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Self psychology at work in trauma therapy

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ABSTRACT

This theoretical thesis examines self psychology and trauma theory, specifically Judith Herman's <u>Trauma and Recovery</u>. A brief history of the psychodynamic study of the influence of trauma on mental illness will be given to orient the present discussion in the field of psychodynamic theory. Major concepts of self psychology, such as selfobject, mirroring, idealization and twinship will be reviewed. Herman's stages of recovery for the trauma survivor, namely establishing safety, remembrance and mourning, and reconnection will be summarized. I will then present my understanding of trauma as anti-mirroring behavior, trauma's ability to corrupt the idealized, and the twinship qualities of the reconnection phase of recovery. A case example is presented to elucidate my understanding of the selfobjects and selfobject functions at work in Herman's conceptualization of the recovery process.

SELF PSYCHOLOGY AT WORK IN TRAUMA THEORY

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master in Social Work.

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ACKNOWLEDGEMENTS

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CHAPTER I

INTRODUCTION

The premise of this thesis is that there are self psychological principles at work in

the trauma survivor's healing process described by Judith Herman in <u>Trauma and</u>

<u>Recovery</u>. I will briefly review the psychodynamic history of the study of trauma. I will

describe major elements of self psychology and trauma theory and then present my

understanding of trauma as anti-mirroring behavior, trauma's corruption of idealized

figures and the use of twinship in the later stages of recovery for the trauma survivor.

Understanding the relationship between these two theories can effectively support clinical

practice with trauma survivors.

> Jennings (2004) cites that
>
> as many as 80% of men and women in psychiatric hospitals have experienced
> physical or sexual abuse, most of them as children. Up to two-thirds of men and
> women in substance abuse treatment report childhood abuse or neglect. 82% of
> young people in inpatient or residential treatment programs have histories of
> trauma.

Diana Russell's (1984) survey of over 900 women revealed the shocking statistic that one

in four women have been raped and that one woman in three was sexually abused in

childhood. Jennings (2004) reports that as of January 2008, over 20,000 men and women

in the U.S. Armed Forces have been injured in the current war**.** Estimates put the number

of soldiers returning with symptoms of post-traumatic stress at one-third of all troops, or

around 300,000.   Trauma is the cause of 166,000 deaths each year in the United States

(Jennings, 2004). The loved ones of these 166,000 must suddenly cope with traumatic loss and grief.

So it is that thousands upon thousands of people living in our communities have endured sexual or physical assault, combat, horrific accidents or crippling losses. Only a portion of these people will seek professional mental health treatment. Many survivors, whether they are in treatment or not, will live with symptoms of depression, anxiety, post-traumatic stress disorder (PTSD), adjustment disorders and other conditions. A great number of practicing clinicians serve clients who have trauma histories. Some are recent traumas. Some happened in childhood. Some of these survivor clients *are* children. In short, it is not difficult to imagine a clinician with a client who is a trauma survivor.

Furthermore, the field of social work is in a particularly good position to explore, understand and support the trauma survivor, given the field's commitment to a "person-in-environment" perspective. McKenzie-Mohr (2004) argues that since trauma is often found in community and family systems, that a study of it from the person-in-environment perspective of social work is critical to understanding it in its more complex reality that a medical model approach would neglect.

It is for the trauma survivor's clinician that this paper is being written. It is my opinion that in light of the degree to which clinicians serve traumatized people, the theory we turn to should do its best to illuminate the unique experience of trauma, in its many forms. This paper is being offered to the ongoing, sometimes sparse, sometimes lively, discussion of trauma and theory in the psychological community.

It is my goal to define the parallels I see between self psychology and trauma theory at this moment in history. This paper will examine some early writing on the involvement of trauma in psychopathology, from Freud and Ferenczi to others. In particular I will examine selfobject functions in the treatment recommendations Judith Herman describes in her book, <u>Trauma and Recovery.</u> Conversely, self psychology's recommendations for treatment will be shown to be complimentary to the best practices of treatment for trauma survivors.

It is my sincere hope that the parallels between self psychology and trauma theory that will be examined here may deepen understanding of the psyche of a trauma survivor, and that it will be of use or comfort to the practitioner who sits at the side of the strengthening survivor-self.

CHAPTER II

METHODOLOGY

This chapter will discuss my rationale for deciding to study the history of psychodynamic treatment of trauma and the reasons for selecting self psychology and trauma theory to explore options for effective treatment for the trauma survivor in further detail. As I discussed in the introduction, the relevance of an understanding of trauma and its sequelae to the practitioner is clear, given the likelihood that clients with attachment, childhood and/or adult traumas will present for treatment.

This thesis takes as one of its assumptions the belief that for most survivors of traumatic experiences, the trauma history has a temporary or permanent negative impact on the survivor's sense of self and their ability to function. In practice, a great deal of theoretical discussion of trauma has stayed in its own camp and psychodynamic concepts and frameworks are not often found in these conversations. Conversely, psychodynamic theories have a long history of neglecting trauma and either ignoring or misinterpreting, trauma's sequelae. In general, when trauma is addressed in psychodynamic discussions, it is often a side topic considered briefly. Given our contemporary understanding of the prevalence of trauma, thanks in no small part to the study of combat-related post-traumatic stress disorder in veterans from twentieth century wars and the feminist movement's exposure of and devoted study of the abuse of women and children, clinicians know full well that a significant portion of their clients over a career will be survivors of trauma/s. It is the intention of this thesis to grow the discussion of trauma

within the field of psychodynamic theory to a proportion that more closely resembles the proportion of survivors seeking mental health care.

Trauma theory is essential to this blending of theory because it has most closely and with dedication examined and conceptualized the experiences of the trauma survivor. In particular, awareness of issues of power in both the traumatizing relationship and the therapeutic relationship seek to prevent re-traumatizing a survivor as she[1] seeks mental health services and goes through the process of recovery. Trauma theory recognizes that a pre-requisite for processing traumatic memories is stabilization. The disruption of biological and affective functioning that follows trauma is recognized as serious and requires education and practice in behavioral techniques and choices to stabilize functioning. For example, the act of moving away from an abuser can begin a long process of a survivor regaining influence over her physiological functions, like breathing and sleeping, as well as her emotions of terror and helplessness. In short, trauma theory alone, among the host of theories available to the practitioner, addresses in detail the issues involved in treating the trauma survivor.

The field of psychodynamic theory is a broad and diverse one. There are a number of theories I could have selected to compare and blend with trauma theory, and I hope that other writers will continue to explore unities between trauma theory and ego psychology, object relations theory, drive theory and others. In fact, Freud's seduction theory, which will be examined in the Literature Review chapter, brought trauma into the

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[1] Throughout this paper, I will use both female and male pronouns to refer to survivors and clinicians. I will use one pronoun for a section of text, and switch to another pronoun at natural breaks in the discussion.

psychodynamic discussion. Given the conflict between recognition of trauma and Freud's later theoretical developments of the concepts of fantasy and the Oedipal conflict, discussion on trauma generally stopped suddenly after Freud abandoned the seduction theory. The history of the seduction theory and what came after it, however, is a long, complex one, rife with controversy, which will only be briefly described in this thesis.

Self psychology is the psychodynamic theory I have chosen to examine and compare with trauma theory. There is a great deal in the literature which highlights damage to the self, self-concept, and the ability of the self to function following trauma. An understanding of the concept of self and the dynamics that support the development of a healthy self are, I believe, a pre-requisite for understanding how this damage to self occurs after traumatic experiences. Traumatic incidents will be shown to damage previously internalized healthy mirroring, idealization and twinship in the self of the individual pre-trauma. Moreover, I propose that the self-selfobject relationship and selfobject functions or their antitheses are present in the traumatic incident and relationship and in the process of effective recovery from trauma. Mirroring, idealization and twinship will be shown to be present in the therapeutic relationship and the treatment process for the trauma survivor.

My discussion of the parallels between self psychology and trauma theory in Chapter VI will compare points in each theory to their counterparts in the other. I will describe how each of Kohut's main selfobject functions is integral to the healing stages Herman describes in Trauma and Recovery. This will be done in a loosely point-by-point way, but because two of Kohut's selfobject functions are present in a minimum of

two of Herman's stages of recovery, each concept's comparison in the other theory will not be discussed strictly separately.

The biases and limitations in this study are both personal and practical. I am not a trauma survivor, so my thoughts and understanding on the experience of being traumatized and on the process of recovery are not thoughts based in personal experience. This may lend a certain ability to be objective in my synthesis of the material in the literature from survivors and experienced trauma therapists. It may also limit my understanding, causing me to miss important points that a writer who is a trauma survivor would include or address.

I am also a beginning therapist who has seen clients in a community mental health setting and in a V.A. Medical Center. I have treated only a handful of trauma survivors in time-limited therapeutic relationships. Some of my ideas in this paper are generated directly from these clients, my sense of their present selves and the impact of their traumas on these selves. However, I defer any expertise in the field of trauma work and self psychology to expert practitioners and writers in these fields and will be using their writing to support for my idea that there are self psychological principles at work in trauma theory.

A certain limitation to this study is the focus within psychodynamic theory I've chosen to research and address. Ideally, a study hoping to describe intersections between trauma theory and psychodynamic theory would include the history and literature from all schools of psychodynamic thinking. Given the nature of this project, I have had to limit my research to the literature of self psychology in particular, and a general history of the stance of psychodynamic thinkers towards trauma, mainly Freud's seduction

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theory, its recantation and the consequences of this recantation to the discussion of

trauma in the field for many decades. It is entirely possible that pertinent theoretical

discussions of trauma in the schools of drive theory, ego psychology, object relations

theory or others are active and presently in use by many clinicians. This thesis will offer

only a perspective on the parallels between trauma theory and self psychology.

A note on reification: because the self is not an entity that can be measured,

replicated or tightly defined with scientific rigor, many may say that in discussing the

concept of self at length, I am reifying the concept, despite lack of proof that it exists. It

is the case that I accept the concept of self without scientific proof that it definitively

exists; it is a concept that finds great traction in the field of psychology even though it is

an entity that defies measurement. The subjective value of the concept of self, much like

the concepts of g/God and love, make discussion of self worthwhile to me and many

others who find the concepts useful without verifiable proof. As Westen and Kegley-

Heim (2003) note,

> a sense of self is rarely an object of reflection and has received little empirical
> attention, although it is central to many pathological views of self and can become
> disrupted in certain forms of psychopathology and by certain non-normative
> experiences, such as sexual abuse" (p. 646).

With the goals and limitations discussed above, the next chapter will give a brief

overview of the history of the psychodynamic understanding of trauma. With that

foundation, I will move on in Chapters IV and V to describe the major concepts of self

psychology and trauma theory that will be compared and unified in Chapter VI.

CHAPTER III

LITERATURE REVIEW

To begin a discussion of the history of psychodynamic consideration of trauma, one must, of course, begin with Sigmund Freud. A number of years before he began thinking and writing about fantasy, Freud was developing a professional belief that symptoms of hysteria were caused by traumatic events in the lives of his patients. What became of this professional belief around trauma is important to know as the context and legacy that trauma has within the field of psychoanalysis and psychodynamic theory in general. There is so much to this history and the relationships of each psychoanalyst and writer to their colleagues and teachers that this review will be a broad overview and will not discuss all the intricacies or developments that many other fine writers have explored more fully.

At the turn of the last century, Sigmund Freud was developing what became known, unfortunately, as the seduction theory.[2] His work with many patients, mostly female, led him to believe that neurosis developed as a response to early sexual trauma (Breger, 2000; Freud, S., 1964; Klein and Tribich, 1982; Westerlund, 1986). First he

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[2] In spite of historical and current connotations to the word "seduction", scholars note that at this point in his writings, Freud was clearly speaking of sexual acts in no way initiated nor elicited by the patient/victim (Masson, 1984; Westerlund,1984). Masson (1984) cites references in Freud's works on the seduction theory to other terms used when discussing these acts: "massbrauch (abuse), traumen (traumas), angriff (attack), attentat (assault), and vergewaltigung (rape)" (p. 3).

believed, like his teacher Charcot, that a person with a hereditary vulnerability could develop a hysteria after an "incidental" or "accidental" cause, which Freud believed could include "mollycoddling, premature awakening of mental activity, frequent and violent excitements…trauma, intoxication, grief, emotion, exhausting illness, anything in short, which is able to exert a powerful effect of a detrimental kind" (Guttman, 2006, p. 184).

More specifically, Freud's new theory explicitly posited that the horrifying reports of abuse, rape and incest from his female patients were not fantasies or lies, but instead real reports of actual events. Freud, when first forming his seduction theory, clearly believes his patients.

> Doubts about the genuineness of the infantile sexual scenes can, however, be deprived of their force here and now by more than one argument. In the first place, the behavior of patients when they are reproducing these infantile experiences is in every respect incompatible with the assumption that the scenes are anything else than a reality which is being felt with distress and reproduced with the greatest reluctance (Freud, 1924/1962, p.204).

Moreover, Freud's clinical observations led him to the conviction that these sexual and violent experiences had the potential to cause long-lasting damage in the form of repression, compromise formations, and symbolic symptoms. Through the late 1880's and up to1896 Freud thought and wrote a great deal about his findings linking trauma and psychopathology. A great deal of his correspondence and authorship with Josef Breuer was on the topic of trauma (Breger, 2000; Guttman, 2006). They discussed repression and splitting, symbol formation, and conversion, or somatization, as common sequelae to, in their opinion, real traumatic events. Freud's works "Project for a Scientific Psychology" (1895), "The Aetiology of Hysteria" (1896), and "Further Remarks on the

Neuro-Psychoses of Defense" (1896) all explore his conviction that sexual trauma is involved in the development of neuroses and hysteria (Breger, 2000; Westerlund, 1986). Eventually, Breuer and Freud differed on the emphasis they put on sexual experience in the origin of neuroses and on whether trauma results in repression (Freud) or dissociation (Breuer). Breger (2000) argues that this was the cause, at least in part, for the split between the two men.

Scholars also observe that close examination of the cases Freud used to demonstrate his growing belief in the influence of sexual trauma in the development of mental illness reveals that he may have seen sexual influences where there were instead traumatic losses (Breger, 2000; Klein and Tribich, 1982). Breger (2000) notes that in "Studies on Hysteria" where Freud presents 11 cases, only three of these cases included clear instances of sexual traumas; the majority of the remainder of the cases describe traumatic losses such as parental, sibling or caregiver deaths, betrayals by loved ones, the challenges of forming a satisfying female identity in a culture that sidelined women and other psychic challenges that were not primarily sexual. Freud seemed to be pushing for a sexual explanation where many times the information just wasn't there: at this point in his practice, his stance could not be described as neutral (Breger, 2000; Klein and Tribich, 1982). Rather than obviating the seduction theory's premise that trauma is part of the development of mental illness, scholars argue that Freud's focus on sexual traumas in particular was simply more narrow than necessary: the case material, Breger (2000) argues, called for a theory that recognized all variety of trauma as potentially damaging experiences.

Another influence on Freud's study of the relation to hysteria and literal traumatic events was his exposure to many autopsies of young abused children in Paris. As a young neurologist, at 29, Freud had traveled to Paris to study specimens of children's brains preserved at the Salpêtrière Hospital. He also attended many lectures by the chairman of the pathology department at Salpêtrière, Jean Marin Charcot (Huopainen, 2002; Masson[3], 1984). In all historic fairness neurologists in France like Charcot and Pierre Janet had already been studying the incidence of trauma in the lives of children in the late 1800's before Freud developed his seduction theory (Huopainen, 2002; Masson, 1984).

Incidentally, it was from Charcot that Freud first learned a great deal about the effect of hypnosis to access forgotten (or repressed) traumatic memories in neurotic patients (Basch, 1989). At the time, most physicians, frustrated by their inability to alter their neurotic patients' symptoms and fixations, generally blamed their patients for their own conditions, citing malingering or fraud. However, both Charcot's use of hypnosis and his belief that neurosis followed a trauma to a hereditarily weakened brain had a significant influence on Freud's knowledge and thinking around neurosis, hysteria and the impact of trauma in patients with these conditions (Basch, 1989; Masson 1984).

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[3] J.M. Masson is a former Special Projects Director for the Sigmund Freud Archives. His book, The Assault on Truth: Freud's Suppression of the Seduction Theory, has been met with mixed praise and critique. Much of the negative review of his book notes his ungenerous, sour attitude towards Freud (See book review by Mitchell, S.A., 1984). It is not the intent of this paper to pass judgment on Freud's character or the value of his theories to practitioners who serve the mentally ill. It is my opinion that Masson, given his unique access to much of Freud's unpublished works and letters, is in an especially strong position to show us more about Freud than we've collectively known thus far. Readers of this work and Masson's book may of course form their own opinions.

While in Paris, Freud also witnessed many autopsies of abused children performed by doctors at Salpêtrière. It seems that Salpêtrière was one of the major hospitals in Paris, and a large number of the deceased of the city would pass through the Salpêtrière morgue. The horrors on the cold bodies of young children, of physical cuts, bruises, broken bones, burns, damage to their genitals and anuses, confronted Freud with physical evidence of severe brutality to children by adults in their lives. These autopsies were pivotal in Freud's process of accepting that such violations, similar to the ones recalled by his "hysterical" female patients in Vienna, occurred in reality and not in fantasy (Masson, 1984).

After many clinical hours, the autopsies at the morgue and much thinking, Freud had clarified his belief in the seduction theory. On April 21, 1896, he did a presentation titled, "The Aetiology of Hysteria", on the connection between trauma and symptomatic behavior to his peers at a meeting of the Vienna Society for Psychiatry and Neurology in Vienna (Huopainen, 2002; Klein and Tribich, 1982; Masson, 1984; Westerlund, 1986). His theory was revolutionary for its time and more particularly, it was a theory that was deeply offensive to the sensibilities of Freud's peers, both in the medical world and in society at large.

Freud's seduction theory was rather specific in its details. It begins with a prepubescent, real traumatic event. Freud believed that without knowledge of sex and sexual relationships, this event is not unpleasant or disturbing to the young, prepubescent child. Later, with this vulnerability, during puberty the child is assaulted, or exposed to the primal scene, or even relatively innocuous sexual stimulation, like sounds, etc. This stimulating event in puberty "revitalizes" the early sexual trauma and "hysterical"

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symptoms ensue because the child is now faced with the meaning of their earlier violation. The memories of the earlier violation are repressed, resulting in the breaking through of hysterical symptoms. The details of this highly specific sequence of events as well as the validity of the theory is less important to this discussion than Freud's general premise that actual assaults were happening to young children, an idea that was new for its time.

It is notable, and somewhat characteristic of Freud (Klein and Tribich, 1982; Masson, 1984; Westerlund, 1986) that despite the fact that his many patients were describing fathers, uncles and brothers as their attackers, when he presented his ideas before his medical peers, Freud described the perpetrators as nursemaids, servants, brothers and sisters. Regardless of this glossing over of clinical data, the implications for the frequency of the sexual and physical assault of children were astonishing and apparently, impossible for the audience to accept. The chairman of the Society, Richard von Krafft-Ebing called Freud's ideas "a scientific fairy tale" (Klein and Tribich, 1982, p. 17).

The Backlash and Retraction

There are many theories about why Freud did not challenge the reception of his paper and why he eventually retracted the seduction theory. One theory could be called "giving into the current of peer pressure." The response to Freud's paper was deeply negative, but also very quiet. Masson (1984) and Huopainen (2002) note that at this time in 1896 it was common practice in medical journals to report a brief summary of a medical lecture and that in the case of Freud's April 21 lecture, this was curiously, silently, skipped. Freud noted this and the "void…forming around me" (Masson, 1984,

p.10) as he was blackballed after his lecture. Westerlund (1986) also notes that since a

good deal of his income relied on referrals from other physicians, his sullied reputation

after the lecture meant his income suffered as well.

In part out of anger and spite at a journal that gave his lecture and article curt

review, Freud wrote down his lecture and published it in the summer of 1896. Masson

observes,

> We are fortunate that he did, for in a few years, Freud would wish he had not been
> so hasty. The early traumas his patients had had the courage to face and report to
> him he was to later dismiss as the fantasies of hysterical women who had invented
> stories and told lies. He was to view his own courage in reporting these findings
> as rash (Masson, 1984, p. 11).

Some time after publishing his lecture, Freud began to distance himself from his

assertions. He reported to his close friend and fellow physician Wilhelm Fleiss that he

was leaving the seduction theory behind because he had lost a number of patients and he

was having difficulty bringing analyses to successful conclusions. He also wrote to

Fleiss that he could not believe that child abuse was as prevalent as the prevalence of

hysteria would indicate (Guttman, 2006; Masson, 1984; Westerlund, 1986). Guttman

(2006) and Huopainen (2002) also make the point that as Freud was addressing trauma

and the seduction theory less, he focused more on infantile sexuality, the drives and

transference, rather than focusing on making the unconscious conscious. The shift in

focus and the working-through of transference in the present relationship with the

psychoanalyst left less room and time for unearthing traumatic memories involving

people from the patient's past.

Lastly, many scholars cite material from Freud's self-analysis as a major

motivation for his retraction of the seduction theory. Westerlund (1986) and Klein and

Tribich (1982) both discuss Freud's examination of his own self-described hysterical symptoms, hysterical symptoms in his siblings and allusions to the possibility that Freud's father abused Freud's siblings. Freud notably does not write that he wonders about his own history of abuse: this worry is confined to his siblings, and to his acknowledgement of his own hysterical symptoms (Klein and Tribich, 1982; Westerlund, 1986). These authors propose that his possible personal history of early childhood abuse was emotionally disruptive and proved too difficult to manage in a self-analysis, thus providing further motivation to abandon a belief in trauma's involvement in mental illness.

Freud publicly retracted the seduction theory in 1905, and in doing so, he was welcomed back into the medical community that had shunned him for believing the stories of his patients (Masson, 1984; Klein and Tribich, 1982). Freud's retraction allowed him to continue practicing psychoanalysis, and put him back in normal communication with his psychoanalytic and medical peers. Masson (1984) describes this crucial moment in the history of psychoanalysis and psychology:

> By 1908 respected physicians had joined Freud…the psychoanalytic movement was born but an important truth was left behind…What caused this momentous about-face that would affect the lives of countless patients in psychotherapy from 1900 to the present? Psychoanalysts have not been overly curious about he reasons for Freud's change of heart, even though they, along with Freud, are convinced that, without the abandonment of this theory, the development of psychoanalysis would not have been possible (p. 12).

As Freud continued to write about psychoanalytic theory, he clarified and shared his belief in the innate sexuality of all children and a belief in the universality of fantasy. It was at this point that he proposed the Oedipal theory of childhood wishes to have sexual contact with the opposite sex parent. Many scholars discuss at length the apparent

incompatibility of the seduction theory and the theories of fantasy and the Oedipus complex (Klein and Tribich, 1982; Masson, 1984; Westerlund, 1986), which left the seduction theory being the fly in the ointment of psychoanalysis, as it was coming to be understood. Klein and Tribich (1982) describe their understanding of Freud's professional shift:

> Indeed, so antithetical was the new theory that for some time Freud was in pure agony. He was not, as one might think, just agonizing over the potential embarrassment of relinquishing the seduction theory. Nor was he, as some Freud scholars believe, merely suffering psychic labors pains because he was soon to give birth to his self-analysis. Freud's torture was in the balancing of two contrasting theories and having to decide between them (p. 17).

It is also relevant that some of Freud's hysterical patients were eventually assessed to be schizophrenic (Guttman, 2006). Given this additional information, it is not strange that Freud was questioning the reality of the memories of his patients and wondered about fantasy: making judgments about the veracity of psychotic patients' self-report are notoriously difficult to get "correctly."

So collectively we abandoned belief in trauma, instead embracing belief in fantasy and the new practice of psychoanalysis. There is, however, evidence in original letters of Freud's that he privately never abandoned belief in the influence of trauma in the pathology of many of his patients (Ginsburg, 2003; Klein and Tribich, 1982; Masson, 1984). Guttman (2006) cites writing late in Freud's career, in 1933, that provides evidence for Freud's continuing endorsement of the pathogenic influence of child abuse paired with the conviction that fantasy has a simultaneous problematic influence on pathology as well. Breger (2000) also discourages an either/or attitude towards the seduction theory and the belief in fantasy, supporting the partial truth of the seduction

theory and the importance of the discovery of fantasy as an element of psychic experience.

Part of the trouble with assessing Freud's opinions on the seduction theory is that as Anna Freud and Ernst Kris edited and compiled Sigmund Freud's letters to Wilhelm Fleiss for publication, they selected letters that voiced his doubts about the reality of trauma, and omitted the letters or passages where he expressed belief in his traumatized patients (Masson, 1984; Westerlund, 1986). The turning away from acknowledging trauma was not as complete in Freud as the literature might lead us to believe; he wavered many times over the course of his life.

The development of the Oedipus complex and the study of fantasy began a debate in psychoanalysis that in many ways has never ceased. The complexities of fantasy, genuine trauma, repression or dissociation of memory and the influence of clinical theory on the client's reality continue to be gray areas in the field. In a larger arena, the field of psychoanalysis in general, Freud's belief in the veracity of patient testimony was stifled. One can see behind the stifling a general disbelief in patient report and a desire to protect the reputation of psychoanalysis by keeping its toes out of the murky, dangerous pond of controversy.

Combat Neurosis and PTSD – Veterans and Clinicians

In general, the psychological community of Western Europe and the United States remained fairly uninterested in trauma until the first World War (Herman, 1992; Huopainen, 2002). There was a virtual absence of discussion of hysteria in the mid-twentieth century. Interest tended instead, to focus on the treatment of schizophrenia and psychosis, and what writing there was on hysteria often bemoaned the broadness of its

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diagnostic picture and the difficulty of study and treatment of the condition given this broadness (Guttman, 2006).

There were exceptions to the disinterest of the majority. Three examples are Melanie Klein, W.R.D. Fairbairn and Sandor Ferenczi. Klein and Fairbairn each made observations that place the origin of pathology in pre-oedipal stages, which allows for trauma theory in a way that Freud's ideas on fantasy and the Oedipus complex could not (Guttman, 2006). Klein's interests in projection, introjection and guilt focus on internal conflict that occurs well before the oedipal phase. Fairbairn saw the pre-oedipal oral stage as the likely source of pathology in cases of schizophrenia, obsessional neuroses and hysteria (Guttman, 2006). Ferenczi, one could say, never abandoned belief in the seduction theory. He was known for his deep compassion for troubled souls and studied and wrote a good deal in his short life about the impact of trauma.

Greater interest in trauma surged during and after the first World War in Europe and the U.S., as many clinicians, soldiers and veterans became invested in understanding more fully "combat neurosis", as the symptoms of what we currently call post-traumatic stress disorder (PTSD) were then called. Soldiers in a war that killed millions and decimated four European empires were exposed, sometimes for years at a time, to unending violence and threat of death. At their breaking point, many men sobbed and wept uncontrollably, like "hysterical" women. Some lost their memory or access to any emotions whatsoever. Some froze or were mute. The numbers of men incapacitated by their wartime experiences were so great that hospitals quickly ran out of room to treat those with symptoms and the military suppressed public dissemination of the numbers of

these soldier patients, as it was considered very demoralizing for the public (Herman, 1992).

At first physicians' theories looked for a physical cause of the hysterical behaviors. Concussive shocks from explosions, called "shell shock", were originally explored as an aetiology. However, many soldiers who were not exposed to explosions or physical trauma were struggling with anxiety disorder reactions. Reluctantly, the medical community turned to psychological hypotheses to determine the origin and treatment of these disturbed behaviors.

Herman (1992) points to the parallel response directed at these fresh, male survivors[4] of trauma, similar to that directed at the "hysterical, wish-driven" women of the turn-of-the-century. Just as the women of Freud's practice and others were shamed, blamed, castigated, sometimes subjected to harsh and painful "medical" treatments to cure their "unclean, sinful sexual urges", traumatized soldiers were humiliated and rejected. The cultural ideal of the brave, emotionless warrior who can always complete his mission was upheld as the only image a soldier could fulfill - certainly a soldier should not freeze in horror or crumble in tears of grief and rage. Herman (1992) cites conflicting philosophies of treatment for these soldiers, ranging from shamings in public

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[4] The terms "survivor" and "victim" will be used throughout this paper as I discuss trauma. In general, I will use the word "victim" only to refer to a person *during* their traumatic experience. I will use the word "survivor" to describe a traumatized person *after* their trauma has passed. There are many negative connotations to the word "victim", and trauma survivors and clinicians each develop their own uses for each word. For my part, it feels disingenuous and presumptuous to describe a person in the throes of being traumatized as a "survivor." I also choose not to use the word "victim" to describe anyone post-trauma because I appreciate the positive re-framing value of the word "survivor."

to compassionate witness of the stories of war: psychoanalysis for the traumatized

soldier. The public and psychological rift over the veracity of trauma, the appropriate

response to survivors and the focus of moral blame continued.

Domestic and Sexual Violence – Survivors and Feminists

> For most of the twentieth century, it was the study of combat veterans that led to the development of a body of knowledge about traumatic disorders. Not until the women's liberation movement of the 1970's was it recognized that the most common post-traumatic disorders are those not of men in war but of women in civilian life…The cherished value of privacy [in domestic life] created a powerful barrier to consciousness and rendered women's reality practically invisible. To speak about experiences in sexual or domestic life was to invite public humiliation, ridicule and disbelief. Women were silenced by fear and shame and the silence of women gave license to every form of sexual and domestic exploitation. *Women did not have a name for the tyranny of private life*." (Italics added, Herman, 1992, p. 28).

Sexual abuse of children was "only gradually rediscovered" in the 1970's and

1980's, through the feminist movement (Huopainen, 2002, p. 96). The modern laws and

protections against child abuse, domestic violence and rape, while many are still works in

progress, owe much to the feminist movement and its authors, speakers and activists,

many of whom were survivors of violence and sexual violence, active in the 1970's and

80's.

Feminist scholars and writers have done a great service to the trauma survivor,

studying power, control, domination, submission, love and hate. Sadly, it is not possible

in this paper to include all the pertinent arguments within feminist scholarship that

illuminate the world of the trauma victim and survivor. The writing of Jessica Benjamin

is just one example of the contributions to psychoanalytic understanding of many

traumatic experiences. Benjamin writes (1988 & 1995) in detail about the challenge of

recognizing the other, and obtaining recognition from the other. We all want to be seen

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and understood, and through being truly seen, to be respected, especially by important people in our lives. Given this fact, there is an inherent human difficulty, Benjamin (1988 & 1995) argues, in maintaining self, by experiencing recognition, while at the same time recognizing the self in the other. We would far prefer, for selfish reasons, to be a self being recognized by the other. In many relationships or moments in them, Benjamin (1988) sees one self being served by the other: the other is not recognized as a true, independent self as well. Relationships with relatively stable self-self interaction are a challenge to realize and maintain. But, she believes, "the balance *within* the self depends upon mutual recognition *between* self and other" (Author's italics, Benjamin, 1988, p. 53).

Benjamin (1988) understands domination to surface when one person's desire to interact with another self is completely absent: there is no recognition of the selfhood of the person being dominated.

> What we see in domination is a relationship in which complementarity has completely eclipsed mutuality, so that the underlying wish to interact with someone truly outside, with an equivalent center of desire, does not emerge (Benjamin, 1988, p. 73).

Furthermore, Benjamin (1988) sees lack of recognition in between male abuser and female victim as a result of the differential consequences to boys and girls when separating and differentiating from their mother. She argues that boys must disavow and repudiate their nurturing caregiver, often a female figure, in order to take on their identity as male.

> In breaking the identification with and dependency on mother, the boy is in danger of losing his capacity for mutual recognition altogether. The emotional attunement and bodily harmony that characterized his infantile exchange with mother now threatens his identity. He is, of course, able cognitively to accept the

principle that the other is separate, but without the experience of empathy and shared feeling that can unite separate subjectivities. Instead the other, especially the female other, is related to as object (Benjamin, 1988, p.76).

Benjamin's (1988 & 1995) works on gender, power and domination are a small portion of the feminist scholarship that have influenced the psychological community's recognition and understanding of the dynamics of violence and trauma that often impact the lives of women, in particular, and people in general.

Another trend that expanded the trauma survivor's access to recognition and recovery was the emergence of consciousness-raising rap groups in the 1970's that gave women space to tell their stories of abuse or control, as well as the chance to listen to the stories of others (Herman, 1992). These groups and other consciousness-raising efforts were focused on social change, but had psychotherapeutic effects as well. Women had chances to experience the catharsis of telling their trauma story, when ready, in an atmosphere of safety and respectful witness. The benefits from these truth-tellings were much like the benefits of psychotherapy: catharsis, capacity for insight and relationship in the healing process. These groups also acted on a social and political level to raise societal awareness of the violence against women and children going on, in private places and homes, in all corners of society (Herman, 1992).

Trauma and Recovery

In 1992, Judith Lewis Herman published Trauma and Recovery, an elegant history of the study of trauma and a model for treatment of the trauma survivor. Herman (1992) describes the "forgotten history" of trauma in the study of psychology and psychoanalysis, the physiological and neurological consequences of trauma exposure, and her conceptualization of three broad stages of healing that summarize a general

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process of recovery she observed in her clinical work with trauma survivors. In Chapter V I will explore in more detail the sequelae of trauma and Herman's stages of recovery, often referred to as trauma theory[5].

The study of trauma, and in particular, psychodynamic attention to trauma, has been inconsistent and lacking in academic rigor throughout much of the last one hundred years. While it is understandable that clinicians, both in Freud's day and in the present, would like to deny the veracity and impact of trauma on the survivor, both the report of many patients and more recent empirical data, tell us that we must accept the reality of trauma in our families and communities. It is with belief in these facts and a commitment to supporting survivors and the clinicians working with the trauma survivor that the following discussion of self psychology and trauma theory begins.

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[5] Trauma theory is not limited to <u>Trauma and Recovery</u>. For example, the concept of the roles of victim-victimizer-bystander is one often referred to in discussions of trauma theory. To provide focus for this paper, I am only exploring self psychology in <u>Trauma and Recovery</u>. Further exploration of self psychological principles in other aspects of trauma theory may prove useful.

CHAPTER IV

SELF PSYCHOLOGY

Heinz Kohut[6] developed the concepts in self psychology after many years as a

practicing psychoanalyst and university professor. He had an interest in those patients

who had what are generally referred to as personality disorders; narcissistic personality

traits were his particular interest. Kohut felt that something was missing from his

approach to and understanding of these patients (Donner, 1988). In particular, he came to

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[6] Kohut was born in 1913 to Felix Kohut and Else Lampl. He grew up in Vienna, receiving an excellent education in schools and with tutors. He obtained his medical degree in 1938 from the University of Vienna and developed an interest in psychoanalysis. In late 1938 he emigrated to Britain without passport or visa. In 1940 he obtained a visa and moved to the United States, settling in Chicago (Strozier, 1985). He got an internship at a small hospital and then a residency at the University of Chicago. Strozier (1985) tells of how neurologists at the university hospital spoke of the "loss to 'real science'" (p. 6) when Kohut left neurology behind to study and teach in the field of psychiatry beginning in 1947. He was known to be brilliant, charming, enthusiastic, energetic and funny. He has also been described as self-centered, often wounding people's feelings. He was hired onto the faculty of the Institute for Psychoanalysis in 1948, where he worked until his death in 1981. He also worked as a professor, who kept students engaged and often lectured extemporaneously (Strozier, 1985). Prior to 1965 Kohut was often referred to as "Mr. Psychoanalysis" (Strozier, 1985), but when he published The Analysis of the Self in 1971, many of his colleagues distanced themselves. Strozier (1985) notes that as his established relationships with other psychoanalysts like Anna Freud and Kurt Eissler dwindled, he developed a following of younger clinicians, many of whom had meetings with Kohut in his home to discuss the writing for each of his three major books on self psychology prior to publication. Some of Kohut's proponents were Arnold Goldberg, John Gedo, Michael Franz Basch, David Marcus, Paul Tolpin, Paul Ornstein, Marian Tolpin, Anna Ornstein and Ernest Wolf (Strozier, 1985).

believe that confronting patients' unrealistic beliefs and expectations was quite often ineffective or damaging to the therapeutic alliance (Donner, 1988).

The alternative ideas that Kohut developed were controversial to others in the psychoanalytic community because his emphasis on empathy as his method of treatment was opposed to the interpretation and confrontation so important to Freud and his followers. Focusing on empathy was an indirect challenge of the psychoanalytic bedrock of instinct theory (Basch, 1989).

Kohut's name for his ideas and alternative treatment focus was *self psychology*. Self psychology is a theory of individual development that focuses on its concept of the central unit of an individual's person: *the self.* In his writings, Kohut defines this self, describes how normal and abnormal development of the self occurs and discusses how the self uses talent and skills to accomplish goals. Kohut published The Analysis of the Self in 1971, which describes the basic elements of self development and a clinical view of psychotherapy with self psychology as a framework when working with patients with self disturbances.

In essence, "the Kohutian self is the nucleus of a person's central ambitions and ideals and the talents and skills used to actualize them" (Westen & Kegley-Heim, 2003, p.653). This "self is cathected with instinctual energy, and has continuity in time, i.e. it is enduring. Being a psychic structure, the self has, furthermore, also a psychic location" (Kohut, 1971, p. xv).

Selfobjects

Just as in other schools of psychodynamic theory, the terms *objects* and

selfobjects do not refer inanimate items like books or tables. A *selfobject* is an

individual's mental representation of a person, item, concept, or practice, such as art or

music that affirms an aspect of the self.

Kohut explains that a selfobject can be something other than a representation of a

mother or father. Rather,

> When in the course of my work, I discuss psychic development, and I speak
> instead of the "empathic responsive matrix" which the child needs for
> psychological survival and growth. It may not make any difference whether it is
> the child's biological mother who is the provider. It may not even make a crucial
> difference whether one or several people are involved in the mothering, as you
> would say, or in *the empathic environment of the child*, as I would say (Italics
> added for emphasis, Kohut, 1985, p.167).

People also require selfobjects throughout the life span, although their functions are

especially critical in a child's early years. Elson (1986) cites the aging process and its

often literal disconnection from supportive figures, through dementia or isolation in a

care facility, as a common impetus for fragmentation of self in the later years of one's

life.

Selfobject Functions

Self psychology defines three essential selfobject functions that each self must

have or experience to develop healthily over his or her lifetime. The primary role of the

self-selfobject relationship is affect regulation (Schore, 2002). These functions are

mirroring, *idealization* and *twinship*. Each of these will be examined in detail below.

Mirroring

The element of the self that Kohut believed needed and received mirroring is *the grandiose self*, or the exhibitionistic self. These terms

> refer to a broad spectrum of phenomena, ranging from the child's solipsistic world view and his undisguised pleasure in being admired, and from the gross delusions of the paranoiac and crudely sexual acts of the adult pervert, to aspects of the mildest, most aim-inhibited and non-erotic satisfaction of adults with themselves, their functioning and their achievements" (Kohut, 1971, p. 25).

The grandiose self is the element of a child's personality that wants someone special to be watching when she first rides a bike without training wheels. It is the element of the adult self that wants to tell someone when they've received a promotion or honor in their work. It is also the manner through which the child, and later the adult, has her feelings recognized and understood by an empathic other (Elson, 1986). Stern (1988) describes the young person's search in their environment for an object that can modify their internal state/s of tension.

> The relative lack of such coordination [between the child and a "gratifying reality", or selfobject] will result not only in greater or lesser degrees of trauma, but in a relative failure to develop the capacity to attribute meaning to one's own states of tension, a type of faulty learning" (Stern, 1988, p 107-8).

When a child is young, good selfobjects in her world will reflect her feelings back to her, or give her the word for what she may be feeling. "You're really frustrated you can't open that yourself, aren't you?" This is mirroring, and it builds capacity in the growing self to identify her feelings and thoughts, as well as self-soothing ability. A young child, overwhelmed by the disappointment of a promised outing that is cancelled, can weather this upset much more smoothly when the disappointment is named, perceived as a

reasonable response to the situation, and ways of coping with the disappointment are
discussed and attempted.

> Development of mentalization ability depends on the response of caregivers, who
> both make inferences about and help clarify the contents of the child's mind and
> allow the child to explore the mind of the caregiver (Westen and Kegley-Heim,
> 2003, p.657).

The grandiose self, which soaks in mirroring throughout the life cycle, is the
archaic form of the source of self-esteem, what Kohut calls "healthy narcissism." Given
an adequate environment and selfobjects throughout development, sufficient mirroring
enables an individual to have positive and realistic self-regard, drive and ambition to use
his talents in meaningful ways, and some ability to recognize, name and regulate his
emotions. Kohut writes that the interruption or interference with the development of the
grandiose self leads to a psychic split where the grandiose self is split off from the reality
ego. Another outcome besides splitting would be repression of the interrupted grandiose
self, being held in its archaic form (Kohut, 1971).

A *mirroring selfobject* can be a mental representation of an admiring father or
mother, the philosophy in a book or a beloved pet. The "actual uplifting of the baby by
the mother; later that becomes the uplifting feeling of looking at a great man or woman
and enjoying him or her …or of a wonderful piece of music" (Kohut, 1985, p. 227).
History is another example of a potential selfobject: "Man tries to support human life,
including psychological life. This is behind everything I have to say. The historian
supports the continuity with the past so that people can feel better about themselves"
(Kohut, 1985, p. 226).

The mirroring selfobject must reflect and affirm some quality of the individual; the reflection of affirmation then results in an emotional response of feeling acknowledged, affirmed or praised. Without adequate mirroring, the child or adult lacks self-esteem, often at a level that impairs functioning.

Idealization

The second element of the growing self that requires a selfobject is the *idealized parent imago*. The idealized parent imago is the second self structure, or "pole" in Kohutian terms, that requires interaction with a selfobject to develop well. Selfobjects that support the idealized parent imago are *idealized selfobjects* or *idealized figures*. These are representations that assure the young self of a child that their caregiver is strong, well-informed about the world and its dangers and able to provide protection and soothing when crisis arrives. The child, who often encounters situations where he is frightened and wants the strength of the idealized caretaker, sees the caretaker as omnipotent and enjoys closeness and psychological merger for a period of development with the idealized caretaker (Kohut, 1971 & 1985). "Since all bliss and power now reside in the idealized object, the child feels empty and powerless when he is separated from it and he attempts, therefore, to maintain a continuous union with it" (Kohut, 1971, p. 37).

The child must also be able to find some quality of their idealized caregiver that he can wish to emulate. It is not necessary that the caregiver/selfobject be perfect or admirable in every way. It is necessary only that the child be given some partial pattern of adulthood that he can long to grow up into. "Only via such a proud father or parents with a sense of inner dignity, which has nothing to do directly with material deprivation,

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can one acquire a sense of one's own worth" (Kohut, 1985, p. 225). This figure, most often the primary caregiver, is experienced, both consciously and unconsciously, as a pattern to follow, a goal that can set standards for the individual's own future achievements, and as the original teacher of ethics and values.

As the individual grows and matures, Kohut observes that the idealized parent imago becomes transformed into tension-regulating psychic structure through the process of *transmuting internalization* of the ethics and capacities of the idealized selfobjects. As the child learns that his caregivers are not omnipotent, the development of ego occurs.

> We can say that the phase-appropriate internalization of these aspects of the oedipal objects that were cathected with object libido (and aggression) leads to the building up of those aspects of the super-ego which direct toward the ego the commands and prohibitions, the praise, scolding and punishment that the parents had formerly directed toward the child. The internalization of the object-cathected aspects of the parent imago transmutes the latter into the contents and function of the superego (Kohut, 1971, p. 41).

The consequence of lacking an adequate idealizable figure are uncertainty in one's own identity and a happiness conditional upon being attached to admired figures (Kohut, 1971). Withdrawal of the selfobject leads to a non-cohesively experienced self, hypochondria or fragmentation.

> Very early disturbances in the relationship with the idealized object appear to lead to a general structural weakness… a personality thus afflicted suffers from a diffuse narcissistic vulnerability. Later - yet still preoedipal - traumatic disturbances in the relationship with the idealized object (or again, especially a traumatic disappointment in it) may interfere with the (preoedipal) establishment of the drive-controlling, drive-channeling and drive-neutralizing basic fabric of the psychic apparatus (Author's parentheses, Kohut, 1971, p. 47).

Twinship or the Alter Ego

Kohut describes a third variety of selfobject which "will make itself available for the reassuring experience of essential alikeness" (Mollon, 2001, p. 23). When children or

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adults have best friends, when siblings are reassured by each other in ways their parents

cannot reassure them, and when social workers are rejuvenated by going to conferences,

these are experiences of twinship. Kohut discussed the experience of belonging as a

quality that twinship provides the individual's self. Rector (2000) writes:

> In the psychological functions of the twinship experience that Kohut did articulate
> (i.e. that the needs for the experience of essential alikeness and belonging are
> fundamental to human nature), they are similar to those of all selfobject
> motivations in their universality and thus constitute part of Kohut's psychological
> anthropology. When these needs are adequately met, self-esteem is enhanced,
> and narcissistic vulnerability is reduced. A sense of cohesion is strengthened, and
> the self is less likely to be derailed in the face of disappointment and narcissistic
> injury (Rector, 2000, p. 258).

A simple example taken from a case of Kohut's describes the patient recalling

being in her grandmother's kitchen at age 4. The grandmother was kneading bread on a

table, and the patient was at her own, smaller table, next to her grandmother, also

kneading bread (Kohut, 1984). "Such selfobject experiences…have inherently a rather

quiet and undramatic quality. They provide silent nutrients for the developing self"

(Mollon, 2001, p. 29). Kohut also speaks about the common occurrence of artists being

in need of an alter ego or twinship figure to reassure the artist of "the reality of self

during creative periods" (Kohut, 1985, p. 193).

Transmuting Internalization

Kohut called the process of internalizing mirroring or idealization from

selfobjects *transmuting internalization* (Kohut, 1971). Similar to the concept of optimal

frustration, when a child whose caregiver is generally responsive (mirrors empathically)

is sick with a cold and slow to respond to the child's need, many children will soothe

their own distress for a period of time in their caregiver's absence. The child will do for

themselves what their adequate selfobject has done for them previously; the child is internalizing a skill from the selfobject gradually, and eventually, if the process continues in a reasonably healthy way, the child will gain full competency in the self-soothing or mentalization ability she previously relied on the selfobject to provide. A healthy developmental history of this leads to adults who can name and discuss their emotions, seek out support they need, and pursue their dreams and desires in effective ways.

Treatment and Empathy

Self psychology defined the innumerable insults to self and dignity that are suffered often by children and selves of all ages. A theory that notes these injuries to self, Kohut believes, must be empathic always, and must interpret little and late, after significant time in treatment has empathically mirrored the client and provided idealizable figures in the client's life. Kohut (1984) describes in many different ways how empathy, truly feeling what the patient feels and/or felt, and expressing this understanding in a way that is meaningful to the client, is the curative factor in psychoanalysis.

Ornstein and Ornstein (1985) quote Kohut's link between empathy and interpretation: "psychoanalysis *explains* what it has first *understood*" (Authors' italics, p. 45). Interpretation and especially confrontation of the patient's unreasonable demands or beliefs, Kohut believed, was often what got in the way of patients accepting insight into the dynamics of their mental health (Kohut, 1984; Ornstein & Ornstein, 1985).

At its core, self psychology proposes that development is a process that occurs between people: between self and selfobjects. Reflection and observation between these two, of varying identities and purposes, solidifies personality, skills and psychic

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structure. An insufficient supply of selfobjects or their functions of mirroring, idealization and twinship can negatively impact development. These concepts will be shown to be closely related to the aftermath of trauma.

The Literature's Discussion of Trauma's Impact on Self

Whether it is done with explicit intention to use the term or not, the term "self" is used often throughout the literature on trauma and post-traumatic stress reactions. Some of these references come from writing on self psychology in particular, some use the term "self" in a more general sense. A few of these references follow, as an introduction to my discussion of how self psychological principles are at work in the recovery process described by Herman in <u>Trauma and Recovery</u>.

> Sexual abuse disrupts organization of self-representations and continuous sense of self, self-esteem also suffers as children often blame themselves for the abuse out of a desire to avoid having to regard the world (and/or an attachment figure who abuses them) as malevolent or unsafe (Authors' parentheses; Westen and Kegley-Heim, 2003, p. 658).

> In the absence of adequate experiences with parents who can mirror the child and serve as an appropriate target of idealization (for example when the parents are self-involved or abusive), the child's self structure cannot develop, preventing the achievement of cohesion, vigor, and normal self-esteem… As a result, the child develops a disorder of the self, of which pathological narcissism is a prototypic example (Westen and Kegley-Heim, 2003, p. 654).

> The real self is present in each of us, but to the degree that we have become neurotic we have shifted our energies away from self-realization toward what Horney called actualization of the idealized image. Neurosis was now seen as a "special form of human development antithetical to healthy growth" (Horney, 1950, p. 13). This special form of development had alienation from the real self as the central neurotic process (Paul, 1989, p. 121).

CHAPTER V

COMMON SEQUELAE OF TRAUMA AND TRAUMA THEORY

Definitions of Trauma

The DSM-IV TR defines a traumatic event as one

in which both of the following were present: (1) the person experienced,
witnessed or was confronted with an event or events that involved actual or
threatened death or serious injury, or a threat to the physical integrity of self or
others; (2) the person's response involved intense fear, helplessness or horror.
Note: in children, this may be expressed instead by disorganized or agitated
behavior (DSM-IV TR, 2000, p. 467).

Huopainen (2002) observes:

A child can be vicariously traumatized by observing violence between his parents,
by hostile divorce proceedings or by the untreated emotional consequences of his
mother's miscarriage or other loss of child…In addition, a child can be
traumatized by physical abuse, a parent's existing dissociative disorder or other
psychopathology, or by experiences of deprivation such as abandonment and
neglect (p. 98).

Robert Scaer defines a

broader 'trauma spectrum' that ranges from catastrophic events such as war and
other extreme forms of violence to 'little traumas' such as childhood neglect,
motor vehicle accidents, and exposure to violence via the media and popular
entertainment. I also include in this spectrum…preverbal trauma, which includes
among other things, in utero exposure of the fetus to the stress hormone cortisol
from the distressed mother, in utero fetal surgery,… traumatic birthing procedures
and exposure of preemies in neonatal ICU's to isolation and inadequate pain
management (Scaer, 2005, p. 97).

Even these "little" traumas, Scaer (2005) argues, can result in constriction of behavioral

options, decreased resiliency, poor physical health and decreased ability to function

independently. Many studies on animals have shown that neonatal separation of the baby

from its mother result in a high, enduring startle response and impaired cognition,

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locomotion and social functioning (Scaer, 2005). Early nurturing behaviors in animals such as licking and grooming, also promote affect regulation and ability to tolerate stress, whereas an absence or minimal amount of nurturing behavior resulted in anxious animal young who showed little ability to tolerate stress. These studies, Scaer (2005) argues, support the idea that early childhood neglect, or a poor match between mother and infant, has a long-lasting negative impact on the infant's neurological responses to stress and their self-soothing capacities.

Ferenczi believed children are traumatized when adults seduce them sexually, or when the parent "denies what he has done, or denies its harmful effect, often becom[ing] physically abusive towards the child (projecting the wickedness onto the child)" (Original parentheses; Rachman, 1989, p. 97-8). Ferenczi and Kohut also saw chronic empathic failures as traumatic (Rachman, 1989), where "psychopathology results from an unwholesome family interaction, where the parents fail to affirm the child's worth or traumatically disillusion him about their own worth" (Rachman, 1989, p. 99).

Sequelae of Trauma

The sequelae of trauma are numerous, inter-related and of course, each survivor experiences his or her own unique collection of these sequelae, with unique levels of severity. In general, the sequelae of trauma, a few of which will be examined more closely below, include hyperarousal, re-experiencing or intrusion symptoms, patterns of avoidance or constriction, dissociation, depression, cognitive distortions, depersonalization or derealization, corruption of relationship skills, such as an equation of violence with expressions of love, and in some cases, personality disturbances or

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disorders (Briere, 1992; Ferenczi, 1933; Herman, 1992; Straker, Watson & Robinson, 2002).

Hyperarousal

A central cluster of symptoms of the nervous system often impact functioning in the survivor of traumatic events who develops PTSD. These symptoms are called the hyperarousal symptoms and include irritability and anger problems, including rages and violent behavior, poor concentration, sleep disturbances and hypervigilance (Briere, 1992; Herman, 1992). The survivor in this state is on constant alert for danger and threat, having been so afraid and helpless during previous traumatic events that they may spend great energy in the present "checking the perimeter", doing lock and safety checks, owning, cleaning and practicing with weapons for self defense, half-sleeping, for years upon years sometimes, and listening for sounds of attack on their homes at night. Herman cites

> A wide array of similar studies [that] has now shown that the psychophysiological changes of post-traumatic stress disorder are both extensive and enduring. Patients suffer from a combination of generalized anxiety symptoms and specific fears. They do not have a normal "baseline" level of 'alert but relaxed' attention. Instead they have an elevated baseline of arousal: their bodies are always on the alert for danger. They also have an extreme startle response to unexpected stimuli, as well as an intense reaction to specific stimuli associated with the traumatic event…The increase in arousal persists during sleep as well as in the waking state, resulting in numerous types of sleep disturbance. People with post-traumatic stress disorder take longer to fall asleep, are more sensitive to noise, and awaken more frequently during the night than ordinary people. Thus traumatic events appear to recondition the human nervous system (Herman, 1992, p. 36).

Briere cites the dominance of arousal symptoms for survivors of childhood physical abuse, while survivors of childhood sexual abuse generally report more concern with re-experiencing symptoms (Briere, 1992).

Re-experiencing or Intrusion

A second hallmark of the traumatized person's life is ongoing reliving of the trauma or traumas as if it were happening again in the present. This set of symptoms is called the *re-experiencing* or *intrusion symptoms*. A trauma survivor often suffers from re-experiencing trauma memories or sensations through nightmares, intrusive thoughts and memories, flashbacks, and reactivity to cues or triggers that remind the person of his traumatic experience. Huopainen (2002) describes how "PTSD patients differ from mildly traumatized or periodically stressed-out people in that they remain stuck in their trauma" (p.93). A Vietnam vet may become immobilized while walking his dog in his neighborhood when a traffic helicopter, which "took me back immediately to 'Nam", flies overhead. A rape survivor in a garage alone may begin to cry when she hears a car door slam behind her suddenly. Many everyday places and activities feel unsafe to trauma survivors due to the likelihood of encountering triggers.

To outsiders, the repetitive consideration the trauma survivor often ends up giving to his trauma memories seems punitive and unnecessary. Herman quotes Freud's bewilderment when considering the soldiers of World War I: "The patient is, one might say, fixated to the trauma…This astonishes us far too little." (Herman, 1992, p. 37) Many speak of this quality of "fixation on the trauma" when observing the repetitive return again and again to the events of the humiliations, pain, injury and powerlessness that survivors recall.

Avoidance or Constriction

Perhaps the most significant cluster of symptoms, though, is the avoidance or constriction cluster. This includes avoidance of previously tolerated activities and places,

isolation from others, emotional withdrawal and numbing, drug and alcohol use and abuse, and dissociation. Many trauma survivors detach from relationships with friends and family, sometimes speaking only with their spouse, sometimes isolating completely with little or no social contact. Survivors who do communicate regularly with people often report a sense of "going through the relationship motions", knowing, for example, that they love their spouse and their kids, but that they just don't *feel much* about them. This is emotional numbing and withdrawal: the mind is keeping at bay affect and memories of trauma, and one of the side effects is keeping at bay a broad array of affect, even that unconnected to the trauma. For the great number of people with PTSD who also suffer from depression after a trauma, the dynamics of avoidance are only compounded by the anergia, anhedonia and sadness of depression.

Many survivors report they go virtually nowhere in public, or are extremely strategic about safety when they do. Some survivors will only go out in public with another trusted person. Others report shopping at 24-hour grocery stores at 2 o'clock in the morning to avoid dealing with too many people in the aisles. A great number of combat veterans no longer attend fireworks displays, parades or situations with crowds at all. The density of triggers at these events, as well as the huge number of people the veteran would need to scan and evaluate as a source of threat, are simply a greater stress than many veterans often choose to approach. As with so many initial responses to stressors, these stress management efforts are effective and adaptive in the short-term, devolving over time and rigid use into maladaptive symptoms and limitations (Briere 1992; Herman, 1992).

Briere also writes:

> It may be that many of the "loner" socially phobic, or schizoid adults presenting to psychotherapists today were quite similar to Egeland et al.'s insecurely attached subjects as children. Certainly, it is the experience of many therapists that clients with histories of parental neglect or emotional unavailability are prone to chronic fears of abandonment, alienation, and perceived isolation in personal relationships, and yet many simultaneously exhibit anxiety in the face of interpersonal closeness (Briere, 1992, p. 51).

Early neglect and abuse can clearly influence a survivor's interpersonal relationships and expectations, sometimes severely limiting functioning.

Many survivors turn to drugs or alcohol to disconnect from recurring memories of their trauma and to manage the depression that often accompanies PTSD and traumatic stress reactions. For many, trouble with their substance use or abuse is what brings them to treatment, so gathering a trauma history in a general assessment will help both client and clinician deal with any co-existing disorders as soon as possible.

The problems that come with avoidance: loss of many or all relationships, substance use problems, a smaller and smaller circle of activities and sources of pleasure are insidious in their ability to dominate the time and attention of the survivor at the exclusion of living an active, meaningful life according to his own choices. It is often these symptoms that trouble the survivor the most.

Dissociation

Dissociation is defined by the DSM IV-TR as "a disruption in the usually integrated functions of consciousness, memory, identity, or perception. The disturbance may be sudden or gradual, transient or chronic" (DSM IV-TR, 2000, p. 519). Dissociation can occur in varying severities, including "spacing out" or disconnecting from one's immediate surroundings, emotional detachment, "disembodied" observation

of oneself in stressful events, amnesia, depersonalization, derealization and multiple personality disorder (Briere, 1992; Herman, 1992; Mollon, 2001). In the context of a discussion of trauma, dissociation occurs when the individual's capacity to tolerate affect or process the events unfolding are overwhelmed by pain, threat or horror at the event/s.

Within the brain, the amygdale receives sensory input. The hippocampus and the prefrontal cortex organize the new information the brain receives and then relate or add the new data to the individual's previous body of knowledge and experience (Huopainen, 2002). Dissociation is thought to be the result of "an excessively high level of stimulation by emotionally charged events caus[ing] a break between the centers receiving sensory input and the hippocampal centers" (Huopainen, 2002, p. 103). There is a long, ongoing theoretical disagreement over whether dissociation or repression is the function that excludes trauma memories from conscious awareness (Breger, 2000; Guttman, 2006).

Cognitive Distortions

Briere (1992) cites cognitive distortions as another set of disruptions trauma survivors frequently encounter. In cases of long-term child abuse, a victim often feels that they have no means of protecting themselves and no ability to stop the abuse. Briere (1992) goes further to say that not only does a victim determine they are without protective options in abusive scenarios, but there is often a tendency to feel they have no options for self-protection in situations where this is not actually the case. He cites the premise from Seligman and Peterson's works that these cognitive distortions may lead to "learned helplessness" and compromised self-efficacy (Briere, 1992).

Psychological abuse in particular can impact cognitions and often is a factor in the development of dysthymia or depression in trauma survivors (Briere, 1992). Regular and unchallenged insults, blame, shaming and ridicule can solidify in the mind of the survivor as true and valid assessments of their character, which can develop into these mood disorders. Another common example of cognitive distortion is the tendency of survivors of abuse, of all ages, to take responsibility for wrongdoing that justifies the abuse. This is an internalization of the psychological abuse from the perpetrator, and is also understood by some as a defense against acknowledging the cruelty and disregard of the perpetrator, especially if the perpetrator is an attachment or idealized figure for the victim. Spitz (1946) and Egeland and colleagues (1983) discuss research findings that supports the connection between early neglect and depressive mood, both at the time of neglect and later in life. Early neglect and abuse have also been shown to result in insecure and anxious attachment styles (Briere, 1992).

Neurobiology of Trauma

Trauma of various kinds has been shown to impact the survivor on a neurological level in a number of ways. Infant neglect or poor bonding between infant and primary caregiver have been shown to have far more traumatizing potential than often suspected in cases of neglect. Infants who have little contact with a primary caregiver have been shown to develop poorly in areas of mood, intelligence and language abilities when compared to peers who had ample physical contact and care from a primary caregiver (Scaer, 2005). Infants provided lots of skin-to-skin contact with their caregiver "cried less, laughed more and predictably showed higher IQ and language scores compared to control subjects at age 5. Infants separated from the mother at birth manifested elevated

cortisol levels that subsequently dropped with resumption of skin-to-skin contact" (Scaer, 2005, p.118). Breastfeeding, cradling and "gaze interaction", the eye contact between breastfeeding mother and child, at an optimal distance for the infant's developing eyesight, all release the maternal hormones prolactin and oxytocin, which have been shown to promote healthy bonding and begin the development of the infant's self-regulating abilities (Scaer, 2005).

It is not insignificant that many of the fetal and neonatal studies that examine fetal and infant exposure and response to trauma are generally ignored and shunned by the medical community. Scaer (2005) references the term "cul-de-sac epidemiology" to refer to this set of studies which are never referenced by other medical articles, nor are these studies replicated or disproven by further research. Scaer (2005) postulates that this is the case because recognition of infant pain and traumatization in utero, in the delivery process and soon after birth, challenges many cultural practices that Scaer (2005) argues the medical community and parents in general are reluctant to acknowledge. The similarity between the disregard of these cul-de-sac studies and the derision and disregard of Freud's seduction theory is quite apparent. On a cultural level, throughout many time periods, it seems the medical community and Western cultures at large are engaged in a sort of defensive denial of the impacts of trauma.

The overwhelming amount and quality of sensory data and affect experienced during and following trauma also create a "weakening of mental capabilities" (Huopainen, 2002, p. 102).

> Encoding sensory, affective and experiential memories about [the trauma] to the autobiographical narrative memory alongside the rest of the self, is originally impossible even for the adult (Van der Kolk, et al., 1996), let alone for a

child…Such an undeveloped ego can hardly deal with the powerful affective experiences stemming from the actions of adults, such as indifference from their caregivers, affective explosions, violence or pedophilia (Huopainen, 2002, p. 102).

The complexities of memory and meaning-making are also challenging in cases of traumatic experience. The information in traumatic memories is encoded in the brain in visual, auditory, sensory and emotional fragments. "Thus an essential starting point in treatment is to use constructs and reconstructions approximating the historical truth to conceptualize what has happened, thereby rendering the experiences in a form which can be cognitively processed" (Huopainen, 2002, p. 94).

<center>*Trauma Theory: Elements of Healing*</center>

In 1992 Dr. Judith Herman published <u>Trauma and Recovery</u>. It is an elegant overview of the "forgotten history" of trauma in the field of psychology, the sequelae of trauma and the process of recovery. She begins her discussion of recovery by saying,

> The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections. Recovery can take place only within the context of relationships; it cannot occur in isolation. In her renewed connections with other people, the survivor re-creates the psychological faculties that were damaged or deformed by the traumatic experience. These faculties include the basic capacity for trust, autonomy, initiative, competence, identity and intimacy (Herman, 1992, p. 133).

The therapeutic relationship is one in the process of recovery that Herman highlights as often helpful to survivors, although many are reluctant to seek the help of mental health professionals, as is their right. If a survivor seeks professional help, it is of the utmost importance that the therapist be aware of power issues and empowering the client when she has a trauma history.

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In many ways, Herman (1992) writes, the therapeutic relationship is like that of the protecting parent. She quotes Otto Kernberg speaking of patients with borderline personality:

> The therapist's empathic attitude, derived from his emotional understanding of himself and from his transitory identification with and concern for the patient, has elements in common with the empathy of the "good-enough mother" with her infant…. There is, however, also a totally rational, cognitive, almost ascetic aspect to the therapist's work with the patient which gives their relationship a completely different quality (Herman, 1992, p. 136).

At its core, the relationship a clinician must foster with a client with a trauma history is one of warm rapport, deep and constant respect, collaboration, and trustworthiness. The clinician must be a representative of all that the trauma and its perpetrator were not: trustworthy, safe, attuned and empowering.

Herman discusses at length the three stages of recovery: establishment of *safety*, *remembrance and mourning* and *reconnection* with ordinary life. She is quick to point out that while these stages can be listed simply, the process of recovery involves "oscillation and turbulence" and that any linear implications from the list of stages are more comforting to the practitioner than a reality for a survivor. She points to many other concepts of recovery stages, from Pierre Janet to modern-day Brown and Fromm (1986) and Putnam (1989) who use varying numbers of stages to describe very similar landmark developments in recovery from post-traumatic states (Herman, 1992, p.156).

Safety

To begin the process of establishing safety with the trauma survivor, appropriate diagnosis and "naming the problem" are critical first steps. Given the propensity of traumatized people to consciously and unconsciously avoid memory or discussion of

their traumas, it is important, according to Herman (1992), that explicit questioning about fear of violence, past or present, be included in assessments. Of course, those with acute, often one-time traumas will generally have less complex presentations and will have easier access to memories of their traumas. Prolonged abuse, especially occurring in childhood, often results in such skewed understandings of relationships, power, autonomy and other qualities that a survivor needs the help of the therapist to access these memories at the appropriate time (Briere, 1992; Herman, 1992). Traumatized people also often require some amount of psychoeducation about what they can expect from others in healthy relationships. The information provided can validate the survivor's adaptive attempts to manage anxiety, separate the attempts to survive from the core of the survivor's values or personality and offer a framework to understand the post-traumatic responses the survivor is facing. Many times survivors of acute or prolonged trauma need practical assistance and advocacy with establishing basic safety and resources by being directed to shelters or services that will support them until they are able to live safely more independently (Herman, 1992).

Herman (1992) describes foci for stabilization, early in the recovery process. Because survivors feel unsafe in their bodies often or constantly, they need biological or physiological tools to help them gain control over their bodies. Herman (1992) points to use of medication to reduce reactivity and hyperarousal, and behavioral strategies like relaxation techniques and hard exercise to alleviate stress. She repeats her counsel that, as with all parts of treatment with the trauma survivor, the clinician must make recommendations for treatment and gain their client's full, informed consent. Any coercion or personal preference on the part of the clinician, e.g. an insistence that trauma

clients take medication, has the easy potential to recapitulate the abuse of power in the client's life. All decisions affecting the client must be made with collaboration and consent from the client.

Beyond physical safety and control over her body, Herman (1992) writes, the survivor needs to regain safety and restore balance in the destroyed attachments in her life. This does not mean she needs to engage in close relationship with people who are unhealthy for her, especially her perpetrator or shaming family or friends. Instead, she has need for one or more supportive safe relationships, one of which can be the therapeutic relationship. And lastly, according to Herman (1992),

> The social alienation of the disorder must be addressed through social strategies. These include mobilizing the survivor's natural support systems, such as her family, friends, and lovers; introducing her to voluntary self-help organizations and often, as a last resort, calling upon the formal institutions of mental health, social welfare and justice (p. 160).

Herman (1992) goes into much more detail on the process of establishing safety, from the safety of the body to the safety of the environment, with consistent caution to listen for cues from the survivor that point to more of the story, significant relationships or meaning in the story and coping strategies and client strengths that will be useful in recovery. Herman (1992) encourages clinician and clients alike to be in this stage of the process until the client is at peace in every day functioning, relatively undisturbed by symptoms of anxiety that plagued him before he learned to manage them. For some this process may take weeks or months. For those who have suffered long-term abuse, this process may take years, with cycles of suicidality or self-harm behavior, rescue fantasies on the part of the survivor, disruptions in the therapeutic alliance emerging from the

damaged trust secondary to abuse, or missteps or unethical behavior on the part of the therapist.

Herman (1992) warns of the desire to get into the secrets of the trauma too early, without solid coping skills and stabilization for the client and the preparedness and desire to begin addressing the trauma memories clearly important to the client. Both the survivor, eager for catharsis to bring relief, and the clinician, can hope for transformation too soon. Deal with safety thoroughly, Herman (1992) advises, to enable recall, affect tolerance and rebuilding later.

Remembrance and Mourning

When stability, safety and balance are well-established, Herman (1992) proposes the client is then likely ready, if he wants to do it at all, to turn his attention to remembering and telling the facts of his trauma from beginning to end. The recall of the facts of the trauma is only the first stage of the examination of the traumatic event. After telling the events of his trauma to his therapist, they review together the events in detail and discuss the survivor's emotion at each moment. This element of the process, in fact any of them, can take a number of sessions, depending on the structure of therapy, and Herman (1992) emphasizes taking one's time. Both client and therapist must check in often about how the pace is and how the client is tolerating the many difficult memories and affects he is examining. After reviewing all the emotional impact of the trauma, the meaning of the events and different aspects of them are drawn from the client. Herman (1992) cautions especially about assumptions here: the most compelling quality of the event to the therapist may not be the most compelling to the survivor. For example, rather than the brutality of an attack being most offensive, the survivor may feel more the

humiliation or helplessness of the attack. The process of remembrance and mourning usually involves grief on the client's part: he has often "lost his old self," lost relationships or safety with cherished people in his life. Sometimes a survivor endured a permanent or disabling injury, and he must mourn the loss of previously held abilities and wholeness of his body. The process of remembering the facts, emotions and meaning of his trauma allows the client to process and integrate all the levels of impact and meaning that his experiences have left him with. When he is finished, after whatever length of time is required, his safety and stability are solidified and he has a cognitively and affectively integrated narrative of his trauma.

Reconnection

When a survivor is generally done recalling, reliving, ordering, feeling and making meaning of her trauma, Herman (1992) describes "the task of creating a future…she must develop a new self…she must develop new relationships…She must find anew a sustaining faith…In accomplishing this work, the survivor reclaims her world" (Herman, 1992, p. 196).

Just as approaching the memories and story of the trauma, when one is prepared to do so, provides relief and release from the grip of the memories and their compensatory symptoms, the act of approaching one's life: goals, friends and lovers, community, values and beliefs, rather than the avoidance of people, events and emotions that comes with constriction after trauma, this pursuit itself is sustaining and empowering. When a survivor has processed her trauma and assesses realistically that she needs self-defense training, in order to be able to reasonably freely go about her daily routines and pastimes, she is seeking and acquiring for herself the skills, awareness and

practice to be able to defend herself if she had the need. Herman (1992) describes the

choices of many survivors of violent attacks to take self-defense classes that teach safety

assessment tools and defensive techniques, attune participants to heightened adrenalin,

allowing them to think and act clearly in times of threat, build endurance and craft an

instinctive self-protective awareness of body and mind. Other programs involve

intensive outdoor survival trips which allow students to see they have reserves of strength

and perseverance that they weren't familiar with. All of these efforts promote the

survivor ensuring the safety of her environment and herself, with her body and mind.

This third stage of healing after trauma is the best place, Herman (1992) writes,

for survivors to confront perpetrators, bystanders, communities or the legal system with

their truth and their comments on it.   The survivor has established safety for her body

and her living environment and has practiced coping and self-soothing skills extensively

in the process of recovery. The vivid, draining, confusing upheaval of recalling and

telling the story of the trauma is past, given its due, and in its proper place for the

moment. The survivor ideally must be prepared to communicate her message as she

wishes, without investment or attachment to any response from the family member,

perpetrator or bystander. Herman writes,

> Family confrontations or disclosures can be highly empowering when they are
> properly timed and well-planned. They should not be undertaken until the
> survivor feels ready to speak the truth as she knows it, without need for
> confirmation and without fear of consequences. The power of disclosure rests in
> the act of telling the truth; how the family responds is immaterial (Herman, 1992,
> p. 200).

This stage is also the time when the survivor does what Herman (1992) calls

"reconciling with oneself." It is a time to determine what will draw the energy that has

previously been given to self-protection in violent states and their aftermath, to the

energy that is relieved of re-visiting a trauma again and again. As one regains more and

more energy (or in the case of early long-term abuse survivors, builds for the first time)

accessing desire, initiative and mastery, the attention of the survivor can be directed with

intention to the goals, dreams or concerns the survivor prioritizes. Survivors often ignite

fascination in studies or hobbies that they had before their traumatic experiences

interrupted their vitality and attention to such things. There is also, Herman (1992)

describes, a new willingness to acknowledge that while the traumas had a certain effect

on one's life, the damage need not be permanent or fixed: the survivor's volition and will

make a difference in the nature of her future, even though the past cannot be undone.

The last broad change Herman (1992) points to for survivors in this stage of

recovery is many benefits of reconnecting with others. The essential trust, openness and

flexibility that were shattered with trauma are strengthening. There is caution, and the

ability to judge where one can take a risk and where one must not. The witness of the

therapist and the empathy of fellow survivors is often the most curative factor cited by

survivors in their recovery (Herman, 1992).

Support groups for survivors are frequently recommended to trauma survivors for

their ability to broaden the audience the survivor shares her story with, promoting more

meaning-making and comfort with her narrative. The survivor also receives in a support

group a kind of support she cannot get from a therapist who is not a survivor of their kind

of traumatic experience. Even when a rape survivor has a therapist who is a rape

survivor, the client can benefit from joining a survivor support group because she now

has many empathic, validating faces looking back at her when she shares her story, and

because, given the therapist's appropriate professional detachment, the client's fellow group members are able to respond in unrestrained, personable ways. The client in a group is also able to hear the stories of other's violations and recovery, in a way that most therapists who are survivors would not share their trauma stories with clients.

Lastly, Herman (1992) describes the common habit of survivors to choose a "survivor mission." This is the tendency that many trauma survivors have to become an advocate for survivors, or counselors or group leaders, out of a desire to help those in pain similar to the pain the survivor felt before and during her recovery process. Many parents who have lost children to death seek opportunities to support other grieving parents in their recoveries. Rape survivors often become rape counselors. All of these efforts are elements of the survivor reconnecting with herself, with others, and with life in general.

In summary, Herman's (1992) approach to recovery with the trauma survivor involves constant empowerment of the client, careful attention to safety and the client's practical and affective stability, guiding the client through remembrance and mourning of her experiences and supporting the client in the many ways she seeks to reconnect with her life as she finishes the process of recovery.

CHAPTER VI

DISCUSSION:

PARALLELS BETWEEN SELF PSYCHOLOGY AND TRAUMA THEORY

There are many references throughout the literature that connect a traumatic experience to damage to an individual's *self,* as I reviewed earlier in the chapters on self psychology and trauma theory.   This theme of trauma's impact on selfhood, as well as the similarity between the concept of twinship and Herman's (1992) reconnection phase of recovery were the impetus for my decision to consider and study the parallels present between self psychology and trauma theory.

The six major terms that I will be comparing below have already been reviewed in previous chapters. They are *mirroring*, *idealization*, *twinship* and establishing *safety*, *remembrance and mourning*, and *reconnection*. For the sake of clarification, I will use two case vignettes, Tommy and the Harrises, to discuss and clarify my meaning on these points.

Tommy

Tommy is a five year-old boy living with his single mom, Cheryl. Cheryl is twenty-six years old, Caucasian, and is working a minimum-wage job at Wal-mart. She cannot afford a car, so she buses to and from Tommy's daycare and her job each work day, making her commute plus her shift a twelve hour day, when there are no delays. Cheryl has a high school diploma and no college experience. Cheryl and Tommy have no health insurance. Cheryl is physically, verbally and emotionally abusive towards

Tommy when she is stressed, which unfortunately is often. Tommy sometimes goes to school with bruises, which so far have gone unnoticed by other adults in his life.

The Harrises

Jill and Evan Harris are a young married couple, ages 32 and 35 respectively. Evan is employed as a factory worker in their industrial city in the Midwest. Jill is an administrative assistant for a small business. Evan has been experiencing stress at work because of conflict between his union and factory management. He is angry both with management for poor work conditions and at the union for some decisions that affect him negatively. Evan has been drinking more heavily than usual since his work stress has been building, and is often drunk and verbally and physically abusive at night. A few nights in the last six months, he has insisted on sex with Jill despite her protests. In discussing these nights with her girlfriends, Jill has never used the word "rape," but is tearful and jumpy when she recalls or describes these sexual interactions.

Trauma as Anti-Mirroring

As selfobjects in their role as caregivers, parents are primary sources of developmental support and experience. When a parent is good enough – adequate - in her caregiving role, healthy development can unfold. We know that when serious and/or chronic neglect of basic needs or emotional development occur, the development of the child will be impaired (Briere, 1992; Kohut, 1971; Scaer, 2005). When a parent abuses a child, she is clearly no longer the good-enough parent. I propose that in this scenario and others where abuse is present, the abusive behavior and the abuser's response to the victim's responses are essentially *anti-mirroring* behavior. Mollon (2001) makes a similar point: "When the caregiver is the *source* of the trauma then this selfobject

function (soothing and empathy) is fundamentally compromised" (Author's italics, p.209).

Let me elaborate with Tommy's vignette. Imagine we could see the moment when Cheryl first struck Tommy's face and he began to cry, cower or plead "No, no!" There would be, on Cheryl's part, a complete disregard for Tommy's affect, cries and body language. As the attack continues, another blow falls, expressly ignoring Tommy's continuing pain and his cries for the abuse to end. There is no source in the boy's reach for assistance in enduring the pain and emotional shock of this beating. Tommy's ability to regulate his affect is still developing at the age of five, so this massive load of affect would be overwhelming to him. If the abuse continues into Tommy's school years and adolescence, he would be nonetheless impacted negatively by the denial of his pain by his mother/abuser because of the corruption of her selfobject role with her abusive behavior.

His attachment to his mother coupled by the abuse creates a set of ambivalent conditions for Tommy with regard to mirroring. "Mommy hugs me and gets me a bandage when I run inside after skinning my knee in the driveway." This is Cheryl recognizing Tommy's hurt and doing something to relieve it. Here Cheryl is doing appropriate and adequate mirroring. The mirroring is then contrasted with the anti-mirroring that occurs when Cheryl becomes abusive. "When people have been mean to Mommy, she gets mad and hits me across the face when I spill milk at dinner. Mommy doesn't see that I was trying to use my fork like a big boy and my elbow knocked over my milk. She doesn't see it was an accident." Cheryl in this moment is expressing her rage and frustration at people and systems far beyond Tommy, and is not accurately

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mirroring to Tommy what his experience of the situation is. Her expression of rage and frustration is traumatic for the object of her rage, Tommy, and actively denies recognition of his affect in the moment. This is anti-mirroring. Herman (1992) says it well: "at the moment of trauma, almost by definition, the individual's point of view counts for nothing" (p. 53). Anti-mirroring trauma usually accompanies unwillingness on the part of the abuser to help the victim process the facts and meaning of the traumatic events, so the victim is left with limited ability to have a reparative experience immediately after trauma (Schore, 2002).

To add insult to injury, if Cheryl uses emotional abuse such as blaming, shaming or ridiculing Tommy for his very appropriate response to physical pain and emotional violence, this can weaken his healthy grandiose self as it has developed up to this point. If Tommy is told he has done something to deserve the beating, this warps his understanding of what is right and wrong, teaching him the corrupt "rules" of his abuser. This is a detour from the healthy mirroring of right and wrong, admirable and unwanted behavior that a selfobject would provide in healthy development. Mollon (2001) cites Kluft's (1994) four components that produce Dissociative Identity Disorder, one of which is a condition of "the child not [being] provided (a) with adequate protection against further overwhelming experiences, and (b) with appropriate soothing and opportunities to express and process their pain – i.e. the necessary selfobjects are not available" (p. 212).

The perspective that trauma is an anti-mirroring dynamic that affects the child's self is evident in many ways following the trauma, including a lack of self-soothing abilities, confidence and agency or volition. Some of the established healthy grandiosity is damaged in trauma, to one degree or another. Herman (1992) speaks of repair for a

trauma survivor beginning with establishing safety. When the sense of safety then re-introduces to the survivor respectful boundaries, basic needs and a chance to stabilize, this is mirroring. The clinician is insisting for the survivor, who is temporarily unable, or as a young child, not yet able, to insist for themselves and acquire adequate housing, clothing, food, and access to treatment as they leave a traumatic environment. A great deal of the reflection done by a clinician in treatment will be validating responses, positive re-framing responses and the appreciation of the survivor as a person – as a unique self. All of this is mirroring. More specific discussion of the approach to treatment regarding mirroring and trauma can be found in Chapter VIII: Summary and Recommendations.

Failure to Aid – Failure to Mirror

The mirroring situation can be much more complicated, though. Let's imagine Cheryl is dating someone who moves into their home. If Cheryl's partner is either unaware of the abuse, unwilling to acknowledge the abuse, or unwilling or unable to confront Cheryl and attempt to stop the abuse, Tommy's situation is even worse. His natural expectations of selfobjects lead him to believe that his mom and all adults will care for him instead of harm him and that they will step in to prevent further harm or danger when it has begun. Instead Tommy is having his physical safety and pain callously thrown back in his face. Mom is denying his injuries and is indifferent to the instability and fear the abuse generates. In addition, Tommy has no back-up protector in Cheryl's partner as his mother beats him. Instead of this adult mirroring to the boy that his pain is something to put an end to and that the ridicule will be defended, the partner stands by while the abuse continues. This non-mirroring by the bystander caregiver is

often so painful that many survivors of incest express more anger and hate towards the bystanders in their abuse histories than the perpetrators themselves.

> An incest survivor describes her rage at her family: 'I have so much anger, not so much about what went on at home, but that nobody would listen. My mother still denies that what went on was that serious. In a rare mood now she'll say, 'I feel so guilty, I can't believe I didn't do anything.' At the time nobody could admit it, they just let it happen. So I had to go and be crazy' (Herman, 1992, p. 101).

Ferenczi also recognized the "traumatic aloneness" that a survivor feels when emotionally abandoned or when their injuries are denied by their caregiver (Frankel, 1998, p. 45). He believed that this aloneness – being forsaken – is a "trauma worse than rape" (Frankel, 1998, p.45).

Anti-Mirroring in Adult Trauma

In the situation of domestic violence between adult partners, the abused partner often receives from their partner both positive, accurate mirroring and anti-mirroring in the form of emotional abuse, physical violence, sexual violence, domination and/or control. As a lover, the abusing partner has the role of selfobject. Many relationships have qualities of twinship, mirroring and idealization pulsing between each partner as they enjoy common interests, appreciate the skills and special uniqueness of each other and offer their particular strengths to the relationship for the other to idealize and rely on when needed. In the Harris vignette, Evan can exert control over Jill by using his ability to influence his wife's grandiosity: one moment her husband's comments leave her the room to feel confident and pretty, the next she is ugly and useless, worth nothing in Evan's estimation. The impact of psychological abuse as well as physical and sexual violence can impact the established self of the survivor to the degree we've seen above in the discussion of trauma: severe self-loathing where there was confidence, self-blame

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where there is no realistic offense, over-estimation of the abusing partner, difficulty maintaining healthy boundaries with others, and so on.

The obvious absence of mirroring in the traumatic interaction plus the impact that anti-mirroring from abusers can have on previously established healthy narcissism, or grandiosity, is one psychodynamic way to look at the impact of trauma on an individual. This can explain in a new way the greater impact of trauma on children, who are still in the process of developing selves, as well as the greater impact trauma can have when the perpetrator is an attachment figure.

The Therapist and Mirroring in Recovery

This perspective also explains much of what is therapeutic in the relationship with the clinician. As the clinician gives great attention and time to issues of establishing safety, he is presenting a set of expectations of personal safety that the survivor can begin to embrace. When the clinician validates the survivor's feelings, this is mirroring, creating many small repairs to the survivor's self which has been damaged by the disregard and ill attention of the abuser. Internalization of appropriate mirroring builds psychic structure (Kohut, 1971; Mollon, 2001).

Mirroring is related to remembrance and mourning as well as establishing safety. Much as with the selfobject in healthy development who shares the child's experiences and provides explanation and interpretation of new events, the therapist who is witness to the trauma memories, story, and aftermath, is mirroring the survivor's experience. Many survivors experience surprise when their therapist responds with genuine shock, horror and sometimes tears at brutal or sad trauma stories. "I just expected nothing else and nobody told me I could fight it, hate it." The survivor's trauma reality becomes more

grounded: more real, more definable and containable, as it becomes known by the

therapist or other selfobject the survivor shares with.

<div align="center">*Trauma Corrupts the Idealized*</div>

The survivor's idealized figure and the elements of his own ego that have been

transmuted already from idealized figures in the past are often severely damaged or

destroyed after a traumatic experience.   When the perpetrator of violence is an idealized

figure of some kind, the impact of the trauma to self will be greater because of the

perpetrator's contributions to psychic structure as a selfobject.

Trauma Impacts the Idealized, Capable Self

A survivor's own ego, his own idealized qualities to think and act protectively and

pro-actively for himself is hobbled after trauma. He instead experiences helplessness,

shame and doubt about whether what he did or did not do was to blame. Whatever

knowledge, skills and traits he has internalized from adequate idealized selfobjects now

belongs to him and these are put to use often to accomplish goals and tasks in everyday

life. The overwhelming and powerless aspects of the experience of trauma challenge the

adequacy of the survivor's idealized self: he was in a situation where he was unable, due

to overpowering force or threat, to protect himself from harm.

Attachment Figure as Perpetrator

It has been noted many times (Briere, 1992; Herman, 1992; Schore, 2002) that

trauma occurring in infancy and childhood is often observed to have the greatest impact

on the mental health and functioning of the child in later years. When the abuser is an

attachment figure, as in cases of incest and many cases of child abuse, the impact is

enormous. Just as abusive behavior is anti-mirroring behavior, it is also expressly

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un-ideal behavior. The figure who has perhaps been a protector is now an abuser. The

selfobject is not providing safety and security, but rather pain and danger. And yet, as

completely as the abuser is not providing safety, the child's attachment needs are so total,

that much psychopathology and justification of the abuser's behavior is often embraced

by child abuse and incest survivors in an effort to keep the un-ideal reality of their

attachment figure at bay.   It is not uncommon, we know, for a survivor to justify or

rationalize the violent behavior of their idealized figure, in an effort to maintain the

attachment and the idealized person's strength and enviability. It is far easier, as we have

seen above, for the survivor of trauma to take responsibility and blame, to shame herself

and believe in the justness of her treatment than it is to relinquish her protector, her pillar.

Other Idealized Figure as Perpetrator

        In cases of trauma where the abuser is not an attachment figure, but is an idealized

figure of another kind, such as in cases like the Harrises, in date rape scenarios or child

abuse by a relative who is not a primary caregiver, there is also the fall from the grace of

idealization when the person the victim admires or loves begins to inflict pain or

humiliation instead of offering respect and kindness. Instead of being a selfobject that

Jill wants to emulate or one that appears strong in the face of crisis, Evan deals with his

workplace stress by beating Jill and forcing her into sexual intercourse rather than

seeking release in a non-violent way. The adult uncle who has many healthy, non-

abusive ways at his disposal to satisfy his sexual urges, callously violates his niece

instead. The functions of idealization as well as mirroring underlie the incredible impact

of trauma on relationships that survivors often experience and work through as part of the

recovery process.

Seeing the relationship between a survivor and her perpetrator with selfobject functions in mind allows the clinician deeper understanding and respect for the complexities of the needs of the survivor when she experiences ambivalence about the relationship she has with her abuser. In this way, self psychology is similar to attachment theory in that it stresses the essential early attachment/selfobject dynamics in healthy development.

The therapist often finds herself idealized in the process of assisting a survivor in recovery. Certainly in the early stages of establishing safety, the clinician is often the only voice in a client's world that is reliable, strong and protective. Just as with mirroring from the clinician, the client can slowly internalize the strength and protective functions of the clinician as she has more and more available psychic energy.

Idealization is relevant in the constant theme in trauma theory to empower the client at every turn. An idealized selfobject who acts with wisdom is careful to not build dependence and over-estimation of themselves in the part of the self, or client, in this case. Herman's (1992) regular reminder to clinicians to avoid the unconsidered use of power in the therapeutic relationship, to empower the client in every decision and accomplishment are all the qualities of an idealized selfobject that observes less and less need in the client for the selfobject functions she has provided as more and more structure is internalized.

The awareness of selfobject needs can also direct the clinician to encourage the client to pursue relationships with idealizable people outside the therapy relationship. When the therapist and client determine who in the survivor's life she can call on for

support, the therapist is helping the survivor client access idealizable figures in her life who can lend her strength and competence while the survivor feels undone, unsafe and ill-equipped at the moment to handle the challenges of her life.

Recovery from Trauma through Twinship

Perhaps nowhere more than with twinship do self psychology and trauma theory reflect one another. When Herman (1992) describes the trauma survivor reconnecting with people in her life she has avoided after traumatic experiences, the survivor can be understood to be reaching out again to people with whom she had selfobject relationships. Certainly a portion of these relationships demonstrate twinship roles. The propensity of trauma survivors to seek out or be referred to support groups with fellow survivors is the strongest example of the effectiveness of alter ego selfobjects in the recovery process for the survivor.

Reconnection with Self

A reconnection with herself – re-embracing her sense of identity including but not limited to her experiences of being traumatized, attending again to her skills, talents, dreams and goals, the everyday joys and struggles of being herself – is a pre-requisite for the survivor to be able to reconnect and find twinship with others. She has, through the healing process, reduced the energy used to live in a state of hyperarousal. She is countering the need and desire to isolate and avoid people and experiences that she once employed to protect herself while in a post-traumatic state. Herman (1992) observes that this is the time when a survivor is looking outward, into her life and the world at large, making choices about what to direct her passions towards as she feels more revitalized.

Kohut (1985) also notes the tendency of a fragmented self to promote reconnection within the self with creative pursuits, like art and music-making.

For many, the process of recovery has empowered the survivor to call herself a survivor, to shift from feeling like and using the term "victim." The active quality of "survivor," compared to the passive connotations of "victim" is taken on with gusto as the survivor reconnects with herself.

Twinship in Reconnection with Others

The similarities are obvious between the ways a self seeks like selfobjects and the survivor, in the last leg of her healing, seeking out and feeling buoyed by the testimony and example of other survivors. The twinship functions in a support group are plentiful; here the survivor meets others with similar experiences and hears stories similar to her own. There is great healing potential in witnessing the agony and triumph of another's trauma and their healing journey: this is twinship. Just as the abuser separates and isolates, using secrets to nail down a story to just two people's knowledge, the recovering survivor is often found in a group of fellow survivors, telling and witnessing secrets that will not be covered anymore. The relative objectivity one can have for another's story allows a survivor to turn self-ridicule for "being bad" into innocence at the hands of the cruel. The sense of having given in to a torturer is transformed into a valiant effort to stay alive. The empathy and compassion that the survivor often has more readily for others, is allowed to travel full-circle and wash down over herself as well. In recognizing herself in the others she shares with, through twinship, the survivor is able to use their strength and bravery to build her own. There is an "essential alikeness" (Kohut, 1984,

p. 13) in each survivor-survivor relationship which supports survivors in the recovery process.

"Intergenerational Twinship"

The pleasant bonds of twinship also offer the survivor a sense of the influence of time on recovery. If one is new to support groups for survivors, it is often the case that survivors are astonished, impressed or filled with longing, at the vitality, self-assuredness and happiness of a survivor who has been recovering from her trauma longer. The benefit to a survivor of seeing many others, in all their varying states of stability and mourning, safety and reconnecting, offers reassurance and a sense of possibility that even a compassionate and skilled clinician could not express as well.

I use the word "intergenerational" to refer to the often lengthy process of recovery. A rape survivor who has just begun to stabilize and have control over her body again is in a vastly different place than a survivor who has examined and told her trauma story in detail. This difference, of experience and processing, is the "generation" I refer to with the term "intergenerational twinship."

It is twinship and intergenerational twinship at work when a survivor chooses to direct her time and energy towards service to or advocacy on behalf of fellow survivors. A combat veteran who chooses to become a counselor or veteran advocate is the selfobject older brother for veterans who are "younger" in their process of healing from PTSD. As he leads a group for traumatized veterans, he allows his own example of trauma, healing and renewed vitality to be a solace, encouragement and example to possibly follow. His reconnection with his own life offers hope to fellow survivors of the

horrors of war, and a veteran fresh from his own traumatic events has an admirable template of what he could become if he attends well to his own recovery.

Self Psychology at Work in Trauma Theory

The parallels between self psychology and trauma theory are vivid because it is frequently people traumatizing people. When a perpetrator inflicts violence on another person, there is a lack of mutual recognition, or mirroring, between abuser and victim. Healing from anti-mirroring trauma will necessarily involve attuned and plentiful mirroring for the survivor.

Despite its superficial appearance of power and control, the traumatizing behavior conceals an absence of healthy strength and competence: the abuser's behavior is not ideal or idealizable in any way. This un-ideal figure must be revealed to be so in the process of recovery, and genuinely idealizable figures must be gathered to surround the survivor to counterbalance the destruction of self that the un-ideal selfobjects of her trauma presented to her.

Finally, the process of recovering from trauma will almost certainly involve twinship selfobjects for the survivor. Resonating with the experiences and healing of other survivors counters the isolation and shame that often accompany trauma. The survivor is able to draw on the vitality and humanity of others like him when he connects with twinship selfobjects.

It is in these ways that the concepts central to self psychology are present in Trauma and Recovery. An awareness of selfobject functions and their use to the trauma survivor will further the work of trauma theory. Attention to the impact of trauma on a client's sense of self and knowledge of the general process of recovery from trauma can

aid the self psychologically informed clinician to more attuned and prepared service to the survivor. A commitment to empathy and empowerment throughout the recovery process will enable repairs to be made to the damaged self of the survivor and will prepare the survivor to approach her life with intention and confidence.

CHAPTER VI

CASE OF ELAINE

Theory informs the work of the clinical social worker, but our work is about people: unique, complex, nuanced people. To that end, I will next present a case study to provide context to the points I made in Chapter VI and to the conclusions I will make in the Summary and Recommendations Chapter to come.

The following is a composite of a former client of mine and other survivor's stories that I have reviewed throughout my preparation of this thesis. No real names or settings are being used for the sake of confidentiality.

Elaine

Elaine is a 45 year-old Caucasian woman living in a major city in Arizona. Elaine grew up near her current home with her parents and her three siblings. Elaine is one of the middle children, with older sister, Patty, an older brother, Bruce, and a younger brother, Alex. Elaine disclosed to her therapist that she was molested by her older brother Bruce a number of times around the time she was eight. "It happened maybe five times. In this small space under the stairs – no one ever knew we played in there. He did things with his fingers and …. (She makes a contorted, disgusted face.) I don't know…. I can't tell you exactly what he did. It made me feel funny in my stomach and I hated him. I didn't want to hate him – before that he was really a pretty good brother. He was kind; he would sit for hours and comb my hair. He thought I was special."

Elaine told her mother about the molestation and reports that her mother said "That's impossible. Your brother is a good boy and he loves you. Stop telling lies. You're such a spiteful child." This denial has continued to the present day. In this episode of treatment, Elaine regularly discusses plans for family events and whether or not she plans to attend. "I won't go if Bruce is going to be there. My mother makes it so that we don't go to the same parties or dinners, 'cause when he's there… (volume rises, she shifts defensively in her chair) where there's sparks…I ignite!"

Sadly, Elaine's childhood trauma did not end with her brother's molestation. Elaine describes a day when she was ten and was at a roller skating rink in her neighborhood for a classmate's birthday party. Elaine had wandered off from the main party with her younger brother, Alex. They were exploring the arcade, the snack shop and the locker rooms. When they were returning to the main crowd of the party, passing through the arcade, two older boys, around 14 or 15 years old, burst in front of Elaine and Alex, threatening them and saying "You're not supposed to be back here." Alex ran and hid in a corner of the arcade, frightened by the older boys' coarse language and rough demeanor. The boys teased and harassed Elaine, and eventually pinned her down on a table, saying they would "show her what being a woman meant." The boys ripped off Elaine's pants and underwear and both boys raped and sodomized Elaine. Alex, terrified and frozen, witnessed the brutal attack on his sister.

Elaine remembers nothing of the attack except the surprise of the boys jumping in front of her in the arcade. Years after the rape, she says "I made Alex tell me what happened. I *made* him. I had to know – he really didn't want to tell me. He had a hard time getting the words out. But I knew he saw what happened, and I needed to know."

Elaine never told her parents of the rape.

Elaine finished high school and attended nursing school. She practiced as a registered nurse for five years, taking great pride then and now in her work caring for people. In fact, one of Elaine's biggest strengths is her proactive approach towards managing her present, multiple health concerns. She lives with diabetes, tardive dyskenisia which makes her gait slow and irregular, and makes her hands shaky. She also has arthritis and digestive problems. Elaine uses her knowledge and skills from nursing to educate herself about her conditions and their interactions, as well as in self-advocacy in medical decision-making.

Elaine was married once for five years. Elaine's relationship with her husband, Ben, was emotionally and physically abusive. Ben struggled with depression and other health complications, and after a number of suicide attempts throughout his adult years, he took his own life. This precipitated Elaine's first psychotic break. She was forty-one years old. She was first referred for mental health treatment after being found by a concerned citizen, and then the police, sitting barefoot on a cold night on a park bench, well after midnight. She was incoherent, tearful and in desperate need of stabilization.

Since then, Elaine has had many hospitalizations for psychosis, an inability to care for herself and suicidal ideation. In general, she can manage the activities of daily living, such as shopping and cooking for herself, grooming and dressing herself and pursuing interests like reading, attending church and exercising. However, when she experiences conflict or stress, she lapses into psychosis, speaking to people who aren't there. A psychiatric nurse reported that while hospitalized, Elaine frequently yelled angrily at a person not in the room, whom the nurse took to be Elaine's mother.

At the time of treatment, Elaine was dating a man named Paul. When they had serious arguments, Elaine would decompensate and once became psychotic, needing again to be hospitalized. When she saw her therapist after these arguments and was not quite psychotic, she was much less coherent than normal. Her sentences would include multiple long pauses. Her thought processes became more tangential and disconnected. She would often breathe unevenly and uneasily, appearing frightened and unable to calm herself.

Finally, a major conflict with Paul surfaced in the middle of Elaine's treatment with her therapist. Elaine learned that Paul had multiple untreated sexually transmitted infections. He had not disclosed this at the beginning of their relationship and they had had frequent unprotected vaginal and anal sex. The latter was not particularly Elaine's preference but "I do it because he really likes it, and I want to make him happy."

Elaine's history is clearly full of trauma and her presentation prompted questions about the stability and cohesion of her sense of self. In the following chapter I will tie Elaine's story to the points I made in Chapter VI on the parallels between self psychology and trauma theory.

CHAPTER VIII

SUMMARY AND RECOMMENDATIONS

The parallels between self psychology and trauma theory can support the following implications for treatment: (1) Self psychology may be particularly beneficial to clients who are trauma survivors. (2) Trauma survivors are especially likely to have incurred damage to their sense of self; some of these survivors will have established healthy, cohesive selves that were damaged by trauma after this development. Some survivors will have inadequately developed selves due to early childhood abuse. (3) The therapist to the trauma survivor can reasonably expect that he will encounter the necessity to mirror, be idealized by, and/or provide twinship for his clients with trauma histories.

The Healing Power of Empathy and Empowerment

Self psychology's emphasis on the use of empathy as a clinical technique or intervention is especially pertinent to the treatment of trauma survivors. In contrast to other models of practice that emphasize detachment or neutrality, self psychology's belief in the healing power of empathy is able to communicate to the trauma survivor that she is deeply understood. The anti-mirroring that the survivor's trauma threw in the face of her actual affective experience at the time can be reversed over time with the accurate, attuned and compassionate stance of the empathic therapist. For many survivors the overwhelming experience of the trauma/s, plus the frequent secrecy of the trauma or the denial of the trauma's reality by others and the perpetrator, are so self-negating that much of the repair occurs when the survivor can finally acknowledge the reality of the

traumatic events and *be believed* by at least one other person. This repair can happen

whether this person is the therapist or not; an empathic friend or other listener can mirror

and validate the survivor's pain for similar effect for the survivor. Through

reconstructing the facts and meaning of her trauma, and experiencing empathy from her

therapist, the survivor's empathy for herself grows (Mollon, 2001).

Sometimes simply accessing the traumatic memories and their related affects and

meanings is much of the work of the therapist. Basch (1985) writes on the concept of

disavowal and how an empathic approach to it can enable the client to address the denied,

repressed and/or dissociated material.

> What is disavowed is not talked about; the self-deception of disavowal is
> maintained by blocking the working over and working through to affect made
> possible by speech. The resolution of disavowal requires that the analyst listen
> carefully for what the patient leaves out, glosses over, mentions only in passing,
> treats as trivial, and so on… empathic understanding of the patient's disavowal of
> meaning guides him as he first creates an anxiety provoking situation for the
> patient and then shows him that he can first speak, then think, and finally confront
> his feelings about previously interdicted areas with good results (Basch, 1985, p.
> 39).

Given that disavowal, avoidance and shame are common responses for the trauma

survivor, attunement and empathy are critical for the survivor if she is to recover.

Huopainen (2002) writes "the psychotherapist's *appropriate attunement* to the patient's

emotional state and his/her empathic description of the patient's experiences, sensations

and affects – when needed - also serves as a focused cure for the patient's shame

(Author's italics, p. 105).

Self psychology's emphasis on empathy is well-matched with Herman's (1992)

emphasis on empowerment of the survivor in all aspects of treatment. Given the power

imbalances present between perpetrator and survivor, informed empathy and a non-

authoritarian stance will naturally be sensitive to recapitulations of power in the treatment setting and relationship. Empowerment efforts on the part of the therapist acknowledge and empathize with the survivor's feelings of helplessness and powerlessness.

In the case of Elaine, she often glowed and had a childlike facial expression of gratitude and feeling lucky when her therapist told her in various ways that she believed that she had been brutally attacked and abused by her brother and the boys at the arcade. At the time, it was hard to reconcile her genuinely happy expression with the topic in the room, but she needed to be believed just as much as she shouldn't have been violated in the first place. In other words, her trauma was real to her and always had been. She didn't need her therapist to tell her it was real, she needed *to hear from another person that they knew* it was real. She needed her trauma to be a reality to another person. This is Elaine's need for mirroring: to have her emotions and experience recognized and felt by another.

Another benefit that self psychology and trauma theory offered to Elaine was a privileging of her voice and expertise on all matters concerning her. This is the empowerment principle in Herman's <u>Trauma and Recovery</u>: that all decisions that have an effect on the survivor must be made with informed consent from the survivor. As you can expect with a client with a damaged self, Elaine often asked her therapist's advice and opinion on matters. The decades of anti-mirroring and the absence of mirroring Elaine received from important selfobjects in her life left her without the instinct to ask herself what she thought, felt or wanted. She was in a place where she discounted her voice often, if she even got to the point where she knew what her voice was telling her.

As a mirroring selfobject for her; part of her therapist's role was to help her become accustomed to asking herself her own opinion.

Damaged Selves

As we have seen above from many sources in the literature, trauma often does significant damage to self. The paired attention of self psychology and trauma theory can have the effect of de-pathologizing our clients. Many of these self-damaged or self-disordered clients come in with a host of serious diagnoses. They can be labeled as depressed, bipolar, schizophrenic, personality disordered or suffering from PTSD, to name a few. While many of the diagnoses our trauma survivor clients carry are legitimate and useful to the clinician in treatment considerations, the tendency to pathologize our clients is well-known. When we can look at the damage to self originating in trauma - that is, from the behavior of a third party, we are better equipped to be able to see our client's symptoms and maladaptive patterns as responses to life circumstances and not intrinsic or permanent disruptions in functioning.

We can understand, as Straker, Watson & Robinson (2002) urge us, that rage, intense shame and other maladaptive behaviors surfacing after trauma are efforts of the "strong" parts of the psyche to protect the "weak" parts of the psyche. Given that there is potential for recovery after trauma, as the lives of countless survivors and Trauma and Recovery describe, then clinicians who recognize this can view their clients' damaged selves with room for hope of repair and reassessment of diagnoses and pathology.

Elaine's self was disturbed in its original development and events later in her life further damaged this uncohesive and incomplete self. The fact that Elaine's frequent response to significant stress, like an argument with her boyfriend or an unpleasant

family event, was to become psychotic and unable to keep herself safe indicates that she had not developed an adequate ability to self-soothe and regulate her affect. She became overwhelmed in the face of stress and needed to distance herself psychically from reality. This is further support that Elaine lacked adequate mirroring and/or experienced too much trauma/anti-mirroring to develop the normal self-soothing abilities that internalizing a selfobject's functions generally provides.

Another aspect of Elaine's underdeveloped and damaged self is her complete ignorance of what she could expect in life in terms of safety. Let me be clear, I blame Elaine's ignorance on the selfobjects in her life, not Elaine herself. For who but our early caregivers/selfobjects tell us that we mustn't hit people, and that if someone hits us, we should tell an adult who can help us redress this wrong? When Elaine was eight and told her mother that her brother touched her inappropriately, Elaine got no validation for her feelings about the event. She got no redress. Her brother was never confronted about the abuse and there were never consequences to him for what he had done. I believe that in this interaction, Elaine's paradigm of expectations of safety and protection were nullified. Not only had she learned that someone could hurt her badly, but that no one really cared if this happened: she was vulnerable to harm and her caregivers were not going to protect her.

Moreover, as is so common in cases of abuse within a family or community, Elaine was scolded for "lying" about her brother. She was not only denied recognition of her experience, but was falsely accused of deliberately fabricating a nasty story about her brother. This was further injury to Elaine's capacity to assess reality, as it was being

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twisted by her mother, and Elaine, rather than her brother, was the wrongdoer in her mother's eyes after she disclosed her abuse.

So part of treatment for Elaine lay in the many moments where her therapist described more normalized safety expectations with her, and prompted Elaine to seek out people outside her family who could support her in protecting herself when she was in danger. Elaine frequently used the after-hours crisis line her mental health agency provided to all its clients. This dependable, accessible support comforted Elaine and helped her to check in for information or reassurance about how to keep herself safe if she had thoughts of harming herself late at night or on the weekends when her therapists were unavailable.

Elaine's need for healthy, adequate selfobjects was clear given how disturbed her relationships with her parents and siblings were. Her continued involvement in family events highlights the attachment needs that she naturally continued to seek from her family despite their betrayals. Throughout treatment, her therapist was keen to point out people and situations where she could interact with selfobjects outside her family. Her case manager, prescriber and therapist could be these for her. She also had a few friends, who, although many of these women dealt with the instability of their own mental illnesses, were often warm, validating and adequate selfobjects for Elaine. All of these relationships were supportive of Elaine's de-fragmentation of self and her recovery process.

Being a Selfobject to the Trauma Survivor

A great deal of Kohut's writing addresses issues of transference and the therapist's role as selfobject for clients. It is my contention that one or more of the types

of transference in self psychology will be present in the therapeutic relationship with the trauma survivor. Given the impacts to self that the literature describes, a survivor will likely have injuries to their grandiose self or idealized parent imago as a consequence of traumatic experiences. The therapist's empathic responses build psychic structure, enhancing the ability of the survivor to self-soothe and to process more material that has been secluded from conscious awareness; gradually the survivor can respond to those around her in more attuned ways (Elson, 1986; Kohut, 1971).

Mirroring

In the case of Elaine, one of the steps of stabilization was teaching Elaine ways to check in with herself to determine what emotion she was experiencing. Her feelings were often shifting and nameless, so providing words to describe them created some order and control for Elaine in her affective chaos, while offering her and the therapist information about what was happening for her, both in the present and in the past. The process of naming and exploring emotions is certainly one quality of mirroring as defined by Kohut. Elaine was not learning the meaning of the words "powerless" or "terrified," the way a young child is gradually given language to describe and orient experience. Elaine needed prompting to consider her feelings again, after so much anti-mirroring had made this irrelevant. She also desperately needed mirroring in the form of validation after she named the emotion at hand. The denial for so many years of her pain, injury, shame and anger meant that the repair necessary for her was in giving value back to her emotions. Her therapist was definitely in the role of a mirroring selfobject in this capacity.

Idealization

Elaine certainly showed signs of idealizing her therapist as well; developmentally it is not unusual that she saw the therapist as a capable, strong protector with knowledge or experience she felt she lacked. However, being aware of both the mirroring-idealizing aspects of recovery and the necessity of empowerment allowed the therapist to build on Elaine's growing sense of self-respect and self-awareness, while also being an idealized figure. If we neglect empowerment, we can easily become rescuers for our clients, which may or may not "save" them, but will certainly leave them as dependent as they began. If the goal is recovery with independence, then mirroring and idealization must be balanced with empowerment.

When we encounter rage from a survivor client, we need to understand it and respond with awareness of themes of helplessness and idealization. Recognizing rage and fury from the survivor to the therapist as an attempt to overturn the helplessness from the trauma can support the therapist in this uncomfortable position as well as guiding treatment with sensitivity to idealization dynamics. The trauma survivor

> may develop intensely idealized expectations of the therapist. The idealization protects the patient, in fantasy, against reliving the terror of the trauma….When the therapist fails to live up to these idealized expectations – as she will inevitably fail – the patient is often overcome with fury. Because the patient feels as though her life depends on her rescuer, she cannot afford to be tolerant; there is no room for human error (Herman, 1992, p. 137).

The therapist's acknowledgment of and empathy towards the client's feelings of powerlessness, as well as the desire to avoid traumatic material, can allow the therapist to pace the sessions and working through in such a way that the client feels she has some control over how much she uncovers or processes. The astute therapist can also use the

understanding of idealization and issues of power to encourage stabilizing behaviors, such as deep breathing or the use of imagery in the session to assist the client in tolerating the many difficult affects she is acknowledging with her therapist. This is one example among many of reasons that the therapist to trauma survivors must establish a good support network for himself. Adequate and available supervision, peer support and/or consultation are necessary to inform and encourage the therapist who is working with demanding, draining and sometimes frightening clients (Herman, 1992).

Twinship

Twinship needs for Elaine were very important. Her friendships that were supportive were encouraged to provide her more sense of being known and understood in multiple areas of her life. Her relationship with Paul, her boyfriend, created particular twinship struggles. Elaine loved Paul a great deal, and enjoyed caring for him in ways she could as his girlfriend. She and he shared a good deal in common: they enjoyed spending time together walking, shopping, sharing meals. Paul was a twinship object for Elaine. However, Elaine was definitely unhappy with their sex life, and as treatment progressed, was more and more angry that Paul insisted so often on having anal sex. This was difficult for Elaine for possibly many reasons, but not in the least because of her history of being sodomized by the two teenage boys at the arcade. Sex with Paul was triggering for Elaine. She also felt very betrayed by Paul for his failure to disclose to her in the beginning of their relationship about his potentially contagious sexually transmitted infections. However, even though she spoke of anger at his omission and her fear for her health, given they had had unprotected sex often, these feelings were much less vivid for

her than her anger during and after anal sex. No doubt the sensory and visual stimuli related to her girlhood attack contributed to her anger in sexual activity with Paul.

After much agonizing about her love and displeasure in the relationship, she decided she needed to break up with him. Elaine was able to articulate her needs for mutual recognition or twinship, although she didn't use these words: "We do share a lot in common, and he does do right by me in a lot of ways. But if he can't understand – and he doesn't! – how upsetting anal sex is for me, because of those arcade boys, then all the other good stuff almost doesn't matter. I need someone who can understand and respect my needs completely, 'cause I've been hurt, a lot!"

As could be expected, Elaine's functioning declined after she broke up with him, in spite of the fact that she was no longer having triggering sex. It was difficult for her to part ways because she was losing a selfobject: a twin spirit who affirmed her value as a person and her skills and interests. Elaine needed more intense and active mirroring and idealizability in her therapist after this break up, and she was also encouraged to spend time with other friends who could validate her and provide her with solace.

Conclusions

The impact of trauma on self cohesion and functioning, the presence of selfobjects in the traumatizing experience and the likelihood of mirroring, idealizing or twinship transferences in the treatment of the trauma survivor all indicate the benefits that a framework that combines self psychology and trauma theory can offer to the trauma survivor and the survivor's therapist.

The field of psychodynamic theory and treatment has had an intermittent, ambivalent relationship with the topic of trauma in the lives of the countless patients

treated by psychotherapists. The difficulties of sorting out reality and fantasy, a collective desire to deny or displace the horrors of traumatic events and the genuine challenges of being a therapist to the trauma survivor all contribute to the halting and unvigorous attention trauma has received from psychodynamic clinicians and theorists.

It is my hope in describing the parallels between self psychology and trauma theory that clinicians treating trauma survivors will be supported by the perspective that a self psychology-trauma theory provides. This benefit can then be passed on to the survivor, who will have her self seen, understood and affirmed. She will have at her disposal an ideal selfobject who will encourage her to find twinship, and who will foster self cohesion throughout the recovery process.

Until violence and exploitation are a thing of the past, no longer presenting in our waiting room chairs, I offer this perspective to the brave, dedicated clinicians who support and guide survivors in their journeys of creating or rediscovering self.

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