

# When the Patient is Abusive to the Therapist

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We like to think of ourselves as healers in many respects, with a task of helping those who have been hurt. But what about times when those whom we wish to help are hurting us, the therapists? Those of us who have any sort of basic training in trauma are not surprised when our patients have negative transference: That is indeed the realm of our work from day to day. But we are often unprepared for the point at which negative transference crosses over the boundary to disrespect, aggression and even abuse, and what to do about it.

There are several reasons why we get caught unawares. Basic training often does not include much in the way of education on limit setting with patients who are verbally aggressive or disrespectful, only addressing those who are outright violent in their behavior. However, the former type of patient is much more common in private practice setting than the latter. We are taught that maintaining the relationship and not being aggressive ourselves are important. They *are*, but not at the expense of the therapist's well being. The therapist should not have to be abused in order to help an abused patient. Allowing a patient to be aggressive and disrespectful toward you only reinforces that this behavior is acceptable in relationships. Often these patients are coming to us precisely because they are losing relationships due to their difficult behaviors, so we have an obligation not to collude with them to continue a destructive course of behavior.

Many therapists have the mindset that therapy is an opportunity for the patient to finally express long suppressed anger, no matter how aggressive or disrespectful. Wrong! It is not expression of anger *per se* that is helpful in therapy. In fact, we know that intense expression of affect in many patients with self regulatory issues tends to increase emotion and out of control behavior, not decrease it. The key is in learning *how* to be angry *while still maintaining a respectful relationship and staying in the present*, regulating it to something manageable, and acknowledging the vulnerability behind the anger. Some therapists may excuse the behavior because it is located in a particular dissociative part, such as one that imitates the perpetrator, or that is always angry. The patient may insist s/he has no control over that part, and the therapist might believe that the only way to get this part into therapy is to accept the behavior. Dissociation is not an excuse for bad behavior! The therapist can say something like, "It is important for all parts of you to participate in therapy. Some parts of you know quite well how to manage your behavior. Let's see how those parts can help the parts of you that have so much trouble with their behavior." Or you might say, "If that part cannot be here without maintaining control, maybe you can be a spokesperson and translate;" or "the adult part of you needs to be here with this part so that you can maintain control." There are some hypnotic interventions to help contain aggressive parts, but they are beyond the scope of this article. Explain why behavioral control is necessary so that the patient has some grasp that the therapist is not just trying to exert control and suppression, but rather is trying to help him or her learn to regulate, an important function in daily life and relationships.

And some therapists have a kind of implicit belief that they must “take it” in order for the patient to heal: disrespect and verbal abuse are part of the package. Again, wrong! We did not sign up to become physical or emotional punching bags. So what to do?

The therapist should first be able to recognize what is abusive or disrespectful. Of course, this can be relatively subjective, but mostly we know (un)acceptable behavior when we experience it. What is important is that we know our own limits as a human beings. There are certain ways in which we would not allow our own children to behave toward us, or our own friends or partners. These limits should be general healthy guidelines in therapy. After all, no one else in the patient’s personal or professional life is likely to tolerate these behaviors very long, so the sooner she or he learns to deal with anger differently, the better. Unacceptable behaviors include: name calling; stalking; harassing, aggressive or threatening emails, phone calls, letters, or texts; bringing weapons of any kind to session; yelling, screaming, or cursing at the therapist; throwing things in session; destroying property on the premise of the therapy office (including parking lots); or threatening the therapist, the therapist’s colleagues, or the therapist’s family.

Of course, the patient’s anger must be brought into the therapy hour, so the therapist must not be avoidant of anger and conflict in general. Therapists who tolerate abusive behavior from a patient typically are feeling helpless, overwhelmed, and intimidated, although a very few have a counter-phobic attitude that ends up promoting more conflict than is necessary. Consultation, supervision, and therapy can be helpful to the therapist in sorting out the ability to tolerate a patient’s intense anger

versus the reality of being abused by the patient, and can support setting appropriate limits.

The therapist should be careful not to unduly provoke the patient into a defensive stance where aggression is more likely to occur. The more stable, consistent, and predictable the therapist and the therapy, the less likely the patient will become dysregulated. The therapist should be willing to admit mistakes and empathically align with the patient’s hurt without supporting aggressive behavior. A few issues that are likely to evoke aggression include: getting into a power struggle (the therapist always loses!); conducting therapy outside the window of the patient’s affective tolerance; premature memory work before stabilization; working with angry or sadistic parts without sufficient preparation; working with child parts in a way that evokes too much dependency; not including the “adult” part of the patient in sessions; evoking shame reactions without the ability to work through them; and defensiveness on the part of the therapist toward the patient. Ideally, the therapist remains grounded in the face of the patient’s dysregulation, able to be empathic *and* set appropriate limits.

Therapists are surprised to discover that dissociative patients can often control more of their behavior than they (therapist and patient) think they can. Of course, the best predictor of violence is a history of violence. Be sure to take a careful history of the patient’s acting out. If there is a history of violence or aggression, especially toward a former therapist, the therapist should take many precautions before proceeding, and regular consultation is in order. The capacity to accurately assess suitability for outpatient psychotherapy is paramount.

State your limits as soon as therapy begins and discuss consequences. For example, "We are here to help you learn to manage your emotions and behaviors in ways that are more productive for you. It seems that anger is something you struggle with a lot. My guess is that when you are angry, a lot of the time it is because you feel threatened and unsafe. We both need to feel safe and not under threat to work together, so we both need to work to make this a safe place. In order to do that, we need clear 'rules of engagement' about how you and I handle anger and conflict. You are welcome to feel angry and to tell me so, but you may not...(throw things, scream, curse, threaten, etc.). If that happens I will stop the session and we will meet again once you are able to calm down. And you should know there are certain behaviors that will result in your termination from therapy. These include...(stalking, threatening, physical violence, etc.). For my part, I will do my best to be as consistent as humanly possible, admit and correct any mistakes or missteps, and talk with you (all parts of you) about ways we can continue to conduct therapy safely.

If a patient becomes increasingly aggressive and the usual grounding and calming interventions do not work, the therapist can suggest a "break" in which the patient leaves the office and walks around outside for 5 or 10 minutes for a cooling off period. Then both return to see if therapy can resume. If the patient continues to be abusive upon return, the therapist can stop the session and indicate that therapy will resume the next session, if the patient can remain within behavioral bounds. It might be helpful to write a brief note for the patient, because s/he will be in no state to retain your verbal comments. This note might say something like, "I stopped the

session because you were (...cursing and screaming), which makes therapy impossible, and disrupts other people in the office. I understand that you are angry, but we cannot conduct therapy when you are unable to have a dialogue and when neither of us feels safe. I am confident that we can continue in the next session and discuss ways to prevent this behavior in the future while still acknowledging your painful and intense feelings. In the meantime, please work on grounding yourself and calming all parts of yourself. We will continue to work together on any obstacles that make these skills difficult to practice effectively." . It is most important to follow through on any consequences that you have set with the patient. Of course, the patient who is asked to leave a session may make innumerable calls or emails to the therapist afterward in an abandonment panic or continued rage (or both). A single, extremely brief written response might be in order that does not address content, but simply says that you understand it is difficult for the patient to wait, and that you will see him or her in the next session and will talk about it then.

When a patient is clearly becoming more agitated, begin immediately to help ground and calm, and stop talking about the topic, "I see that this is hard for you to talk about. We are going to stop talking right now and help you get grounded. That doesn't mean I don't want to hear you, but we need to wait until you can talk about it without feeling out of control." Avoid the pull to continue with the topic. Also avoid answering challenging questions, such as "You just can't tolerate that you are incompetent, can you?" or "You don't care about me, do you?!" Continue calmly repeating your message in simple words. Set your limits clearly: "You can work with me to calm down and get grounded now, or you can go

out and talk a walk for 10 minutes outside and then come back. Or if you can't do that, we can stop the session so you have more time to calm down, and we will talk about this next time." Be sure to enforce the limit right away and not continue trying to engage. If the patient does not respond to your limits, you can then say something like, "I am leaving the room now and will call security to escort you out of the building."

Be sure your limits are enforceable. For example trying to force a patient to sit down and stay in the session may not be helpful: give them a safe out. The most important thing is for the patient to know you will follow through with your limits: this will help him or her control the behaviors and ultimately give a greater sense of security to both of you.

Try to listen underneath a tirade for the real reasons for the upset, beyond the facts. Most likely the patient has felt misunderstood, betrayed, or threatened. It is common for abandonment, rejection, shame or humiliation to trigger rage. You can make powerful interventions by acknowledging these: "I can see that what I said made you feel so humiliated. That is so painful and I am sorry; I did not intend for that to be the case. Let's take a minute to help you calm down and then I would like us to talk about that awful feeling of humiliation if you feel like you can." This kind of statement may diffuse the situation. If not, those feelings can certainly be brought up later in another session to help the patient recognize and handle them differently.

The therapist should try not to take anger personally, and work to stay grounded and composed. The more defensive the therapist, the more aggressive the patient can become. Unfortunately, it is not uncommon for a therapist to freeze, get

foggy, or shut down when a patient becomes so angry. This can be perceived by the patient as an abandonment, which further activates his or her rage. And for a very few sadistic patients, can be an invitation to become more hurtful. It can be helpful to role play with other colleagues so the therapist becomes more adept at dealing with hostility and aggression in patients and learns to respond more effectively. The more grounded you are, the more you are likely to influence the dysregulation of the patient for the better. Our patients need us to tolerate their intolerable affects; they don't need for us to tolerate their intolerable behaviors. Our clear limits, coupled with empathic understanding of and careful approach to the terrible affects and conflicts from which our patients suffer, are our best tools to help them move beyond the perpetuation of abusive cycles of violence.