The Survivor-Analyst as Analysand: An Autobiographical Account of an Analytic Treatment of Complex Trauma

Abstract

An autobiographical account of an analytic treatment of complex trauma is presented. The analyst/patient is conceptualized by this author as living at the interface between treatment and theory, and is seen as especially qualified to assess the value of psychoanalytic treatment. The author describes her traumatic history of early surgeries and chronic parental neglect and the onset of dissociative symptoms which included passive influence/interference experiences. She shares her view that specific aspects of her analyst’s relativistic stance and empathic listening have served to mitigate these symptoms. The author’s process of re-embedding experiences in their appropriate contexts has commenced a process of reintegration of dissociated/disowned parts of herself. Specific foci of treatment are highlighted: specifically, validation of terror, mitigating mistrust, owning victimization, creating a narrative, and sharing survivorhood with one’s analyst. The author explains her view that her analyst’s history of trauma, intersubjective approach, and use of non-interpretative measures facilitated the growth of a relationship that provided a relational home for dissociated feelings related to her trauma.
In recent years, the psychoanalytic literature devoted to trauma and dissociation has grown exponentially.\(^1\) Contributing factors to this proliferation are the challenge to the concept of a unified self posed by theories of dissociated, multiple selves and self states (e.g., Davies, 1996; Bromberg, 1996), and the findings of infant and attachment research and their implications for psychoanalytic theory (e.g., Bowlby, 1969; Ainsworth, Blehar, Waters and Wall, 1978; Fonagy, 1991a; Slade, 1996; Beebe, Lachmann, and Jaffe 1997). I also propose that the events of 9/11/01 brought us together as a community of survivors who were compelled to understand the psychical implications of trauma. As salient as these events were, perhaps the strongest contributor to this efflorescence is the integration of psychoanalytic theory and the neuroscience of trauma (Schore, 2002).\(^2\) Neuroscience has given us a new vision for understanding pathogenesis that serves to highlight the significance of trauma and dispel the remnants of moralisms that have long been attached to various forms of pathology. A possible product of this neutralization is what appears to be a greater freedom and comfort among analysts with the idea of making public such traumatic states (e.g., Davies 1999). However, there is little sharing of the phenomenology of personal trauma from the analyst’s perspective.\(^3\) I have read accounts

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1 A quick search of the Psychoanalytic Electronic Publishing (PEP) database shows that before 1990, the word “trauma” occurred in 5,065 articles, and “dissociation” in 1,264. From 1990 – 2010, “trauma” occurred in 12,486 articles, and “dissociation” in 3,440.

2 For comprehensive reviews, see Van IJzendoorn, Schuengel, Bakersman-Kranenburg et. al. (1999), Schore (2001), Anda, Felitti, Bremner, et.al. (2006), and Van der Kolk, (2008).

3 Analysts seemed more inclined to reveal their emotional struggles and the details of their analyses during the 1950s through the 1970s (see Little, 1981; Jung, 1973; and Guntrip, 1975).
by analysts of profound emotional responses to illness, loss, and struggles with major life
decisions (Schwartz & Silver, 1990; Chasen, 1996; Ragen, 2009), and descriptions of analysts’
enactment of affective difficulty with patients (see examples in Hoffman, 1994; Howell, 2002;
Silverman, 2006). These authors have pioneered the open exchange about how we use ourselves
in our work. However, they do not place their clinical work within the greater context of their
lives or their analyses. Would not the perspective of the analyst as traumatized person also be
useful to our understanding of how analysis heals?

One such depiction of an analyst’s response to trauma is found in Stolorow (2007) where
he describes his trauma surrounding the death of his wife. Eighteen months after her death,
Stolorow sees his latest book on sale at a conference and reflexively turns to share his excitement
with her. His exuberance dissolves into despair as he feels a psychical space grow between him
and his colleagues whom he believes could never understand his experience. From that point on,
they would live in “altogether different worlds” (p. 14). Stolorow struggles to comprehend and
conceptualize his sense of estrangement and isolation. He emphasizes his sense of alienation and
his belief that his need to be deeply understood could only be met by another who personally
experienced trauma.

As analysands and analysts, we stand at the interface between theory and experience.
Presuming that many of us have brought traumatic experiences into our analyses, I believe we
are in a unique position to contribute to the articulation of the nature of trauma and to evaluate
the evolving concepts relevant to its treatment. Consequently, I deeply appreciate the uniqueness
of Stolorow’s contribution. He opens a highly personal discussion of phenomenology that stands
in contrast to the usual attempts to describe our patients’ experiences of trauma second-hand.
This may well be a better way to inform one another about the inner life of the traumatized.
Perhaps we stop short of sharing our personal struggles because we believe that, as analysts, we must present ourselves as masters of our own individual psychologies. I am comforted by the point that Davies (1999) makes about the belief that our training analysis puts us in a position of superior mental health vis-à-vis our patients. She argues that this is a “form of arrogant self-protection and denial” (p.187). The irony of the pretense of “superior mental health” is heightened by the fact that one person’s analyst is often another analyst’s patient. However, it is easy to fall into the trap of presenting our patients’ experience of their own pathology as categorically different from ours. In particular, in discussions of enactments there is frequently a normalization of the analyst’s pathology, although what is being enacted by the analyst often reflects something of a profound nature. In the contexts mentioned above, I came to feel motivated to “come out” as a trauma survivor and to contribute to the discussion of the first-hand experience of trauma and its aftermath. Let me share my history.

My Story

I was the fourth and last child born into my family. Three of us were born with visible birth defects that promised lifetimes of social, psychological, and physical challenges. I shared with my brother the fate of being born with a cleft lip and palate. Myths abounded in the family regarding the reason for these misfortunes, but I now know that the most likely explanation is that my mother drank too much alcohol during her pregnancies.

My physical traumata resulting from early medical interventions were considerable. I believe that my particular journey into the realm of enduring trauma began at two months with
my first neonatal surgery, which was most likely performed without anesthesia. Surely, the assault of surgery on my lip, palate, and nose, with its negative implications for feeding and self-soothing, had considerable detrimental effects.

It is clear that the psychological sequelae of trauma are mediated by the subject’s interpersonal matrices (for example, Cozolino, 2006; Stolorow, 2007). That I was born with a “flaw” is true, but that I came to see myself as inherently flawed—body, mind, and soul—was the product of my early attachments and the traumatic emotional landscape created by them. My sense of being inherently flawed became the wellspring of my most powerful self-condemnation.

I know little about my early days but, not surprisingly, my mother characterizes herself as having been “devastated” after my birth.

**Model Scene 1**

* I am a young adult. It is evening time, after dinner. My parents have been drinking, and I am alone with my mother at our dining room table. She takes a confidential tone and tells me that when she was first married, she imagined having four strapping sons who would go to Ivy League schools. “Now if I had it to do over, I wouldn’t have had kids at all.” she said.

As a mother, I can imagine how traumatic having three of four children with such problems would be. I speculate that physical problems with early feeding were compounded by my mother’s emotional state, and that early mirroring was compromised by the fact that I wore

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4 To protect the child, neonatal surgery is often performed without anesthesia (Anand & Hickey, 1987). The prevailing theory, which is now strongly refuted, has been that the brain of a newborn is not yet wired to sense pain.

5 See Lachmann & Lichtenberg (1992) for explication of the “model scene” concept.
my defect on my face. I experienced my parents viewing my birth defect as their tragedy much more than a tragedy they shared with me.

Model Scene 2

I am in my early teens. It is late evening. My parents have been drinking and my mother has gone to bed. I am alone with my father in our living room. The lights are dim, and the tone of our conversation becomes more intimate as he begins what feels to be not just a monologue, but a soliloquy. His gaze is focused downward. “After you were born, the doctor took me aside and said that there was a colony in Switzerland for children with cleft lip and palate that we could send you to. I remember I went to look at you in the hospital nursery. All of the other babies were crying, but you were lying there so calmly, like you’d been through it all before. I thought to myself ‘that son of a bitch!’”

I had many reactions to this story. I was horrified that parents would simply get rid of their baby because he or she had a cleft lip and palate, and I wondered if my parents seriously considered the doctor’s suggestion. My sense of being critically disfigured was reinforced. I appreciated the fact that my parents did not send me away. But my overriding response, based in my enduring wish that my father might favor me, was to hope that his uncharacteristically intimate sharing with me in that moment–albeit in a grossly misattuned manner–meant that he did see me as special. I could not give voice to any of these thoughts because I was afraid that doing so would disrupt the intimacy I felt, his warmth would turn to contempt, and the moment would be ruined. I suffered in silence. Thus the double bind: To be loved, I had to hide my feelings; but having to hide myself made me feel unloved and isolated. The implicit demand from my parents was that in order to maintain their attachment to me, I had to privilege their misfortune over mine.
Meanwhile, I endured gazes that felt like they were filled with repulsion from other children who would ask “what happened to your lip?” upon meeting me, and constant teasing and physical threats from the meaner kids at school.

**Model Scene 3**

*In grade school, one of the school bad boys sat next to me on the bus one day. I secretly had a crush on him, and when he approached me, I was excited. Then he asked the dreaded question “what happened to your face?” When I followed the advice my mother had given me and replied “I was born that way,” he asked “Did the doctor reach up your mother’s cunt with a knife and do that?” He then got up and walked away. It would be several years before I even knew what that word meant.*

I felt shocked and humiliated. I quickly looked around hoping that no one on the bus had overheard our conversation. I could not tell. I flushed and, as my face grew hotter, I felt mortified for thinking that he might have wanted to sit next to me for the ride home.

My siblings were unreliable allies. There were many moments of closeness, but we were as ruthless in our competition for our parents’ favor as we were drawn together in our own struggles to realize ourselves. My parents aggravated our competition by making comparisons. For example, my parents would compare my marred face with my sister’s perfect one. At the same time, my sister’s perception that my parents favored me incurred her envy of me.

My brother and I never really openly bonded over our physical impairments. He learned to respond to teasing by beating up his persecutors, and he offered to do the same for me. As a solution to my isolation and out of a wish to feel as powerful as he, I developed the fantasy that since we both had cleft lips and palates, we must be twins. When I shared this fantasy with him,
he curtly reminded me that with six years between our ages, we could not be twins. I felt disappointed and abandoned.

My most profound need was to exceed my father’s expectations, and to show him that I could be “normal.” However, becoming normal entailed surgery, which was an awful prospect. I lived in dread of the moment when my parents would sit me down and tell me that surgery was imminent.

Model Scene 4

The day before surgery when I was 11, my father drove me to a hospital in New York City. I was shocked and frightened by the atmosphere of the inner city hospital. The bed I was to occupy still had the soiled sheets from the prior patient, and I had to wait before I could settle in. I had to share the small room with two other girls, one who appeared near death. My father left, and I began to cry. I comforted myself with the knowledge that my mother would be by my side when I awakened after surgery the next morning. But when I awoke, no one was there. A nurse told me that my mother had left to go home to make dinner. She had left me a turkey wishbone as a present. It would be three days before I received my sole visit from my family during my five-day hospitalization. They called once or twice. I dialed their number over and over but could not reach them because I did not know about area codes.

Although there were sources of nurturance outside the family that helped me to develop into a fairly good student and, in general, a “high functioning” person, my secret sense of being flawed and unlovable was a constant in my inner world. I believed that no one could truly understand my experience. The best I could hope for was the kind of pity that someone might show a disabled person. As I grew older, I began to notice that fewer people commented on my
lip; those who did were usually doctors who would invariably inspect the areas of surgery and say, “They did a good job.” I ascribed people’s silence about my appearance to their kindness. I could not accept the idea that they did not see my scar and misshapen upper lip. To this day, my lip remains the the dominant feature in my reflection.

Fall out

A total stranger one black day

knocked living the hell out of me-

who found forgiveness hard because

my(as it happened)self he was

but now that fiend and I are such

immortal friends the other’s each

e.e. cummings (1965)

Trauma breeds paradox. When we are traumatized we seek out what we most fear, we cling to what is most dangerous, hide what we are desperate to share, idealize that which is most horrific, and what is most memorable, is elusive.

In spite of the psychological abuse and neglect that I experienced at the hands of my mother, separating from her induced in me an engulfing sadness. When my mother would leave for work I would desperately cling to her because her presence sustained my very being. She would always push me away, and I would weep inconsolably. As I grew older, my parents’
continuous scorn for my persistent difficulties in separating amplified my self-condemnation for my need for a sustaining attachment. I also knew that the quality of my need for my mother made me different from other children whose lives seemed effortless. My inner turmoil continued to be my secret. I was very proud when I achieved a façade of indifference to her comings and goings, and could hold my tears until I found a private place to cry. When these feelings were still with me as a teenager, I began to fear that they would always be there. Over the years, rage at my parents also brewed within me, and I came to hope that my anger and contempt for them would serve as an antidote for my condemnable dependence on them. An aspiring painter, I soothed myself with fantasies that once in college I would be recognized as a great artist. But this persona of the superior artistic being, which gave me hope for my parents’ admiration, my self restoration, and a normal separation, proved to be but a fragile veneer once my mother drove off after leaving me at my college dorm.

I felt that I had been thrust into a dangerous world with no means of survival, and I reacted with a full mind-body protest. I had a terrifying feeling of being entirely untethered, as if I were doomed to float endlessly in absolute isolation. I was unable to contain my intense fear and pain, and wept uncontrollably. I felt utterly alone, regarding the other students at school as hostile strangers who were contemptuous of my struggle. I was certain that they were incapable of understanding my emotional state; after all, they were “normal.” My pleas to my parents elicited disgust and further rejection. In spite of her clear indications to the contrary, I continued to believe that my mother would rescue me if only I could make her understand that I felt as if my line to vital oxygen had been cut, and that I was certain that I could not breathe on my own.

With enormous effort, I was able to achieve some semblance of normalcy and fulfill my academic obligations. Although this seems miraculous to me, I now understand that I had a
near-conscious agenda: I was determined to prove that I was a person of value in spite of the history of devaluation that I experienced in my relationship with my parents. I struggled to demonstrate that recognized authorities of the art and music world—people of greater acclaim than anyone in my family ever hoped to be—could value me highly. Academic failure meant surrender to my intrinsic flaw and the relinquishment of my potential, and having to succumb to the indignity of being dependent upon my parents. At the same time, my craving to return to the safety of my parents’ home was relentless.

What followed was a gradual wearing away of the remaining adaptations that I had always brought to bear to sustain my fragile sense of cohesion. This process was hastened by my failure to compete as an art major, and the disorientation I felt as I simply dropped my profound commitment to my identity as an artist. I moved on to music, and my fantasies of celebrity were revived. Ultimately, this plan would also fail, but for the short term, I felt that I had found a solution to my emotional difficulties.

In retrospect, I understand that I entered a hypomanic state that culminated in what would be a defining moment of my life. While attending a concert, my mind wandered to the fact that it was the birthday of Ginny, a friend whom had recently committed suicide. I noticed a woman across the concert hall who resembled Ginny, and she seemed to be looking back at me. I convinced myself that it was Ginny’s ghost, and became terrified. My panic surged out of control when I realized that if I actually were seeing a ghost, there was no one to tell and that no one would believe me. I had the horrifying sensation of my will being taken over, or hijacked, by another mind that urged me to scream, or jump off the balcony. I fled the hall, and thus began a decades-long struggle with what I have learned are called “passive influence/interference experiences” (Kluft, 1987; Putnam, 1997), now considered to be a variety of dissociative
phenomena. Similar to thought insertion, these dissociative states entail strong impulses that feel as if they come from an external agency.

I have come to know that I dissociated my rage in response to what felt like my parents’ final act of abandonment and betrayal: their refusal to rescue me from my terror and to let me come home. No longer living with my parents, I had no way to sustain the fantasy of their involvement with me. My recourse was to express my distress by using myself as a weapon against them. My “other mind” seemed to goad me towards self-destruction, generally by means that were violent or humiliating. When triggered, I scanned the environment for the information I needed to generate a “worst case scenario,” which then would compel me to enact. The list of ideas that would come to me was very long, including screaming obscenities, jumping out of windows or in front of subways, and various forms of self-mutilation and self-humiliation. Once the “other mind” had an idea, my attention was relentlessly drawn to visualizations of enacting it and the horrific consequences that would follow. Sometimes the other mind would intensify its intimidations, telling me “it must be done” and sometimes trying to convince me that I had already done its bidding. Each time the “other mind” was triggered, it was as if it were the first time, fresh in its horror, and I would feel helpless against its power. There were points when I was so tired of struggling against this “other mind” that I thought I would just get it over with and succumb. But I never did. I continued to pursue my subversive agenda: I was miserable, but damn it, I was going to show them all that I would function according to my own high expectations. So I gave recitals, won academic awards, held several jobs simultaneously, while secretly I engaged in what felt like mortal combat with myself. Eventually, I withdrew from numerous activities that would trigger the “other mind.”

My Analysis
I believe with utmost certainty that my analysis has been mutative and that my analyst’s intersubjective orientation facilitated my transformation. I am a work in progress, but the results of my treatment are palpable. My understanding of myself now usually overrides my image of myself as a crazy person, and I know what I need and how to reach for it. I have a solid understanding of how I came to be the person I am, with the courage to meet new challenges. I have found my voice as a writer, an analyst, and a person in a general sense. I am now only rarely afflicted by passive influence/interference experiences and I am increasingly aware of what triggers my dissociative moments.

Cases of complex trauma may have much in common, but in most ways are actually incomparable. There is still much to learn from a discussion of my lengthy analysis which constituted four meetings a week, to ask the questions: “What is it like to be on the patient’s side of an intersubjective analysis of complex trauma?” and “How has the treatment worked?” I have chosen to use Stolorow’s (2004) concept of the “relational home” as a means of organizing my discussion of my treatment.

The critical need for a relational home as a vehicle for healing trauma is based in the fact that trauma elicits unbearable feelings that one cannot shoulder alone. When the load is too great, a general shut-down occurs leaving the survivor feeling like her very life has been drained from her. Her cognitive and perceptual capacities are similarly enervated. Reanimation occurs when she feels that she is deeply understood and accepted, allowing her unique affectivity to be reintegrated into her sense of existence. It is critical to understand that one’s solitary experience of the full affective burden of trauma is at once isolated and isolating. We are as alone in the

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6 I recall as a young child noticing that colors seemed suddenly muted to me. I commented to my mother “Red doesn’t look red anymore.”
trauma as we imagine we will be in death and, further, do not believe that we can be joined in the horror that dominates our affectivity. Our belief that we are condemned to this isolation is maintained by organizing principles born out of early attachments, crystallizing the conviction that others regard our terror and pain as self-indulgent, infantile, and generally offensive. In fact, these feelings were probably threatening to my parents. If such a person finds an accepting other who will listen, take us seriously, and attempt to understand, we may begin to feel that we are present in that other person, that an aspect of our relationship with her has taken up residence within her. That is to say, in my analyst’s presence, I am able to “experience her experiencing me” (Slade, personal communication, June 10, 2007), and I am reassured of my existence as coherent, continuous, valuable, and vital. I feel accompanied through life and develop a sense of belonging, safety and calm. As one can imagine, finding this home is a difficult task for anyone whose attachments have been traumatogenic.

When I entered treatment, I wanted to have my passive interference/intrusion symptoms excised. I thought that perhaps some early experience might have to be unearthed through analysis of the dictates of “the other mind” and that through catharsis I would be healed. I now know that the analysis of the function of and context for my dissociative experiences has been most important, and that dissociative experiences arise from a complex set of affect states that relate to my deep desire for sustaining attachments and my rage at having been denied them. Finding a relational home, through illuminating and transforming the unconscious principles that organized my inner life, has met these yearnings and indeed has been the goal of my analysis to this point. What follows is an attempt to chart my path and to identify what has impeded and what has facilitated our work as we have travelled along this road.

My Analyst’s Stance: The path to the relational home
Upon meeting my analyst I was relieved when I sensed that she was different from any therapist I had known before. I perceived that what I revealed to her of my inner life neither frightened her nor made her distance herself from me. I now know this impression reflected her knowledge of such matters and her specific orientation toward the human condition which evolved from a comfort with a relativistic stance. This orientation, coupled with an empathic listening stance (Kohut, 1959; Schwaber, 1981; Stolorow, Brandchaft and Atwood, 1987) within a self-psychological, and later, an intersubjective systems theory framework, created an interpersonal ambience that came to be safe enough.

My analyst’s devotion to deeply understanding my subjectivity has allowed her to accompany me through exploration of the dark, frightening, and secret parts of my self. As she feels her way into my world by reviving her comparable inner experiences, I feel a safe intimacy with her, and my belief that she is truly dedicated to me and to my analysis is strengthened. Her attunement allows for her verbal and implicit communication of a deep understanding of me. Her approach has been in stark contrast to other therapists whose theoretical postures resulted in interventions that attempted, early in treatment, to challenge my ‘illogical’ and contradictory, trauma-generated perspectives, and forced me to embrace the ‘truth’ embedded in their alleged objective reality. For example, regarding my perception that the scar from my cleft lip is my primary facial feature, therapists have said something like: “I never would have guessed that you had a cleft lip. I don’t see anything.” This kind of intervention left me feeling humiliated, misunderstood, and abandoned. Significantly, my analyst’s responses to me indicated that she knew how desperately I needed to have my suffering taken seriously.

Because of the persistent misunderstanding in the literature of the empathic stance as “too nice,” I am moved to state that being on the other end of this kind of close investigation is neither
easy nor always soothing. Such exploration has frequently led to our confrontation with painful aspects of my internal world, and at times I have been inconsolable. Mostly such encounters are with my suppressed experiences of victimization or an acknowledgment of my limitations, but often enough they involve my confronting my real or imagined guilt in some wrongdoing: in effect, my self-condemnation. At these times, my analyst helps me to understand myself by contextualizing my experiences and feelings, and we work together to quell my fear that my “badness” has ruined our attachment.

**Validation of Terror**

The most valuable and hard-won personal truth that has come forth in my analysis is that my life is organized around the pursuit of safety and the warding off of terror. I was introduced to this idea by my analyst’s saying “You are not a bad person, you are a frightened person” when I was in a severely self-condemning state. My acceptance of this revelation has come after years of grappling with organizing convictions about my basic nature. My entrenched belief in my innate flaw and my profound shame for being “too needy” acted as barriers to my understanding of this self-organization. My own education about trauma has supplemented my analysis and enabled me to become more comfortable regarding myself as a survivor. I can now say with clarity and understanding, if not without some shame, that terror often rules my life and I constantly struggle to mitigate its force.

For me, terror is equated with abandonment in the form of physical or emotional absence by needed others for any amount of time. These abandonments are terrifying because they invoke fears of falling apart: when I am alone I fear that I might fall prey to overwhelming internal states that are sustained by profound self condemnation. Over time, the nature of my
attachment to my analyst made moments of abandonment in relation to her inevitable. For example, in a session close to a long summer separation, she and I had this exchange:

A: “You’re making a very bold connection between all the transformations you’ve gone through and the connection with me, as if I’m the sole cause of those transformations, which is not true at all. This was something that we participated in together. So I’m not really the locus of your change.”

J: [This is a terrifying idea. I suddenly have a feeling of floating, untethered, in space.]

“That’s frightening to hear.”

A: “Because?”

J: “I’m not really sure.” (long pause)

A: “What are you thinking of right now?”

J: (long pause) “I guess it’s frightening because it feels… I guess I still believe that there’s… that you have the magic, and I don’t know why I need to believe that.”

A: “Because it’s better than being alone.”

In this exchange, my analyst’s suggestion that we co-constructed my transformation led me to believe that she did not grasp the desperate nature of my tie to her. In her statement “I am not really the locus of your change,” I heard “you don’t need me as much as you think you do.” My perpetual fear that she did not understand me or my tie to her triggered a state of profound isolation and feeling “untethered,” and after her comment “Because it’s better than being alone,” I felt even more certain that she did not understand my need for her. I asked her why I might need to see her as the locus of my change, and she interpreted that this belief was based in a need for caretaking that was injured by my parents’ haphazard approach to meeting my needs. Later,
we came to the conclusion that I defended my wish that my parents were better caretakers by blaming myself for being too needy. We continued:

A: “So you can just imagine what the history of that wish was, if you had already concluded that needing was bad. That wish had really been to war.”

At this point, I was reassured that she did know how much I needed her. However, it was not the interpretation that convinced me. It was her choice of the words “to war” that signaled that she knew me. Often, it has been the passion in her affect or choice of words that has been most effective in communicating her knowledge of me and her reliable involvement. These interventions serve as moments of mirroring, and are a balm for the ruptures in my sense of being known. Once I am thus reassured, I may then think about the interpretations she has offered.

**Mitigating Mistrust**

Another basic truth that has emerged from my analysis is that I am desperate to find sustaining attachments but I am deterred by mistrust. I would cling to those who would be close, but find myself scrutinizing their words and actions, undermining any budding trust with my suspicions. My desperate need to connect to other people drives me towards them, and my fear that I will be retraumatized drives me away. Ties are easily severed and objects lost. This dynamic is described in the literature concerning trauma’s effects on attachment, where the relationship between childhood abuse and the child’s inability to hold onto connections with needed others has been cited (Herman, 1997; Van der Kolk, 2008). This inability is variously referred to as “failure to attain object constancy” (Gunderson, 1984, p.60), the “anchoring” function,7 difficulty “holding” in mind (Rachman, Yard, and Kennedy, 2009), and

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7 Rachman et al. (2009) attributes the concept of the “anchoring” function to Winnicott (1965).
“mentalization” (Fonagy, 1991b). While these concepts emphasize the absence of these functions in the child, I now know that this condition arises initially due to the presence of an impaired function in the caregiver: that is, the parent’s inability to be attuned to the child’s needs and affects. Indeed, a salient feature of my disrupted attachment has been my inability to know that I exist in the minds of others when I am not in their presence, let alone that they grasp my experience. I have come to realize that my reaction to being alone is based in past experiences of being away from my mother and believing that she did not hold me in mind. The only way I could ensure that I existed—for her and for myself—was to be in her physical presence so that I could watch her every response to see if it were true.

As Batchelder (2010) reminds us, traditional psychoanalytic theorists (e.g. Freud, 1913, 1919; Greenson, 1965) regarded a capacity for trust, which evolves from consistent and reliable care giving in early years, as a prerequisite for analysis. More recent self-psychological theorists (Brothers, 1995; Kohut, 1977; Tolpin, 1980) have posited that a sense of trust is innate in the infant, but that it can be damaged by early traumatic experiences. Drawing on the concepts of organizing principles (Stolorow et al., 1987) and Orange’s (1995) idea of emotional convictions, and Slade’s study of the relationship between beliefs, assumptions, and convictions(1992), Batchelder posits a trust/mistrust system that is “[the] configuration of beliefs, expectations, and assumptions about the consequences of trusting and mistrusting” (p. 4). The trust/mistrust system is fashioned by early relational experience, and nonconsciously determines what we expect will happen in relationships. Batchelder suggests that what happens in successful psychoanalytic treatment is not so much the gaining of the patient’s trust, but the erosion of her mistrust.
I have experienced my analyst’s consistent interest and caring in her attuned responses and her rigorous empathic inquiry, but I do not think that these experiences, which are mostly verbally mediated and generally contained within the consulting room, would have been enough. I have identified some other factors that have helped to cement my faith in her good intentions.

*Concrete acknowledgment of need*

Similar to what Rachman et al. (2009) have called “non-interpretative measures,”8 aspects of my treatment have arisen from thinking beyond the constraints of traditional analytic technique. When I have been terrified to be alone, and convinced that nothing but my analyst’s continuous presence would make me feel safe, her use of concrete modes of communicating concern, such as Davies (1999) did by providing a blanket for her patient Dan, were enormously helpful. For example, early in treatment when I was terrified to leave her, my analyst gave me small knickknacks that she happened to have in her office. There was also a period of time when she would write down something from the session on a piece of paper, which I would keep in my wallet. Having these things temporarily softened the blow of having to leave. They lost their magic over time, but they definitely lengthened the life of the experience of attachment from minutes to hours or even days, and reminded me that she understood that I could not hold on.

The function of these objects is reminiscent of Winnicott’s transitional object (1975), but different in one significant way. He wrote that “[the object] comes from without from our point

8 Noninterpretative measures are “[those] that allow the analysts to create a variety of clinical interactions other than the tradition of interpretation, such as active roles for the analyst and the analysand; cocreated clinical interventions…analyst self-disclosure…[including] elasticizing the boundaries of analytic work to reexperience and work through childhood traumas unreachable by conventional verbal interaction and interpretation” (pp. 260-261).
of view, but not so from the point of view of the baby. Neither does it come from within…” (p.233). In contrast, these objects belonged to my analyst, and she gave them to me. Their power came from my sense that they were tangible evidence of her connection to me.

*Availability outside treatment hours*

Those who treat trauma survivors are usually enjoined to maintain firm boundaries with their patients⁹. Holding the analytic “frame” is emphasized especially regarding disallowing extra-session contact lest the patient overwhelm the analyst with demands, or draw the therapist into an enactment. The justification continues: Patients learn to trust through the analyst’s observance of strict boundaries that she is trustworthy, and unlike the abuser, will not blur the lines between what is relationally appropriate and inappropriate. However, not all trauma survivors are oblivious to the constraints of the professional relationship.¹⁰ Furthermore, some may actually need to know that the analyst is willing to be contacted outside of session times in order to sustain their connection. I am such a patient. In fact, my analyst was determined to violate my expectations, and to reach out to me when I needed her. This required her being aware of my affective states, and that my need for her would not be overwhelming to her. In my experience, my analyst has co-constructed with me firm reassuring internal processes, which, like the treatment, are unique to our work. They are guiding rules for our mode of communication, that is, for how open and honest we can be with each other.

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⁹ This technical advice is prescribed especially when the diagnosis of borderline personality has been assigned to the patient (Kernberg, 1975). As Herman & Van der Kolk (1987) have determined, a large majority of people with this diagnosis are survivors of childhood trauma.

¹⁰ Davies & Frawley (1994) observe that “[the trauma survivor’s] boundaries are either nonexistent or rigidly maintained” (pp. 49-50).
My analyst’s willingness to be present physically for major life events has also played a key role in my building a reliable attachment to her. By far, the most significant example in this regard was her presence after my child was born. What made this particularly meaningful was its lack of planning. There were no prior discussions and no question that she would be there. At the time, I was not sure that I appreciated her presence as fully as I do in retrospect. Indeed, her reliable presence in my life in this way has had great retrospective value; its memory has helped me to reconstitute my connection to her when, in my perception, disjunctures have threatened our tie.

**Understanding brain function**

Referring to the trend toward integrating neuroscience and psychoanalysis, Orange (2011) cautions analysts to be wary of the “sirens of reductionism” (p. 9) that lure us away from a holistic stance. However, speaking from the perspective of the patient, I find that understanding the physical mechanisms of my self states is profoundly validating and affirming of my life-long experience of feeling different. Although brain function is imperceptible, it is rather uncanny that the description of what happens to a brain during dissociation resonates with my own experience of how my mind feels during a dissociative event. Surely as analysts we need to embrace complexity, but for patients dealing with dissociation, understanding how the brain contributes to the underpinnings of their dissociative states can make a bizarre experience more understandable, and consequently, less frightening.

**Owning victimization**

In the post-traumatic scramble to right ourselves, our minds often recast the experience of victimization and disempowerment to support a grandiose defense. In my case, I believe that my capacity to endure suffering made me stronger and wiser than the other girls. While they were
busy worrying about hair and makeup, I pondered the meaning of life, art, and music. This attempt to self-right is closely related to the adaptive strategy that has been labeled “identification with the aggressor/abuser” and is thought to preserve a positive valence in a connection with a needed but abusive caregiver (Davies & Frawley, 1994). Indeed, I felt a primordial tie to my parents through this vision of myself as a noble sufferer. My grandiose denial of the actual impact of their victimization allowed me to glorify my struggle, a struggle that I believed I could weather only because I shared their tough genetic stock. This adaptation provided a refuge from the pain of my actual experience. However, until I could tolerate the knowledge of my victimization, I would remain disempowered (Slade, personal communication, February 12, 2009). I would continue to deprive myself of true connection with others and remain in isolation, living out the limited view of myself that evolved from my early attachments.

As my analyst and I continued to unearth the principles that organize my experience, I began to feel that I might finally be heard, and that my rage and contempt would be mollified. I entrusted my analyst with containing my extreme emotional states; I allowed her to soothe me. In my inner world, she became the force that would stop me from enacting the terrifying ideas of the “other mind.” At the same time, as if I were my own double agent, I maintained an alliance with my parents and my loyalty vacillated between my parents and my analyst. One summer, several weeks before my analyst’s annual vacation, I experienced an increase in the intensity of my dissociative experiences. I had called her when I felt especially plagued by seemingly irresistible thoughts of hurting myself. However, as immersed as I still was in my parents’ historic disregard of my suffering, part of me thought of my ailment as merely an inconvenience, and it did not occur to me that my analyst might be alarmed. She urged me to have a
consultation with a psychopharmacologist who could serve as a cover clinician while she was away, and to go to a hospital if I came to feel truly unsafe.

This suggestion, which seems entirely reasonable to me now that I frequent the therapist’s chair, hit me like a ton of bricks. Although I could not articulate these thoughts at the time, I read between the lines of her proposing medication that I was truly insane, and that I had good reason to think that I might act on my crazy thoughts. Further, my analyst was not only planning to desert me, she had relegated me to the “other world.” My dissociative experiences took on an even more frightening character as, for the first time, I truly grappled with the idea that something profoundly destructive had happened to me as a child. When we resumed sessions after a grueling summer, one of the first things I said to my analyst was “I surrender.”

What I meant by surrender is that somewhere deep inside of me I accepted the fact that I needed help. I was asking for my analyst’s partnership in the project of truly learning about what had happened in my life to bring me to this point. The fact that I was extremely mistrustful made my surrendering a huge leap of faith. A few years later, Emmanuel Ghent wrote his great paper on the subject of masochism, submission, and surrender in the analytic setting (1990). When I read the paper approximately 15 years later, I found that his definition of surrender and the contrasting idea of submission articulated what had transpired between my analyst and me. To paraphrase, I handed over my self to my analyst in order to facilitate my rebirth, with the intention to discover my sense of my self, my wholeness and my sense of unity with other living beings. This surrendering would be the first of many, but marked the beginning of the co-construction of a narrative and a further understanding of the nature of my victimization.

Creation of a narrative
During the early years of my analysis, my words often felt hollow and inaccurate, and I thought I might be lying. My history of being told that I was too sensitive made me think that I was being overly melodramatic. I know now that the way in which I was forced to place my perceptions of my parents’ experience before mine made it impossible for me to validate my own reality, and rendered me unable to create a story about myself that felt wholly truthful.

However, narratives are not wholly linguistic and they are not linear, but multidimensional constructions that are amplifications of interpersonal events. One of the most important aspects of developing a narrative is that it allows the individual to re-embed experiences in their appropriate contexts. When I take experience out of context, I cannot maintain my subjective truth. An instance of the subtle re-embedding of experience into context occurred in a session when I felt ashamed, and I expressed feeling that I was a bad person. When my analyst responded “You are not a bad person, you are a frightened person,” she introduced the idea that the action that I saw as “bad” might have been self protective: that is, I was responding to something that felt dangerous to me. When we articulated that moment within the analytic context, I gained a perspective on myself that was never able to develop because of my destructive tie to my parents.

Placing my experience within context has been critical to my understanding of what evokes my fear responses. When I first came to analytic treatment, I was well aware, in a general sense, of what kinds of situations would trigger my panic and dissociative symptoms. However, I could not understand what was so terrifying about these situations. Without the context, I could only see myself as an irrational, isolated actor whose responses were enigmatic.

Sharing survivorhood with my analyst
My analyst has reminded me that during our first session she told me that she had a severe chronic illness. I believe she also told me she was a psychoanalyst. Neither of these things seemed important to me, but they would have major implications as we traveled on our long journey together. Meeting multiple times during the week was a financial and logistical challenge for me but I know now that I needed frequent contact in order to form the kind of attachment and trust that were critical to my treatment. As for her illness, it has drawn us closer together than I might ever have imagined. Her openness about her suffering has allowed us to bond on a deep level as trauma survivors.

Stolorow (2007) makes the controversial statement: “When I have been traumatized, my only hope for being deeply understood is to form a connection with a brother or a sister who knows the same darkness” (p.49). While Stolorow’s position would be difficult to test, I believe that he is absolutely right. It is not, however, by dint of being traumatized that an analyst can understand: This understanding can only come from the analyst’s analysis of his or her traumatic past.

It is important to note that my initial encounters with people who have had cleft lip and palate surgery are far from comforting. I feel intensely exposed and ashamed when I realize that I resemble the person I am seeing, and when I imagine that he or she sees my scars. I think in those moments my sense of safety and balance are pierced, and I am thrown into a panic. My reaction points to the fact that for me, finding a relational home in a fellow traveler differs from what Stolorow describes. It seems that his relational home had to be found in one whom he believed had similarly suffered a “devastating loss” (p.14).
Even though it is rare that an analyst admits to having a traumatic past to his or her patients, there are some exceptions. Davies (1999) describes a dissociative moment in which she implicitly communicates her survivorhood to her patient, Daniel. She finds herself:

“…standing next to Daniel’s chair wrapping a blanket around his shoulders, not quite sure how I had ended up there. I did remember reaching with a disembodied arm into the cabinet where I kept the blanket for my own occasional use and then getting up out of my chair, but these were not considered actions…the lack of just this kind of thoughtful consideration, the lack of conscious awareness that several alternatives might be open to me…seemed remarkably inconsistent with the way my work usually goes. This was clearly an action that had proceeded from one naked, exposed, and humiliated child to another.

…But Daniel was no slouch. As he left the session he stared at me intensely.

‘You know this place,’ he said. I nodded. ‘It explains a lot about the way we can talk to each other,’ he continued. ‘Yeah, I think it does,’ I responded.” (p. 193–194).

It is clear that Davies regarded this interaction as a strikingly important one. Davies’s description of her dissociated state during this encounter and her portrayal of herself as a “naked, exposed, and humiliated child” certainly pricked my longing to hear more about her experience. Her words are like a furtive wink or a secret handshake; they hint at a special understanding, a common suffering. However, I have learned that my yearning to find fellow travelers colors my perception of others’ meanings. Had I been in Daniel’s place, I would need more concrete evidence of her understanding to banish my mistrust: I would need to know that my analyst would let me take her blanket home.
Several years into my treatment, my analyst’s illness came out of remission and she was unable to work for six months. The initial phase of her illness occurred during her long summer vacation, but I became aware of the recurrence of her disease through a fellow patient who had been in touch with her. I recall entering a state of brittle optimism regarding her timely return to work. Eventually I moved into a condition that I call “survival mode,” in which I feel that I am simply “going through the motions” in a world that feels colorless and devoid of understanding. Although I did not allow myself to dwell on the idea that my analyst might not return, I nevertheless felt as if I had lost my only ally. I soldiered on because there was no other choice. I continued to attend a therapy group that my analyst had co-led which gave me a small measure of relief from my isolation. However, attending the group meant visiting my analyst’s office suite, where the door to her dark office remained open. This sight made me feel the full brunt of the reality of her absence. The group meetings were only somewhat useful to me without my analyst at the helm. In my beleaguered state, I had the paranoid fantasy that other members of the group had access to my analyst, but that I was being kept away from her because my presence would be too burdensome for her in her compromised state. My once-weekly private meetings with the group’s co-therapist were somewhat helpful, but in the moments that I saw that she did not understand me as well as my analyst, I felt great despair and loss.

When my analyst finally returned to work, she was thin and pale and her voice was hoarse and weak. After my initial jubilation at her return had faded, we set to the work of re-discovering the tendrils of attachment that I had begun to form prior to this episode. The trauma of almost having lost her made me fearful about investing in a connection, but at the same time I wanted to become closer. This was another level of surrender that allowed us to be more honest with one another. I told her that I felt that her suffering was so great that I had no right to
complain about my own. She reassured me that she did not quantify or compare our suffering, and that my experience was as important to her as it had been before she had fallen ill. This communication struck at the heart of the conviction that I had held for a lifetime—that my subjectivity was of no interest to anyone—and introduced a greater sense of mutuality in our relationship. Through this ongoing dialogue, which has become increasingly intimate and revealing, my initial sense of her has been affirmed: she was one who could understand, and who wanted to help me face my demons because they were her demons, too.

**Conclusion**

In summary, I wish to underscore that although no two cases of complex trauma are the same, we do know that the neurological sequelae of trauma are mediated by the individual’s interpersonal matrices. I believe that an analytic relationship within an intersubjective field may provide the optimal medium for co-creation of a relational home for unbearable terror, pain, and the complex of paradoxical trauma-generated experiences. Within this dyad, a sense of safety may develop that allows for the articulation of these experiences and their accompanying feelings, and the true nature of the individual’s victimization. Slowly, through re-embedding experiences into contexts, a narrative can be composed that feels wholly truthful and self-sustaining. Finally, I wish to re-emphasize my belief that survivor analysts are in a unique position to contribute to the articulation of traumatic experience, and to appraise the theoretical and clinical contributions that have been made to the ongoing development of the analytic treatment of trauma.
References


