Between Primary Maternal Preoccupation and Exposure Therapy: From Challenges in Integrative Treatment of Children with PTSD to a Reexamination of Transitional Space

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Abstract

Processing a traumatic event is one of the central junctures in treatment of children who suffer from post-traumatic stress disorder (PTSD). This crucial stage makes it particularly difficult for the therapist to assume an integrative position and to combine concepts and interventions promoted by different theoretical approaches. In this article, the authors use D. W. Winnicott's conceptualizations to propose an integrative model that strives to find the balance between two seemingly opposing positions: (1) empathy focused, which is close to the patient's experience (primary maternal preoccupation) and (2) reality focused, an intersubjective position (prolonged exposure therapy). The proposed model enables a dialectical movement between these therapy approaches. The clinical case described in this article focuses on children, but the theoretical insights rising from it may be relevant to adults who suffer from post-trauma issues.

Keywords: Post-traumatic stress disorder (PTSD), children, prolonged exposure, primary material preoccupation, Winnicott, transitional space, cognitive-behavioral therapy (CBT), trauma narrative, integrative psychotherapy

Fourteen-year-old Deborah (alias) and her family were involved in a serious car accident. One of her brothers was killed, and her father was seriously injured resulting in permanent disability. Deborah was referred to treatment for post-traumatic stress disorder (PTSD). About 4 months after the accident, her school

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reported that she isolated herself socially and that her educational functioning had significantly declined. At home, Deborah displayed violent rage outbursts toward her parents and her brother, spent most of her time alone in her room, and avoided riding in a car as much as possible. In addition, she vehemently refused to talk about the accident or her late brother, and any mention of the subject was accompanied by significant behavioral regression.

Dozens of children like Deborah, who have suffered various traumatic events, arrive each year at the Post-Trauma Center for Children and Adolescents at the Hadassah Hospital in Jerusalem. When the symptoms point to post-traumatic stress disorder, the preferred treatment, supported by evidence displaying its high rate of effectiveness, is often trauma-focused cognitive-behavioral therapy (TF-CBT) (Cohen et al., 2018). However, the wide variety of patients seen at the hospital requires therapists to be familiar with different therapy methods in order to assign to each patient the most suitable intervention. The therapists, therefore, train in both psychodynamic therapy (DT) and TF-CBT. In practice, most treatments are integrative and combine conceptualizations and interventions from various theoretical approaches.

Psychotherapy integration (i.e., a wide range of efforts to pull together the differing strengths of various approaches to therapy) has received significant attention over the last decade (Wachtel et al., 2020). However, many who identify as integrative therapists do not pay enough attention to the type of integration they actually perform. In a world flooded with information and theories, even academic institutions and psychotherapy schools struggle to encompass the ever-growing amount of therapeutic knowledge and often do not offer clear instructions on the desired manner of integrating different methods. As a result, most interventions are more eclectic than integrative (Norcross & Goldfried, 2005).

This article explores the argument that the theoretical integration of methods generally perceived as opposites can provide a springboard to understanding the traumatic state and identifying interventions that will alleviate it. We address the role of treatment, especially in instances in which there is a gap between the patients's will and their need—instances that we identify as crucial junctures in the therapy process when integrative therapists are faced with a weighty dilemma. We conceptualize this dilemma using Winnicott's (1960) theory and propose an integrative model centered around dialectical movement as an essential tool for fostering patient progress in general and for children with PTSD in particular.

Integrative Treatment for Children with PTSD: The Processing Stage as a Crucial Juncture

After 6 months of treatment, Deborah and her therapist formed a good relationship. During this period, the therapist fluctuated between openly discussing everyday subjects that preoccupied Deborah and exercising her adjustment skills and providing psychoeducational information about anxiety and trauma. Deborah renewed some of her social relationships and began to attend school regularly again. However, she continued to report feeling discouraged and avoiding social gatherings and traveling by car. Her parents said that Deborah continued to show withdrawal and disquiet. The therapist proposed that he and Deborah together write down a narrative about the accident. Deborah received a psychoeducational explanation about the importance of processing, and she understood its significance. She and the therapist outlined the main points of her narrative, and she even wrote the first chapters about herself, her childhood, and her family. But when the time came to work on the chapters related to the accident, she began to miss sessions and made repeated attempts to change the subject of conversation. Despite understanding the importance of processing, Deborah vehemently refused to address the difficult aspects of the traumatic event. The therapist faced a typical dilemma: On the one hand, he assumed that without processing the experience of the accident by returning to its physical details and tackling the loss and mourning, no significant progress could be made; on the other, Deborah conveyed one message loud and clear—"I cannot talk about this subject."

The traumatic experience is characterized by disintegration of the dimension of time and the sense of belonging and meaning. Patients fear that engaging with memories associated with the experience may overwhelm them, causing regression and intrusive sensations of reexperiencing the traumatic event. Deborah's avoidance can therefore be seen as a defense mechanism against the potent sense of threat arising before each encounter with the traumatic memory, which she experienced as an ongoing reality.

Indeed, patients with PTSD continue to vividly experience the traumatic event(s) for months and even years. One of the most common and well-established presuppositions in trauma treatment is conceptualizing the traumatic event as an unprocessed experience (Schnyder & Cloitre, 2015). The clinical consequence of this conceptualization is the conviction that the treatment must include a significant component of processing and transcribing the traumatic narrative in order to shift the encoding of the experience from the sensory limbic

areas of the brain to the hippocampus and the speech-related frontal regions (Malizia & Nutt, 2000).

Following dozens of encounters with patients and individuals who have undergone guidance sessions, we argue that processing the traumatic event is one of the important junctures of integrative therapy in children with PTSD. This stage of treatment is often accompanied by significant signs of resistance. The children use different and surprising methods to avoid processing the traumatic memory: from elegantly changing the subject of discussion and play, through skipping sessions, to explicitly resisting processing and even leaving therapy altogether (Najavits, 2015). In their guidance sessions, the parents, too, question whether it is helpful to reopen the event. They express sincere concern that there will be a regression in the child's emotional state, fearing that the child will not be able to cope and will break down.

At the same time, the therapists voice their concerns during staff meetings and seminars, where one of the central questions is when is it appropriate to perform exposure intervention and trauma processing? Indeed, even therapists are susceptible to avoidance patterns and to the fear of engaging with the traumatic experience. Herman (1992) described the reluctance to address trauma that therapists may feel and their concern about possibly causing another traumatic experience during the session. This concern may lead therapists to avoid examining and treating the trauma, even in cases when the patients themselves are willing and able to do so (Zoellner et al., 2011).

For example, Cohen and Serdtse (2014) analyzed the journals of therapists who treated children suffering from post-trauma after the 2006 Lebanon War. They found that despite undergoing suitable training, the therapists themselves experienced difficulties in performing trauma-focused interventions and tended to avoid addressing the trauma. In fact, the therapists initiated engagement with the experience of war three times less frequently than the children did. When a child raised the subject, only in a third of the cases did the therapists explore or expand on it. The most common reason for avoiding performing trauma-focused interventions, according to the therapists' journals, was the therapists' concern that such an intervention would cause the patient distress or even retraumatize them, thereby leading to secondary trauma. These findings are in line with those of Cook and her colleagues (Cook et al., 2004), who found that therapists' avoidance stemmed from their concern about arousing powerful emotional stimulation in their patients.

So, what is the appropriate intervention when treating children with PTSD? DT instructs therapists to proceed cautiously and wait for the patient to feel safe enough to engage with the traumatic content. It may also direct therapists toward projective techniques (e.g., play therapy, drawing, etc.) hoping that these will help raise the subject. On the other hand, TF-CBT guides therapists to recruit the patient for focused exposure and processing. Each theory emphasizes the shortcomings of the other. TF-CBT argues that an overprolonged waiting period feeds into the patient's avoidance and may hurt treatment by implicitly suggesting that the traumatic content is not only frightening but actually dangerous and demands caution. In contrast, DT claims that insistence on exposure may harm the therapist-patient relationship, cause the patient to reexperience the lack of control experienced during the trauma, and/or placate patients without bringing them to actively participate in the processing stage.

Deborah's therapist arrived at the staff meeting distraught. "I think she will leave treatment," he said sadly. "She missed two sessions already, and even when she arrives, we deal with a thousand other things but not with the thing itself. Maybe I moved too quickly." The therapist who was leading the parental supervision sessions with Deborah's parents had this to add: "The parents are really worried, too. They say that there was a major improvement, when all of a sudden she went back to shutting herself off in her room. We spent the whole last session discussing whether the exam period is a good time to reopen the accident. The mother thinks this is abuse—that it reminds Deborah of the horror of the summer just when she has finally managed to lift her head a bit. The father is going crazy that she won't go in the car with him anywhere unless they absolutely have to and that on every drive she won't stop gripping the handles with all her might, screaming that they're going too fast."

Opinions in the meeting room varied. The dynamic therapists urged "go by Deborah's rhythm. Her avoidance shows that she isn't ready yet, and you don't want to force the trauma on her again." The CBT therapists countered that "you won't be able to effect any change without gradual exposure to trauma processing. Avoidance is not only a symptom of PTSD, it perpetuates the pathological behavior. Going along with avoidance sends the message that talking about the trauma is as dangerous as experiencing it. Show her you trust her; she can take it!"

This is the problem facing therapists who strive for integration: Each of the two approaches propounds a completely different intervention. The therapist cannot insist on exposure and processing work and simultaneously wait for the patient to perform it at his or her own pace. We propose to resolve this dilemma through an

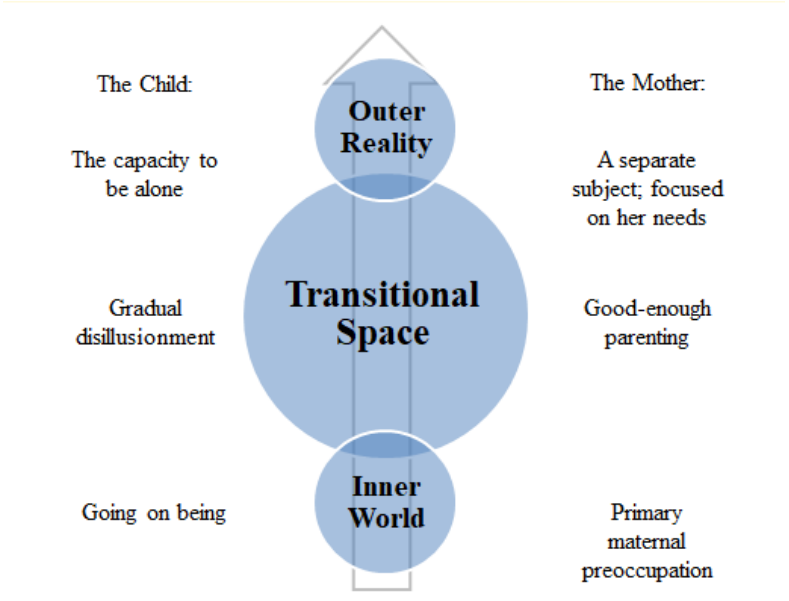
integrative approach that conceptualizes the problem in theoretical terms drawn from Winnicott's work. Although he was a psychoanalyst and his work is not necessarily identified with an integrative approach, on rereading, the paradoxical nature of his theory enables the integration of two seemingly antithetical methods.

Between Subjectivity and Reality: Winnicott's Model

Winnicott's (1956) maturational process can be briefly described as a three-stage chronological passage from inner subjectivity, through transitional space, to outer reality. According to him, because the consequences of the mother's behavior toward the child differ in each stage, her role changes with the passage from one stage to the next. The child's true self emerges through the mother's gradual adaptation, as a holding environment, to the child's needs. This adaptation begins at the primary maternal preoccupation stage, gradually transitions to good-enough mothering, and finally reaches the point of making the mother's distinct subjective needs present (see Figure 1).

Figure 1

A Schematic Description of Winnicott's Maturational Process. Right: the mother's role as a holding environment; left: the child's developmental achievements in each stage



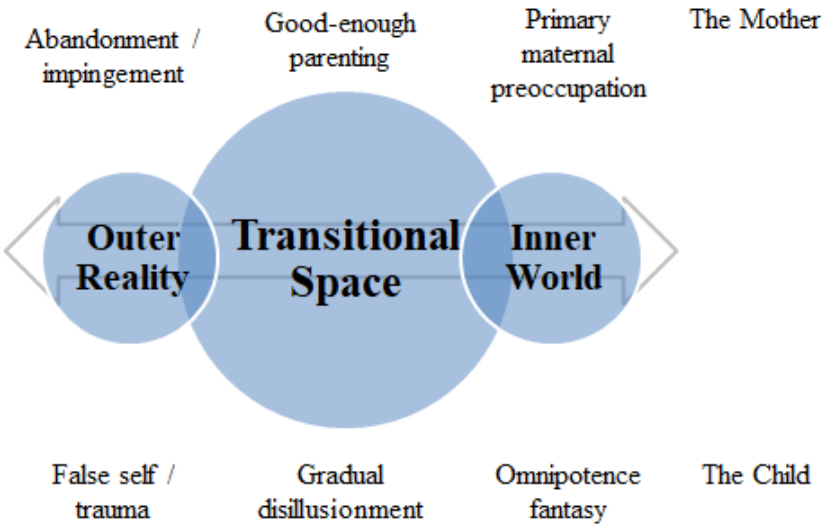
At the heart of Winnicott's theory is the transitional space, but a substantial part of his writing revolves around primary maternal preoccupation. Devoted maternal care during the first few weeks of the child's life is a necessary precondition to the formation of the self. In his article "Primary Maternal Preoccupation," Winnicott (1956) described the mother's emotional state during those first few weeks when she experiences the infant as an inseparable part of herself. At this stage, when the newborn looks for an extension of the experience of the womb, the mother's role is to anticipate the baby's needs before the child feels them. In this stage of the mother-child dyad, it is impossible to imagine a separation between child and mother; in Winnicott's (1960) words, "without maternal care there would be no infant" (p. 587). He referred to these comfortable times, when the baby does not display excitement or distress and when the formation of the self is made possible, as moments of "going on being" (Winnicott, 1963/1965b, p. 86). He stressed the importance of this period, which gives the baby a feeling of continuity and consecutiveness. Only when the maternal environment satisfies the baby's needs is he or she free to absorb the world and form a sense of self.

According to Winnicott, only if the primary maternal preoccupation stage passes successfully, and the baby absorbs the maternal figure, will he or she be able to grow and develop the capacity to be alone (Winnicott, 1958). This is made possible through good-enough parenting, which creates measured frustrations without producing persecutory anxiety (Winnicott, 1956).

A slightly different reading sees Winnicott's three stages not as chronological development but as a balancing act that lasts throughout one's life (see Figure 2). In Winnicott's (1953) words, "The task of reality-acceptance is never completed; no human being is free from the strain of relating inner and outer reality" (p. 18). Imagined as a spectrum, at the center are the attempts of the facilitating environment to produce good-enough parenting, and at either end are the preoccupations with an inner world or with outer reality. Out of such a reading emerges a more balanced picture of the parent's role and the negative consequences of not fulfilling it. Two tendencies therefore emerge: first, a tendency toward making reality present (referred to here as leaning toward outer reality and described in the next section), and second, a tendency toward primary maternal preoccupation (to which we shall refer as leaning toward the inner world and will discuss shortly). Each of these two tendencies can negatively affect the child's life.

Figure 2

The Winnicottian Maturational Process as a Continuous Spectrum. Top: the parental role; bottom: the risks to the child's development of leaning too strongly toward either end



The Dangers of Leaning Toward Outer Reality: Developing Trauma or a False Self by Making Reality Present Too Quickly

According to Winnicott, when the mother is not good enough, impinging or abandoning the child, and when the baby cannot see his or her own reflection in the mother's gaze but only her expectations and disappointments, the baby may experience a threat of annihilation, an anxiety of falling into the infinite and nonbeing. The baby's defense against this anxiety is to develop a false self, which responds to and complies with the mother's expectations:

> The mother who is not good enough is not able to implement the infant's omnipotence, and so she repeatedly fails to meet the infant gesture; instead she substitutes her own gesture which is to be given sense by the compliance of the infant. This compliance on the part of the infant is the earliest stage of the False Self. (Winnicott, 1960/1965a, p. 144)

This threat disturbs the baby's state of calmness, forcing him or her to react, to give up his or her wishes, and to prematurely accept, and be shaped by, the limiting nature of reality (Greenberg & Mitchell, 1983). The central consequence of this process is a fragmentation of the baby's experience, which then focuses

compulsively on the demands and requirements of others. The child loses touch with his or her needs and spontaneous gestures because these have no relationship to how the mother experiences the baby and to what she offers. Winnicott characterized this fragmentation as a split between the true self and the false self, whose content is shaped by the mother's expectations and demands. This split affects cognitive functioning and may cause overactivity of the mind and dissociate intellectual activity from its affective and somatic foundations (Winnicott, 1960/1965a). Here the roots of primary developmental trauma can be found: If normative development is based on a unified mother-child relationship, harming this relationship—by the mother's abandonment or impingement—will distort the development of the baby's self. As Winnicott stated, "When the mother's adaptation is not good enough at the start the infant might be expected to die physically… But in practice the infant lives, but lives falsely" (p. 145).

The Dangers of Leaning Toward the Inner World and Sinking Into Primary Maternal Preoccupation: Delaying the Development of Intersubjective Separateness

Winnicott (1956) described the baby's thinking process during the initial developmental stages as leading to a feeling of omnipotence ("I am hungry and so a breast with milk appears"). When the emergence of the need appears concurrently with its satisfaction by the mother, the baby creates the illusion that the need produces its own satisfaction:

> *My body is filled with painful hunger → My mouth meets the nipple, and warm milk flows to my stomach → The pain subsides → Hence, the hungry one (me) created the milk.*

When this is the state of the baby's reality, he or she does not need to know the other and is not required to acknowledge the mother's subjectivity. This is the omnipotence illusion, which causes the baby to think, without being corrected, that he or she makes the world go round. In the first days of the baby's life, the mother allows her baby a delusional existence, from which he or she should be disillusioned during infancy. This state was later described by Ogden (1993/2018) as follows: "The mother exists only in the form of the invisible holding environment in which there is a meeting of the infant's needs in a way that is so unobtrusive that the infant does not experience his needs as needs" (p. 211).

Despite assigning great importance to the primary maternal preoccupation stage, Winnicott (1953) also warned of the dangers of remaining too long in this

parental position: “The infant can be disturbed by a close adaptation to need that is continued too long, not allowed its natural decrease, since exact adaptation resembles magic and the object that behaves perfectly becomes no better than a hallucination” (p. 14). He went so far as to claim that “illusion, that which is allowed to the infant … becomes the hallmark of madness when an adult puts too powerful a claim on the credulity of others, forcing them to acknowledge a sharing of illusion that is not their own” (p. 4). In other words, remaining too long in the primary maternal preoccupation stage may prevent the developing child from recognizing the separate subjectivity of the other, thus prolonging the omnipotence illusion to the point of a delusional existence bordering on madness.

Winnicott and Other Theorists: Between the “Father Model” and the “Mother Model”

The central innovation of Winnicott’s maturational process is the concept of transitional space, where the dialectical connection between inner and outer realities takes place. The presence of the (good-enough) mother who knows to adapt herself to her baby’s changing needs allows the child to become disillusioned gradually. As described earlier, Winnicott outlined two main courses that may disrupt this maturational process. The first occurs when the identification between mother and child is too perfect, without any frustration and without having the mother’s subjectivity present. This can cause the baby to protract the omnipotence illusion without shifting to the potential space. The second course occurs when outer reality (i.e., the mother) cannot adapt itself to the baby. This manifests in the parent’s impingement on the child and may lead to the development of a false self. Alternatively, it may manifest in a state in which the mother is not present for the baby, leading to experiences of abandonment and trauma for the child.

Winnicott stressed the importance of maternal adaptation during the early stages of the baby’s maturation and the danger of what we call “leaning toward outer reality,” thereby creating a large, premature gap between the baby and outer reality. One might even say that Winnicott highlighted the dangers of outer reality and emphasized the significance of leaning toward the inner world. To understand why he emphasized primary maternal preoccupation, it is important to mention the sociocultural environment in which he worked and the contemporary perception of parenting at that time. Winnicott had special relationships with a wide variety of mothers, both in the therapy setting and in his public work (as a pediatrician in Paddington General Hospital, for example, and

through the radio programs for mothers he gave on the BBC). He recognized in his patients the results of the parents' tendency to rush toward making outer reality present.

Sometimes it seems that this emphasis made Winnicott's followers and readers understand the good-enough parenting position as closer to primary maternal preoccupation than to the mother as a separate subject, even though such an erroneous pairing, in fact, expresses a tipping of the scales toward the inner world. Placing the devoted, close-to-the-experience approach at the center of his theory was undoubtedly revolutionary given the prevailing attitudes of the time, so it is not surprising that other theorists followed in Winnicott's footsteps. For example, Fromm (1956) referred to the symbiotic union between the pregnant mother and the fetus, a state in which they are two and yet one, as a significant factor opposing the loneliness of existence and separation anxiety. Ogden (1993/2018) argued that the mother's role is to provide an environment that suspends psychological separation (from the womb) and that the mother-child dyad, in fact, creates an illusion in which inner and outer realities are one. Similarly, Tustin (1981) stressed that there is a psychological birth alongside the physical birth, stating that the baby needs an adapted maternal environment that will allow the psyche to be born. Balint (1968), too, discussed primary love, and how a primary social environment that provides a clear and calming presence without the mother making herself overly present is essential for the child's psyche to evolve. The theory of the self in self psychology also emphasizes the importance of adapting the environment to the child. For instance, Kohut (1985) argued that babies experience the selfobject as a continuation of themselves. This state is made possible when the baby's primary environment feeds his or her inner world by merging others as the self. If the parent cannot feel or express adaptation and satisfaction when in contact with the child, the child's ability to feel valued and have meaning will be damaged.

It should be mentioned that although DT is often said to emphasize the necessity of adapting the environment to the child, many psychoanalytic theorists refer to the need for gradually making the environment and outer reality present. Kohut (1985), for instance, discussed the two poles of the self: a balanced sense of ability on one end and ambitions and goals on the other. In addition to emphasizing the need for adaptation of the child's external environment and the significance of the selfobject for healthy maturation, Kohut (Kohut & Seitz, 1963/1978) described *optimal frustration* as an important component in developing ambition and goals in the sense of self. Similarly, Bion (1967) saw moderate, bearable deprivations as essential conditions for the development of thinking. He explained that experiencing lack or absence stimulates the baby to

imagine the desired object, which is when his or her thinking ability begins to develop. Maternal care that does not provide deprivations and frustrations because of overcompliance with the baby's needs delays this development. Benjamin (1998), too, emphasized the importance of the mother as a subject and the position in which the mother makes herself present as a complete, independent person. According to this approach, the mother is not just a "mirror" for the baby but also an independent other with her own reactions. To develop, the child needs a relationship that acknowledges both his or her self and the parent's self.

Despite numerous dynamic theories recognizing the child's need for optimal frustration in the maturational process, it seems that many of them expect this frustration to occur of its own accord, with no need for the parent to push toward change. According to Cohen and Lwow (2004), most of these theories focus on the damage that may occur to the child's psyche when forced to adapt to the adult world. Various theoreticians see different types of damage: Freud described the parent as castrating and accusatory, Klein portrayed him or her as an oppressor, Winnicott illustrated an impinging and alienating parent, and Kohut presented such a parent as devaluing. The conclusion is that in order to assure children's undamaged development, one needs to create an environment that does not expect them to adapt themselves to their surroundings; in other words, one needs to create an expectation-free environment. For generations of therapists, Winnicott, like many other theoreticians, emphasized the importance of leaning toward the child's inner world and the crucial importance of the adapted maternal presence. In this regard, one should mention that object relations theory, from which Winnicott hailed, emphasized the centrality of the correspondence between the therapist's approach and the maternal position. Furthermore, this theory highlighted the importance of the therapist's empathy skills and the accurate understanding of the patient's inner world.

The Dilemma of Trauma Treatment From an Integrative Theory Perspective

In order to propose a possible integrative approach in the dilemma facing therapists of children with PTSD, we will first examine it from the perspective of the Winnicottian spectrum described earlier. DT parallels "leaning toward the inner world," that is, toward primary maternal preoccupation. This approach goes hand in hand with patients, fully attentive to their wishes and wants and cautious of making a painful reality or a different subjectivity present too quickly. Its most salient benefit is that it is close to the patient's experience and refines and

validates it. The disadvantage of this approach is that it can fail to challenge patients, that is, not confront them with reality and therefore leave them lost within their own subjective experience. It may, moreover, convey a hidden message to the patient: “I do not trust you to cope with the traumatic memory without breaking down; your memory really is dangerous.” In contrast, CBT corresponds to “leaning toward outer reality” or toward the reality principle. Its main advantages are challenging patients, refusing to cooperate with their avoidance, and trusting their ability to overcome their fear. It is not, however, always attentive to patients’ pace and is far from their experience, frustrates them, and may even destabilize them or cause them to abandon treatment.

This is not merely a token comparison but one that has substantial clinical consequences. Choosing to consider Winnicott’s three stages as inviting therapists to search for dialectical equilibrium opens a path for an integrative perception of the challenge of treatment. The therapist must continually search for the right balance between in and out, subject and object, imagination and reality. The simple solution, especially in light of a therapist’s rising concern, is to lean toward either end of the spectrum. In such cases, the therapist will be either dragged into a prolonged waiting period before the patient is ready or compelled to begin an exposure process whether the patient is ready or not. Both options, as can be learned from Winnicott, may lead to harming the patient.

A Vignette from Deborah’s Treatment

Therapist: Hi, Deborah. How are you doing this week?

*Deborah: I’m fine. I don’t know; I don’t have energy. The English test was a nightmare. And my brother Daniel pi**ed me off. He thinks he deserves everything, and always I’m the one who has to back down. I’m sick of him.*

Therapist: Oh, this happens to you every time …

Deborah: But my parents think that I have to be the grown up and back down. It’s really annoying!

Therapist: Yes, it’s very frustrating when you’re put in this position, when you need to do things you don’t really want to. I think that today, too, we need to do things you don’t really want to do…

Deborah: Don’t start! I don’t feel like it today. Some other time, OK?

Therapist: Yes, today might not be a good day. I remember that we discussed how when we'll come close to writing the story of the accident, it will probably make you want to run away.

*Deborah: What's running away got to do with it?! I'm telling you Daniel pi**ed me off! That my parents don't understand me! Until there's finally a place where I can talk to someone who gets me, you start as well? It's not like you!*

Therapist: You're angry that, like your parents, I don't understand you … maybe because all of us are asking you to do things you do not want to do.

Deborah: It's not that there's no connection. It annoys me that I have to fight everywhere I go.

Therapist: That really is exhausting. And you say that maybe part of what's exhausting is people telling you to do things you don't want to do.

Deborah: Exactly! And see, all week I've been thinking about how I'm going to tell you about the accident, and that will clear my head. But I'm worn out from this week, and I don't have the energy!

Therapist: I see. It's as though you were drained by the fight with Daniel and by how your parents took his side and told you to back down again, and it's even more annoying because you thought that today you'll finally be able to talk about the accident.

Deborah: That's right. I'm sick of trying hard all the time and no one appreciating it.

Therapist: You want someone to see your effort and appreciate it.

Deborah: Yes! Someone to see what a nightmare this life is! No one knows what I'm dragging with me everywhere!

Therapist: You're very alone in this. … You know, it's like a snowball, because just when you're tired of all the loneliness and you desperately want to talk, you feel like no one would listen to you and you shut off even more.

Deborah: Yeah …

Therapist: Deborah, what if we break the vicious circle?

Deborah: Again with this?

Therapist: Yes, a little bit ... But now it is because I understand that if I don't insist, I'll leave you very alone.

Deborah: Sometimes that's what I want.

Therapist: Yes, that's part of the snowball. A little like how you were left alone after the accident.

Deborah: (Sighs)

Therapist: But maybe we'll try to start from a less exhausting place. Which part of the accident will be the easiest for you to tell me about?

During this meeting, the therapist shifted from one approach to the other: recognizing the patient's difficulty and consequently providing her with validation and understanding while simultaneously holding both the patient's need to make the discussion of the accident present and her inner voice that understands the need to process the traumatic memory. Throughout the vignette, one can see the therapist's "dance," the balancing act between the containing and validating position and the encouraging and challenging one.

This kind of paradoxical thinking, when conflicting positions are true at the same time, is one of the central characteristics of Winnicott's theory. He (Winnicott, 1956) argued that the capacity to accept and contain our mental contradictions and paradoxes and to recognize the opposing components that make up our psychology can lead to a more complete and healthy life. The question of how one can simultaneously hold two types of thinking is emphasized during post-trauma treatment when the therapist faces a patient who resists discussing the traumatic event.

Following Winnicott, the major challenge of a good therapist is searching for the transitional space or good-enough parenting. Such an integrative approach should, on the one hand, validate and be attentive to the patient's subjective experience; it should truly understand the horror of encountering the finality of life, the rupture of abandonment and loss. On the other hand, it should not cease to challenge the patient's locus of avoidance and should, gradually and persistently, make the outer world present, even if it is painful and overwhelming. This intervention insists on seeing and validating the patient's subjective experience but refuses to remain imprisoned within his or her subjectivity, thereby inviting the person to open the door to an encounter with objective reality.

This transitional space position offers the therapist a bridge between theories that appear to be complete opposites. In the argument proposed here, CBT

neither contradicts DT nor offers an alternative to it; rather, it serves as an integrative complement. Only therapists who are constantly searching for the transitional space—who see before them reality and the treatment's objective as well as the patient's capability—will manage to sidestep the dangers flagged by Winnicott. Only these therapists will be able to help the patient go through the gradual disillusionment that has special intensity in the post-traumatic experience. Such an integrative position allows the therapist to meet realistic goals in a unique and patient-specific manner.

Discussion and Conclusion

When faced with the difficult task of treating children with PTSD, the therapist is confronted by the limits and limitations of various theoretical approaches. In this article, we consider this challenge as an opportunity to reflect on an integrative approach in which the benefits of one theory compensate for the disadvantages of the other. In directive therapies such as CBT, the therapist may end up forcing the child to talk about the trauma, thereby disrespecting the child's wishes, or worse, retraumatizing him or her. On the other hand, waiting for the patient's readiness may, as Cohen and Serdtse (2014) showed, be drawn from an unconscious cooperation with the patient's avoidance. By taking that pathway, the therapist unconsciously relays the dangerous message that talking about trauma is something worth avoiding. Assuming that PTSD is a product of difficulty in processing the trauma, such a message may also have an impact on the patient's ability to heal.

Therefore, we suggest a dialectical intermediate pathway in which the therapist respects the patient's inner rhythm and full autonomy but is also careful not to expand the vicious cycles of avoidance. The conflict revealed in working with children with PTSD exposes therapists' implicit assumptions. Many clinicians feel that the traumatic event is a disintegrating experience for the patient, and they worry that engaging with those memories will overwhelm the patient and lead to regression. Consequently, they tend to acquiesce to the patient's wish to avoid exposure work, even though studies show that exposure is essential to processing the traumatic experience, to alleviating symptoms, and to healing.

Therapists trained to emphasize the importance of empathy, the closeness of experience, and containment are particularly prone to leaning toward the inner world on the Winnicottian spectrum described earlier—that is, toward primary maternal preoccupation—and may be extra cautious about making a painful reality present too quickly. These therapists may find it difficult to encourage

patients to confront their fear of exposure work, thus cooperating with their avoidance. On the other hand, therapists who were trained to stress direct engagement with the symptoms are apt to lean toward outer reality on the specturm, strictly adhering to applying exposure techniques and trying to enforce the process without due attention to the patient's pace and level of preparedness. Both approaches may harm the patient. The former will create a too-prolonged waiting period for the patient's readiness, unwittingly conveying the message that their memories are, indeed, dangerous and that they are too weak to cope with them. The latter approach will impair the patient's holding experience, invite a disintegrating encounter with pain, increase the experience of loneliness, and create a higher risk of the patient leaving treatment prematurely.

One of the main reasons behind such impasses in post-traumatic therapy appears to be that patients—and also therapists—hold a dichotomous, either-or position and oppose a complex view that contains the dialectic of both approaches and their possibilities. The therapist's thinking can go along the lines of "either I wait for the patient to raise the subject of trauma, or I force them to talk about it."

By using Winnicott's concept of the healing transitional space, we propose a third, dialectical approach to resolve the dilemma. Winnicott's theory is based on the importance of both gradually making the environment and outer reality present in the child's world and on continual movement from the inside out. The maturational process he described includes transitioning from a state of near-complete identification toward a gradual reduction of adaptation according to the child's development. On rereading, Winnicott's transitional space places the therapist in a continual dialectic: understanding the inner world of the patient well and acknowledging his or her hidden fears while at the same time making outer reality present and helping the person confront it. Only in this space can one look for equilibrium in every patient between the attentive approach that validates their subjective experience and understands the difficulty involved in revisiting the traumatic memory and the position that insists on gradually and stubbornly making outer reality present, even if reality is painful and overwhelming.

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