Under the Influence of Unconscious Process:

Countertransference in the Treatment of PTSD and Substance Abuse in Women

MARGARET A. CRAMER, Ph.D.*

PTSD and addiction are a marriage made in the avoidance of unbearable affect; an avoidance that is costly in the resulting traumatic reenactments experienced by patients whose attempts to escape the past keep them evermore tightly bound to it. Rather than "difficult patients" a more dynamic and intersubjective conceptualization emphasizes the notion of a "difficult treatment dyad." Vicarious traumatization, unconscious affects about addiction, and pressures within the treatment surround conspire to pull the therapist out of connection with the patient at critical points, and toward sadistic abandonment or collusive indulgence. The concomitant desires to rescue and desert patients create forces for action in the therapist, precisely when what is needed most is the ability to tolerate and contain one's own and the patient's affective experience. The pull for action is also felt by treatment systems, eager for "action" that can be measured in "behavioral observables." Support for the therapist in the form of process supervision can assist the therapist to contain, identify, and acknowledge his/her affective responses evoked in treatment. The therapist is called upon to "grow one's own heart" through a confrontation with the undeveloped parts of self that are vulnerable to the dynamics of the treatment.

In the chaos of settling into my new office in a well-known Harvard Department of Psychiatry, I focused on scheduling appointments and becoming familiar with clinic policies and procedures. It was several days before I glanced at the charts representing my new panel of patients. Browsing through the termination summaries, I read the final notes from the previous therapists.

Clinical Vignette 1

The chart described Ms. A., a single, white female in her late twenties with Schizoaffective Disorder, Bipolar Disorder, Borderline Personality Disorder, and Atypical Psychotic Disorder who, while in an alcohol-induced

*Clinical Instructor, Harvard Medical School. ***Mailing address**: 40 Beacon St., Melrose, MA 02176-5603.

psychosis nine years previous, had attempted to murder her five-year-old son. Numerous psychiatric hospitalizations had resulted from her many suicide attempts of high lethality, always while intoxicated.

Clinical Vignette 2

Another chart described Ms. B., a middle-aged white female with Borderline Personality Disorder, Atypical Psychotic Disorder, and Dissociative Disorder, who was characterized as "chronically suicidal, often psychotic in the transference, and frequently hospitalized." Chart notes revealed that the patient had a history of severe early-childhood physical, sexual, and emotional abuse at the hands of both parents. The patient was also reported to become paranoid frequently. Buried in a progress note was speculation regarding the patient's possible abuse of narcotic analgesics, originally prescribed for headache but more frequently misused to alleviate intolerable affects.

Clinical Vignette 3

A final chart read, "Ms. C. is a 50-year-old African American female, diagnosed with Post Traumatic Stress Disorder, Acute Stress Disorder, Atypical Psychotic Disorder, and Borderline Personality Disorder. Early childhood history included brutal physical and sexual abuse by adoptive parents." In the medical section of the chart, I noted that her most recent hospitalization had been for a minor automobile accident. There had been some speculation regarding the possible involvement of drugs or alcohol, but when the police officer learned of the patient's psychiatric history, no field sobriety test was conducted.

As I closed the charts and prepared myself to meet these patients, I noticed several responses. Intellectually, I noted that despite apparent differences in histories and experiences, these women's lives were strikingly similar. All had been diagnosed with a variety of Axis I and Axis II diagnoses; all had experienced traumatic events in childhood and had the behavioral sequelae in adulthood that replicated their inner wounds and chaos; and all had utilized alcohol and/or other chemical substances to ameliorate their suffering. In addition, all had had their substance use minimized or ignored by the providers of their care.

Physically, I noticed that I was suddenly quite tired and slightly nauseous, so I sat up a little straighter and attempted to take a few deep breaths. Before heading to the waiting room, I stopped at the hospital gift shop and purchased a pack of Lifesavers, a candy I never eat. I came to understand much later that that moment was an initial attempt at self-soothing and rescue; apparently, I could not bear knowing that I was

already feeling inadequate to the job. Without realizing it, I was, even prior to meeting any of these patients, feeling pulled into the vortex of denial, minimization, and shame that characterizes addiction and trauma.

These women represent a growing number of so-called "difficult" patients with substance abuse and some form of PTSD that present special challenges in treatment for both patient and therapist. This paper will explore the treatment dilemmas in work with this population as mutually constructed, unconscious cocreations of both therapist and patient. I will discuss the paradoxical nature of these experiences as constructions in the present and as repetitions of old injury, as threats to affect containment, and as the ground upon which a new affective competence grows. Throughout, the centrality of the treatment alliance and the management of countertransference affects will be emphasized. Finally, the benefit of process supervision in the treatment of this population will be explored.

PTSD, ADDICTION, AND WOMEN

This population is of clinical interest for several reasons. First, the prevalence of traumatic violence and substance abuse in women makes this a symptom constellation worthy of study. The National Co-Morbidity Study found that women were twice as likely as men to develop PTSD after exposure to traumatic stimuli (1). Research has suggested that, although women begin using substances later than men and seek treatment earlier in the course of the illness, they have a significantly higher prevalence of comorbid psychiatric disorders than men, especially depression and anxiety (2). The second most common psychiatric disorder in women with PTSD is substance abuse (1). A history of traumatic violence results in impairments to the acquisition of adequate coping skills. This increases reliance on addictive substances for coping, and addiction itself is a high-risk life-style that increases an individual's risk of exposure to additional trauma (3).

Second, the biphasic neurobiological dysregulation found in the symptom clusters of PTSD leads to diagnostic difficulties. Patients can easily meet the criteria for disturbances of thought, mood, and character depending on the presenting problem and current level of stress (4). In addition, substance abuse can mimic, mask or exacerbate psychiatric symptoms. Similarly, withdrawal from substances can mimic, mask or exacerbate psychiatric problems (5).

Finally, the level of psychopathology generated by the co-occurrence of these disorders is severe. Kessler (6) found that individuals with PTSD were six times more likely to attempt suicide than controls. Chronic

physical abuse, sexual abuse, and neglect, especially prior to age 15, create a pervasive experience of psychological threat, one all the more damaging because, unlike a discrete event, it is an atmosphere to which one becomes habituated. Early childhood trauma undermines the capacity for both intrapsychic and interpersonal relatedness, such that affect tolerance and relational competence are compromised in profound ways. Mental states lose elasticity, affect regulation becomes impaired, and the personality structure takes on the familiar rigidity often associated with character disorders. Individuals in this population are particularly vulnerable to developing Type II Alcoholism. These patients utilize alcohol and other drugs to relieve the stress of painful internal states associated with extraordinary life events. It is generally considered to be an earlier and more severe form of addiction (7).

IMPORTANCE OF THE THERAPEUTIC ALLIANCE

Clinical studies, theoretical discussions, and treatment-outcome research have indicated that the therapeutic alliance is the cornerstone of successful treatment with dually diagnosed individuals. Miller and Rollnick (8) found that nonspecific variables, i.e., characteristics of the therapist, accounted for two-thirds of the variance in positive treatment outcomes in a study of addicted patients. In psychotherapy, Modell noted, "the treatment depends. . . on his (therapist's) capacity to maintain a sustained interest in and relationship with his patient," (9). The therapist's ability "to convey an intrinsic interest in the patient" has been shown to be more decisive in treatment success than position, technical knowledge, or theoretical orientation (8, 10). Petry and Bickel (11) found that among dually diagnosed substance abusers, a strong therapeutic alliance was essential to successful treatment completion. The therapist's qualities of empathy, warmth, strength of mind and character (heart), then, must be maintained throughout treatment crises and cannot be faked, making the affective competence of the therapist and the management of countertransference a central component of treatment (12).

THREATS TO THE TREATMENT ALLIANCE

Clinically, PTSD and substance abuse are a marriage made in the mutual avoidance of affect. The coincidence of high-risk behaviors associated with traumatic reenactments and the use of chemical substances to alleviate intolerable feeling states result in patients progressing through treatment more slowly, being hospitalized more frequently, and suffering more severe regressions of both illnesses than patients experiencing either one

alone. Conflict-free areas in the patient's character can deceive both patient and therapist into believing that the patient is more capable than he/she actually is to take risks and explore painful affect. Among a host of other impairments and once full-blown, PTSD and substance abuse function as mutually reinforcing impairments to the capacity to feel. Patients become trapped in a cycle of using substances to numb, as well as to stimulate affect, in an increasingly futile attempt to ward off deadening numbness or overwhelming affective flood. Early traumatic abuse and neglect create an intolerable dilemma for the child in that the needed caregiver and potential source of safety is also the source of threat. If the internal state of the caregiver is hostile to the child, the child must avoid empathic connection to the needed other. If the child is effectively cut adrift from his/her own internal experience and the soothing potential of relationships with others, the development of empathy for others and reflexive functioning is impaired. It is from the ground of this relational disaster that the characterological difficulties associated with Borderline Personality Disorder emerge.

As a result of these vulnerabilities, traumatized addicted patients communicate in "the theatre of action" rather than the "theatre of language," creating an enhanced sense of urgency, the desire to act rather than feel, and an ambience of jeopardy for both patient and therapist. When the patient's most vital affective information is communicated in action, the therapist is challenged to become quickly a fluent behavioral translator.

These behaviorally eloquent patients often bring outside scrutiny to the treatment in the form of dramatic and self-destructive acting out, legal involvements, and anxious ancillary care providers. Systems fragmentation, lack of communication, and the absence of a shared vocabulary between systems set the stage for a parallel process in which the treatment surround itself becomes involved in recreating the confusion and unpredictability of the patient's early environments. For example, the first step of AOD (alcohol and other drugs) recovery requires the admission of powerlessness over the disease. If her psychological treatment focuses on empowerment, the patient could feel confused and triggered for a relapse of either or both disorders.

Diagnostic confusion, high levels of psychopathology, social attitudes regarding the use of alcohol and other drugs, and impingements on the treatment surround make the clinician treating such patients vulnerable to feelings of shame, rage, and despair that mimic the patient's core experience and threaten the treatment alliance. Unmetabolized affects associated

with traumatic injury and addiction leave the therapist vulnerable to action through the need for control, a desire to reject, suspicion of the patient's culpability, and a compulsion to rescue, bend the rules, or make exceptions. Ehrenberg Bregman (13) noted that while most clinicians subscribe to the notion that the patient requires our unconditional positive regard, these patients are particularly adept at inducing hatred in the analyst. Blame and disgust of the patient are not uncommon, and the overwhelming desire to distance oneself from such extraordinary experiences threatens containment. Numerous treatment crises conspire to pull the therapist out of connection with the patient and toward collusive indulgence or sadistic abandonment.

Though there has been some literature on the topic of vicarious traumatization, the unconscious process and primitive affects associated with the treatment of chronic PTSD and addiction, especially for the therapist, have been relatively unexplored. Therapists report being burned out by such patients; some leave jobs, and others leave the field entirely (14). Understanding the psychological terrain of this treatment may assist therapists in anticipating the dilemmas ahead, but more than didactic education is necessary.

INSIDE THE CONSULTATION ROOM

The wounds the patient has suffered and the attempts to soothe with chemicals result in a false self-presentation that is brittle and unconvincing. Any understanding of the patient seems ephemeral and is often eclipsed by the direct influence of drugs. Indeed, initial treatment can have a counterfeit quality that is often experienced by the therapist as "here's another manipulative addict with crocodile tears and a desire for only one kind of help: drugs." It is as if there were a third patient in the treatment, with the drug of choice functioning as the central relationship in the patient's life, the one thing that has not disappointed, abandoned, or injured.

Clinical Vignette 1 (cont.)

Ms. A. outlined her current dilemma and the challenge for the treatment ahead in the first session. "If I don't drink, I'll die," she stated, yet every one of her multiple suicide attempts had been committed while under the influence of drugs and alcohol. Although she was guarded and angry through much of the hour, her demeanor changed dramatically when I inquired about what she loved about using and about the history of her relationship with alcohol. When she spoke of her first episode of intoxication her eyes glowed, her face relaxed, and she smiled for the first time.

"Finally, I felt that I belonged; I was like other people. It was like I had been waiting for this my whole life, like something that was missing from me was now there; I was whole. I thought, 'Maybe this is the way normal people feel all the time.'" It became clear that alcohol functioned for Ms. A. as an antianxiety, antidepressant medication that eased the chronic discomfort of being with others and protected her from an equally unbearable internal emptiness. It was the needed maternal object that could be summoned at will. Alcohol was the love of her life, and attempts to too quickly suggest a divorce would be met either with superficial compliance followed by preemptive termination or simply by preemptive termination. The knowledge that the relationship was costly and destructive was obscured from the patient's consciousness, while as the therapist I was all too aware of the danger. It was from this enmeshed and deadly love affair that I was to coax her away through the substitution of a dependence on the treatment relationship for a dependence on alcohol and other drugs.

The difficulties of being able to tolerate relatedness with others and one's own feeling states when frenetic chaos has been one's psychological "home base" can make treatment frustratingly slow for both patient and therapist, create more treatment impasses and crises, and provoke rage and despair in both members of the dyad.

Clinical Vignette 2 (cont.)

During the initial assessment of Ms. B, she was angry and direct. She could not identify disadvantages to her drug use, as she was certain she would kill herself. "It's only a question of 'when,' not 'if,'" she stated glaring at me and daring me to talk her out of it. It was a straightforward plan. Drugs would ease the pain for now and provide the vehicle for her destruction. They were her tormentor and savior, her ultimate antidepressant, her escape hatch. Ms. B. was thus trapped in a nightmare world of counterfeit comforts and increasing risk from which she was only mildly interested in escaping.

Core anxiety and fears of relationship resulted in acting out that was so crisis ridden and saturated with risk that the establishment of the treatment frame itself felt like a long-term and impossible goal. Indeed, the initial phases of these treatments were marked by an increasing sense of confusion diagnostically, and a growing sense of alarm professionally and personally. One session, the patient presented with depression, the next, panic disorder, and a third, psychosis. Tales of near escapes, late-night walks in risky neighborhoods and liaisons with addicted men filled the

hour. Observations offered regarding the neglect of self and level of danger being courted were greeted with derision and ridicule: "You think this is bad; you don't know the half of it." These narrations served a number of important functions: narcissistic display, the exercise of sadistic power over me by "forcing" me to listen, an invitation to "victimize" her through sadistic control, or to sink into the apparent hopelessness of her situation and foreclose the dangerous possibility of change. Further, the compulsion to repeat forced the fundamental dynamics and roles of trauma, victim, perpetrator, and witness into the treatment alliance.

Calls to action were numerous as each patient tested the notion that our paying attention to her and coming to understand her experience could possibly help. Sessions often opened with, "you have to . . ." or "you must help me . . ." or "you've got to do this for me." Any perturbation of the treatment frame, such as my planned absence for vacation, easily undermined a fragile sense of psychological safety. It was also experienced as a humiliating narcissistic injury that provoked rage and the impulse for retaliative, self-destructive behavior. Though somewhat responsive to my attempts at containment and reassurance without concrete action, the patient's desire to control me sadistically, cloaked as it was in masochistic helplessness, was a powerful force in the room. I interpreted these observations in the sessions and attempted to interest each of my patients in a collaborative effort to be curious about their difficulties. I thought initially that the task of treatment was to interest each woman in redefining control and power in her life as sobriety and stability rather than addiction and affective volatility. I came to realize that the risk of forming a relationship with me to accomplish these tasks was the first, last, and enduring challenge.

The challenges for me were less clear. I understood the dynamics intellectually; the patients' relational impairments were coming alive in the treatment in an accurate rendering of both the fundamental problem and its best-to-date solution. Though I felt focused in the sessions, I noticed that I felt less "well" outside the clinic and began to dread the upcoming hours. Paradoxically, missed sessions left me even more vigilant and worried. I began to feel that I was doing too much and too little, and the worse I felt, the more I hid it from my colleagues and myself. Staying with these patients in what is thought of as experience-near interpretations meant managing my increased levels of anxiety and with them a desire to do what every other provider had done: attempt to control their behaviors rather than treat their illnesses, or collude with their addiction by ignoring or minimizing it. Affective containment of the patients' and my affects

emerged as a linchpin of the treatment; it was the fulcrum on which the precarious work of treatment balanced.

THE COCONSTRUCTED TREATMENT DILEMMA

Clinical Vignette 3 (cont.)

I was grateful to have at least some of the action inside the consultation room. A pattern developed for Ms. C. such that, as the time of the appointment grew near, I would be notified that she had presented to the Emergency Room with a new crisis: something had happened on the job; she'd had contact with her abusive biological mother; one of the neighbors had insulted her. The real crisis, of course, was the impending danger of her upcoming encounter with me in treatment, a crisis that had to be highlighted, disguised, encountered, and avoided by the emergency room drama. Her terror around feeling at all vulnerable was displayed in a withering, contemptuous tone with which she addressed interpretations regarding the real source of her worry: "Oh, you think this is about you; you think I have feelings about you. How patronizing you are. No, wait, you're not patronizing, you're matronizing." Often, my patient's introjects and internal working models of relationships were so intensely negative, hostile, and destructive, that the atmosphere of risk, jeopardy, and hostility to the treatment relationship filled the consultation room like carbon monoxide, colorless, odorless, and absolutely lethal. Sometimes she would ask me to guess whether or not she had been using. I steadfastly interpreted her sadism and desire to control me as ways to help me understand what it had been like to be her, to give me a taste of what it felt like to be one down and to be treated with contempt and disregard, and how wonderful and awful it felt to be on the other end of things for a change. The notion that something could truly be about and for her without the risk of exploitation was virtually incomprehensible. Past trauma washed over the details of here-and-now life, as she struggled to notice her own hand in the perpetuation of chaos and crisis. Brief moments occurred when she could bear to be in the room in a less anxious and aggressive way. These were easily disrupted and followed by a paranoid and angry retreat.

Clinical Vignette 1 (cont.)

Ms. A. often missed appointments, and at times showed up unsure of the type of healing we could accomplish together. For example, Ms. A. arrived at the clinic for a session 25 minutes late with a bleeding arm, having driven past several hospitals on route to show me the wound, asking "Can you help me with this?" After asking her if she could walk, I escorted her to the emergency room and reminded her of our next session. Several

months later, she reported having driven drunk to the emergency room, where she felt badly treated. When she fell in the bathroom, Ms A. threatened to sue the hospital for having neglected her. Her all-too-real wounds were emblematic of a deeper dilemma. Without dramatic, bleeding wounds and urgent crises, would anything about her be worthy of attention at all? Would she be seen without an "obvious" wound? What about her was important? Her conviction that all attempts to seek help would result in exploitation, abuse or neglect was unshakeable at first. Creating the possibility of a new experience would be the fundamental work of the treatment. In the meantime, I was soon on a first-name basis with all staff shifts of the emergency room.

Clinical Vignette 3 (cont.)

During a relatively quiet week, I was paged to the waiting room in the Department of Psychiatry. When I arrived, my patient, Ms. C., was no longer there, but evidence of her distress remained in the overturned chairs, tables, strewn magazines, and unhappy faces I encountered. The patient had apparently appeared in the clinic without an appointment and had demanded to see me. She was intoxicated. I had apparently not appeared quickly enough. Before I could inquire or explain, I was paged again, this time to a utility closet near the maternity ward. With security in tow, I was again too late, but in time to receive disapproving and somewhat scornful looks from the staff. My patient was apparently belligerent and loud and reeked of alcohol. This cat-and-mouse game continued through several more rounds until I caught up with Ms. C. in the emergency room. From a darkened bay and in four-point restraints, my patient bellowed, "It's about time you _____ing showed up." I recognized the staff in the ER as the usually helpful, competent, and empathic crew who routinely treated complicated psychiatric patients with great skill and care. Now, however, these faces looked at me with distinct disapproval. Through pursed lips the Unit Manager said, "I believe that's *your* patient, Doctor." I don't know if my face flushed with the rush of shame I felt inside, but the walk across the ER was among the longest in my life. It occurred to me that the parents of delinquent children must feel this way. The implication was clear. If the patient had a more competent, smarter, better therapist, the patient would not be in this kind of trouble. Certainly, she would not be drunk.

Intellectually, I understood many elements of the drama: the need to have me as immediately available as the drugs had been; the search for mother (the stop at the maternity ward); another rendering of the victim/

perpetrator/witness paradigm into our relationship; an expression of, and attempted solution to, the essential relational dilemma. Consciously, I was aware of some of my discomfort and the need to remain constant, available, and protective of the treatment frame. My unconscious rage, helplessness, and grief over my patient's dilemmas, and the intense desire to escape my distress, however, were creating an ambient risk to the treatment relationship; they were also constructing the stage on which the patient's most profound concerns would be replayed, not, hopefully, in a traumatic reenactment, but in a healing experience. In the emergency room the day I chased my patient, my affective experience as I crossed the room to my screaming patient under the scrutiny of my colleagues and the disapproval of my own superego included shame at my incompetence, the desire to abandon my patient ("I think she'd do better with another therapist"), the desire to flee the scene ("I could start over in a new city, in a different field where no one knows me"), and boiling hatred of my patient. Those feelings temporarily outshouted my tiny observing ego that thought, "What's the message here? Does she want me to feel some of what she has felt? Is this a test of my willingness to work with her? Or is she presenting me with a fundamental dilemma: will I be able to stay connected to her without allowing her to control and overwhelm me, but without sadism and shaming?" Her compulsion to repeat early experiences of harm and its concomitant self-destructive rage had become the organizing system for all she could not remember, feel, and integrate into experience. In a very real here-and-now way, then, the treatment alliance itself would represent "the scene of the crime," the world of affective experience in the field of two people that presented hope and dread for change. Just as my traumatized patient had experienced so often in her life, my immediate concern was to survive the circumstances before me and then regroup. I began to think less of a "difficult patient" and more in terms of a "difficult treatment dyad."

The patient's profound concerns about autonomy were counterpoised, of course, with deep yearnings for connection. The negotiation of these twin imperatives played an important role in the maintenance of the treatment alliance. Ms. C.'s desire to gain control over a chaotic life experience was weak, mistrusted by patient and therapist, and felt to be too feeble to protect effectively against "inevitable" usurpation by the therapist. The patient searched for evidence that her recovery was the therapist's agenda and often experienced offers of assistance as intolerable bids for control. Tests to the alliance multiplied, as the patient waited for the inevitable: she would succeed in manipulating the therapist or the

therapist would succeed in controlling the patient and the treatment would be doomed. As the patient balked, lied, evaded, and manipulated, the therapist responded internally with injuries to her image of self as benign, helpful, and tolerant.

Although it appeared that each of these patients was beginning to form some attachment in treatment, there were numerous hospitalizations, detoxes, and crises well into the first year. And while I felt able to attend to them in each hour, I began to notice that I felt increasingly fatigued and, somehow, dispirited outside of session. After approximately three months of what felt like the longest spring of my life, I had successfully taken on the affective features of my most traumatized patients: sleep disturbance, affective numbness and withdrawal, and a generalized experience of pervasive dread, all encompassed in an increasingly globalized atmosphere of threat. Worse, I was ashamed to admit my growing feelings of incompetence. At home I became quiet and reclusive; I developed a sudden and keen interest in mafia murder mysteries and television programs about home construction. When I finally tried to discuss my distress with colleagues, my attempts to communicate bore an uncanny parallel to my patients' experience of feeling disappointed and misunderstood in trying to share the details of their traumatic experiences. I was told smilingly that I was doing "fine." After all, I had been given some of the clinic's "heavy hitters." Sober discussion proved inadequate. When I burst into tears in a meeting with a colleague, I was heard. It was a reminder, I thought, of the power of affect, and one reason why my patients act out so "loudly." Perhaps they feared not being heard.

COUNTERTRANSFERENCE AND PROCESS SUPERVISION

Once considered a technical error, countertransference has been more recently and dynamically called "the therapist's inability to feel" (12). Russell proposes that what must be felt and understood are the affects the patient needed to experience in order for psychological growth to continue. He noted that trauma could be understood as stopping points in the growth of early "necessary relationships," places of developmental arrest that create maturational impairments in the patient's capacity to feel. But in the coconstructed treatment dilemma, the therapist participates unconsciously in the avoidance of affect and in the reenactment of the patient's core conflict. I did not want to feel the power of my own murderous rage, the narrowness of my compassion, and the depth of my fear. More than anything, and in a manner parallel to the women with whom I was working, I did not want anyone to see these shameful limitations.

Process supervision provided a haven for the affective disorientation and distress I was experiencing. Unlike clinical case supervision, where the focus is on the progress of the patient, process supervision offers the opportunity to examine the state of the treatment relationship. Especially for less experienced clinicians, process supervision can provide vital shoring up of leaks in affect containment. One consultant likened the enterprise to the manner in which mountaineers belay or tie ropes around each other to support one another in the climb. These patients were out on dangerous cliffs. In order to reach them, I needed to be safely anchored myself.

My consultant, Dr. G., listened closely to the details of an hour with each of my patients. Without realizing it, I conveyed my unconscious belief that neither the patients nor I were up to the task, and that I resented them deeply for exposing my failures so clearly. I started to understand that my ability to survive each session while feeling depressed and overwhelmed outside of it was deeply meaningful to the developing language of the treatment. My experience unconsciously mirrored the patients' terror, shame, and feelings of incompetence. My wishes and fears found their way into action: mafia murder mysteries to satisfy my rage and sadness as both victim and perpetrator; home construction as a tangible expression of the slow and difficult work in treatment. Together we were constructing the tenuous "play-space" in which the patient would tell the only story of her life that really mattered: not the drama of terrible abuse per se, but the broken-hearted, self-loathing mistrust, and deep sorrow that comprise the legacy of having been so profoundly unloved.

Dr. G. refused to shame me for real or imagined errors and invited my most difficult affects into the room. Most importantly, she established an atmosphere of warm, lighthearted collaboration in the face of the serious work ahead; in doing so, she modeled the affective climate I would soon establish with my patients. She reframed my distress as a "perfect affective attunement" to my patients. "You're doing your job too well," she said, and I relaxed for the first time in months. My feelings of being overwhelmed and the potential for my rage and sadism to spill into action eased into something warmer and more manageable. Finally, my heart could join my mind full strength in the service of the treatments. I felt hope and a renewed faith that I could sustain the process of treatment for all of these women. We scheduled the next meeting and she headed for the door. "Don't worry," she said, "this will be fun."

It is well known that the task of mourning for the patient is painful and daunting. But what must the therapist grieve: the loss of the fantasy of

empathic perfection; shame in the face of one's own profoundly unlovable affects; the loss of the myths of the perfect patient/therapist relationship (the one who, much like the fantasy of a lost parent or imagined lover, is difficult only in ways that can be managed well); the loss of our good reputations with ourselves; and potentially, the actual loss of regard from colleagues and ancillary providers whose provoked anger and anxiety has led them into a traumatic reenactment of their own, e.g., calling the therapist with demands that "you have to *do* something!" What truly had to be done, of course, was for me to increase my ability to tolerate the patients' and my sorrow and rage; to understand in a heartfelt way that the patients' pull for sadism, rejection, and hopelessness from me, was met by my desire to desert, avoid my shame, and remain unaware of my distress or control it by acting in the treatment.

After months of process supervision and a more intimate relationship with my own murderous rage, shame, and the limits of my own compassion, my energy, love of the work, and delight in my patients returned. This was illustrated one afternoon in the clinic when a clinically sophisticated and deeply offended psychopharmacologist came by my office and said, "*Your patient* (Ms. A.) tried to get *drugs* from me." My patient had used all of her street smarts and savvy to obtain klonopin from my colleague. "She's a drug addict," I smiled, "that's what she's supposed to do." Together we talked about where this patient was in her readiness to change, her current stresses, her shame, her profound mistrust of us, and our ability to help her. We discussed a plan that would allow both patient and prescribing physician to build trust in her ability to manage medication safely and effectively. Most importantly, I tried to give this lovely and compassionate man a way to think about her that would allow him to treat her without hating her or ignoring her addiction. I tried to pass on to him some of what had been given to me by my process supervisor.

Increasingly, more benign versions of the central treatment dilemmas emerged, and with them challenges for therapist and patient to grow. The patient's ability to move from action to affect within the treatment frame and within the treatment hour was eloquently demonstrated as I was leaving for a planned vacation. Ms. C. arrived for the session with a plastic bag filled with "gifts," such as gum, pieces of candy, etc. One by one she took these from the bag and tossed them across the room, with increasing emphasis. The sadistic smile on her face said it all. The wave of hatred that washed over me was no longer alarming but a signal to be understood. The affective pull of the hatred contained two significant pieces of information: it was an invitation to counterattack by using my power to shame and

control her as she was attempting to do to me; and it was a communication of her fear that I was trying to humiliate her by exposing her dependency on the treatment and me by abandoning her. After a while I said, "You're so furious and sad with me that I'm going away. Yet you're trying so hard to say goodbye well." The brittle mask crumpled and Ms. C. began to cry. She had been able to risk vulnerability. Nothing would be the same again.

Ms. A. felt very unsure about letting go of her resolution to kill herself. "Resignation is at least peaceful; don't torment me with hope," she warned. By attempting to manage my own anxiety about her level of risk, I was able to set a pace we could both bear. I struggled to allow her commitment to dying into the room during each hour, neither joining in her despair nor trying to argue for living. I had a frequent association during those hours of the two of us donning miners' hats and with headlamps and flashlights traversing the dark caverns of her depression and hopelessness to the burning rage at its center. Together we negotiated a successful hospitalization on a dual-diagnosis unit, different from other hospitalizations, "because," she said, "I had decided to be there. Maybe I can live after all; maybe I even want to." Slowly, deep narcissistic wounds around self-effieacy, power, control, vulnerability, and dependence began to heal in what could be termed "baby steps" rather than the lock-step improvements expected from individuals recovering from either illness alone. Moving from action to affect within the treatment dyad created both safety and the contrasting experience that these women had longed for and dreaded. For each, the establishment of a mutual, collaborative relationship as opposed to the one-down, power-based exploitation that was expected/hoped for/feared was both the vehicle for treatment and an important part of the "cure."

CONCLUSION

Unconscious affects associated with trauma and addiction can evoke the therapist's feelings of deprivation, the need to be gratified as a good and competent person, and the desire to escape or avoid the experience of being trapped in an impossible situation. Profound relational deficits associated with early-childhood trauma cut patients off from relationships as a source of soothing and increase their vulnerability to a form of addiction characterized by novelty seeking, higher risk, and poorer prognosis. The therapist is vulnerable to reaction formation that turns loathing into a false empathy, a kind of sympathy that is one-way and functions as a denial of the therapist's painful affects. The therapist's parallel experience/desire to escape the treatment; the fantasy that other clinicians have

"better" patients, easier lives; despair that other therapists would manage these patients in smarter, more effective ways; and hatred of this "bad patient" create the inevitable dilemma that is both an opportunity for healing and a risk for reenactment.

Holding the "middle ground" between two disparate and contradictory realities simultaneously is no small task. The therapist must believe that he/she can keep the patient alive and help her improve, while, at the same time, knowing absolutely that he/she has no such power. The patient knows this as well, though not consciously, and returns again and again to the questions of hope and despair about change. The repetition compulsion's power to "make" things happen within the treatment is the "necessary danger" that the treatment alliance forms and confronts; the container for affective distress and the theater in which the deepest pain is yielded into the "action" of language and affect.

The therapist must do what the patient cannot, sit still and feel, while remaining attuned to the patient's experience and his/her own internal states. Not unlike our patients, we also may have the fantasy that "this time, it'll be different, I know more. I won't get lost or have to feel such heightened levels of distress," knowing the whole time, of course, that we will. Communicating acceptance of the patient while "going to war" against the illness that robs her of the ability to feel, live, love, and work, is the ultimate challenge and opportunity of the treatment. It demands humility and courage on the part of both patient and doctor to improve.

REFERENCES

1. Brady K, Killen T, Brewerton T, et al. (2000). Comorbidity of psychiatric disorders, *Journal of Clinical Psychiatry, 61* (suppl 7).
2. Breslau N, Davis G, Peterson E, et al. (1997). Psychiatric sequelae of posttraumatic stress disorder in women, *Archives of General Psychiatry, 54*, January.
3. Brown P, Wolfe P (1994). Substance abuse and post-traumatic stress disorder comorbidity, *Drug and Alcohol Dependence, 35*, 51–59.
4. Brady K (2000). Advances in diagnosis and treatment of posttraumatic stress disorder, *Primary Psychiatry, 41,* March (suppl 3).
5. Brady K, Randall C (1999). Gender differences in substance abuse disorders, *The Psychiatric Clinics of North America, 22*, 2, June.
6. Kessler R, McGonagle K, Zhao S, et al (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Archives of General Psychiatry, 51,* 8–19.
7. Crystal H (1982). Character disorders: Characterological specificity and the alcoholic, In EM Pattison, E Kaufman (Eds.), *The encyclopedic handbook of alcoholics.* New York: Gardner Press.
8. Miller W, Rollnick S (1991). *Motivational interviewing: Preparing people to change addictive behavior.* New York: The Guilford Press.
9. Modell A (1990). *Other Times, Other Realities: Toward a Theory of Psychoanalytic Treatment.* Cambridge, MA: Harvard University Press, p. 23–24.

10. Connors G, DiClemente C, Derman K, et al. (2000). Predicting the therapeutic alliance in alcoholism treatment, *Journal of Studies on Alcohol, 61*, 139.
11. Petry N, Bickel W (1999). Positive therapeutic alliance helps clients complete substance abuse treatment, *The Brown University Digest of Addiction Theory and Application, 18*, July.
12. Russell P (1998). The role of paradox in the repetition compulsion, In J Teicholz, J Guss & D Kriegman (Eds.), *Trauma, repetition, and affect regulation: The work of Paul Russell.* New York: The Other Press, LLC.
13. Ehrenberg Bregman D (1992). Constructive use of countertransference and dangers of countertransference resistance, In C. Stuart (Ed.), *The intimate edge: Extending the reach of psychoanalytic interaction,* New York: Norton.
14. McCann L, Pearlman LA (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims, *Journal of Traumatic Stress, 3*, 1.