

TRAUMA
AND
RECOVERY

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A Healing Relationship

THE CORE EXPERIENCES of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections. Recovery can take place only within the context of relationships; it cannot occur in isolation. In her renewed connections with other people, the survivor re-creates the psychological faculties that were damaged or deformed by the traumatic experience. These faculties include the basic capacities for trust, autonomy, initiative, competence, identity, and intimacy.¹ Just as these capabilities are originally formed in relationships with other people, they must be reformed in such relationships.

The first principle of recovery is the empowerment of the survivor. She must be the author and arbiter of her own recovery. Others may offer advice, support, assistance, affection, and care, but not cure. Many benevolent and well-intentioned attempts to assist the survivor founder because this fundamental principle of empowerment is not observed. No intervention that takes power away from the survivor can possibly foster her recovery, no matter how much it appears to be in her immediate best interest. In the words of an incest survivor, "Good therapists were those who really validated my experience and helped me to control my behavior rather than trying to control me."²

Caregivers schooled in a medical model of treatment often have difficulty grasping this fundamental principle and putting it into practice. In exceptional circumstances, where the survivor has totally abdicated responsibility for her own self-care or threatens immediate harm to herself or to others, rapid intervention is required with or without her consent.

But even then, there is no need for unilateral action; the survivor should still be consulted about her wishes and offered as much choice as is compatible with the preservation of safety.

This principle of restoring control to the traumatized person has been widely recognized. Abram Kardiner defines the role of the therapist as that of an assistant to the patient, whose goal is to "help the patient complete the job that he is trying to do spontaneously" and to reinstate "the element of renewed control."³ Martin Symonds, working with hostages, describes the principles of treatment as restoring power to victims, reducing isolation, diminishing helplessness by increasing the victim's range of choice, and countering the dynamics of dominance in the approach to the victim.⁴ The community activists Evan Stark and Anne Flitcraft state as their therapeutic goal with battered women the restoration of autonomy and empowerment. They define autonomy as "a sense of separateness, flexibility, and self-possession sufficient to define one's self-interest . . . and make significant choices," while empowerment is "the convergence of mutual support with individual autonomy."⁵ From their perspective, the same woman who looks like a helpless and "deteriorated" patient in the traditional medical or mental health clinic may look and act like a "strong survivor" in a shelter environment where her experience is validated and her strengths are recognized and encouraged.

The relationship between survivor and therapist is one relationship among many. It is by no means the only or even the best relationship in which recovery is fostered. Traumatized people are often reluctant to ask for help of any kind, let alone psychotherapy. But many people who suffer from post-traumatic stress disorder do eventually seek help from the mental health system. For example, a national study of Vietnam veterans found that most combat veterans with a post-traumatic syndrome sought treatment for mental health problems at least once after their return from the war.⁶

The therapy relationship is unique in several respects. First, its sole purpose is to promote the recovery of the patient. In the furtherance of this goal, the therapist becomes the patient's ally, placing all the resources of her knowledge, skill, and experience at the patient's disposal. Second, the therapy relationship is unique because of the contract between patient and therapist regarding the use of power. The patient enters therapy in need of help and care. By virtue of this fact, she voluntarily submits herself to an unequal relationship in which the therapist has superior status and power. Feelings related to the universal childhood experience of dependence on a parent are inevitably aroused. These feelings, known

as transference, further exaggerate the power imbalance in the therapeutic relationship and render all patients vulnerable to exploitation. It is the therapist's responsibility to use the power that has been conferred upon her only to foster the recovery of the patient, resisting all temptations to abuse. This promise, which is central to the integrity of any therapeutic relationship, is of special importance to patients who are already suffering as the result of another's arbitrary and exploitative exercise of power.

In entering the treatment relationship, the therapist promises to respect the patient's autonomy by remaining disinterested and neutral. "Disinterested" means that the therapist abstains from using her power over the patient to gratify her personal needs. "Neutral" means that the therapist does not take sides in the patient's inner conflicts or try to direct the patient's life decisions. Constantly reminding herself that the patient is in charge of her own life, the therapist refrains from advancing a personal agenda. The disinterested and neutral stance is an ideal to be striven for, never perfectly attained.

The technical neutrality of the therapist is not the same as moral neutrality. Working with victimized people requires a committed moral stance. The therapist is called upon to bear witness to a crime. She must affirm a position of solidarity with the victim. This does not mean a simplistic notion that the victim can do no wrong; rather, it involves an understanding of the fundamental injustice of the traumatic experience and the need for a resolution that restores some sense of justice. This affirmation expresses itself in the therapist's daily practice, in her language, and above all in her moral commitment to truth-telling without evasion or disguise. Yael Danieli, a psychologist who works with survivors of the Nazi Holocaust, assumes this moral stance even in the routine process of taking a family history. When survivors speak of their relatives who "died," she affirms that they were, rather, "murdered": "Therapists and researchers who work with members of survivors' families encounter individuals whom the Holocaust deprived of the normal cycle of the generations and ages. The Holocaust also robbed them, and still does, of natural, individual death . . . and thus, of normal mourning. The use of the word 'death' to describe the fate of the survivors' relatives, friends, and communities appears to be a defense against acknowledging murder as possibly the most crucial reality of the Holocaust."⁷

The therapist's role is both intellectual and relational, fostering both insight and empathic connection. Kardiner notes that "the central part of the therapy should always be to enlighten the patient" as to the nature and meaning of his symptoms, but at the same time "the attitude of the

physician in treating these cases is that of the protecting parent. He must help the patient reclaim his grip on the outer world, which can never be done by a perfunctory, pill-dispensing attitude."⁸ The psychoanalyst Otto Kernberg makes similar observations on the treatment of patients with borderline personality disorder: "The therapist's empathic attitude, derived from his emotional understanding of himself and from his transitory identification with and concern for the patient, has elements in common with the empathy of the 'good-enough mother' with her infant. . . . There is, however, also a totally rational, cognitive, almost ascetic aspect to the therapist's work with the patient which gives their relation a completely different quality."⁹

The alliance of therapy cannot be taken for granted; it must be painstakingly built by the effort of both patient and therapist. Therapy requires a collaborative working relationship in which both partners act on the basis of their implicit confidence in the value and efficacy of persuasion rather than coercion, ideas rather force, mutuality rather than authoritarian control. These are precisely the beliefs that have been shattered by the traumatic experience. Trauma damages the patient's ability to enter into a trusting relationship; it also has an indirect but powerful impact on the therapist. As a result, both patient and therapist will have predictable difficulties coming to a working alliance. These difficulties must be understood and anticipated from the outset.

TRAUMATIC TRANSFERENCE

Patients who suffer from a traumatic syndrome form a characteristic type of transference in the therapy relationship. Their emotional responses to any person in a position of authority have been deformed by the experience of terror. For this reason, traumatic transference reactions have an intense, life-or-death quality unparalleled in ordinary therapeutic experience. In Kernberg's words, "It is as if the patient's life depends on keeping the therapist under control."¹⁰ Some of the most astute observations on the vicissitudes of traumatic transference appear in the classic accounts of the treatment of borderline personality disorder, written when the traumatic origin of the disorder was not yet known. In these accounts, a destructive force appears to intrude repeatedly into the relationship between therapist and patient. This force, which was traditionally attributed to the patient's innate aggression, can now be recognized as the violence of the perpetrator. The psychiatrist Eric Lister remarks that the

transference in traumatized patients does not reflect a simple dyadic relationship, but rather a triad: "The terror is as though the patient and therapist convene in the presence of yet another person. The third image is the victimizer, who . . . demanded silence and whose command is now being broken."¹¹

The traumatic transference reflects not only the experience of terror but also the experience of helplessness. At the moment of trauma the victim is utterly helpless. Unable to defend herself, she cries for help, but no one comes to her aid. She feels totally abandoned. The memory of this experience pervades all subsequent relationships. The greater the patient's emotional conviction of helplessness and abandonment, the more desperately she feels the need for an omnipotent rescuer. Often she casts the therapist in this role. She may develop intensely idealized expectations of the therapist. The idealization of the therapist protects the patient, in fantasy, against reliving the terror of the trauma. In one successful case both patient and therapist came to understand the terror at the source of the patient's demand for rescue: "The therapist remarked, 'It's frightening to need someone so much and not be able to control them.' The patient was moved and continued this thought: 'It's frightening because you can kill me with what you say . . . or by not caring or [by] leaving.' The therapist then added, 'We can see why you need me to be perfect.'"¹²

When the therapist fails to live up to these idealized expectations—as she inevitably will fail—the patient is often overcome with fury. Because the patient feels as though her life depends upon her rescuer, she cannot afford to be tolerant; there is no room for human error. The traumatized person's helpless, desperate rage at a rescuer who lapses even momentarily from her role is illustrated in the case of the Vietnam veteran Tim O'Brien, who describes how he felt after being wounded in battle:

The need for revenge kept eating at me. At night I sometimes drank too much. I'd remember getting shot and yelling out for a medic and then waiting and waiting and waiting, passing out once, then waking up and screaming some more, and how the screaming seemed to make new pain, the awful stink of myself, the sweat and fear, Bobby Jorgenson's clumsy fingers when he finally got around to working on me. I kept going over it all, every detail. . . . I wanted to yell "You jerk, it's shock—I'm dying," but all I could do was whinny and squeal. I remembered that, and the hospital, and the nurses. I even remembered the rage. But I couldn't feel it any more. In the end, all I felt was that coldness down inside my chest. Number one: the guy had almost killed me. Number two: there had to be consequences.¹³

This testimony reveals not only the helpless rage of the victim in terror of death but also the displacement of his rage from perpetrator to caregiver. He feels that the medic, not the enemy, almost killed him. Further compounding his fury is his sense of humiliation and shame. Though he desperately needs the rescuer's help, he is mortified to be seen in his defiled physical condition. As his wounds heal in the hospital, he broods on a plan of revenge, not against the enemy, but against the inept rescuer. Many traumatized people feel similar rage at the caregivers who try to help them and harbor similar fantasies of revenge. In these fantasies they wish to reduce the disappointing, envied therapist to the same unbearable condition of terror, helplessness, and shame that they themselves have suffered.

Though the traumatized patient feels a desperate need to rely on the integrity and competence of the therapist, she cannot do so, for her capacity to trust has been damaged by the traumatic experience. Whereas in other therapeutic relationships some degree of trust may be presumed from the outset, this presumption is never warranted in the treatment of traumatized patients.¹⁴ The patient enters the therapeutic relationship prey to every sort of doubt and suspicion. She generally assumes that the therapist is either unable or unwilling to help. Until proven otherwise, she assumes that the therapist cannot bear to hear the true story of the trauma. Combat veterans will not form a trusting relationship until they are convinced that the therapist can stand to hear the details of the war story.¹⁵ Rape survivors, hostages, political prisoners, battered women, and Holocaust survivors feel a similar mistrust of the therapist's ability to listen. In the words of one incest survivor, "These therapists sound like they have all the answers, but they back away from the real shitty stuff."

At the same time, however, the patient mistrusts the motives of any therapist who does not back away. She may attribute to the therapist many of the same motives as the perpetrator. She often suspects the therapist of exploitative or voyeuristic intentions.¹⁶ Where the trauma has been repeated and prolonged, the patient's expectations of perverse or malevolent intent can prove especially resistant to change. Patients who have been subjected to chronic trauma and therefore suffer from a complex post-traumatic syndrome also have complex transference reactions. The protracted involvement with the perpetrator has altered the patient's relational style, so that she not only fears repeated victimization but also seems unable to protect herself from it, or even appears to invite it. The dynamics of dominance and submission are reenacted in all subsequent relationships, including the therapy.

Chronically traumatized patients have an exquisite attunement to unconscious and nonverbal communication. Accustomed over a long time to reading their captors' emotional and cognitive states, survivors bring this ability into the therapy relationship. Kernberg notes the borderline patient's "uncanny" ability to read the therapist and respond to the therapist's vulnerability.¹⁷ Emmanuel Tanay notes the "sensitivity and intense perceptiveness" of survivors of the Nazi Holocaust, adding that "fluctuations in attention of the therapist are picked up by these patients with readiness and pathological hypersensitivity."¹⁸

The patient scrutinizes the therapist's every word and gesture, in an attempt to protect herself from the hostile reactions she expects. Because she has no confidence in the therapist's benign intentions, she persistently misinterprets the therapist's motives and reactions. The therapist may eventually react to these hostile attributions in unaccustomed ways. Drawn into the dynamics of dominance and submission, the therapist may inadvertently reenact aspects of the abusive relationship. This dynamic, which has been most extensively studied in borderline patients, has been attributed to the patient's defensive style of "projective identification." Once again the perpetrator plays a shadow role in this type of interaction. When the original trauma is known, the therapist may find an uncanny similarity between the original trauma and its reenactment in therapy. Frank Putnam describes one such instance in a patient with multiple personality disorder: "As a child the patient had been repeatedly tied up and forced to perform fellatio on her father. During her last hospitalization, she became severely suicidal and anorexic. The staff members tried to feed her through a naso-gastric tube, but she kept pulling it out. Consequently, they felt compelled to place her in four-way restraints. The patient was now tied to her bed and having a tube forced down her throat all in the name of saving her life. Once the similarity of these 'therapeutic' interventions to her earlier abuse was pointed out to all parties, it became possible to discontinue the forced feedings."¹⁹

The reenactment of the relationship with the perpetrator is most evident in the sexualized transference that sometimes emerges in survivors of prolonged childhood sexual abuse. The patient may assume that the only value she can possibly have in the eyes of another, especially in the eyes of a powerful person, is as a sexual object. Here, for example, a therapist describes the final session of a long and successful treatment of an incest survivor who had been diagnosed with borderline personality disorder: "She now felt like a grown-up daughter; still, if she did not have intercourse with me, perhaps it was because she was not sexy enough. In

the final session, she wondered if I could know how much she appreciated the therapy if she did nothing except thank me verbally. At the door, she realized that perhaps thanking me was sufficient. It was 7 years after our first meeting.²⁰

Patients may be quite direct about their desire for a sexual relationship. A few patients may actually demand such a relationship as the only convincing proof of the therapist's caring. At the same time, even these patients dread a reenactment of the sexual relationship in therapy; such a reenactment simply confirms the patient's belief that all human relationships are corrupt.

The patient with multiple personality disorder represents the extreme in the complications of traumatic transference. The transference may be highly fragmented, with different components carried by different alters. Putnam suggests that therapists working with these patients prepare for intensely hostile and sexualized transferences as a matter of routine.²¹ Even in patients who lack such extreme dissociative capacities, the transference may be disorganized and fragmented, subject to the frequent oscillations that are the hallmark of the traumatic syndromes. The emotional vicissitudes of the recovery relationship are therefore bound to be unpredictable and confusing for patient and therapist alike.

TRAUMATIC COUNTERTRANSFERENCE

Trauma is contagious. In the role of witness to disaster or atrocity, the therapist at times is emotionally overwhelmed. She experiences, to a lesser degree, the same terror, rage, and despair as the patient. This phenomenon is known as "traumatic countertransference" or "vicarious traumatization."²² The therapist may begin to experience symptoms of post-traumatic stress disorder. Hearing the patient's trauma story is bound to revive any personal traumatic experiences that the therapist may have suffered in the past. She may also notice imagery associated with the patient's story intruding into her own waking fantasies or dreams. In one case a therapist began to have the same grotesque nightmares as her patient, Arthur, a 35-year-old man who had been sadistically abused in childhood by his father:

Arthur told his therapist that he still feared his father, even though he had been dead for ten years. He felt that his father was watching him and could control him from beyond the grave. He believed that the only way to

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overcome his father's demonic power was to unearth his body and drive a stake through his heart. The therapist began to have vivid nightmares of Arthur's father entering her room in the form of a rotting, disintegrated body.

Engagement in this work thus poses some risk to the therapist's own psychological health. The therapist's adverse reactions, unless understood and contained, also predictably lead to disruptions in the therapeutic alliance with patients and to conflict with professional colleagues. Therapists who work with traumatized people require an ongoing support system to deal with these intense reactions. Just as no survivor can recover alone, no therapist can work with trauma alone.

Traumatic countertransference includes the entire range of the therapist's emotional reactions to the survivor and to the traumatic event itself. Among therapists working with survivors of the Nazi Holocaust, Danieli observes an almost impersonal uniformity of emotional responses. She suggests that the Holocaust itself, rather than the individual personalities of therapists or patients, is the primary source of these reactions.²³ This interpretation recognizes the shadow presence of the perpetrator in the relationship between patient and therapist and traces the countertransference, like the transference, to its original source outside of a simple dyadic relationship.

In addition to suffering vicarious symptoms of post-traumatic stress disorder, the therapist has to struggle with the same disruptions in relationship as the patient. Repeated exposure to stories of human rapacity and cruelty inevitably challenges the therapist's basic faith. It also heightens her sense of personal vulnerability. She may become more fearful of other people in general and more distrustful even in close relationships. She may find herself becoming increasingly cynical about the motives of others and pessimistic about the human condition.²⁴

The therapist also empathically shares the patient's experience of helplessness. This may lead the therapist to underestimate the value of her own knowledge and skill, or to lose sight of the patient's strengths and resources. Under the sway of countertransference helplessness, the therapist may also lose confidence in the power of the psychotherapy relationship. It is not uncommon for experienced therapists to feel suddenly incompetent and hopeless in the face of a traumatized patient. Putnam describes experienced therapists as feeling intimidated and "deskilled" when they encounter a patient with multiple personality disorder.²⁵ Similar feelings arise among those who work with survivors of extreme

political violence and repression.²⁶ The case of Irene, a victim of sexual terrorism, illustrates a temporary therapeutic stalemate occasioned by the therapist's loss of confidence:

Irene, a 25-year-old woman, came into treatment complaining of a post-traumatic syndrome with prominent hyperarousal, intrusive symptoms, and severe constriction. Previously sociable, she had withdrawn from most activities and was virtually a prisoner in her home. A year previously she had fought off a rape attempt on a date; since that time the perpetrator had harassed her with obscene, threatening, late-night phone calls. He also stalked her and kept her house under surveillance, and she suspected that he had killed her cat. She had gone to the police once but felt they had no interest in her problem since "nothing had really happened."

The therapist identified with Irene's frustration and helplessness. Doubting that psychotherapy had anything to offer, he found himself offering practical advice instead. Irene despondently rejected all of his suggestions, just as she had rejected suggestions from friends, family, and the police. She felt sure that the perpetrator would defeat anything she tried. Therapy was not helping either; her symptoms worsened, and she began to report thoughts of suicide.

Reviewing the case in supervision, the therapist realized that he, like Irene, had been overwhelmed with a feeling of helplessness. Consequently, he had lost confidence in the utility of listening, his basic skill. In the next session, he asked whether Irene had ever told anyone the whole story of what happened to her. Irene said that no one wanted to hear about it; people just wanted her to shape up and get back to normal. The therapist remarked that Irene must feel really alone, and wondered if she felt that she could not confide in him either. Irene burst into tears. She had indeed felt that the therapist did not want to listen.

In subsequent sessions, as Irene told her story, her symptoms gradually abated. She began to take more action to protect herself, mobilizing her friends and family, and finding more effective ways to get help from the police. Though she reviewed her new strategies with her therapist, she developed them primarily on her own initiative.

As a defense against the unbearable feeling of helplessness, the therapist may try to assume the role of a rescuer. The therapist may take on more and more of an advocacy role for the patient. By so doing, she implies that the patient is not capable of acting for herself. The more the therapist accepts the idea that the patient is helpless, the more she perpetuates the traumatic transference and disempowers the patient.

Many seasoned and experienced therapists, who are ordinarily scrupulously observant of the limits of the therapy relationship, find themselves violating the bounds of therapy and assuming the role of a rescuer, under

the intense pressures of traumatic transference and countertransference. The therapist may feel obliged to extend the limits of therapy sessions or to allow frequent emergency contacts between sessions. She may find herself answering phone calls late at night, on weekends, or even on vacations. Rarely do these extraordinary measures result in improvement; on the contrary, the more helpless, dependent, and incompetent the patient feels, generally the worse her symptoms become.

Carried to its logical extreme, the therapist's defense against feelings of helplessness leads to a stance of grandiose specialness or omnipotence. Unless this tendency is analyzed and controlled, the potential for corrupting the therapy relationship is great. All sorts of extreme boundary violations, up to and including sexual intimacy, are frequently rationalized on the basis of the patient's desperate need for rescue and the therapist's extraordinary gifts as a rescuer. Henry Krystal, who works with survivors of the Nazi Holocaust, observes that the therapist's "impulse to play God is as ubiquitous as it is pathogenic."²⁷ The psychoanalysts John Maltsberger and Dan Buie sound a similar warning: "The three most common narcissistic snares are the aspirations to heal all, know all, and love all. Since such gifts are no more accessible to the contemporary psychotherapist than they were to Faust, unless such trends are worked out . . . [the therapist] will be subjected to a sense of Faustian helplessness and discouragement, and tempted to solve his dilemma by resort to magical and destructive action."²⁸

In addition to identifying with the victim's helplessness, the therapist identifies with the victim's rage. The therapist may experience the extremes of anger, from inarticulate fury through the intermediate ranges of frustration and irritability to abstract, righteous indignation. This anger may be directed not only at the perpetrator but also at bystanders who failed to intercede, at colleagues who fail to understand, and generally at the larger society. Through empathic identification, the therapist may also become aware of the depths of the patient's rage and may become fearful of the patient. Once again, this countertransference reaction, if unanalyzed, can lead to actions that disempower the patient. At one extreme, the therapist may preempt the patient's anger with her own, or at the other extreme, she may become too deferential toward the patient's anger. The case of Kelly, a survivor of childhood abuse, illustrates the error of adopting a placating stance toward the patient:

Kelly, a 40-year-old woman with a long history of stormy relationships and unsuccessful psychotherapy, began a new therapy relationship with a man

of "getting out my anger." She persuaded her therapist that only unconditional acceptance of her anger could help her to develop trust. In session after session, Kelly berated her therapist, who felt intimidated and unable to set limits. Instead of developing trust, Kelly came to see the therapist as inept and incompetent. She complained that the therapist was just like her mother, who had helplessly tolerated her father's violence in the family.

The therapist also identifies with the patient through the experience of profound grief. The therapist may feel as though she herself is in mourning. Leonard Shengold refers to the "via dolorosa" of psychotherapy with survivors.²⁹ Therapists working with survivors of the Nazi Holocaust report being "engulfed by anguish" or "sinking into despair."³⁰ Unless the therapist has adequate support to bear this grief, she will not be able to fulfill her promise to bear witness and will withdraw emotionally from the therapeutic alliance. The psychiatrist Richard Mollica describes how the staff of his Indochinese Refugee Clinic nearly succumbed to the patients' despair: "During the first year, the major task of treatment was to cope with the hopelessness of our patients. We learned that the hopeless feelings were extremely contagious." The situation improved as the staff realized that they were becoming overwhelmed by their patients' stories: "As our own experience deepened, a natural sense of humor and affection began to develop between ourselves and our patients. The funereal atmosphere was finally broken—not only after we witnessed that some of our patients had improved, but also after the staff recognized that many of our patients were infecting us with their hopelessness."³¹

Emotional identification with the experience of the victim does not exhaust the range of the therapist's traumatic countertransference. In her role as witness, the therapist is caught in a conflict between victim and perpetrator. She comes to identify not only with the feelings of the victim but also with those of the perpetrator. While the emotions of identification with the victim may be extremely painful for the therapist, those of identification with the perpetrator may be more horrifying to her, for they represent a profound challenge to her identity as a caring person. Sarah Haley, a social worker, describes her work with combat veterans: "The first task of treatment is for the therapist to confront his/her own sadistic feelings, not only in response to the patient, but in terms of his/her own potential as well. The therapist must be able to envision the possibility that under extreme physical and psychic stress, or in an atmosphere of overt license and encouragement, he/she, too, might very well murder."³²

Identification with the perpetrator may take many forms. The therapist

may find herself becoming highly skeptical of the patient's story, or she may begin to minimize or rationalize the abuse. The therapist may feel revulsion and disgust at the patient's behavior, or she may become extremely judgmental and censorious when the patient fails to live up to some idealized notion of how a "good" victim ought to behave. She may begin to feel contempt for the patient's helplessness or paranoid fear of the patient's vindictive rage. She may have moments of frank hate and wish to be rid of the patient. Finally, the therapist may experience voyeuristic excitement, fascination, and even sexual arousal. Sexualized countertransference is a common experience, particularly for male therapists working with female patients who have been subjected to sexual violence.³³ Krystal observes that the encounter with the traumatized patient forces therapists to come to terms with their own capacity for evil: "What we cannot own up to, we may have to reject in others. Thus, the friendly, compassionate attitude which one regards as most helpful may be replaced by anger, disgust, scorn, pity, or shame. The examiner who acts out his anger . . . is displaying a symptom of his own difficulty, as is the one who suffers from depression, or who has the need to overindulge or seduce the patient. What I have said is of course well known, but we must be especially alert to this problem in dealing with massively traumatized individuals . . . because of the extraordinary impact of their life stories."³⁴

Finally, the therapist's emotional reactions include not only those identified with victim and perpetrator but also those exclusive to the role of the unharmed bystander. The most profound and universal of these reactions is a form of "witness guilt," similar to the patient's "survivor guilt." In therapists who treat survivors of the Nazi Holocaust, for example, guilt is the most common countertransference reaction.³⁵ The therapist may simply feel guilty for the fact that she was spared the suffering that the patient had to endure. In consequence, she may have difficulty enjoying the ordinary comforts and pleasures of her own life. Additionally, she may feel that her own actions are faulty or inadequate. She may judge herself harshly for insufficient therapeutic zeal or social commitment and come to feel that only a limitless dedication can compensate for her shortcomings.

If the therapist's bystander guilt is not properly understood and contained, she runs the risk of ignoring her own legitimate interests. In the therapy relationship she may assume too much personal responsibility for the patient's life, thus once again patronizing and disempowering the patient. In her work environment she may similarly take on excessive responsibility, with the attendant risk of eventual burnout.

The therapist may also feel guilty for causing the patient to reexperience the pain of the trauma in the course of treatment. The psychiatrist Eugene Bliss describes treating patients with multiple personality disorder as being "like performing surgery without general anesthesia."³⁶ As a result, the therapist may shy away from exploring the trauma, even when the patient is ready to do this.

Additional complications of countertransference are to be expected with patients who have a complex post-traumatic syndrome. Especially with survivors of prolonged, repeated abuse in childhood, the therapist may initially respond more to the damaged relational style of the survivor than to the trauma itself. Indeed, the origin of the patient's disturbance in a history of childhood abuse may be lost to the patient's awareness, and all too commonly it is lost to the therapist's awareness as well. Again, the traditional literature on borderline personality disorder contains some of the most subtle analyses of this complex countertransference.

The patient's symptoms simultaneously call attention to the existence of an unspeakable secret and deflect attention from that secret. The first apprehension that there may be a traumatic history often comes from the therapist's countertransference reactions. The therapist experiences the inner confusion of the abused child in relation to the patient's symptoms. The rapid fluctuations in the patient's cognitive state may leave the therapist with a sense of unreality. Jean Goodwin describes a countertransference feeling of "existential panic" when working with survivors of severe early childhood abuse.³⁷ Therapists often report uncanny, grotesque, or bizarre imagery, dreams, or fantasies while working with such patients. They may themselves have unaccustomed dissociative experiences, including not only numbing and perceptual distortions but also depersonalization, derealization, and passive influence experiences. At times, the therapist may dissociate in concert with the patient, as in the case of Trisha, a 16-year-old runaway with a suspected but undisclosed history of extensive childhood abuse:

In her first session with Trisha, the therapist suddenly had the sensation of floating out of her body. She felt as though she were looking down at herself and Trisha from a point on the ceiling. She had never had this feeling before. She surreptitiously dug her fingernails into her palms and pressed her feet against the floor in order to feel "grounded."

The therapist may also feel completely bewildered by the rapid fluctuations in the patient's moods or style of relating. The psychoanalyst Harold Searles notes that the therapist may have strange and incongruous

combinations of emotional responses to the patient and may be burdened with a feeling of constant suspense.³⁸ This suspense actually reflects the victim's constant state of dread in relation to the capricious, unpredictable perpetrator. Reenactment of the dynamics of victim and perpetrator in the therapy relationship can become extremely complicated. Sometimes the therapist ends up feeling like the patient's victim. Therapists often complain of feeling threatened, manipulated, exploited, or duped. One therapist, faced with his patient's unremitting suicidal threats, described feeling "like having a loaded gun at my head."³⁹

According to Kernberg, the therapist's task is to "identify the actors" in the borderline patient's inner world, using countertransference as a guide to understanding the patient's experience. Representative pairs of actors that might figure in the patient's inner life include the "destructive, bad infant" and the "punitive, sadistic parent," the "unwanted child" and the "uncaring, self-involved parent," the "defective, worthless child" and the "contemptuous parent," the "abused victim" and the "sadistic attacker, and the "sexually assaulted prey" and the "rapist."⁴⁰ Though Kernberg understands these "actors" as distorted, fantasied representations of the patient's experience, more likely they accurately reflect the early relational environment of the traumatized child. Rapid, confusing oscillations in the therapist's countertransference mirror those of the patient's transference; both reflect the impact of the traumatic experience.

Traumatic transference and countertransference reactions are inevitable. Inevitably, too, these reactions interfere with the development of a good working relationship. Certain protections are required for the safety of both participants. The two most important guarantees of safety are the goals, rules, and boundaries of the therapy contract and the support system of the therapist.

THE THERAPY CONTRACT

The alliance between patient and therapist develops through shared work. The work of therapy is both a labor of love and a collaborative commitment. Though the therapeutic alliance partakes of the customs of everyday contractual negotiations, it is not a simple business arrangement. And though it evokes all the passions of human attachment, it is not a love affair or a parent-child relationship. It is a relationship of existential engagement, in which both partners commit themselves to the task of recovery.

This commitment takes the form of a therapy contract. The terms of this contract are those required to promote a working alliance. Both parties are responsible for the relationship. Some of the tasks are the same for both patient and therapist, such as keeping appointments faithfully. Some tasks are different and complementary: the therapist contributes knowledge and skill, while the patient pays a fee for treatment; the therapist promises confidentiality, while the patient agrees to self-disclosure; the therapist promises to listen and bear witness, while the patient promises to tell the truth. The therapy contract should be explained to the patient explicitly and in detail.

From the outset, the therapist should place great emphasis on the importance of truth-telling and full disclosure, since the patient is likely to have many secrets, including secrets from herself. The therapist should make clear that the truth is a goal constantly to be striven for, and that while difficult to achieve at first, it will be attained more fully in the course of time. Patients are often very clear about the fundamental importance of a commitment to telling the truth. To facilitate therapy, one survivor advises therapists: "Make the truth known. Don't participate in the cover-up. When they get that clear don't let them sit down. It's like being a good coach. Push them to run and then run their best time. It's OK to relax at appropriate times but it's always good to let people see what their potential is."⁴¹

In addition to the fundamental rule of truth-telling, it is important to emphasize the cooperative nature of the work. The psychologist Jessica Wolfe describes the therapeutic contract that she works out with combat veterans: "It's clearly spelled out as a partnership, so as to avoid any repetition of the loss of control in the trauma. We [therapists] are people who know something about it, but really they know much more, and it's a sharing arrangement. In some of the things we might be recommending we would be serving as a guide." Terence Keane adds his own metaphor for the ground rules and goals of the therapy relationship: "I felt like a coach when I started out. That's because I played basketball, and I just felt it: I was the coach and this was a game, and this is how you play the game, and this is the way to go, and the object is to win. I don't say that to patients, but that's how it feels to me."⁴²

The patient enters the therapy relationship with severe damage to her capacity for appropriate trust. Since trust is not present at the outset of treatment, both therapist and patient should be prepared for repeated testing, disruption, and rebuilding of the therapeutic relationship. As the patient becomes involved, she inevitably reexperiences the intense long-

ing for rescue that she felt at the time of the trauma. The therapist may also wish, consciously or unconsciously, to compensate for the atrocious experiences the patient has endured. Impossible expectations are inevitably aroused, and inevitably disappointed. The rageful struggles that follow upon disappointment may replicate the initial, abusive situation, compounding the original harm.⁴³

Careful attention to the boundaries of the therapeutic relationship provides the best protection against excessive, unmanageable transference and countertransference reactions.⁴⁴ Secure boundaries create a safe arena where the work of recovery can proceed. The therapist agrees to be available to the patient within limits that are clear, reasonable, and tolerable for both. The boundaries of therapy exist for the benefit and protection of both parties and are based upon a recognition of both the therapist's and the patient's legitimate needs. These boundaries include an explicit understanding that the therapy contract precludes any other form of social relationship, a clear definition of the frequency and duration of therapy sessions, and clear ground rules regarding emergency contact outside of regularly scheduled sessions.

Decisions on limits are made based upon whether they empower the patient and foster a good working relationship, not on whether the patient ought to be indulged or frustrated. The therapist does not insist upon clear boundaries in order to control, ration, or deprive the patient. Rather, the therapist acknowledges from the outset that she is a limited, fallible human being, who requires certain conditions in order to remain engaged in an emotionally demanding relationship. As Patricia Ziegler, a therapist with long experience working with traumatized patients, puts it: "Patients have to agree not to drive me crazy. I tell them I'm sensitive to abandonment too—it's the human condition. I say I'm invested in this treatment and I won't leave you and I don't want you to leave me. I tell them they owe me the respect not to scare the daylight out of me."⁴⁵

In spite of the therapist's best efforts to define clear boundaries, the patient can be expected to find areas of ambiguity. Therapists usually discover that some degree of flexibility is also necessary; mutually acceptable boundaries are not created by fiat but rather result from a process of negotiation and may evolve to some degree over time. A patient describes her view of the process: "My psychiatrist has what he calls 'rules,' which I have defined as 'moving targets.' The boundaries he has set between us seem flexible, and I often try to bend and stretch them. Sometimes he struggles with these boundaries, trying to balance his rules against his respect for me as a human being. As I watch him struggle, I

learn how to struggle with my own boundaries, not just the ones between him and me, but those between me and everyone I deal with in the real world."⁴⁶

Some departure from the ordinary strict ground rules of psychotherapy is common in practice and may at times be very helpful.⁴⁷ In the case of Lester, a 32-year-old man with a history of severe childhood abuse and neglect, a symbolic boundary violation enhanced his ability to care for himself and deepened the therapy relationship:

Lester brought a camera to a therapy session and asked to take his therapist's picture. The therapist felt put on the spot. Though she could not think of a reason to refuse Lester's request, she had an irrational feeling of being controlled and invaded, as though the camera was going to "take her soul." She agreed to allow the picture, on condition that Lester would agree to talk about what it meant to him.

Over the next few months, the picture became the focus for a deepening understanding of the transference. Lester did indeed wish to control and intrude upon the therapist, in order to defend against his terror of abandonment. Having the picture in his possession allowed him to do this in fantasy without actually intruding on the therapist's life. He often used the picture as a reminder of the relationship to calm himself in the therapist's absence.

In this instance, the therapist's decision to permit the photograph was based upon an empathic understanding of its importance to the patient as a "transitional object." The object served the same function with this adult patient as it does normally in early life, enhancing the sense of secure attachment through the use of evocative memory. Prisoners frequently resort to the use of such transitional objects in order to fortify their sense of connection to the people they love. Those who were prisoners in childhood may resort to the same devices as they face the task of building secure attachments for the first time in adult life.

Allowing the patient to take the picture represented a departure from the ground rule of psychotherapy that requires the expression of feelings in words rather than in action. It became a constructive addition to the therapy, rather than a seductive boundary violation, because its meaning was fully explored. The therapist gave careful consideration to both her own and the patient's fantasies, to the impact of the picture-taking on the therapeutic alliance, and to the function of the picture in the patient's overall process of recovery. Negotiating boundaries that both parties consider reasonable and fair is an essential part of building the therapeutic

alliance. Minor departures from the strict conventions of psychodynamic psychotherapy may be a fruitful part of this negotiating process, as long as these departures are subjected to careful scrutiny and their meaning is fully understood.

Because of the conflicting requirements for flexibility and boundaries, the therapist can expect repeatedly to feel put on the spot. Distinguishing when to be rigid and when to be pliable is a constant challenge. Beginner and seasoned therapists alike often have the feeling of relying on intuition, or "flying by the seat of the pants." When in doubt, therapists should not hesitate to seek consultation.

THE THERAPIST'S SUPPORT SYSTEM

The dialectic of trauma constantly challenges the therapist's emotional balance. The therapist, like the patient, may defend against overwhelming feelings by withdrawal or by impulsive, intrusive action. The most common forms of action are rescue attempts, boundary violations, or attempts to control the patient. The most common constrictive responses are doubting or denial of the patient's reality, dissociation or numbing, minimization or avoidance of the traumatic material, professional distancing, or frank abandonment of the patient. Some degree of intrusion or numbing is probably inevitable.⁴⁸ The therapist should expect to lose her balance from time to time with such patients. She is not infallible. The guarantee of her integrity is not her omnipotence but her capacity to trust others. The work of recovery requires a secure and reliable support system for the therapist.⁴⁹

Ideally, the therapist's support system should include a safe, structured, and regular forum for reviewing her clinical work. This might be a supervisory relationship or a peer support group, preferably both. The setting must offer permission to express emotional reactions as well as technical or intellectual concerns related to the treatment of patients with histories of trauma.

Unfortunately, because of the history of denial within the mental health professions, many therapists find themselves trying to work with traumatized patients in the absence of a supportive context. Therapists who work with traumatized patients have to struggle to overcome their own denial. When they encounter the same denial in colleagues, they often feel discredited and silenced, just as victims do. In the words of Jean Goodwin: "My patients don't always believe fully that they exist, not, much less,

that I do. . . . This is made all the worse when my fellow psychiatrist treats me and my patients as though we don't exist. This last is done subtly, without overt brutality. . . . If it were only one time, I would not worry about being extinguished, but it is one hundred and one hundred hundreds, one thousand thousand tiny acts of erasure."⁵⁰

Inevitably, therapists who work with survivors come into conflict with their colleagues. Some therapists find themselves drawn into vituperative intellectual debates over the credibility of the traumatic syndromes in general or of one patient's story in particular. Countertransference responses to traumatized patients often become fragmented and polarized, so that one therapist may take the position of the patient's rescuer, for example, while another may take a doubting, judgmental, or punitive position toward the patient. In institutional settings the problem of "staff splitting," or intense conflict over the treatment of a difficult patient, frequently arises. Almost always the subject of the dispute turns out to have a history of trauma. The quarrel among colleagues reflects the unwitting reenactment of the dialectic of trauma.

Intimidated or infuriated by such conflicts, many therapists treating survivors elect to withdraw rather than to engage in what feels like fruitless debate. Their practice goes underground. Torn, like their patients, between the official orthodoxy of their profession and the reality of their own experience, they choose to honor the reality at the expense of the orthodoxy. They begin, like their patients, to have a secret life. As one therapist puts it, "we believe our patients; we just don't tell our supervisors." These underground practices can be benign, as in the case of Shareen, a 30-year-old woman with a history of severe childhood abuse and abandonment by multiple caretakers:

Shareen tended to become disorganized during her therapist's absence. Just before one vacation, she asked to borrow a Russian matryosha doll that decorated the therapist's office. She felt that this would help remind her of her continued connection with the therapist. The therapist agreed, but told Shareen: "Don't tell anyone I prescribed a doll; I'd be laughed out of town."

In this case the therapist's therapeutic technique cannot be faulted. The problem lies in her isolation. Unless the therapist is able to find others who understand and support her work, she will eventually find her world narrowing, leaving her alone with the patient. The therapist may come to feel that she is the only one who really understands the patient, and she

may become arrogant and adversarial with skeptical colleagues. As she feels increasingly isolated and helpless, the temptations of either grandiose action or flight become irresistible. Sooner or later she will indeed make serious errors. It cannot be reiterated too often: *no one can face trauma alone*. If a therapist finds herself isolated in her professional practice, she should discontinue working with traumatized patients until she has secured an adequate support system.

In addition to professional support, the therapist must attend to the balance in her own professional and personal life, paying respect and attention to her own needs. Confronted with the daily reality of patients in need of care, the therapist is in constant danger of professional overcommitment. The role of a professional support system is not simply to focus on the tasks of treatment but also to remind the therapist of her own realistic limits and to insist that she take as good care of herself as she does of others.

The therapist who commits herself to working with survivors commits herself to an ongoing contention with herself, in which she must rely on the help of others and call upon her most mature coping abilities. Sublimation, altruism, and humor are the therapist's saving graces. In the words of one disaster relief worker, "To tell the truth, the only way me and my friends found to keep sane was to joke around and keep laughing. The grosser the joke the better."⁵¹

The reward of engagement is the sense of an enriched life. Therapists who work with survivors report appreciating life more fully, taking life more seriously, having a greater scope of understanding of others and themselves, forming new friendships and deeper intimate relationships, and feeling inspired by the daily examples of their patients' courage, determination, and hope.⁵² This is particularly true of those who, as a result of their work with patients, become involved in social action. These therapists report a sense of higher purpose in life and a sense of camaraderie that allows them to maintain a kind of cheerfulness in the face of horror.⁵³

By constantly fostering the capacity for integration, in themselves and their patients, engaged therapists deepen their own integrity. Just as basic trust is the developmental achievement of earliest life, integrity is the developmental achievement of maturity. The psychoanalyst Erik Erikson turns to Webster's dictionary to illuminate the interconnection of integrity and basic trust: "Trust . . . is here defined as 'the assured reliance on another's integrity.' . . . I suspect that Webster had business in mind rather than babies, credit rather than faith. But the formulation stands. And it

seems possible to further paraphrase the relation of adult integrity and infantile trust by saying that healthy children will not fear life if their elders have integrity enough not to fear death."³⁴

Integrity is the capacity to affirm the value of life in the face of death, to be reconciled with the finite limits of one's own life and the tragic limitations of the human condition, and to accept these realities without despair. Integrity is the foundation upon which trust in relationships is originally formed, and upon which shattered trust may be restored. The interlocking of integrity and trust in caretaking relationships completes the cycle of generations and regenerates the sense of human community which trauma destroys.

CHAPTER 8

Safety

RECOVERY UNFOLDS in three stages. The central task of the first stage is the establishment of safety. The central task of the second stage is remembrance and mourning. The central task of the third stage is reconnection with ordinary life. Like any abstract concept, these stages of recovery are a convenient fiction, not to be taken too literally. They are an attempt to impose simplicity and order upon a process that is inherently turbulent and complex. But the same basic concept of recovery stages has emerged repeatedly, from Janet's classic work on hysteria to recent descriptions of work with combat trauma, dissociative disorders, and multiple personality disorder.¹ Not all observers divide their stages into three; some discern five, others as many as eight stages in the recovery process.² Nevertheless, there is a rough congruence in these formulations. A similar progression of recovery can be found across the spectrum of the traumatic syndromes (see table). No single course of recovery follows these stages through a straightforward linear sequence. Oscillating and dialectical in nature, the traumatic syndromes defy any attempt to impose such simpleminded order. In fact, patients and therapists alike frequently become discouraged when issues that have supposedly been put to rest stubbornly reappear. One therapist describes the progression through the stages of recovery as a spiral, in which earlier issues are continually revisited on a higher level of integration.³ However, in the course of a successful recovery, it should be possible to recognize a gradual shift from unpredictable danger to reliable safety, from dissociated trauma to acknowledged memory, and from stigmatized isolation to restored social connection.

The traumatic syndromes are complex disorders, requiring complex