THE THERAPIST AS VICTIM: A PRELIMINARY DISCUSSION

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ABSTRACT

Increasingly reports are being received from colleagues, supervisees, and consultees from around the country that patients who were severely abused as children and are pathologically dissociated as adults may be increasingly prone to victimize their therapists intentionally. Actions taken by such patients have included the filing of frivolous or malicious complaints or lawsuits, the spreading of rumors about the therapist, harassment of other patients of the therapist, and violation of the therapist's privacy and personal space, among many others. Such behaviors may be in response to patients' own internal distress, to unrecognized complexities within the therapeutic process, to re-enactments, and/or to patients' resistance against focusing on their own issues. The authors contend that although some therapists have behaved inappropriately with their patients, there are identifiable dynamics within the patients and within the therapeutic relationship that could alert the therapist to the potential of destructive acting-out towards the therapist. The purpose of this paper is to acknowledge the phenomenon of therapist victimization, to discuss some of the underlying dynamics, and to begin to address possible preventive measures.

INTRODUCTION

We have become aware from personal experience, from incidents described by those we supervise and consult with, and from conversations with other therapists around the country of a number of difficult and destructive situations which have occurred in treatments of individuals with pathological dissociation. In these situations, therapists have been treated quite harshly by patients. The number and seriousness of these incidents have caused us to believe that we are seeing a phenomenon which is occurring nationwide.

The purpose of this presentation is to acknowledge the phenomenon of therapist victimization, to encourage more open discussion of the process and of its toll on therapists, to describe some possible indicators of its destructive potential, to discuss some of the underlying dynamics, and to begin to address possible preventative measures.

Although many therapists have behaved inappropriately with dissociative disorder patients (Chu, 1988; Greaves, 1988; Kluft, 1990), a number of such patients have intentionally created personal and/or professional difficulties for their therapists. Direct attacks, apart from verbal and physical assaultiveness to the therapist, have included unusual behaviors such as leaving dead animals on the therapist's porch, poisoning and/or releasing of therapist's dogs, attacks on the therapist's possessions and/or person, and shooting guns in the therapist's office or home. More usual types of attacks have taken the form of filing frivolous or malicious lawsuits and reports to supervisors and/or Ethics Boards, harassing telephone calls, violating the therapist's space by refusing to leave (Fine, 1989), refusing to pay, and bringing guns or knives to the therapist's office.

Indirect attacks, which may be no less damaging, include the presentation of selected or fabricated material to other patients, friends, family members or other professionals with the intent to hurt the therapist, seeking information about the therapist from others, and harassment of other patients (Fine, 1989).

Although leaders in the MPD field were initially optimistic about treatment prognosis (Kluft, 1985; Greaves, 1989) for MPD patients, we have seen that treatment does not always work. Recently, Putnam (1990) estimated that one-third of MPD patients are not treatable. Some of the reasons these patients are not treatable include the extent, length, and intensity of the patient's trauma; the propensity toward re-enactment in the patient's adult life; the co-existence of medical psychiatric conditions; the tendency toward secondary gain; the incapacity to attend to stimuli without cognitive or affective distortion; compromised intellectual capacity; and the strength of the desire to overcome the past and lead a reasonable life without unreasonable fears. Other important factors include naiveté, grandiosity, or pathology on the part of the therapist, and mismanagement of the patient-therapist relationship. Any one of these factors can add to the possibility of patient acting-out feelings. A general review of factors involved in treatment impasses is available (Kluft, 1992).

Why Patients Attack

Patients attack their therapists for a variety of reasons, but the primary motivation is to feel better. Attack serves a purpose. As Epstein (1977) wrote, "Hateful transactions can provide a poorly integrated ego with a means of restoring its equilibrium. The feeling of hate can provide an ongoing

sense of ego-identity" (p. 451). This is a particular concern for MPD patients.

For patients raised in abusive families, the perpetrator/victim polarity is a familiar one. MPD patients bring with them into therapy enormous rage and aggressive patterns of behavior as a result of repeated, long-standing abuse (Terr, 1991). Patients who have lived sado-masochistic relationships may energetically attempt to replicate that style of relationship within the therapy setting (Stoller, 1989).

The discharge of rage in a cathartic explosion can provide a welcome sense of relief. Patients who know the relief of discharging tension through abuse may choose the relative ease and instant gratification of re-enactment to the long rigors of the therapeutic work of containing, remembering, and resolving.

Therapists often seem shocked by the emergence of a hateful relationship towards them and tend to take such incidents quite personally. They have failed to fully comprehend the significance of the previously adoring relationship, which was equally based on transference. The tendency of some MPD patients, like that of the narcissist, is to "permanently live in a magic circle of seeking new and devaluing exhausted sources of gratification in a series of idealizations and dissatisfactions and internal restlessness." (Svrakic, 1985, pp. 720-724)

At times during treatment, many MPD/DD patients may cause harm to their therapists. What differentiates the dangerous patients is the predominance of the pattern of acting out rather than working through. Langs (1987) wrote:

> ...The combination of a parasitic mode of relatedness and a high level of communicative resistances is characteristic of patients who enter treatment ... to ... abuse the therapist and exploit the treatment situation. These patients are often agitated, rather paranoid, and quite demanding of pathological satisfactions. In the absence of meaningful material, their intention to mainly do harm to the therapist is in full evidence. (p. 190)

UNDERLYING DYNAMICS

Splitting

Internal tension is created by the existence of split self and object representations (Horner, 1990), an experience of every MPD patient: "... intolerable sense of intrapsychic non-integration and conflict ... is alleviated by projective identification[,] [e]xternalization and acting out [which] promote the illusion of intrapsychic unity and harmony." (p. 38)

Externalizing and acting-out behaviors are most often seen in those MPD patients with prominent borderline or narcissistic features. We agree with authors who describe borderline and narcissistic personality disorders on a continuum rather than considering them to be distinct entities (Adler, 1981; Chessick, 1979; Meissner, 1983) and, additionally, we view dissociation primarily as a defense.

Some attacks or difficulties arise from the tendency of patients with traumatic pasts to live in a flashback world (Loewenstein, in press), a world in which they seem unable to differentiate between their past reality and their present reality. While professional observers may recognize the disabling limitations of such fluid perceptions, this state is not necessarily considered problematic by the patient, who may perceive everything and everyone else as the problem, without accepting any personal responsibility for present life circumstances. These patients pose serious difficulties for therapists, because the reality of their perceptions about the present is distorted, and both their perceptions and their memories of therapy sessions may undergo distortions (Chu, 1991) which they then perceive as reality. Chu wrote of his patient in the midst of an abreaction who thought the abusers were in the office. When she was confronted with the fact that only he and she were present, she responded, "Then why are you hurting me?" (p. 328).

The combination of the tendency to distort reality and the tendency to repeat the malevolent patterns lived as children combine naturally with rage towards the therapist and a very real conscious and/or unconscious desire to avoid painful material. This combination of proclivity, learned behavior, and affect creates a volatile and, therefore, potentially dangerous situation.

Attachment Disturbance

Abnormal attachment behavior, one of the profound effects of repeated emotional or physical abuse or abandonments (Bowlby, 1973; Barach, 1991), underlies and motivates some patient attacks. Distorted attachment can be expressed by malicious angry outbursts by the patient, expressions originally intended to dissuade parental figures from leaving, but long since rigidified into angry relational patterns.

Patients who have reported the abuse MPD/DD patients claim to have experienced, particularly those who allege ritual abuse, must have seriously damaged attachment patterns because attachment cannot develop normally in such environments. Therapists frequently naively over-estimate the strength or the existence of the therapeutic alliance based on selected comments from parts of the patient and/or on the therapists' own personal desires. To assume that a limited relationship formed late in life with a stranger whom one must pay is sufficient to remediate years of abuse in short order minimized the patient's life experience.

Adler (1979) holds that real relationships between patient and therapist are impossible for borderline or narcissistic patients, a population less traumatized than are MPD/DD patients. He posits that both the borderline and the narcissistic personality disordered patients have such character pathology that they are able only to form relationships with their own transferences rather than with the real person of the therapist during most of the therapy.

Attachment disturbances and the development of antisocial or amoral proclivities have long been considered to go hand-in-hand, a connection we forgot at our risk. "Masterson (1972) as cited by Horney (1990) sees the psychopathology of the sociopath as a manifestation of the use of detachment to deal with repeated separations from the mother. The inability of the sociopath to form rela-

tionships is well known ... " (Horner, 1990, p. 11).

A childhood of extreme abuse and deprivation sets the stage for acting out in extreme and destructive ways with little evidence of regard for other people. Patients may lie viciously, intentionally or almost absent-mindedly. "Such patients have little concern for what harm their lies may inflict on others as a result of their impaired morality" (Snyder, 1986, p. 1289). We need to remember that lies and impaired morality were their norm, and for many, remain their norm. It is not an easy task for them to address deep destructive impulses, and many choose to avoid them, contenting themselves with maintaining their equilibrium in a compromised manner.

The Therapist

Difficulties within the therapeutic relationship do not always originate within the patient. As therapists, we have our own narcissism and may fall prey to any one of "the three most common narcissistic snares ... the aspirations to heal all, know all, and love all" (Maltsberger & Buie, 1973, p. 626). We may violate commonly accepted therapeutic boundaries in an effort to "heal all" without remembering that "the impulse to make an exception—especially with patients with borderline personality disorder—no matter how plausibly rationalized, is suspect and should set off red flags of caution" (Gutheil, 1989).

The therapist must be aware that even the smallest amount of extra giving to some patients can create a sense of special relationship and may inadvertently stimulate primitive grandiosity which the patient cannot contain, leading to acting out rather than to working through. The resulting heightened sense of entitlement, based on internal reality or wish rather than external reality, may finally explode into a regression of negative affects at the time of actual or imagined withdrawal of this special state (Apter, Plutchik, & Sevy, 1989).

When we "love all," we may inhibit our acceptance and/or awareness of our patients' rageful and vengeful feelings, thus making their own acknowledgement of their "shadow side" even more difficult. We may ignore threatening aspects of our patients in order to maintain our own positive view of humanity. When we attribute the patient's hateful or vicious feelings to "introjected abusers" or just parts of them that need help; we speak as if we believe that these "others" are not part of the patient, but are a foreign substance introduced by the abusers. This stance reinforces their need for dissociative barriers against important parts of themselves.

Qualities of Patients Who Cause Harm to their Therapists

As we began considering this topic of patient attack and therapist victimization, we noted that patients who have become problems for their therapists have some qualities in common. They have prominent borderline or narcissistic features; they often maintain a powerful positive, negative, or vacillating attachment to their families of origin. They may establish what Horner calls a "masochistic triangle" (Horner, 1990). In the "masochistic triangle," the idealized, good object representation is projected onto the therapist and the real parent is experienced as the all-bad, persecuting object, thus externalizing the internal struggle and making the patients' choice of allegiance a recurrent question. The separation between good and bad is maintained rather than contained, a defense that will not ultimately help the patient to heal. Horner points out that narcissistic issues may become intensely sexualized (a pattern common for those who have experienced inappropriately sexualized relationships). In such situations, transferences become particularly intractable (Horner, 1990) for these patients. Kernberg's sketch of the narcissistic patient who attacks rather than contains may sound familiar to many. He wrote:

> Narcissistic personalities with joyful types of cruelty; patients who obtain a sense of superiority and triumph over life and death, as well as conscious pleasure, by severe self-mutilation; and narcissistic patients with a combination of paranoid and explosive personality traits, whose impulsive behavior, rage attacks, and blaming are major channels for instinctual gratification, all may reflect the condensation of aggression and a pathological grandiose self, and may find the treatment situation a welcome and stable outlet of aggression that militates against structured intrapsychic change. (Kernberg, 1984, p. 195)

Other qualities or patterns which might alert the therapist to the possibility of trouble include patients who enter therapy with unusual requests and react with anger when the requests are not fulfilled; patients who express a "need" to be able to call the therapist whenever they want and become enraged when that is not possible; patients who may bring in volumes of material for the therapist to read outside of session; patients who have a history of repeated hospitalizations and failed therapies; patients who have an inability or unwillingness to function in the work-world; patients who have chaotic or pathological relationships; and/or patients who have a history of rageful acts. Patients who do not state their expectations but act as if they have already been offered the run of the therapist's life may present even more serious difficulties.

Therapists should be aware that ritual abuse would violate human rights in even more extreme ways than would more conventional abuse. Thus, a reported history of ritual abuse can inform the therapist that the patient may have been forced to experience, and therefore, perhaps internalize, even greater and more perverted emotional and behavioral oscillations. Such a patient may be more prone to aggressive behavior against the therapist.

RECOMMENDATIONS

Safeguarding the integrity of the treatment frame is the best precaution against treatment complication. It will not prevent all treatment complications, but the provision of a consistent treatment frame will help the therapist differentiate early in treatment those patients who want re-parenting, those patients who desire to recreate sado-masochistic relationships, and those patients who choose to find relief in hurting others, from those who will do the hard work

required to heal pathological structures.

Therapist precautions with patients who have characteristics associated with victimizing therapists might include careful note-taking to document patient difficulties, video- or audio-taping sessions, perhaps never seeing a particular patient alone in the office, or having a window in the office door. Consultation, even repeated reconsultation, can be of significant benefit. In Gutheil's words, "In addition to providing valuable input and perspective, such consultation opens the case up and avoids the dangerous insularity of the treatment dyad... the illusion of the magic bubble" (Gutheil, 1989, p. 598).

CONCLUSION

When we ignore the possibility of some patients' acting out against us, we do so at our own risk, a stance that could compromise both our own well-being and the patient's therapy. We believe that with thought and care, the potential for therapist victimization can be reduced, but never totally eliminated. ■

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