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Original citation: Challenor, J. (2016). ‘Not dead…abandoned’ - A clinical case study of childhood and combat-related trauma. European Journal of Psychotherapy and Counselling,

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TITLE PAGE

Author: Julianna Challenor
Affiliation: City, University of London
Contact details: julianna.challenor@city.ac.uk
Department of Psychology
City University London
Northampton Square
EC1 0HB
Tel: + 44 (0)207 040 0238

Title:
‘Not dead…abandoned’ - A clinical case study of childhood and combat-related trauma.

Abstract

This clinical case study examines inter-subjective processes with a counselling client who presented with symptoms of complex trauma including severe anxiety, low mood, dissociation and suicidality. Therapy lasted 12 months and the ending was unplanned. Psychoanalytic and phenomenological hermeneutic frameworks are drawn on in theorizing the work. From this perspective, loss associated with trauma is conceptualized as relational, as traumatic states threaten psychological organization and the continuing experience of relational ties that are needed for survival.

Dissociation is understood as a defensive state that changes the way that temporality is experienced. The client's capacity for dissociation appeared to have developed in early childhood in response to physical abuse, predisposing him to further ongoing and severe trauma as an adult soldier. There will be a focus on the way that dissociation and enactment in the therapeutic relationship limited the therapist's capacity to provide the client with inter-subjective regulation of disavowed affect. The client's unconscious experience of unbearable affect led to a breakdown of the therapeutic relationship and the termination of therapy.

Detailed session and supervision notes, and correspondence received from the client were used to evaluate theory and practice links, as well as some methodological aspects of case study research.

Keywords: Trauma; dissociation; enactment; inter-subjective systems theory; relational psychoanalysis.

‘Not dead…abandoned’ - A clinical case study of childhood and combat-related trauma.

Introduction

In this article I present a single clinical case study that aims to explore some key relational processes from an inter-subjective, relational psychoanalytic approach to working with complex and chronic trauma. There will be a particular focus on my understanding of the client’s dissociative experience and the abrupt ending of the therapy as an enactment of this.

Almost one year after beginning work with the client, ‘Peter’ [1], I received the following email:

> *…I feel that our sessions have become more dangerous for me as it is raising my consciousness of suicide. I find myself thinking and obsessing about dying and what it would mean for others (in my more inclusive thoughts). I feel, maybe incorrectly that I do not at the moment have the energy to deal with the pain that comes with looking inward… I would like to stop coming to our sessions and just delve back into numbness and do the best I can with the tools and space you have created for me, with me.*

The abrupt, unplanned ending came as a shock, yet it was not entirely a surprise. There had been many times during the previous 12 months of therapy in which Peter and I had tried to make sense of why the therapy was increasingly being experienced by him as dangerous and persecutory. With hindsight and a close reading of the case, I am going to argue that this is something that I should have foreseen. Whether it could have been prevented, however, I am not certain. My aim in this report is to suggest one possible way of understanding what happened.

An understanding of the complexity of Peter’s presentation begins with his experience of physical abuse and domestic violence from early childhood until his

[1] The client’s identity has been disguised, some details have been changed in order to maintain confidentiality and he has consented to the use of this material.

teens. The violence lead to the dissociative capacity necessary for a highly successful military career in which further multiple traumas were experienced. Cumulatively, this was psychologically devastating, but the trauma did not fully manifest itself in symptoms until some years after the end of his military service, when he was in a civilian job and a stable relationship with a supportive partner.

Methodological validity in case studies

The current case study draws on process notes that were completed immediately after every session, together with ongoing self-reflection and regular supervision with an experienced psychoanalytically trained clinical supervisor. Process notes focused on the main themes of the session, the dominant affect and the transference/countertransference relationship, and were drawn on in clinical supervision. Supervision offered the opportunity to develop the formulation over the course of the therapy, discuss the use of interpretations and as a place for containing countertransferential responses.

The use of the case study as a research method can be argued to possess value through its power to inform theory and practice and '…provide the groundwork for hypotheses that can be tested empirically' (Kudler et al., 2009, p355). The selection can be justified as an example of an extreme case, which reveals information not available in representative cases (Flyvbjerg, 2006). Integrating qualitative research methodology with experiential clinical material, particularly that from a psychoanalytically informed perspective, is inevitably wrought with tensions however and there was an ongoing attempt to minimize these by remaining grounded in qualitative methods. The research questions can be summarized as: What is my (subjective, theoretically informed) understanding of the process of the therapy with this client? How useful and effective is the particular case formulation and to what extent have I been able to implement the formulation in practice?

The method loosely follows the structure of Fishman's (2005) pragmatic case study approach, and uses an analytic strategy that can be described as a deductive, or theoretical, thematic analysis (Braun & Clarke, 2006). A framework consisting of theories of dissociation and enactments (Bromberg, 2011), and temporality and trauma (Stolorow, 2007) has been selected due to the nature of the presenting problems, and coding of the text has been guided by these clinical concepts. The final stage of the analytic process is to shape the interpreted themes into a

meaningful narrative. A particular strength of this research is that it covers 12 months of therapy and is able to take into account contextual factors and a sufficient number of incidents of the phenomenon being examined (McLeod, 2010). It therefore constitutes a phase analysis that makes sense of complex material (Yin, 2009).

An important limitation is that empirical validity is difficult to argue for in clinical case study research when transcripts of sessions are unavailable. There is an inevitable subjectivity at work when the therapist and researcher are same person, with the risk of '…selective remembering and reporting' (McLeod, 2010, p15). In response, I draw on the argument that psychoanalytic epistemology is a depth hermeneutic tool based in self-reflection (Habermas, 1971). Further to this, Stolorow (1997) describes psychoanalysis as a phenomenological, intersubjective inquiry, within which emotional experience is considered to be regulated in relational systems. I argue that the in-depth approach of the research method mirrors the therapeutic process, with the analytic strategy of the current research essentially a continuation of the clinical relational process, in which the subjectivity of the therapist is employed in making meaning of the client's experience.

Interpretation of the subjective experience of the client takes place at two points in time. First in the session itself, and for a second time in the textual analysis of the process notes. Two hermenuetics are at work here, with phenemonological inquiry meeting a psychoanalytic interpretive framework. The application of this method lacks the intersubjective, moment-to-moment responses of the client to the therapist's interpretations however, and is therefore limited and necessarily tentative in its findings. To ensure that I have represented the joint experience of the therapy in as truthful and representative a way as possible, I obtained the client's consent to write this paper, and invited a response to the material at draft stage. Peter chose his own pseudonym and approved the account of his therapy. It remains, however, predominantly a subjective reading of my experience, rather than of Peter's, and in this respect the research findings themselves can be considered to be only partially inter-subjectively produced. This inevitably moves the research away from the relational paradigm on which the clinical process is founded.

Many valuable alternative methods exist for evaluating clinical process. A conversation analytic approach to transcripts of sessions would provide a close reading of micro-processes and say something useful about what is happening inter-subjectively, yet would not provide answers to the research questions outlined

above. An alternative qualitative research approach would be for (a second researcher) to interview the client about his experience of the therapy and for this text to be subjected to a narrative analysis or a hermeneutic method such as Interpretative Phenomenological Analysis (Smith, Flowers & Larkin, 2009). This too would generate useful findings and would represent the lived experience of the client.

Theoretical understanding of the case

Inter-subjectivity systems theory

In this section I draw on the inter-subjectivity theories of Stolorow (2007) and Bromberg (2011), and Schore & Schore's (2008) contemporary extension of attachment theory, to outline a developmental understanding of affective bodily-based processes and regulation. These theories are situated within a psychoanalytic understanding of the unconscious and conscious experience of trauma and of therapeutic change. Affect regulation is considered as a pragmatic framework to understand psychopathology and therapeutic change. The therapeutic aim is to be able to empathically regulate the client's arousal state using the transference-countertransference relationship (Schore & Schore, 2008). These relational psychoanalytic theories provide a framework for understanding the experience of dissociation in both the client and the therapeutic dyad, and any subsequent enactments. They are also able to provide an account of trauma that incorporates both conscious and unconscious experience of a therapeutic relationship.

The effectiveness of psychodynamic psychotherapy as a treatment for PTSD and trauma related to combat, childhood physical abuse and domestic violence is supported in a review by the Task Force of the International Society for Traumatic Stress Studies in the US (Kudler, Krupnick, Blank, Herman & Horowitz, 2009). The PTSD Task Force provides treatment guidelines based on extensive reviews of the clinical and research literature and states that the aim of such an approach is to progressively understand the psychological meaning of traumatic events in the survivor's unique historical context, their individual personality structure and their goals (Kudler et al., 2009). Psychodynamic therapy for trauma aims to address '…wishes, fantasies, fears and defences…' generated in the therapy and the therapeutic relationship should emphasise '…safety and honesty' (Kudler et al. p583).

The theoretical concept of attunement is privileged in relational psychoanalytic accounts of individual development and the therapeutic process. Founded in Kohut's (1971) self psychology, attunement can be defined in the parent-infant relationship as the parent's appropriate reactiveness to the child's experience, such as offering comfort when the child is distressed (Stern, 1995). It consists of a psychobiological regulation of affective states, involving both autonomic and central nervous systems, that has an integrating effect and forms the attachment bond (Schore, 2001). The lack of attunement in childhood, such as in abuse or neglect, leads to the absence of integration of affect, and dissociation or disavowal of affective responses. The child who has developed in this way is unable to feel that their emotions are an integrated part of themselves, and throughout their life will be vulnerable to traumatic states which threaten their psychological organization and the continuing experience of relational ties that are needed for survival.

> *'Lacking a holding context in which painful affect can live and become integrated, the traumatised child…must disassociate painful emotions from his or her ongoing experiencing, often resulting in psychosomatic states or in splits between the subjectively experienced mind and body'* (Stolorow, 2007, p10).

Developmental trauma is thus understood as the experience of unbearable affect (Stolorow, 2007). A child's recurring experience of mal-attunement leads them to become unconsciously convinced that their experience of yearning for their unmet needs, and resultant painful feeling states are due to some inherent inner badness or defect in themselves (Stolorow, 2007). The neurological effect of this mal-attunement is summarized in a strikingly appropriate military metaphor by Cozolino (2014): 'In the face of early interpersonal trauma, all the systems of the social brain become shaped for offensive and defensive purposes…when the brain is shaped in this way, social life is converted from a source of nurturance into a minefield' (p279). Cozolino (2014) describes an experience of 'core shame' that results from childhood abuse or neglect in which the self is felt to be 'fundamentally defective, worthless, and unlovable …' (p282).

When an individual who has developed in this way enters a therapeutic relationship, affect or emotion will need to be defended against and there will be a fear or anticipation of re-traumatization. Stolorow (2007) suggests that the client in this situation will experience their emerging feeling states as intolerable to the therapist

and their incapacity to believe that they can or will ever be understood by another person will make itself felt in the transference. Additionally, when a child has experienced early trauma, the capacity to use affects as 'guiding signals', for understanding subjective experience has not developed. Therapeutic impact will thus be determined by the extent to which the client experiences the therapist as attuned to their subjective affective experience, as well as the transference meaning of the experience. Stolorow (2007) draws on Heidegger's existential notion of 'resoluteness' to conceptualize the possibility for change: '…in resoluteness, one seizes upon or takes hold of possibilities into which one has been thrown, making these possibilities one's *own*' (p43).

Within this relational model of trauma, the ability of the therapist to provide an experience of attunement for the client is mediated by the dyad's capacity for dissociation. Dissociation in trauma is a defensive state and is experienced as a shattering of time and its unifying nature (Stolorow, 2007). Temporality, the experience of a past, present and future at any given moment, is relationally or inter-subjectively derived; our belief that we will continue to exist in a stable, ongoing and predictable way, comes through our shared experience of time in relationships with others (Stolorow, 2007). By taking away the experience of the world as stable and predictable, emotional trauma destroys this structural experience of temporality, altering one's very sense of selfhood as a unitary being, and of being in time (Stolorow, 2007). The world and other people thus lose their significance and ability to anchor the person, leading to an experience of total aloneness, estrangement, and detachment. This creates unendurable anxiety that must be disassociated from in order to survive it.

Multiple self-state, trauma and enactments

Bromberg (2011) explains dissociation by contrasting the notion of a unitary experience of self with that of multiple self-states. The capacity to dissociate is a 'normal hypnoid capacity of the mind' that can become part of the structure of personality (Bromberg, 2011, p178). It is used as a defence against trauma so as to allow the self to bear what is unbearable by disconnecting the mind. 'Hypnoid' in this context refers to the capacity to create an experience of the absence of consciousness. This dissociative structure becomes active to allow incompatible self-states to continue to function without awareness of other self-states. In situations with the potential for dangerous (shame-inducing) intersubjectivity, dissociation is

needed to prevent a potentially traumatizing encounter with the mind of the needed other. Dissociation protects from the storm of emotions but means that in this state, intersubjective regulation of affect such as that intended in the therapeutic relationship, becomes impossible.

When the client experiences unprocessed trauma in the company of the therapist, there is '…almost always…' a '…dissociated here-and-now shame experience', according to Bromberg (2011, p180). In bringing alive the trauma, the client's (developmentally unmet) hunger for relief, comfort and soothing is also brought back to life but cannot be communicated symbolically, leading to the experience of shame and triggering dissociation. As it cannot be symbolized, this experience can only be communicated through enactment. The therapeutic relationship itself becomes dangerous to the traumatized client, arousing affect that cannot be contained as internal conflict within an integrated sense of self or consciousness (Bromberg, 2011). Trauma can neither be held nor processed as a memory, and talking about it brings no relief because the unbearable and shameful affect is relived through talking.

When working with clients who have developed a dissociative structure of mind the role of the therapeutic process is to increase the client's confidence in their ability to withstand their overwhelming affect by providing a transitional space (Bromberg, 2011). The clinician must strive to remain as attuned as possible to the client's experience of being unable to hear or experience the therapist's subjectivity, and be aware of the potential for creating dissociative states in the client.

The case: Assessment and formulation for 'Peter'

When Peter self-referred to me for therapy, he was under the care of his GP and the community mental health team as he was considered to be at risk of suicide. I am a chartered Counselling Psychologist in independent practice. Counselling Psychology training in the UK is theoretically pluralistic, and my practice, ongoing training and clinical supervision since qualification have been informed by psychoanalytic psychotherapeutic approaches. Peter had been prescribed medication for anxiety, which made his experience of symptoms just about tolerable. His suicidality and the severity of his symptoms meant that he was not considered suitable for local primary care counselling, and he refused to consider psychiatric or secondary care. As his military service had not been for UK forces, he did not qualify for psychological

support from the organizations that provide this to British soldiers and veterans.

At assessment, Peter was experiencing flashbacks, periods of dissociation, panic attacks, low mood, and he had clear plans for killing himself if he felt this to be necessary. There was occasional self-harming behaviour by cutting, which had a grounding function himself when he felt himself to be dissociating. He was very afraid that he would become violent and harm someone during a dissociative episode, though this had never happened. He deliberately abstained from alcohol and drugs but craved the relief that they would have given him and had used both in the past for this purpose. Whilst Peter could tolerate the physical symptoms of panic attacks in the knowledge that they would eventually end, he was very afraid that he would permanently 'break down' psychically. He described a recent precipitating incident at work in which he had emailed some incorrect documents to his boss – a man he admired - and had been 'publicly humiliated' for the error. This was experienced as a betrayal of trust with a resulting steep rise in anxiety.

From a very young age, Peter was severely and frequently beaten by his father. He described his mother as detached and also abused by her husband, unable to protect Peter. He had one older brother who was reportedly spared the violence, and to Peter's perception, was favoured. His father's violence ended abruptly when Peter was 14 and for the first time retaliated, not in his own defence, but his mother's. After leaving university before graduating, he became an elite forces soldier for five years. Training lasted 18 months and was characterized by sadistic and brutal methods, particularly torture, in which recruits took turns at being the victim and then perpetrator. Peter described how he was able to submit to episodes of torture without having to be restrained. He was infamous for his extraordinary capacity to withstand physical pain.

On entering therapy, Peter was initially unable to hold in his mind any thoughts or feelings about the emotional and physical pain that he suffered, and struggled to hear my description of his early experience as child abuse. Over a number of weeks he became gradually more able to consider this possibility, but this meant that he had to confront the awareness and subsequent anger at his mother's failure to protect him.

It became evident through his descriptions that he had developed the adaptive capacity to dissociate from painful and frightening experiences as a very young child.

As a solider, this dissociative ability earned him his reputation as fearless and able to withstand extreme physical and mental pain, and led directly to him experiencing countless more traumatic situations.

An important aspect of Peter's sense of himself hinged on never turning away from danger, but always going towards it, as well as undying loyalty to his platoon, and his willingness to put his own life at risk. He described how he felt that he lived in a parallel world to everyone around him. He could see and be seen by other people, but they could not understand what he felt like and he could not feel like them because he was 'different', not 'normal'. I understood this fantasy of his own specialness as a defence against the unconscious belief that he was in fact monstrous, a killer, unable to feel remorse and potentially lethal to others. In his current life, he experienced overwhelming anxiety when placed in interpersonal situations in which he experienced himself being ambushed and shamed. Situations like this occurred at work, when line managers or bosses either disregarded his recommendations or called his competence into question. Anxiety would lead either to panic, or to dissociation.

The course of therapy

In this section I will try to give a sense of what it was like to be with Peter, focusing on our experience of dissociation and subsequent enactments. Peter was terrified of 'breaking down' into what he imagined would be madness, afraid of an impending mental storm. He felt as though he was being pulled inexorably towards disintegration, and outside of the therapy frequently experienced a dislocation in time through dissociation. In sessions, while he was not as starkly dissociative, he would quickly shut off from emerging painful feelings, often through using a kind of gallows humour. Peter was afraid and angry at the possibility of being forgotten and unrecognized, and experienced a profound sense of loneliness in the world. At times it felt to him that he was the last person alive, disconnected entirely from both his own feelings and from others. At work, he struggled to concentrate and was distressed by this, as his exceptional professional capabilities had always been an important element of his self-concept. Peter's conscious experience of anger could be experienced only somatically. He recognized the physical sensations, but was afraid that if he allowed himself to feel anger as an emotion in his mind, he might kill the person he was angry with. This led to him feeling highly anxious around other people and he described how he would become frozen and fearful in everyday

situations. At this time he reported having nightmares that he could not remember on waking.

Peter described coming to therapy as like violating himself. It forced him to re-evaluate his experience entirely, all of the structures that he had created to keep himself psychically safe, everything that he thought he knew about himself and the things that he had done and had done to him were now in doubt. This felt to him overwhelmingly hopeless, and that he was now adrift, unable to see a way back to ever feeling as though he could manage. He described it as a *Catch 22*; he did not want to remember because it felt too awful, but was convinced that unless he remembered there could be no way out of his intolerable pain. I was caught in this double bind with him. His sense of isolation was profound, and critical thoughts about himself – all the criticism he had ever heard - dominated his conscious experience.

Peter was able for short periods to allow me to feel concern for him, yet he found my concern, and that of others anxiety provoking. It had to be closely monitored. He was certain that he did not have feelings like normal people, instead believing that he was not like other people, that he was not really 'human'. At this point in the therapy, he was dissociating less frequently and tentatively seemed to be resolving to live. He began to be able to tolerate for brief periods of time feelings of loss and regret. There seemed to be a glimmer of the possibility of survival, yet this change came hand-in-hand with a growing sense of dread, and a deep grief and mourning for the irretrievable loss of control over feelings.

Around this time, Remembrance Sunday took place, and recognition of war dead and injured evoked an intense envy in Peter. He said that he felt 'lost'. Misrecognition was also experienced at work, where points of difference with colleagues were experienced as intolerably difficult to bear. It made him feel 'hollowed out', unseen. I thought about how physical danger had provided a way for him to feel acutely recognized and I became more aware of the extent to which he felt cut off from other people, isolated and with no hope or possibility of any alternative existence. This was the defining subjective experience of his trauma. Over the course of therapy, Peter's tendency to dissociate rose and fell, to be replaced by constant, debilitating anxiety, making the dissociation seem preferable.

After about six months, the therapy began to be increasingly experienced by Peter as persecutory. He felt more desperate and suicidal. His experience was only just

tolerable and I felt that he was certain that I would not be able to bear it with him. Although I felt helpless and miserable about his experience, I also believed that this capacity to acknowledge my recognition of him would have been impossible at the start of therapy and as such represented change. A tendency to dissociate now returned with force, and Peter described periods of 'absence' in which he felt no sense of time passing. He no longer recognized himself and I experienced a complementary helplessness. He craved a return to an earlier state of not knowing. Comprehension of the harmful effects of his father's violence was felt to be 'dreadful', because once thought, it could not be changed and he felt himself to be without hope. He began to mourn for himself, and experience regret, an experience that felt only just bearable for us both in sessions. He believed that the pain he experienced must mean that he was 'normal' after all. I wondered whether along with the horror, that there may be some relief in this too. The possibility of survival began to tentatively exist, but there was a psychic cost to this change, with the recognition of what was being lost. His previous ability to perform at consistently high levels had been imbricated with his trauma, but now ordinary failures had to be countenanced. Ambivalence was possible, but the fear of 'something worse' in the unreachable parts of his mind lingered, and once the effects of a new medication settled, time and its dislocation began to be felt again. At this point there was a scheduled break for the end of the year.

After the break, Peter's persecutory experience of the therapy intensified. His constant anxiety was only just tolerable and he was exhausted. It seemed as though his pain and anguish continued to build with each session, with no hope of respite. He brought a dream of digging a grave in which he became trapped. Any feelings became dangerous, even happiness, which was too closely linked to sadness, and therefore anger. He punished himself relentlessly by thinking about past mistakes. One morning Peter arrived and told me that he had had a fantasy the day before that I was a spy, and that even while knowing that it was not true, found himself on the brink of panic. I said that he felt that I was dangerous to him. This interpretation had little effect on his anxiety, and he decided that he would take a four-week break from the therapy. I felt that I had no choice but to agree. The therapy itself had become a perversion of care, it seemed that something malignant was being enacted and anything I did would be experienced as persecutory. By leaving, Peter was doing the only thing he could think of to protect the therapy and me.

On return, Peter said that had thought about how he experienced the therapy as good, but that after the sessions he would be compelled to undo all of the goodness with relentless criticism of himself. Anger began to be felt and he continued to be terrified that this meant that he would become dangerous. Interpersonal situations at work were an ongoing source of distress, and everyday conflicts caused him to respond as though he was under serious threat, unable to think. He described a 'chasm' in his mind and how he longed for nothingness, and quiet. At this point there was an unscheduled break because of a work commitment that had been arranged for him without his prior knowledge, and we had only one more session after this. In an email written almost exactly one year after our first meeting, Peter told me that he feared that if the therapy continued, it would lead to him killing himself.

Discussion

Peter's goals at the beginning of therapy were the reduction in his experience of anxiety and suicidality. This was not achieved, yet much that was therapeutic was. At the end of therapy, he remained alive, which was a considerable achievement on his part. He had been able to tolerate a year of therapy, during which it is impossible to underemphasize the profound changes he underwent in his understanding of his experience, in both his present and past. He had been able to make links, extend to himself some compassion and experience grief for what he had suffered, without his mind disintegrating, or 'breaking down', as he had feared he would. He had gained a new understanding of emotions, and what it meant for him and others to have them. There were brief glimpses of the 'resoluteness' described by Stolorow (2007), in which Peter appeared to be experiencing the beginning of a desire to go on living with an acceptance of what had happened to him.

In the end though, the therapy itself had to be destroyed because it represented care, and with limited capacity to care for himself, my attempts were experienced as creating the possibility of something that in phantasy was intolerable. Intersubjective regulation of affect, or attunement, was impossible for Peter to experience at these times, and the therapeutic situation could not be experienced as safe (Bromberg, 2011). Impending and actual breaks seemed to elicit the most disturbing transferential experiences. It was my supervisor who noted the deleterious effect of the unscheduled break two weeks prior to Peter ending the therapy, and that furthermore we had begun to discuss the approaching long summer break. The persecution Peter experienced in nightmares and fantasies always intensified after a

break or a scheduled holiday, no matter how longed for it was.

It is my contention that had we been able to have sessions more frequently than once a week, it may have been possible to contain Peter's unbearable affect more effectively, enabling him to tolerate this experience. I want to suggest that our subsequent joint dissociation from unbearably painful affect can be usefully thought about as enactments in which Peter experienced my subjectivity as shame-inducing, although at the time, I felt unable to interpret this. We both felt helpless. He was in the grip of intolerable shame, and I too was caught in his dilemma. I imagined at the time that if I tried to persuade him too forcefully to remain in therapy, I would be intensifying his experience of being attacked, but by letting him go, I was failing to bear his pain. Stolorow (2007) provides an explanation of this inter-subjective dilemma, suggesting that the developmentally traumatised client unconsciously expects their "…emerging feeling states to be met with disgust, disdain, disinterest, alarm, hostility, withdrawal, exploitation…or that they will damage the analysis and destroy the therapeutic bond" (p4). I have wondered whether the outcome could have been different if I had been able to find a way to interpret this understanding to him in a way that he could have made use of. Instead I settled for a compromise, in which I tried to let him know as gently as possible that I believed in the goodness of the therapy as a joint endeavour, and in our capacity to survive it.

Bromberg (2011) suggests that the therapist has to recognize and be able to work with the client's shame or they will feel worse than they did before, with the part of the self that holds the shame remaining dissociated and unreachable. I believe that this is a useful description of Peter's experience, demonstrated when he spoke of his terror at the possibility of an imminent 'storm' in his mind in which he believed he would disintegrate and 'break down'. Thinking about killing off this experience in suicide was the only possible way to soothe himself. The actual 'safeness' of the therapeutic situation was meaningless to him at this point (Bromberg, 2011). With his very sense of stability of self at risk, it was too dangerous for him to drop his dissociation. It was at these points that I believe I was also pulled into the dissociative process.

Through undertaking a close reading of the case, I now believe that at these times I was unable to remain securely enough anchored in the transference to be able to formulate the joint process of dissociation, and crucially, to be able to represent this understanding of unconscious experience to Peter (Stolorow, 2007). For my own

future practice and for clinicians working with this kind of complex trauma presentation, I suggest the need, based on the theoretical approach outlined above, to be acutely alive to the possibility of enactments in which both members of the therapeutic dyad dissociate to avoid affect. On occasion, I became aware that I was colluding with Peter's avoidance of affect and yet counter-transferentially experienced a reluctance to interpret this to him, believing that the therapeutic alliance would be at risk if I did so. It can be argued that at these times, I was incapable of giving Peter an experience of attunement through letting him know when I recognized the potential for the therapy to become traumatizing for him. Rather than not interpreting at these moments, I now believe that I ought to have made my understanding explicit. In addition to the clinical value this finding has, writing the case study has provided an opportunity to reflect deeply on my own process, acknowledge that the study may represent an attempt to create an ending for work that felt to me to be unfinished, and to work through some of the inevitable questions that remain unanswered. It could be interpreted as an attempt to do what I was unable to do in the sessions.

In June, one month after ended therapy, I received the following email:

> *…I wanted to say that I am not doing well, but that I am coping without hopefully being destructive. The anxiety is high and self harm happens more often now, but somehow I feel more me…You have given me an understanding of myself that I would not have had otherwise. So yes, just saying I am still alive and managing to not slide too far back from where we left it.*

Peter continued to send short emails from time to time, letting me know that he was struggling but alive. I received them gratefully and with a tentative, ongoing sense of hope for him.

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