THE SURVIVOR

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Table of Contents

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Case Presentation

Anne is twenty-eight, a nurse at a hospital in New York City. She is afflicted day and night by involuntary memories of childhood abuse. These flashbacks keep her from sleeping, and she is exhausted. She relives these memories in a trancelike state from which she can be brought out by gentle shaking and insistence on eye contact. The expression on her face at these moments reflects a disoriented horror and agony. The therapist surmises that she is especially vulnerable to these memories whenever she thinks that she has done something wrong or that she is imposing on anyone.

At the first consultation, Anne said she was finding it impossible to pursue her studies toward certification as a psychiatric nurse. She was afraid of flunking out, being unable to give oral reports, or losing control, although

so far her work had always been acceptable. These usual-sounding student worries reflected a deeper anxiety that she might be unsuitable for mental health work because of what she had gone through and that if she failed, she would be exposed and subjected to punishment for attempting too much.

Anne was a victim of incest and torture by her father throughout her childhood. He construed both sex and torture as punishments for alleged misbehavior. When she was eleven, he threw her out of the house. She became associated with a drug gang, who used her to smuggle drugs. She describes herself as "up for grabs," meaning she had sex with members of the gang as necessary. Her father also picked her up from the streets for sex and then returned her to the streets. Twice, he showed the gang members how he "taught her a lesson." The gang allowed him to do whatever he wanted with her because she was on loan to them; he could have had her picked up (possibly carrying drugs) at any time by the police, as she was still a minor.

It appears that the father projected all of his self-loathing onto her. Her mother, a passive cripple, went along with whatever her husband wanted, at times collaborating with him. After Anne, they had three more children. The parents maintained what to Anne seemed normal relations with the other children. However, Anne was not included in the family; she was not allowed to eat at the table nor to sleep in her bed.

Anne was hospitalized sixteen times between the ages of four and eleven. The first time was at four, when her father threw her down the cellar steps. She was kept in the dark cellar, naked, subject to rape and sadistic abuse much of her childhood. She was forced to eat dog food from the family dog's bowl, without using her hands. She says that to this day she feels discomfort eating with other people at a table and that some nights she feels as though she has no right to sleep on a bed; to relieve this feeling, she gets off her bed and curls up on the floor.

Anne's manner and voice are honest, and her story is internally consistent. She suffers intensely in searching out and expressing each piece of her past. There is nothing at all about her to suggest that she would invent these atrocities. In spite of Anne's fears that she is "crazy," she seems to her therapist to be just the opposite. She is someone who has suffered a million times the trauma the human mind and body were meant to take, and yet she has always coped as well as she could. She has retained a remarkably balanced judgment about most real issues, she has learned and applied useful skills, and she shows considerable concern for others.

Throughout her childhood and adolescence, Anne denied her parents' fiendish natures and hoped for reconciliation with them. Concomitantly, she lacked the ability to become enraged at their crimes; it seems to have been tortured out of her. Anne said that she never thought of what her father did as

torture; that was her therapist's word for it. "How did you think of it, then?" he asked. "It was just Dad doing his thing," she said. This form of denial was given up soon after therapy began. A second, more insidious form—"Since the other children were spared, I must have been bad as Dad said"—has not been wholly overcome.

When she was five, her father saw her "blowing bubbles" into her younger brother's belly, a common way of playing with babies. Accusing her of sexual interest in the baby, her father raped her as punishment. She told her mother what had happened and showed her the blood on the sheets, but her mother merely scolded her for going back to bed. Not long afterward, her father raped her again, this time adding an excruciating torture that was often present as an element thereafter. He heated metal objects and put them into her.

Anne spent much of her childhood hiding in a closet, delirious, rocking in pain, or locked in the cellar. After one severe burning, when she was "unable to go to the bathroom," she was taken to the hospital. Her father, a consummate dissembler, told the staff that she played with fire and burned herself. Thus, she eventually acquired a psychiatric record of sixteen occurrences of accidental or intentional self-injury that has put the parents beyond legal retribution.

On one occasion, a teacher told Anne to tell her what was troubling her. Anne told her, and the teacher slapped her face. No one in schools or hospitals believed Anne's stories.

On another, more recent occasion, her father trapped her alone, tied her up, raped her, and burned her. Afterward, she attempted suicide. Largely because this torture followed the pattern of her father's description of what Anne had done to herself in childhood, a grand jury did not find sufficient evidence to indict him. It was her word against his, and the jurors were swayed by the sixteen hospital records reflecting her parents' accounts that Anne had injured herself.

The father carried out a repertory of sadistic acts upon Anne, but she repressed these memories totally. That is, although she suffered from waves of horrible feelings, she did not connect them to events in her past. In time she decided to leave the streets and make something of herself, so she studied nursing and has worked as a nurse for six years. In sessions over the past three months (supportive psychodynamic exploration and elicitation of abreaction, mostly), the walls of repression have crumbled, and she remembers everything now, too well, in flashbacks that overwhelm her as often as minutes apart. She is rarely spared them for as long as an hour.

One of the worst memories, brought up in pieces through several

sessions, was of Christmas Eve when she was twelve years old. She felt unusually tired and returned home to sit by the tree. Her father said, "You look terrible," and then observed that she was pregnant; she had not known. Anne says it was his child. He tied her to the kitchen table and aborted the fetus by punching her in the belly and inserting household implements. Her mother made her put the fetus into a garbage can and clean up the blood. Her father doused the fetus with gasoline and forced Anne to ignite it, saying, "Look what you did! You killed it!"

Later, Anne's father threw her out again, and she walked several miles back to Times Square, where she collapsed. When she came to in a clinic, she was told that the pregnancy had gone about six and a half months. It had been possible to determine this from examination of her tissues and the extent of the tearing of them.

Anne cries over and over, "I didn't want to burn my baby!" The therapist does all he can to persuade her that no guilt attaches to her, that it was her father's crime—against her.

Anne has had a love relationship for more than four years. For the past year, the lover has been on a study-work program in a distant city, but they write, telephone, and spend a weekend together about every three months. Anne's social life with her peers is circumscribed by the nearly total hearing

loss she suffered in her early twenties. She has dinner occasionally with one or another coworker.

Anne's therapist asked her, when the image of her father coming at her occurs, to scream. The abreaction gives Anne relief that lasts for hours, but then she is exposed to new and more detailed memories, probably because her screaming and her therapist's acceptance has weakened the repression.

Anne is a determined patient. She sometimes rejects suggestions when they are too frightening to her, but at other times, as she is able to, she may attempt what is for her exceedingly painful and scary work. An example is the suggestion that she express rage toward her visualization of her father. For some time, she was unable even to begin, but now she will hit a bolster a few times while uttering a few harsh angry sounds.

Anne's psychotherapist would be interested in other therapists' experiences with victims of torture and in what psychological methods they have used to deal with patients' obtrusive memories. Hypnosis, an approach that suggests itself, is not readily applicable for two reasons. First, her deafness presents a problem. Anne is a skilled lip-reader, but lip-reading is a demanding exercise even for the conscious mind. Second, as soon as she relaxes her defenses or gives up contact with reality, she is tormented by memories.

Formulations and Treatments

Larry E. Beutler (Eclectic)

I was overwhelmed by the degree of abuse and destructiveness wreaked upon a victim who appears to be a true survivor. I was also aware of my own rescue fantasies aroused by the intensity of Anne's neediness. The presentation of Anne's case leaves me with great respect for the therapist and even greater respect for the patient. I am impressed by the collaborative nature of the relationship, and I am optimistic that the process will take a natural course of resolution in time. The therapy relationship will allow Anne's fears to unfold naturally, slowed only by the fears that she constructs in her own cognitive-imaginal life. What I can add in the way of specific technical suggestions will surely have less power than the collaborative, supportive, and evidently caring nature of the relationship between therapist and patient.

Since much detail is missing, let me reconstruct the case of Anne as I imagine her to be. I must make certain assumptions about the patient based upon clues within the narrative and upon my experience with individuals who have been victimized. I imagine Anne as an individual who has not yet decided how to resolve and interpret the abusive events—sometimes questioning her own stability and worth, at other times expressing halting

anger at her victimization. I see her memories and their expression as efforts to incorporate the therapist into her world as a supportive resource and as a sounding board. The simple trust that the patient reveals, the intensity of her struggle, and her efforts to involve other people in it provide the basis for a productive therapeutic alliance.

Beyond this general formulation, there are some other pertinent assumptions and inferences upon which my recommendations will be made: (1) The therapist observed that the patient adopts a trancelike state in response to intrusive, disruptive, self-generated thoughts. These qualities suggest that the flashbacks are dissociative but not hallucinatory. (2) The narrative portrays Anne as a survivor, now overwhelmed by her anxiety. I assume she is not currently a suicide risk. (3) I assume the patient's memories and reports of flashbacks are in part motivated and constructed to derive something from interpersonal relationships, including that with the therapist.

On the basis of the description, I must infer certain coping style characteristics for treatment planning. I assume that Anne does not maintain either the detached or rebellious stance that characterized her earlier efforts to cope.

Individuals with histories of severe victimization are often demanding

and active nurturance seekers, and they often vacillate between intense attachment and withdrawal when their needs are not met. If Anne is like this, she may attempt to establish reassuring relationships and to invest herself in other people, and she may frequently feel abandoned, victimized, and rejected when these efforts are not reciprocated. Her efforts to involve herself as a helper, and to provide others with what she was deprived of, in part represent this externalizing and redirecting defensive strategy.

At the same time, Anne may be pushing herself to earn other people's approval, and she may deny or control her anger by translating it into feelings of interpersonal rejection. These internalizing patterns may lead to emotional lability, tearfulness, and crying spells. Together, the internalizing and externalizing patterns may suggest a cyclical and unstable coping style at the present time (Beutler & Clarkin, 1990).

The Anne I am reconstructing from her history also has a high need to maintain a sense of interpersonal control, is on guard against other people, and is excruciatingly sensitive to rejection and to the withdrawal of attachment objects. She alternates between feeling helplessly needy and, at other times, being resistant, suspicious, and feeling abandoned. Hence, I would expect her to react moderately against directive interventions.

Setting aside the question of the accuracy of the foregoing

reconstruction, let me share some thoughts about treatment. After forming some understanding of the patient, the next step is the development of a bonding relationship. According to the case history, this has been successful, and the initial relationship has allowed the patient to recontact a painful history. Therapist and patient are now at a second stage in which neither the bonding with nor the caring support of the therapist is sufficient alone for the patient to derive a sense of safety to allow her fears to be extinguished.

In this stage of increased instability and sensed danger, issues of the patient's safety come to the fore. If the patient is presenting suicidal gestures and thoughts, the pattern of instability and the probability of few intimate sources of support would lead me to raise the possibility of a brief hospitalization.

My effort would be to move the patient from introjection to a more outward expression of anger, and to confront her urgency to make others love her in order to feel safe. I might use two-chair dialogues and role reversal (Daldrup, Beutler, Greenberg, & Engle, 1988) with her imagined father to help her express her rage, to integrate her view of her father, and to review her cognitive injunctions. The aim would be to help her disincorporate the negative image of self and to direct her resentment externally.

I would be mildly but gently directive, trusting Anne's ability to tolerate

therapeutic interventions and to benefit from them. I would help her construct sentences to externalize the anger, and I would validate her rehearsal of those sentences to cope with the intrusive thoughts (Beutler, 1983). I would shy away from abreactive interventions since Anne's arousal level and vulnerability to deterioration are so high. The internal representations of her struggle, her guilt, and her anger also lead me to attempt to reduce her arousal level by providing structure, support, and safety. Anne's sense of security would be enhanced by reassurance and by some social support systems to help guide, monitor, and structure the expression of her struggle. Hence, I would favor group therapy as a modality of intervention. Within a victims group, she could learn to share secrets, reassuring herself that others are also victims. And she could gain vicariously through others' efforts to resolve feelings of defeat, victimization, and neediness.

Anne may be resistant to group work; she might point out that she has a number of "good friends" (who may turn out not to be intimates) and that she needs more individual attention. But the group can help defuse her needs to be treated as special, and in any event, group therapy does not preclude concurrent individual therapy.

The extensiveness and disruptiveness of the symptoms, and the fear attached to those symptoms, suggest that the therapist must attempt to go

beyond symptom removal. I would focus on Anne's needs to attach to others, to find support in others, and to heal others as representing her needs to complete herself. Transference issues in our relationship would help us explore how she works ineffectively to gratify her needs.

Since my reconstruction is of a patient who exhibits both external defensive patterns and overactive ideation, I would look for therapeutic interventions that combine cognitive and behavioral strategies (e.g., Yost, Beutler, Corbishley, & Allender, 1986) and that are designed to reinforce the patient's sense of control, to resolve dependency conflicts, to reframe her stance as a victim, to reduce the amount of anxiety present, and to deemphasize the therapist's control. In analyzing her self-criticisms, I would try to provide her with skills for controlling her emotions through self-instruction and cognitive rehearsal.

An early task would be to reduce Anne's arousal level and increase her tolerance of being alone. I agree with the therapist that hypnosis might be terrifying. Given that her interpersonal boundary definition is weak, hypnosis might threaten her boundaries rather than strengthen them. The same would be true of any therapist-controlled procedure for which the patient is expected to be receptive. I would look, instead, to interventions that reinforce her individuality and provide structure in her environment.

Paradoxical interventions are particularly useful with patients who resist loss of interpersonal control—as reported in Anne's case—at least sometimes in psychotherapy sessions. With respect to Anne's intrusive thoughts, for example, I would encourage her to have them, rather than avoid them, and concomitantly to work to establish stimulus control for these thoughts. I would suggest that Anne establish locations at home and at work that she can use as "worry places." After a trial run in my office and then at her home, I would urge that she retreat to one of her worry places whenever the thoughts intrude upon her. I would suggest that when there she make herself anxious by recalling frightening memories. By reversing the patient's nonfunctional but natural tendency to try to reduce anxiety, I would expect the anxiety to lose both its intensity and the second-order fear associated with it. Additionally, I would endeavor to clarify the interpersonal anticipations that activate Anne's anxiety, and I would attempt to help her understand the relationship between her fear and the associated sense of dependency on others.

To the degree that Anne's intrusive thoughts increase or decrease under paradoxical instructions, I would reinforce her exercise of them. I would continue to ask her to monitor and even to exaggerate the frightening images, at her own pace, over the course of some weeks. As she acknowledged the change, I would begin a process of cognitive analysis and self-instruction.

We would try to define the demands and overgeneralizations associated with her anxiety and deprivation of love. Then, we would construct tests of these beliefs and more comforting alternatives that Anne could practice in times of stress. As the anxiety associated with her thoughts decreased, cognitive rehearsal, social support, and thought replacement would be used to redirect and refocus energy when the intrusions occurred. These replacements would be developed as consistent alternatives to the dependency themes that evoke her anxiety. The therapy relationship will supply other opportunities to reflect on and change thoughts associated with Anne's interpersonal neediness.

I would trust the strength of the collaborative and caring relationship to ride the process through. In the meantime, I would provide whatever assurance I could that her resolution process is a natural and workable one, and I would strive to avoid being intrusive in a natural process. This process would entail pointing out to her repeatedly that she is a survivor, one whose many internal resources have already allowed her to overcome obstacles far greater than oppressive memories. The reality is that she copes, that she can establish relationships, and that she can function as an unimpaired individual. At this point, she is a victim only of her remembrances, and as she learns to disown self-incrimination to establish her justified, outward anger, I would convey my faith that her therapeutic goals would be achieved.

Again, my compliments to the therapist and, particularly, to the patient.

Spencer Eth and Saul I. Harrison (Integrative)

Formulating a treatment plan begins with the process of differential diagnosis. The possibility of premature closure increases when we are confronted with a case history as horrifying as that of Anne. The historical events are so compelling that even reading about them elicits countertransference reactions, to phrase it euphemistically. Some clinicians might summarily dismiss Anne's story as a perverse fantasy, too terrible to be believed. It is painful indeed to contemplate the brutal torture of an innocent child, and disavowal has served to protect most of us in this culture from that awareness. On the other hand, we must guard against the temptation to accept uncritically everything a patient confides. It is incumbent on us to be empathic and caring, without suspending our judgment—the state that medical sociologist Rene Fox (1957) labeled *detached, concern.* With these caveats in mind, what *DSM-III* (American Psychiatric Association, 1980) Axis I diagnostic considerations are relevant for this patient?

Anne's presenting complaint centers on her fears of failure, and such fears suggest the possibility of an anxiety disorder. The panoply of symptoms described suggests elements of *social phobia* (a persistent fear of one or more situations in which the person is exposed to possible scrutiny by others and

fears that he or she may act in a way that will be humiliating or embarrassing), *generalized anxiety disorder* (unrealistic or excessive anxiety and worry about life circumstances), and *posttraumatic stress disorder* (experience of an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, followed by persistent re-experiencing of the event, persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness, and persistent symptoms of increased arousal).

Anne's therapist describes repeated episodes of a "trancelike state" from which she can be brought out "by gentle shaking and insistence on eye contact." The essential feature of such *dissociative disorders* is a disturbance or alteration in the normally integrative functions of identity, memory, or consciousness. Included in this category, and perhaps relevant to Anne, are *depersonalization disorder* (persistent or recurring experiences of depersonalization during which reality testing remains intact) and *multiple personality disorder* (the existence within the person of two or more distinct personality states—each state with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment—with at least two of these personality states recurrently taking full control of the person's behavior). Multiple personality is associated with histories of severe physical and sexual abuse in childhood (Kluft, 1985).

Some or all of Anne's symptoms could be a product of a *borderline personality disorder* (a pervasive pattern of instability of mood, interpersonal relationships, and self-image, beginning by early adulthood and present in a variety of contexts). Childhood cruelty and deprivation may figure prominently in the genesis of serious character pathology, and the diversity, severity, and chronicity of Anne's symptoms are not inconsistent with this condition.

The final entity, which should be mentioned for the sake of completeness, is *factitious disorder with psychological symptoms,* presupposing that Anne's symptoms and perhaps her history are not genuine. This diagnosis can be established only after other etiologic explanations of the problem have been excluded. In raising this possibility, it is vital to remember that although these patients' symptoms are self-induced, their suffering is real, and treatment, albeit of a different kind, is indicated.

With such an array of diagnostic possibilities, definitive treatment planning requires further assessment. The clinician should obtain all medical records: pediatric, gynecological, and psychiatric, along with available legal and social-service reports on Anne's family. Depending on what is found, further medical, neurological, audiological, and gynecological examinations and psychological testing may be needed. Interviews with family members and friends might provide valuable data, especially if Anne experiences

dissociative memory gaps. Sequential sessions with Anne would add to the material gathered and would confer a needed longitudinal perspective on her mental status.

To formulate a treatment plan based only on the data at hand, let us assume, as a provisional principal diagnosis, posttraumatic stress disorder. What, then, can be offered to help this young woman?

Our treatment model is a biopsychosocial one. The therapeutic application would be integrative (Engel, 1980); however, for the purpose of exposition, each component will be considered in turn.

Although the term *posttraumatic stress disorder* (PTSD) is relatively new, the concept has received attention throughout this century. Biologically based treatments, alone or in conjunction with psychotherapy, date back at least to World War I, when it was found that sedation, nutrition, and exercise were therapeutic. In World War II, cathartic abreactive psychotherapy was promoted by the intravenous administration of barbiturates under the rubrics of narcosynthesis and narcoanalysis (Grinker & Spiegel, 1945).

The present-day application of biological psychopharmacology is more sophisticated. At least three different classes of drugs are in common use to ameliorate the distress of PTSD (Ettedgui & Bridges, 1985). Benzodiazepines

(such as Valium or Xanax) are employed for the immediate, nonspecific relief of the symptoms of anxiety and insomnia. Two types of so- called antidepressants, the tricyclics, such as imipramine, and the monoamine oxidase inhibitors (MAOI), such as phenelzine, have been found to be beneficial in several small studies of PTSD in Vietnam veterans (Hogben & Cornfield, 1981). These medications typically require several weeks of treatment before symptoms are controlled and are accompanied by appreciable side effects at therapeutic dosage; some patients experience relapse when medication is withdrawn. The desired response to these agents does not appear to depend on the presence of an affective disorder. In this regard, the drugs are not acting as antidepressants, although the underlying neurochemical pathophysiology of PTSD may overlap with that of major depression. Both the tricyclics and MAOIs are also standard preventive treatments for endogenous panic attacks, another severe anxiety disorder. In the authors' experience, flashbacks and nightmares, comparable to those upsetting Anne, have been highly sensitive to the so-called antidepressant medications.

Psychological treatments for PTSD abound, ranging from traditional psychoanalysis to behavior modification (Horowitz, 1986). A catalog of available individual psychological treatments would include but would not be limited to supportive psychotherapy, open-ended exploratory psychodynamic

psychotherapy, brief focal psychotherapy, cognitive therapy, hypnotherapy, systematic desensitization, biofeedback, and flooding. In addition, a variety of group therapies have been employed.

Individual therapy with PTSD patients should be flexible and should accommodate the incident-specific features of this condition. An interview protocol for use with traumatized children, applicable also with adults, has been elaborated (Pynoos & Eth, 1986). Mastery requires an affectively charged, thorough experiencing of the traumatic event. Although the sessions often may be exquisitely painful, sharing the terrible memories is fundamental to the process of overcoming the helplessness inherent in the traumatic state. With each reworking of the experience, greater confidence and enhanced coping are achieved. And the patient might have the opportunity to compensate in the transference for the deprivations and indignities suffered in childhood.

Anne's presenting fear of failure in the educational program could be dealt with in sessions wherein she was exposed to imagery or role-playing the anxiety-evoking situation, in combination with relaxation techniques. Such procedures in some cases have produced significant, lasting improvement. A relaxation technique often used is systematic desensitization augmented with biofeedback. The patient's overall sense of self-efficacy may be enhanced with the newly learned capacity to interrupt escalating anxiety

and to perform in a stressful environment (Jansson & Ost, 1982).

The social dimension should be a major concern in Anne's treatment. The proliferation of incest support groups affords Anne the chance to connect with other women in similar predicaments. Mutual support and friendship are powerful forces countering the alienation and despair with which the stigmatized survivors of sexual abuse are afflicted. Anne should be advised also to investigate whether there are legal avenues open to her. A civil suit against her father for damages arising from multiple assaults and rapes could take Anne from the role of victim and engage her in the role of competent adult seeking appropriate redress. Also, there may be an indication for vocational counseling to explore rationally the advantages and disadvantages of her chosen career, psychiatric nursing. To the extent that Anne may be nursing troubled patients to restore what she was deprived of and vicariously to cure herself, her efforts may be handicapped, and she risks remaining unfulfilled.

The biological, psychological, and social components of Anne's therapy are complementary. A complete treatment would encompass each of these dimensions and very likely would draw on the expertise of many specialists. Anne represents a therapeutic challenge, but given the availability of a full array of mental health services, her prognosis is not unfavorable.

Nolan Saltzman (Experiential)

What does it say about Anne that she survived a home like a private death camp, where solitary confinement, rape, and genital torture were routine, and then adolescence with a drug gang, to become a nurse working for psychiatric certification—despite deafness? My first principle would be to acknowledge that there is no body of knowledge that encompasses this case or delimits what this young woman may be capable of.

The history barely mentions the mother, beyond saying that she was a passive accomplice. Did she ever succor Anne? Did Anne hope her mother would rescue her? The dismantling of defenses as described should lead to more memories of mother's role.

While Anne's chosen career as a psychiatric nurse may be a self-fulfilling one, she has oriented herself to meet others' needs through a course that is arduous and presumably painful for her. In contrast, her therapist's account of her love affair at a distance sounds idyllic. I would accept Anne's report of it for now, and, when appropriate, try to learn more about the relationship. Is there a mutual exchange of nutrients, or is Anne relating primarily through meeting her lover's needs, as she (and her mother) had to meet her father's needs?

Anne came to therapy with adjustment problems, but she has evidently been induced to gamble for higher stakes. I suspect she has a fixed delusion that she is bad and deserved what was done to her. Such feelings protect a false self by keeping down any sign of rage, for which she was (further) tortured. The delusion of being bad also allows the hope that, by trying ever harder, she might become good, escape the torture, and be accepted as the other children were. To undermine this delusion, a perceptual coping scheme from childhood to the present, is risky. It ought to be undertaken only when a sufficiently strong bond with the therapist enables her to give up the false coping self. Anne may then be ready to leave the safe island, where she suppresses her rage and feels bad about herself, and to strike out through a terrifying void for the shore, where she would own her rage and a new sense of acceptability as a human being.

I would suggest to Anne that if she strives for characterological integration, her cognitive and behavioral patterns must change together in three ways: (1) She needs to accept that she is a good person, entitled to be loved, but, then, (2) she always was good, implying that her parents' treatment of her was wanton cruelty, and (3) she has the right to express killing rage toward them. Or, another sequence is possible: (1) She allows herself a killing rage at her parents, enabling her to stop turning her rage and loathing against herself, (2) that healthy reversal of the direction of the rage

will also allow her to get angry at the obtrusive memories, the agents of her father's punishments in her own mind, and drive them out, and (3) she will then feel for the first time like a good person, entitled to receive others' love.

Assuming Anne develops trust in me, I would confront her on using the word *punishment* to describe her father's sexual abuse and tortures, pointing out that no one but her parents and she would use that word for what he did. I would ask Anne to use words the same way everyone else does. "Anne, suppose we were to go down to the street and ask the next fifty people, 'Was that *punishment* or *torture*?'—what would they say?"

In another session, I would ask Anne to say to me, with feeling, "I'm a good person," anticipating that she would dispute this or avoid it or that if she attempted it, the words would engender distress. Although I would be concerned about the risks of stripping away the delusions that enabled her to build a life separate from the agonies of her childhood, I would not hold Anne back if that was what she wanted to do. I would continue the approach of the presenting therapist. Since Anne is willing to engage in abreaction in a supportive environment, it affords her relief that lasts for hours, and it also brings up new and more detailed memories.

There are many entries to climactic expression besides the useful one mentioned by the therapist—that of visualizing the approach of the abusive

father. A simple phrase such as "I'm a good person" or "I have a right to be loved" can also provide access to the depths of the emotions in a person who has never been allowed these feelings about himself or herself (Casriel, 1972). In my bio psychotherapy, I integrate psychodynamic, cognitive, and experiential methods with the techniques called EEVR—eliciting emotions in a setting where they meet with spontaneous validating responses. I elicit climactic expression (gut screams) as part of a learning experience, never for so-called ventilation (Saltzman, 1989).

More than fifty years ago, Ferenczi tried "loving his patients healthy," hugging and coddling them to restore what they had been deprived of in infancy. De Forest (1954) remembers a discussion in Budapest, not long before Ferenczi died, in which Ferenczi said, "Psychoanalytic 'cure' is in direct proportion to the cherishing love given by the psychoanalyst to the patient." Ferenczi's approach often did not work well. His patients had not exposed their deep emotions, so he was embracing all the layers of defense. However, Ferenczi had the right idea, and today we know how to let love fulfill its healing role when the patient casts aside his or her defenses in out-of-control expression.

In the present instance of a young woman sexually abused and tortured throughout childhood by psychotic parents, a therapy based on loving responses as initiated by Anne's therapist appears to be a good prescription.

As always, one must respond lovingly to healthy expressions of the self, not to symptoms, which may be interpreted as defenses against expression. Further, the therapist had better not show sympathy or pity, because they muddle the expression of love. It is likely Anne would tend to reject love as pity, anyway, and it is incumbent on the therapist to respond cleanly and, as necessary, to help Anne discriminate responses.

As with all patients who enter intensely emotional work, but especially with survivors of incest and abuse, it would be necessary for Anne and the therapist to agree that the therapist's "love" means good feelings toward her essential nature, that a hug expresses these feelings, and that the therapist's touch is never motivated by lust or sadism. Unless Anne accepts these notions at least intellectually, holding is ruled out. If Anne accepted the initiation of a hug, but then became violently fearful, the embrace itself could become a passage to intense emotional expression.

Anne may already know how to lose control of her screams. If not, since she is deaf, I would ask her about working out a mode of communication such as squeezing her shoulder for "Louder!" and rubbing her upper arm for "Longer!"

One approach to EEVR would be to ask Anne to express parental attitudes she was forced to accept. When she says, "Since the other children

were spared, I must have been bad as Dad said," I would say, "Yes, you must have been. Would you say to me, 'I'm bad!' " Then, I would urge her to say it louder and louder, longer, again and again, until she was screaming it out through loss of control. This approach does not reinforce the dysfunctional feeling. Instead, if Anne would scream "I'm bad!" until she was out of control, she would ultimately become enraged and reject it. I note that she is able to work up to a "few harsh angry sounds." If Anne were unable to go further, to express climactic rage, she would likely become depressed. I would anticipate the depression, but I would point out to her that in the session she had expressed some anger to her father and that there had been no consequent torture. And I would point out that she now has an ally who feels closer to her and heartened by her ripening rage and that she can choose to relate to these changes and perhaps get still angrier next time. In fact, it may take a long time, with much other material intervening, but, one hopes, growing trust will accompany the change.

The clinician will understand why I describe much of my work as *emotional conditioning,* by analogy to behavioral conditioning. Since expressing emotion is a primary mode of behavior in human beings and in primates generally, it is behavioral conditioning, too.

Another method of EEVR is referred to as *exorcism* (Saltz- man, 1983). I would ask Anne to acknowledge at least intellectually that she had learned

bad feelings about herself through bad treatment. If she acknowledged that, I would assert that anything learned can be unlearned. No patient has ever challenged that. It is the crux of the matter, but I am not at all certain that a psychological structure to which traumatic experience contributed can always later be undone—even by the greatest effort of the patient or the tenderest care by the therapist. If Anne raised the doubt, I would acknowledge my doubt, and ask her whether she wanted to back off because it may not work or to take the leap on the chance that it may. If she assents, I would ask her to lie on her back. (I have a mat in my office, but a couch or reclining chair away from walls is usable.) I would sit or recline on the mat by her. If she did not assume an open position, I would suggest she put her arms at her sides and uncross her legs. I would ask her if she were ready to cast out bad feelings and be rid of them. Her assent would help create a suggestible state. With my voice comforting but decisive, I would reiterate that underneath the imposed bad feelings are the natural, rooted, good feelings about herself that she was born with.

I would begin by resting a hand supportively on Anne's shoulder and saying, "When I say to, not just yet, make a sound, Ahhh. Let your body make the sound. The sound your body makes will be the bad feelings about yourself." The key word, *be,* is much better than *stands for* or *represents.* Anne might bring herself halfway out of her suggestible state by remarking, "I don't

know how to do it." I would say, "Your body will know once you begin. If you wholly choose to, that will be enough."

The sound Anne would make might express pain, disgust, or the fear of retribution. Whatever it was, I would urge it louder and longer, using our special mode of communication, and through loss of control. When Anne was done, I would ask her to see that I accepted her, and I would offer a hug.

Sometimes victims of torture recapitulate counterpain maneuvers, such as slamming the head to the mat or rubbing together the fingers of a (formerly bound) hand. I would restrain any movements by which she might injure herself. I would also secure her permission to block counterpain efforts generally. Then, if, in reliving experiences of torture, she began to writhe in silent agony, withholding her screams by exercising a counterpain maneuver from her past—all out of vocal contact—I would interrupt the maneuver by holding her head or her hand, for example. This action would tend to trigger abreaction, but survivors attempting to relive traumatic experiences have told me they feel comforted by a firm handclasp or embrace, which they apprehend on some level as protective, not as abuse.

After months of individual work, I would bring Anne into one of my intensely emotional groups. Most group members would feel valuable in contributing to her recovery, and the one or two who might not be able to

take her regressions to the torture scenes could be offered a transfer to another group or to individual work. The warmth and support of the group would help Anne eventually to feel accepted as a regular person rather than as a survivor or a psychiatric nurse.

Points of Contention and Convergence

Larry E. Beutler

I agree with Eth and Harrison when they assert that a clear and specific differential diagnosis is central to treatment planning. However, unlike them, when I make this statement, I am referring to a spectrum of observations broader than those required for the differentiation among traditional diagnostic labels. Elsewhere, I (Beutler, 1989) have outlined the problems with traditional diagnostic labels when planning comprehensive treatments that include psychosocial and psychotherapeutic interventions. Briefly, diagnostic labels are symptom descriptions that are founded in a level of abstraction that is better suited to psychopharmacology than to planning psychotherapy. Formal diagnostic criteria help in determining whether a person requires treatment and in selecting among broad classes of medication (anxiolytics versus neuroleptics versus antidepressants), but the *DSM-III-R* categories are of little use in the decisions that characterize psychotherapy.

Consistent with their emphasis on formal diagnosis, Eth and Harrison spend some time developing a case for and against various medications. The nonspecificity of diagnoses for even these decisions is observed in the poor relationship between the diagnosis and the drug selection. For example, if Anne is diagnosed with PTSD, any of the three classes of medication described by Eth and Harrison is likely to be used, but the effectiveness rates are unimpressive for all of them. Scrignar (1984) observes that benzodiazapines are likely to be effective only in the acute stage of PTSD. If the condition becomes chronic and resolves into a panic disorder, the selection of medication is quite unrelated to the diagnosis. Alprazolam (a benzodiazapine), tricyclic antidepressants (TCAs), or MAOIs all may have some value. Similarly, if PTSD resolves into a depressive constellation or if the patient develops recurrent panic attacks, either TCAs or MAOIs may be indicated. Hence, this diagnosis provides only a general contraindication for the use of benzodiazapines.

While antidepressants are probably the most prescribed medication for treating chronic PTSD, their uncertain efficacy further demonstrates the shaky value of diagnosis as a basis for treatment decisions. In what is still one of the best recognized studies of medication usage in PTSD following nonmilitary crises (war-related PTSD may be a very different condition), Burstein (1986) reports weak effects of antidepressant drug treatment,

observing that nondiagnostic and environmental variables, more than diagnostic ones, seemed to account for patient response to treatment.

John Clarkin and I (Beutler & Clarkin, 1990) have emphasized that since specific psychotherapeutic procedures are useful for and adaptable to a variety of diagnostic conditions, a comprehensive treatment plan must rely upon an assessment of environmental demands and supports and upon a delineation of several nondiagnostic personality and attitudinal variables. By and large, these variables may be combined with information about the therapist's intervention style to aid in the selection of procedures that will both enhance the therapeutic relationship and result in resolution of the presenting problem.

A final point of disagreement between my own position and that of Eth and Harrison may represent only a matter of emphasis. Namely, I find the categorization of psychological treatments by brand names to be of little value. Like patient diagnoses, global categorizations of psychotherapies provides insufficient information about relevant variables to serve as a guide to treatment selection. Most brand-name psychotherapies have much in common as well as having some distinctive qualities. I prefer to describe psychotherapies in terms of long-term objectives, mediating goals or tasks, formal demand characteristics, and probable effects. Hence, I would select a cross-cutting menu of procedures that would aim at conflict resolution (as

opposed to symptom change). Moreover, I would address the sequential mediating tasks of relationship maintenance, arousal reduction, cognitive change, and affective redirection, and I would select techniques and procedures at each stage that would be likely to accomplish these goals.

Specific therapeutic procedures are only tools to accomplish the specified goals and subgoals of treatment by directing and maintaining the patient's attentional focus, imbuing the therapist with positive valence, managing the patient's level of arousal for optimal therapeutic effect, and selectively exposing the patient to avoided information or experience. As such, procedures are best discussed within the context in which they are implemented, and with a knowledge of the therapist's fit with the patient. Without attending to this context, identifying theoretical brand names has little value.

Turning to Saltzman, I find myself in agreement with his formulation of Anne's important dynamics. That is, I agree that the goal of treatment is to resolve conflicts about emotional expression and to reawaken and redirect suppressed and denied rage at parental figures. I also agree that redirecting and reconstructing language patterns may be useful for this patient because of her cyclical and somewhat unstable coping pattern. Relabeling her *punishment* as *torture* might help break down her denial and redirect her rage externally.

On the other hand, I disagree with the use of experiential, abreactive procedures with this patient. Ventilation procedures like those used in EEVR are potentially intrusive and, like most such procedures, are designed to raise arousal levels in the face of denied experience. The evidence is very poor for the therapeutic value of catharsis (ventilation) without redirection, and the evidence is relatively good that such emotional escalation can and does produce deterioration in individuals who are critically distressed (e.g., Beutler, Frank, Scheiber, Calvert, & Gaines, 1984; Lieberman, Yalom, & Miles, 1973). Anne's arousal and distress level is already critical, as implied by her dissociative states and the (apparently) recent flood of childhood associations.

Given the foregoing and the assumption that Anne is reactive to external direction, I would certainly want to encourage a slower and less therapist-controlled direction than that suggested by Saltzman. I consider healing to be a normal process, not one to be forced. Therapist direction is necessary when patients have constructed defenses to protect themselves from anxiety, and the natural presence of anxiety is an indication of unforced movement potential. Here, the therapist should work to keep anxiety from getting so high that it impairs reasoning and perceptual efficiency (indexed in Anne by derealization and dissociative states) rather than to raise it further. To use intrusive measures under these circumstances is very risky. By fostering (and

forcing) the retrieval of painful memories at a speed that is faster than Anne can achieve with some degree of comfort, the therapist may inadvertently recapitulate the patient's victim status, now with the therapist as the victimizer who forces her to stand naked before him. This unfortunate recapitulation of victim status is all the more likely if, as suggested, the arousal potentiating effects of the interventions result in the therapist physically restraining Anne.

While I do not disagree with the value of using touch and other experiential procedures, I certainly do urge caution. There are certain things that a good therapeutic alliance does not automatically justify. Lying beside Anne as she reconstructs painful memories may be a stimulus whose power is too great and may arouse her anxiety to levels that seriously impede her ability to process information and that therefore actually prevent the desired extinction from taking place.

Spencer Eth and Saul I. Harrison

Beutler and Saltzman propose treatment plans that include some elements we endorse and others that generate discomfort. For centuries, the healing professions have assigned priority to the dictum *First Do No Harm.* It is vital, particularly with someone like Anne who has suffered so much, that the patient not be subjected to the risk of further victimization via therapeutic

misadventure, however well intended.

Unhesitantly, we endorse Beutler's formulation that treatment has entered a middle phase in which the patient has bonded with her therapist. It is encouraging to consider the apparently constructive elements in the therapeutic alliance. The next challenge is to decide how most appropriately to proceed to assist Anne in expressing anger directed toward her sadistic father. We join Beutler in advising caution in mobilizing angry, aggressive affects in such a fragile and disturbed young woman, burdened with the potential for self-destructive acting out. Two-chair dialogue, role reversal, cognitive rehearsal, thought replacement, and paradoxical interventions are among the several potentially useful approaches to addressing Anne's problems and to facilitating her mastery of them. Although our therapeutic transactions very likely would appear markedly different than what would transpire in Saltzman's so-called emotional conditioning, there nevertheless are conceptual overlaps.

It is evident that we are concerned about the therapeutic approaches suggested by Saltzman. Characterizing Anne's self-appraisal as an erroneous belief, we would join Saltzman in confronting her with her use and apparent endorsement of the concept of punishment in lieu of describing her experiences more accurately as torture.

We cannot recommend the technique Saltzman describes as EEVR since we do not understand the rationale for so-called gut screams. Further, the suggestion that the therapist respond lovingly with physical embraces is, we believe, contraindicated. Although a hug may be intended and appear to be nurturing, it represents a potentially dangerous transgression of professional boundaries. Patients such as Anne, with histories of prior sexual victimization, are at greatest risk (Pope & Bouhautsous, 1986).

We are troubled also by the technique Saltzman referred to as "exorcism," whereby the patient lies on her back and the therapist sits or reclines next to her. The patient is then instructed to "cast out bad feelings and be rid of them." This abreactive approach has not been accepted generally and again poses the risk of unintended emotional and sexual exploitation (Eth, Randolph, & Brown, 1989).

Nolan Saltzman

I admire Larry Beutler's deep and encompassing reconstruction of Anne, but I disagree with some of his methods. Let me first list some suggestions with which I concur. Square brackets denote my variations from the given approach.

1. Considering a brief (voluntary) hospitalization

2. Working toward outward expression of anger helping Anne construct sentences to externalize anger [intensifying the work toward climactic expression of killing rage]

3. Setting up two-chair dialogues [intensifying expressions of terror, pain, and rage as they arise; while role reversal with the father would not arise in the usual sequence of my adaptation of this gestalt mode, I might try it here as an experiment but would quickly withdraw the suggestion if Anne resisted]

4. Helping counter self-criticism through cognitive rehearsal [although I would not couple this with provision of so-called skills for controlling her emotions, since I work toward emotional freedom rather than control]

5. Collaborative defining of demands and over-generalizations associated with Anne's anxiety and deprivation of love; testing of her beliefs and supplying of (reality-based) comforting perceptions

6. Clarifying the interpersonal anticipations that activate Anne's anxiety

7. Providing assurance that her resolution process is workable and that she is a survivor whose many internal resources have already allowed her to overcome obstacles greater than oppressive memories

Spencer Eth and Saul Harrison's "principal provisional diagnosis" of

PTSD is reasonable. I would incline toward depersonalization disorder, which they also think may fit. I might offer Anne their discussion of the medicinal menu to prepare her for a visit to a psychopharmacologist; I concur with their prescriptions for friendship and a support group. Legal action appears not feasible here, unfortunately.

Eth and Harrison's prescription for Anne of "affectively charged, thorough re-experiencing of the traumatic event" converges with the intent (and perhaps, to some degree unclear to me, with the techniques) of the emotional work that I would use.

Methods I would not use involve encouraging Anne "to monitor and even exaggerate the frightening images," establishing of a "worry place" (Beutler), and teaching Anne relaxation techniques, conventional desensitization, or biofeedback (Eth and Harrison). Anne is overwhelmed with memories—so far as we know, not just images, but memories—of which it seems impossible to exaggerate the terror and anguish. Furthermore, memories overcome her "every few minutes," so that there would seem no chance of getting to a special place. Nor would I want to suggest, say, imagining a pleasant event or bucolic scene to someone struggling against memories of a father with sizzling implements of torture. In sum, I estimate that all these well-motivated prescriptions may be too weak in this case. They do not seem to me likely to allow the reconstruction of Anne's sense of self

that can be accomplished by elicitation and validation of intense expression of the emotions associated with the traumatic memories. However, since I have not treated a single survivor of abuse and torture by relaxation, desensitization, or biofeedback methods, my preference is nothing more than my preference. I could be wrong.

On the other hand, the principles my fellow panelists advance as underpinnings for their approaches also provide a rationale for eliciting intense emotional expression and validating responses (EEVR). In Beutler's words, "By reversing the patient's natural tendency to try to reduce anxiety, I would expect the anxiety to lose both its intensity and the second- order fear associated with it." And, again, Eth and Harrison's prescription of "affectively charged, thorough re-experiencing of the traumatic event" sounds as though it is just what the therapist is achieving; he needs encouragement to stay the course.

When the patient relives the memories of abuse and torture, utters climactic screams of pain and terror, and experiences the loving, comforting response of the therapist, then the primary terror (of the pain) and the secondary fear (of expression of pain and fear) will abate.

Recall that Anne experiences hours of relief after each session involving climactic expression with her supportive therapist. Given what she survived

and what she has made of herself, despite deafness, she will only become more stable in the course of intensely emotional therapy with a caring, supportive therapist.

Editorial Comment on Therapist-Patient Boundaries

We feel compelled to respond to the imputation of sexual impropriety in eliciting and validating climactic emotional expression. Criticism in the "Points of Contention and Convergence" sections may cause many panelists to feel misunderstood, and perhaps they all deserve another round for rebuttal. However, the potential damage in these hottest of charges requires special consideration.

In reproving "catharsis (ventilation) without redirection," Beutler cites studies of therapy unrelated to Saltzman's in origin, theory, or practice. Beutler ignores Saltzman's explicit statement that he never elicits emotional expression for ventilation, but always as part of the learning experience afforded by a spontaneous, warm response. Eth and Spencer write that they do not understand the rationale for gut screams. Yet Saltzman proposes not simply eliciting screams, but a deep process: ". . . to let love fulfill its healing role when the patient has cast aside his or her defenses in out-of-control expression."

Referring to elicitation of emotional expression, Beutler introduces pejorative phrases such as “forcing” and “intrusive” and projects the therapist as “forcing [the patient] to stand naked before him.” This may describe his own impulses or fantasies, since Saltzman prescribes collaboration and tender support. That climactic expression of emotion is achieved only through the patient’s will and determination to become whole again (not under duress and not compromised to please parents or others) is a major condition of its efficacy.

Eth and Spencer’s censure of a proposed offer of a hug after the most soul-wrenching work could be nearly as harmful to our profession as the “potentially dangerous transgression” they conjure up. A hug is a hug, not a touch on private parts. To suggest that these are the same—or that, because sexual congress between lovers sometimes begins with a hug, the offer of a hug must be tabooed as an invitation to sex— can have a chilling effect on a healing aspect of many therapeutic relationships. It would be as illogical to suggest that psychoanalysis or hypnosis or marriage counseling or dentistry leads to sexual violation of the patient. When exploitation occurs in any of these, it is not the profession or the method that is to blame, but a gravely dysfunctional mindset in the professional.

Similarly, Beutler cautions against lying next to the patient, although it is not uncommon in contemporary therapy for the therapist to recline on an

elbow next to a patient regressing to an early childhood state. Clinicians who defend against impulses toward impropriety by maintaining vertical, non-contact attitudes can be respected. On the other hand, therapists capable of finding sexual and emotional fulfillment in their own personal lives are not tempted to exploit their patients, obliterate their therapeutic accomplishments, and ruin their reputations. Hence, they need not abstain from reclining next to a patient or imparting warmth to heal the wounds of early abuse and deprivation.

As Saltzman states, if transference causes the patient to perceive the therapist as lustful, extractive, or sadistic, then holding is ruled out. Eliciting memories of traumatic abuse and validating a patient's emotional responses through giving the tender affection deprived in infancy demand the utmost professional skill and delicacy. Exploitative intent or behavior is incompatible with the character of a therapist capable of performing this work.

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