

TEN TRAPS FOR THERAPISTS IN THE TREATMENT OF TRAUMA SURVIVORS

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ABSTRACT

Patients who have survived trauma, particularly those who have experienced early childhood abuse, stand out in the clinical experience of many therapists as being among the most difficult patients to treat. These patients have particular patterns of relatedness, along with intense neediness and dependency which make them superb testers of the abilities of their therapists. They often push therapists to examine the rationales and limits of their therapeutic abilities, and frequently force therapists to examine their own personal issues and ethical beliefs. A conceptual framework for understanding treatment traps is presented, along with ten traps which these patients present, consciously or unconsciously, in the course of treatment. Included are traps around trust, distance, boundaries, limits, responsibility, control, denial, projection, idealization, and motivation. These are certainly not the only traps which occur in the course of treatment, but they highlight the experience of treatment and the difficulties which are encountered between the therapist and the patient. This paper is intended to be clinical in orientation to help prepare and support therapists in their work.

Trauma survivors, particularly those with histories of early childhood physical and sexual abuse, seem to be among the most distressed patients (Bryer, Nelson, Miller & Krol, 1987) and often the most difficult to treat. They present in a variety of ways with dissociative disorders, borderline states, substance abuse, eating disorders, and various syndromes of anxiety and depression. My own experience in working with such patients and in consulting to and in supervising their therapists, confirms that difficulties occur frequently, repeatedly, and with remarkable predictability. Other investigators, such as Kluff (1894), have also described therapists experiencing "bewilderment, exasperation, and a sense of being drained (p. 51)." This paper describes the nature of certain therapeutic impasses or "traps" in their psychotherapy, and outlines a conceptual framework as to why such traps are particularly difficult with trauma survivors. Ten common clinical traps are also presented along with suggestions for intervention. One caveat: an understanding of the traps does not prevent them from occurring. However, an understanding prevents therapists

from becoming enmeshed in traps, and helps therapists tolerate them with less anxiety.

THE NATURE OF TREATMENT TRAPS

In treatment traps, or therapeutic impasses, often both the patient and therapist feel immobilized. In these difficult clinical situations the therapy is brought to a standstill or even regresses. These kinds of treatment traps seem to arise from resistances brought by patients to the therapy. However, in that psychotherapy involves interaction in an interpersonal arena, traps are fully activated only if the therapist responds inadequately or inappropriately to these resistances. Resistances throughout the course of treatment are normal and expectable. Unless such resistances are acknowledged by both the patient and the therapist, an impasse or unfortunate clinical result occurs (Glover, 1955; Greenson, 1967; Langs, 1981). Appropriate responses on the part of the therapist allows resistances to be understood and resolved. Greenson (1967) defines the steps which are often necessary to resolve resistances as confrontation, clarification, interpretation, and working through. In other words, both patient and therapist need to acknowledge and consider the resistant behaviors, understand them on a conscious level, and to make progressive changes. If this occurs, the therapy is enhanced, but without an appropriate resolution, the therapy flounders.

What leads therapists to make non-therapeutic responses to manifestations of patient resistance? Inexperienced or naive therapists often overlook evidence of resistance. Even experienced therapists, on occasion, can miss or misunderstand evidence of resistance, and can find themselves in difficult clinical straits. Often, however, the difficulty in dealing with patient's resistances are due to more complex therapist dynamics. The therapist's countertransference, that is, the therapist's own thoughts, feelings, and wishes which are projected into the patient, may interfere with productive interventions. Langs (1981) has stated that: "it is incumbent upon the therapist to ascertain his own contributions to each resistance before dealing with those sources which arise primarily from the patient (p. 540)." Not understanding countertransference contributions in relation to patient resistance (either in promoting resistance or in response to resistance) almost certainly leads to nontherapeutic responses. Such responses might range from feeling immobilized, to rage at being attacked, to being overgratified by the patient. One other area of therapist contribution to treatment traps comes from therapists' counterresistance

(Glover, 1955). Patients in therapy may activate thoughts, feelings and fantasies in their therapists which their therapists attempt to fend off. Thus, therapists' counterresistances, particularly in trying to cope with angry reactions or sadistic fantasies towards patients, can lead to therapists using such defenses as reaction formation, avoidance or withdrawal. Streaun (1985) mentions possible forms counterresistance can take: "oversolicitousness; unnecessary reassurances; ... postponing confrontations, questions or interpretations regarding a client's tardiness or absence; glossing over... the negative transference; and denying the existence of pathology, conflict, or resistance in the client (p. 85)."

TRAPS IN THE TREATMENT OF TRAUMA SURVIVORS

The painful difficulties that inevitably appear in the treatment of trauma survivors seem to be the result of two factors, the first having to do with particular characteristics of these patients. Many trauma survivors who later develop psychiatric disorders have come from highly pathological family backgrounds. Many investigators cite trauma victims' social environment and the reactions (or lack of reaction) to abuse as critical in the long term sequelae (Finkelhor, 1984; Herman, 1981; Russell, 1986). Psychopathology within the family as is the case with incestuous abuse, lack of familial support, or unsupportive reactions from the family to the abuse all seem to contribute to long term difficulties. Spiegel (1986) describes the "double bind" of abused children who later develop dissociative disorders. The child receives totally contradictory messages (such as being both "loved" and abused) and is forbidden from addressing the contradictions. The family which nurtures the child is also the source of abuse, abandonment, and betrayal. It is hence not surprising that trauma survivors have enormously impaired abilities to engage in a therapeutic relationship with a therapist to help resolve their difficulties.

As a result of their abusive backgrounds, many trauma survivors have extraordinary manifestations of resistance (Chu, 1988). Many of these patients use extensive repression and dissociation, which may make it difficult for the patient to consciously know, much less communicate, the nature of his or her difficulties. Moreover, these patients are understandably resistant to the necessary work of exploration and retrieval of very painful and intolerable experiences. The powerful resistances of trauma survivors lead them to engage with therapists in particular ways. Many such patients, who are often bright, articulate and creative, can be extremely persuasive in arguing for certain directions in treatment or in the gratification of certain needs. Although often correct in the assessment of their own felt needs, patients may lead therapists to ignore underlying resistances, vulnerabilities, errors in judgement, possible detrimental consequences, or even the therapist's own needs.

The second factor leading to treatment traps with trauma survivors has to do with therapists' contributions. The extreme pain of past experiences and the reservoir of overwhelming affect may, at times, be nearly as difficult for the therapist as for the patient. In addition, many patients have highly fragmented personality structures and poor ego

functioning, resulting in profound dependency and neediness. The need not to be alone, the need to know more about the therapist in order to feel secure, the need to be loved and cared about, are all too urgent and genuine. It is normative for therapists to want to deny, distance and withdraw on the one hand, and to want to gratify need, soothe, comfort and rescue patients on the other. Such feelings of the therapist, if unrecognized, make the therapist the unwitting partner in actions which often lack perspective and judgement, to the detriment of the patient, the therapist, and the treatment.

Treatment traps often occur with the combination of the patient's acute distress, the emerging of overwhelming past traumatic experiences, fierce resistances as the patient finds the treatment itself painful, and extreme difficulty in maintaining a therapeutic alliance. It is no wonder that therapists have difficulty in managing their own responses and reactions to patients in crisis, and repeatedly find themselves conflicted, confused, frustrated, intimidated, anxious, and frightened. Nonetheless, particularly early in treatment, when the patient most lacks overall perspective, it falls to the therapist to make informed decisions about treatment. Although the therapy could not (and should not) proceed without extensive input from patient, it remains the responsibility of the therapist to assess the needs of the patient, the wisdom of any particular course of action, the consequences of such action, the realities of the environment, and the limitations of therapy and the therapist. The discussion and clinical illustrations below are intended to give some framework to making such decisions. In all cases, the identity of patients and therapists have been disguised. Patients are referred to in the feminine gender, as the majority of these patients who present for treatment appear to be women.

TRAP #1: TRUST

The most common trap for therapists, particularly those unfamiliar with the treatment of trauma survivors, is the assumption of the presence of trust. It is crucial to recognize that patients who have backgrounds of abuse, neglect, and abandonment, often at the hands of their caretakers, do not know the meaning of trusting human relationships. In fact, the inability to establish and maintain healthy relationships based on mutuality is a primary disability of many such patients. Many discussions of treatment in the multiple personality disorder literature (often involving the treatment of patients who have been severely and extensively abused) make explicit the need for the establishment of trust (Braun, 1986; Wilbur, 1984). However, a reasonable level of trust often takes months or years to develop, and a normal level of trust usually exists only when the treatment nears its end. Throughout the therapy patients repeatedly test their therapists, and therapists find themselves trying to demonstrate, both verbally and behaviorally, that trust is possible. The problem is particularly painful given that not only does the patient not have any reasonable notion of trust, but fully expects betrayal of trust, and will look for any evidence of untrustworthiness on the part of the therapist. When a crisis inevitably occurs because the patient perceives

some reason, reality based or not, to mistrust the therapist, the therapist is required to have the patience to weather the storm rather than to make superhuman efforts to prove trustworthiness, or to withdraw in frustration. On the positive side, patients usually desperately wish to be able to trust, and are aware that others around them are capable of trusting and engaging with people in a way that they are not. However, this may also lead to their presenting a facade of trusting, and the development of trust must always be measured by the patient's actions as well as words.

Case Illustration. A young woman was progressing well in therapy over the first six months with her therapist, and had had a marked reduction in self-mutilating activity. This was largely accomplished by weekly contracts with her therapist not to hurt herself. Although she talked with her therapist, she did not allow her most angry and regressed sides to emerge. She was still vague, and perhaps secretive, about details of her background, only hinted about numerous episodes of childhood abuse. However, the patient was symptomatically better, appeared more comfortable at home and at work, and spoke optimistically about her future. Following a therapy session one week, the therapist realized that he had neglected to renew the weekly contract, but decided to take no action feeling that enough trust had been established to make contracting unnecessary. The patient, on the other hand, feeling certain that this oversight was a sign that her therapist was losing interest and soon planned to terminate with her, make a serious suicide attempt, resulting in hospitalization. The therapist became quite frustrated and angry, and talked to the hospital staff about the patient's "attention seeking behavior" and lack of motivation to improve.

TRAP #2: DISTANCE

In response to patients' resistance to trusting, therapists may respond by becoming distant. Certainly, in the face of overwhelming neediness and constant pleas for reassurance, therapists may understandably feel the urge to withdraw. Therapists who have been trained in the psychoanalytic tradition, where distance and passivity are deliberately used to encourage transference phenomena, may be particularly vulnerable to withdrawing. However, it is worth considering whether distance is appropriate for patients who have major problems in maintaining basic relationships. For patients who have been previously abandoned and traumatized, the distance may simply be a recapitulation of their previous experience of being left alone. Mays and Franks (1985), in a discussing negative outcomes in who they define as "high risk patients" (many of which share characteristics of trauma survivors), recommend matching such patients with "therapists who are able to sustain the highest levels of empathy, warmth, and genuineness (p. 294)." Chessick's (1982) "existential alliance" classification seems most appropriate for patients with traumatic histories, in which the therapist provides a real interpersonal sharing of the patient's experiences. In this sense, the therapist must be a participant as well as an observer in the therapeutic relation-

ship. It is very helpful for therapists to see the therapeutic relationship as a dynamic, interpersonal arena in which both parties participate, rather than seeing only the patient and the patient's behavior as determining the nature of the relationship. In clinical practice, during times of crisis within the relationship, very often what is required is for the therapist to move closer to the patient rather than to become more distant. This often has the effect of reducing or eliminating the crisis in the treatment. However, therapists often find themselves moving further away from what they see as inappropriate neediness and dependency on the part of their patients. This frequently results in harm to the patient, to the therapy, and flight from treatment.

Case Illustration. A woman in her forties had been in psychotherapy for the major part of her adult life. It was known she had a sexual abuse history, but this was unacknowledged in most of her therapies. Her current therapy consisted of once a week with a male therapist who worked in a very traditional manner. All attempts on the patient's part to get the therapist more involved in her treatment were met with an increasing sense of distance. The patient was quite chronically angry at her therapist but felt so dependent on him that she largely repressed her anger. Symptomatically she did not improve and continued to have bouts of anxiety, depression and rage, at times engaging in self-destructive behavior. She began to quarrel with the therapist over appointment times and telephone calls during the session. The therapist seemed to respond by becoming more erratic in scheduling appointment times and insisting on taking telephone calls during the session. Finally, towards the end of one meeting, the patient had the overwhelming sensation of being strangled by her father. She felt physically choked and panicked. As she struggled to let the therapist know what she was experiencing, the therapist got out of his chair, turned his back, and announced that the time was up. The patient left therapy shortly after this incident.

TRAP #3: BOUNDARIES

Children who are abused usually come from families which provide extremely inconsistent nurturing (Spiegel, 1986) and where family roles are grossly distorted (Herman, 1981). Interpersonal boundaries in the therapy are extremely important as the patient has little idea of what to expect from the therapist. For example, in the transference, a patient might expect even a warm and nurturing therapist to turn and strike her, or may constantly be on guard for a role reversal where the therapist looks to the patient for nurturing. It is this lack of trust and this not knowing what to expect that often leads patients to push interpersonal boundaries. The patient may feel strongly that to know more and participate more in the therapist's life will lead to more security and trust, and may attempt to convince or coerce the therapist into revealing personal details. Willingness to provide a certain amount of self-disclosure and reflection of feelings may be extremely helpful to some patients (Richert, 1983). However, boundaries are essential wherever they are placed. Therapists may choose where the boundaries are to

be placed, according to his or her style and comfort, but must recognize that they are essential to helping the patient maintain control and perspective. The self-perceived need for reassurance on the part of the patient is endless, and issues around trust will arise no matter where the boundaries are placed. The wise therapist realizes that it is stabilizing in the long run to be clear about boundaries, and for patients to realistically understand the nature of the relationship. Furthermore, therapists need to feel personally comfortable with boundaries that protect their privacy in order to function effectively as therapists.

Case Illustration. Over the course of several months a patient pushed her therapist to tell her more about the therapist's personal life so that she could feel more secure in the relationship. Repeatedly, the patient asked the therapist to tell her how the therapist managed her problems so that the patient could have a better grasp on how to manage hers. Over time, the patient became intimately acquainted with the details of the therapist's life, including her marital relationship. Although the therapist was increasingly uncomfortable with these intrusions into her personal life, she allowed them to continue, feeling strongly committed to showing her patient that she cared and could be trusted. She feared saying anything that would make the patient angry, and occasionally was also secretly gratified at the opportunity to talk about some of her own problems. However, when the patient began appearing at the therapist's home, the therapist informed her that she would not permit this, and would no longer discuss any matters pertaining to her personal life. The result was a stormy interchange in which the patient accused the therapist of abusing her by leading her to expect that she could be a part of the therapist's personal life. She questioned the therapist's ability to follow through with any of her promises, as well as the therapist's competence, commitment, and caring. Knowing a great deal about the therapist's personal life, the patient suggested that the therapist's marital relationship was unstable, and that the therapist was using her to gratify unmet needs. The therapist was immobilized with anger, anxiety and confusion.

TRAP #4: LIMITS

Closely related to the trap of failing to establish boundaries is the failure to set limits. Part of the treatment of many patients, and particularly traumatized patients with very dysfunctional behaviors, is to provide a containing environment. "Good enough holding" (Winnicott, 1965) often involves appropriate limits to contain dysfunctional behaviors. Although the treatment of these patients requires thoughtful flexibility, there is no need to endlessly gratify patients' demands. Not only does this allow potentially dangerous behaviors, but demonstrates to the patient that even excessive needs can be met, and that no change is necessary to meet the demands of reality. Too often therapists find themselves so identified with the patient's experience that they become immobilized along with the patient. Therapists may also be invested in providing corrective

emotional experiences for patients with a history of deprivation, and hence may fear replicating what patients see as depriving or abusive experiences. Even extreme efforts to meet patients' demands and to avoid patients' anger usually fail. All too often, therapists neglect their own needs and find themselves implicitly promising to meet needs they cannot fulfill. In the long run, limits are as important as flexibility to establish a safe therapeutic environment, and to make clear what is necessary to live in the real world.

Case Illustration. An experienced therapist, who prided himself on being able to meet even the extreme needs of his patients, became involved in the treatment of several patients with a history of sexual abuse. As a successful product of medical education and training, the therapist had taken on the belief that he should be able to respond at any hour, day or night, even at the cost of his sleep, health, mental stability, and family. He soon began to find himself awakened regularly at night, often being asked to engage in long discussions around the issue of suicide. He learned to dread the ring of the telephone and slept poorly, expecting to be awakened. The introduction of a new puppy into his household, and the responsibility of getting up at dawn's first light to walk the puppy, brought him to the brink of exhaustion. Violating his teachings not to talk to his patients about his own needs, the therapist told each of his patients that he retired early and that he expected each of them to respect his needs. Although he made it clear that he was available for serious emergencies, he also emphasized that he did not enjoy late night calls and would be much more capable of helping patients during office hours. After a stormy period of protest and rage on the part of his patients, evening and night calls decreased dramatically to only one or two calls every month. One of his patients later explored how she was acting out her anger by sadistically calling him repeatedly at home.

TRAP #5: RESPONSIBILITY

The initial contract for psychotherapy (either explicit or implied) between patient and therapist involves a mutual agreement to pursue treatment which might eventually result in a positive benefit to the patient. As the therapy proceeds, however, this situation often becomes less clear. The therapy itself is arduous for the patient, involving extending trust which appears to be an invitation to be hurt. It also involves the uncovering and reliving of traumatic experiences which at times is overwhelming and intolerable. As a result, patients may wish to flee, either through leaving therapy completely or even through suicide. At such times the locus of the responsibility for the treatment seems to shift from a mutually held responsibility to being the therapist's responsibility. Therapists often find themselves in the position of urging patients to stay in treatment, or trying to convince patients not kill themselves. To these kinds of interventions patients frequently respond with logical sounding and compelling reasons as to why they should leave treatment or suicide. These situations leave therapists in untenable therapeutic positions where they seem to have the

full responsibility of the patient's life and continued treatment. Moreover, in these kind of situations, the patient does not have to deal with her own ambivalence about the treatment. Since the therapist maintains the positive stance, the patient is actually more freed up to be more negative. Langs (1973) argues that even slight changes in the therapeutic contract are harmful to the therapy; in actual clinical practice, the therapeutic contract evolves along with the therapy, but certain basic tenets must remain. While therapists must empathize with the patient's experience of the difficulty of the therapy, they must also frequently clarify the nature of the therapy and the sharing of the responsibility for the work. Although it is sometimes the therapist's position of needing to be the one who maintains hope and to preserve the patient's safety, therapists must also understand the need to step back and allow their patients to assume their share of the responsibility for their treatment and well-being.

Case Illustration. About six months into the therapy of a young woman who had been brutally sexually abused as a child, the patient became very angry with her therapist at what she saw as an intrusive and unempathic remark. She fired her therapist who (probably correctly) insisted that she continue her therapy with him. She refused to come to appointments, at which point the therapist began calling her repeatedly at home and sometimes prior to her appointment times reminding her that she was to see him. The patient began angrily telling her therapist that she wanted to kill herself and that he could not prevent her. She convincingly argued that every day of her life involved great emotional pain, and if he really wanted to help that he would help her die. The therapist, who was feeling frustrated and confused, secretly wondered whether the patient was correct. He could easily see that the patient was leading a tortured existence, and wondered whether he should hospitalize her. Following consultation with a colleague, the therapist finally had a session with the patient in which he explored her choices about treatment. He explained that if necessary that he would take measures to keep her safe, but ultimately it was her choice whether or not to be in treatment with him, or even to be alive. He pointed out that it seemed that he was in the position of trying to persuade her to live, whereas the original agreement was to work on ways she could improve her life and not to kill herself. Following this discussion the patient appeared to be slightly calmer, and was able to talk about how trapped she felt in the relationship, which mirrored previous abusive relationships. The therapy continued on from that point.

TRAP #6: CONTROL

Patients with a traumatic past, including those with histories of severe childhood abuse, exhibit the biphasic response described by investigators of post-traumatic stress disorder (Horowitz, 1976). Van der Kolk (1987, p.3) describes this biphasic response as "intrusive responses [consisting of] hyperactivity, explosive aggressive outbursts, startle responses, intrusive recollections in the form of nightmares

and flashbacks, and reenactment of situations reminiscent of the trauma," alternating with the "numbing response consist[ing] of emotional constriction, social isolation, retreat from family obligations, anhedonia, and a sense of estrangement." In other words, many patients seem to alternately exist in either states of overwhelming loss of control or of attempting to maintain rigid control of themselves and their feelings, much like a light switch being turned on or off. It seems that having been in the position of being powerless in the face of abuse, and having been controlled by abusive figures, that these patients often attempt to take rigid control of their own lives and attempt to control events around them. However, given these patients' internal instability and their maladaptive self-reliance, this control is tenuous and frequently breaks down, resulting in periods of loss of control and inability to regain control, much to the frustration of their therapists. The knowledgeable therapist insists that some measure of control be let go in ways that can be productive, and does not accept long periods of the patient being sealed over as being inevitable. Similarly, therapists should not be in the position of tolerating endless flashbacks, and should make realistic demands for the patient to control these episodes. Often it later appears that the patient consciously or unconsciously arranges the circumstances to allow the flashbacks to continue, which relieves internal pressures for a time, but does not result in true abreaction or integration of the experiences. Although overcontrol and loss of control are inherent in the experience of traumatized patients, therapists need to push for increased ability to both let down control and to be in control, as a major goal of the treatment.

Case Illustration. Even following many months of treatment, a patient continued to have long periods during which she distanced herself from her therapist, punctuated by episodes where she was out of control for long periods, having flashbacks of past traumatic experiences and becoming extremely regressed. These episodes resulted in long sessions often lasting two hours or more in the therapist's office, or the therapist being called to the patient's home for episodes which often extended into the early hours of the morning. Often the episodes were without clear therapeutic value, as the flashbacks were far too much for the patient to integrate, and thus were merely re-repressed. It also appeared that the patient was extending the episodes, insisting on poor lighting, avoiding eye contact, and refusing to focus on the real and present environment. After discussing the situation with the patient, the therapist began insisting that the flashback experiences be stopped after a short period of time, and that the patient use techniques that would achieve some sense of control. The patient readily admitted that she avoided having abreactive experiences in general, but when flashbacks finally occurred, she prolonged them, feeling that this would enable her to go for another long period of time without such experiences.

TRAP #7: DENIAL

Denial is a core defense for patients with a history of

trauma. The need to believe that certain experiences did not occur, or that certain affects are not present, leads to the use of repression and dissociation. Collusion with patients' denial is a dangerous trap in treating traumatized patients. A long tradition of professional and social denial of the existence of child abuse and its long term sequelae (Goodwin, 1985; Masson, 1984) has encouraged such collusion, to the detriment of patients. Goodwin (1985), in discussing professional incredulity about multiple personality patients and child abuse, writes:

When professionals join the family in insisting that nothing happened, . . . dissociative defenses are strengthened. . . . We observe, in interactions with patients with multiple personality disorder and abused children and their families, a shared negative hallucination. . . . The multiple personality patient and the physician cling to the series of false symptoms and false diagnoses in proportion to their mutual need to blot out the reality of the multiplicity, and to blot out the unbearable experiences of real pain that triggered it (pp. 13-14).

Collusion in denying the often horrifying abusive backgrounds of traumatized patients makes it impossible to begin to address these experiences and eventually to neutralize them. Patients often convincingly argue that they have imagined stories about their pasts. Although this does occur (rarely), such statements must be reviewed skeptically since it is a good deal more common for patients to fabricate stories about good upbringings and uneventful childhoods, rather than to admit that their parents abused them (Goodwin, Sahd & Rada, 1979). Similarly, patients may acknowledge the history of trauma or abuse, but deny its significance (Chu, 1987). They may convincingly argue that they are aware of what happened to them and that they have worked such experiences through. However, the therapist must clearly examine whether the patient has affective understanding of the traumatic experiences and has thus worked them through, or whether the patient has only cognitive memories of the traumas and continues to be vulnerable to the re-emergence of the old affect. In any instance where the therapist colludes with denial on the part of the patient, there is likely to be a non-therapeutic, and perhaps dangerous, outcome.

Case Illustration. Early in the therapy of a patient with suspected multiple personality disorder, a therapist began hearing about vague memories of physical and sexual abuse in childhood. Angry and tearful personalities appeared and began relating details of the abuse which was reported to have been sadistic and persisted over years. The therapist listened sympathetically to the story, but retained a healthy degree of skepticism. He interviewed the patient's father, the alleged abuser and a respected minister in his town church, who emphatically denied any abuse, and informed the therapist that the patient was a liar even as a child. In a subsequent discussion with the patient, the patient stated that she had lied about the abuse to get attention from the therapist and had faked multiple personalities. She proceeded to talk about her father's good qualities as a minister

and parent, and was remorseful about maligning such an innocent person. The therapist, feeling vastly relieved of the burden of pursuing the issue of abuse any further, talked with the patient about the necessity of getting attention for positive actions rather than through false accusations. The patient was subsequently not prepared for a visit home to her father where she was attacked and raped, which was confirmed by medical examination.

TRAP #8: PROJECTION

The traumatized patient defends against intolerable experiences, conflicts, and affects by disavowing them. Through dissociation and personality fragmentation, these phenomena can be owned by different parts of the self, or can be projected onto the external environment. Although most extreme in the case of multiple personality disorder, the internal world of many traumatized patients is conflicted and fragmented. The resolution of internal conflicts involves the exploration of their genesis in childhood trauma and abuse, and it is far easier for the patient to see the external world as a projection of the internal fragmentation. Thus, the therapist becomes the object of many confusing transferences (Wilbur, 1984, 1986). He or she is alternately seen as nurturing, abusive, friendly, hostile, empathic, cold, etc. The patient's inability to confront what is seen as intolerable and unbearable frequently results in an inability to make progress in treatment, but it is the therapist who is blamed for not being enough, not knowing enough, or not doing enough. The experience of being regarded in so many different ways (sometimes even in the course of a single hour), and the patient's tendency to blame the therapist provokes a wide variety of feelings and responses in therapists. Therapists must avoid acting out their own feelings such as anger or sadism, and must understand and interpret the transference. Therapists must also avoid colluding with the resistance, since this will lead to both patient and therapist becoming immobilized and blaming the therapist. Hospitalization of these patients usually raises even more confusion, as various staff members may become the object of projections, with some staff being regarded as nurturing, good, and helpful, and other staff being seen as insensitive, rigid, and incompetent. Combined with the inevitable struggles over control, the tendency of these patients to project can make inpatient hospitalizations major battles rather than helpful experiences.

Case Illustration. During a period of patient's panic, her therapist made a comment which reflected some of the therapist's own experience, and which she felt the patient would see as comforting and empathic. To her surprise, the patient became furious and subsequently escalated to the point of requiring hospitalization. In the hospital, the patient began complaining that the staff was "on power trips" and attempting to control her. She claimed that certain staff members were inconsistent with one another, and that some staff members were hostile and abusive with her. The therapist met with the staff, who, in reality, were frustrated and angry at the patient and each other. She helped the staff

understand that they were reacting to the patient's view of them as projections of her own internal chaos and ambivalence, and suggested a structure of non-punitive symptom control and work around aftercare issues. She then met with the patient, urging her to explore reasons for hospitalization rather than becoming side-tracked in battles with the staff. After a number of supportive interpretations about the patient's need to see the external world in conflict rather than to deal with her own internal conflicts, the patient was able to talk about how much the therapist became too close with her empathic comments, and how such intimacy became enormously threatening and intrusive in view of past abusive experiences. She spoke of how it was easier to distance through anger, seeing the therapist as violating her privacy, rather than to deal with past experiences, which led her to remain isolated.

TRAP #9: IDEALIZATION

There are few therapists who are not gratified by their patients regarding them as sensitive, clever, knowledgeable, and superior in their abilities. The trap is believe that this represents the sum total of the patient's view of the therapist. As discussed in the trap of projection, the idealized transference is only one of the fragmented ways that the patient sees the therapist (Wilbur, 1984). The naive therapist can easily ignore the negative transferences, and can find himself or herself angry and confused when treated as a hostile abuser. An even more unfortunate scenario occurs when both patient and therapist unconsciously collude to avoid the negative transference, often leading to self-destructive activity, and not allowing for the resolution of the inevitable hostility and rage which result from abuse. Ambivalence about others, including the therapist, is a hallmark of traumatized patients; after all, such patients lack an integrated sense of themselves, and hence see others in a variety of fragmented and divergent ways. Therapists need to have a healthy sense of self-awareness as to who and what they are, in order to keep their heads in the shifting of transferences as presented by their patients. One particular form of idealized transference, the eroticized transference, is particularly difficult. The intense dependency of the patient is often reflected in the intensity of the eroticized feelings, and therapists must be aware of the underlying ambivalence in the relationship, as well as any resistances which are hidden behind sexualized or romantic feelings (Wilbur, 1984).

Case Illustration. A bright and articulate patient began in therapy by discussing the ignorance and rigidity of her previous therapist. To the therapist it did seem as though the previous therapist was not sensitive to the patient's needs, and he felt flattered by the comparison. As the therapy progressed, the patient complimented the therapist on his expert handling of various situations, leaving him enormously gratified. After several months of more or less harmonious work, the patient finally revealed that she was in love with her therapist, and felt that he was the only one who would ever be able to understand her and her needs. The therapist, who was unaware of concurrent negative transferences, felt quite

uncomfortable with this situation, viewing it as an unfortunate result of the patient's responding to his warm and appealing personality. He responded that he did not feel the same way about the patient, which resulted in the patient's becoming enraged and reorganizing the office furniture. She later called the therapist letting him know that she intended to kill herself since there was no hope of ever having the therapist the way she wanted. After consultation, the therapist began to explain transference to the patient, and to explore the full range of her feelings towards him. The angry and self-destructive behavior subsided somewhat, although the patient continued to feel "stupid" for having revealed her feelings to her therapist. On the other hand, the patient began to understand how her insecurities focused her needs and affections on her therapist.

TRAP #10: MOTIVATION

Given the extreme emotional pain that is often a part of the therapy of patients with abusive pasts, it often seems quite remarkable that patients can tolerate their own treatment. Certainly, the nature and amount of past abuse (and the corresponding level of disturbance) influence the eventual therapeutic outcome; in some instances, the psychological damage done by repeated and pervasive trauma is simply too much to repair. However, such factors as ego strength, ability to maintain even a conflicted relationship, and motivation play major roles in determining the outcome of treatment. The presence of ingrained severe character pathology, marked rigidity in coping mechanisms, or insufficient motivation suggests a poorer prognosis. Motivation is a complex phenomenon, and is certainly influenced by both the patient's internal characteristics and the external environment. For example, a history of personal failures leading to a strong belief of one's inability to change, the necessity for maintaining functional ability, or the need to maintain crucial relationships may all impact on the amount of motivation that the patient brings to the therapy. For most patients, motivation is assessed by actions and behaviors over time. Although it is usually difficult to assess progress over a few weeks or months, it is realistic to expect overall forward motion over several months. Verbalization is much less reliable than behavior. All patients verbalize ambivalence about the therapy. Some move on while others seem to have the conscious or unconscious goal of maintaining the status quo. Such "stuck" patients may verbalize a wish for progress but may actually only use the therapist as an ego resource for coping with reality. Therapists need to be aware that patients vary widely in their motivation and ability to improve, and it is prudent to set realistic goals. Not all patients are interested in resolving past events or in personality change and integration, and it is certainly acceptable to help a patient achieve some level of stability and more harmonious functioning and relationships.

Case Illustration. Following three years of individual psychotherapy with a competent and experienced therapist, a young woman seemed to be more stable. The therapy had consisted of individual psychotherapy up to three times a

week, and intermittent hospitalizations for suicidality, including one admission of over a year. Although the patient continued to verbalize that she wished to understand past traumatic events, she continued to resist dealing with her past in many different ways. Following confrontation about her resistance, the patient reluctantly admitted that she felt she couldn't tolerate the feelings which accompanied the discussion of old traumas. She felt that her ultimate goal was simply to find people to be sensitive to her needs and to take care of her. She expressed little or no interest in independent functioning. She was fearful of exploratory psychotherapy but felt compelled to say that she wanted to pursue it in order to please her therapist. She also feared that any progress she made would result in abandonment by the therapist. The therapist and patient agreed that they would limit the goals of treatment, and would have an on-going relationship based on supportive interventions to help the patient function better in her life. The therapist also felt that therapy with him, a man, might have been making the therapy more difficult and suggested that the patient add a women's support group. With these changes, the treatment appeared to proceed with fewer self-sabotaging activities and more obvious signs of progress.

CONCLUSION

Traps, binds, dilemmas, and conflicts in treatment are common in the psychotherapies of many conditions, but

seem to have an added drama in the intense relationship between therapist and trauma survivor. Patients who are trauma survivors present with a variety of resistances including reluctance to wrestle with the abusive experiences, the inability to adequately trust the therapist, and the inability to draw on memories. Therapists respond in a variety of ways based on their level of skill and experience, and on their countertransference and counterresistance. Experience and understanding do tend to reduce the anxiety inherent in these situations, but even experienced therapists find themselves in treatment traps, as they are an intrinsic part of the therapy of traumatized patients.

The case illustrations and discussions of treatment traps are self-explanatory. This paper is not intended to cover all treatment traps or to establish rules for what to do, or not to do, in any particular situation. Rather, the paper is designed to encourage therapists to be thoughtful in making decisions through understanding the dynamics of the treatment arena. Finding a balance in such issues as flexibility versus limits, acceptance versus confrontation, or even the patient's versus the therapist's needs, are all part of the skill, judgement, and art of psychotherapy. Finally, it is important to realize that the issues raised in this paper are core issues in the treatment itself, and how they are managed is a crucial part of the therapeutic process. Knowledge, understanding, patience and compassion on the part of the therapist will enhance the therapeutic process, and may make it more productive for the patient and therapist. ■

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