Memories Lost and Found: Developing a Connection with a Traumatized, Suicidal Patient

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Abstract This paper uses a detailed case description to illustrate how a connection was developed with a severely traumatized, suicidal woman and contributed to her regaining dissociated memories and affects. This enabled her to develop a coherent narrative of her life and a sense of self and personal meaning. The aim is to describe treatment as an emergent and co-constructed, dynamic, intersubjective process of dialogue and interaction of differently organized subjective worlds.

Keywords Trauma • Suicidality • Intersubjectivity • Connection • Memory

Introduction

Recently my patient Catherine told me of several ideas she has for the title of the book she is writing. “The one I like best is Thawed Out Embryo,” she announced. She held her hand in a fist and said that, before analysis, she was like that: frozen and wanting to die. She had no freedom of movement and felt hopeless. Then she somehow began to thaw and develop a sense of self, feeling that maybe she could live. This included gaining a more coherent narrative of her life by piecing together lost memories and dissociated affect in an emergent intersubjective process.

I began to think about what had led to that thawing in the context of our psychoanalytic relationship. I wondered what had facilitated Catherine’s self-discovery and budding sense of hope. I realize I had been trying to find a way to enter the world of a traumatized, suicidal woman whose main defense against retraumatization had been to cut herself off from intimate human contact. My willingness to meet her in ways that were important to her was significant. She had given up any hope of feeling acknowledged by others and attempted to wall off the desperate longing for emotional understanding through social isolation, alcohol, and finally a failed suicide attempt. It was important to realize that her fears of retraumatization were based on actual lived relational experience, rather than viewing them as the resistance of an isolated mind. Showing interest in her ideas and the things that were meaningful to her provided a scaffold for her to begin to believe that a relationship need not be annihilating and could allow room for her subjectivity.

This paper will illustrate how the analyst’s continuous quest to understand the patient’s subjective world, while keeping an awareness of her own emotional responses and their basis in her lived emotional experience, can help develop a connection with a patient that leads to emotional growth and development. With our most traumatized patients it is especially important to meet them in their own experiential world. We frequently hear “I don’t belong in this world;” “I feel like an alien;” or “I always wondered if I somehow ended up in the wrong family.” These statements reflect deep feelings of alienation, the result of having been met with chronically misattuned responses early in life. Some of these patients, like Catherine, may subsequently defensively hide from others to protect themselves from further traumatization.

I believe that a thorough grounding in self psychology and intersubjective systems theory helps to keep the therapist from traumatizing the patient further. What patients have missed most is the experience of feeling deeply accepted and understood. Validation of the patient’s emotional reality is a new experience that provides a
perturbation (Thelen and Smith 1994) of their organizing principles (Stolorow and Atwood 1992). Organizing principles are the meaning structures of experience; the cognitive-emotional schema of how we make meaning. Understanding this helps us to view our patients, not in terms of deficits or defects in their “selves,” but as being in the grips of these organizing principles that are crushing and constricting. This is very different from the classical view where we presume that the patient is distorting reality and that we, as analysts, somehow have an objective view of what reality is and how the patient should adjust to it. Because Catherine’s mother always had to be right, I needed to maintain my attitude of open inquiry, holding my preconceptions lightly. This had profound transference meaning to Catherine, and certainly helped to develop our connection.

I also believe that healing occurs through shared affective experience, through which the patient feels understood and loved, thus having the experience of seeing and being seen through another’s compassionate eyes. Emotional understanding (Orange 1995) and resonance experiences (Coburn 2001) are needed to sustain the analysis by contributing to an ongoing sense of connection. This entails sustained empathic inquiry and accepting the patient who is with you, not the idea or fantasy of who or what the patient should be or where she should end up. In contrast to Benjamin’s concept of intersubjectivity, which presumes the need for mutual recognition (Benjamin 1988), the intersubjectivity of which I speak does not require the patient to recognize the therapist. For many of our patients, and this was true of Catherine, we need to allow them the space and time to find themselves through our interest in and ongoing attempts to understand them in their emotional worlds. As the therapist works to understand through inquiry and reflection, the patient begins to have curiosity about and reflect on her life experience.

Key to maintaining the connection is the analyst’s attunement to the transference, which includes awareness of what dimension of the transference is in the foreground. These dimensions can be broadly defined in terms of the developmental and repetitive (Stolorow et al. 1987), and fluctuate and alternate between background and foreground. The developmental dimension contains the patient’s hopes for expanded potentialities, whereas the repetitive dimension carries the fears of retraumatization. It is important to remember that these dimensions can overlap and interact in multiple ways. For instance, the hope for a more expansive, personally meaningful life can be fraught with fears of being shamed or punished for attending to one’s own needs. I believe that listening for these dimensions releases us from the grip of a focus on pathology, and allows us to hear stirrings for an expanded world, even when those stirrings are filled with fear.

My ideas are based on a system’s view of what happens in treatment. There is no fixed, pre-determined pattern or set goals. Rather, what happens is an emergent property of a system of two interacting subjective worlds. For example, rather than seeing an experience the analyst is having as something the patient has put into her, i.e. a projective identification, I think it is more helpful to understand that a feeling that is evoked in the analyst is part of that system and based on the interaction of each participant’s history, current situation, state, goals and ambitions. Countertransference, rather than being viewed as an obstacle, is assumed to be present as part of the system at all times.

The connection between analyst and patient is partly based on the analyst’s awareness of conjunctions and disjunctions (Atwood et al. 1989) between herself and the patient. Conjunctions are when the meaning the analyst assigns to her patient’s experience is similar to the patient’s meaning; whereas disjunctions are when the meanings assigned by the therapist are discrepant with those of the patient. In contrast, in a classical analysis an agreement about how something is understood could be viewed by the analyst as the patient having good reality testing, and a difference in understanding could be viewed as poor reality testing. However, the way these conjunctions and disjunctions are understood through intersubjective systems theory, is to examine them to better understand their origins in a relational context. The pursuit to understand how the patient has come to organize and make meaning of experience enhances the connection between the patient and analyst. This is what happened with Catherine when we seemed to be at an impasse.

In the Beginning

Catherine was a 55-year-old woman who initially came to me feeling confused and emotionally fractured after a failed suicide attempt. Early on, I endured her challenging, confusing, and chaotic process. She told me I should not believe anything she said because she was always proved wrong by her family. She had made such a serious suicide attempt that she had to spend 5 days in intensive care before being admitted to the psychiatric hospital. I experienced considerable anxiety in the face of her florid suicidality; but what held me was my belief that the best hope for her survival would be through her sense of connection to me by feeling emotionally held and understood. When she told me she would not return to her first post-hospital psychiatrist because he told her to get rid of her stash of pills, I understood that she needed to preserve a way out of her crushing reality. I appreciated that this was her only avenue to a sense of agency at that time. I did not demand that she do something to reduce my anxiety.
An essential function I provided early in treatment was to listen to the flow of words that came from her and to sit with the silences as they occurred. The implicit message was that I was interested in her—that her way was just fine with me. This provided a perturbation to her organization of relational experience. She had never had her subjective experiences acknowledged, let alone validated through sustained empathic inquiry. In fact, she had not believed there was any place for her to enter into a dialogue with others; she preferred to retreat from the social world into solitary activities such as gardening and writing. My continuing interest in and efforts to understand her allowed her to begin to experience herself as someone who could affect another. This met a developmental longing to be understood and, however strangely unfamiliar my responses felt to her, they had the effect of violating her expectations of me as another person who would crush her with criticism, revulsion, and rejection. This new experience had the effect of destabilizing old forms of organization (Lyons-Ruth 1999). As I sat listening to her chaotic narrative my mind was busily attempting to make sense of these disparate threads. I tried to provide a reflective space as I kept the feelings and thoughts in mind and responded in a way that I hoped would allow her to see her experiences from another perspective. She wasn’t just a bad, angry girl as her mother saw her; she was desperate to be heard and acknowledged. Her mother couldn’t tolerate her active, energetic little self, worrying more about the shine on her floors than about her daughter’s tender feelings. My responses, based on listening for the developmental and repetitive dimensions, were in sharp contrast to her history of feeling her mother was constantly disappointed with her. Years of feeling repellant, totally unacceptable to her mother and others, and undeserving of recognition resulted in her organizing principle that she was ignorant, boring and worthless, and that no one would want to be with her.

I was primed to listen, enraptured by Catherine’s stories. As a little girl, I was not to read or held very often by my mother. Some of my fondest memories are of my grandmother sitting on the edge of the large bed I slept in at her house, scratching my back and telling me stories of her childhood in Russia. She was the one person by whom I felt nurtured: she fed me her home-baked goodies and vanilla ice cream with chocolate Bosco sauce. Part of the way I developed the connection with Catherine was by allowing her to speak without speaking much myself. My extended silences were intuitive, pre-reflective, and procedural.

I, too, grew up feeling defective, having had a mother who told me nothing she did for me ever helped and a father who abandoned me. In our deepest feelings of unacceptability, Catherine and I had an intersubjective conjunction. Fortunately, we also had an intersubjective disjunction, in that I did not share the negative attitude she had toward herself. Our ways of coping with unbearable feelings have been very different. Because of my need to keep my mother present for me, in light of the chaos in her life and her ever-lurking depression, I became her emotional caretaker. Part of propping my mother up was to give her the continuous mirroring she needed. I have described it as unconsciously climbing inside her body and looking out at the world through her eyes. Although I may have tended to over-accommodate throughout my life, this tendency also helped to prepare me for what Donna Orange (1995) calls “entering the other’s whole emotional predicament” (p. 16). Unlike me, Catherine took the opposite tack with her mother and became oppositional. When Catherine and I first met, she told me she went to boarding school as an adolescent because, if she had not, her fights with her mother would end by one of them killing the other. She devoted her life to trying to be nothing like her mother. What she lost in this, we have come to learn, was the ability to self-delinate in a positive way by accessing her own voice. She struggled to find her authentic voice through our work together. Initially, whenever I responded to her as an interesting, worthwhile and valuable person, she would say I was just doing my “therapist job.” With Catherine, I generally found this job to be an interesting and compelling one. This was because she provided an optimal responsivity that met my particular selfobject needs (Bacal and Thompson 1998). Catherine’s commitment to the analysis and her comments regarding my helpfulness to her gave me a feeling of effectiveness. The dynamic created by the particular characteristics of our dyad were beneficial and facilitated our analytic process.

**Hide and Seek**

The crashing, swirling flow of Catherine’s words and images were hypnotic, yet intriguing. At times I was almost lulled to sleep, falling into a semi-dissociated state as she went on talking. She spoke of having traveled to exotic places, having received a Fulbright scholarship at seventeen, and having studied at several prestigious universities. I was not sure what to believe, but I wanted to try to make some sense of all this information. Others might be put off by her presentation—the stained and tattered clothing she wore, the leaves in her hair, or her tsunami of words—but I wanted to hear more. I was desperately trying to follow her, as if we were involved in a game of chase, except that I could never quite catch her.

**Remembering Together**

I tolerated Catherine’s deluge of words and slowly tried to make sense of her story through contextualizing what
seemed, to her, random events. I attempted to connect her dissociated affect by lending my own affective responses as possibilities. This is much like helping children label feelings and provided the holding environment and scaffolding that she had sorely missed as an infant and child for integrating these frightening affects.

As she told her frenzied narrative, I often sat with chills running down my spine. For example, she told me how her second husband had fun shooting his gun around her as she sat on the couch. She laughed and said, “I was so mad at him for putting holes in it.” I was appalled. My reactions provided a kind of responsiveness that Catherine had never received. Where was her fear, I asked myself, as I did after so many of her stories. Dissociation again, I thought.

I understand Catherine’s lack of memory as a result of having lived with chronic emotional malatunament that led to an experience of discontinuity over time (Stolorow and Atwood 1992). Without an attuned relational environment, her affects were cordoned off in order to maintain whatever ties did exist. They remained as unformulated experience (Stern 1983). In the new relational context of the analysis, Catherine could begin to make sense of what had seemed to be confusing, unrelated events and feelings coming from nowhere. For example, much of Catherine’s memory was experienced in hallucinations and bodily states. She would hear knocks at the door but find nobody there, see “furries” scurry along the floor, and hear the sounds of someone in the house when she knew she was alone. She would also wake in the night, jumping out of bed totally disoriented, but with a sense of urgency that she needed to escape. Rather than focusing on the pathology of this or confronting her on “reality,” I understood these experiences as a lack of mental integration, which could only be attained through a collaborative relationship within which to articulate and integrate relational understanding and ways of being (Lyons-Ruth 1999). Together, Catherine and I re-created her personal narrative through continued exploration of meaning and affect. Her dreams and other non-verbal experiences, as well as her affect much of the time, contained a theme of impending annihilation. One dream was about a premonition that the boogey man was coming to get her and she had to hide. She went into a closet and jumped into a large box, trying not to disrupt the items sitting on top of it, so she would not be found. She told me she believed she could not make a peep. The associated affect was pure terror. “Aha”, I thought, here was the dissociated fear!

The few times she arrived late for her session, I worried that maybe she finally had killed herself. I would try to calm myself as my anxiety rose. My mind raced. Why hadn’t I insisted she go to the hospital? What would her family say to me? I struggled with doubts about the strength of our connection. When she did show up she kept talking, telling me her story in bits and pieces lacking any chronology. It has taken us years to weave together these disparate threads, and we still have a sense that the story is only partially understood.

Catherine often spoke of having been raped multiple times. In spite of tears and rage about many other things, she would relate these stories in a matter-of-fact way. In one session, as we began to talk about one of these experiences, I again focused on her affective experience, what she felt during a particularly gruesome tale of a gang rape during her high-school years. She began to sob. “I was so scared,” she said. “I thought I was going to die; but I tried not to show it, hoping they would let me go.” She remained sad and shaken throughout the session. The next day, she reported that these feelings were fleeting, although she had wanted to hold onto them. She was mystified by the fact that she could not retain those feelings of sadness, fear, and vulnerability without me there with her. We began to reflect on this together.

I understand this phenomenon through intersubjective systems theory as articulated by Orange (1995) when she writes, “The intersubjective ... field both organizes and gives meaning to emotion (p. 95).” Catherine’s feelings had never been met with any sort of empathic or understanding response, so they had been defensively walled off. They came to her attention in confusing and overwhelming ways, often not connected to the context in which they had originally arisen. “Remembering is experienced as dangerous because it includes the memory of being alone with whatever the trouble was, without the support and validation of [a] witness” (Orange 1995, p. 138). Catherine gained enough trust in me that the memories and associated affects could emerge in our intersubjective space.

The Tendrils of a Forward Edge

Early in treatment, and partly to ease my own anxiety about her suicidality, I told Catherine she could call me anytime. For months, she never called. Then, the night before she was to visit her mother at the family farm for the first time since her suicide attempt, she did call. As I was to learn, when Catherine called in a fragmented, traumatized state like the one she was in that evening, she just began talking, without introducing herself, as soon as she heard my voice.

“I don’t know what’s wrong,” she said. “I don’t understand!” It took me a moment to orient myself as to who was on the other end of the line.

“Catherine?” I asked.

“This has never happened,” she said. “I don’t know what it is, but I’m crying and shaking and I can’t stop.”

“Do you think you’re worried about how things will go with your mother?” I asked.
Catherine slowly calmed, and we talked about how she might experience staying with her cold and critical mother when she was still feeling so vulnerable. This conversation seemed to have been a turning point in our work. My authentic empathic response to her fragmented state helped develop our connection by increasing her sense of emotional safety with me. It was contrary to her organizing principle that no one would want to be with her, especially in her despair, and provided a perturbation to that belief. Not only did I tolerate her, but I was also trying to join her in making sense of her frightened and frightening feelings.

On returning to Los Angeles, she spent the next several months cleaning up her garden. When she was satisfied with the result, she invited me to come and see it. I had fantasies of being picked up by the psychoanalytic police for my infraction on the way back to the office. I was concerned, of course, about not gratifying my patient, but as I explored what it would mean to her, I came to see her request as part of the developmental dimension of the transference and in the service of greater self-articulation. She said I couldn’t really know her unless I saw her garden. When I was there I introduced myself to each and every one of her plants, trees, and one-of-a-kind ferns. She was like a proud mother pointing out all the skills of her precious and beloved toddler. Of course, I was duly impressed. I knew that inviting me into her space, her refuge from a cold, cruel world, was an act of bravery on her part. I understood my going to her garden, not as a provision, but as another step toward building our relationship and advancing the analysis.

Only in retrospect can the analyst know whether a particular intervention is useful. Judging from her delight and expansiveness as she guided me through it, I believe going to her garden was the optimal response because it was therapeutically most relevant at that time in the context of Catherine’s analysis and our particular relationship (Bacal 1998). In the garden, Catherine was able to show a vital area of herself that otherwise I could not have seen. There, she was an expert, and I could appreciate and take pleasure in her sense of agency. Catherine was demonstrating the developmental dimension, or what Tolpin (2002) calls the forward edge of the transference, which she defines as “transferences of still remaining healthy childhood development in the unconscious depths, albeit in the form of ‘tendrils’ that are thwarted, stunted or crushed” (p. 67). She wanted to know whether I could both tolerate and appreciate her. The mirroring and idealizing selfobject functions that I provided added to our connection and contributed to her ability to continue growing in an emotionally expansive way.

In marked contrast to her enlivened affect in the company of her plants, Catherine was filled with dread and anxiety in human relationships. The only significant relationship Catherine had when I met her was with a married man in a far-away tropical country, her paradise. She had been there nearly 40 years earlier with her first husband and continued to love this place half-way around the world, far from the bleak, cold, and desolate farm where she was raised. She met the man a couple of years before while planning a return trip and searching the internet for an old friend there. She believed this man was her twin, that she had finally found someone like herself, in a miserable marriage and suffering terrible depression. They began an e-mail relationship. She could show him the feelings, thoughts, fantasies, creative writing, and poetry that she could share with no one else. His responses were always inconsistent and finally became a trickle. I told Catherine she could e-mail me if she wanted. Thus began a new way to deepen our connection. My willingness to extend myself in this way came quite naturally to me and, again in retrospect, contributed to the thawing of Catherine’s embryonic self. In her e-mails Catherine could express her most distressing feelings, and I brought the e-mails into session where we worked together to contextualize and elaborate them. This process provided her with the opportunity to integrate and organize those feelings as meaningful, rather than simply as signs of her defectiveness.

I believe that allowing Catherine to email me was an important way to let her know that I wanted to hear all of her feelings. This was in marked contrast to her experience with her mother, who could tolerate almost no affect from her. She had always been told that she was too sensitive and just putting on or too exuberant and to settle down. On a visit home, she told her mother that she was feeling depressed. Her mother’s response was, “the lilacs need pruning.” Later, as we sat in session together, we were able to reflect on this experience and understand how repeated non-contingent responses like this contributed to her dissociation of affect and why she had always felt the need to run for her life. I believe the emails lead to a vital step in her development as Catherine began to bring her pain directly into the analysis. During a session, she told me in gruesome detail how she picked at the eczema scabs on her head and enjoyed the blood dripping down her face. I tried not to reveal my rising revulsion. My ability to relate empathetically was being tested by my sense of disgust, but I again tried to understand the meaning of Catherine’s actions within her subjective world. I interpreted these activities as a way for her to stay in charge of the pain, planning and knowing when it would come, rather than feeling sideswiped by other’s attacks. I suggested that it was a way she could test her ability to survive pain and that the scars were a visible sign of her suffering. She was then able to reveal to me, through tears, that she was, metaphorically, hemorrhaging inside. My interest in exploring and attempting to contextualize her affects allowed her to
elaborate and more fully express them and contributed to her gradually beginning to experience the validity of her psychic reality.

Co-creating a Coherent Narrative

Much of the second year of working together involved our developing an increased sense of coherence in her narrative. For example, I knew that she and her first husband had lived in two different cities in order to attend their respective schools during the week. They would stay at his school on the weekends. She told me with great bewilderment that she had made up a lie about her husband pushing her down some stairs as an excuse to leave the marriage and fly back across the country to her home state. On other occasions, when describing her experiences at her school in a big city, she spoke of roaming the streets into the early hours of the morning and wondered why she had not been afraid. At, yet, other times, she spoke of becoming involved in prostitution, being afraid of a pimp, and feeling a need to escape. Somehow, in the middle of her chaotic narrative, these disparate stories came together in a coherent way for me. I suggested that she had made up the story about her husband as a creative solution to escape from the dangerous situation of her involvement in prostitution. She experienced relief at our making sense of her confusing narrative and erratic behavior.

Almost two years into the treatment, Catherine was becoming more able to identify, articulate, and tolerate her feelings. However, she experienced ambivalence as she oscillated between the repetitive and developmental dimensions of the transference as foreground and background. She said, “Until therapy, I didn’t know I couldn’t exist.” The chronic malattunement she had experienced growing up contributed to her experience of herself as a frozen embryo. Winnicott (1971) describes how the baby learns of his existence by seeing himself in his mother’s face. I think that, because of the positively tinged feelings I had toward Catherine, she could look at me and begin to trust her perceptions, thus allowing her frozen state to begin to thaw.

Catherine’s ambivalence about her growing self-awareness and trouble tolerating the intensity of her conflicting feelings, especially about people on whom she depended, began to emerge in our work. This was reflected in an e-mail that said, “I’m wondering about all this therapy. I used to cry once every few years or so. Now it’s every other day ... I don’t know if I should thank you or kick you in the stomach.” The developmental dimension of the transference was reflected in a beginning sense of a self that could speak up rather than simply hide in silence paralyzed with fear at sharing her feelings. She became able to self-reflect rather than drink a pint of vodka to stop those fearsome thoughts and feelings.

Conclusion

Creating a therapeutic connection with a severely traumatized patient can help the patient regain dissociated memories, strengthen her sense of self, including integrating a wider range of feelings, and find her way back into a relational world. This was certainly true in my work with Catherine and led to the thawing of her experience as a frozen embryo: an incompletely formed being whose hopes for a fully embodied sense of aliveness had been crushed. Because the analytic process is dynamic, emergent, and intersubjective, it begins even before our first meeting with the patient. The hospital discharge planner who called me looking for a therapist for Catherine said that she was borderline and had a history of suicidality, two things that could trigger an aversive reaction in many therapists. I immediately felt compassion for someone being treated in such a pathologizing manner. Certainly, in the classical view, someone who presented in the chaotic, fragmented way she did would not have been considered appropriate for psychoanalysis. But, as Orange (1995) says, “analyzability resides in the analytic couple, not in the individual” (p. 49).

Creating the kind of analytic environment that helps the patient become more compassionate with herself and expand her world of potential, rests on principles outlined in this paper. First and foremost is understanding that organizing principles are based on real lived relational experience. Therapists come to learn these through the unrelenting use of empathic inquiry as a mode of psychological understanding and investigation. Doing so can enhance the connection to our patients as we seek to understand the meanings they attach to our actions (and those of others), rather than becoming defensive or trying to educate the patient to adapt to some “objective” view of “reality.” We need to hold in mind that we can unwittingly retraumatize our patients. This is a difficult idea for many therapist to entertain, but is essential to building a connection with a traumatized patient. Understanding of and attunement to the transference, including the repetitive and developmental dimensions and conjunctions and disjunctions, helps us view our patients from a non-pathologizing perspective, wherein the forward thrust for development is kept in mind. Finally, holding a view of the dyad as an evolving dynamic system with unknown possibilities helps contribute to an openness in listening. These principles can help our patients experience a sense of being understood in a way that can open the door to a more expanded life, including more intimate connections to others.
References


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