly disturbed sleep as well as some dissociative symptoms, she was able to refrain from self-destructive behavior. More details of the childhood abuse began to emerge, including some memories of sexual assault. Although the process was quite painful, the patient felt strongly that she was making progress in finally understanding the course of her life and how to come to terms with her past.

CONCLUSIONS

With the combination of so many powerful factors—the repetition compulsion, post-traumatic syndromes, and the results of relational disruption—it is clear why people who have been abused as children are much more likely to become the victims of subsequent traumatization. In addition to negative effects of the psychological (and perhaps biologic) need to rework early experiences, childhood abuse also has profound negative effects on individuals' later adaptability to their environment and resilience with respect to aversive experiences. Unless the cycle of victimization is broken by effective treatment, people who have suffered childhood abuse continue to be at risk for the recurrence of traumatic and harmful experiences.

Those who treat past victims of childhood trauma need to realize fully the extent to which these individuals are at risk for revictimization. Therapists must recognize the exceptional vulnerability of such people as well as the active role that they sometimes take in reenacting their own past traumatic experiences. Each of the factors that predispose patients to revictimization should be monitored carefully so that repetitions and post-traumatic syndromes are recognized and relational supports are maintained.

This maintenance of relational supports is perhaps the most important factor in the successful treatment of childhood abuse survivors. All psychotherapeutic work depends

on the maintenance of the relational support of the therapeutic alliance. It is this relationship that makes it possible for the previously abused individual to begin to exercise self-care and to eventually overcome the extraordinary traumatic experiences of the past.

Discussions of revictimization are often controversial, particularly when they focus primarily on the victim and do not address issues related to the perpetrator. This discussion has outlined how survivors of abuse play a role in their own revictimization and how the mechanisms of revictimization need to be understood and overcome. Therapists need to work with patients so that they are able to take personal responsibility for their own safety, but this is not to imply that patients are to blame for being revictimized. An understanding that people with histories of early abuse are intensely vulnerable to subsequent revictimization should in fact only serve to underscore the responsibility of a perpetrator who intentionally inflicts harm on another. The availability of vulnerable individuals does not absolve the perpetrators, who often seem to search out those whom they can exploit.

Although abuse survivors need to understand the mechanisms through which they may be exploited and to control any behaviors that leave them more vulnerable, they cannot be held responsible for the sadistic and often illegal actions of others. If anything, those who have suffered the ravages of childhood abuse and whose lives have been driven by those experiences need to be viewed as the intensely vulnerable human beings that they are, in need of guidance, protection, and treatment. To blame childhood abuse survivors for their own vulnerability and for causing their own subsequent exploitation may be one final form of revictimization.

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